Supporting Communities Away From Home

Lessons From the 2025 Evacuation Season

A Post-Evacuation Report by the
Indigenous Primary Health Care Council

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INDIGENOUS PRIMARY HEALTH CARE COUNCIL

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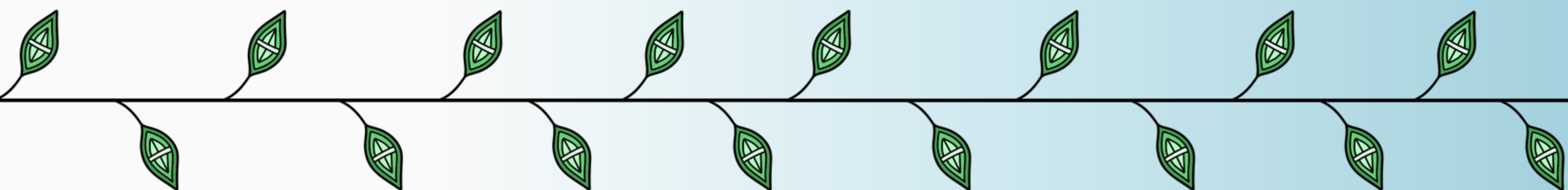

Acknowledgements

This report honours the Indigenous communities who were forced to leave their homes during the 2025 emergency season, and the providers who stepped up to care for them while they were displaced. We thank the Indigenous Primary Health Care Council's (IPHCC) member organizations for taking time during a busy season to share their experiences. Their willingness to speak openly about what worked, what did not, and what could be done differently is what made this report possible.

The experiences reflected here belong to those who lived them. IPHCC's role is to carry them forward so that communities, partners, and decision-makers can better understand what is needed to strengthen future responses.

Executive Summary

The Indigenous Primary Health Care Council (IPHCC) is an Indigenous-governed, culture-based, and Indigenous-informed organization. IPHCC is a member-based organization representing over 20 Indigenous Primary Health Care Organizations (IPHCOs) across more than 40 locations in Ontario. These organizations provide Indigenous primary health care, which views health as a wholistic and relational concept encompassing physical, mental, emotional, and spiritual wellbeing. This approach recognizes the importance of relationships, community, culture, land, and the interconnected nature of health throughout the life course. IPHCC advocates for the inclusion of Indigenous Primary Health Care Organizations in evacuation planning and response, recognizing that during evacuations, maintaining access to this model of care is critical to supporting the overall wellbeing of evacuees.

The 2025 emergency season was marked by a series of severe environmental events, including infrastructure failures, flooding, and the second-worst wildfire season in Canadian history, which impacted 73 First Nations communities (Canada, 2025). These events created unique challenges, including interprovincial evacuations and prolonged displacement lasting several months. IPHCOs across Ontario played a critical role in this response, providing primary health care, wellness programming, medication support, and cultural care, often with very little notice.

Between November 2025 and January 2026, IPHCC held structured conversations with member organizations that directly supported evacuation responses. This report reflects their experiences delivering Indigenous primary health care services during the 2025 season. It brings forward a grounded account from a frontline and organizational perspective.

The recommendations outlined in this report aim to strengthen coordination across jurisdictions, improve communication and preparedness, and support the delivery of culturally safe care during evacuations. Collectively, these findings are intended to inform future emergency planning and response efforts, contributing to more effective, equitable, and less disruptive evacuation experiences for Indigenous communities.

Introduction

Every year, more Indigenous communities in Ontario are forced to leave their homes because of wildfires, floods, or infrastructure failures. When a community is evacuated, its members are sent to host locations outside of their territory and are often required to travel significant distances. Evacuees are typically housed in a hotel or university residence for the duration of their stay. In the process, people are separated from their usual health supports, including access to primary care, medications, treatments, and community-based services.

Evacuations unfold quickly and under conditions of uncertainty, often with limited time for advance planning. In these contexts, access to health care becomes both immediate and essential. However, the delivery of health services in host communities is not always clearly defined. Provincial and federal systems, community governance structures, host providers, and local Indigenous organizations all play a role in supporting evacuees. At the same time, gaps in coordination, communication, and role clarity can emerge. In practice, Indigenous Primary Health Care Organizations often take on an expanded role to support continuity of care in host communities.

This report reflects the experience of IPHCC's members that provided care during the 2025 evacuation season. It brings forward what was encountered on the ground and identifies practical areas for improving how health services are planned, coordinated, and delivered in future responses.

What 2025 Looked Like

The 2025 season opened early. By mid-April, the first community was being relocated because of an infrastructure failure. By the end of May, wildfire and flood evacuations were running in parallel across Northern Ontario. Evacuees from Manitoba also arrived in Ontario, adding cross-provincial complexity that had not been anticipated or previously experienced.

IPHCC's member organizations supported at least thirteen distinct evacuation events during the season, across regions from Thunder Bay and Sioux Lookout in the northwest, to Hamilton, Niagara, Toronto, Peterborough, and Kingston in the south. The 2025 season saw host locations expand into new municipalities, as more communities were evacuated than expected, and staying longer than anticipated. IPHCC members involvement ranged from a few hours of walk-in clinic support to months of sustained daily clinical operations. No two responses looked the same, and in many cases, supports had to be adapted in real time to meet changing needs.

How We Gathered Information

This report is based on conversations with IPHCC members who supported emergency evacuations during the 2025 season. The conversations were held virtually between November 2025 and January 2026. All members were invited to participate if they had been directly involved in an evacuation response, and, in total, six interviews were conducted. Interviewees included executive directors, clinical managers, nurses, and program coordinators. Several sites had more than one staff member present, which allowed conversations to reflect both frontline and leadership perspectives.

A semi-structured interview guide was used to prompt conversation. IPHCC members were encouraged to tell their stories in their own way. This included what happened, what they noticed, what they wished had gone differently, and what went well. The guide was loosely organized around three phases: before, during, and after the evacuation. Most conversations ran between forty-five minutes and an hour. All interviews were audio-recorded with consent and transcribed. After the interviews, IPHCC staff reviewed the transcripts together and grouped observations into themes. The sections that follow reflect consistent themes and practical insights across their experiences.

Scope and Limitations

The findings in this report reflect the firsthand experiences and perspectives shared by IPHCC members who participated in evacuation response efforts. While these findings identify important challenges and gaps within the response system, they do not represent the full scope of experiences related to emergency evacuations.

This report did not include direct engagement with evacuated community members or community leadership. Further research and engagement with communities affected by emergency evacuations would be required to develop a more complete understanding of evacuation experiences and response needs.

What We Heard

Before the Evacuation

"Evacuations are emergent, but they happen every year. So, planning can still be done."

1.1 Lack of Early Involvement in Planning

Across interviews, IPHCC members shared varied experiences about how they were brought into evacuation response planning. In one case, an IPHCC member described being invited to a planning table that began months before the active season. This allowed health partners to clarify what role they would take on during the evacuation season. However, this was not always the case. More commonly, IPHCC members learned about an evacuation only once it was already underway, or were contacted when evacuees were in transit. In some cases, regions were identified as host sites without prior inclusion in pre-season planning conversations, which left little to no time for preparation.

1.2 Lack of Access to Client Information

Every IPHCC member interviewed raised the absence of advance client information as a significant challenge. IPHCC members received rough headcounts, but very little about acuity, age range, pregnancies, chronic conditions, language, or medications. In at least one case, an IPHCC member prepared for a low-acuity group and received evacuees with complex health needs, including pregnancies in advanced stages, that they had not been informed of.

In the absence of records, IPHCC members relied on evacuees themselves to complete a paper intake form on arrival. These were often completed after a long day of travel, sometimes in a second language, by individuals who had just been forced to leave their homes. In this context, it is not realistic to expect someone to accurately identify and disclose their full health needs. Important health information was often incomplete or missing. The intake form could not serve as a reliable substitute for a proper health record.

During the Evacuation

"When you're already taking a group of people from their home, it's a really high-stress situation. Cultural safety should be a priority. That's the minimum."

2.1 Delivering Care

Across the interviews, IPHCC members described delivering a wide range of services to support evacuees. This included primary health care, prenatal care, public health supports, land-based wellness programming, cultural workshops, social work, provision of harm reduction supplies, naloxone training, and coordination with local health units, pharmacies, and hospitals. Services delivered often depended on who was nearby and the scope each organization could take on. Some of IPHCC's members went in with clear boundaries to protect their capacity. Others expanded their role to fill gaps, taking on responsibilities that had not been clearly assigned.

Beyond role clarity, the physical spaces available for clinical assessments also presented challenges. Inadequate space affected the quality of care that could be delivered and limited the ability of providers to operate effectively. Together, these gaps reflect the importance of ensuring that operational conditions at host sites are set up to support effective care delivery.

2.2 Gaps in Wholistic Care

The clearest pattern across the interviews was that planning for mental health and traditional supports were not meaningfully included in host site planning. IPHCC members who supported primary care needs often observed community members struggling with grief, displacement, and fear without clear supports in place to respond. For Indigenous evacuees, mental health and traditional healing supports are not optional or supplementary. They are essential to their wellbeing and continuity of care. When these supports are not included in planning, the response does not fully meet the needs of the people it is intended to serve.

In practice, this meant that supports such as access to Elders, Knowledge Keepers, healing circles, cultural practitioners, and community-specific healing practices were either absent or arranged informally rather than planned. These supports look different across communities but share a common purpose of grounding people in identity and connection during a disorienting experience. In one case, an IPHCC member did commit to providing traditional programming and community-led activities, but these efforts relied on local capacity and initiative rather than a coordinated or planned approach to Indigenous emergency management.

2.3 Communication Challenges

IPHCC members described communication across the response as difficult to navigate and reflective of broader system-level coordination gaps. Communication relied heavily on email and frequent multi-partner meetings. At peak periods, some IPHCC members reported attending two to five regional calls per day, many scheduled with little advance notice and focused on high-level updates. It was often unclear which meetings were relevant, who the main point of contact was, or where to access consistent information.

From the perspective of some IPHCC members, there was no consistent evacuation lead, and new contacts would introduce different processes or expectations week to week. Members described what felt like an absence of a centralized communication structure across partners and jurisdictions. As a result, this made it difficult to maintain shared situational awareness and resulted in largely reactive communication rather than coordinated planning. The absence of a centralized approach also meant that key operational information was not consistently shared. Providers often had to request information such as orientation processes and safety protocols, and in some cases, did not receive it. This reflects the absence of a standard communication and escalation process across the response system.

Communication to and from communities and community governance structures was also reported as inconsistent, and community members were not always aware when and where services were being offered. Facebook was frequently used to share updates and was viewed as a valuable tool for reaching many community members quickly. However, relying primarily on Facebook did not consistently reach all evacuees and created gaps in awareness. Several IPHCC members emphasized that having reliable, timely information delivered through multiple, accessible channels would help reduce stress and better support community wellbeing. Suggestions included establishing consistent weekly schedules for clinics, cultural supports, and recreational activities to help create greater predictability during displacement. An IPHCC member also recommended displaying this information through daily calendars on hotel televisions, in common areas, and in evacuees' rooms, as a simple way to ensure information is accessible to all evacuees in real time.

2.4 Gaps in Information Continuity and Access to Care

IPHCC's members consistently described significant gaps in access to health information at the point of arrival. Providers often spent significant time trying to obtain information that should have been readily available. This included electronic medical records (EMR), lab and imaging results, medication histories, vaccination records, and assessment notes. In some cases, communities were using paper-based record-keeping systems, while in others, EMRs could not be shared with providers at the host sites. Once communities were evacuated, community nursing staff operating under Indigenous Services Canada were often inaccessible, creating further gaps in access to records or follow-up information. As a result, responding providers frequently relied on time-intensive efforts to locate critical health information.

Jurisdictional boundaries, between provinces, and between federal and provincial systems, further complicated access to care. These divisions created barriers in sharing records and confirming eligibility. In the rush of evacuation, many community members did not bring their identification cards, which added another layer of complexity. Without proper documentation, evacuees could not always access medications or health services in a timely way.

One example illustrates how these gaps led to duplication of effort. In one case, a need for immunization was based on incomplete or inaccessible health records, and preparation began for a clinic. It was later confirmed through the community-based nursing staff that the community had already been vaccinated. Immunization documentation had been stored across separate systems, and neither local providers nor the community were consulted before mobilizing vaccination supports. This fragmented system resulted in avoidable time, effort, and costs that have yet to be recovered.

Lab and imaging services in host communities presented additional challenges. Several IPHCC members reported labs rejecting out-of-province health cards (e.g., Manitoba), refusing to recognize Non-Insured Health Benefits, or requiring upfront payment. This created financial strain and delays in care. In one case, an IPHCC member was able to establish a billing arrangement with a local imaging provider, allowing requisitions to be billed directly and later reimbursed by the Ontario Health Region. While this enabled timelier access, it required significant coordination and was not consistently available across sites.

Gaps in follow-up care were also a consistent concern. Providers described seeing clients, documenting their care, and then having no clear process for ensuring that follow-up care happened or that results made it back to the client's home providers. In some cases, significant coordination effort went into simply locating individuals within hotels to remind them of outstanding appointments, lab results, or imaging. There was no defined accountability for who was responsible for closing the loop on clinical care once a provider's shift ended or a clinic closed. For individuals experiencing extended stays, this created a real risk of people falling through the cracks between providers, sites, and jurisdictions.

Overall, these experiences reflect a fragmented system where critical health information does not follow individuals across jurisdictions. In the absence of a coordinated, standardized approach to information sharing and access, providers were left to bridge gaps in real time, contributing to delays, inefficiencies, and inequitable access to care.

2.5 Experience at the Hotel

IPHCC members described consistent concerns about the host hotel experience across sites, including:

- A lack of cultural awareness, safety, and humility was evident in how some environments were managed. Visible police and security presence, punitive messaging from staff such as "break the rules and you're out," and concerns about child welfare reports or threats of reporting contributed to fear, confinement, and a lack of psychological safety.
- Hotel staff were often unfamiliar with the communities they were hosting and, in some cases, interactions were culturally unsafe.
- Dining and common areas were poorly maintained, including unclean eating spaces.
- Food quality was often described as inadequate, with limited access to traditional food.
- Bed bugs and unclean rooms were reported at multiple sites.
- Promised amenities and spaces were not always delivered as described.

2.6 Language Barriers

IPHCC members consistently identified language access as a gap across multiple host sites. Many evacuees spoke Indigenous languages as their first language, yet interpretation was not available at the host site or the services evacuees accessed. Language access should be treated as a standard component of evacuation planning and response, not as an added service. Ensuring interpretation is available across all points of contact is essential to safe, effective, and culturally appropriate care.

After the Evacuation

"Honestly, the only communication we got was that the nurses are going back on this day, so the community can go back. And that was the end of it."

3.1 No Standard Process for Repatriation

Across the interviews, a consistent theme was that IPHCC members were infrequently told when communities were going home. Some only learned after the fact, through word of mouth or news updates. There was a reported lack of a formal repatriation process. During the evacuation, IPHCC members documented substantial records of care, and in most cases, no mechanism existed to return that information to the community providers after repatriation. One IPHCC member mentioned that they had extensive clinical documentation prepared and received no requests for any of it. In some cases, individual providers took personal initiative to send evacuees home with additional medication supplies, recognizing that returning community infrastructure might still be unstable. None of this was systematic.

3.2 Inconsistent Reimbursement Pathways

Reimbursement was one of the most variable parts of the 2025 response. The interviews surfaced a wide range of experiences, reflecting the absence of a consistent, network-wide approach to funding evacuation support. IPHCC members described a range of approaches used to support evacuation-related costs, including funding agreements with provincial agencies and host-provider reimbursement. However, awareness and access to these pathways were inconsistent.

In some cases, costs related to staffing, supplies, and operations were partially or fully covered. In others, reimbursement was not available, leaving organizations to absorb costs. The absence of a shared, transparent understanding of reimbursement pathways created additional administrative burden during an already high-pressure response. Organizations were required to navigate different processes, requirements, and expectations without consistent guidance.

3.3 Limited Post-Season Debriefs

Not all IPHCC members had the opportunity to participate in post-season debriefs or share feedback on their experiences. One IPHCC member reported being invited to a debrief call and was offered the option to complete a survey. However, they were unable to participate due to scheduling constraints and limited capacity at that time. There were also no options for smaller or one-on-one conversations, which could have supported more participation. Debrief processes need to reach all supporting organizations, offer multiple participation formats, and ensure that feedback is captured and used to inform future evacuation processes.

Success Stories

Several strengths were identified across the evacuation response that contributed to more culturally safe, effective, and coordinated support for evacuated communities.

4.1 Strong Relationships

Across interviews, much of what worked well was made possible through strong relationships and the initiative of providers on the ground. One IPHCC member described having a strong relationship with their local pharmacy, where the pharmacist was highly community-oriented and went above and beyond to ensure evacuees had what they needed. This included tracking down prescriptions across provincial lines, delivering medication twice daily, providing naloxone kits, and leading naloxone training for host site staff.

In another example, an Ontario Health region identified a need at host sites and recruited Indigenous Patient Navigators (IPN) to support the response. These IPNs were brought in from hospitals and organizations across the region and were able to move between hotels, accompany community members to the hospital, support admissions, and provide continuity as clinical staff rotated. Their presence was integral to keeping services coordinated and the primary health care clinic functioning effectively. For most IPHCC members, what made the difference was not simply having partners at the table but having partners who were genuinely committed to the communities they were serving. Without that level of dedication, the response's success would not have been possible.

4.2 Central Coordination

In one response, an Ontario Health Team took the initiative to lead coordination among health partners on the ground. Daily morning meetings were used to identify gaps, align service, and share updates, followed by written summaries to ensure consistency across teams. This approach helped create shared awareness of what was happening, what had changed overnight, and where to direct questions. However, this coordination role was taken on voluntarily, in addition to existing responsibilities. For coordination to be dependable in future responses, it needs to be formalized, resourced, and built into defined roles.

4.3 Community-Led Decision-Making

Some of the strongest responses were those where community priorities were clearly centred, and partners worked to support and align with them. In one example, evacuees were brought to a location where relationships and regular health services were already in place, rather than being dispersed across the province. As one health provider reflected: "The community knows what they want. They know what's best for their community members, and they need to have a voice in this experience." When communities and their leaders are treated and engaged as partners from the onset, rather than recipients of a predetermined response, the outcomes are more aligned with community priorities and needs.

4.4 Grounding Support in Culture and Ceremony

IPHCC members highlighted the importance of integrating culture and ceremony throughout the evacuation experience. In one response, a land-based healing coordinator provided a drumming welcome for a community arriving at the airport and again as they prepared to leave. This had a lasting impact. When community members later saw the coordinator at the hotel, a connection had already been established. This simple but meaningful act helped set the tone for the weeks of support that followed.

Cultural programming also played an important role in supporting community wellbeing. Another IPHCC member described offering beading, skirt-making, medicine pouch creation, music, and other workshops. These activities provided opportunities for connection, cultural grounding, and a sense of familiarity while away from home. They were also consistently met with positive feedback. These examples highlight how culturally grounded supports were not only valued but also essential to wellbeing during displacement.

Recommendations

The following recommendations reflect what was consistently identified across interviews and are directed to all partners involved in evacuation planning and response.

1. Engage Indigenous partners early in evacuation planning processes and clearly define the roles and responsibilities of responding organizations (see section 1.1)

2. Designate a health coordination lead and maintain a current, shared contact list across all responding partners (see section 2.3)

3. Provide responding partners with advance site information, including scope of services, workflows, escalation pathways, and available resources (see section 1.1)

4. Set and enforce minimum standards for host sites, including appropriate clinical space, safe living conditions, and access to recreational and wellbeing supports (see section 2.5)

5. Enhance cultural safety and trauma-informed training with all personnel involved in evacuations, including hotel staff, security, and service providers (see section 2.5)

6. Develop shared baseline guidance for evacuation service delivery, including core services, staffing models, and setup requirements (see section 2.1)

7. Improve cross-jurisdictional health record sharing and interoperability to ensure evacuees receive uninterrupted, coordinated care from different health providers, regardless of jurisdictional, administrative, or system barriers (see sections 1.2 and 2.4)

8. Identify, assign, and fund mental health supports, traditional healing supports, and interpretation services as core components of every response (see sections 2.2 and 4.4)

9. Maintain continuity of primary care by supporting evacuees in staying connected to their existing care providers and expanding virtual care options during displacement(see section 2.4)

10. Establish clear communication protocols across all phases of the response, including coordination among responding partners, consistent information flow to and from community leadership, and ensuring evacuees receive timely and accessible information about their situation and available services (see section 2.3)

11. Implement a clear and consistent reimbursement approach with transparent eligible expenses and cost recovery processes (see section 3.2)

12. Build a structured repatriation process that includes care transitions, return timelines, and preparation for conditions in communities (see section 3.1)

13. Conduct inclusive post-season debriefs with all responding partners and communities, offering multiple avenues for participation, and ensuring feedback is documented and used to inform future planning (see section 3.3)

14. Provide training and resources for health partners on evacuation preparedness, including considerations for supporting evacuated populations, and an overview of evacuation processes, roles, and administrative requirements across jurisdictions (see section 1.1)

References

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