2017

Matawa Health Co-operative Initiative Annual Report 2016-17

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3/20/2017

Matawa Health Co-operative Initiative

Annual Report 2016-17

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This work was funded through Matawa First Nations Management by Health Canada and the Ontario Ministry of Health and Long-Term Care.

Matawa Health Co-operative Initiative

Annual Report 2016-17

A. Introduction

On February 4, 2016, Matawa Chiefs in Council resolved to begin the process of developing an alternate health and social service delivery system for communities to take over those services.

The Matawa Health Co-operative Initiative (MHCI) is the planning and development process for that culturally appropriate, Matawa First Nation owned alternate health and wellness service delivery system.

The alternative delivery system for physician, nursing, elder, mental health and public health services and service support structures will be integrated into a co-operative governance structure.

B. Background

The Matawa traditional territory is located in remote northern Ontario and encompasses the mineral deposit known as the Ring of Fire. There are 9 Matawa First Nation communities; 5 remote (Eabametoong, Martin Falls, Neskantaga, Nibinamik and Webequie) and 4 road-accessed (Aroland, Constance Lake, Ginoogaming and Long Lake #58) communities.

The Matawa traditional territory and communities are currently dissected into 2 federal health care zones, 5 provincial health care districts, 4 health authorities and a number of different regional mental health and social welfare service providers. As a result, Matawa First Nation health and wellness services and service support structures lack the integration, coordination and aggregation they need for health and wellness services to be adequately delivered. Adequate health care delivery must support cultural healing, eliminate health care gaps, address suicide pandemics, work with addictions and more. The solution is to:

- Create a Matawa-owned health service delivery system to provide and coordinate health and wellness services and service support structures at both the community and regional level to all Matawa communities;
- Define health and wellness services and service support structures needed by Matawa communities;
- Include Anishinabek culture in Matawa health and wellness services and service support structures; and,
- Transfer federal and provincial funding for Matawa health and wellness services and service support structures to the new Matawa health service delivery system – the Matawa Health Co-operative (MHC).

For the Matawa First Nation owned and directed Matawa Health Co-operative (MHC) to be a successful solution, its development must include the following objectives:

1. Integrate, coordinate, and aggregate health and wellness services for Matawa communities;
2. Improve access to community-based and regional health and wellness services;

3. Improve the cultural relevance (practices, interests and priorities) of health and wellness services;
4. Address health service deficiencies and funding gaps in Matawa health care; and,
5. Develop needed health and wellness infrastructures in Matawa communities and their traditional territory.

The MHCI is advanced on 4 general overlapping streams of activity into which our objectives are woven and met by more specific activities identified in a workplan. The 4 general streams of activity are:

1. Defining MHC governance & service delivery models;
2. Community & service provider engagements;
3. Planning health/wellness service components and staff training; and,
4. Planning implementation, partnerships and federal/provincial resource transfer.

On July 28, 2016, a resolution from the Matawa Chiefs in Council further directed the development of a Mental Health Crisis Response Team, a Mental Wellness Service Team and capacity building training through the Matawa Health Co-operative Initiative (MHCI).

C. Funding

From the time our Chiefs in Council resolved to develop an alternate health and wellness delivery system until the Health Canada Health Services Integration Fund (HSIF) application deadline, was less than three weeks. We worked with the lead community, Eabametoong, to gain insight into community needs to form a very rough framework for respectfully advancing the project. From this rough framework, we created our budgets for 2 years; roughly $800,000/year with a total budget of approximately $1,600,000.

HSIF offered only $300,000 spread over 2 years. We chose to use the HSIF for a part of the project that could be used to unlock the rest of the funding. It was used for the Regional Matawa Health Co-operative Coordinator and travel. The plan was to acquire funds for:

- Community engagements from Indigenous and Northern Affairs Canada (INAC), Strategic Partnership Initiative
- Physician training from the Ministry of Health and Long-Term Care (MoHLTC), Health Canada and Ministry of Northern Development and Mines (MNDM), Ring of Fire Regional Framework Agreement (RFA) under the health and social pillar;
- Health and wellness services integration planning from MoHLTC;
- Governance Structure and cultural inclusion component plans from INAC;
- An office with support staff from MNDM; and,
- Plans for implementation, training, partnerships and federal/provincial resource transfer from their respective government agencies.

Our HSIF proposal for the Matawa Health Co-operative Initiative (MHCI) was approved on April 26, 2016.

We first approached Bob Rae (Matawa RFA negotiator), Lori Churchill (Ring of Fire at MNDM) and Christopher Cornish (Ring of Fire Secretariat at INAC) with workplans and budgets for the MHCI in February 2016. Final proposals were submitted to INAC and MNDM in early May.

In July, MNDM indicated the MHCI qualified for funding under the RFA but that all funds were allocated. Later in October, MNDM indicated they would not contribute funds to the MHCI. At the same time in July, the Ring of Fire Secretariat at INAC denied requests for MHCI funding.

We continued moving the MHCI forward using HSIF funds and in-kind contributions while working to secure other funding. The co-operative governance model, physician training pilot program and Mental Wellness Service team model, in particular, advanced at a quick pace.

Health Canada declined to contribute to physician training or physician services, asserting these were under provincial jurisdiction. However, Health Canada is open to creating a funding stream for the devolution of nursing stations, equipment and nursing contracts to the developing Matawa-owned co-operative.

We pursued mental health funding with Health Canada from the announced $70 million for our mental wellness service team. By September, it became clear these funds would not be accessible to Matawa First Nations Management (MFNM) or Matawa communities.

In June, MoHLTC declared its willingness to fund the physician training pilot program. They committed $37,126 to MFNM toward integrating the training program with the developing MHC's physician and primary care services.

MoHLTC suggested in September we redefine our physician/nursing/mental health care delivery into a primary care model using an interdisciplinary team and an Aboriginal Health Access Centre. The $222 million in funding announced for the Ontario First Nation Health Action Plan (OFNHAP) would become available for the 2017-18 fiscal year and the MHCI could be eligible for funding, if we were ready where readiness included an incorporated Matawa Health Co-operative able to enter into Transfer Payment Agreements. Calls for proposals should come out in April 2017. Community engagements, Matawa primary care and the mental wellness service team could all be funded under OFNHAP.

In-kind contributions have come from a variety of partners, including from Matawa communities for staff participation, Chief and Council participation and lead community discussions.

MHCI funding and in-kind contributions for 2016-17 are listed below:

Partner	2016/17
Health Canada - Health Service Integration Fund	$166,000
Min. of Health & Long Term Care	$ 37,126
North West Linked Health Integrative Networks In-Kind	$ 3,600

Indigenous & Northern Affairs Canada		$
Min. of Northern Development & Mines		$
Northern Ontario School of Medicine	In-Kind	$ 58,240
Saint Joseph's Care Group	In-Kind	$ 2,250
Anishnawbe Mushkiki	In-Kind	$ 1,500
Thunder Bay Regional Health Sciences Centre	In-Kind	$ 1,200
Dr. R. Velamoor	In-Kind	$ 1,500
Matawa Communities	In-Kind	$ 31,500
Lead Community (EFN)	In-Kind	$ 26,400
Matawa First Nations Management	In-Kind	$ 18,000
Total		**$347,316**

D. Engagement

A large portion of the planned 2016-17 HSIF work centered around in-depth community engagements. Without INAC and MNDM support, these engagements had to be put on hold until an alternative source of funding could be developed. To adapt, we used travel funds in the HSIF to undertake limited engagements. The results of limited engagements were used to create frameworks (models without full details) for different aspects of the project.

Note: OFNHAP funding for Interdisciplinary Team development will include funding for in-depth community engagements, so they will still occur.

To prepare the MHCI to receive funding from MoHLTC under OFNHAP, we had to adapt to their idea of project development. MoHLTC wanted 4 project development phases for funding. The 4 phases of project development are:

1. Strategy Development
2. Framework Development
3. Team Development
4. Implementation

Limited engagements allow for different aspects of the MHCI to have their strategies verified and advanced to where we can prepare funding proposals for MoHLTC. We have used 4 basic types of limited engagements. They are:

1. Lead Community Engagement:

   Eabametoong (EFN) has led the MHCI since January 2016. EFN provided insight into community health service delivery needs for writing the HSIF proposal, is a partner in the physician training pilot program, provided insight into mental health service and program needs, and provides a community voice at meetings with government agencies

   The MHCI is working to create multiple lead communities for different aspects of the developing MHCI. In this way, each community can contribute their strengths at an early stage in project development. EFN has requested that other communities, should they

agree, share the lead where possible.

2. Community Leader Engagement:

   The Regional MHC Coordinator has been visiting each Matawa community to speak with Chief and Council and with Health and Social Services staff. The MHCI is explained during these visits and its different components are presented. Participants provide suggestions and feedback to ensure that developing frameworks respect their community's health governance structure and includes their staff, training, service and program needs.

   At the time of writing 7 communities have been visited. When community visits are completed, a summary report will be prepared and circulated to all community's.

3. Health Director Engagement:

   Health Directors from the 9 communities are the Working Group for the MHCI. They were first introduced to the MHCI in March 2016. Their input was used to fine tune the HSIF proposal for final consideration by Health Canada.

   Using limited funds, Health Directors were brought together in July and then again in August. In July, partners and first year objectives were introduced. These included defining the governance-corporate structure and creating a Remote First Nation medical residency program in Fort Hope. Terms of reference for the Working Group and Advisory Committee were discussed.

   The August Working Group meeting was a workshop on the co-operative model, a presentation of the Northern Ontario School of Medicine's (NOSM) Remote First Nation Medical Residency Training Proposal and an introduction to the Mental Wellness Service Team Model. The Working Group provided the Chiefs in Council with a briefing note containing statements and recommendations on the topics covered.

   The most important conclusion from the August meeting was that a health co-operative could respect Anishinabek culture, be owned and directed by Matawa First Nations and deliver needed services, funding and training.

4. Opportunistic Engagements:

   We were able to insert the MHCI into 2 Matawa Chiefs in Council meetings, August and December 2016, to introduce the MHCI, report on the MHCI and to receive feedback or direction from Chiefs.

   The MHCI piggy-backed onto a Health Directors meeting in December to update Health Directors and receive feedback.

E. Key Outcomes

The primary objective for the MHCI is the creation of a culturally appropriate Matawa First Nation owned alternate health and wellness service delivery system (the MHC) and the integration of its services and service support structures for physician, nursing, elder, mental health and public health services into a co-operative model. Contained within this primary objective are key outputs

(goals) used in our HSIF planning process. They are:

1. Create a core First Nation health co-operative, ready for incorporation, that can adapt and evolve to include all aspects of health and mental health care delivery;
2. Create a model for the integration, coordination and aggregation of primary care services;
3. Create a pilot program to supply physicians to remote First Nation communities;
4. Create a pilot program to supply nurses to remote First Nation communities;
5. Create a plan for physician services;
6. Create a plan for nursing services;
7. Create a model for the integration, coordination and aggregation of mental wellness care services;
8. Create a plan for mental health services;
9. Create a model to incorporate traditional healing and cultural practices into primary and mental wellness care services;
10. Create a plan for elder services; and,
11. Create a plan for public health services.

Note: It is important to keep in mind that the HSIF provides funds for the <u>planning process.</u> Implementation processes are separate and not part of HSIF.

The planning status of each output will be briefly reported by looking at:

a. HSIF status indicators reported to Health Canada for 2016-17:
b. Partner roles:
c. Progress to date: and,
d. Funding sources and potential funding sources.

1. Core Health Co-operative

a. HSIF Status: ☒ Started

1.Model Development:
- ☐ Strategy work engaged
- ☐ Framework engaged
- ☐ Detail work engaged
- ☒ Ready to Implement

2.Articles & By-laws:
- ☐ Engaged in discussion
- ☐ Engaged in writing
- ☒ Complete

b. Partners:

Partners in the creation of a core Matawa Health Co-operative are primarily the Matawa First Nations. Communities will own the co-operative and directors from each community will oversee the co-operative while directing resources as needed.

Vanessa Hammond of the Health Care Co-operative Federation of Canada delivered a workshop to the Working Group (community Health Directors) on co-operatives. Ted Scollie of Erikson and Partners, provided legal review of the Articles of Incorporation and By-laws.

c. Progress:

Individual components of the health and mental wellness care are advancing in the project at vastly different rates based on opportunity. Some, such as the creation of a Remote First Nation Family Medicine Residency training program are ready for implementation and need a corporate structure for agreements, policy and program administration to occur.

Funding for the development of primary care and a wellness team from MoHLTC, funding from Health Canada for nursing transfer, and other provincial and federal funding for health and wellness care services also need an incorporated entity to sign contracts and be accountable to funding agencies.

For these reasons, the MHC needed a small core part of the co-operative up and running that could receive funding, build in components as they become ready and evolve as needed. Bringing the co-operative on line this way, creates a very manageable multiphasic implementation for services into the co-operative. Further, it provides early access to some services rather than waiting for a number of years before everything hits the ground at the same time. The MHC will be the first First Nation owned and directed health co-operative in the world.

Work towards creating the corporate governance structure progressed as follows:

- Early discussions with our lead community (Eabametoong) provided the background for the corporation governance model.
- Health Canada introduced us to Vanessa Hammond of the Health Care Co-operatives of Canada. Discussion with Ms. Hammond suggested the co-operative model would meet corporate governance needs outlined by our lead community.
- Ms. Hammond delivered a workshop to the MHCI Working Group (Health Directors) on co-operatives. The co-operative model was able to meet the expectations of the working group for a Matawa health services delivery governance model. Each community could decide on how to govern their community's ownership of the co-operative.
- The basic model for the Matawa Health Co-operative (MHC) was presented to Matawa Chiefs in Council.
- A brief from the Working Group with recommendations was submitted to the Chiefs in Council.
- Communities were visited by the Regional MHC Coordinator for

community leader engagements. Each community's preferences for governing their community's ownership of the co-operative was received.

- An advanced model of the MHC was presented to Matawa Chiefs in Council.
- We drafted incorporation articles and core by-laws for the MHC using the Working Group and communities' input as guidance. These articles and by-laws were then legally reviewed by Ted Scollie at Erikson and Partners.

d. Funding:

Funding to develop the health cooperative model and prepare the incorporation of a core working structure came from Health Canada through HSIF.

2. Primary Care Model

a. HSIF Status: ☒ Started

1.Model Development:
- ☐ Strategy work engaged
- ☒ Framework engaged
- ☐ Detail work engaged
- ☐ Ready to Implement

2.Agreements:
- ☒ Engaged in discussion
- ☐ Engaged in writing
- ☐ Complete

b. Partners:

The Thunder Bay Regional Health Sciences Centre has partnered with us to provide access to their records (diagnostic) for qualified personnel and to help coordinate referral appointments.

Anishnawbe Mushkiki has offered to partner with us by providing an urban access point for community member primary health care while our community members are in Thunder Bay. They have also offered to partner with us to provide expertise with the development and implementation of a primary health care access point in the Long Lake – Ginoogaming area.

MoHLTC should be partnering with us through OFNHAP (Ontario First Nation Health Action Plan) to develop and implement an Aboriginal Health Access Centre in the Long Lake – Ginoogaming area with a remote node in Fort Hope and an urban connection to Anishnawbe Mushkiki.

Project partners are still evolving as we move forward and plan for physician, nursing, mental health and elder services within the primary care delivery system.

c. Progress:

Physician services fall under provincial jurisdiction but the First Nation and Inuit

Health Branch (FNIHB) does provide some limited levels of ancillary support. After exhausting potential federal funding streams for physician service development, we turned to the province, MoHLTC.

MoHLTC wanted the development of physician services to be part of primary care and for primary care to evolve in a 4-step funding model: (1) strategy development; (2) framework development; (3) team development; and (4) implementation. So, we transformed our physician, nursing, record management, case management and *etc*. aspects of the project and fused them with our initial strategies for remote and rural physician hubs.

This created a primary care structure similar to a provincial Aboriginal Health Access Centre (AHAC) with a service hub in Long Lake – Ginoogaming and distal nodes (service access points) in Fort Hope and Thunder Bay. The new primary care model then qualified us for funding under interdisciplinary team development within OFNHAP funding.

Early discussions with our lead community (Eabametoong) provided the background we needed to write the physician models into the HSIF application. The application proposed a remote physician hub in Eabametoong supported by partnership with a medical school for in-community resident training and a rural physician hub in the Long Lake – Geraldton area supported by a partnership with a local regional hospital.

Work towards creating the primary care structure progressed as follows:

- The Northern Ontario School of Medicine (NOSM) partnered with MFNM and Eabametoong First Nation (EFN) to create a remote First Nation medical residency training program based in Eabametoong – see later in *4. Physician Supply Pilot.*
- Health Canada declined involvement in remote physician training as it is a provincial service, although they will work with us so we can deliver physician services from the EFN nursing station. The rural hub in Long Lake – Geraldton was considered provincial jurisdiction by Health Canada.
- The basic model for the MHC with remote and rural physician hubs was presented to Matawa Chiefs in Council.
- Discussions occurred with Anishnawbe Mushkiki, Thunder Bay Regional Health Sciences Centre and MoHLTC. The current primary care model emerged with a central Aboriginal Health Access Centre in the Long Lake – Ginoogaming area, a remote access node in Eabametoong that included medical residency training and an access node in Thunder Bay through Anishnawbe Mushkiki.
- Communities were visited by the Regional MHC Coordinator for community leader engagements. The primary care model was presented and feedback received.
- The primary care model was presented to Matawa Chiefs in Council.
- Health Canada purchased a digital x-ray machine and other equipment requested by the MHCI to upgrade the EFN nursing station for physician

training. The equipment will be made available in the 2017-18 fiscal year.

d. Funding:

Funding has come in part through MoHLTC for integration of the pilot training program to supply physicians.

Funding to develop and implement the primary care delivery model should be coming from MoHLTC through OFNHAP Interdisciplinary Team funding. A pre-requisite for funding is an incorporated MHC.

Ontario froze its promised $222 million in OFNHAP funds until the 2017-18 fiscal year, including funds for interdisciplinary team development. We expect a call for proposals in the next few weeks.

3. Physician Supply Pilot

a. HSIF Status: ☒ Started

1.Model Development:
- ☐ Strategy work engaged
- ☐ Framework engaged
- ☐ Detail work engaged
- ☒ Ready to Implement

2.Agreements:
- ☐ Engaged in discussion
- ☒ Engaged in writing
- ☐ Complete

b. Partners:

The Northern Ontario School of Medicine partnered with us in March 2016 to build and implement a Remote First Nation Family Medicine Resident training program. They also partnered with us to provide professional support for the development of physician service delivery programs.

Eabametoong First Nation (EFN) partnered to provide a remote First Nation community base for physician training and to provide the MHC with a remote primary care service delivery hub.

NOSM has also provided support to MFNM for extending broadband infrastructure into Matawa communities.

MOHLTC gave its support for the joint development of the Remote First Nation Family Medicine Resident training program.

Minister Michael Gravelle, Ministry of Northern Development and Mines (MNDM), also gave his support for the physician training program. This support has extended to developing broadband infrastructure into Matawa communities for things like tele-health.

c. Progress:

In-community access to physician services was flagged by remote Matawa

communities as a priority need. The only community with a large enough population to support full-time, on-site physician services at this time is Eabametoong. Physicians based in Eabametoong can also supply services to other remote Matawa Communities until those communities become large enough for their own full-time physicians. Other communities will be engaged.

A model was developed to supply physicians to Eabametoong using a new medical school training stream for medical residents. (Medical residents are doctors who have graduated from medical school but still need the more specialized training found in a residency program before they are licensed to practice on their own.) Part of the requirement for entrance into the training program would be a 4-year contract with Matawa communities to provide physician services where needed – in our remote and rural primary care hubs. These contracts are called a Return of Service Agreement.

The new medical training stream provided by NOSM would be a 2-year program based on a Family Medicine residency but tailored to First Nations patient needs. The program would be called a Remote First Nation Family Medicine Stream and be the first of its kind in the world; it would be a pilot program.

The program would include joint (Matawa – NOSM) candidate selection and joint curriculum development. The remote First Nation aspect of the residency training would include traditional medicine and healing, addictions, mental health and cultural competency.

Work towards creating the physician supply pilot using a new medical training stream progressed as follows:

- Discussions with our lead community (Eabametoong) provided the background for work on remote physician services.
- A working partnership was struck early with NOSM for the creation of a training stream for Matawa physicians. We did this early in the project because after a candidate is selected for training, it takes 2 years to have a licensed physician. So, to get physicians in 3 years, we had to start immediately.
- MoHLTC engaged and requested a proposal, with budgets, be submitted.
- We worked with NOSM to prepare a proposal for the joint development of the Remote First Nation Family Medicine Residency Stream. We presented the proposal first to Eabametoong and then to Matawa Health Directors for comment and input.
- The proposal for the Remote First Nation Family Medicine Residency Stream was presented to the Matawa Chiefs in Council and then submitted to MoHLTC.
- MoHLTC created a joint table that met every 3 weeks with EFN, MFNM and NOSM to advance the proposal.
- We worked with NOSM and EFN to develop culturally respectful screening criteria for the selection of medical graduates into the new Remote First Nation Family Medicine Residency Stream.

- Communities were visited by the Regional MHC Coordinator for community leader engagements. The Remote First Nation Family Medicine Residency Stream and the Return of Service Agreement was presented and feedback received.
- Pilot selection criteria and processes have been used to select residents for the new training stream using a joint EFN-NOSM selection committee.
- Work is progressing on agreements between NOSM, EFN, MFNM, MoHLTC and the selected residents.
- Work is planned for joint development of the First Nation-specific aspect of the training curriculum.

d. Funding:

Funding has come in part through MoHLTC for planning resident training program integration into the MHC's primary care model and physician services.

All other funding for the development, implementation, maintenance and evaluation of the Remote First Nation Family Medicine Resident Training Program will be provided by MoHLTC through NOSM.

The MNDM's support appears to be materializing with the priority advancement of highspeed internet access for Matawa communities. It is hoped an announcement from Industry Canada, and Ontario, will be forthcoming in the Spring of 2017 to finalize for support broadband service to the Matawa First Nations.

4. Nurse Supply Pilot

a. HSIF Status: ☒ Started

1.Model Development:
- ☒ Strategy work engaged
- ☐ Framework engaged
- ☐ Detail work engaged
- ☐ Ready to Implement

2.Agreements:
- ☐ Engaged in discussion
- ☐ Engaged in writing
- ☐ Complete

b. Partners:

The Registered Nursing Association of Ontario (RNAO) has partnered with us to develop a supply of nurses for remote and rural First Nation communities. The RNAO is the Ontario regulatory nursing body for nurse licensing and nursing standards.

The RNAO released a report in late 2015 on supplying nurses to rural and northern communities that was received by the Chiefs of Ontario.

Project partners will continue to evolve as we move forward.

c. Progress:

Primary care discussions revealed a need to create a nursing supply program to ensure an adequate supply of nurses for Matawa health care. Work on developing a supply of physicians for Matawa communities suggested that developing a specialized training program which selects for nurses interested in working within remote communities would provide a reliable supply of nurses.

Work towards creating the nurse supply pilot has progressed as follows:

- Discussions with our lead community (Eabametoong) helped provide the background for work on nursing supply needs.
- Communities were visited by the Regional MHC Coordinator for community leader engagements. Feedback on nursing needs was received.
- Discussions occurred with NOSM on nursing training opportunities for community members.
- Contact was made with the RNAO and a commitment was made to work together to resolve nurse shortages in northern Ontario.
- Background information and data were requested from Health Canada, but have not been received.

d. Funding:

A source of funding will be explored when a more definitive model is developed.

5. Plan for Physician Services

a. HSIF Status: ☒ Started

1. Program Delivery Plan: ☒ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Physician services are provincial services funded by MoHLTC through the NWLHIN for Matawa. We have partnered MoHLTC and the NWLHIN.

Project partners are still evolving as we move forward.

c. Progress:

Physician services will be delivered through the MHC from either a remote or rural primary care hub. Physician will be supplied by 4-year Return of Service Agreements with 2 years of services in each of the remote and rural hubs.

The remote hub will be in Eabametoong providing Eabametoong with full-time physician services and Martin Falls, Webequie, Nibinamik and Neskantaga with part-time services. The remote hub will be an Aboriginal Health Access Centre (AHAC) node.

The rural hub will be in the Long Lake – Ginoogaming area and will make physician

services available to Aroland, Long Lake #58, Ginoogaming and Constance Lake. The rural hub will be a full AHAC.

Work towards creating the plan for physician services has progressed as follows:

- Discussions with our lead community (Eabametoong) helped provide the background for work.
- The basic plan for physician services was presented to Matawa Chiefs in Council.
- Communities were visited by the Regional MHC Coordinator for community leader engagements. Feedback on physician needs was received.
- Discussions with MoHLTC have occurred on physician contracting models.
- A more advanced model for physician services was presented to Matawa Chiefs in Council.
- Further detail will be added as the primary care model and physician supply pilot further develop until a detail plan for physician services can be prepared.

d. Funding:

No funding has come for this component from Health Canada, other than through the HSIF.

Funding has come in part through MoHLTC for integration of the pilot training program to supply physicians.

Further funding for will come for integrating physician services into primary care interdisciplinary team development funding for the primary care model through OFNHAP.

6. Plan for Nursing Services

a. HSIF Status: ☒ Started

1. Program Delivery Plan: ☒ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Health Canada is a partner with Matawa for health services integration.

MoHLTC will partner through OFNHAP and the development of an interdisciplinary team for Aboriginal Health Access Centre (AHAC) nursing services. It is hoped this will work alongside and in partnership with the Health Canada nursing service transfer process.

Project partners are still evolving as we move forward.

c. Progress:

Health Canada has encouraged the transfer of nursing services, facilities and equipment to Matawa First Nation and the MHC.

Each community wants the maximum amount of full-time nursing staff living in their communities. Communities do not want multiple fractional nursing positions with services available once a month. They prefer multi-faceted nurses capable of a multitude of supportive care.

Whenever possible, communities want local members to provide nursing care within their community. They also want nursing staff to be chosen by, and accountable to, the community.

There is also a regional component to nursing that the MHC is needed for. That includes: Entering into Transfer Payment Agreements, creation of a pool of nurses, salary and contract negotiation, continuing education, training, relief and other benefits accorded to the profession.

Work towards creating the plan for nursing services has progressed as follows:

- Discussions with our lead community (Eabametoong) helped provide the background for work.
- Communities were visited by the Regional MHC Coordinator for community leader engagements. Feedback on nursing needs was received.
- Discussions with Health Canada have occurred on the transfer of nursing to Matawa communities through the MHC. Transfer protocols were requested from Health Canada but have not been received by MFNM
- The possible acquisition of nursing contracts by the MHC was presented to Matawa Chiefs in Council. The MHC will need to be incorporated to enter into Transfer Payment Agreements with Health Canada for nursing contracts.
- Details on nursing compliments and contracts were requested from Health Canada but have not been received.

d. Funding:

No additional funding has come in this area, other than the initial contribution of Health Canada through the HSIF.

Further funding for the integration of primary care with nursing services will come from interdisciplinary team development funds for the primary care model through OFNHAP.

7. Mental Wellness Care Model

a. HSIF Status: ☒ Started

1.Model Development:
- ☐ Strategy work engaged
- ☒ Framework engaged
- ☐ Detail work engaged
- ☐ Ready to Implement

2.Agreements: ☒ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Dr. Varadaraj Velamoor (psychiatrist) has agreed to work with us to develop cultural wellness indicators and assessments for use with a Matawa mental wellness service team.

Saint Joseph's Care Group (SJCG) has agreed to work with us to develop the nuts and bolts of a mental wellness service team. SJCG will also provide professional staff and help develop training for community mental health staff.

MoHLTC should be partnering with us through OFNHAP (Ontario First Nation Health Action Plan) to develop and implement the Mental Health Wellness Service Team.

Project partners are still evolving as we move forward.

c. Progress:

In July 2016, The Matawa Chiefs in Council passed a resolution (Resolution #31) calling for the MHC to create a Matawa Mental Wellness Service Team as part of the mental health planning for the MHCI. The intention of Chiefs was for the MHC to obtain support through the announced $70 million in Health Canada Mental Health funding. Unfortunately, the call for expressions of interest did not materialize.

We approached MoHLTC for provincial funding. The same 4-step funding model, as with the primary care work (see earlier), applied and we transformed a large part of our mental health planning into a mental wellness service team model that we understand will qualify for funding under OFNHAP.

The mental wellness care model contains community mental health staff, regional professional mental health staff, case management, training, land-based programs, community funding and the creation of cultural mental wellness indicators and assessments to provide in-community client assessments and program evaluations.

Work towards creating the mental wellness care structure progressed as follows:

- Prime Minister Trudeau announced $70 million over 3 years in mental health funding and Matawa Chiefs in Council respond at the MFNM AGM with a resolution for the MHC to create a mental wellness team, crisis response team and team building.
- Discussions with our lead community (Eabametoong) provided the background for work on the mental health component of the MHC.
- Using information from the lead community, we prepared a base model for mental wellness with cultural indicators and assessments.
- No call for a proposal for the $70 million occurred and the funding became unavailable to us. We approached MoHLTC for funding under OFNHAP.
- Communities were visited by the Regional MHC Coordinator for community

leader engagements. The mental wellness care model was presented and feedback received.

- Using information from community leader engagements, more detail was added to the base mental wellness service team model and submitted to MoHLTC for feedback. They suggested the proposal fit into the 4-step funding model at a point for framework development.
- The mental wellness model was presented to Matawa Chiefs in Council.
- We worked with Dr. Velamoor and Dr. Jack Haggerty (SJCG) to create a mental wellness service team framework development proposal which is ready for submission to MoHLTC.

d. Funding:

Funding to develop and implement the mental wellness care model and implement the Mental Health Wellness Service Team should be coming from MoHLTC through OFNHAP funding. A pre-requisite for funding is an incorporated MHC.

Ontario froze its promised $222 million in OFNHAP funds until the 2017-18 fiscal year. We expect a call for proposal in the next few weeks.

8. Plan for Mental Health Services

a. HSIF Status: ☒ Started

1. Program Delivery Plan: ☒ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Health Canada is a partner with Matawa for health services integration, including mental health services.

MoHLTC will partner through OFNHAP and the development of its mental health components.

Saint Joseph's Care Group (SJCG) has agreed to work with us to develop the nuts and bolts of a mental health programming.

Project partners are still evolving as we move forward.

c. Progress:

The Mental health funding process has become convoluted with a number of delays in a complicated process.

Discussions with Health Canada, MoHLTC and the Ministry of Community and Social Services (MCSS) are being worked through Nishnawbe-Aski Nation and the Chiefs of Ontario. Very little information has come from Sioux Lookout First Nations Health Authority or DILICO for planning mental health services.

The planning of MHCI service and program details for mental health is dependent on the yet-to-be-announced MoHLTC and Health Canada plans for mental wellness and crisis management teams.

We have prepared a mental wellness team model and engaged (see earlier) to build the framework with mental health professionals. It is ready for funding. The execution of the work within that proposal will define services we need for detailed mental health program planning (see earlier).

Work towards mental health planning progressed as follows:

- Discussions with our lead community (Eabametoong) provided the background for work on the mental health services within the MHC
- Communities were visited by the Regional MHC Coordinator for community leader engagements. Feedback on mental health issues and need was received.
- The mental health component of the MHC was presented to Matawa Chiefs in Council.
- Using information from discussion with us, SJCG has begun to determine staff and program needs for mental health service delivery.
- We are awaiting opportunity to submit our mental wellness service team framework development proposal to MoHLTC which will provide funds to finish planning service delivery.

d. Funding:

No additional funding has come for this initiative other than the initial part through Health Canada and the HSIF.

Further funding for the integration of mental wellness and crisis management programming will come from interdisciplinary team development funds for the primary care model from MoHLTC through OFNHAP. Calls for a proposal should occur in the next few weeks.

9. Cultural Inclusion Model

a. HSIF Status: ☐ Started

1.Model Development: ☐ Strategy work engaged
☐ Framework engaged
☐ Detail work engaged
☐ Ready to Implement

2.Policies: ☐ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

All Matawa First Nation are partners in the development of a model to include culture

into the MHC and Matawa health and wellness services and programs.

Project partners will continue to evolve as we move forward.

c. Progress:

We know that our culture must form the foundation of our health care. Cultural inclusion is not about window dressing or adding on ceremonies. It is about our traditional medicine, healing practices, definitions of health and our way of life being an integral part of our health care system.

The MHCI's plan was to engage communities in depth within the first year of HSIF work so that a cultural model could be established early to underlay everything that would be developed. Unfortunately, we relied heavily on the promise of engagement funds from federal and provincial departments involved in Ring of Fire. This did not materialize and effectively shut down in-depth engagement until another funding source could be found.

In the absence of in-depth engagement funding, we shifted to limited community engagements and the earlier Matawa Mental Health Wellness Continuum report, done with the Thunderbird Partnership Foundation, to gather enough cultural information to create our model frameworks for the health co-operative, primary care and mental wellness service team.

We believe we have found funding which will become available in the new fiscal year.

d. Funding:

No funding has come in this area, other than the initial contribution of Health Canada through the HSIF.

Funding can be obtained to engage in in-depth community consultation under OFNHAP funding for interdisciplinary team development engagement. This funding would be part of the Primary Care Model development (see earlier).

Ontario froze its promised $222 million in OFNHAP funds until the 2017-18 fiscal year. We expect a call for proposal in the next few weeks.

10. Plan for Elder Services

a. HSIF Status: ☐ Started

1. Program Delivery Plan: ☐ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Health Canada is a partner with Matawa for health services integration, including elder services.

MoHLTC will partner through OFNHAP for the development of interdisciplinary services, which include elder care.

Project partners are still evolving as we move forward.

c. Progress:

The planning of service and program details for elders is dependent on models for delivery of primary care and mental health care plus the plans for physician and nursing service delivery. Elder care in these areas will be included as each of these programs.

Elders also require geriatric-specific care that will need to be integrated into the service delivery model for the MHC. This would include support for existing Homemaker and Nursing Services Agreements (NWLHIN), the Home and Community Care Program (Health Canada) and other home making programs.

Consultation on elder health needs is part of the delayed community engagements (see earlier). However, we have included discussion on elder care in our limited engagements:

- Discussions with our lead community (Eabametoong) have provided some background on elder-specific healthcare needs.
- Feedback on elder care needs have been received by the Regional MHC Coordinator during community leader engagements.
- Discussions on palliative care have occurred with Lakehead University's research project in First Nation Palliative Care Initiative.
- Discussions have also been initiated with the Canada Mortgage and Housing Corporation (CMHC) and INAC on elder residential housing capital requirements in Matawa communities.

d. Funding:

No funding has come for this component, other than the initial part through Health Canada and the HSIF.

Further funding will be developed.

11. Plan for Public Health Services

a. HSIF Status: ☐ Started

1. Program Delivery Plan: ☐ Engaged in discussion
☐ Engaged in writing
☐ Complete

b. Partners:

Health Canada is a partner with Matawa for health services integration, including public health.

Project partners are still evolving as we move forward.

c. Progress:

While the health care gaps for the delivery of First Nation health services are numerous, one of the most blatant is the public health gap. The lack of potable drinking water, the lack of appropriate wastewater processing, overcrowded housing, moldy housing, moldy work environments and *etc*. will all fail a public health inspection.

The issue will not be acquiring funds and training to have a health inspector for Matawa communities. The issue will be how do we finance the repairs to bring our communities up to a reasonable standard of health.

Early discussions have been initiated with Dr. Janet Desmilles, Thunder Bay District Health Unit, on funding sources and collaborating for public health with Matawa communities.

Public Health work has been started for four remote Matawa First Nations through the Sioux Lookout First Nation Health Authority Public Health Initiative with Health Canada and MoHLTC.

d. Funding:

No funding has come for this component, other than the initial part through Health Canada and the HSIF.

Further funding will be developed.

E. Moving Forward

The MHCI is advancing well. We have been able to adapt to a changing landscape and work with what we have. We are ready to:

- Start up a small core of the Matawa Health Co-operative so it can receive funding and begin to build in components as they are ready;
- Work to acquire funds and agreements for the Matawa Health Co-operative;
- Start up the Remote First Nation Family Medicine Residency Stream with NOSM to train physicians for Matawa communities;
- Submit our framework proposal to develop the Mental Health Wellness Service Team;
- Prepare a framework proposal for our primary care service delivery system to obtain support for an Aboriginal Health Access Centre, service nodes and interdisciplinary team development.
- Consult our communities in-depth using interdisciplinary team development funds for details on needs, programs, cultural respect, *etc*.; and,
- Continue the planning needed for physician, nursing, mental health, elder and public health services delivery. Planning includes cultural integration, training, education, policies, programs, protocols, administration, management, facilities, equipment, case management, records, Non-Insured Health Benefits, devolution and more.

Human resource needs will balloon as we begin to bring service components on line through the

MHC. Most of that will not occur until the 2018-19 fiscal year. Currently, the MHCI advances on the work of the Regional MHC Coordinator, Dr. Richard Herbert, and our Political Analyst, Paul Capon. We will need to strategically create positions as funds become available. Human resource needs that will likely arise in the coming year include:

* Community Residency Liaison Coordinator - EFN
* Tribal Residency Coordinator - MFNM
* Administrator – MHC
* Nursing Manager – MHC

As planning progresses in the upcoming year, we will need to plan for capital investment into the MHC and our communities. As we may well imagine, the larger the capital spending needed, the longer it will take to have that aspect of health services come on line. Early work has started on obtaining equipment (digital x-ray equipment), improving health care connectivity (broadband services) and elder housing (CMHC). Our capital needs and their corresponding 1,3, 5 and 10 year plans will become more clear this year.

Funding was our limiting factor in 2016-17. It may have even extended the time to complete the MHC planning. We will know as the year progresses and funding rolls out from federal and provincial governments. The longer it takes for funding to arrive, the more time will be added onto the project's completion. Not to worry, we did anticipate the problem and set the MHC to start up in a way that will allow it to continue to move forward on its own power, if needed.

The projected budget to finish planning work started with the HSIF is:

Estimated MHCI Planning Budget 2017-18		
Partner		Dollars
Health Canada Health Service Integration Fund		166,000
Additional Contributions		?
MoHLTC Primary Care Framework		444,000
Mental Wellness Framework		200,000
Planning Services		220,000
North West Linked Health Integrative Networks	In-Kind	90,000
Indigenous & Northern Affairs Canada		?
MNDM Com. Wellness Coordinators (9)	In-Kind	162,000
Matawa Communities Health Directors (9)	In-Kind	176,400
Chief & Council (9)	In-Kind	28,800
Lead Community Health & Social Serv. Staff	In-Kind	20,000
Health Director	In-Kind	3,600
Chief & Council	In-Kind	2,800
Matawa First Nations Management	In-Kind	72,000
Total		1,585,600