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The Honourable MaryAnn Mihychuk

Standing Committee on Indigenous and Northern Affairs

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● (1620)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): Welcome, everybody.

To those of you who have been waiting, our apologies. We had a number of votes in the House and couldn't get away for a 3:30 start. I would welcome you to come and join us at the table to present your information.

We're here at the indigenous and northern affairs committee and we're doing a study on long-term care on the reserve. It's always important for us to recognize that we're on the unceded territory of the Algonquin people. I come from the lands of Treaty No. 1 and the homeland of the Métis people in my riding of Kildonan—St. Paul.

Thank you very much for coming today.

We have three presenters. By video conference, we have the Okanagan on the right and Alberta on the left, and then we have a group in front of us.

Each group gets 10 minutes. After the 10 minutes, we'll have a series of questions from the MPs and that will run out the clock for the hour. Keep your eye on the clock, because I don't want to have to cut you off in the middle of a thought.

Chief Garnet Woodhouse, welcome. *Meegwetch*.

We're very honoured to have you here. Would you like to be the first presenter?

Chief Garnet Woodhouse (Chief, Pinaymootang First Nation): Good afternoon.

I am Chief Woodhouse from the Pinaymootang First Nation in Fairford, Manitoba. With me is Gwen Traverse, who is the director of health. She will be doing the presentation on what we are recommending for our community.

Once again, thanks to all of you for giving us this opportunity.

Gwen.

Ms. Gwen Traverse (Director of Health, Pinaymootang First Nation): It is an honour and a privilege to be here today to present to the standing committee on long-term care on reserve.

My name is Gwen Traverse. I'm the director of health for Pinaymootang First Nation, which is located in Manitoba's Interlake region. I have been a director of health in my community for almost 12 years. Prior to that I was away from my community for 17 years in order to get an education and work experience.

Upon my return and once I had been hired to look after health, one of the first things I noticed was how far back the first nation was in terms of meeting health care needs and how much jurisdiction has played a factor in creating division within health care for first nations. Today I have seen how community-based approaches have positively impacted our community by having services closer to home.

Pinaymootang is a thriving community, especially in the area of health. The community has an overall population of 1,700 on-reserve residents. Pinaymootang Health Centre is a health facility accredited by Accreditation Canada. Pinaymootang is under a five-year block transfer agreement under which transfer was first signed in 1998. Pinaymootang Health provides a variety of health and wellness services to support members of the community as well as surrounding neighbouring communities. Our goal is to operate an on-reserve continuing care facility that meets the needs of our first nations people in the areas of primary care and long-term care. This will allow our first nation members to receive care in a location convenient to their communities and their families, with services delivered in a culturally safe and respectful manner.

Pinaymootang does not have a long-term care facility in the community but is working on a continuum of care to address the range of holistic, medical and social services for those who do not have or who have lost some capacity for self-care.

In 2011, Pinaymootang First Nation, along with the three neighbouring first nation communities of Little Saskatchewan, Dauphin River and Lake St. Martin, were devastated by flood waters. This created many negative impacts for our first nation people physically, emotionally, mentally and spiritually, almost similar to the residual effects of residential schools, of being displaced. We are now slowly seeing repatriation happen after seven long years.

In late 2017, the first nation met with the provincial government on the repatriation priorities and impacts of long-term care. The first nation took the lead in the development of a comprehensive quality health service plan, with feedback from surrounding first nations within the Interlake region to ensure that a common position is identified in priority areas of health care services. Recommendations were provided and we have yet to see action being taken.

As part of repatriation, it has to be recognized that services in the Interlake have changed drastically. Some of the recommendations have included providing culturally safe and respectful services, ensuring retention of health care providers, improving access to comprehensive mental health and addiction services, improving access to emergency care, broadening the scope and mandate of health centres in first nations, and improving access to dialysis services.

Dialysis services in our area were once operational at full capacity, but since the flooding impacts and provincial budget cuts, we are now seeing many of our people accessing services further out, which causes financial impacts on our first nations.

We have faced many challenges when it comes to long-term care. Through the home and community care program, the palliative care component is now being funded and developed in our region. The communities have been providing palliative care with limited capacity. Respite services are very limited on reserve due to human resource capacity, lack of facilities in order to meet the need, and funding disparities in comparison with provincial systems, which then places the burden of financial care on families who live with limited resources.

There are non-indigenized care facilities near our community, and many times provincial policies dictate a first-bed policy, which can place our first nation's people in facilities that are a greater distance away from their home community and their families.

● (1625)

The home and community care program is a FNIHP-based program that was designed to meet the needs of short-term care nursing care. However, it is now functioning more as chronic care management for diseases and conditions related to issues such as diabetes, cancers and cardiac issues.

The first nations population is also prone to comorbidities. It is very common to have multiple disease conditions within the same person. For example, a person can be living with diabetes, depression, mental illness and cardiac issues. We also recognize that the disease process occurs earlier in our population.

In recent months, Pinaymootang has partnered with a private health firm to provide physician care services in the community. Since the beginning of this fiscal year, we have estimated that a total of 800-plus clients have been seen, and that is only increasing to the point where our human capacity cannot hold up much longer.

Pinaymootang Health Centre provides more of a primary health care service than what we are intended to provide. We recommend that health centres be evaluated based on the primary health care services they provide. We are providing services that are equivalent to a nursing station, yet we are designated and funded as a health centre.

Pinaymootang is filling an obligation to first nations in our area to bring services closer to home. In Pinaymootang we're also leaders in the Jordan's principle approach for the Manitoba region. Prior to the announced funding of Jordan's principle, we were funded under the health service integration fund as a pilot.

Pinaymootang developed a community-based approach program to assist families and children with disabilities. This program was successful in meeting the needs and was recognized as a best practice model with the Canadian Home Care Association. The first nation developed a tool kit guide in a 10-week period for Manitoba region to assist other first nations in developing and implementing their Jordan's principle programs. We have provided service coordination to half of Manitoba's first nations as well as to other regions.

There were also research projects developed in July 2017 by McGill University on the challenges of our first nation members faced in accessing services. To date we still see gaps in service such as the capital to properly facilitate care and the age out process. There is a high expectation that once age out occurs, those under Jordan's principle should transition into home and community care when, in fact, this expectation is unrealistic, given the human resource capacity in first nations and the complex needs of those affected who require long-term supports.

Many families want to take care of their own, and by saying this, we recognize that these initiatives should be grassroots-driven and that expertise should be acknowledged within first nation communities.

In closing, I want to say that Pinaymootang has worked really hard to improve systems in health care and the challenges we face to restore the dignity and pride that is lost. We foresee greater needs and greater demands for service, and we have an obligation to ensure that our most vulnerable are well cared for.

Meegwetch.

● (1630)

The Chair: *Meegwetch*.

Our next group, our next presenters, are from Calgary, Alberta: Piikani Nation.

I turn it over to you. You have 10 minutes.

Welcome.

Mr. Keith Grier (Chair, Health, Aakom Kiyii Health Services): Good afternoon, everyone, and thank you for giving us the opportunity to act as witnesses and make a presentation to the Standing Committee on Indigenous and Northern Affairs.

First off, I'd like to introduce myself. I'm Councillor Keith Grier, chair of Aakom Kiyii Health Services advisory committee. To my left, I have our health director, Dustin Wolfe, and to my right, I have council member and advisory committee member Troy Knowlton.

I'd like to say thank you on behalf of chief and council, Aakom Kiyii Health Services, the Piikani Nation membership and our elders for giving us this opportunity. It is a great privilege and an honour to be heard by your committee and to speak on behalf of our elder continuing care facility.

I'd like to give you a little bit of background and our geographical location. The Piikani Nation is a proud member of the Blackfoot Confederacy and Treaty 7, which is composed of four member nations. The Blackfoot Nation is located in Montana, U.S.A. The remaining three sister tribes, the Kainai, Siksika and us, the Piikani, are located in southern Alberta. In total, we comprise approximately 45,000 Blackfoot members.

The Piikani Nation, along with all the member nations I mentioned, are on a journey to reclaim and preserve the Blackfoot language and practise traditional and spiritual values and norms that are consistent with the Blackfoot customs.

The Piikani Nation is a population of approximately 3,700 registered members, of which 2,500 members live on the reserve. The Piikani Nation is located west of the town of Fort Macleod in southern Alberta, and east of the town of Pincher Creek.

The Piikani Nation is a proud and productive growing community, and we have a diverse range of health care needs. Aakom Kiyii Health Services, AKHS, exists to serve these health needs and has done so for many years through our contribution agreements with the federal government.

With our population rapidly growing, with young families, young people and rapidly aging older members presenting increasing rates of multimorbidity, our nation wants to be proactive and future-oriented in our approach toward health care. To address these population trends, our nation wishes to pursue planning for a better future for our elders living in the community through developing an accredited, on-reserve elderly continuing care facility. In pursuing this initiative, the Piikani Nation wishes to build a 40-bed large care centre for the nation's elders, on reserve for proximity to family members and on traditional lands.

The Piikani Nation also wishes to design and deliver a continuing care program that's Piikani-centric, while meeting the standards of care defined by the Alberta Health Services, AHS. In doing so, we would incorporate Blackfoot traditional practices and language, employ Piikani Nation members, integrate into other departments and programs in the community, maintain an AHS long-term agreement, and hopefully develop a tri-party agreement among the federal, provincial and the Piikani Nation governments.

Currently, Aakom Kiyii Health Services provides a variety of primary care, community care, home care and preventive services. However, elders require supportive care, long-term care, respite and restorative care, and palliative care, as we know.

Currently, we do not have a facility on the reserve, and those requiring those services must access AHS-funded facilities in Lethbridge, Fort Macleod and Pincher Creek. Unfortunately, the situation separates nation members from families, traditional lands and practitioners who are familiar with the Blackfoot language, traditions and customs.

We are in a time of truth and reconciliation with the federal government, provincial government and first nations across Canada. It must be understood that a lot of these health issues are a direct result of extreme stress and the poor socio-economic status of first nation people, and they have a long-term negative effect on some first nation people across Canada. The Piikani Nation is no exception.

● (1635)

The extreme stress I speak of is poor federal government policies that were introduced and are well known to first nations people across Canada as the residential school era, where, as you know, for 140 years children were legally and forcefully taken away from their way of life, their parents, everybody they loved and everything they knew, and introduced into a Eurocentric world view.

The Health Council of Canada report also indicates that the lasting effects of residential schools have been described as a form of post-traumatic stress disorder. Many first nation elders delay seeing health care practitioners and professionals regarding their symptoms until they are seriously ill, as they are afraid their diagnosis would mean that they would be sent away and never returned home.

The proposed Piikani Nation continuing care facility would put elders with trusted, skilled and locally trained professionals, assuring them that their health concerns would be raised in a safe environment. Under the first nations transformation agenda, first nations, the federal government and provincial governments have identified reconciliation of health outcomes that exist for first nation communities as a priority.

I believe an elderly care facility would assist in filling those gaps by providing a safe and culturally appropriate environment to grow old in, improved health care for our elderly, and familiar surroundings, culture, language and relatives leading to a richer patient experience. It would provide a learning space where Piikani professionals, researchers and AHS officials can share ideas, develop new approaches and test innovative practices for other indigenous communities. It would expose Piikani youth to various health care careers, as well as provide opportunities for language, culture and tradition to be shared and passed down from the elders before it's too late, as well as opportunities for family members to visit more frequently.

The proposed facility would be one step in addressing an unacceptable statistic highlighted here by our nation, ownership in our own community over elder care and ensuring opportunities identified by our nation.

The Piikani Nation would have to comply with the specific mandatory requirements and standards that govern both accommodation and health services for continuing care. These requirements are in place to ensure accommodations maintain a high level of service, i.e., meal preparation, building maintenance, security and housekeeping, which promotes safety and security and a better quality of life. We will work and consult on an ongoing basis with Alberta Health Services to ensure a proper level of care and services will be offered, and how the facility would be staffed with respect to the number and type of health care and support staff.

On page 25 of the feasibility study that we have shared with you, operating expenses associated with a large 40-bed facility were estimated based on actual operating expenses obtained by Meyers Norris Penny, one of our partners, for an existing large elder care facility operating in Ontario. The cost to operate the facility in a centralized building concept is $617,253 annually.

We've looked at the capital costs that need to be laid out for this facility. The construction and site development for a large facility would require considerable investments—we know that. However, we feel that with the current population trends and the health issues that exist with our elderly it is justifiable. The actual cost of construction would be determined after final drawings, fit-ups and construction firms are chosen. A table is provided on page 24 of our feasibility study, and the cost would be $11,419,002.

We have partnered with the Good Samaritan Society. We have also partnered with AHS, which is Alberta Health Services, and we've partnered with MNP.

● (1640)

In closing, the Piikani Nation, in conjunction with Aakom Kiyii Health Services and our partnerships, have been committed to developing and establishing an accredited 40-bed elderly care facility to provide an overall richer experience, and one rooted in Blackfoot customs.

I'd like to thank the standing committee for hearing us and listening to us, and reviewing our feasibility study. Thank you for your time.

The Chair: Thank you.

I just want to point out that the study referred to has been sent in and received, but it's in translation. You'll get it when that process is complete.

Our last presenters are coming from British Columbia. They're from the Okanagan Indian Band.

Whenever you're ready to go, you have 10 minutes to present. Thank you again for coming. Go ahead.

Mr. Allan Louis (Band Councillor, Health, Okanagan Indian Band): Thank you, Madam Chair.

Thank you for the opportunity to participate in this discussion. I'll do quick introductions, and then we'll get started. Gareth Jones is the community service director and April Coulson is the home care manager. We're going to divide this into three equal presentations.

I just want to give you a bit of information about who we are. The Okanagan Indian Band is located in Vernon, B.C. We're part of the Okanagan Nation, which consists of seven bands. The seven bands are all located in the Okanagan Valley, and mainly in Penticton, Kelowna and the Vernon area. There are approximately 5,500 people in our nation. Our community chief is Chief Byron Louis. Our grand chief is Grand Chief Stewart Phillip.

With that, I know time is short, so I will get started.

Currently the Okanagan Indian Band has approximately 2,100 members. Currently about 428 of them, which is about 25%, are aged between 50 and 64. In five years, we're going to have trouble taking care of what amounts to about 25% of our population. They will be over 65, or in that ballpark. We won't have the capacity to take care of our people if our program funding doesn't change.

The Okanagan Indian Band does not have a long-term facility. The Okanagan Indian Band's health services program offers home care services. Home care programs are not structured or funded as long-term care. This results in gaps in continuity of care. They require regular and mandatory assessments for eligibility.

Clients of both programs must be status Indians living on a reserve. This creates a hardship for people who can't afford to live in our community. Housing is one of the large issues of not having enough homes for everybody to be in our community.

Both programs have criteria and limited funding to provide care to clients in need of extensive support, resulting in requests for long-term care placements sooner.

● (1645)

Dr. Gareth Jones (Director, Community Services Department, Okanagan Indian Band): I'm going to speak about our adult home care program. It's currently funded under Indigenous Services Canada to help our home care service workers who work within that program, primarily providing home cleaning, meal preparation, transport to social activities and companionship. These activities obviously help to allow many of our clients and members the opportunity to maintain their independence within the community.

Within that we run our home and community care program. These services are needed to support and often use simultaneous support from family members as well. Our team of six people includes one registered nurse, one manager and four home care aides. They support the day-to-day operation of the health services department with two additional on-call health care aides to assist when others aren't able to attend.

The goal of home care services is to keep our clients physically independent, safe and at home as long as possible. The home and community care program is funded through the First Nations Health Authority.

The team provides an opportunity for clients to continue living in their homes, even those with complex health conditions. They add an additional challenge to the team, and we are able to provide them with personal care, medical monitoring, assistance in eating and dressing, and therapeutic care, including exercise interventions to help reduce falls and some light home management and repair to keep homes safe. We also provide transportation to medical appointments.

Our health services program has additional supports for our clients and elderly population. They come to our band clinic to help with foot care, bathing and a drop-in day program. We also provide services for wound care, nursing assessments and referrals, and we offer monthly pharmacy reviews. We also help to provide hospital discharge planning, respite care, medical equipment support and health promotion activities. But that's only done by a few people and obviously the challenges become bigger as we have more and more people entering our home care program.

Currently in 2018, our community care members have accessed approximately 145 members of our community who have sought the help and assistance of our health care services through the community care program. Twenty-seven of those individuals are enrolled through our adult home care and 24 individuals are registered through our home and community care program with an additional 63 individuals accessing regular home care, nursing specific for wound care, physical assessments, intravenous treatments and injections.

Mr. Allan Louis: We want to also touch on the challenges of long-term care needs on reserve. Although our health services program provides support to those still able to remain in their homes, this program cannot sustain when care needs exceed the program's abilities—for example, clients who require 24-hour care, monitoring or assistance with activities of daily living.

At this point, placement into long-term care is often recommended. However, there is a lack of culturally appropriate facilities in the surrounding area. Wait-lists for community facilities are lengthy and often difficult to organize through DISC funding. It is mandatory that clients accept the first placement offered or risk being placed at the bottom of the waiting list again.

The other issue or big challenge we have is transportation. We are currently located outside the city of Vernon. Some of our band members are as close as 16 kilometres, but others are 40 kilometres away, making travel appointments costly and difficult at times. We currently have some transportation that the health or social development departments have, but they are aging out and currently we don't have funding to replace them. We also have staff who are using their own vehicles. They have challenges with maintaining a vehicle on the wages and expenses given through the First Nations Health Authority.

One of the other problems we have as well is training and education. We've made some great strides in education. We're proud of our heritage and culture. We work with the local school district. We have our languages taught in local school district 22. We have problems with obtaining training funding for long-term front-line workers: health practitioners, doctors, as well as even care aides. We get some funding to make this possible, but we have problems keeping our members in our own community with outside agencies like Interior Health, First Nations Health Authority and the private sector stealing away our members because we can't play on a level playing field when it comes to wages.

When it comes to home safety, often community members require mobility aids for safety that are not covered by the First Nations Health Authority. Examples include wheelchair ramps, grab bars, hip protectors and stairlifts. These are difficult to find funding for. There is a lack of funding for nutritional supplies and vitamins that impact the health and strength of the clients as well.

Many of our homes are in need of repairs, repairs that are necessary to prevent falls and maintain employee and client safety. However, funding opportunities are limited, and community members are again left waiting for months for approval for renovations and gaps. Many of our houses are two storeys. When they were built, we didn't consider the aging out of many of our baby boomers. Now we're faced with bathrooms and bedrooms on different floors from the main living areas.

● (1650)

The Chair: I hear you.

Let's try to wrap up.

Mr. Allan Louis: I'll let you finish, April.

Ms. April Coulson (Nurse, Home and Community Care , Okanagan Indian Band): A long-term care facility at the Okanagan Indian Band would address a lot of the gaps we talked about and would help with the continuity of care. Access to culturally appropriate long-term care is very limited right now, as it's 64 kilometres away. Okanagan Indian Band faces a lot of barriers for transportation and for the ability to maintain relationships and connection with their aging family members if they're that far away.

It's also important to note that while the first nations facility is there, it's rooted in their culture. It's not rooted in Okanagan Indian Band culture. The cultural connection piece is missing. The impact of removal from one's community can be very traumatizing and symbolic of removals endured in childhood.

The Chair: Thank you.

Thank you to everyone who has presented. I know that 10 minutes just disappears and that you have a lot to say to us. We appreciate that you are trying to put it all in so quickly.

Now we move into our question period and we begin with MP Yves Robillard.

[*Translation*]

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Thank you, Madam Chair.

Thank you for your testimony.

My first questions are for Chief Garnet Woodhouse and Ms. Gwen Traverse.

In a report of findings and recommendations, entitled “Honouring Jordan's Principle”, you compiled the challenges related to services for children in your community.

What recommendation related to Jordan's principle would you make as regards long-term care in your community?

● (1655)

[*English*]

Ms. Gwen Traverse: I'm really happy that Pinaymootang led the way for Jordan's principle in the Manitoba region and in some of the gaps and services that our families have faced.

In terms of long-term care, one of the recommendations that I would make is the age-out process. Right now, there's a fear that, once age-out occurs to our children that have these disabilities, they will fall through the gaps again, once they're transitioned into the home care program. Right now, the home and community care program is not feasible for them to just transition because our resources are too limited in the community to provide care, especially to those who have complex needs.

Through Jordan's principle...of course, we were a pilot. One of the biggest issues was also the capital, in order to ensure better care and service in our area. Still, even though we underwent an expansion of our health facilities, it was just not enough.

However, it is progressing. The family stories.... We're also involved as one of three programs selected on a national basis to do an evaluation. I think we justified the need to continue the program. I'd like to see more OT services happening in our first nation communities because it's just not there. The mental health aspect of it is huge.

[*Translation*]

Mr. Yves Robillard: Apart from building facilities on reserves, what measures could facilitate access to long-term care for members of your community?

[*English*]

Ms. Gwen Traverse: A facility on its own would help maximize the services through Jordan's principle. The reality is that the funding that just came into play was given to first nations. It was like, "Here is your funding. Run with it." There's a lack of facility space in our first nation communities and that was one of the biggest gaps and challenges that we had to face.

Right now, in our first nation, by going through the expansion process, we've identified two rooms in our health facility to accommodate six people, who are members of the Jordan's principle program.

[*Translation*]

Mr. Yves Robillard: Thank you.

[*English*]

I have a question for the people on the video, but in French. Is that okay?

The Chair: I think they have translation. Please go ahead.

[*Translation*]

Mr. Yves Robillard: My next question is for Mr. Lowell Yellow Horn and Mr. Troy Knowlton.

Your community has an elders' group called the Peigan Crowlodge Elder Society, which provides various programs and activities for the mental and social well-being of seniors in the Piikani nation.

Can you tell us more about their services and the challenges they face, given that your community does not have a long-term care facility?

● (1700)

[*English*]

Mr. Troy Knowlton (Council Member, Piikani First Nation): My name is Troy Knowlton. The Crowlodge Elder Society is a group comprised of those who are able-bodied and are interested in participating in activities on the reserve and activities that the centre provides. They do fundraising initiatives for themselves and for some of the other special interest groups on the reserve, whether for cultural, scholastic or athletic endeavours.

In terms of some of the benefits they have, they meet once a week. They develop an agenda for the following month on what types of activities they are going to participate in. They fundraise for these activities, and they travel to different areas within our Blackfoot traditional territory advocating for the Blackfoot people, in recognition of what our territory is.

As I said, most of the people there are of able body. They are aging. I think our oldest member is 92 years old. It's a social group. They have nurses and health care aides who will come in and take their vital signs while they are there, during these activities, to help them identify any problems that may be coming up. They also support each other in wanting to make sure that they are well at home, that their home care is adequate, and that they have somebody there to care of them.

It is a rather small group when you look at the total number of elders because it is voluntary to be there, and we do have a lot of elders who are not able-bodied and are not able to negotiate the type of transportation in order to participate. It is quite centralized, and the elders' stories and wisdom are utilized by our schools, day cares, and so on, in their daily programs.

The Chair: Great. Thank you.

Questioning now moves to MP Arnold Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair. Thank you to our guests for being here.

I want to go to the folks from Osoyoos. You mentioned that you have your own health authority. Could you broaden that out and explain to us what that entails? How does long-term care fit under your health authority?

Mr. Allan Louis: Osoyoos is one of our communities in the nation. We're actually from the Vernon part.

Mr. Arnold Viersen: Oh, Okanagan, sorry.

Mr. Allan Louis: That's all right.

The health authority is British Columbia First Nations Health Authority. All funds that flow through the federal government flow through the health authority and out to the nations. Currently, instead of Health Canada handling funding for health in British Columbia, First Nations Health Authority does that on behalf of Canada.

Mr. Arnold Viersen: Okay, so that's not just for your band. That's for all first nations in British Columbia.

Mr. Allan Louis: That's right, yes.

Mr. Arnold Viersen: Is that unique to British Columbia?

Mr. Allan Louis: Yes, it's the only one in Canada.

Mr. Arnold Viersen: Is it working reasonably well?

Mr. Allan Louis: Yes, we believe it is. There are growing pains. We're only in the fifth year.

Mr. Arnold Viersen: All right.

I'll move to the folks in Alberta. Do you have anything like your own health authority?

Mr. Dustin Wolfe (Director, Health, Aakom Kiyii Health Services): No, we don't.

Mr. Arnold Viersen: Are you working towards it, or are you going it alone as your own band, so to speak?

Mr. Dustin Wolfe: We're going along as our own band. I don't want to speak on behalf of my councillors, but there was some talk about a confederacy initiative.

Mr. Arnold Viersen: Okay.

Mr. Keith Grier: Right now, we've transitioned from a Treaty 7 management into the Blackfoot Confederacy. That still needs to be talked about a little more.

Mr. Arnold Viersen: Would the Blackfoot Confederacy be cross-border?

Mr. Keith Grier: Yes. The Blackfoot Confederacy is comprised of the four bands that I talked about, but when we negotiate on the Canadian side, it's mostly Piikani, Kainai, and Siksika. They make up the Canadian side.

Mr. Arnold Viersen: One of the previous witnesses we had here talked about first nations. He said that they are caught between the bark and the wood of a tree, referring to the provincial and federal jurisdictional issues around health care. We see that in B.C. they have their own health authority. How have you dealt with that at this point?

● (1705)

Mr. Keith Grier: Right now, it's set up so that we have an operational agreement, or a contribution agreement, with the federal government. We have to comply with those regulations. The health director administrates that on its behalf.

As far as AHS, Alberta Health Services is concerned, right now it's just conversation-level. There are still those jurisdictional issues we have, with them coming onto the reserve. I can give you an example. When they did their study on how many people they would actually fund in a master, just in conversation they suggested they would only fund 10 beds based on the surrounding information. The one thing they didn't have access to was our nation membership on the reserve.

That's why we actually lobbied for funds to get the feasibility study that targeted our nation membership who lived on the reserve. I believe appendix 9 of our feasibility study outlines how many people are in need of those services and what their multimorbidity issues are.

Mr. Arnold Viersen: One of the other things we have heard from previous witnesses is around cultural sensitivities, particularly around food. Have you had any interaction with how that's run, or how that's dealt with in your community?

Mr. Keith Grier: Dustin, go ahead.

Mr. Dustin Wolfe: Back in the day, we had our traditional diets. Having been taken away from that is why we see all these health detriments that we're dealing with now. It's on account of getting away from our traditional diets. We have conversations with individuals who we are going to be bringing into the continuing elders care, to have everyone up to speed on that option of having our traditional diet in place so that health conditions could improve for our people. We're not only starting there, but also starting with our youth and helping them see that this is traditionally what we ate, and then mix it with exercise.

It's a learning process, but it's just getting the individuals who we are going to be bringing into the elders care centre up to speed on where we are as a people traditionally.

Mr. Keith Grier: I will add to that. As you look at it right now, a lot of the time our elders have a limited amount of funds. The socio-economic conditions are limited for them, so they end up buying a lot of refined sugars, a lot of refined flours and things of that nature. Those are definitely not part of our diet, as you know. Processed meats and things of that nature versus wild game....

When we do have ceremonies, we offer a lot of wild game that the hunting community offers to our elders. We definitely need to look at getting back to a diet that's consistent with a holistic approach for first nations people, versus what we eat today. The dollars for a dietitian are pretty short in the contribution agreement, as you know.

Mr. Arnold Viersen: I have one last question.

The Chair: Make it very short.

Mr. Arnold Viersen: Do you have a plan?

One of the things we always hear about is the lack of personnel for long-term care facilities. I'm sure you're working on building capacity within your own community. Do you have a plan? Probably all you have time for is yes or no.

Mr. Dustin Wolfe: Yes, we have, but look at our population—45,000 members. Yes, we do.

The Chair: Questioning now moves to MP Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Hello, and thank you all for being here with us today.

Throughout this whole study, we've heard many times that indigenous communities are often far behind the rest of Canada due to a lack of long-term funding. We hear that jurisdiction is a huge barrier because it's part of this going back and forth. I heard a couple of mentions today of issues like if you don't have a status card on reserve and you're there, you can't be eligible for those services, and trying to figure out how you're going to support the community to the best of your ability.

I'll be happy to start with Ms. Traverse first. I'm just wondering if you could just talk a little bit about what that means, to be behind. You talked earlier about palliative care and how you're trying your best to provide it, even though you don't have the actual resources to do it. If you could talk about some of those challenges, I would appreciate it.

● (1710)

Ms. Gwen Traverse: I have a really strong vision of Pinaymootang being a hub centre, providing primary health care, long-term care within our community based on the 2011 flood impacts. We're slowly seeing communities repatriate homes, but once these communities repatriate homes, everyone's at different levels of health service.

Pinaymootang wasn't one of the communities affected as drastically as the surrounding communities nearby that are 10 to 15 minutes away. Throughout the seven years, we've seen changes happening in our health care that weren't improving. They were changing drastically. We had physicians turn over every two to three years, so there was no sustainability or continuity of care, especially to our diabetes clients.

We took every initiative to ensure that we were bringing services to our community. That's why I made mention that we partnered with a private health firm. If we don't do it, who's going to do it for us?

We partnered with a private health firm from Winnipeg that travels two and a half to three hours to our community just to provide service. We also partnered up with the regional health authority, but it's so limited. Their contract physicians don't care to even provide that continuity of care, so sometimes they'd rather see 10 people while this physician sees 50 and up. It's causing a really high strain on the human resource capacity of our staff.

Based on the impacts we face, we're going to see a high need for mental health, and a high need of care and service for these people who don't have. They're beginning from scratch. The closest place for them to come is our facility, and we can't help but feel an obligation to our own first nation people. If the provincial government is not going to do it, who's going to do it? The liability falls on the first nation.

Ms. Rachel Blaney: Thank you.

I'm going to go over to Piikani. Going back to that part about the jurisdictionality being a barrier and how you interact, one of the things we're seeing clearly is that it's different in each province. If we're going to look at it as a national issue, how do we look at that but also understand the nuance? If you could talk about that, I'd really appreciate it.

Mr. Keith Grier: It's pretty much a line drawn in the sand. The Alberta government sits on this side, and we're federally funded. There are conversations about their being able to provide in-kind services, but we're strapped for funding. Our population is growing fast like every other first nation. We have the same challenges as everybody else.

The funding agreement, pretty much 70% of it, is allocated to the employment of those folks inside the existing Aakom Kiyii Health Services department, and then there's so much for programming. The programming is where it falls short, because there's a large demand on the services.

We've tried to address that issue with Alberta Health. At this point in time, it's challenging to say the least, but yes, there's a very clear distinction in Alberta. There's a very clear line that has been drawn.

Ms. Rachel Blaney: I would like to put the same question to the Okanagan Indian Band. Just where does the rubber meet the road, and what are those challenges to really get the services you need for your community? How challenging is that jurisdictionality?

● (1715)

Mr. Allan Louis: As you know, I mentioned earlier that we're under the First Nations Health Authority here in British Columbia. Each region—there are five regions—deals with different health authorities. In our region it's the Interior Health Authority. We've made some headway with sharing information. If a patient goes to the hospital, our staff are informed, but sometimes it takes a little bit too long. It might be a couple days behind when the patient is actually in the hospital, and we're not aware of it. The Interior Health Authority in our area takes care of first nation members who live off reserve and also takes care of our needs when we have to go to a hospital or long-term care or palliative care. We have huge issues just as everybody else does.

Currently, with the First Nations Health Authority [*Technical difficulty—Editor*] agreement that we [*Technical difficulty-Editor*] twice a year and work through some of these issues that are pretty blatantly obvious and try to break down those barriers. I think that's one thing we've done well. Change can't come fast enough. We're worried about the people who are on the ground needing—

Ms. Rachel Blaney: Sorry to interrupt but I have only a second.

In the five years that you've had that health authority, have you noticed a difference for your community, in discussing that jurisdictionally?

Mr. Allan Louis: Yes. In terms of the relationship, it's small but we are moving in the right direction.

The Chair: Thank you.

We now move to MP Will Amos.

Mr. William Amos (Pontiac, Lib.): Thank you, Chair.

Thank you particularly to our witnesses today. This is important testimony. I think many of us here in the room are on a steep learning curve because these are experiences that we have not lived through ourselves. The field of health is one in which, obviously, the province is traditionally predominant, so it's not an area in which I feel particularly comfortable or in any way an expert. I'm a layperson.

I'm interested in knowing about the federal programming with which your communities are engaged directly. What aspects of the services provided do you think are being done well and you support and would encourage more of? What are the aspects for which you think the way the federal civil service is structured or what is being done could be improved? I want to give you an opportunity, because we're going to hear from them as well. I'm sure they will admit they'd love to have more funding to do more things, including capital investments. I think this is a great opportunity also to learn about that.

I'd like to give each of our witness groups an opportunity to speak to that.

Maybe I'll start with Ms. Traverse.

Ms. Gwen Traverse: In terms of what's working federally, the Jordan's principle fund aimed at children with disabilities has worked very well. It has allowed our children to be kept at home rather than having to go off reserve to ensure they get those services. That was one of the best solutions governments had, funding Jordan's principle aimed at children with disabilities.

In terms of what's not working for us, we're being funded as a health centre, but we're providing more primary health care. Health centres provide prevention, education and awareness, but we're working more beyond that scope. We're providing a service that's more of a nursing station than anything else. We're trying our best to improve systems within what we have in our own community and to ensure that services are being offered in our own home communities.

We need to be recognized as a nursing station rather than a health centre. As I mentioned, we've served a total of more than 800 clients in our communities, as well as the surrounding communities. The non-first nation communities have been travelling into our community just to see our physician, because there are so many things happening within the regional health authority, such as for ambulances, emergency room closures, or physician services that are closed. Our community had to do whatever it took to ensure that services are being provided in the community.

Fund us as a nursing station that's providing better primary health care. As well, what I'd like to see is a long-term care facility nearby in our region that will help serve the surrounding communities, one that's more indigenized and could offer more services. Right now, we have five community members in acute care who have been waiting for two years already to get into a personal care home. It has been a struggle.

Again, going back to the flooding, that caused huge impacts in our communities and it still does to this day. That's why I made those comments. There are going to be greater needs and greater demands in services, especially the mental health aspect.

● (1720)

Mr. William Amos: Okay. Thank you, Ms. Traverse.

Chair, how much time do each of our remaining three witnesses have to get their grain of salt into this meeting?

The Chair: You have about two minutes.

Mr. William Amos: If you could be brief in your comments, I would appreciate that, because I think getting your perspective on where we can do better would be helpful.

The Chair: Specifically who are you going to start with?

Alberta looks very anxious. Go ahead.

Mr. Keith Grier: You had asked what is working.

Our home care program seems to be working, but we're short in attracting good, qualified nurses and health practitioners. They want to go somewhere else. We need the dollars and the capacity to be able to attract those people. That's the way it seems to be nowadays, because if you look at the amenities they're being offered by the surrounding towns, that to anybody is attractive, rather than having to come to a reserve where there are minimal amenities and minimal housing. They have to travel in. Those types of components are ones we have to think about.

Some of the shortfalls we see are definitely in medical transportation. It seems to be a big one. With the gas support and being held by non-insured benefits, there seems to be a logistics problem there.

You have to remember that there's a responsibility of the federal government under treaty. It has a fiduciary duty to uphold the proper funding for the nations. We're not seeing that.

I'll give you an example. In Alberta's budget last year, I think they budgeted $21 billion to go into health care. That's over half their provincial budget. If you work that out, it's about $5,200 in expenses on a per capita basis across the province. The federal transfer dollars, we all know, are probably about $1,075 per capita, and then we're only getting half of that on the reserve.

Those are the shortfalls that I see.

The Chair: You really didn't leave any time for B.C., but I'll leave that between the two provinces. There was no time for B.C.

Questioning now goes to MP Arnold Viersen from Alberta.

We know you're going to give everyone a fair shot.

Mr. Arnold Viersen: Thank you, Madam Chair, and you know, we have lots of grace for B.C. when we get a pipeline built.

I'd love to hear B.C. out on the same question, for sure.

What seems to be working and where can we make some improvements?

Mr. Allan Louis: Working for us is the First Nations Health Authority. We have the ability to work with First Nations Health Authority to build partnerships with regional health authorities like Interior Health in our area. We work on common things. A big issue in most regions is racism. We work with cultural programs looking at [*Technical difficulty—Editor*] that are delivered in hospitals. This wouldn't be possible if we didn't have a good relationship, and it all started with First Nations Health Authority.

We're looking as well at innovative programs that should change how we fund communities. I speak as a First Nations Health Council representative. I also sit on the health council of British Columbia, so I do know what's going on with the health authority.

What's not working is some of the things that are out of our control. When it comes to healthier citizens or members, we have issues with housing, which is out of the control of the social development department. Education funding is not part of what we control, but it has a big input in how our citizens live and have the ability to make a living.

We all know that the more.... You don't have to be rich, but at least close to middle class, in order to eat better and have that sense of.... I don't want to [*Technical difficulty—Editor*] because it's not just about money. It brings you the ability to do what you want to do, including what you eat, to partake in cultural events and to raise your children and send them to proper schools. That's is a big one for us.

The other thing that doesn't work is [*Technical difficulty—Editor*] planning dollars. We live day-to-day when it comes to social development. With a skeleton crew and our numbers increasing every day, it consumes our time and our community. We don't have time to hire or we don't have the funds to hire people to do the planning that we need to carry us into the next five or 10 years.

● (1725)

Mr. Arnold Viersen: Thank you.

I'll just going back to British Columbia for a moment.

You touched on this a bit, that an ounce of prevention is worth a pound a cure. How is the health authority helping you with working on the front end rather than working on the back end?

Mr. Allan Louis: I guess the best way to describe it is this. One of the elders at a meeting in British Columbia told us, “We have this river of people who are sick that keeps flowing by us”. We have to start investing in preventing people from getting into that river in the first place. We have to start investing in food safety and how we eat so we don't get diabetes. We have to look at the reasons why our numbers in cancer are rising and why our children are hungry going to school. All that wraps around a healthier citizen.

Another thing is that we're looking for partnerships with education, because we know that people who are better educated live longer and have healthier lives. For example, we discovered that people who have a second or third language tend to have more active minds, and they are usually healthier individuals, so what we're trying to do is to encourage first nations in British Columbia to recapture their language.

That's one of the big pushes that we've done in our immediate community. We have School District 22 onside, and they use the nsyilxcen language as a second language in our community, but we also got the universities to recognize it in British Columbia. They can use the first nations second language or first language, which is their community language, as a alternative to French or....

Mr. Arnold Viersen: That's good.

Thank you.

The Chair: We don't have any more time. Any second now the bells will ring for us to go back to Parliament for another vote.

Before we adjourn, I want to thank everybody for participating in today's hearings. Your testimony will be in the official record and your words will make up part of our report. That's the relevance. We will have the opportunity to give that to all parliamentarians, so what you're recommendations are going to be heard by the ministers, all parliamentarians, and will be in the record for all Canadians.

Meegwetch. Thank you for coming and taking the time on the video conference. It's appreciated.

The meeting is adjourned.