HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Indigenous and Northern Affairs

INAN • NUMBER 118 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Wednesday, September 26, 2018

Chair

The Honourable MaryAnn Mihychuk

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● (1530)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): I call the meeting to order. Welcome, everybody.

It's a lovely fall day in Ottawa. We're very grateful that you came all the way to our committee. We are on the unceded territory of the Algonquin people. Canada is in a process of truth and reconciliation. This committee, in particular, always recognizes that for both the location and the broader meaning.

Pursuant to Standing Order 108(2), we are conducting a study of long-term care on reserve. We have with us a delegation of three who are going to spend 10 minutes with their presentation, and then we'll have an opportunity to do questions from the MPs, both on the Liberal and the opposition side.

Anybody who wishes to start, please go ahead.

Robin, welcome to our committee.

Ms. Robin Decontie (Director, Kitigan Zibi Health and Social Services, Kitigan Zibi Anishinabeg First Nation): Thank you.

First I'd like to acknowledge my ancestors of this land, the Algonquin Anishinabeg first peoples.

My name is Robin Decontie. I'm the director for Kitigan Zibi health and social services.

I was born and raised in Kitigan Zibi. I left home for 10 years to pursue my education, to then return to work for our community health centre over the past 20 years in different capacities. I'm now the director of our combined approach of health and social services programs. We've been a transferred health services community since 1989, and we're categorized as a high-functioning, low-risk administration community under ISC.

I'm also a member of the board of directors of the First Nations of Quebec and Labrador Health and Social Services Commission. Hence, I have some insight into what challenges there are on a regional basis as well.

With that in mind, today I offer you a community perspective of our challenges in delivering on-reserve long-term care and potential solutions to these issues. We're a community that believes in doing the work for our own people, by our own people. We believe in capacity-building. Policy-level changes impact good practice at the community level; therefore, I'm honoured to be here today to engage in this important topic of long-term care on reserves and I thank you all for this opportunity.

I'll describe challenges to long-term care on reserve and present some solutions for thought.

The major issue we're facing in many areas of service delivery is medicare delegation to the provinces and the associated jurisdiction issues.

Our community members are dependent on the provincial medicare system for our long-term medicare needs, as all Canadians are. We are dependent on our medicare system for our illness and health care. ISC is not a medicare authority in Canada and delegates these authorities to the provinces via the Indian health policy of 1979. This dependence creates issues when we try to work with the provincial medicare system for, one, uniform communication with first nations liaisons positions to facilitate better access to provincial medicare; two, proper health service delivery practice supervision; and three, planning for chronic disease service delivery and health planning.

Concerning uniform communication with first nations liaisons positions within the medicare system, Quebec's provincial ministry of health and social services liaisons within regional health boards do not have a standardized way of communicating and networking with on-reserve first nations providers in their province. We are dependent on each other to provide care to those needing long-term care on reserve, from womb to tomb. There needs to be a better way for on-reserve service providers to communicate with regional health boards in Quebec that would improve the health services access problems we are experiencing in communities.

For example, I have with me a document entitled “Portrait of the Situation for English-speaking First Nations: Accessing Health and Social Services in English in the Province of Quebec”, from the Coalition of English-Speaking First Nations Communities in Quebec. The portrait identifies the need for provincial boards to have a clearer role and responsibility for first nation liaison agents of the health system to work in partnership with on-reserve health services for long-term care. This is one example of an access issues study.

The solution is to obligate the ministry of health boards throughout the provincial ISC services to mandate a standardized first nations liaison that will meet the needs of communicating with first nations on-reserve care systems to allow for greater access to provincial services on reserve. There needs to be an obligation from the ministry of health and social services of the province to their own provincial medicare system to have a solid, standardized liaison practice from one regional health board to the next, to communicate and work in partnership with first nations communities to improve access to their medicare system.

I have this report. It's translated. It's bilingual.

Regarding proper health service delivery practice supervision, currently there are administrative obstacles with the ISC intermediate resource home facilities. These homes are for semi-autonomous people on reserve. This population will eventually have a growing need for care as their independence continues to diminish. A legal opinion that Quebec first nation intermediate resource homes indicated that non-certified ISC-funded homes on reserve are running an illegal practice of care that can be subject to heavy fines from the province if the province wishes to pursue our homes' care activity.

I have a copy of this opinion in English, if you wish me to submit it as well.

This means that the group homes on reserve in Quebec are providing services beyond the ISC levels 1 and 2 care because there is a growing need for these services with our aging populations. In so doing, we are working against provincial medicare law. There needs to be a congruent way to evaluate autonomy of the human condition between the ISC assisted living service and the provincial medicare system. Currently there is no provision to obligate the provincial medicare system to work with the on-reserve service provider to determine definitive levels of care that a client may need.

Currently our community services use a provincial assessment tool, which rates autonomy from levels 1 to 15 rather than the 1 to 5 that ISC uses. The ISC criteria of care between levels 2 and 3 is a grey zone, which leads to the home having to provide more services than it should in providing to clients in this grey zone. Hence comes forward the illegal practice of providing more help and care in these homes than we should, according to the province.

With the provision of more long-term helping services in the group homes beyond levels 1 and 2 come nursing services that the professional Order of Nurses of Quebec restricts in these homes. According to Bill 90 of the Quebec health act, nurses are not allowed to practise services in intermediate resource homes that are not certified by the province. Hence, we have inadequate supervision available to us by the provincial medicare system as needed. Nursing licences can be revoked by the Order of Nurses of Quebec if nurses are found practising nursing in group homes that are not certified by the province.

Currently our Kiweda group home, funded by ISC's assisted living program, is not a certified home under the province, but we are accredited by Accreditation Canada. Nonetheless, there is no legal provision in Quebec to secure any nursing services we may need to provide to the client in this home. This has always been a contentious issue for our health care team when deciding what care we can provide on reserve to our own people legally.

Our community mirrors the aging population situation, as in the rest of Canada. More aging people will be needing more care in the future, up until the next generation. Nursing home care, which is currently regulated by the province, will be the next set of residential services that we will need to provide to our community members on reserve. We need to ensure that nursing care licensing and certification processing for these homes is better facilitated between the provincial medicare system and first nations service providers on reserve, so that we can provide long-term care by our own people for our own people.

A solution perhaps is to provide the budget resources for assisted living homes to become certified in a culturally appropriate manner, equal to the province. This would mean infrastructure funding to upgrade our homes to meet provincial certification standards, and changes to scope of practice would need to happen to allow for cultural activity. For example, proper sprinkler systems for fire safety would need to be installed in homes, and certification would be needed to allow wild meats to be eaten in these homes, which is not allowed by current provincial certification. The province should be obligated to allow capacity-building approaches for our own community workers to provide the work for our own people by our own people in certified homes as well.

As well, provide the budget to allow first nation home and community care services to expand their hours of service delivery as needed to help community members remain at home and out of the provincial hospital care system as long as possible.

With regard to planning for chronic disease service delivery and health planning, there are other conditions besides elderly aging that constitute the need for long-term care on reserve. There are emerging concurrent disorders needing long-term care, such as people with mental health disorders and physical disabilities and people with chronic concurrent pain crisis management and addictions.

Those struggling with these mental health conditions concurrently with their physical conditions have very limited capacity for decision-making and are dependent on service provision, because they cannot live on their own. With the onset of the opioid crisis that we're experiencing in North America, we are observing the need for long-term care for community members struggling with addictions to have a place to go to so they don't die young.

The Chair: You have 40 seconds

Ms. Robin Decontie: Forty seconds?

The Chair: Yes.

Ms. Robin Decontie: For solutions, obligate the first nations liaison to configure aggregate public health and medicare data to be accessible for first nations communities to determine what chronic diseases the communities are dealing with, for a better medicare system and better health planning for long-term care.

● (1535)

Here is our conclusion.

Improve the obstacles between the provincial medicare partners and first nations who are capacity-building to provide care for our own people by our own people. Federal funds are disseminated to the province to provide first nation care; therefore, there should be more accountability as to what the province is providing to first nations in medicare.

Provide law changes to the provinces to allow for more jurisdiction and decision-making authority to first nations on-reserve services regarding medicare services development. The province must be open to working with first nations on reserve under federal jurisdiction to create and sustain safe medicare for those communities that are ready to provide medical practice themselves for long-term care.

We are in changing times now. Our community members are becoming more educated in health fields. We need to look at how we can provide better services to our elderly, chronically ill community members, prenatal and postnatal mothers, and children with chronic care needs.

Currently the province is able to deny service delivery on reserve due to our communities being under federal jurisdiction. It's observable, and data is available proving our province is not understanding that we do not have jurisdiction over medicare in our communities. They have been redirecting our people back to services on the reserve because we live on federal lands. There needs to be an obligation for the provincial medicare system to work in partnership —not simply to discard the responsibility—with on-reserve service delivery providers to create, sustain, and practise medicare in our communities, for those communities that are ready to take on that challenge.

Thank you.

● (1540)

The Chair: Thank you.

We were a bit lenient on the time because, of course, we have one delegation. I hope members understand.

We have a new member of our committee. MP Robillard has joined us. He will be opening the questions in this round.

Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.): No, sorry, Madam Chair. This is just a question. Do we only have one presentation?

The Chair: I thought it was one. Oh, I should have cut you off. Now I'm sorry.

Okay, you guys can fight it out. I don't know. I'm sorry for the misunderstanding.

We'll have the second presentation, please.

Ms. Sharon Rudderham (Director of Health, Eskasoni First Nation): I'll just introduce myself. My name is Sharon Rudderham and I'm the health director of Eskasoni First Nation.

Eskasoni is the largest first nation or Mi'kmaq community east of Montreal, in Nova Scotia. It has a population of 4,500 people. Half of our population, about 2,200, are young people in our community, so we have a significant youth population.

As you know, I'm here today to talk about long-term care and the needs related to it. We know that the impacts of the Indian residential school system have created an unwillingness by our people to access long-term care services outside of our communities. They prefer for services to be provided within our communities.

We've been working collaboratively with the Province of Nova Scotia in trying to resolve what we believe to be discriminatory policies that exclude provision of care to first nations people within Nova Scotia.

I also want to reference in my presentation—and I'm not sure if you're aware—that when the Health Council of Canada did a research study in 2012 and surveyed aboriginal people across this country, they found that aboriginal people feel fearful, powerless, and discriminated against, and have little trust in the public health system as it exists outside of our first nations communities.

I want to reference some data specific to our communities here in Nova Scotia. This data comes from what's called the Nova Scotia First Nations Client Linkage Registry. It's a unique identifier that allows first nations to extract data from provincial data sources. This was done through an agreement with our provincial government and our first nations communities.

Death before the age of 75 is considered premature. Between 2004 and 2013, 80% of deaths in our first nations communities were considered premature in comparison to the rate for Nova Scotia, which was only 30% premature deaths.

As you all know, the rates of diabetes are significant in our communities, with the rate almost double or triple the provincial diabetes rates.

I know we have limited time. I have some statistics. I'm referencing the importance and need around chronic disease management and the supports that we need to have in place and in process within our communities to support our population affected by these diseases.

Looking at heart attacks and heart failure, within our first nations communities the median age of someone who has a heart attack is 56. In Nova Scotia, the average age is 69. For heart failure, the average age was 67 years compared to 78 years for Nova Scotia overall.

You're probably wondering where I'm going with this. It's to give you an example of the need and the differences that exist between aboriginal and non-aboriginal communities. We do have a young population in our communities, but we have higher rates of chronic disease and disability that are being created because of these high rates of chronic disease.

We have small numbers around Alzheimer's and dementia, but when we look at the premature death rate that exists, if 80% of the people in our communities die before the age of 75, people are not getting diagnosed and not reaching those ages in the same manner that the entire country is reaching those ages and filling our long-term care facilities.

● (1545)

Mr. Stephen Parsons (General Manager, Eskasoni Corporate Division): My name is Steve Parsons. I am the general manager of Eskasoni corporate services. My job in this whole team concept is to help negotiate with the province, on behalf of the band, for a long-term care facility.

It is important for members to understand that we're the model for Nova Scotia and that we could potentially be the model for the country. There's no such mechanism, no such long-term care, in the province of Nova Scotia as it exists today. One of the reasons this is a priority of the chief and council is that we do have a population of elders who need this care. We have had elders staying in existing non-first nations long-term care facilities, and they're struggling. Members need to understand that they want to come back to their communities because of cultural differences and language differences.

Take palliative care. Death in first nations communities is different from death in non-native communities. Palliative care is very important. When somebody is dying in our community, they are supported by family. When they go to our regional hospitals, the staff get inundated because they can't handle the number of people coming in to support the person who's dying. These people are dying in long-term care facilities and they want to be able to live in their communities. There is no mechanism in place when you go, and because people don't understand the language, they're fearful of it. Therefore, they stop going to the non-aboriginal homes. The support then can't be there.

We're currently negotiating with the Province of Nova Scotia. The fact that they have recognized and are negotiating a 48-bed facility for our community.... It's not just for our community. We've created a model that is for all Mi'kmaq in Nova Scotia. There are approximately 15,000 first nations people in Nova Scotia.

We have submitted our presentation for your reading at bedtime, or whenever you want to do it. We're creating a model that reflects the need of the community. We even went so far as to pre-empt this by training 10 continuing care workers in our community three years before we started the negotiation. Why? These are employment opportunities for our young people—which we have—who can participate in employment opportunities and give back to their people in a setting and in a service that we can provide ourselves.

We know that the negotiations are provincial, but there is a role for the federal government. The role is to help with capital infrastructure. These things aren't cheap to build. You all come from communities where infrastructure is built. Infrastructure is the primary focus. You can't have a home to provide the service unless you have a home.

We have three full-time doctors in our community. A natural progression in our community is from primary care to long-term care. In a lot of first nations communities today, there is a housing opportunity. Elders are living with large-sized families, and the level of care that they need is not there. We have 400 people in our community who require home care. The natural progression for these people is that they end up in a long-term care facility. Right now in Nova Scotia—I know it's a provincial issue—we have a waiting list not only in our region but in our province. There are 3,500 Nova Scotians right now on a waiting list for a home. Identifiably, the need is there.

We're saying that we could be the model for Nova Scotia first nations Mi'kmaq. We could provide that service in our community no differently than we do for alcohol and drugs for Nova Scotia Mi'kmaq. We do that out of our community. We're a large and progressive community. We want to be able to do this in conjunction with federal and provincial help and our own community chief and council.

We're willing to finance this. The need is there. We've costed it out, and we have an operating partner. We know we can't do this ourselves. We have an operating partner agreement with Shannex, the largest operator in Atlantic Canada for long-term care facilities. Their name is in our report. Shannex provides services for thousands in Atlantic Canada right now.

We knew we couldn't do it ourselves. We don't have the expertise or the capacity. We married that up with a joint venture. We have a management contract for a term. We want to get our people up to those administrative jobs. We have nurses and PCWs in our community today. What we're trying to do is take it to the next level and provide the services beyond "A", which is there. The band did a feasibility study that cost $30,000. Why? We needed to understand the proper scope of the province.

We made a pitch to our provincial government to be a partner, in a per diem per day of 48 beds: If these beds are not filled by all first nations people, we're willing to help out the present waiting list. Empty beds don't pay the per diems that you need to operate. We set this up so that this is not a burden on the band and it's not subsidized by the band annually. It has to run on its own operationally. That's why we went out and got a partner—to create those opportunities, provide the service, and create the jobs for young people that are desperately needed as well.

Thank you.

● (1550)

The Chair: Very good.

Now I'll do a rewind and invite MP Robillard to start off the questioning.

[*Translation*]

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

I will ask my questions in French.

First of all, I would like to thank everyone for being here today.

My first question is for Robin Decontie.

Could you describe the specific needs of the various age groups requiring long-term care in your community?

[*English*]

Ms. Robin Decontie: Approximately 25% of our community membership will be over the age of 65 within the next five years. There's a growing aging population, which will subside perhaps in the generation after that. It's been referred to as the baby boomer generation, the set of elderly population that will be needing long-term care, but that's for aging purposes. There are other people and other patients in our community needing long-term care for other issues than just aging, as I mentioned quickly in my presentation, needing long-term care for chronic disease and chronic illness. We would like to get that population addressed as well. We would like to offer service delivery for them as well.

[*Translation*]

Mr. Yves Robillard: Thank you.

My next question is for Stephen Parsons or Sharon Rudderhan.

In 2014, your community informed the provincial government that it wanted to build a long-term care facility. What steps could the federal government take to further coordinate its funding process with that of the provinces?

[*English*]

Mr. Stephen Parsons: As to the long-term care process right now, we have no other choice but to work through the process of standardization with the province as far as homes are concerned. The province basically had to sign off on everything from the management agreement to the staffing levels to the operations—the whole gamut. There's really no role, as we're told by the province as it relates to....

The province has the authority to grant a licence. Our goal is to garnish that licence for 20 years. In order to finance such a project, we need per diems based on our model for 20 years. Our project is shovel-ready. Yes, we go through the process of acquiring the licence, signing off on permits and so on and so forth with every department within the government from environment to agriculture and so on. That will take its course. This is territory where we've never been. No first nations in the province have gone down this road; we're the first.

We've had communications with the Minister's department, and we've had communications with our local MP. The role of the federal government here, knowing that decision-making process has been turned over to the province to administer, would be to help support that through a partnership not only in working with provincial counterparts, but at the end of the day we feel that the federal role here is one that could help establish the home. Whether a committee and/or the federal Department of Health wants to go back and engage with the province, I can't shed any light on that, on how to improve that, because I don't know that. I know that we've created a model. There's a role for the federal government and there's a role for the provincial government. That's why we're here hoping to encourage our MPs who are sitting on this committee to talk.

I want to back up just for a second. It really brings to light what members need to understand. I have a lot of friends who work in long-term care as staff. Not knowing the first nations, not understanding them, not knowing their traditions or their culture is really a sin. It's somewhat degrading when families of first nations go to visit their elders in homes and the staff say, “Oh my God, here they come again.” You really need to understand that. Picture your own family going into a home. It's inevitable that people, when they get elderly, need services. That's what governments do. That's what we all do collectively; we provide for that. Imagine families coming in from Eskasoni, and the staff says, “Oh my God, here they come again.” That's worrisome.

● (1555)

Ms. Sharon Rudderham: It's discriminatory.

[*Translation*]

Mr. Yves Robillard: Thank you.

I will give the floor to my colleagues.

[*English*]

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): I have a few very quick questions.

Right now you're looking at a facility with how many rooms?

Mr. Stephen Parsons: It's a 48-room long-term care facility.

Mr. Mike Bossio: How many jobs does that create?

Mr. Stephen Parsons: It creates 74, to be exact.

Mr. Mike Bossio: Would it be open to both indigenous and non-indigenous people?

Mr. Stephen Parsons: We're training people as we go.

Mr. Mike Bossio: No, I mean the residents.

Mr. Stephen Parsons: Yes, absolutely.

Mr. Mike Bossio: Right now you're saying that the big problem is that the province might be willing to give a licence and funding, but they're looking for a partner in that capital funding up front. That typically hasn't been the federal government's role when it comes to long-term care. Are you recommending that the federal government consider a pilot project whereby they take two or three or four different communities around the country and do a pilot around capital expenditure for long-term care beds?

Mr. Stephen Parsons: In working with the department, we've talked about that modelling. We talked about and encouraged.... If this is a national issue and a national opportunity, then somebody has to go first. We feel that we're ready, we're capable, we have the management agreement, and at the end of the day, members, we will finance this. With a licence for 20 years, you're able to go to the bank and finance it. We're saying there's a role for the federal government to come in here as a partner to help us bridge that financing.

Mr. Mike Bossio: Perfect.

Mr. Don Rusnak: Stephen, I don't have to imagine that. I'm the only first nation member of Parliament in Ontario. I have family members in homes, and I know that. I know from our community members that we face that discrimination in homes that are in our communities. There's not that cultural understanding sometimes and there isn't that training.

The Chair: We've run out of time; sorry.

The questioning now goes to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you.

I'd like to start with Ms. Decontie.

You talked about an illegal practice of care and a lawsuit. I remember that a number of years ago there were issues in terms of day care because the provincial government had very strict regulations around infant/toddler certificates and early childhood ratios. I know that for first nations communities it didn't always work particularly well, because especially the smaller communities didn't have the right component of ages to meet the standards. It really was a conflict and it was a problem in terms of the licensing standards.

Is this a similar issue? Do you have people in assisted living who are...? Can you explain what this lawsuit is all about?

Ms. Robin Decontie: It can be a potential lawsuit. The province can pursue the care activity in our homes. If it's found that a nurse is providing nursing care in an uncertified home.... The issue is that nursing care is being provided in the uncertified group home funded by ISC. Level 1and level 2 care is all we're supposed to provide. However, when the evaluation tool determines that a patient or client in the home needs more than level 1 or 2 care, nurses need to do home visits the same as they do in the other home care programs. Because the resident is living in an uncertified ISC assisted living home, the nurse is not allowed to practise nursing under Bill 90, which is a law in Quebec regulating the reserve duties of health professionals.

It's really a licensing issue. The nurse's licence is threatened if she's found to be providing nursing care in homes uncertified under the province. Our home is accredited by Accreditation Canada. We meet all the safety and quality improvement standards of care. However, that's not enough to deter the threat of a nurse having a licence revoked by the Order of Nurses of Quebec if she's found nursing in these homes. That's a professional order.

● (1600)

Mrs. Cathy McLeod: Do you see any potential solutions? Are you in conversation with the provincial government to try to resolve these issues? I'm not sure I see a federal role with that particular challenge. Do you see a federal role?

Ms. Robin Decontie: The federal role I see is a long-term one involving a discussion of the jurisdiction of medicare in communities. Right now there is no federal jurisdiction of medicare in communities under federal jurisdiction. It's all delegated to the province, correct?

There needs to be some movement now, in these changing times, to explore how to move the responsibility and the practice of medicare on reserve under federal jurisdiction. If we are going to be increasing our services and doing work for our own people, by our own people, how is this going to happen securely and legally without the threat of a nursing licence being revoked or a risk to a family physician or practitioner who infringes on any regulation in that capacity as well?

Mrs. Cathy McLeod: My next question is for both Sharon and Robin.

Probably within your roles you have the opportunity to meet with your colleagues across the country. Are there any jurisdictions or communities that you see are leading the charge on some of these issues you just identified? You talked about where you are at. Have you had conversations in British Columbia, for example, with the First Nations Health Authority? Do you see any activity happening across the country that you want to comment on?

Ms. Robin Decontie: I can comment.

There is movement in Quebec right now to develop a governance project that the health commission is undertaking with all first nations health centres of Quebec to determine the best model to use in developing a health authority similar to what B.C. has. It is a work in progress. There are steps being taken for discussion. With the new movements in governance, we're considering that as well: How does that fit into a health authority role in Quebec?

There is movement in Quebec. We have been consulting other provinces as well to find out what we can develop for ourselves in Quebec, so there is movement there on Quebec's part.

Ms. Sharon Rudderham: Also, in Nova Scotia we have obtained support and resolution from all the leadership for the establishment of a Nova Scotia Mi'kmaq health authority. We have informed the current political government in Nova Scotia. They have been advised by our leadership that we are proceeding down this road, and plans for discussions are under way, I guess. That is progressing as we speak.

● (1605)

Mrs. Cathy McLeod: Would you envision the health authority starting with some of the current roles—for example, public health, and home and community—and then as capacity increases, that being the model for assuming more responsibility in different areas? Is that what the long-term vision is?

Ms. Sharon Rudderham: It's true. We do have.... I didn't bring any of my documentation with relation to that.

Often the challenges we face in first nations communities are around the availability of data to support our stories. With the data linkage project we did in Nova Scotia, the data then began to open the door and open discussion to have government officials understand clearly what we were trying to express—the current rates of cardiovascular heart disease, etc., and all the chronic diseases that were currently being measured within Nova Scotia for the general population.

Data, we understand now, is an extremely important component to documenting the needs of our fist nations communities. That has primarily been our focus for the last 10 years. Now that we have the data linkage completion, we are beginning to look at the establishment of a governance process.

Thank you.

The Chair: Thank you, Sharon.

The questioning now moves to MP Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you.

Thank you all for being here with us today on this really important issue.

Robin, I will start with you.

One of the things we've heard very clearly across this study is that jurisdiction is just a continuous issue. You talked about medicare and how it would be good to see the provincial—if I'm saying it wrong, tell me—government more accountable to the federal government for the medical care that is needed on reserve. You talked about people actually being denied and sent back to the reserve with nothing, and you guys don't have the power. Could you talk a little bit more about that? Also, you said that you have data that backs up some of these claims. Could you talk about that?

Ms. Robin Decontie: I indicated that the provinces should be more accountable to the federal government as to what medicare they are providing to first nations. Right now when we try to find data to find out what service delivery is happening for first nations in Quebec, it's not there. It's not readily available. There should be some more accountability on their part to provide that data. There should be some sort of reporting system in place that the provinces need to submit to the federal government for the funding they are receiving to provide service delivery to us.

I'm sorry; what's the second part of your question?

Ms. Rachel Blaney: You talked about how people are sent back. Are you collecting any data on people who are coming back to the community and saying they tried?

Ms. Robin Decontie: I can submit this report to Mike MacPherson, perhaps. I'm not sure how to submit reports. This is a study of the English-speaking first nations of Quebec to define what access issues they are experiencing and how at the community level, the grassroots level, they are experiencing being sent back to reserve communities that don't have medicare authorities to provide treatment and whatnot. There is some evidence there.

The power of observation in our community, as well, is on a continual basis. We receive community members back from trying to access CLSC services and provincial care services, with these types of services referring them back to our health centre that does not have the same mandate, the same level of authority to provide medicare.

Ms. Rachel Blaney: Thank you.

One of the things we have heard a couple of times in this report is that Jordan's principle needs to be applied a lot more broadly, because it becomes that jurisdictional issue instead of just serving the client and figuring out who pays for it later.

I would love any of you to speak about how you feel about that.

Ms. Robin Decontie: I have a bit of an opinion on that. Jordan's principle, with the immense work that happened there proving there are some disparities in service delivery for first nations children, actually applies to adults in similar situations as well. I'm sure the data can be found as to the arguments that happen with jurisdictions as to who's paying for these chronically ill needs that are long term and prevent some adults from returning to their communities. They are stuck in the provincial medicare system.

I share your perspective on that. There needs to be some way to ensure the jurisdiction issue doesn't impede the wellness of the community member and their return to the community after having secured medicare.

● (1610)

Ms. Rachel Blaney: Thank you.

Sharon, would you like to add to that?

Ms. Sharon Rudderham: As to Jordan's principle, yes, I'm in agreement. Even when you look at children with disabilities, when they reach the age of 18, what's going to happen to them? If Jordan's principle is providing tons of support to the family because of the jurisdictional barriers around their care, then what's going to happen when these children age out of Jordan's principle? Who is going to be responsible?

I guess it does become a federal government responsibility to work with the provincial governments to resolve these jurisdictional issues, because right now they are not being adequately resolved.

Ms. Rachel Blaney: Another thing we've heard through this committee and through the people who have come to see us is that data continues to be a challenge. You talked about the Nova Scotia first nations client linkage data, I think for elders as they age, really being able to show what's happening, being able to identify that some of those health concerns happen a lot earlier, as you said, than in the rest of the Canadian population.

Could you talk a little bit about the journey of how you guys put that together and some of the results?

Ms. Sharon Rudderham: Sure. As I said, we began this process more than 10 years ago because we face the same issues as all first nations. We don't have data. A lot of the data we were collecting for Health Canada or INAC—I'm sorry that I don't know the new names—was related to the accountability of funding and the spending of resources, whereas it didn't necessarily support the documentation of needs within the community, and those could be based on stories.

In my community of Eskasoni, we began a research project specific to Eskasoni and we tried to do data linkage through postal coding and all that kind of stuff to see if we could extract information from current databases and work with universities and stuff like that. That wasn't sufficient, so we continued to work on this project and continued to get funding through the aboriginal health transition fund and different initiatives and whatever project funding we could get to continue this work.

Ultimately, after many years, we've developed a unique identifier that does use the Nova Scotia health card number and the INAC registry to be able to link these together, and it's completely under the control and management of first nations in Nova Scotia.

Ms. Rachel Blaney: Okay. Thank you so much.

The Chair: We've run out of time.

We are now moving to MP Will Amos.

Mr. William Amos (Pontiac, Lib.): Thanks to all three of our witnesses.

I'll start by reacknowledging the fact that we are on traditional and unceded Algonquin territory.

It's a real privilege to have you here with us, so *meegwetch*, Ms. Decontie. Thank you also for being an important leader in the health and social services field in KZ. I know you're on the board of the Wanaki Centre, so your responsibilities are actually really broad—a substance abuse centre and the health and social services centre.

As irony would have it, Pauline Whiteduck once worked with my father before I was even born, so there's a little connection there.

I wanted to bring in Mr. Parsons' comment around the need for capital infrastructure and bring that question to you and ask you to put it in a Kitigan Zibi context. If the federal government were to be asked by Kitigan Zibi to enable capital infrastructure investments to enable greater long-term care, is that something that's in the field of dreams, something that is sought?

I have a sense of the complexity of the relationship between CISSSO, the regional health authority in KZ, and it's complicated for everyone without even introducing the federal government into the equation. I almost want to park that issue of jurisdiction and just go to an area where the federal government might have a more direct play, which is to finance needed infrastructure. What does Kitigan Zibi need and want when it comes to long-term care infrastructure?

● (1615)

Ms. Robin Decontie: We were actually discussing this prior to coming here and saying that we're in the same boat as to the need for greater infrastructure investment in long-term care facilities. Capital is always a challenge to our community, and when we have access to increased operational costs with nowhere to put people or nowhere to practise service delivery, that becomes an issue, of course.

Infrastructure investment would go into long-term care units in our community, for sure. There is no doubt that there can be an extension of what we have, but with that we would need to look at the legal components of care practice, because we could have a facility, but sneaking around to provide care for our people that we may not be regulated to do should not be an issue for us. We need to be able to have some sort of mechanism in place to resolve that with our provincial medicare systems.

The two go hand in hand, I would say. We need the infrastructure investment to create the building for people in long-term care situations, as well as the regulation body for safe and proper medicare that we can provide ourselves with the proper supervision and rights to do so in our own communities.

Mr. William Amos: Thank you.

I understand that there has been a promise made by the previous provincial member of the national assembly, and, I believe, by the current provincial government to invest in a significant seniors' care facility in Maniwaki. It's not clear to me how that works with neighbouring Kitigan Zibi. For those who don't live in that community, they're literally right beside each other.

I'm trying to figure it out because I'm not discussing these matters with the provincial health minister.

Ms. Robin Decontie: I'm glad you brought that up. I'm not clear about it either.

The provincial medicare system is indicating that this infrastructure will be happening close by. We've offered to be involved. I have two nurses who are willing to go and be part of the development committee. We have not heard from them. I don't know where this project is going, and this is not unusual in working with the province. We'd like to work in partnership. However, it has always been difficult to work with the province as far as accessing medicare and playing in a partnership role. It's very difficult.

Mr. William Amos: Okay.

Ms. Robin Decontie: This is where we need some work done.

Mr. William Amos: Maybe that's an area for future collaboration. I'm always aware of doing things according to protocol, making sure that I go through chief in council first, but I think the invitation should be an open one from our end, to work with Kitigan Zibi to engage with the province in a discussion around that. It will be a major investment for the region, and it would be a pity if it weren't done in a manner that was collaborative with Kitigan Zibi's health and social services.

Are there other major health care infrastructure objectives that you have presently? We're talking about long-term care in general, but I'd like to open that up to you as well, so that you have the opportunity.

Ms. Robin Decontie: Expanding our service delivery for those struggling with addictions is something that we need to look at in connection with long-term care. They are biologically harmed as individuals and won't return to the normal state of being they had before their higher level of addiction got the best of them. We're concerned, especially about the young men, the younger male population in the community, who are engaging in a higher level of addiction.

We would like to have that addressed somehow internally. We're looking at it internally, but we need to be able to practise more medicare in that area and to work in partnership with the province and to be on board with the province as well.

We'd like to increase our service delivery at the health centre and increase our nursing authority to practise more of the nurse practitioner type of care that's being offered with proper supervision.

It's mainly the medicare issues we're having with the province that seem to be the obstacle areas we're trying to deal with.

I was hoping to be able to contact the SAA liaison we have to see what kind of connection we can communicate with our provincial facilitator to do that.

● (1620)

Mr. William Amos: *Meegwetch*.

The Chair: Thank you.

We move questioning to MP Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair, and thank you to our guests for being here today. I really appreciate it.

Robin, you talked a little bit in your remarks about traditional food —wild meats, and that kind of thing. Could you give me a little more detail on that issue?

Ms. Robin Decontie: I was indicating that if we resort to being certified by the province to have a group home for semi-autonomous people, we would need to comply to their provincial standards of safety, of service delivery and whatnot. We don't necessarily want to do that if it means giving up the types of community traditional foods we want to eat. We like to eat moose meat, and that's considered wild game in a kitchen of a certified semi-autonomous home. That may present bacterial infection and whatnot, according to their infection prevention and control guidelines.

There would need to be some sort of mechanism to enable certification of long-term care homes on reserve to be culturally appropriate, rather than following what the provincial standards are.

Mr. Arnold Viersen: Earlier you mentioned addiction among your young men. We did a study on suicide prevention in the north. One of the big things they talked about was how hunting and getting out on the land really helps. It seems to me that there would be a nice bridging mechanism to get the wild meat into the seniors care facilities while also giving the young men some sense of meaning again.

Is that a possibility where you are from?

Ms. Robin Decontie: Yes. That would be a possibility if we were to expand our care facilities. Having the young male population assume the caregiving role for our elderly would help to bridge the gap there.

Mr. Arnold Viersen: Okay.

Do you have a clear recommendation that you could make around the wild meat or maybe traditional...?

We often like to say, “I'd recommend this.”

Ms. Robin Decontie: I would recommend to the SAA liaison at the ministry of health and social services to start to network with their boards. There are, I believe, 17 regional boards in Quebec. They need to recognize the importance of networking with us in determining certification standards. We want to be accountable. We want to be certified. We want to have safe and secure care practices in our community. We want that. We are willing to work with the province. However, the communication network and communication linkage is not there.

Mr. Arnold Viersen: And you just started eating moose meat yesterday, I'm sure.

Ms. Robin Decontie: Oh, oh!

Mr. Arnold Viersen: Sharon and Stephen, you mentioned a earlier that you had a per diem kind of agreement with the province.

Mr. Stephen Parsons: Not yet.

● (1625)

Mr. Arnold Viersen: Okay.

Are you aware of anything from the federal level from one of the departments? When we had the department officials here right when we started this study, they talked a bit about how they are often not in the business of building facilities but are often in the business of funding the day-to-day care of individuals who happen to be in a facility anywhere in the country.

Have you pursued that avenue? From your perspective, what does interacting with the federal government look like?

Mr. Stephen Parsons: I'm smirking because you mentioned recommendations. I will have a couple before I leave today, if so warranted.

Mr. Arnold Viersen: Yes. I would—

Mr. Stephen Parsons: That being the case, the process is to negotiate a cost of the services provided to the facility, based on the number of beds. That's a provincial negotiation.

We have homes in our province ranging from 20 beds to 300 beds. In order to provide and operate the facility, that's a formula that they use—per diem, per day, per bed, to offset the operating costs of the facility. There's a range, depending on the level of service.

Mr. Arnold Viersen: What about from the federal level? To me, it sounded like a similar program, but it starts at the other end, right? It starts from the individual, and then works it way towards the facility.

Mr. Stephen Parsons: Those discussion have not been had at the federal department level because, from what we were being told when we initiated this four years ago, long-term care is a provincial issue and a provincial responsibility, and some of those costs have been downloaded to the province.

In terms of a recommendation, absolutely.

Ms. Sharon Rudderham: I do agree with our counterpart here as well. Provincial and federal standards need to be changed to meet the needs of our indigenous people.

I'll give you an example. We just built a brand new $7-million health centre in our community. Already, I'm full to capacity. This building—

Mr. Arnold Viersen: I'm sorry. I'm out of time. Perhaps my colleague will—

The Chair: I'm sorry. We're out of time, as the whole session has come to an end.

I want to thank you for coming out and presenting.

Mr. Stephen Parsons: Chair, could I make one last comment? It will just put things into perspective for members.

We heard a key message when we did our assessment, and not until you hear these words can you really get an appreciation.

Our elders of today are residential school survivors. It was brought to our attention that when they go to these homes as elders, we're re-institutionalizing them. I want to say that again: We are re-institutionalizing them.

That's the opportunity. I heard today that it doesn't pay to create a program. Programs are designed by thinking outside the box. If there's a need, if a proper assessment has been done, if it has been vetted, if you're organized and prepared to go down the road, then collectively, we need to think outside of those proverbial boxes.

Thank you.

The Chair: That concludes the remarks.

Thank you, everyone, for coming out and presenting.

We will have our second panel.

Thank you very much.

● (1625)

(Pause)

● (1630)

The Chair: Chief Peltier, why don't we get started? You'll have 10 minutes to present to us. Then it will go to Chief Collins. Then we'll go into questioning.

You have 10 minutes to present. As soon as you're ready, you can get started, and after the two presentations we'll have the questions from MPs.

Welcome.

Chief Ogimaa Duke Peltier (Leader, Wikwemikong Unceded Indian Reserve): *Meegwetch.* [Witness speaks in Anishinaabemowin]

Thank you, everyone, for allowing me the opportunity to come and make a presentation in regard to some of the services that we provide to the elders and seniors in our community, mainly from two perspectives—long term care programming as well as a long-term care home that we operate in our community.

I'll begin there. I am Duke Peltier, the elected chief in my community. I've been in that position now for six years. I just recently got re-elected, and I'm in my fourth consecutive term now. I thank you for the opportunity to make this presentation.

The current long-term care program services that are in our community provide services for longstanding chronic illnesses, which include services for frail elders, complex clients, and clients who are palliative. Programs have been funded through the Ontario Ministry of Health and Long-Term Care since 1997, and since then our services have witnessed the need for delivery of services to the aging population. Our nursing services and personal support workers are slowly shifting to evening and/or weekend work to accommodate the demand for the services required. A generic transportation program has also increased to full-time hours due to the demand of the clientele.

Palliative care is a service also provided to our clients wanting to stay at home during this time. Although many of the families do take the lead role in caring for their family members at home, supports are provided through our health centre and offered by the nurse and/or personal support workers. It would be preferred if hospice services were available through our long-term care home, which is a 24-7 long-term care facility that we've been operating since 1972.

Currently the Ministry of Health and Long-Term Care provides funding to support our clients to remain at home for as long as possible, but not through a 24-7 operation. The budget that we have to service our community is just a little over $1 million, which does not allow for the delivery of the services 24-7.

One of the issues that we experience in operating our long-term care home—I might be bouncing back a little bit here, so please bear with me—is through the admissions process. It is a challenge to our home from mainly an operational perspective, because that admission process is conducted by the Community Care and Access Board and through the LHINs. In those kinds of situations, because there's advanced funding provided to our home—100% funding based on the number of beds that we are licensed at—each day that each bed sits empty reduces our operational dollars. That's one of the issues that we don't have any control over, and it's something that we'd like to consider, especially when a member of our community does have a request to enter into the home to receive services within our community.

The intent back in 1972 was to have that home to care of our elders and to service them in their own language and through the diets that they're accustomed to. I appreciate the comments from the earlier presentation in regard to the traditional foods. That is a challenge. We've had to eliminate those from our menus because the existing provincial regulations do not allow for our own foods to be served within the home. The existing regulations dictate that most of the diet that's required to be served in the home is processed food, which many of you wouldn't appreciate eating every day either. If we have a donation of fish that comes from the lake and is freshly caught, they still can't serve it.

● (1635)

That's definitely a challenge, and I think it's definitely one of the issues that needs to be considered in any approach nationally.

Part of our challenge with services in long-term care and in the home is behavioural supports. Ontario does provide some supports to the home on a monthly basis; however, there is a need for funding to have on-site training of staff members due to the increasing number of responsive behaviours they're experiencing from clients who are attending our homes.

Additionally, there are language barriers with residents who are coming into the home. Our staff do not have access to any interpreters, in particular those who speak the French language or an indigenous language other than the one we speak in our community. Funding is required to have access so we can provide appropriate support to those with communication challenges. Perhaps some of those supports could be provided via Skype or video conferencing technology, which are widely available nowadays.

We do experience staffing challenges, in particular with regard to the director of care, who operates the long-term care home. It's a regulated position that clearly defines how a director of care is to operate within the home, and, in particular, the qualifications that are necessary. What we've been experiencing over the last six years is that at times we continually get written up for being non-compliant mainly from that perspective, because the director of care is required to have experience in an existing home or a home prior to coming into the position of director of care. The challenge is that many of the people who have experience as a director of care are already in positions, and if they're leaving, they're retiring.

There are no training opportunities for any young first nation nurses who wish to have that ability to be one of the lead administrators and lead caregivers of our elders in our community. If there are available training opportunities for qualified first nation nurses to become directors of care, I'd like to know where they are, because those are the supports that are necessary to allow that capacity to be available in our community or in any other first nation community that operates a long-term care home.

There are additional staffing challenges in terms of personal support workers. They're in high demand across the province, and access to that education is limited in our area.

Even though our friends from northern Ontario say that we're in southern Ontario, our southern Ontario friends say that we're in northern Ontario, so we're caught in the middle. We're on Manitoulin Island, and we just do not have the numbers necessary to allow on-site training opportunities for these positions.

These are also very demanding positions. It takes a special breed of individual to want to do this kind of work, and typically they're paid a very limited wage.

These kinds of supports are necessary in order for an individual to aspire to this type of work, not only in a long-term care home but also within the community through long-term care services.

Some of the demographics we're experiencing in long-term care are changing. We're no longer servicing just our grandmothers and grandfathers. We're seeing younger generations requiring long-term care now as a result of a number of issues, whether it be behavioural issues or mental health issues, including autism and fetal alcohol spectrum disorder issues. Those are now being experienced in our community. The younger generation is growing up, so now they also require that kind of care in the community.

● (1640)

We do struggle to get access to services for our residents who have these challenges. We don't get support from the medical teams when sending residents for psychiatric evaluations. My community has a resident population of 3,500 within the community on reserve. We look at some of our neighbouring municipalities that have populations of 400 or 500 and see that they have family health teams available to them.

Our community is one that does not have a family health team. We've been making requests over the last 10 years to provincial and federal officials to allow for that family health team to be funded in our community, but that is one of the challenges. We think that many of the supports and services necessary for our community could be alleviated through the introduction of a family health team.

Many of the regulations that exist within the North East Local Health Integration Network are very prescriptive and do not allow for consultations within the regulations that exist within the Ministry of Health and Long-Term Care Act. There are many things...many areas that have us....

I'm not used to this.

Voices: Oh, oh!

Chief Ogimaa Duke Peltier: I've travelled a long way to speak. I'll try to speed it up. I'll get to some of the other points here.

Our home is currently classified as a “C” home. It was constructed in 1972. We are required by provincial regulations to redevelop and renovate prior to June of 2025. Otherwise, we risk losing the licence to have these services available in our community. We're currently working on a feasibility study to increase the number of licensed beds to roughly a hundred beds. We've previously applied for an increase. That still hasn't been accepted. One of the things that—

Oh, they're turning the lights off on me now too.

Voices: Oh, oh!

● (1645)

The Chair: I need you to wrap up.

Chief Ogimaa Duke Peltier: There is a high need to establish a full-time diabetes program, not only in my community but in many other communities. That's where we seeing the results of early onset long-term care for many individuals, because diabetes is being experienced by many of the younger generation. There's the recreational prevention aspect of a program—

The Chair: Chief Peltier, we normally give 10 minutes. You're now at 12 minutes.

Chief Ogimaa Duke Peltier: I started late.

The Chair: We do want an opportunity for members to ask you questions.

Chief Ogimaa Duke Peltier: Go for it. I'll cover them off then.

The Chair: All right. You do that. Remember the rest of your comments. We'll get there.

Now we want to hear from Chief Collins.

Chief Peter Collins (Fort William First Nation): Thank you, Madam Chair. Like Chief Duke, I've travelled a long way to have our voice heard here.

The Chair: Yes.

Chief Peter Collins: I've been a chief in my community for 18 years now. It's been a long journey, to say the least.

Mr. Don Rusnak: You had a little break.

Chief Peter Collins: I had a two-year hiatus and I took a rest, but, you know, it's a tough job. We're in a different position than my friend Duke is, because they have a long-term care facility. We're in the early onset of that and we've been in discussion for quite some time with the provincial government. They are lifting the licence moratorium that's been in place for quite some time, so I think we have finally made some inroads on that. Right now Dilico is pleased to be in the position of entering into phase 2 of the Ministry of Health long-term care allocation on the 96-bed long-term care facility. The development of an indigenous LTC facility will assist Dilico to fulfill its unique mandate to deliver services for the complete life journey of the Anishinabeg nation people. The government should be aware that the proposed facility is closely aligned with several calls to action from the Truth and Reconciliation Commission of Canada, including call to action number 18:

> to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties;

call to action number 20:

> to recognize, respect, and address the distinct health needs of Métis, Inuit, and off-reserve Aboriginal peoples;

call to action number 21:

> to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental,...and spiritual harms caused by residential schools;

call to action number 22:

> to recognize the value of Aboriginal healing practices;

and call to action number 23:

> to increase the number of Aboriginal professionals working in the health-care field [and] ensure the retention of Aboriginal health-care providers in Aboriginal communities.

Dilico is a leader in the provision of integrated holistic and culturally safe care to urban, rural and remote first nation children, families and communities. Dilico has identified a current need for the development for a 96-bed indigenous-designated LTC facility, which hopefully will be expanded to meet the demand for 128 long-term care beds in the future. The facility will provide LTC services in a culturally appropriate environment to elders aged 55 and over from the 13 communities that are in partnership with Dilico and its organization and partnership with Fort William First Nation as we go forward.

Locating the LTC on the traditional lands of Fort William, on the homelands of Fort William, has advantages, including availability of land and close proximity to complementary health services, including Dilico's health services, indigenous family health teams, traditional healers, home and community care, and personal support services.

One of the only things that divides Fort William and the city of Thunder Bay right now is a river. I won't talk about a bridge, but....

Voices: Oh, oh!

Chief Peter Collins: In addition would be culturally appropriate recreational opportunities in a partnership with Fort William First Nation and the Thunder Bay Regional Health Sciences Centre. I recently had a discussion with the CEO. He told me that he could fill our 96-bed facility himself because of the burden on the health organization there itself.

In the current landscape, there are significant challenges in determining the number of indigenous elders in Ontario. The health care system is a challenge. To begin, the question of indigenous identity is not asked at the time of application or admission to LTC. According to NorthWesthealthline, there are eight LTC homes, and none provides public information about indigenous identity. Many residents will state that they believe Hogarth Riverview Manor has the highest number of indigenous elders. Hogarth operates a 544-bed LTC facility offering specialized Alzheimer and dementia care for our elderly with higher-intensity medical needs and general long-term care. As of November 30, 2017, there were 629 long-term care homes with 78,943 licensed beds in Ontario. Of those, four long-term care homes are located in first nation communities.

You heard Chief Duke talk about the long-term care facility in his community. The other organization, Six Nations, has 50 beds. Oneida has 64. The Mohawks of Akwesasne have a 100-bed facility.

● (1650)

The number of indigenous youth is growing at a faster rate than any other population in Canada. It's the same with the elderly. In 2006, 4.8% of the aboriginal population was 65 years of age or older. We hold a Christmas party, and we can tell in our community every year that the number of elderly people is growing. We host upwards of 400 people at our Christmas dinners. Our elderly population is growing, and they need a facility to help them to the end of their journey. The population of Métis and Inuit 65 years of age and older could be more than doubled by 2036, according to Stats Canada.

“Canada's most vulnerable: Improving health care for First Nations, Inuit, and Métis Seniors” tells us that first nation communities are responding by implementing and developing a home and community care program and personal support services to keep elders at home in their communities. One of the things we're working on developing right now, once we get the facility up, is a training centre. It will be a training ground not only for our community but for all the shortages in Thunder Bay and throughout northwestern Ontario. We do have a partnership that we're structuring right now with Confederation College to have on-site training for PSWs, dieticians, and all of the stuff that goes hand in hand with a long-term care facility.

Dilico serves many elders through the home and community care and personal support services program, and knows how many elders refuse to go to nearby cities to avoid the possibility of being put in a permanent long-term care arrangement or refuse to receive medical care and attention for fear of the outcome of being placed permanently in a foreign institution.

Why have an indigenous long-term care facility on a first nation? In June 2017 North West LHIN, Chiefs of Ontario, first nation chiefs, and senior officials from the Ontario Ministry of Health and Long-Term Care, Health Canada, and Indigenous and Northern Affairs formed a tripartite working group for first nation long-term care. I was part of that working group. We made some inroads, but what we're trying to do through the process we're working on—Mohawks of the Bay of Quinte and Fort William First Nation in partnership with Dilico—is to have phase 1 of the approval done and then try to get through the next two phases. We'll be laying down a foundation for others to develop long-term care in their communities, and we've done a lot of legwork on that aspect.

The working group determined that four themes emerged from the discussion: improved access to services, improved capital planning and financing, strengthened decision-making, and improved data collection. Fort William First Nation and Dilico are committed to these priorities and to working in partnership with Canada and Ontario to realize the full potential of elder care in our communities.

The tripartite working group tells us about the population demographics of first nations in Canada and Ontario and the population health needs, providing necessary context for the discussions on availability and the need for health services in first nation communities. In 2011 the median age of first nation people in Ontario was 29.4 years old. The off-reserve population was 29.8 and the on-reserve population was 27.4.

First nation and other indigenous people are younger than non-indigenous, whose median age is 40.2. That's Don's age now.

Voices: Oh, oh!

Chief Peter Collins: In 2016, 236,685 people identified as first nation people. A little under two-thirds—64%, or 151,210—reported being treaty Indian, a registered Indian, as identified by a racial piece of legislation called the Indian Act. Just under one-quarter—23%, or 54,000—of all first nation people reported living on reserve.

Overall, indigenous people in Canada have higher rates of chronic conditions such as diabetes. The prevalence of diabetes is three to five times higher among indigenous people as compared with the general population.

● (1655)

Of Canadian children diagnosed with type 2 diabetes, 44% are of indigenous descent.

Diabetes has long-term health consequences, including increased risk of cardiovascular disease, renal disease, and amputation. In 2013, the Health Council of Canada published "Canada's most vulnerable: Improving health care for First Nations, Inuit, and Métis seniors" , which discussed the common challenges faced by indigenous seniors.

The Chair: Chief, you need to wrap up.

Chief Peter Collins: Yes. I'm just about at the end of it. I'm not looking at you because I want to see this.

Some hon. members: Oh, oh!

Chief Peter Collins: As Ogimaa Duke said, we travelled a long way to have our voices heard. I'll try to cut to the back end and why Fort William in collaboration is the ideal leader.

Fort William First Nation and Dilico have over 30 years of experience developing programs, services, and governance. They've developed comprehensive and integrated services for Anishnabe people. Dilico as an agency has specialized in the expert knowledge and delivery of responsive health care. The value of the project is far-reaching and will service an underserviced, often vulnerable, population.

Indigenous seniors struggle with many issues, including not accessing health care, mental health, and end-of-life care. An indigenous long-term care facility would address physical and mental health, the effects of colonization and residential schools, language, our foods, our teachings, our properties, and our lands.

There are lots of different aspects of long-term care and why it is important to be built in our community. As I said, Ogimaa Duke has one in his community. We're on the verge of having one. We need the federal and provincial governments to look at a contribution of infrastructure dollars. That's what we're here for. We're hoping our voices are heard loud and clear—

The Chair: Well, let's see.

Chief Peter Collins: —throughout this organization and throughout the structure.

I'll cut it off there.

The Chair: Okay, Chief. You'll have an opportunity to continue, perhaps, with the questions coming from MP Rusnak.

Mr. Don Rusnak: Thank you, Chiefs, for travelling a far way. It's a trip I'm well used to. I do it twice a week.

I've been to both of your communities: Wikwemikong, a large community on Manitoulin Island and, of course, Fort William First Nation in my riding, my largest first nation community.

As I was saying before to the individuals from Eskasoni here, I am Ontario's only first nation member of Parliament. I understand the difficulties, having family members of my own going to facilities that aren't culturally relevant to them and having individuals at certain facilities saying, "Oh, here come those Indians again" and "They're taking advantage of our system", and being treated unfairly.

That, of course, can be remedied by having facilities within our own communities that are culturally relevant and responsive to the needs of our elders, especially—and I believe it was Mr. Parsons who said this—our elders who are survivors of residential schools.

What is your ask of the federal government in terms of these facilities? What is most important? As part two of the question, what would you ask of the provincial government? We of course report back to Parliament, but we can be influential in provincial legislatures.

I'll start with Chief Ogimaa Duke Peltier. Those are two questions.

● (1700)

Chief Ogimaa Duke Peltier: Two questions on what we are asking....

Well, I think the federal government likely has a role in assisting first nations in creating long-term care regulations and laws in collaboration with us and funding services appropriately, because in terms of the services that are required within our home, the province is very slow in responding to on-reserve servicing, for whatever reason. It's jurisdictional issues....

However, a person is a person. We need to provide that care. I think that's the approach that is solidified in case law now, through things like Jordan's principle and other human rights cases: that we are just as human as any other individual.

That would be one—work in collaboration with us—but also, institute a full funding regime in regard to prevention-type servicing. That would alleviate a lot of the issues we're experiencing with regard to early onset chronic care. We would be able to tackle the issue in my community of 15% of the population experiencing diabetes. That's obviously a large number.

I think there has to be a fundamental paradigm shift with regard to health delivery and collaboration with first nations.

The current system, whether you talk about a justice system or a health system, is all loaded on the back end when issues happen, as opposed to appropriately funding issues that are preventive in nature, such as children's programming. Introduce them to sports and physical activity and have those types of programs funded appropriately.

If I'm looking at diabetes-type programming in my community, we're funded with $53,000 annually to service 3,500 residents. That's obviously not enough. When we're talking about some of the professionals that come in to do some of that servicing, we can't even afford to pay them with that amount.

That's one of the things I would like to see.

Chief Peter Collins: I'll make my answer shorter.

Voices: Oh, oh!

Chief Peter Collins: I'm more direct and to the point anyway.

What I'm looking for here is help to assist us in getting a facility built. We're going to finance a $23.3-million project here, and without any federal money or provincial help for the infrastructure.... What we're looking for is for the federal government to make a contribution to help with the infrastructure dollars and the O and M dollars for the long term, for an evergreening. That's what we're looking for here today.

Mr. Don Rusnak: Well, in terms of an infrastructure program, I guess for Chief Peltier it would be an infrastructure program for renewal of the facilities and possible expansion, and for Fort William new construction...?

Chief Peter Collins: Yes. For Fort William, it would be a brand new structure, a brand new facility.

Mr. Don Rusnak: In terms of your dealings with the provincial government, you mentioned a bit of that in your presentation. We have a new provincial government in Ontario. How have those conversations progressed with the new government in power? Is there push-back on plans that you have going forward, or is everything staying the same?

● (1705)

Chief Peter Collins: Well, we haven't had any push-back from the province as of yet. The last message I got from Sharon Lee Smith, the ADM there, was that this thing will continue forward. The government is trying to find their way through the system right now in terms of how to deal with it. When you look at their announcements, you see that they're still announcing several long-term care beds in Ontario.

Our project is in the works. From our perspective right now, it's still moving in the right direction. We haven't had a new discussion with the new government. That's where we're at right now. We're waiting for that to balance out, to figure out where they are, so we can get back to that table.

Mr. Don Rusnak: There's still—

The Chair: You have about 30 seconds.

Mr. Don Rusnak: They're still reviewing. Essentially, you haven't had conversations, but in terms of the administration, I guess the bureaucrats are still on hold until the provincial government does their review of whatever they're doing a review of.

Chief Peter Collins: That's absolutely where it is right now. We're just waiting for it all to pan out. As I said, they're still making those commitments to long-term care, and hopefully we're still in that. We passed the first phase of their approval process in advance of the election, but we'll see where it goes now.

Mr. Don Rusnak: Hopefully it continues along.

Chief Peter Collins: Yes, absolutely.

The Chair: Good.

The questioning now moves to MP Kevin Waugh.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Thank you, Chiefs Collins and Peltier, for making the long trip here to Ottawa.

We were told by government officials at Indigenous Services Canada that there are only 53 long-term care facilities in Canada. Ontario has five, so, Chief Peltier, just fill us in. Are you one of the five?

Chief Ogimaa Duke Peltier: Yes.

Mr. Kevin Waugh: How's that going? There are only five in Ontario and only 53 in Canada. Now you seem to be one of the privileged ones. We could probably quadruple that 53 number, but there are only five in Ontario.

Could you maybe talk about that system of long-term care facilities? There are five in Ontario out of 53, so how do you fit in?

Chief Ogimaa Duke Peltier: We fit into the grand scheme of things, as I believe we've essentially been grandfathered in because our facility was built in 1972. It's one of the earlier ones—actually, one of the first ones—across Canada that was built in a first nation.

The approach at that time, as I indicated earlier, was to have a place for our own community members to go to if they didn't have supports at home. We wanted it to be culturally responsive, where the community members could have their own food and be able to speak their own language with staff members who also spoke the language of our community.

So, from that perspective, it had been operating as it should. Then, in 2007, new regulations came in with the provincial ministry's Long-Term Care Homes Act, which essentially placed our home in non-compliance for a number of reasons. One of the main ones was the diet that we were feeding the community members. Typically, the diet was traditional foods. We had cooks from the community who were adept at preparing the traditional foods, and these foods were the main staple of the daily diet.

Once the regulations came in, we weren't allowed to do that anymore, although, essentially, it was cost-saving in nature because we were able to use the local game and fish. We were able to have that available for the individuals. Now we have to get everything transported in, and it's all processed stuff.

The regulations have really challenged our home because of training requirements and staffing requirements. People with the training qualifications that are required for people in administrative-type positions with regard to the care of the elderly are not readily available close to home or in other first nations. The opportunities aren't necessarily available for our younger generations to come and fill those gaps that exist. Because we've been operating since 1972, many of those individuals are now getting to retirement age, but we aren't able to fill the vacancies.

Mr. Kevin Waugh: Yes, we've heard that loud and clear here.

In our long-term care study here, Chief Collins, I think the partnerships are important. You're close to Thunder Bay. Here in government, we're always looking for partnerships. You said that you have 13 communities.

● (1710)

Chief Peter Collins: We have 13 first nation communities under the Robinson-Superior legal umbrella.

Mr. Kevin Waugh: Could you talk about what your vision is along with, let's say, the City of Thunder Bay?

Chief Peter Collins: With regard to the developing numbers in Thunder Bay, you're not only talking about the 13 communities that are in partnership under the legal umbrella. There is also Nishnawbe Aski Nation, and a lot of its members are migrating into Thunder Bay for health care and for health care programming and initiatives. They end up in long-term care facilities, and we continue to work on many aspects on that front to make sure that not only our communities are looked after, but also that their elders are looked after and can feel at home in our community. That's the whole concept around why we're trying to build it in Fort William.

We have a great relationship with the City of Thunder Bay. Our partnership and our structure with the city has strengthened since 2011. We have a declaration of commitment to work together to build our economy, to build our communities and to build northwestern Ontario for that matter. If we stay on track, this opportunity with the long-term care facility that's going to be in our community will provide probably 100-plus sustainable jobs. That will not only impact our community, but also the city of Thunder Bay at the same time.

Mr. Kevin Waugh: Yes, that's big.

Since February, we've often heard around this table that data collection is a big problem in this country.

How do we correct that? Should there be one organization, such as AFN, to look after data? It always comes back to the data, and we have not talked enough around this table about a solution to the data aspect.

Chief Peter Collins: That's a good point. Maybe it's time for you guys to fund a one-site location for data collection that we monitor, not the federal government or the provincial government or anybody else. It's our data, and it's for our use for making the arguments. We hear the data stuff all the time when we're talking about health care and the opioid crisis and everything. Well, give us our data. We have to go fish around and look for papers that show the impact.

Chief Ogimaa Duke Peltier: One of the proposals that has gone stagnant was the first nations statistical institute that one of the Nishnawbe nation communities, Nipissing First Nation, was looking to establish, but it hasn't been lifted off the ground as of yet.

I know it was a proposal that would definitely take a look at all the data that exists within first nations, as well as all the services they provide. I think it would be an appropriate clearing house, not only for our communities to submit proposals for enhanced programming and services but also through sharing with the Government of Canada as well as the Government of Ontario. They could collaborate more efficiently on the appropriate supports that are necessary.

Mr. Kevin Waugh: You mentioned special needs. We haven't even gone there. You talked about autism and fetal alcohol syndrome. Is there any solution to that?

The Chair: In 10 seconds.

Some hon. members: Oh, oh!

Chief Peter Collins: If we had that solution, we wouldn't be sitting here, that's for sure.

Chief Ogimaa Duke Peltier: I can say this: there is programming that exists within the province; however, access to it is very limited, because they will stop at the first nation line. They will not come in. That's what needs to change there.

Chief Peter Collins: I want to add maybe a little bit to that.

You see the opioid crisis that's having an impact on all of our communities. It doesn't matter what walk of life you come from. You see them fall and become frail. Those are people who are going to end up in the long-term care facilities. Some of them get so bad. I see some of them in our community. One of them had an arm chopped off. They're so frail now that they really belong in a long-term care facility, not out on the streets.

Mr. Kevin Waugh: Thank you for that.

The Chair: With that, we're going to move the questioning to MP Rachel Blaney.

Ms. Rachel Blaney: Thank you, both of you, for being here with us today.

I remember my granny went to residential school from ages 4 to 16. When she was in the hospital, we all had a plan about who was going to be with her at all times, because it was so traumatizing to be in that environment. I really appreciate the mindfulness of bringing that up, because this is also an issue of justice, not only about legalities.

I have a couple of questions.

I'm going to come back to the data, because this aspect really concerns me. I think a lot of communities are erased because small communities simply don't have the capacity to gather the data that is always requested of them.

I'm wondering if you have any thoughts on whether this is something we need to do nationally, so that we have a representation of all of Canada and what's happening in indigenous communities and we can pull out different communities. If we did do something at that level, who would actually get that? I realize that you don't want to give that necessarily to the federal Government of Canada.

● (1715)

Chief Peter Collins: No. That's like intellectual property that belongs to first nations. All that data collection is something we need to discuss. We were close at one time. It just broke down and went in a different direction.

With regard to who would get the data, it would be our communities. It would be tools for us to talk about health care or long-term care or schooling issues, and all the different issues that we deal with on a constant basis. The data would belong: in our hands and on our property.

That's the way I look at it, anyway. I'm not sure—

Chief Ogimaa Duke Peltier: There are sources. There's the Institute for Clinical Evaluative Services. It has kept records and they are accessible, at least to our first nation. They categorize them that way. We do have records for the time period of 2002 to March 31, 2015, for all services obtained by our people within the North East LHIN and within Ontario.

It has given us a whole wide range of statistics, but we do know from them that we're 1.9 times more likely to have hospitalization in the first year after diagnosis of diabetes. We're 3.3 times more likely to have an emergency department visit in the first year following diagnosis. We're also 1.3 times less likely to have a non-urgent visit in the first year following that diagnosis. The people with diabetes in my community at one time were 1.9 times more likely to develop heart disease or stroke.

These are critical numbers that we have to deal with. The one that really strikes us is that people in my community are 10.8 times more likely to have an amputation. I'm now seeing amputations on individuals younger than I am. I'm not very aged, and they're younger than me, and that's a cause for concern. I grew up with some of these individuals. Why is this happening?

We know about it from the data that exists and from ongoing monitoring. In fact, working with the province, we initiated.... In 2016, we wanted to establish dialysis services in our community because we had 13 individuals who were travelling two hours each way for dialysis. They didn't have much of a quality of life. We were lobbying and advocating for them to have services within the community. We had to have a requisite number to provide those services in our community because they were doing it in other locations. During the time period when we were advocating for that, in a two-and-a-half-year time period, we lost eight of those 13, because they just gave up.

We've made it an issue with the Ontario Renal Network. We started a screening process. We know who has early onset diabetes and who's at risk. We know how many diabetics are in the community because we've made it a point to assess as many individuals in our community as possible. Now we know we're sitting at about 60% of our population that is diabetic. That's where I'm coming from.

In order to alleviate the long-term care services in the future, we need to do something about the diabetes complications, because they're coming.

Ms. Rachel Blaney: Yes, you talked about how a lot of the resources are on the back end, not at the front end where you can do some of the preventive work.

One of the things you talked about, Chief Peltier, is the family health team and how the provincial area has it but you don't have it. Can you tell us a little bit about what that looks like and what you see as the federal government's role in helping establish that?

Chief Ogimaa Duke Peltier: I had the Hon. Minister Philpott, who is also a physician, visit the community in July. She was well aware that our community should be serviced by a family health team. How that gets rolled out in collaboration with the federal government and the provincial government I'm not sure, but I believe there's probably a solution that could be made available.

Our neighbouring municipality is five minutes away from my village, and it has a full family health team that provides servicing to that municipality. We're being serviced by a family health team that's 45 minutes away. They come into our community to provide 15-minute appointment increments three times a week. That's what our community is serviced with.

Most times, if individuals are having complications with something and they want to see a nurse or a doctor, they go to our health centre, but they're just waved on through. They're told to go to emergency, to go to the hospital, which is a 45-minute trip.

Perhaps it's cheaper to run a medical transportation program. I'm not sure. I don't know who designed the system, but that's what's happening.

● (1720)

Ms. Rachel Blaney: The last thing—and I only have a few seconds left—is that it sounds as if the federal infrastructure funding would be really helpful to both of you in terms of your facilities.

Chief Peter Collins: That would be the major contributor for us right now. That's the thing we're looking for because, as I said, we're going to finance it. Fort William has the ability to finance a $23-million building, but when we're looking after people and dealing with our elders, the federal and provincial governments need to make a contribution to help build that facility, other than giving us that provincial licence right now and lifting that moratorium.

We also need the resources to help maintain it. We all know that long-term care facilities are marginalized. If we have to finance a lot of it, it's going to be even that much tougher to run it. Can I borrow some money?

Chief Ogimaa Duke Peltier: I want to say one piece on the infrastructure.

The Chair: Say it quickly.

Chief Ogimaa Duke Peltier: Programs have been established in recent years for which my community and others across the country were not eligible because we are first nations. We were pushed towards Indigenous Services Canada and forced to apply through that process. Amounts were limited over there, yet there were billions of dollars that were allocated through this Building Canada fund, which we were not eligible for. Individuals with equity, like Chief Collins here, had the ability to fully access that program, but they were ineligible. That's a problem.

The Chair: That is a problem.

We're going to wrap up questioning with MP Robillard.

[*Translation*]

Mr. Yves Robillard: Do you mind if I ask my questions in French?

[*English*]

The Chair: We have a translator.

[*Translation*]

Mr. Yves Robillard: First of all, thank you for being here.

We know that across Canada, and not only in your communities, the aging of the population turns our minds to our seniors.

What immediate steps do you think the federal government could take to ensure that culturally appropriate practices are adopted in long-term care?

[*English*]

Chief Peter Collins: There are a couple of things, if I look at it from my perspective in Fort William. In our community and throughout our territories and partnering communities, how you can help us again goes back to the resources. If we look at the original signatories to the treaty, we're one of them. That treaty talks about sharing, and yet we're here kind of with our hands out looking for our portion of help. Share some of those resources that you have at the federal level. Those are things we look at on a constant basis.

Our community is a pretty dynamic community. We have a lot of different things happening, but we still struggle, and that's because we're an urban community. Unlike Ogimaa Duke, we've all but lost our language in our community, and that's one of the things that needs to be regenerated back, not only to our elders but from our elders into our young people, because we've lost a lot of our elders who used to speak that language. That's where the work needs to begin—at the elders level and from the federal level—to help us regain and make sure our folks stay at home, where it's most appropriate.

● (1725)

Chief Ogimaa Duke Peltier: I would just like to add that the existing funding envelopes are very prescriptive from a top-down approach. We're not allowed any flexibility to address the real trends that we're experiencing in our communities. In spite of the budgets that are provided, if there's no opportunity to provide that servicing because there are no clients, we have to send the money back because we can't use it any other way. That's one of the issues: flexibility in the funding approaches and the funding envelopes that exist.

[*Translation*]

Mr. Yves Robillard: Of course, if we had more time, I would talk to you about what you said earlier about the training you would like to give to your young and old, so that they can hold important positions in the community.

[*English*]

Chief Peter Collins: I guess if we had more time we could talk for hours. You could drill us for hours and we could answer those questions for hours, I guess.

Our young people are our most important assets in our community. We're starting to see our young people turning towards our culture and our language and starting to regain that. That's a great step for us, but we're also struggling with the opioid crisis in our community.

As I said, every community struggles—it doesn't matter what walk of life you come from. One thing we're proud of is that we had 100 or so students who graduated again this year. That represents great steps and great strides for our community. Our young people are the most important to us. Our elders likewise—we need to make sure they live a comfortable life at the end of it.

Chief Ogimaa Duke Peltier: Along the same vein, we've had a lot of graduates at the post-secondary level. We have 100 post-secondary graduates this year, four of them at the doctorate level.

I believe that as far as the prevention aspect goes, the use of language is a prevention tactic also. Because many of our people are walking around without an identity—they don't know who they are and they're struggling with their culture and looking for it—we've been initiating some work in our community on behalf of the territory to reinstitute supports for language.

I'm going to do a plug here for challengeforchange.ca. Check it out. Donate if you can. It's developing an online portal so that the grandmothers and grandfathers who don't speak anymore could be made available to a younger person who has that spark to relearn the language and the culture of our own people.

Mr. Yves Robillard: Thank you very much.

When you come back, we'll have more discussion on this.

The Chair: Mike, you have about 30 seconds.

Mr. Mike Bossio: I have just one final thought.

To feed off what you've been saying about the federal government getting involved at the infrastructure level, do you feel it would be important in this report to make a recommendation that the federal government run a pilot project to fund a number of these? The Mohawks of the Bay of Quinte are in the same boat as you—they have the licence, they have the provincial commitment. Should we do a pilot project to fund these projects?

Chief Ogimaa Duke Peltier: Whether it's a pilot or not, the challenge we're experiencing is that a number of years ago, there was a 2% cap that was instituted on our first nations for funding. It's really had a detrimental impact, and not just on operations and maintenance of facilities: There was also no consideration for renewals of those facilities.

I think there's opportunity for some new type of programming and creative-type thinking, like a pilot project, that would allow some private investment, and some security from that private investment, to allow for those partnerships to exist internally.

Chief Peter Collins: Just to respond to that, as you've said, the Mohawks of the Bay of Quinte are like us. We have approval on the first phase, on the provincial side of the approval process. If you want to make a pilot project, use us both. Use one from the south and use one from the north. I don't know where I belong, because sometimes they tell me I'm from northwestern Ontario, and then when it comes to funding, they tell me I'm from the south.

The Chair: That was a good lob from Mike, and a good closure from you.

● (1730)

Chief Peter Collins: Thanks a lot, Madam Chair.

I have a flight to catch back to Thunder Bay. It's been a long day.

The Chair: Back to Thunder Bay—there's no place better.

Okay, *meegwetch*. Thank you for coming out; we appreciate it.

The meeting is adjourned.