Community-Based Emergency Care
An Open Report for Nishnawbe Aski Nation
March 2014
People in remote and isolated First Nation communities should have access to excellent community-based first response emergency care.
INTRODUCTION & KEY TERMS

This report summarizes the learnings of the Community-Based Emergency Care Roundtable, a two-day multi-jurisdictional meeting held in October 2013 in Sioux Lookout, Ontario. The purpose of this meeting was to discuss and address pre-nursing station emergency care needs in remote and isolated First Nation communities in Ontario. Representatives of First Nations’ governance and community organizations, Ontario Provincial and Canadian Federal governments, nursing and paramedical services, and non-governmental organizations joined together to develop shared understandings and a vision for the future of emergency care in remote and isolated settings. This report offers a Vision, Key Recommendations and Guiding Principles with which to improve emergency care for all injured and ill people in remote and isolated First Nation communities in Nishnawbe Aski Nation.

Emergency Care
Management of urgent health conditions where timely care is critically important. For example: heart attacks, strokes, mental health crises, and severe injuries. Effective emergency care is an important part of local emergency management capacity, and it is a key element of an equitable health care system.

Remote and Isolated Communities
Communities with no permanent road access and communities that are more than two hours by road from an Emergency Department. Many of these communities lack local paramedical and 911 dispatch services. Transportation to an Emergency Department is most often by airplane.

Pre-Nursing Station Care
The initial component of pre-hospital care in remote First Nation communities. This care takes place outside a nursing station and involves the initial on-scene management and transportation of ill or injured patients to a nursing station. “Nursing station” is used interchangeably with “health centre” or “clinic”.

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STATUS OF REMOTE EMERGENCY CARE

25,000
Ontarians who need to board a plane to access an emergency department¹

2,000
Medical evacuations from remote First Nation communities in Ontario in 2012

29
Remote communities in northern Ontario with no formal paramedical or 911 service (as shown on map)

15%
Trauma deaths that can be reduced by pre-hospital services²

4
The number of times more likely First Nations people are to experience severe trauma relative to the average Canadian³


Map data sources: Statistics Canada, Ministry of Health and Long-Term Care, KNET Keewaytinook Okimakanak
EXISTING INITIATIVES

First Nations Emergency First Response Program:
Provincially funded medical training for First Nation communities. The program relies on community support by way of a Band Council Resolution and a team coordinator to recruit volunteers from the community to be trained in emergency first response, first aid and CPR. The program provides medically vetted training, required medical and communications equipment.

James Bay Ambulance Services:
An accredited paramedic service in Northeastern Ontario that provides paramedical services to five remote communities with dispatch services provided by the Timmins Central Ambulance Communication Centre. The program also supplies host support services to Weeneebayko Area Health Authority First Response Teams in surrounding communities.

Sachigo Lake Wilderness Emergency Response Educational Initiative:
A community-based emergency care pilot project in Sachigo Lake First Nation. This collaborative program aimed to build community resilience and local emergency care capacity by delivering and evaluating a comprehensive approach to pre-nursing station health emergencies, including mental health crises. The program trained 6.5% of people in Sachigo Lake.

Community experiences enabling first aid training programs shared by health leaders

“Out of the proper support and coordinations of a team is required to ensure any measure of longevity. Community support is also incredibly important. The Emergency First Response group are dedicated volunteers trained to respond to every medical emergency, it is a daunting task for many citizens.”

Capacity Building from Emergency Care Training

“A young woman from Sachigo Lake First Nation participated in a five-day course that was a part of the Sachigo Lake Wilderness Emergency Response Education Initiative Before the training, she'd been uncertain about whether she'd feel comfortable – the sight of blood had never been her favourite. But, being involved in the simulated health emergencies helped and motivated her. She decided to go to college to train to be a paramedic. When she graduates, her goal is to work in remote First Nation communities like Sachigo Lake.”
EXISTING NEEDS

Emergency Care:
Remote First Nation communities face elevated rates of emergency conditions, such as heart attacks, stroke, injury and mental health crises\(^4,5\).

Human Resources:
Nursing stations are staffed by nurses and occasionally by visiting physicians. Many First Nation communities in the Nashinawbe Aski Nation (NAN) region do not have local paramedic or 911-dispatch services (see map). It is often the case that healthcare providers are unable to leave the nursing station to provide care.

Layperson Training:
Community members provide first response care and transportation for injured and ill people in these areas. Some communities have sought first aid and CPR training. Resource limitations and distance mean that training is infrequent, inconsistent or unavailable.

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Challenges shared by health leaders in remote First Nation communities.

“*Our community doesn’t have a program to address emergency response. We don’t have an ambulance response service, and that is required. We make use with what we have. We’ve been lucky so far.*”

“*There is willingness to pay for janitors to clean schools, but not in paying for first responders to save lives.*”
All attendees of the Community-based Emergency Care Roundtable, including participants from the Nishnawbe Aski Nation, Health Canada First Nations and Inuit Health Branch, the Ontario Ministry of Health and Long-Term Care and the Ministry of Aboriginal Affairs, formed consensus and voiced shared commitment around a vision:

People in remote and isolated First Nation communities should have access to excellent community-based first response emergency care.

Potential Benefits of Community-Based Emergency Care:

- Reduced preventable morbidity and mortality from a wide variety of illnesses and injuries.
- Safer, more resilient communities.
- More local health knowledge, local health workers, and local leadership in health services.
- Enhanced emergency response and crisis management capacity.
- Personal and economic development from related service and job opportunities.
RECOMMENDED ACTIONS

These recommendations emerged directly from the conversations that took place at the Roundtable between key partners.

1. **Build a Working Group:**
   The Nishnawbe Aski Nation lead a collaboration with Health Canada and the Ontario Ministry of Health and Long-Term Care to build a Working Group mandated to advance the *Roundtable Vision*. This process will require funding considerations from government partners. Further attention will be needed to develop a framework for this process and to define the relationships of all partners.

2. **Represent key partners in this Working Group:**
   The Working Group considers the following priority representatives: representatives from Nishnawbe Aski Nation communities, the Sioux Lookout First Nations Health Authority, Weeneebayko Area Health Authority, Health Canada First Nations and Inuit Health Branch, Aboriginal Affairs and Northern Development Canada, Ontario Ministry of Aboriginal Affairs, ORNGE Air Ambulance, The Northeast and Northwest Ontario Local Health Integration Networks, Sioux Lookout Regional Physician Services Incorporated, the Northern Ontario School of Medicine, university researchers, and the non-profit sector.

3. **Follow Guiding Principles to advance Community-Based Emergency Care:**

4. **Plan and Test a Model for Community-Based Emergency Care:**
   Based on these guiding principles, develop, deliver and evaluate a community-based emergency care program in partnership with a selection of remote or isolated First Nation communities.

**Perspectives of Roundtable Participants**

- “Spirit of giving and life exists in the communities. Celebration of doing something is important to bring about ownership.”
- “There are champions in the community and conveners who are eager to start something. Look at the room, everyone is willing to start something!”
- “Sachigo took the plunge, we should all do it. Part of that was the community; leadership being involved in establishing the process.”
GUIDING PRINCIPLES

Six key principles emerged during the Community-Based Emergency Care (CBEC) Roundtable as central when advancing solutions in pre-nursing station care in remote First Nation Communities.

1. COMMUNITY-BASED
   Identify, respect, and learn from the diversity of remote and isolated First Nation communities. Address individual and population health needs by building on local priorities, relationships, skills, strengths and culture. Develop, deliver and evaluate programs with the community, and for the community.

2. SUSTAINABLE
   Strive for lasting and scalable community-based emergency care programs, rooted in sound health, human resources, economic, and community planning. Build on opportunities to develop community resilience and health services as a sustainable and renewable local resource.

3. CAPACITY-BUILDING
   Build capacity by providing emergency care training across a large cross-section of community members. Explore opportunities to develop employment opportunities for local emergency care and training.

4. COLLABORATION
   Work with partners in healthcare delivery, such as community health workers, nurses, paramedics and physicians in the design, delivery, evaluation and funding of community-based emergency care programs. Develop programs as a collaboration between First Nations and local, provincial and federal governance organizations.

5. INTEGRATION
   Ensure that CBEC programs integrate with emergency health services provided by nurses, paramedics and physicians, as well as other community emergency management strategies including Canadian Rangers and Crisis Response Teams.

6. EXCELLENCE
   Evaluate and study programs in collaboration with communities, to bring high-quality, equitable, innovative and evidence-based emergency care to ill and injured patients in remote communities.
Where do we go from here? Building upon the four Recommended Actions, Nishnawbe Aski Nation, First Nation communities, federal and provincial governments, as well as other partners should consider the following strategies to develop community-based emergency care (CBEC).

1. **DEVELOP GUIDELINES FOR APPROPRIATE EMERGENCY CARE IN REMOTE SETTINGS:**
   Lead initiatives with remote and isolated First Nation communities to identify appropriate educational and patient care strategies for pre-nursing station emergencies. Standard first aid and emergency medicine guidelines face limitations in remote settings.

2. **INVESTIGATE THE HEALTH EFFECTS OF CBEC PROGRAMS:**
   Study the effectiveness of CBEC programs to understand their impact on community and individual health and wellbeing. Innovative research in remote communities can uncover the best ways to develop CBEC programs to save lives and reduce illness in these settings.

3. **UNDERSTAND AND BUILD ON THE ECONOMIC COSTS AND BENEFITS OF CBEC:**
   Build sound financial strategies for program development and sustainability. Explore and understand the cost-effectiveness of these initiatives as well as their economic and financial impacts on communities.

4. **EVALUATE EFFORTS TO DEVELOP AND DELIVER CBEC PROGRAMS:**
   Work with communities to create and evaluate CBEC systems that address health needs by building on local priorities, skills, strengths and culture. Evaluate programs to improve quality and maintain excellence.

5. **DEVELOP PARAPROFESSIONAL POSITIONS FOR CBEC PROVIDERS AND TRAINERS:**
   Explore opportunities to partner with post-secondary educational institutions to develop and deliver an emergency paraprofessional educational program for residents of remote and isolated First Nation communities. This program could establish a new community emergency health worker, emphasizing CBEC delivery and education. Consider deploying and employing these new paraprofessionals in remote and isolated First Nation communities.
FORCES FOR AND AGAINST PROGRESS

What is working in favor of change? What needs to be overcome? This force field analysis identifies factors that will promote change towards excellent community-based first response emergency care, and factors that might make positive change challenging.

✓ CHAMPIONS:
  Community leaders and members, government officials and academics are dedicated to the *Roundtable Vision*.

✓ EXISTING INITIATIVES:
  Two established *programs and a pilot project* enhance emergency care in remote communities.

✓ BODY OF KNOWLEDGE:
  There is existing knowledge about the importance of emergency care, and community-based efforts

✓ EXISTING COMMUNITY SERVICES:
  Volunteer Firefighting, Nishawnbe Aski Police Services, Canadian Rangers, First Response Teams, and Crisis Response Teams can guide ongoing efforts.

✓ NEW TECHNOLOGIES:
  Telehealth, Global Positioning Systems (GPS), internet and mobile phone services enhance opportunities for training and care.

✗ MULTI-JURISDICTIONAL ISSUES:
  Lack of clarity regarding responsibility for funding and delivery of pre-nursing station care.

✗ RESOURCE LIMITATIONS:
  Human and financial infrastructure is needed to build a sustainable system.

✗ RESOURCE-INTENSITY:
  Scale-up could be costly.

✗ SPORADIC EMERGENCY CARE DEMAND:
  Communities have a low volume of high acuity cases to maintain first response knowledge and skills.

✗ DIVERSITY OF COMMUNITY NEEDS:
  Regional efforts must be adapted to community-specific needs.
ACKNOWLEDGEMENTS

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This report summarizes the many discussions from the Community-Based Emergency Care Roundtable and was developed in close consultation with many of the Roundtable participants. While the Roundtable participants’ many ideas and voices are represented in this document, it cannot capture all of the important details from this gathering. Ultimately, the Report’s specific language is that of the Roundtable Organizing Team and should not be attributed individually to any of the Roundtable participants or the institutions and organizations that they represent.

- The Roundtable Organizing Team

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