



Medical Transportation Transformation Project Health Benefits and Services

ENGAGEMENT SUMMARY 2022



First Nations Health Authority
Health through wellness

We paddle together on the journey to health and wellness.

We are connected by the elements and our diverse experiences.

The strength and resilience of Communities will continue to guide us on the road to transformation.



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Executive Summary





Executive Summary

It can be challenging for many First Nations community members to access health care services. Through its medical transportation program, the First Nations Health Authority (FNHA) supports clients to access medically required services not available in their communities of residence.

According to the Tripartite Agreement (2011), the FNHA was to “renovate and improve the Non-insured Health Benefits Program – including the medical transportation (MT) Program.” In 2019, the FNHA received feedback from First Nations communities about the need to improve the MT program. In March 2020, the FNHA initiated the MT Transformation Project to bring about much-needed change and improvements to achieve better health outcomes for its clients.

This project aims to improve MT services to support First Nations clients and communities in their health and wellness journeys and is guided by the FNHA’s [Operating Principles](#) and the 7 Directives:

- Directive #1: Community-Driven, Nation-Based
- Directive #2: Increase First Nations Decision-Making and Control
- Directive #3: Improve Services
- Directive #4: Foster Meaningful Collaboration and Partnership
- Directive #5: Develop Human and Economic Capacity
- Directive #6: Be Without Prejudice to First Nations Interests
- Directive #7: Function at a High Operational Standard

The FNHA and FNHDA co-hosted nine engagement sessions between October 2021 and January 2022. The engagement activities covered a wide range of topics related to MT, such as cultural safety, provider selection, administrative processes and tools, budgeting, and the capacity to deliver the program in First Nations communities. Through this dialogue, several key themes emerged that provide a strong foundation and basis for improvements to the program and, ultimately, transformation.

Key Themes:

- The current MT service model, which is largely unchanged since the transfer from Non-Insured Health Benefits, may not suit the FNHA’s evolving operating model, including regionalization. The approach to MT funding agreements may also need to be revised to be more efficient and responsive. Moreover, the needs of clients living in urban settings and those living away from their home communities may need to be re-evaluated.

- Some MT program policies need to be improved to ensure clarity and alignment with the FNHA's wholistic approach. Notably, the "closest appropriate provider" policy is unclear and subject to different interpretations. Cultural safety concerns with providers, specialist referrals to providers that were not closest to the community and provider availability were commonly cited concerns. Another area of concern is the requirement for benefit exceptions to be approved before arranging travel.
- There is a broad interest in bringing services closer to home to mitigate the ever-increasing demands on the program and provide better access for clients. This can be accomplished in various ways, such as by increasing provider access into communities and primary care centres. Virtual services such as FNHA's Virtual Doctor of the Day and Virtual Substance Use and Psychiatry Services also play a role in improving access to services in communities.
- Communities need to be supported in building their capacity for the effective and efficient delivery of medical transportation services. This means recruiting, training and retaining staff to perform administration and travel coordination work. It also requires that workload, working hours and work-related stress are reasonable and do not contribute to burnout.
- MT administrators need to be supported with appropriate technology and tools. These tools are necessary to support efficient processes, simplified reporting and assurance that client data is kept private and secure.



The First Nations Health Benefits team is grateful for the wisdom shared in the engagement sessions. The knowledge we have gathered will be invaluable to informing subsequent stages of the project and building future changes to the MT program.



Background



Background

About the First Nations Health Authority

The First Nations Health Authority (FNHA) is the health and wellness partner to over 200 diverse First Nations communities and citizens across British Columbia (BC).

In 2013, the creation of the FNHA marked a new chapter for BC First Nations health governance and health service delivery, taking responsibility for programs and services previously delivered by the First Nations and Inuit Health Branch, at the time, a part of Health Canada. Among other programs, this included the Non-Insured Health Benefits (NIHB) program, which was renamed First Nations Health Benefits (FNHB). Since then, the FNHA has been working to close existing service gaps by creating meaningful partnerships and collaborations, promoting health system innovation and reform, and by redesigning health programs and services for First Nations in BC.

The FNHA is committed to championing cultural safety and humility across the broader health care system. The FNHA works with partners to embed cultural safety, humility and Indigenous-specific anti-racism into the health system to improve health outcomes and experiences for all First Nations people living in BC.

About First Nations Health Benefits

Since the FNHA's inception, FNHB has transitioned all health benefits from the NIHB program. FNHB delivers six benefit areas to eligible First Nations living in BC: vision, dental, medical supplies, pharmacy, mental wellness counselling and medical transportation (MT). FNHB also provides in-community oral health services and oversees the Children's Oral Health Initiative. The FNHA has worked to improve access to benefits through partnerships with BC PharmaCare (2017) and Pacific Blue Cross (2019). Aligned to the FNHA's vision, mission, values and the 7 Directives, FNHB continues to transform health benefit programs and services through community-driven engagement processes.



Health Benefits Transformation Journey

Comprehensive review of Health Benefits with community input to determine the path forward

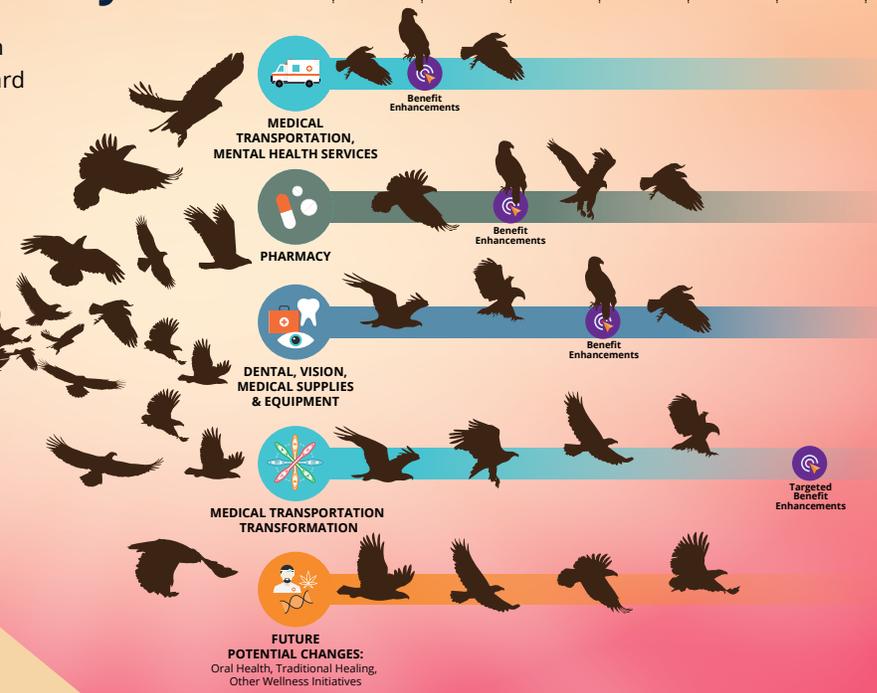


*We work together,
not apart, to lead
transformation!*

First Nations Health Benefits

Community driven, nation based change opportunity

2013 2015 2017 2019 2021 2023 2025



About the review of the medical transportation program

The MT program supports eligible First Nations to access medical and traditional healing services outside their communities by covering the costs associated with transportation, accommodation and meals. In April 2020, based on community feedback, the FNHA initiated the MT project to transform this essential benefit. Through the review, FNHB has conducted discovery and engagement activities to assess the current MT program and identify how to transform the program to better support clients and communities in their health and wellness journeys.

This interim engagement summary report is a compilation of feedback from internal and external partners regarding the program.

Engagement Overview





Engagement Overview

Engagement objectives

FNHB partnered with the First Nations Health Directors Association (FNHDA) to complete a health lead engagement series to gather community perspectives and feedback on the existing MT program. The engagement series was inspired and informed by the FNHDA's Health Benefits survey and report completed in 2014.

Engagement process

The engagement process began with an online survey issued to community health leads from First Nations communities across BC.

The survey generated 108 responses that were cumulative scored and ranked in order of importance using appropriate quantitative analysis methods. Using open-ended questions in the survey design, key qualitative insights were added to the survey findings.

Topics were ranked based on their ability to transform the MT program. The topics are listed below from highest to lowest priority as established by the survey.

- Community-driven decision-making and travel planning
- Access to culturally-safe, timely and high-quality service providers
- Arranging transportation from remote and rural communities
- Access to in-community medical service providers
- Benefit exceptions and appeals
- Budgeting and funding agreements
- Booking travel and accommodation
- Access to virtual health services
- Program administration and training
- Access for urban and away-from-home members

The FNHA planned and facilitated nine virtual health lead engagement sessions that drew upon the survey feedback. Engagement sessions were held between October 2021 and January 2022.

Engagement sessions

FNHB and the FNHDA co-hosted nine engagement events to gather community insights on the MT topic areas. The engagement sessions also served as a channel to validate survey feedback. Community representatives from all five regions in BC participated in the sessions.



What We Heard





What We Heard

At the engagement sessions, participants were asked questions centred on specific MT topics previously identified in the survey. A summary of the key points gathered from the survey and sessions is provided here.

Community-driven decision-making and travel planning

The theme of a community-driven decision-making model emerged as a top priority through the survey and across the resulting engagement sessions. Participants understand the needs of their community members, and decisions around medical travel should ideally be made at the community level. They further expressed the importance of client choice in provider selection.

Key Points from Health Leads:

- Participants emphasized that community-based decision-making and travel planning should be brought closer to home. A regional model (compared to a provincial one) may help make the connection better for the community.
- Participants highlighted that the current policy based on the closest appropriate provider for a given service is rigid and needs to be more flexible so it can accommodate the specific needs of clients and communities.
- Participants expressed that the program does not clarify which medical provider(s) clients are eligible to see if there is a visiting physician in the community or the closest provider. They also felt that wait times should be considered since providers closest to the community may have limited availability or capacity.
- Health leads shared stories of their clients experiencing racism, stereotyping and discrimination when receiving health services. Participants stressed that decision-making about medical provider selection should consider cultural safety and rapport.

Health Lead Quotes:

- “Trust that employees and patients know the providers who work in the community, know their appointment availability and know their willingness to work with the surrounding First Nations communities.”
- “Each community and scenario is unique. Each has a different approach to medical travel. The current policy is a catch-all, and it needs to be adapted to communities.”
- “The current cookie-cutter approach does not work for us.”
- “The nearest provider policy is an ongoing issue. It feels like we are dictated on the health professionals that we can see.”

- “Being located on the North Island, the nearest provider is usually in the Courtney/ Comox area. We are forced to stick within the North Island region when other options are available farther away.”
- “Consistency of care with the same provider is crucial to appropriate care, and rules about closest provider, etc., should be secondary.”
- “It is frustrating because the closest provider for some things is not the greatest for the most reliable care.”

Access to culturally-safe providers

Participants highlighted cultural safety as a top priority in provider selection. It was expressed that the closest provider is not always felt to be culturally safe by community members. Requiring clients to see the nearest available provider may result in culturally-unsafe experiences.

Key Points from Health Leads:

- Participants emphasized that cultural safety training at the provider level should be mandated to increase client safety and comfort and foster trust in the provider-client relationship.

Health Lead Quotes:

- “We do not have a lot of culturally safe service providers in [the nearest city]. The optometrist is especially an issue; many of our members prefer to travel to Williams Lake or Prince George to get their eyes checked as the ones [nearby] have displayed racism. It is frustrating for the members when they cannot get travel assistance to go to a different community to avoid feeling stigmatized here.”
- “Boundaries are being crossed, providers are prejudiced and racism is rampant. We shouldn’t have to see a provider who talks down to us. We are limited in our options based on the closest provider policy.”
- “Our people travel from the community and speak the language. There needs to be cultural understanding and cultural training for providers.”
- “People need to be patient. Cultural sensitivity can’t be taught. Our local hospital is heavily reliant on nursing staff. They don’t know our individuals. Online courses are not sufficient. They must build a rapport with the community, build empathy.”
- “It is important to have a cultural person in the community who can start the day off with a good smudge/prayer. Cultural safety will become the norm. Every clinic should have a cultural advisor to be there for a death crisis.”

Access to in-community medical service providers

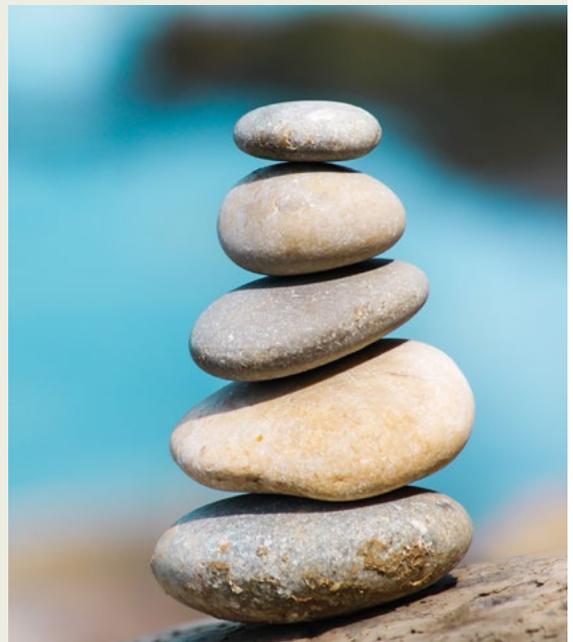
Participants emphasized the importance of having access to service providers in (or closer to) their communities of residence.

Key Points from Health Leads:

- Health leads underscored the need for more physicians and other providers to come into their communities to reduce the need for travel.
- Participants indicated that the aging population requires in-community care services since it is taxing on their bodies to be travelling for long periods to go in for a quick checkup or get a prescription refill.
- Several participants identified the need for having dialysis facilities, as many community members need regular access to them. There are difficulties securing transportation to reach these facilities, and support is required to help members get to their dialysis appointments safely and reliably.

Health Lead Quotes:

- “Bring services closer to home. An in-community nurse is needed.”
- “Services need to be brought closer to home. We are working with the community on data collection. Bring in mobile ultrasound services. The greatest thing about EMR is that it can track all the data.”
- “One of our Elders is a 78-year-old that travels out for dialysis. Because we are local, we don’t get MT. With HandyDART, you must wait an hour before you get picked up. There are so many stops before the client gets home. We don’t have MT support.”
- “There needs to be a dialysis service in the Campbell River Hospital. Cumberland only takes mobile clients; if not mobile, they must go to Nanaimo or Victoria. It’s not easy for many of our member Nations to afford this service.”
- “Folks travel three hours from Campbell River to get to a dialysis clinic. We would like to see a dialysis clinic here in Campbell River.”
- “There is a dialysis clinic in Cumberland, but they are not set up for patients that require wheelchair access or have mobility issues, so they have to travel to Nanaimo for treatment.”





Consideration for Elders and other clients with physical and/or economic barriers to travel

The difficulty Elders face when travelling was emphasized in the survey and during engagement sessions. Due to mobility issues, fixed/limited income or other social factors, Elders may require transportation support even if the provider is within the community of residence. For out-of-town appointments, travel can be challenging due to poor travel conditions, long distances and/or limited modes of travel.

Mobility difficulties are not limited to age and often result from other conditions. These difficulties often make travel challenging and highlight the need for comprehensive care for persons with limited mobility. Some community members also experience financial hardships, creating additional challenges when accessing or travelling to services.

Key Points from Health Leads:

- Language barriers and/or hearing difficulties can prevent Elders from getting the care and attention they need from their providers. In these instances, having an escort is of value. They play a significant role in improving the Elder's experience by increasing feelings of safety, reducing anxiety, and providing a familiar environment while being away from home.
- Elders may need more time to rest when attending multiple appointments.
- Elders may be on a fixed budget and may have more difficulties finding affordable transportation to appointments.
- Some medical conditions may cause mobility issues and make travel harder on clients.
- In some circumstances, clients pay out of pocket for travel costs and then need to seek reimbursement. Travel may also involve other incidental expenses, such as parking costs, that are not covered within the program policy.

Health Lead Quotes:

- "Elders require more services, such as dialysis, cancer treatment and telehealth."
- "Our elders need more time to rest when attending multiple appointments. It is too far to make separate trips, but they feel rushed to get home even with an escort."
- "Elders should not need to submit physician notes for escorts. Once you reach 65, the clients should be automatically eligible."
- "In our community, we have some Elders who prefer day trips, some prefer overnights and some require extended overnights. They know what works for their medical conditions. I understand that we cannot have a one-size-fits-all for younger travellers. I would like to see more flexibility for our Elders with medical conditions that limit their ability to travel."

- “Situations are very challenging. Elders are travelling for ophthalmology. They are 95 years old, and it’s hard on their health to travel to Terrace. We asked the doctor to switch to Vancouver, and the doctor would not. The patient travel clerk supported her. The travel clerks are getting hit hard from stress.”
- “The closest bus stop to an Elder is half an hour away that they must walk. The lack of in-town travel benefit is hard for Elders.”
- “People who have to hire someone due to their mobility issues to take them to appointments have difficulty finding the support because the travel amount is not enough.”
- “Folks who travel for medical services out of community typically fall below the poverty line.”
- “When we pay out of pocket for fuel and for clients that are low income or living beneath the poverty level – it is an issue. Hotels are further away from the hospital. It is even harder when clients do not have a vehicle.”

Mileage rates

Participants raised the importance of mileage rates under the current MT program. They stressed that inflation, poor road conditions, older vehicles and vehicle maintenance costs were concerns for many. Many stated that these factors contribute to additional costs beyond the mileage rate benefit.

Key Points from Health Leads:

- Participants cited differences in gas prices across the province, advocating for higher mileage rates. They expressed that gas can be more expensive further away from urban areas, so it costs more to get around.
- It was noted that travelling on gravel roads and in winter conditions is not the same as driving through inter-city highways, which significantly affects vehicles (and their passengers). Vehicles travelling on logging roads tend to be larger and less fuel-efficient.

Health Lead Quotes:

- “Increase the mileage rates. The cost of fuel steadily increases, and it is difficult especially for low-income people and Elders to travel on \$0.23/km when fuel costs are currently \$1.51/litre.”
- “Higher rates for mileage are needed. Travel from our community is partially on a logging road and is hard on our vehicles.”
- “Paying out of pocket for gas/mileage is an issue. It is especially challenging if the person is on a fixed income because they live cheque to cheque. It would be great if there were an increase in mileage, especially with gas price increases in the province. With MT being a subsidy, our low-income families and Elders tend to suffer financially.”



Travel for cancer patients to access treatments

Providing flexibility for cancer patients and their families was important to health leads. Participants indicated that in Indigenous cultures, it is essential to be physically close to family members undergoing treatment.

Key Points from Health Leads:

- Participants expressed that cancer patients need to be in a comfortable place so they can rest and recover. There is an interest in having more accommodation options beyond the provincially supported cancer lodges.

Health Lead Quotes:

- "Cancer patients are being told to stay at the cancer lodge. We had some clients not wanting to stay there due to culture. Also, family members can't visit. Give them a choice to stay at a lodge or place with a kitchenette."
- "Cancer clients should not be forced to stay at a lodge. They should be given the option of staying at a hotel or Airbnb."
- "When cancer patients are Chiefs of the Nation, more people need to come in and see them on business matters. The cancer lodges are not open to visitors. Therefore, there is a cultural component for consideration for cancer patients for us."

Benefits exceptions and appeals

The process of submitting benefit exceptions was emphasized by health leads, with many requesting further clarity on the basis for adjudication decisions.

Key Points from Health Leads:

- Participants felt that waiting for approval of exceptions or appeals can be slow and that people living on fixed incomes cannot afford to wait if their travel is time-sensitive.
- Some participants felt that if the FNHA adjudicates exceptions, there cannot be a community-based approach, as the FNHA is placed in a decision-making position.



Health Lead Quotes:

- “The exceptions and appeals processes take too much time and effort – streamline them.”
- “It is hard to tell the patients if their benefit exception has been denied.”
- “What are the set criteria for exceptions, and how are decisions made on exceptions and appeals?”
- “Bella Coola is in Vancouver Coastal, with Williams Lake as the closest provider. It would be culturally safe and less stressful if remote communities could stay within our health authority without navigating the process of benefits exceptions and justifying medical travel to Vancouver – our health authority.”
- “How is each appeal dealt with? Most times, it’s easier to explain verbally than in writing. How can the decision-makers make an informed decision without hearing the whole story?”

After-hours travel authorizations

Health leads called for resources to support clients needing transportation authorization and other support outside of regular business hours.

Key Points from Health Leads:

- Participants shared their experiences of travel requests arising outside of typical working hours. Situations arise where a patient has been released from a health care facility late at night without arrangements to travel back home. They explained that continued instances of these calls create additional stress on the patient travel clerks.

Health Lead Quotes:

- Hospitals will often discharge patients when it is late and nothing is open. I agree something needs to be put in place, or a position needs to be in place to help everyone who gets an ambulance out with one to go with them and no money and no means to pay for a hotel.”
- “Hospitals release people late at night. How do we support them if they have no one to go to?”

Access for urban and away-from-home members

Health leads underscored that urban and away-from-home clients need more information about their MT benefits. With the away-from-home client population growing, it is necessary to share current MT program, eligibility and benefit information through appropriate channels and organizations.

Key Points from Health Leads:

- Some clients have limited contact with their home communities and may not know the MT benefits they are entitled to. They may not be comfortable contacting their communities for support in some cases.
- The MT program does not cover medical travel costs within the same municipality as the client’s residence, which is an issue if clients do not have their own means of transportation.
- Funding agreements vary in how they address off-reserve or away-from-home members. This may result in confusion about who provides MT support and benefits administration.

Health Lead Quotes:

- “Members may have no idea these benefits are available to them. They are not aware.”
- “Each funding agreement can be different, so folks do not know if/how they are covered.”
- “Urban and living-away-from-home clients should be able to access MT in an easier format. Also, proper transportation is needed for clients living in urban areas.”
- “How can we support band members living away from home?”
- “My community is close to urban services. I know that should be a non-issue for our members. Despite this, many of our members do not have vehicles, so they need help with this often. We manage to deal with this, but it can be challenging at times.”
- “We have many clients in urban settings that have difficulty getting to their appointments due to not having money for cabs/buses or licences.”

Budgets and funding agreements

Health leads shared that communities face many barriers to securing appropriate budgets for community programs. MT funding is one such area. There is a high demand for medical travel, but funding has largely remained the same in recent years.



Key Points from Health Leads:

- Several topic areas converged in the discussion of MT budgets and funding agreements, indicating that funding was central to many issues in the program.
- Health leads indicated that ongoing concerns with insufficient budgets, the rising costs of program operations, aging transportation assets and increasing demand for MT services all contribute to the need for more funding for community-delivered travel.

Health Lead Quotes:

- "Our community ends up in a deficit due to the MT services we provide."
- "Increase funding for patient travel."
- "Each fiscal year, we are in deficit due to MT, and it takes a long time to get reimbursed from the FNHA."
- "How do we get reimbursed for program deficits? What happens when we go well outside our budget, and the term for reimbursement is lengthy?"
- "More funding is needed as our clients are getting older. More health conditions like long-term illnesses, cancer, wound care and diabetes are some of those concerns."
- "In our community, we have a large group of 40–60-year-olds and anticipate us needing more funding for travel."
- "More funding is needed for administration. We spend more hours on MT than we are funded for."

Support for patient travel clerks

There was consensus among health leads that the patient travel clerk job can often be a complex and challenging position. Examples were shared that many communities had patient travel clerks working in the same role for as long as 20 years. Other communities were dealing with high turnover, with clerks leaving less than one year into the role.

Key Points from Health Leads:

- Being a patient travel clerk is a stressful job, as they listen to or absorb frustration from clients requesting medical travel.
- When a referral is made to a provider that is not the closest, clerks are not comfortable asking clients to find a nearer alternative.
- There are instances where one patient travel clerk is supporting several communities simultaneously. This increases their workloads and stress levels and adds another layer of strain to an already stressful job.
- High turnover for patient travel clerks results in service gaps and increased strain on health leads who need to fill in to support clients and retrain new hires.

Health Lead Quotes:

- "Clients sometimes get angry when their requests get denied and blame the patient travel clerk. There are instances where one clerk is supporting several communities. Maybe the best way to address these problems is to have a bigger budget and hire more clerks."
- "The patient travel clerk is a thankless job. People are frustrated, and they just want to blame the clerk for everything."
- "I feel terrible for my patient travel clerks. They are now social workers, case managers, patient navigators and travel agencies. "
- "We have been looking for a patient travel clerk, but no one applies. They have heard how stressful this job can be."



Conclusion and Next Steps



Conclusion and Next Steps

Conclusion

The FNHA extends its gratitude to the community health leads and other engagement participants for their time commitment, thoughtful comments, and open dialogue. We thank all participants for bringing their knowledge and experience to this initiative. We would also like to extend our sincere thanks to leadership for their support and look forward to an ongoing partnership with communities to create a better MT program.

Reflecting on the engagement sessions, we heard the need to adapt the MT service, policies, and benefits in line with the FNHA's 7 Directives and Shared Values. Health leads expressed the importance of updating MT policies and benefits to reflect the diverse needs of communities and clients' medical travel needs.

Next Steps

Demand for medical travel and the resulting MT expenses have grown substantially since the FNHA assumed the program in 2013. This growth reflects the dynamic needs of First Nations communities and increased awareness of the role of MT in connecting First Nations clients to health and wellness services. We are aware that budgets for MT funding agreement holders have largely remained static despite the growth in medical travel appointments. We will review the program's funding models to identify opportunities to redesign MT funding agreement terms, program funding, responsibilities and how regional partners may support the vital service.

Medical travel needs are distinctly local, community, and context specific. We will assess how the service can incorporate community decision-making. We may identify new roles and participation opportunities for community and regions to shape and operate the transformed MT program. Through the FNHA's policy assessment, there may be opportunities to transform specific policies such as closest provider, exceptions or eligible benefits.

We acknowledge the important concern participants voiced for the support available to Elders, people with mobility issues, those with limited budgets and cancer patients. We are fully committed to working with the FNHDA, community health leads and our internal





partners to identify and build the MT supports that address these equity-seeking groups.

As we assess opportunities to improve program policies, there is a need to provide a consistent MT program that benefits all clients, equally. The FNHA is building a web-based MT administrative system with IT vendor Bright Health Solutions. This new system, and training, will support change adoption of the improved MT program as it is implemented.

We will continue to expand awareness and communication efforts, patient travel clerk training and support for communities operating the program. We will provide refreshed training to community-based patient travel clerks to support an in-depth understanding of the program and how the benefit can be administered. We believe that ongoing communication, understanding, collaboration and support are the foundation for transforming the MT service.

Future engagement opportunities

We acknowledge that some health leads could not attend our engagement sessions due to other priorities. MT transformation is an ongoing initiative. If you missed the sessions, the FNHA will plan additional engagement opportunities. Where we learn more through further engagement, we can revise and update this engagement report to reflect additional feedback.

The FNHA has established a website for all interested participants and the public to learn more and find updates on the MT transformation effort. The website <https://medicaltransportation.fnha.ca> is current and shares program updates, engagement opportunities, training and support for community funding agreement holders and access to the program's regular Journeys bulletin.

If you would like to engage with the FNHA and the transformation effort directly, please contact us at mtproject@fnha.ca.



Appendix

Overview of the medical transportation program

Program purpose

The MT program provides eligible First Nation clients residing in BC with access to medically-necessary health services not available in their communities of residence. The program supplements travel costs (or mileage), accommodation and meals for eligible clients and their medical escorts (where applicable).

Eligibility and coverage

For an MT trip to be eligible for support*, several criteria must be met:

1. The client has an Indian Status Number and has resided in BC for three months or more.
2. Travel is to access eligible, medically necessary health services.
3. The service is not available in the client's community of residence.
4. Travel is to the closest appropriate health professional or facility.
5. It is not accessible through any private insurance or public programs.

* For full details of the MT program policy eligibility parameters, see the [MT Benefit Schedule](#).

Delivering MT services

Clients request MT benefits through community patient travel clerks or FNHA-coordinated travel assessors. This section describes service delivery through these channels.

Community-coordinated patient travel

Many First Nations communities in BC receive MT through an umbrella service organization serving one or multiple communities. The patient travel clerks work with their members to administer MT benefits for eligible travel requests. Patient travel clerks can approve clients' requests for medical travel based on FNHA MT policy guidelines.

Travel requests are recorded to the community's MT log. The log and year-end reports are submitted to the FNHA for accounting and audit purposes.

Communities administering their own MT programs receive an additional FNHA MT administration budget, which is 15% of the community's annual MT travel budget, to support the costs of the community's patient travel clerk salary and services.



FNHA-coordinated patient travel

The FNHA administers MT travel on behalf of those clients whose communities do not administer MT. In these cases, clients contact an FNHA assessor by calling the FNHA Health Benefits line at 1-855-550-5454. The assessor reviews the client's request and coordinates their travel and benefits.

Patient travel for clients living away from home Most First Nations people residing in BC live away from their home or member communities. Individuals living away from their home community may not know the MT benefits they are eligible to receive or know what organization can administer MT travel benefits. These are the clients who may use their local Friendship Centres. However, these are not necessarily where they would access patient travel services.

Exceptions

The underlying medical reason for travel categorizes MT requests for service. Assessors and patient travel clerks can approve requests for travel that meet the program eligibility requirements or MT Benefit Schedule. Reasons for travel outside the benefit schedule are submitted to and reviewed by the FNHA as exceptions.

The FNHB team recognizes the time sensitivity of these medical requests. Exceptions are reviewed and adjudicated within two business days of receipt.

Training for community-coordinated patient travel programs

The FNHB provides training to community patient travel clerks and health leads. Before the COVID-19 pandemic, MT training was conducted in person. The training was an engaging learning experience but was limited by the clerks' abilities to travel out of their home communities to attend.

COVID-19 shifted MT training to an online delivery model. This delivery model has allowed the FNHA to deliver recurring half-day training sessions with small cohorts of patient travel clerks of four to six participants in each session.

In 2021, MT training was enhanced with more procedure-based and on-the-job support for patient travel clerks and health leads. The updated training is divided into four concepts using the format below:



Each program concept will be introduced with a practical focus:

-  **What is this?** An explanation of the concept
-  **Why is it Important?** Why the concept matters and its purpose within the medical transportation program
-  **Need to know information** – The need-to-know information to book travel and administer medical transportation benefits
-  **Apply this on the job** – Practical, procedure-based instructions to apply when booking travel
-  **Discussion and Examples** – Common scenarios patient travel clerks may encounter on the job with a chance to ask questions and discuss with your peer learners

The updated MT training includes opportunities to practice the program concepts and receive individualized support from FNHA staff on MT benefit administration and reporting. Attendees receive an Excel-based MT benefit calculator to support the consistent administration of these benefits with their community members.

Program funding

Communities receive an annual MT budget to spend on the program. Funds are typically paid out every three months as recurring payments from the FNHA to the community. Various data and software platforms calculate communities' actual spending at the end of the year to assess spending and variances. Upon receipt of complete annual program and financial reporting, Health Benefits reimburses eligible deficits incurred by communities, and may recover surpluses if appropriate.

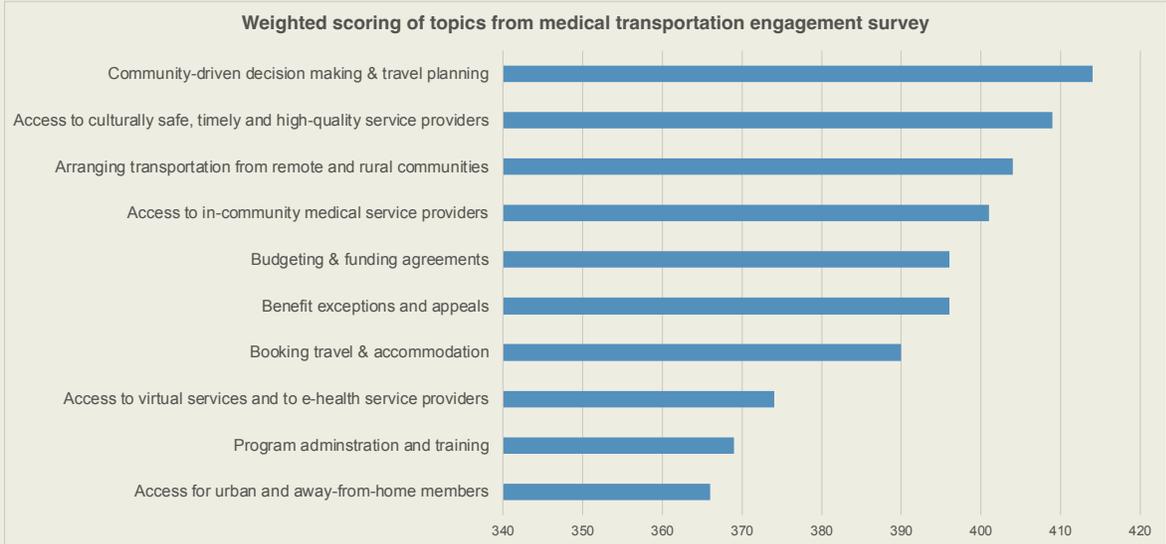
Funding agreements

Communities administering their MT programs have FNHA funding agreements that outline their annual MT budgets. Communities are expected to operate their MT programs within the funding agreements and budgets established with the FNHA. Many of the community MT funding agreements were inherited by the FNHA from Health Canada in 2013. Since then, the FNHA has updated some funding agreements based on demonstrated need and adherence to reporting requirements and program policies.

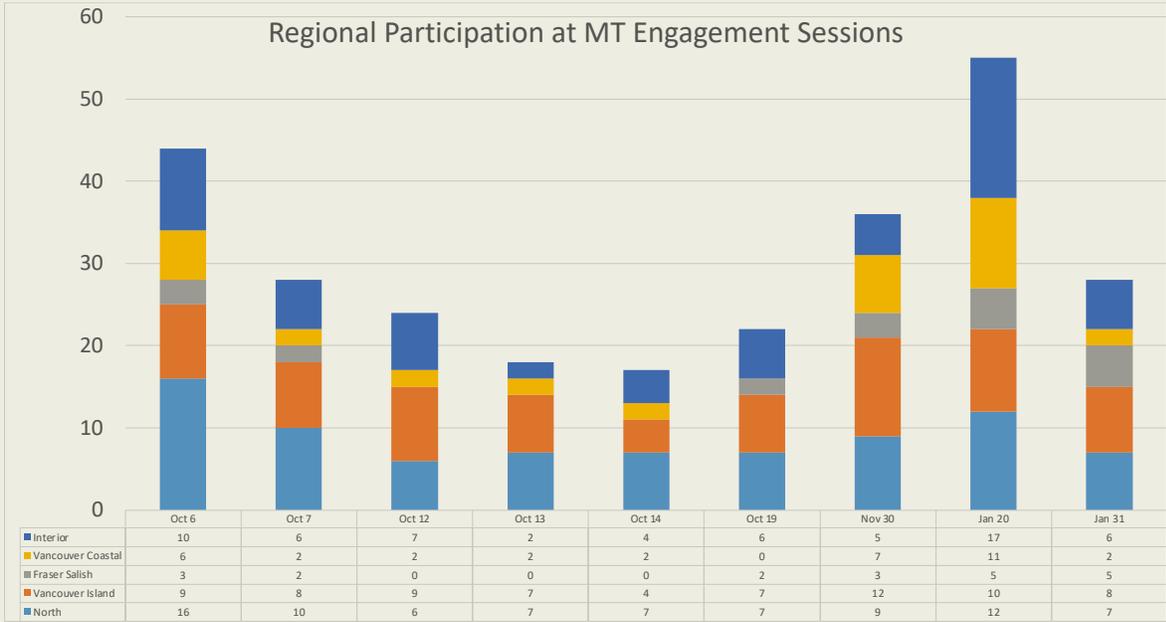
Program costs and sustainability challenges

The FNHA has experienced a steadily high demand for medical travel across the province. Between 2015 and 2020, there has been an average of 90,126 trips per year. While the average number of trips has remained consistent, trip costs have increased.

MT engagement survey results



Community participation at MT engagement sessions



Engagement session participation lists and meeting minutes are available upon request.

Medical Transportation Engagement Summary



First Nations Health Authority
Health through wellness