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MATAWA FIRST NATIONS MANAGEMENT

Matawa Health Cooperative Initiative

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Executive Summary

The Matawa traditional territory is located in remote northern Ontario and encompasses the mineral deposit known as the Ring of Fire. The nine Matawa communities are dissected into 2 health care zones, 3 health care districts, multiple health authorities and a number of different regional mental health and welfare service providers. As a result, Matawa First Nations cannot create local and regional health programs, coordinate/integrate health services or direct resources to address crises or gaps that exist in their health care. Matawa communities need to comprehensively plan their local and regional social services (health and wellness), and the delivery of those services, from the ground up to address gaps in health care, suicide pandemics, addictions and more.

Matawa First Nations Management (MFNM) will engage in the two-year comprehensive community-regional planning process needed to form a Matawa Health Cooperative (MHC). The MHC will be First Nation owned and directed. It will deliver integrated health and wellness services that respect the four components of Matawa traditional health (physical, mental, social and spiritual) at both the community and regional levels. The MHC planning incorporates processes to create the infrastructure for permanent solutions to Matawa health and wellness needs. The planning process also includes work to create short-, medium- and long-term solutions for current health and wellness crises. The 2 year planning process is referred to as the Matawa Health Cooperative Initiative (MHCI).

Matawa communities will not be ready to weather the impact from the Ring of Fire resource development until addiction and mental health concerns are addressed.[1] The 2014 regional framework agreement signed by Matawa communities and the Government of Ontario for the development of the Ring of Fire contains a social development pillar. The MHCI is part of the planning process to create Matawa-owned social infrastructure through which health care and culturally-based healing (wellness) services and programs can function.

The MHCI planning process will be both community-specific and regional. In this way, each community can direct and control their health care as they are able but yet benefit from the support and administrative services of the regional MHC. The MHC will be grounded on traditional health care components to ensure culture will integrate into Matawa health care.

The MHCI will consult Matawa communities (elders, citizens, councils and governance), local and regional service providers, and other stakeholders as they are identified. It will also draw from work previously done in communities. Consultation results will define cultural service parameters and tradition-based programs, identify service needs and inadequacies, help coordinate community services and provide the base upon which to comprehensively plan the integration, coordination, aggregation and devolution of Matawa health and wellness services. All consultation and planning will follow respectful cultural processes.

After receiving elder and community definitions for traditional health components and health/wellness needs, the MHCI will plan MHC governance structures, service delivery, case

[1] (2016) *"Our job is to close the gap," Minister of Indigenous Affairs tells First Nations*. CBC News. April 19, 2016: http://www.cbc.ca/news/canada/thunder-bay/first-nations-suicides-mining-carolyn-bennett-1.3541419

management and health/wellness services on a foundation of Anishinabek culture. The MHCI will then focus on planning the integration of physician, mental health, nursing and elder health care and wellness services.

Within physician services, the MHCI will plan a sustainable remote physician hub in Eabametoong First Nation, create a "remote" First Nation medical school resident training program for First Nation health care, and establish a physician/medical graduate recruitment program to retain doctors in the Matawa territory. Other aspects of physician-related services that will be addressed include; travel times, case management, access to outpatient services and problems with Uninsured Health Benefits.

After planning the integration of physician, mental health, nursing and elder health and wellness services, the MHCI will work to plan the coordination, aggregation and devolution of integrated services into the MHC and Matawa communities.

The MHCI will also provide the information underlay and coordination for Matawa Chiefs and leaders to work with provincial and federal governments and agencies to undertake memoranda of understandings and agreements, as needed, to advance a tripartite partnership that will define health care roles, lead to a formal transfer of health care authority to Matawa First Nations and that will affirm a commitment to close the gap between Matawa First Nation and non-First Nation people in Ontario health care.

A completed MHC will improve access to health care, wellness services and the quality of health/wellness services for Matawa communities by addressing missing cultural components, service inadequacies and funding gaps within the current social health and wellness system while including traditional healing. The MHC, with functioning culture-based programing, will help provide the readiness Matawa First Nations need to prepare communities for the development of the Ring of Fire.

Background

Matawa First Nations Management (MFNM) is a tribal council established in 1988 serving the nine Matawa First Nation communities; four communities have year-round road access while the remaining communities are remote (fly-in). Matawa traditional territory is located in northern Ontario and includes the Ring of Fire mineral deposit. Matawa communities are:

1. Aroland;
2. Constance Lake;
3. Eabametoong (remote);
4. Ginoogaming;
5. Long Lake #58;
6. Marten Falls (remote);
7. Neskantaga (remote);

8. Nibinamik (remote); and,
9. Webequie (remote) First Nations.

Matawa health care is currently divided into three districts within the North East and North West Local Health Integration Network zones; Northern, Thunder Bay and Cochrane Districts. Health, mental health and child welfare care are further fragmented across a myriad of service providers from these districts. These service providers include: First Nation and Inuit Health Branch - Health Canada, Dilico Anishinabek Family Care, Sioux Lookout Health Authority (Nodin and Meno Ya Win services) Tikinagan Child and Family Services, Kunuwanimano Child and Family Services, Geraldton District Hospital, Timmins and District Hospital, Notre Dame Hospital and the Thunder Bay Regional Health Services Centre. Injected into this fragmented health care system are the gaps in First Nation health care (high disease prevalence, poor access to health and wellness services, insufficient funding, and the neglect of other health determinants)[2, 3, 4, 5, 6, 7] and the fallout from generations of residential schooling, including: Addictions, suicide and social welfare issues.[8, 9]

Matawa communities are committed to working together and focusing collective efforts on strategic priorities, including health care. However, the fragmentation of Matawa social services (health and wellness) between governments and service providers makes it impossible to:

- Create regional health/wellness programs;
- Coordinate in-community health/wellness services (case management);
- Integrate traditional healing into Matawa health care; and,
- Direct resources to crisis situations or health/wellness service deficiencies.

The solution is to:

- Define health and wellness services and programs needed by Matawa communities;

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[2] (2012) *First Nations Regional Health Survey (RHS) Phase 2 (2008/10): Ontario Region Final Report: Ontario Region Report on the Adult, Youth and Children Living in First Nations Communities*. Ottawa: First Nations Information Governance Centre (FNIGC).

[3] (2012) *First Nations Regional Health Survey (RHS) 2008/10: National Report on Adults, Youth and Children Living in First Nations Communities.* Ottawa: First Nations Information Governance Centre (FNIGC).

[4] (2015) Allan, B. & Smylie, J. *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada.* Toronto, ON: The Wellesley Institute.

[5] (2006) Patterson, L.L. *Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005*. Ottawa: Library of Parliament PRB 06-04E.

[6] (2011) *Status Report of the Auditor General of Canada to the House of Commons: Chapter 4 Programs for First Nations on Reserves*. Ottawa: Office of the Auditor General of Canada.

[7] (2015) *Spring 2015 Reports of the Auditor General of Canada: Chapter 4 Access to Health Services for Remote First Nation Communities*. Ottawa: Office of the Auditor General of Canada.

[8] (2015) Truth and Reconciliation Commission of Canada. *Canada's Residential Schools: The Final Report of the Truth and Reconciliation Commission of Canada Chapter 5 The Legacy*. Montreal: McGill-Queens University Press.

[9] (2016) The People's Inquiry into Our Suicide Pandemic. *Nobody Wants to Die: They want the Pain to Stop*. Moose Factory: Mushkegowuk Council.

- Include Anishinabek culture in Matawa health and wellness services and programs;
- Create a Matawa-owned health cooperative to provide or coordinate health and wellness services and programs at both the community and regional level; and,
- Transfer federally and provincial funding for health and wellness services to the new Matawa Health Cooperative.

Introduction

In an oversimplification, Matawa First Nations define wellness with the four interrelated components of the medicine wheel; mental, physical, social and spiritual health. To provide culturally effective services, the MHCI must provide health services that integrate these four components. Western medicine can best understand the medicine wheel components by seeing health services in the constituents of physical health, mental health, social services and services for other determinants of health including public health and spiritual healing - the analogy is not perfect. Overall, goals of the culturally appropriate MHCI are:

1. To integrate, coordinate, and aggregate health and wellness services for Matawa communities;
2. To improve access to health and wellness services;
3. To improve the cultural relevance (quality) of health and wellness services;
4. To address health service deficiencies and funding gaps in Matawa health care; and,
5. To develop health and wellness infrastructures in preparation for future mineral and resource developments - particularly, development of the Ring of Fire.

The MHCI is the two-year comprehensive community-regional planning process that brings definition to the MHC. There will be four interrelated streams of activity occurring simultaneously to create the underlay for the MHC and its four cultural components while working more definitively on the physical health services component. They are:

1. Engagement processes;
2. Defining MHC structure.
3. Planning MHC health/wellness service components and their integration; and,
4. Planning the coordination, aggregation and devolution of integrated community health/wellness services into the MHC.

Engagement

Matawa communities and health/wellness service providers will be engaged in a comprehensive manner.

A/ Communities

Preliminary discussions with the project's lead community, Eabametoong First Nation, revealed several community health issues. The engagement process of the MHCI was planned to ensure that all issues, and more, raised by EFN during preliminary discussions would be captured during consultation.

Please note: Information obtained in the following manner is considered a temporal interpretation of modernized immemorial rights and culture for that aspect of social care that involves health and wellness services. As such, definitions of immemorial rights and culture-based health and wellness infrastructure must be enabled for further definition as needs and situations change.

The goals of community consultations are to:

- Bring relevant cultural components of Anishinabek health care into the MHC to close those aspects of the health care and wellness gap that arose from historic culture-based injustices - this includes the exclusion of traditional healing;
- Identify community health and wellness needs; and,
- Identify community health care problems.

All information recorded during community consultation is relevant. Oral history, legends and traditions provide explanations and details of pre-existing societies in which cultural components of health care will be found. However, specific topics for which information is needed to harmonize with outside jurisdictions should be identified in advance to ensure the consultation will be adequate for downstream needs. This is accomplished by building needed-information algorithms[10] prior to consultation. These "Consultation Algorithms" are completed during consultation through the skillful use of prepared base and bridging questions. The proposed base questions for consultation are:

1. What is traditional Anishinabek health care?
2. What is traditional Anishinabek healing?
3. What are the problems with the community's health?

Bridging questions add on to a specific base question to provide further detail. However, there can only be a small number of bridging questions or the consultation becomes too targeted. The proposed bridging questions for consultation have yet to be formulated from discussion with community health directors based on provincial and federal authorities' information needs. However, topics that will need bridging questions include:

1. What is traditional Anishinabek health care?
    - Roles, health determinants, health measures and health outcomes.

[10] (2010) Herbert, R.G., Report II Expansion of Research and Preparation: Ross River Dena Council – Yukon Government Dog Management Pilot Program, p 25 and 73. http://caid.ca/CAIDYKDogResPreII2010.pdf

2. What is traditional Anishinabek healing?
    - Medicine, diet, spiritual, land, family and community.
3. What are the problems with the community's health?
    - In health care delivery and healing.

In a generic consultation format, elders are consulted. Results from elder consultation are presented with the same questions to citizens, councils, community service providers, the regional tribal council and governance for additional comments. From this we receive:

- Cultural guidance from elders;
- Individual and family program needs from citizens;
- Special group program needs from councils;
- Resource needs from service providers;
- Infrastructure needs for service providers from regional councils; and,
- Policy needs from governance.

The nine Matawa communities will be consulted using each their own protocol for which base and bridging questions will be adapted. Consultation results will be used to:

1. Identify in-community health and wellness service needs and delivery inadequacies;
2. Provide definition to the four cultural health components upon which to base services and programs;
3. Provide definition for:
    a. Cultural service parameters and needed culture-based programs;
    b. In-community and regional services and roles for integration and aggregation within the MHC; and,
    c. In-community service coordination needs.
4. Provide community guidance for:
    a. Program needs;
    b. Program delivery; and,
    c. The integration of current community health and wellness services into the MHC.

To minimize problems that may occur with community consultations due to time constraints, language barriers, low attendance, and inadvertent exclusion of individuals or groups, the MHCI will:

1. Schedule consultations to respect traditional times of land-based activities;
2. Include food and gift sharing when appropriate (ie. elder gifts);

3. Use multiple, non-consecutive consultation visits to each community;
4. Work with nine community-based facilitator/translators;
5. Receive written presentations from local councils and service providers;
6. Utilize a week-long drop-in format for citizen participation; and,
7. Consultation governance last, presenting the combined results of consultation, before finalizing outcomes.

B/ Service Providers

Health care service providers for Matawa communities are both in-community and regional. Services providers will have their services, programs, resources and organization's structure catalogued. The results of service provider mapping will enable planning for the integration, coordination and aggregation of health and wellness services at both the community and regional levels.

Stakeholders, other than health care and wellness service providers, exist at both the community and regional levels and will also be catalogued. These include: Travel-related and hospitality-related services.

MHC Structure

The community and stakeholder consultation results will be used to define the four cultural health components (physical, mental, social and spiritual). These Matawa definitions will be used to create a cultural base upon which services and programs for regional and community services will be planned. After these definitions are presented to each of the communities, adjusted as needed and ratified, they will be used to ensure the model governance structure for the MHC is culturally appropriate and to plan the integration, aggregation and coordination of Matawa health services for the MHC.

The MHCI will work with Health Canada (HC), the Ministry of Health and Long-Term Care (MoHLTC) and the North West Linked Health Integration Networks (NWLHIN) to plan the MHC structure, funding and governance model.

MHC Services

The MHCI is the planning process to create infrastructure for permanent, long term solutions to Matawa health care service and delivery inadequacies. However, the MHCI will also facilitate short and medium term solutions by sharing knowledge acquired in the engagement process and actively participating in Matawa and regional First Nation health forums and initiatives; including developing solutions for addiction, suicide and other community health/wellness determinants.

Matawa First Nations already have varying degrees of work invested in their four traditional

health care components. That information will be included with the results of the engagement process to help define each community's needs and resources for local and regional aspects of the MHC. The MHCI will then focus on planning the integration of physician, nursing, mental health and elder health and wellness services with community and regional service providers to meet those needs.

While the MHC is planned to administer health services for the nine communities, it will not terminate existing relationships with current community service providers. **The creation of the MHCI is not about a quick fix through transferring services to Matawa ownership, it is about Matawa control at both the community and regional levels for service delivery, access to services and the quality (cultural relevance) of services and programs. While some change in service providers will occur, and the MHC will ultimately deliver services and programs, no immediate changes in service providers are planned.**

A/ Physician Services:

In-community and off-reserve access to physician services is a problem for Matawa communities.[11] A remote physician hub will be planned for the community of Eabametoong (EFN) using HC facilities. The remote hub will provide physician services to EFN and other fly-in Matawa communities. The MHCI will also work with a local regional hospital to plan a physician service hub for road-access Matawa communities and a base from which to train medical residents. Services provided from the two hubs will be planned using engagement results. The MHCI does intend to devolve all physician services into the MHC. Depending on consultation results and the model developed for governance, services may be contracted from the current service providers.

The MHC's physician services will:

1. Increase remote community access to physicians;
2. Decrease waiting time to obtain medical/surgical referrals;
3. Decrease travel problems for referral health services;
4. Improve discharge protocols;
5. Improve case management;
6. Improve access to outpatient hospital services; and,
7. Resolve other problems revealed during engagement processes.

The sustainability of remote northern Ontario physician services represents a challenge. To ensure sustainability:

1. As part of closing the health care gap for Matawa health care, the MHCI will negotiate with HC and the MoHLTC to:

[11] Orkin, A., VanderBurgh, D., Ritchie, S., & Fortune, M. *Commuity-Based Emergency care: On Open Report for the Nishinabe Aski Nation.* Thunder Bay: Northern Ontario School of Medicine, 2014. www.nosm.ca/.../pub-roundtable_**report**_web_final_NOSM.pdf. Accessed 2016-03-14.

a. Fund residency placements for medical graduates that sign a Return of Service with the MHC; and,

b. Recruit physicians internationally, if needed, to work within the remote or hospital hubs on a "one-of" basis.

2. A "remote" First Nation residency program will be created with the Northern Ontario School of Medicine (NOSM):

   a. Resident selection criteria is being considered to preferentially select qualified First Nation medical school graduates who indicate an interest in practicing in remote First Nation communities and will return service to remote First Nation communities; and,

   b. If First Nation graduates are not available for selection, preference is being considered for medical graduates who indicate an interest in practicing in remote First Nation communities and will return service to remote First Nation communities.

B/ Nursing Services:

The MHCI does intend to devolve nursing services and community facilities into the MHC. However, depending on consultation results and the model developed for governance, which of the programs provided by the current in-community nursing services that may be devolved with the facilities remains to be determined.

C/ Mental Health Services:

The MHCI does intend to devolve mental health services into the MHC. However, depending on consultation results and the model developed for governance, which of the services that may be devolved remains to be determined.

The mental health care component currently has work in progress with the *Matawa First Nations Mental Wellness Continuum Framework Project* funded by the Thunderbird Partnership Foundation. There is also work commencing within the communities of Webequie, Marten Falls and Naskantaga.

D/ Elder Services:

The MHCI does intend to devolve elder services into the MHC. However, depending on consultation results and the model developed for governance, which of the services may be devolved remains to be determined.

Plan to Aggregate, Coordinate and Devolve:

The consultation results, planned cultural component structures, the governance model, and the integration plans for physician, nursing, mental health and elder health and wellness services will be used to plan the aggregation and coordination of community and regional Matawa services

into the MHC. Planning will include:

1. Human resources;
2. Financial resources;
3. Capacity building, professional development and training;
4. Capital needs; and,
5. Implementation schedules based on priorities.

The MHCI will work with HC, the MoHLTC and the NWLHIN for the aggregation and coordination planning. The MHCI will ultimately plan mechanisms for health and wellness services transfer to the MHC. Model governance and tripartite commitments for the MHC may draw from the British Columbia First Nation Health Authority (BCFNHA) as an example of needed regulatory structures. However, the differences in Ontario's health care system and the smaller number of Matawa communities will make the process much more streamlined and unique. Memoranda of Understandings and agreements will:

1. Advance a tripartite health care partnership;
2. Lead to a form of health care authority transfer to Matawa First Nations; and,
3. Affirm a commitment to close the gap between Matawa First Nation and non-First Nation health care in Ontario.

Project Details

This initiative will improve access to health services for the nine Matawa First Nation communities by engaging in a comprehensive community – regional planning processes to create a Matawa First Nation-owned health cooperative. There are 4 basic streams of work that will occur simultaneously:

1. Engagement processes;
2. Defining the MHC structure – culture and governance;
3. Planning MHC health and wellness service components and their integration; and,
4. Planning the coordination, aggregation and devolution of integrated community health and wellness services into the MHC.

General objective-based activities arising from the above four work streams are:

1. Engagement processes:
   1.1. Consultation of Matawa communities' elders, citizens, service delivery organizations, councils and governance; and,
   1.2. Catalogue in-community health services, programs, resources and service provider organization structures.

1.3. Catalogue regional (extra-community) health services and programs.

2. Define the MHCI structure:

   2.1. Develop a health governance model and funding streams for defined services and programs of the MHCI and,
   2.2. Define the 4 cultural health components for regional and community services and programs from consultation results**.**

3. Plan Matawa health components:

   3.1. Facilitate short & medium term solutions to health crises.

      3.1.1. Engage with communities and regional resources to participate in forums and initiatives for short-term solutions to health crises as opportunities arise.

   3.2. Plan physician services:

      3.2.1. Plan remote and regional-based physician service hubs:
      3.2.2. Create a post-secondary remote physician medical residency training and recruitment programs for remote First Nations:
      3.2.3. Plan the integration of Matawa physician services with regional service providers:

   3.3. Plan mental health services:

      3.3.1. Plan the integration of Matawa mental health services with regional service providers.

   3.4. Plan Matawa nursing services:

      3.4.1. Plan the integration of Matawa nursing services with regional service providers:

   3.5. Plan Matawa elder services:

      3.5.1. Plan the integration of Matawa elder services with regional service providers:

4. Plan the devolution of aggregated, coordinated and integrated community health services.

   4.1. Plan the aggregation and coordination of integrated community and regional health services; and,
   4.2. Develop a Memorandum of Understanding(s) to advance and define the MHCI's health care relationship with provincial and federal health authorities in a manner that devolves health care to the MHCI.

Please request the 2016-2018 Work Plan for more detail.

Summary

The MHCI will plan the aggregation, coordination and integration of health and wellness services and programs for Matawa communities, plan the integration of cultural components into the MHC and help prepare Matawa communities for the development of the Ring of Fire.