Annual Report 2020/21

Keewatinohk Inniniw Minoayawin Inc.

Northern Peoples' Wellness

Keewatinohk Inniniw Minoayawin/Northern Peoples' Wellness

KIM's Logo is meant to convey:

- The uniqueness of each First Nation and health sovereignty, through the three distinct medicine bags. Each First Nation should have the ability to exercise choice as to what to include for health and wellness services in their Nation's "medicine bag" – including the choice to access traditional and western medicines.
- The three-part inclusive and accountable governance structure – the Keewatinohk Inniniw Okimowin Council of First Nations elected leaders, the 6 First Nations caucuses, and the Board of Directors.
- Continuity of care without gaps – with a single string that joins the three medicine bags.
- A sense of home and belonging on our lands – the northern lights, waterways, and the trees.
- The organization overall as a welcoming place, with ownership by northern First Nations people and a unifying connection to it.

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Acknowledgement of Leadership – MKO Chiefs Task Force on Health

We acknowledge the dedication and significant commitment of time, effort, and leadership by the members (past and present) of the MKO Chiefs Task Force on Health. As well, we thank the MKO Chiefs in Assembly who resolved to appoint the Task Force in January of 2019 to guide the establishment of a northern First Nations-led health transformation entity.

The Chiefs Task Force on Health

- Chief Gilbert Andrews (former member), God's Lake First Nation
- Chair, Chief Larson Anderson, Norway House Cree Nation
- Chief Clarence Easter, Chemawawin Cree Nation
- Chief Marcel Moody, Nisichawayasihk Cree Nation
- Chief Simon Denechezhe, Northlands Denesuline First Nation
- Chief David Monias, Pimicikamak Cree Nation
- Grand Chief Garrison Settee, Manitoba Keewatinowi Okimakanak, Inc.

Governance Major Milestones

Spring to Fall 2019 – Chiefs Task Force on Health directed the MKO's health transformation leads to seek a new way of governing, in a model that would be more inclusive and reflective of what was shared through initial engagements on First Nations health transformation in the north. Met frequently with the team to review and guide next steps on the various governance models put forward for consideration, until an acceptable model was identified.

December 2019 – Chiefs Task Force on Health signed the first Bylaws establishing Keewatinohk Inniniw Minoayawin (Northern Peoples' Wellness). As well, they directed the inclusion of a preamble to the Bylaws with specific mention of important aspects such as Treaty rights, portability, and the Canada Health Act and the Canada Health Transfer.

The three-part governance model is described in the Bylaws and consists of the Keewatinohk Inniniw Okimowin Council of elected leaders, six First Nations caucuses reflective of existing groupings in the north, and a high functioning and caring Board of Directors.

Fall 2020 – Appointed Dr. Barry Lavallee as CEO of Keewatinohk Inniniw Minoayawin, Inc.

March 2020 to March 2021 – The Chiefs Task Force on Health leadership worked alongside our CEO, MKO and other First Nations leaders in successfully advocating to health systems leaders for health equity with respect to the pandemic and the potentially devastating impacts in the north.

The MKO Chiefs Task Force on Health remains as the interim governing body of KIM until the three-part governance structure is fully established and functioning.

More than two years have passed since these dedicated leaders committed to undertake this work. They remain optimistic and are wise and measured champions of KIM and what it could do for northern First Nations people. Their contributions have been significant, and we will always be grateful to them.

Excerpt from the Preamble to the KIM Bylaws

The Keewatinohk Inniniw Minoayawin is established as a non-share corporation solely to support, provide and contract for health and wellness related services to northern Manitoba First Nations and their citizens.

A function of the Keewatinohk Inniniw Minoayawin is to seek and provide for First Nation identified solutions to healthcare gaps while aiding in the achievement of First Nations health sovereignty, Nation by Nation. The corporation will source and distribute funding for both

aggregate and First Nation-specific health care solutions, engage in contracts to fill health services gaps, and address other health and wellness priorities with respect to northern Manitoba First Nations.

The Keewatinohk Inniniw Minoayawin will not derogate from Treaty and Aboriginal Rights of the northern First Nations and their citizens, who are rights holders under Treaties 4, 5, 6 and 10. The Keewatinohk Inniniw Minoayawin will work to advance the portability of Treaty and Aboriginal Rights when it comes to health care for northern First Nations citizens, wherever they reside.

The work of the Keewatinohk Inniniw Minoayawin, in supporting both the collective and individual Nations, will continue at least until the achievement of its vision and mission and/or when First Nations are autonomous and treated as equal to Canada's federation governments and on a Nation-to-Nation basis. The legal mechanisms for equal negotiation do not exist within the federation of Canada as it stands today, although there are precedents such as the very existence of the historic numbered Treaties as well as certain aspirational aspects found within modern-day Treaties in British Columbia and the negotiated agreement that formed Nunavut.

The Canada Health Act and the Canada Health Transfer do not guarantee that the Province of Manitoba will ensure a standard of care to northern First Nations citizens some of whom reside in remote and isolated locations where limited access places citizens in continuous peril. These federal policy instruments are meant only to "facilitate reasonable access to health services." The federal and provincial governments retain jurisdiction in the Transfer negotiations and in the interpretation of reasonable access. Until that changes First Nations remain stronger together.

The Keewatinohk Inniniw Minoayawin corporation will support and align with northern Manitoba First Nations as well as other First Nations organizations in Manitoba and Canada that are negotiating with the federal and provincial governments specific to the achievement of essential health services for First Nations, including enabling legislation and the related fiscal authorities.

KIM Governance Model

An Inclusive Northern First Nations Model

Caucuses

Each Caucus, through its own process, is responsible for appointing that number of persons who are either a Chief or a Councilor of a First Nation to serve on the Keewatinohk Inniniw Okimowin Council, as set out in the bylaws to serve as the Members.

Keewatinohk Inniniw Okimowin Council

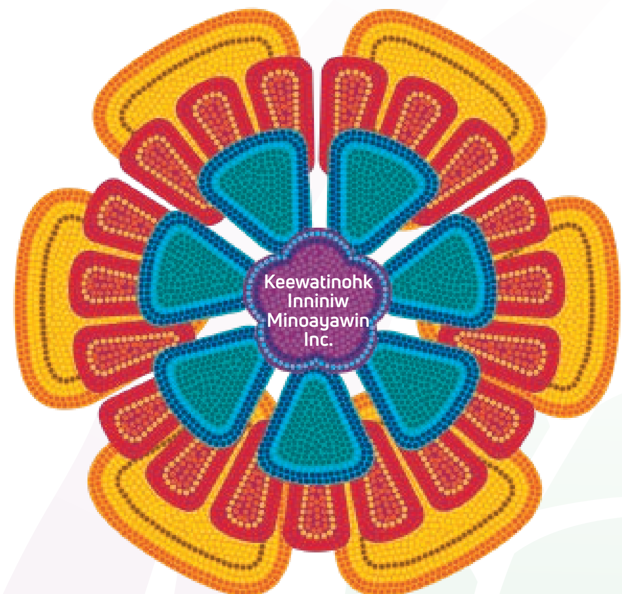
Members are appointed by the Regional Caucuses and must be a Chief or Councilor of a First Nation. This group forms the membership of the Corporation.

The Council appoints the Board of Directors, advocates for Keewatinohk Inniniw Minoayawin, and is the only part of the governance structure with the authority to change the bylaws

Keewatinohk Inniniw Minoayawin Board of Directors

Directors are individuals who reflect a broad range of skills and experience enabling them to act together effectively to fulfill the mandate of the Corporation.

The Board of Directors is responsible for the overall affairs of the Corporation. Members are selected by the Keewatinohk Inniniw Okimowin Council



What is a caucus?

- a grouping based on combined population sizes with respect to the existing structures of Tribal Councils and First Nations (includes on and off reserve numbers)
- there are currently 6 caucuses representing 23 First Nation communities

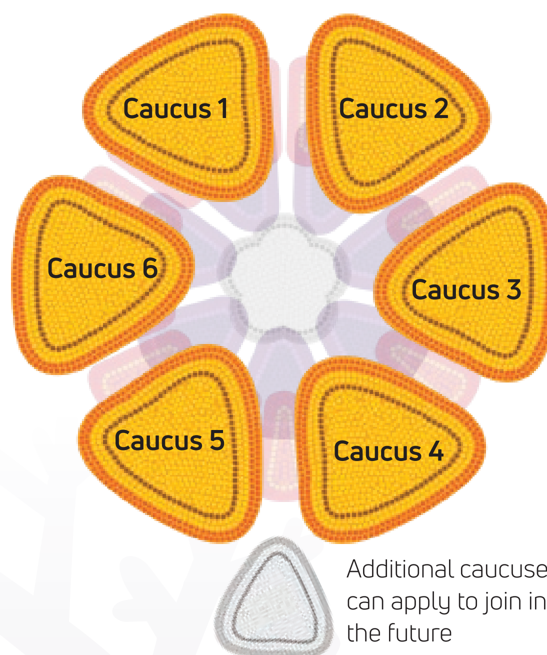
Caucus 1 Keewatin Tribal Council	Caucus 2 Swampy Cree Tribal Council	Other Caucuses
Barren Lands First Nation	Marcel Colomb First Nation	**Caucus 3** Pimicikamak Cree Nation
Northlands Dene First Nation	Mathias Colomb Cree Nation	**Caucus 4** Norway House Cree Nation
Sayisi Dene Denesuline Nation	Chemawawin Cree Nation	**Caucus 5** Nisichawayasihk Cree Nation
Fox Lake Cree Nation	Misipawistik Cree Nation	**Caucus 6** O-Pipon-Na-Piwin Cree Nation
Tataskweyak Cree Nation	Mosakahiken First Nation	
War Lake First Nation	Opaskwayak Cree Nation	
York Factory First Nation	Sapotaweyak Cree Nation	
Shamattawa First Nation	Wuskwi Sipihk Cree Nation	
Bunibonibee Cree Nation		
God's Lake First Nation		
Manto Sipi Cree Nation		

An Inclusive Northern First Nations Model

CAUCUSES

CAUCUS	Representatives	Based on Total Population
Caucus 1: Keewatin Tribal Council	5 members	18,853
Caucus 2: Swampy Cree Tribal Council	5 members	20,196
Caucus 3: Pimicikamak Cree Nation	3 members	8,905
Caucus 4: Norway House Cree Nation	3 members	8,359
Caucus 5: Nisichawayasihk Cree Nation	2 members	5,275
Caucus 6: O-Pipon-Na-Piwin Cree Nation	1 member	1,700

- The Caucuses are based on the existing structure of Tribal Council Nations, First Nations unaffiliated with Tribal Councils, and their populations
- The concept and formula for determining Caucuses is set out in Schedules A and B of the By-Law. This ensures consistency when population and caucus changes require recalculation, from time to time
- Caucus changes may occur where there is a realignment to form a new caucus, an additional caucus who wishes to join, or a withdrawal of a caucus



Additional caucuses can apply to join in the future

Message from the KIM CEO

It has been many months since the COVID-19 pandemic was declared on March 10th, 2020. The evolution of Keewatinohk Inniniw Minoayawin (KIM) came to an almost abrupt stop given the magnitude of support and preparation required within the communities, the health care systems, the provincial and federal governments to face one of the smallest and deadliest life forms on earth. While my knowledge and skills reside in my work as the primary care physician, this helped somewhat to navigate through complex social and health systems that for most part ignore the ongoing colonially constructed oppressions. Negotiating access to equitable resources and considerations as the response to the pandemic manifested with the federal and Manitoba public health-systems required intense work to ensure First Nation members had access early to the vaccines. The key message is clear: the communities, their leadership and the tenacity of the First Nation communities drove the response to this pandemic. But what about KIM? What are we doing? Where are we at? What are we achieving? These questions are important as we move forward with the leadership, the communities, our sister organizations, and the allies who support a vision of health and healing for all First Nation citizens.

KIM seeks to engage with communities as before, while knowing how challenging it is to communicate and dialogue while still in the pandemic. This time will come. There are processes and actions KIM will undertake to set a path for innovation through the current resources provided to communities. The old ways are full of moments of good care delivered by a single provider in community or out of community. But the reality is that First Nation members seeking care and seeking ways of reducing or eliminating suffering are confronted with racial violence, discrimination, social exclusion; this results in furthering of the trans generation trauma of the years of incarceration for many at the residential schools across this province. We have a lot of work to do. The day will come when the common experience of a First Nation person who requires health care at home or away is valued and documented and if necessary, acted upon.

We understand the root of wellness, health and opportunity originate at the most sacred time in the development of a human being. Core to this is the wellbeing and health of First Nation women, families and children. At the moment of conception, any disruption such as a future mother and father experiencing stress (both acute and chronic) disable the genetic road map of that baby. And if that family experiences continued trauma, the child will suffer more. What is KIM's involvement here?

Notably during this past year, communities have struggled with ways to support members who suffer from a substance misuse disorder. Newer ways to understanding these community members are found within the harm reduction approach, a term that seeks to see the person as dealing with their own traumas the best way they know how. While this can be hard to understand, we know there are increasing deaths of community members due to overdoses from unsolicited street drugs, now marked by newer drugs that kill. New ways are needed to assist members and community leadership. One community has taken on a managed alcohol program. Its success will be shared in the future.

We need to focus on the development of KIM's governance model; seek equity for all communities and members; and examine what transfer of FNIHB functions to KIM will mean for First Nations and what additional resources are required to ensure it is done in an innovative and community-centered way. We will change the way things are done to improve First Nation health and wellbeing.

KIM is about all of us, the journey is collective, and we are honoured to be at this moment with you.

Ekosani, Miigwech, Merci

Dr. Barry Lavallee, MD, CCFP, FCFP, MClSc
Chief Executive Officer

KIM Staff

As we continue to expand and grow our organization, we have engaged People First HR Services to provided a flexible human resource support service. This will assist in KIM's ongoing development and growth initiatives which will compliment our existing HR in the workplace.

Through hard work and dedication from the following team members, the important work outlined in this report was made possible.

- Dr. Barry Lavallee, Chief Executive Officer
- Moriah Davis, Chief Operations Officer
- Sharon McKay, CCT Program Manager
- Caroline Chartrand, Senior Nurse Advisor
- Dr. Yvette Emerson, Primary Care Advisor
- Brian Flamand, Administrative Coordinator
- Marcie Friesen, Administrative Assistant
- Theresa Garson, Mental Wellness Benefits Analyst
- Eva Goulet, Research & Engagement Coordinator
- Teena Legris, Communications Officer
- Monique McKay, AIRO Senior Advisor
- Ovide Mercredi, AIRO & Lead Negotiator
- Kathleen North, Jordan's Principle Clinical Liaison
- Annica Ramkissoon, Communications Officer
- Piper Riley Thompson, AIRO Legal Advisor
- Dr. Michael Routledge, Population Health/Medical Advisor
- Catherine Stadnichuk, Planning & Organizational Development Coordinator
- Gwen Sutherland, Nurse Advisor
- April Tawipisim, Human Resource Generalist
- Joanna Thich, Registered Dietician
- Joni Wilson, Director of Pandemic Response
- Theresa Yetman, Mental Wellness Manager

Special Report: COVID-19 Pandemic

KIM has worked closely with MKO and many external stakeholders to support the health, wellness, and safety of First Nations people in Northern Manitoba throughout the COVID-19 pandemic.

The Novel coronavirus (COVID-19) was officially declared a pandemic on Wednesday, March 11th, 2020. Rightfully so, this date has been referred globally as "the day everything changed." While discussions between KIM, health experts and Leadership had already been in play since the discovery of the virus in China the previous December, activities were put in full force once the virus reached a pandemic level. Manitoba saw its first three cases of the coronavirus on March 12th, 2020.

KIM rallied its employees as all-hands-on-deck, and with the collaboration of MKO, created COVID "check-in teams." The MKO region was divided up into six geographic areas, with each check-in team assigned several First Nations to liaise with and provide support. Check-in team members reached out to the health directors and pandemic leads on a regular basis and helped to escalate any issues that required follow-up or action by KIM or other entities, or advocacy by the MKO Grand Chief's office.

KIM/MKO check-in teams continued to work directly with First Nations and key stakeholders well into the second wave, then tapered off as the needs for external supports lessened over time.

For a point in time report or "snapshot" of the early COVID-19 collaborative advocacy work of MKO and KIM (January-May 2020), requests can be made for the **MKO/KIM COVID-19 Report May 1, 2020.**

Manitoba First Nations Pandemic Response Coordination Team (PRCT)

During the early onset of the pandemic, engagement took place amongst MKO, KIM, the Assembly of Manitoba Chiefs (AMC), Southern Chiefs' Organization (SCO), and the First Nations Health & Social Secretariat of Manitoba (FNHSSM). Common goals of responding to COVID-19

led to the development of the Manitoba First Nations Pandemic Response Coordination Team (PRCT). A mandate to serve as the regional pandemic coordination team was provided by the Chiefs in Assembly and work amongst the various team members commenced. Over time, some of the membership had changed, including the addition of Ongomiizwin Health Services (OHS) and Canadian Red Cross (CRC), and the branching off of SCO to provide a more focused approach with the southern First Nations.

The PRCT provided a wealth of combined skill and resources to the collective in the pursuit of supporting First Nation people across Manitoba, both on and off reserve. Areas of focus varied according to the ebb and flow of the pandemic and the needs arising during these times. Tasks were often divided up according to the areas of expertise of the PRCT members or organizations. MKO often provided support by way of advocacy at both the provincial and federal levels, while KIM offered its health expertise via their in-house physicians, public health doctor and clinical support staff. Both organizations worked collectively with regional entities to ensure delivery of health services and supports were not only provided but heightened during the pandemic. Likewise, when it was identified that already over-stretched community human resources were under even more strain due to COVID outbreaks at the community level, members of the PRCT worked together to coordinated and deploy surge support to the First Nations. This surge capacity was to become the Rapid Response Team (RRT), which served to provide COVID-19 testing, contact tracing and surveillance within affected communities.

KIM offered its health expertise via their in-house physicians, public health doctor and clinical support staff.

Sustained communication also played a large part in supporting both the First Nations and PRCT in pandemic response.

In early winter, Manitoba experienced its "second wave." With increasing requests for support, MKO and KIM worked together to establish a core team of staff to have a targeted focus on the pandemic. The MKO-KIM Pandemic Response Team was formed and identified three additional focus areas:

1) First Nation Personal Care Homes
2) Harm reduction strategies
3) COVID-19 vaccine roll-out

First Nation Personal Care Homes

In the first wave of the COVID-19 pandemic, there was ample evidence available on the rapid transmission and high mortality rates of elderly residents of long-term care facilities. While outbreaks occurred in personal care homes across Manitoba in the first wave (often with high hospitalization and mortality rates), First Nation personal care homes did not see their first positive case until the fall of 2020. It was at that time that three of the eight First Nations personal care homes (two located in the MKO region) experienced outbreaks. However, through fast action of each staff and early support facilitated by KIM, the personal care homes' outcomes faired very well.

Rapid testing – In order to prevent transmission of the COVID virus within the care facilities, it was identified that point-of-care testing for screening and surveillance could provide detection of COVID-19, even in asymptomatic staff. Plans were set in motion to mobilize the deployment of point-of-care testing analyzers to the eight First Nation personal care homes. One community was selected as a pilot site to provide rapid testing and to help identify and rectify any challenges that arose. The Panbio Rapid Testing devices were introduced/implemented starting in December 2020 inclusive of two (of the four) northern First Nation care homes. Further sites are planned to receive testing devices in the 2021/22 fiscal year.

Managed Alcohol Program (MAP)

As the number of community outbreaks increased during the second wave of the pandemic, KIM was approached by numerous First Nation Leaders requesting assistance with respect to emergent concerns around addiction behaviors in their communities. Guidance and supports were sought on how to quickly address them, primarily (but not only) because the behaviors hampered efforts to contain the spread of COVID-19 and posed additional challenges for leadership and the people.

In response to the requests, KIM's CEO pulled together a group of experts on addictions to look at harm reduction strategies best suited for the communities, including the Managed Alcohol Program (MAP).

One of the northern First Nations adopted the harm reduction strategy and MAP was introduced to a small group of community participants in December 2020. With the service in place and less person-to-person contact in the community, the First Nation could better control the spread of the virus, with the notion that those using substances would be accessing medicinal alcohol at various times throughout the day at a single, safe, controlled site. Less contact in the community would occur, thus reducing the potential spread of the virus. There is preliminary evidence to support the success of the MAP in the community as there was a reduction in violence, less apprehensions of children, decreased service utilization, improved health outcomes, and it helped stabilize alcohol intake. In addition, family relationships improved, and one client who had previously been medevaced out of the community on a weekly basis, had only been transported out once over a period of three months.

The managed alcohol program is still in use in this community, and surveillance of its effectiveness and positive outcomes are being documented. Discussions and plans are also underway with respect to the expansion of MAP to other northern First Nations requesting the service.

COVID-19 Vaccine Roll-out

COVID-19 vaccines were at the top of every conversation from the onset of the pandemic. There were the questions of which pharmaceutical companies would have their vaccines approved for use first, the efficacy of the various COVID-19 vaccines, the age range to which they would be approved for, side effects documented, supply available in each region, and the number one question – when could clinicians begin "getting needles in arms?"

To ensure a place at the decision-making tables and assist in the construction of a unique-to-First Nations approach for equitable access to the vaccines, appointments were made by MKO, AMC and SCO for representatives to work in collaboration with the provincial and federal governments. MKO's key representation at the vaccine planning table was provided via KIM's clinical and pandemic team, led by CEO, Dr. Barry Lavallee. In late December 2020, the First Nation Vaccine Implementation Task Force (VITF) was formally established. This trilateral table worked collectively on the rollout of the COVID-19 vaccines, inclusive of those residing on First Nations, in urban centers and rural areas, while also considering factors such as health inequities, remoteness, access to health care, and availability of vaccines. PRCT findings showed disproportionate impacts of COVID on the First Nation population in Manitoba.

The first shipments of Moderna vaccine left Winnipeg on Thursday, January 7th, 2021, with Pimicikamak Cree Nation and Norway House Cree Nation being two of the earliest northern First Nations to receive their vaccines. Fifty-three hundred (5,300) vaccines were earmarked for use by First Nation communities to begin, however, through advocacy efforts by First Nation representatives, these were doubled by the province to help address second doses. Priority groups were established for first doses. These included:

- Ages 60+ and health care staff in remote and isolated First Nations

- Ages 70+ in First Nations with year-round road access
- First Nation-based Personal Care Home residents and staff
- First Nation-based communal elder facility residents and staff
- Healthcare workforce, including Traditional Healers, Mobile Crisis Response Team members and MMIWG employees

The Pfizer vaccine had been designated for use at vaccine "supersites" in Winnipeg, Brandon, and Thompson due its cold chain requirements, while Moderna was more portable and available for use in various locations throughout Manitoba. Vaccinations were expanded to include Astra Zeneca for use in certain age groups, but was later omitted due to reported side effects.

Rollout to First Nation communities increased with the availability of more vaccines, thus so did the need for community-level supports. Similar to the Rapid Response Team model, the PRCT and Ongomiizwin Health Services played a key role in coordinating and deploying human resources as short-term support in the First Nation clinics. KIM's Senior Nurse Advisor served as a vaccinator on the First Nation surge support teams. When access to vaccines became more readily available in March of 2021, commitment was made by members of the VITF to provide "100,000 vaccines in 100 days" to the 63 Manitoba First Nations. Surge supports were also ramped up.

As the on-reserve vaccine rollout was happening, the VITF worked to address vaccines for off-reserve members and those residing in more isolated and remote communities. In the northern region, a central fly-in clinic was created at the Thompson airport, in a refurbished hanger referred to as "VaxPort." The idea for VaxPort was that the site could be utilized for community-wide vaccinations, bringing in large groups one at a time via chartered planes and buses. The realities of executing the plan proved more difficult than earlier anticipated. Building an airfield-based site from scratch came with its challenges, while delayed arrival of vaccines also played a major factor. In the end, VaxPort did not serve its intended purpose and it was redesigned as ground zero for Canadian Armed Forces team members who assisted in the northern vaccine surge supports.

In the northern region, a central fly-in clinic was created at the Thompson airport, in a refurbished hanger referred to as "VaxPort."

In the urban vaccine rollout, First Nation members of the VITF utilized the PRCT COVID-19 data to validate recommendations for lowered age criteria for accessing vaccines by First Nation people. Outcomes for positive COVID clients indicated more severe outcomes for Indigenous clients compared to the non-Indigenous counterparts 10-20 years younger. An age differential of 20 years was accommodated for First Nation vaccinations. Efforts were also made by KIM and other First Nation VITF members for prioritization of congregate living settings that housed higher rates of Indigenous people.

Representatives also ensured that Indigenous-specific vaccination sites would be established in major centres such as Thompson, Winnipeg, and Brandon. These Urban Indigenous Vaccine Clinics would be staffed mainly by First Nation, Inuit, and Metis employees. Through a partnership between SCO/MKO/KIM and the Province, "supersites" would also employ First Nation Liaisons and Outreach workers. KIM's CEO provided cultural and anti-racism training to all vaccine call centre employees in order to best address concerns for access to culturally appropriate services and treatment when Indigenous members booked their appointments at provincial sites.

By the end of March 2021, first doses of COVID-19 vaccines had been administered across all 63 Manitoba First Nations and the Urban Indigenous rollout was well underway. Many First Nations were already provided second doses for their Elder population and plans were in the works for the expansion of immunizations to youth 12 to 17-years-old in the following months.

Special Report: Addressing Racism in the Health Care System

Joyce Echaquan died on September 28, 2020, while in a Quebec hospital. Prior to her death, she video recorded the abuse she experienced at the hands of health care providers and shared it via social media. What she captured prior to her death set off a firestorm of anger towards systems (people make up systems meant to serve) and widespread support for her and others who have experienced abuse and even death due to racism.

Following her death, the federal government called an emergency meeting for October 16, 2020, to begin to address anti-Indigenous racism in the healthcare system.

Dr. Barry Lavallee devoted his entire career to ending racism against Indigenous people in the healthcare system, as have many of his colleagues in Canada and in other parts of the world. With his comprehensive knowledge of what racism in the healthcare system does to people and precisely how it is done, he felt strongly that he should contribute to the national conversation. On October 13th, KIM reached out via letter to Val Gideon, Assistant Deputy Minister, Indigenous Services Canada, and soon after Dr. Lavallee was invited to the October meeting as one of many experts.

Participants and experts listened in on the various presentations, including the heartfelt words of Joyce Echaquan's husband and child as well as many Indigenous health care providers who experienced racism throughout their careers. It was important to hear their words, but also to recognize the potentially exploitative nature of sharing from the heart where there are no ties to policy changes or changes in the understanding of Canadian citizens.

Following that first national meeting in October 2020, correspondence was received from three federal ministers – Marc Miller, ISC; Caroline Bennett, Crown and Indigenous Relations; and Patty Hadju, Minister of Health:

Thank you to all who were able to participate in the October 16, 2020, Urgent Meeting to Address Racism Experienced by Indigenous Peoples in Canada's HealthCare System. This meeting offered an important opportunity to listen, understand and reflect upon the tragic passing of Joyce Echaquan, the unacceptable racism she faced, and express support to her family and community. The lived experiences of First Nations, Inuit and Métis facing serious instances of racism in federal, provincial, and territorial health institutions requires the concerted actions of all of us in a spirit of renewed trust, commitment, and reconciliation.

We've set the next meeting for January...we are asking you to prepare plans for concrete actions in the shorter and longer terms to bring forward to the January meeting.

Supporting the development of an office to address anti-Indigenous racism in health care

Between October 2020 and the next national meeting scheduled for January 27-28, 2021, Dr. Lavallee formed a technical team that included both MKO and KIM expertise.

The agenda for the next national meeting was received a week before the January 27-28th meeting dates, entitled *Addressing Anti-Indigenous Racism in Canada's Health Care Systems* with the objectives noted below:

- Offer an opportunity for governments and organizations to listen and reflect on actions presented and shared by others
- Provide a platform for governments, organizations, and experts ready to lead this work to share short and long-term concrete actions to eliminate anti-Indigenous racism in the health care systems
- Demonstrate a collective commitment to eliminating anti-Indigenous racism in Canada's health care systems
- Encourage all organizations to continue developing and implementing response strategies

Throughout this period KIM and MKO continued to plan. Early discussions included establishing the model along the core pillars of education, research, advocacy, and case management. KIM and MKO are frequently asked to respond to individuals who have negative experiences when accessing healthcare. There is an urgency to getting the case management approach 'right,' to obtaining

resources for an intake system, and to establishing strong referral relationships with other trusted organizations.

As directed by Dr. Lavallee, KIM's goal was to have a fully developed proposal by the fall of 2021. The proposed model would aid KIM in responding appropriately to incoming requests; in creating a repository for well-documented data; and fostering trust among the people and organizations who will be impacted the most by the model once implemented. Key advice received was that no matter how difficult the issues, truth telling and respect should be paramount throughout all interactions, education sessions, and interventions. Dr. Lavallee well understands the urgency and has often stated, "We need to be able to respond quickly because people are experiencing violence in the health care system now."

Recognizing the Role of the Knowledge Keepers

KIM acknowledges the experience and expertise of the Knowledge Keepers group formed to aid the ongoing development of the model and entity. The Knowledge Keepers working group is made up of Elders, former Chiefs and Councilors, lawyers, educators, social workers, administrators, and community leaders. These individuals offer rich perspectives and guidance rooted in lived experiences of attending Residential Schools and Day Schools; cultivating expertise in grassroots organizing, oral history, and knowledge of Treaty relations; and fluency in the Cree and Dene languages. Original members of the Knowledge Keepers group included: Robert Wavey (Fox Lake Cree Nation), Edwin Jebb (Opaskwayak Cree Nation), Moses Okimow (Manto Sipi Cree Nation), Eunice Beardy (Tataskweyak Cree Nation), Leonard Linklater (Nisichawayasihk Cree Nation), Cathy Merrick (Pimicikamak Cree Nation), Sarah Samuel (Northlands First Nation), and Elder Simon Samuel (Northlands First Nation). Elder Sarah Yassie (Sayisi Dene) joined in June 2021.

Highlights, successes, and challenges

In the early months of 2021, KIM's team and MKO staff met regularly to consider the possibilities and gain an understanding of what could be accomplished – all towards establishing the mission, vision, and scope of this new entity. The team drew on the stories of residents from northern First Nations communities and their experiences interacting with the health care system. The team quickly identified gaps and problems that Indigenous patients and practitioners face within the health care system. Narrowing the scope of work became one of the biggest challenges.

Racism in the Healthcare Journey

As of year end March 2021, the KIM anti-racism office is in the process of developing a patient centered approach that appreciates the need for systemic and transformational change. The office will first focus on assisting patients who have experienced harm including racism during their experience in any aspect of the health care system. At the same time, they will make a strong effort to create partnerships with organizations and institutions that deal with a significant number of KIM citizens.

The team has identified many places that patients experience racism throughout their health care experience. These include transportation to the hospital, hotels provided for pre-hospital stays, nursing stations, hospital admission, surgery, nursing and physician care and discharge.

As they work with individuals, they will collect data to analyze patterns to assist KIM in determining which organizations and institutions they should prioritize to develop partnerships with or to identify as an entity that requires transformational change to properly serve Indigenous people. They will also develop partnerships with Indigenous led organizations so that they can take a holistic approach to patient care and ensure people have access to services that impact health.

Dr. Lavallee will continue his oversight role and direct the team in articulating a functional service plan with detailed budget, identified partners and other resource requirements.

Options for naming the office / model, as identified by the Knowledge Keepers

"eltth I hawulye" in the Dene language means "let's do it right together" in the English language

"minowechawitowinokamik" in the Cree language means "helping in a good way office" in English

Special Report: Validus Healthcare Economics

Supporting First Nations Priorities for Health Transformation

It has been the privilege of Validus Healthcare Economics (VHE) to provide technical and research support to Keewatinohk Inniniw Minoayawin Inc. (KIM) in their ongoing work to advance self-governance and achieve health transformation for First Nations people in Manitoba. VHE has worked with KIM since the organization's inception and has had the opportunity to assist with several initiatives that address vital logistical challenges and promote important First Nations priorities. Recent VHE work has included providing research support and expenditure modeling for the proposed development of a KIM-led referral, coordination and advocacy service for medically necessary travel. It has also involved the elaboration of a framework to facilitate the efficient collection and sharing of data to coordinate patient care and evaluate program outcomes in a way that affirms the imperatives of First Nations' ownership of, control over, access to, and possession of data as elaborated by OCAP®. Other KIM projects VHE has provided consultation for are in the areas of women's health and elder care, for which VHE has conducted extensive research to help inform discussions and future steps. In addition to work on these long-term health transformation projects, VHE has also provided ad hoc technical expertise to aid MKO communities in their response to the SARS-CoV-2 pandemic. Notably, this has included providing early quantitative modeling to highlight vulnerabilities in the population and advocate for the prioritization of vaccinating Northern and Indigenous people in Manitoba. Each of these projects is challenging and multi-faceted, and it has been a pleasure for the VHE staff to engage with them.

Laying the Groundwork for Self-Governance in Health

The journey to establishing KIM involved many steps from MKO. In 2018, a memorandum of understanding between the Government of Canada and MKO set the stage for health transformation in northern Manitoba with significant federal support. In the lead up to the KIM's official launch in 2020, VHE conducted research work to support MKO as it laid the groundwork for further self-government of health services.

A necessary first step was to benchmark the level of government spending on First Nations health in Manitoba. In 2006, Drs. Josee Lavoie and Evelyn Forget conducted estimates of health spending for on-reserve and off-reserve First Nations in Manitoba for the Intergovernmental Committee on First Nations Health in Manitoba, a committee of provincial, federal, and First Nations government representatives. In 2018, Dr. Melanie O'Gorman of the University of Winnipeg was asked by MKO to perform a fiscal analysis of northern health expenditures for First Nations communities in Manitoba. She used a broadly similar methodology to Lavoie and Forget, providing a final report for MKO in January 2019. VHE reviewed these estimates, found some areas to refine, and provided an updated report for MKO in January 2020. A further analysis was conducted of the 1964 Agreement whereby the Province of Manitoba agreed to provide health services for the northern First Nations communities of Fox Lake Cree Nation, Misipawistik Cree Nation (Grand Rapids), Mosakahiken Cree Nation (Moose Lake), and Chemawawin Cree Nation (Easterville). VHE was able to identify important flaws in the 1964 Agreement as a model for First Nations health transformation and self-government in health services. These preliminary projects were important for informing the policy direction of KIM.

Improving Medical Travel from the North

One of the first large KIM projects VHE was involved with was the planning of a logistics, support and advocacy services hub for medically necessary travel. Improving the experiences and outcomes of the more than 26,000 First Nations individuals annually who must travel from remote northern communities to urban centres in Manitoba to receive medical care is a major priority for First Nations. Medical travel is currently arranged by the First Nations

and Inuit Health Branch of the federal government (FNIHB); however, it is often insufficiently coordinated and inconsistent, leaving the process fragmented and inefficient, and exposing patients to unnecessary emotional stress and financial strain. This can make managing chronic conditions like diabetes especially burdensome and turn joyful occasions like childbirth into isolating ones. Establishing a First Nations-led service to coordinate medical travel and provide support and advocacy to First Nations patients has the potential to significantly improve healthcare access, outcomes and satisfaction. It also represents a significant step forward for First Nations self-determination in Manitoba.

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To ensure KIM has the necessary information to move forward on this key project, VHE surveyed programs and services that have been developed to improve medical transportation in other jurisdictions, identifying promising practices and models for KIM to consider. A detailed review was also conducted of the current patient journey from northern communities to urban hospitals, highlighting potential communication failures, service gaps and inefficiencies. The system was shown to be opaque and difficult to navigate for many patients, with poor communication and coordination between the different providers, medical institutions, and levels of government responsible for providing care. Systemic racism and stereotyping are also persistent problems that cause considerable distress and creates barriers to care for First Nations patients. In ongoing discussions with KIM, the Kivalliq Inuit Centre was determined to be the service model most suited to addressing these issues and meeting the needs of MKO communities. Winnipeg was chosen as the optimal location for the first centre, with the potential to extend satellite sites in Thompson and The Pas. KIM identified improving physical, mental, social, traditional, and spiritual health and wellness, as well as addressing systemic racism, inequities, and health system gaps, as First Nations' foremost priorities for this project and they served as the guiding objectives of VHE's work.

With these priorities in mind and taking the Kivalliq Centre as a starting point, VHE sought to re-envision an ideal patient journey, and to develop a patient-centered coordination service model to realize this ideal. In this model, each stage of the patient journey is coordinated to ensure clients receive all pertinent information in a timely and appropriate manner, and in their preferred language. Referral clerks serve as advocates and liaisons between patients and healthcare professionals to ensure effective communication, trust, and cultural safety. The booking of appointments and accommodation is centralized to ensure efficiency, avoid wait times, reduce redundancy in

travel for multiple appointments, and ensure that the necessary prescriptions and follow-up care are recorded and arranged. Ground transportation is provided to patients within Winnipeg to help them navigate the city and prevent missed appointments. Patient support and spiritual care are also integrated into the model, with traditional healers, a Christian chaplain and Indigenous birth helpers on staff and available for those who want their services. The final VHE on this model report includes five-year expenditure estimates and micro-costing for each of these components as well as preliminary recommendations for efficient data sharing between the stakeholders to allow for effective program evaluation and to track improvements in patient outcomes as well as inefficiencies in the system.

Caring for Vulnerable Populations

Another priority identified by KIM has been to develop compassionate and innovative approaches to improving care for vulnerable members of First Nations Communities. These populations include women and elders, groups who have traditionally had respected leadership roles within their communities but now experience marginalization and poor health outcomes within the Manitoba medical system. KIM has asked VHE to investigate ways of improving care and prevention for these populations through holistic, community-based solutions that keep them closer to home.

The impact of colonialism on Indigenous peoples in Canada has been gendered, resulting in a range of poor health outcomes for First Nations women and leaving them vulnerable to sexual abuse and intimate partner violence. The experience of childbirth has also been colonized. Mothers from remote and northern First Nations communities are compelled to leave home, often several weeks before they are due, to await labour in southern hospitals separated from the support of partners, family, and friends during an emotionally and physically challenging period. Despite disruptive relocation in the name of risk-reduction, First Nations maternal and infant outcomes continue to lag those of the non-Indigenous population, and the infant mortality rate remains high.

Another priority identified by KIM has been to develop compassionate and innovative approaches to improving care for vulnerable members of First Nations Communities.

To assist KIM in its efforts to address the specific needs of women in its constituents, VHE has undertaken research and environmental scans to aid in program development along two tracks: the creation of a mobile health care program to bring providers specializing in women's health to communities on a consistent rotation, and the establishment of permanent, in-community pregnancy, birthing, and post-partum support services. Together, these programs are intended to address the wellness needs of First Nations girls and women at all stages of life, including vaccinations; education, screening, and support for all aspects of sexual and reproductive health; breast and cervical cancer screening; mammogram services; nutritional services; and screening for osteoporosis. Mentorship from community member and traditional knowledge will be an important element of care within both programs. Advocacy and birth support, including Indigenous doulas services, will also be an important component of maternal care services for women who must leave the community, and can be integrated with the medical transportation services to provide seamless support throughout pregnancy, birth, and the postpartum period.

Along with First Nations women, First Nations elders are among the most vulnerable populations in Canada and providing effective, culturally-safe care has been similarly compromised by colonialism and remoteness. Elders are honoured in First Nations culture for their knowledge and counsel, but this wisdom is lost when some must leave their homes to receive long-term care outside of the communities. Moreover, recent experiences with SARS-CoV-2 have exposed the extreme inadequacy of staffing and other resources in many personal care facilities in Manitoba. Social determinants of health including poverty and poor housing, as well as Indigenous

specific determinants such as racism and the traumas of residential schooling, have led First Nations elders to have greater care needs while also increasing the likelihood that they will end up in poorly resourced facilities. Families have expressed the need for more community-based services and supports as well as end-of-life care to allow the elderly to remain in their homes longer and keep them in the community. At the same time, care homes in some Manitoba First Nations that experienced COVID outbreaks appear to have fared significantly better than those in Winnipeg, with fewer deaths and more recoveries among infected residents. VHE is now undertaking an in-depth analysis of the challenges and gaps in care that First Nations elders face, as well as the strengths and knowledge which already exist in MKO communities. This includes conducting an environmental scan of First Nations elder care services, models of Community Based Supports and Services for elders, and public health protocols at long term care homes managed by First Nations and those managed by non-Indigenous organizations.

Preparing for COVID-19

KIM leadership participated in the Manitoba First Nations COVID-19 Pandemic Response Coordination Team (PRCT), which has been crucial in advising on policy as well as developing and coordinating a response to the COVID-19 pandemic for First Nations in Manitoba. To aid in this rapid response effort, VHE did demographic research and computer-simulated infection modeling starting in December of 2020. This was in the very early days of COVID-19 vaccine policy development in Canada and having prompt information on Manitoba First Nations demographics, public health, and vulnerabilities to infectious disease was very important. VHE provided estimations regarding the vulnerability of Indigenous peoples across Canada, and Manitoba in particular.

Granular data on pre-existing health conditions that is disaggregated by categories like First Nations status, gender, and age, is crucial to epidemiological modeling but is also extremely limited in its availability. Through a special request to Statistics Canada, VHE acquired microdata from the Canadian Community Health Survey (CCHS) for non-Indigenous Manitobans and Canadians as well as Indigenous persons living off-reserve (Metis, Inuit, and First Nation). For First Nations living on-reserve, VHE acquired estimates of chronic conditions by age from the First Nations Regional Health Survey (RHS). Combining these sources, VHE showed that for any given age group First Nations were much more likely to be vulnerable to infectious disease due to higher rates of pre-existing conditions. This helped inform the vaccine policy in Manitoba whereby First Nations were given priority to vaccines at younger ages than non-Indigenous Manitobans. This policy has been very successful in helping First Nations communities and other Indigenous populations in Manitoba to get vaccinated at high rates, with those on-reserve doing particularly well. This is in stark contrast to the tragic and disproportionately worse outcomes for Manitoba First Nation communities during the H1N1 outbreak in 2009.

Getting Data Collection and Sharing Right

KIM's ambitious plans for health transformation in northern Manitoba, both through the enhanced logistics and support hub as well as other initiatives, will require tremendous data and information. This is both to provide progress metrics to federal and provincial funding partners, but also to fulfil important accountability obligations to First Nations citizens and service users. Fine-grained data can inform KIM whether its programming and services are on the right track and enable KIM to respond to emerging First Nation health needs. The First Nations Health Authority (FNHA) in British Columbia, an epitome of First Nations self-government and transformation of health services in-action, has comprehensive data sharing agreements and governance protocols with federal, provincial, and other First Nation entities.

To assist with the first steps of establishing a data sharing and management framework for KIM, VHE has been researching First Nations data governance institutions and data sets, and exploring potential operational metrics. The de facto ethical standard for working with First Nations data are the First Nations principles of OCAP®: Ownership, Control, Access, and Possession. OCAP® is a registered trademark of the First Nations Information Governance Centre and means First Nations control data collection processes in their communities and protect, own, and control how their information is used. In many cases where First Nations governments and organizations lack their own data governance infrastructure and

technical capacity, the use of an outside organization as a data steward bound by a data sharing agreement may ensure OCAP® principles are fulfilled. A VHE has reviewed the history of OCAP® principles and the implementation of OCAP® in health services across Canada. This has required us to develop an understanding of the institutional arrangements and data linkages that underpin the FNHA in BC, the Tui'kn Partnership in Nova Scotia, and the First Nations Cancer Surveillance System in Ontario. Among other things, this has given us an understanding of the careful arrangements and considerations needed to prevent unauthorized disclosure of First Nations community health data through provincial Freedom of Information and federal Access to Information requests.

VHE is also exploring various internal surveys and measurements KIM could use to gauge client satisfaction with the logistics and support hub as well as for other initiatives. Patient-Reported Experience Measures (PREMS) and various health outcome indicators are under review. Likewise, approaches to measuring the operational efficiency of the enhanced logistics and support hub are being evaluated. One possibility under consideration is a loss distribution model to identify things like redundant travel for multiple appointments which could have been booked together. While most often used in finance, this approach has been applied to health management contexts as well. VHE is currently enumerating and identifying the data sources that would be necessary to use this model in KIM operations.

Looking to the Future

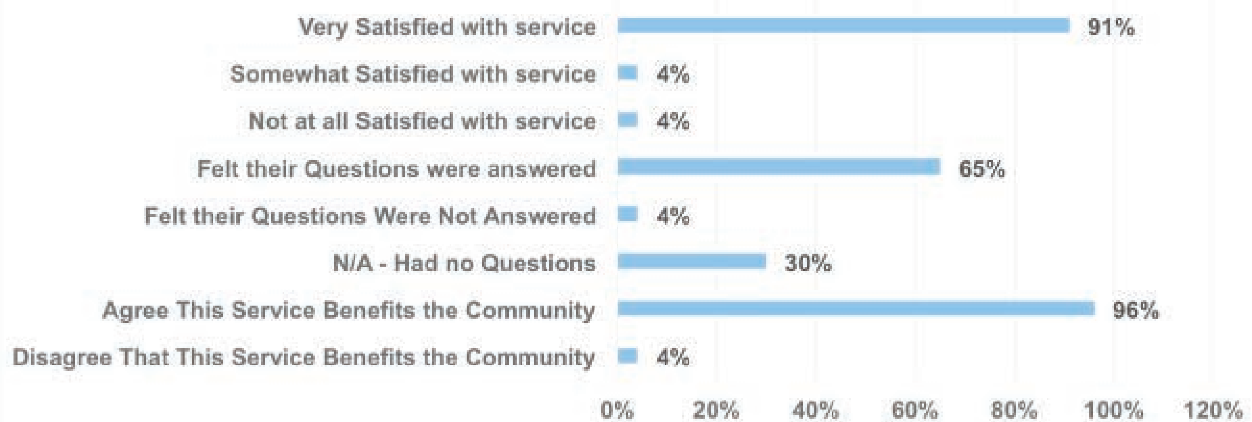
The challenges facing First Nations health and wellness are complex and require long-term transformative solutions. As an organization, VHE shares in KIM's vision for equitable, safe, First Nations-run healthcare services in Manitoba, and values the opportunity to contribute to the important initiatives that KIM is undertaking.

The challenges facing First Nations health and wellness are complex and require long-term transformative solutions.

Clinical Partnerships: Diagnostics and Clinical Services

Ultrasound at Pimicikamak Cree Nation (Cross Lake Nursing Station):

- An ultrasound machine and disinfecting system was installed in the Cross Lake Nursing Station. As this equipment is digital, the studies are submitted electronically to the radiologist almost immediately after the patient's appointment resulting in a quick turnaround to receive the reporting results.
- This project has brought a service closer to home that other Manitobans have had access to for some time. Not only is it innovative, but it contributes to early detection of issues resulting in better health outcomes as well as saving on travel costs.
- A total of 607 studies were completed from April 1, 2020 to March 31, 2021. A service agreement was put in place with Southern Manitoba Diagnostic Imaging who provided sonographers consistently for 3 days per week in the community to complete the studies. Patient satisfaction surveys were handed out at various times throughout the fiscal year resulting in positive feedback from the patients.



X-ray

- KIM committed to upgrading the remaining old film x-ray machines in the remote/isolated nursing stations in Northern Manitoba. In addition to the vendor, this project required the help of First Nations and Inuit Health Branch, Boundary Trails Health Center as well as Broadband Communications North (BCN). Each community had their old film equipment removed and replaced with a new portable digital x-ray machine, workstation, infant immobilizer as well as a mobile barrier. Almost all sites required installation of data drops into the x-ray rooms in order to accommodate the new equipment which we coordinated with BCN.
- 19 First Nations received the new equipment – Barren Lands First Nation (Brochet), Manto Sipi First Nation (God's River), Northlands Denesuline (Lac Brochet), Nisichawayasihk Cree Nation (Nelson House), Bunibonibee Cree Nation (Oxford House), Mathias Colomb First Nation (Pukatawagan), Shamattawa First Nation, O-Pipon-Na-Piwin (South Indian Lake), Tataskweyak Cree Nation (Split Lake), Sayisi Dene (Tadoule Lake), York Factory (York Landing), Poplar River, Berens River, Little Grand Rapids, Pauingassi, Bloodvein, St. Theresa Point, Garden Hill and Wasagamack.
- Application training was provided at the time of the install with additional application training provided remotely in December 2020 and March 2021. Due to staff rotations (some were not on site at the time of the install when training was provided) this helped to ensure they had the necessary training and support to feel comfortable using the equipment. This also helped with training new staff that were hired after the installation, and many took the training again as a refresher.

Some operational and clinical benefits of digital radiography over the old film images are:

a. DR emits lower levels of radiation benefitting the patient & contributing to the safety of staff.

b. No toxic chemicals required with new equipment = potential health benefits to staff working with the equipment & better for the environment.

c. Upgrade is a step towards providing equitable services to First Nations in remote/isolated communities that the rest of Manitobans have had for some time now.

d. Improved x-ray services are now available to over 45,000 First Nations people.

e. Reduced travel costs.

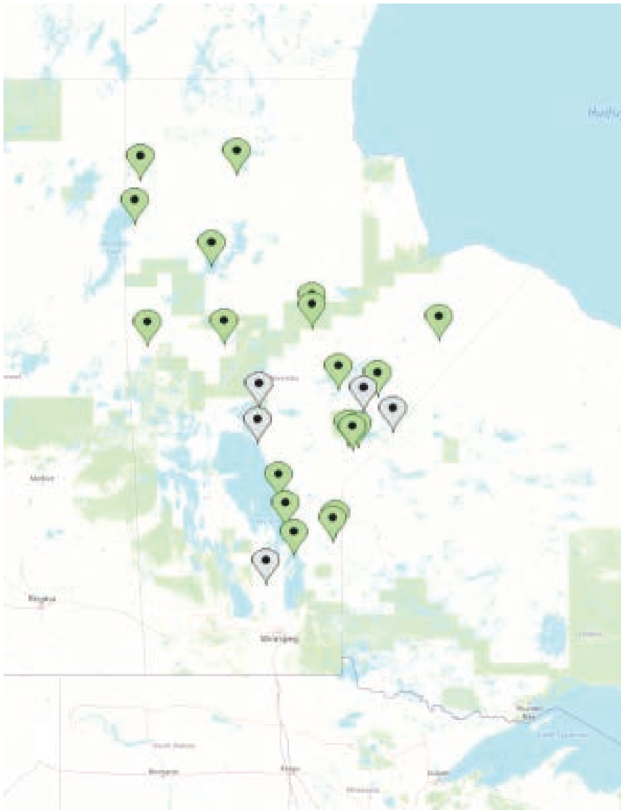
Some clinical benefits of digital radiography over the old film images are:

a. The time from when an x-ray is performed to when it is interpreted by the Radiologist is reduced to a day or two from a week or two.

b. Helps facilitate patient management at the local site or transfer to a larger institution.

c. The film quality is markedly improved allowing for a more accurate interpretation by the radiologist and helpful to local staff to interpret images locally.

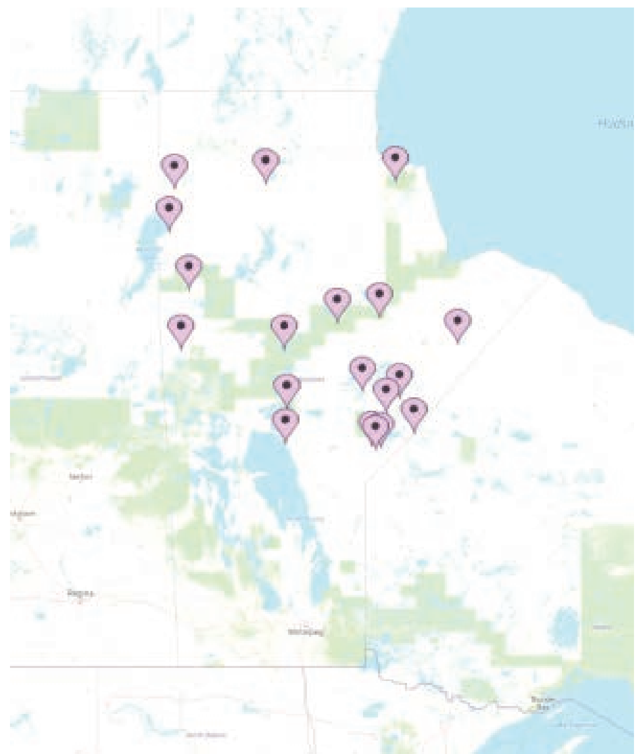
***Green plots represent the 19 locations that were upgraded**



Point of Care Ultrasound

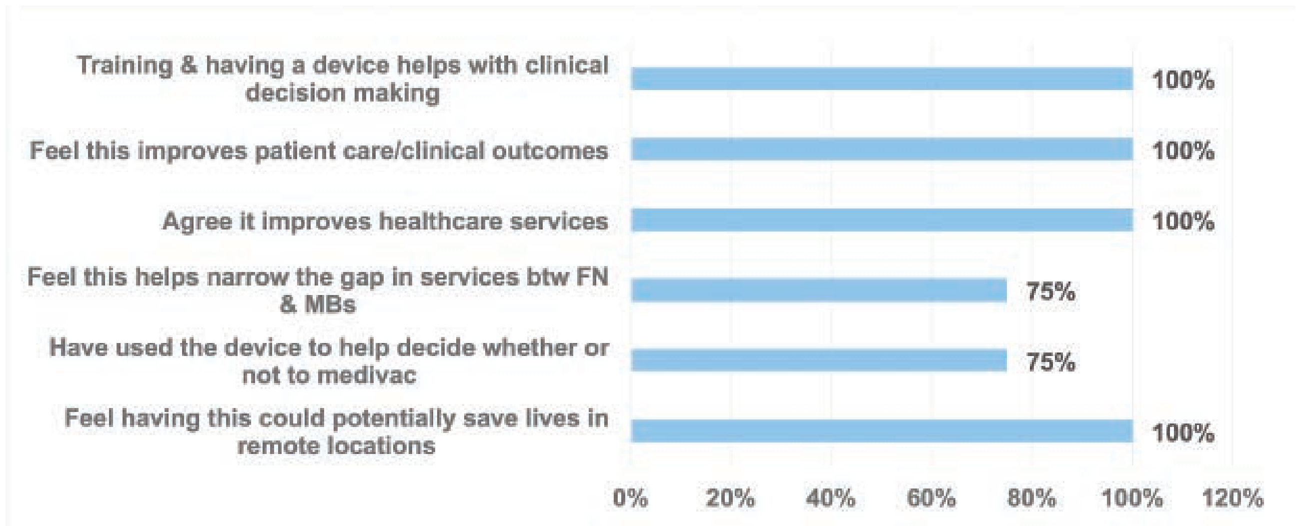
- KIM brought point of care ultrasound to MKO communities by reimbursing the cost of the training to physicians who provide services to remote/isolated locations in Northern Manitoba. We felt that investing in the physicians professional development and providing the equipment for them to apply the new training would directly benefit the community members. This is not only innovative, but it can help aid the physician's clinical decision making by adding an extra layer of assurance in the provision of care.
- SonoSite PoCUS Devices were provided to 4 First Nations: Pimicikamak, Norway House, St. Theresa Point, and Garden Hill
- Vscan PoCUS Devices were provided to 11 First Nations communities: Gillam (services Fox Lake), Tataskwayak Cree Nation (Split Lake), Barren Lands (Brochet), Northlands (Lac Brochet), Sayisi Dene (Tadoule Lake), God's Lake, Manto Sipi (God's River), Bunibonibee Cree Nation (Oxford House), Lynn Lake (services Marcel Colomb), Mathias Colomb (Pukatawagan), and Shamattawa
- In response to the global pandemic, training sessions at the UofM and other institutions across Canada were cancelled. When new sessions are offered, we confirmed that priority will be given to those MDs who were enrolled previously.

***Plotting shows the vast area of the north that now has PoCUS equipment and trained physicians**



Feedback from MDs that took the training and are using the devices provided:

- This service is now available to an estimated population of 78,000 people.



Physician & Clinical Services

- AMDOCs physicians continue to provide weekend services to Pimicikamak
- 4147 patients had been seen over the period from April 1, 2020 to Mar 31, 2021
- Ongomiizwin Health Services began providing in-community weekend services to both St. Theresa Point and Garden Hill.
- The additional physician services have been effective at improving the quality of care in these two communities.
- Reporting is now being reviewed the same day it arrives at the nursing stations which was not the case in the past.
- Contributes to physician confidence in diagnosis and decisions as they are in community and able to follow up.
- Decreased the need to send patients out for some procedures and conditions.
- In other cases, some patients may travel more due to the increase access to care in the community which has allowed the MDs to spend more time with patients as well as identifying and investigating more conditions as well.
- The long patient listing of who needs to be seen by a Physician has been eliminated as a result of this extra capacity over the weekends.
- As part of this same agreement, additional Physician service hours were being provided to the communities of Mathias Colomb, Berens River, Bloodvein, Poplar River, Little Grand Rapids, Pauingassi, Red Sucker Lake and Wasagamack weekly.
- As well, some additional specialist physician hours to the communities of Sayisi Dene, Barren Lands, Northlands, Nisichawayasihk, O-Pipon-Na-Piwin, York Factory and Mosakahiken.
- Quest Health (formerly Natawiwewak Clinic) continues to provide services to members of God's Lake, Chemawawin, Bunibonibee, and Manto Sipi First Nation
- The medical clinic operates with a staff compliment consisting of Primary Care MDs along with a Physician Assistant. The clinic is equipped with 2 telehealth units and has maintained ongoing virtual care with community members which has enhanced service accessibility and equity through the pandemic.
- Land based healing camps for youth and adults in partnering communities were held over the past year.
- The patient services program began and is situated in the front lobby of the Quest accommodations site. Since opening, the staff have been successful in supporting community members to access pharmacy support services, eye and vision care, dental services, urban based medical transportation as well as medical supplies and equipment.

- Quest Health entity continues to meet the ongoing challenges of the provision of health and mental wellness services in a way that is transforming health care approaches in Northern Manitoba.

Opaskwayak Health Authority projects/programs:

- **Counselling services** have been delivered out of the Beatrice Wilson Health Center consisting of behavioral health services, counselling services as well as educational support through learning circles.
- **Nurse Practitioner services** have been delivered out of the Beatrice Wilson Health Center consisting of primary care, school health, diabetes management and community education (supported by learning circles).
- **Registered Nurse services** specific to Opioid Replacement Therapy have been delivered which addressed the waiting list for the ORT program and supported the existing OHA team of nurses by filling the gap in the patient to nurse ratio that was identified.
- **Psychology Services** have been delivered in community along with additional services provided by virtual means. These services supported the mental wellness integrated care team by providing senior consulting services to the mental health team, as well as therapeutic services to individuals and groups along with public teaching sessions to the community.
- **Registered Psychiatric Nursing services** have been provided out of the Beatrice Wilson Health Center which provided clinical and counselling services, educational support and capacity building in SCTC communities.
- **STBBI/Public Health Project** began initial hiring phase to address the Public Health Crisis in Opaskwayak and surrounding region.

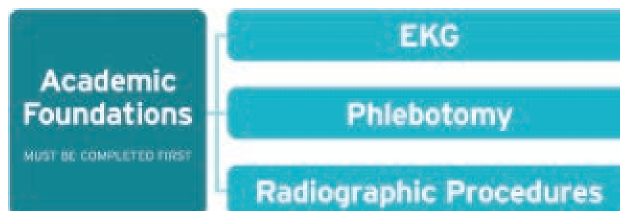
Telepsychiatry Services – MCDermot Group pilot project – **Completed**

- Provided psychiatric consultations to Emergency Departments and rural First Nations Communities for children and adolescents presenting with a mental health crisis and developed a care plan. Psychiatric assessments for the period of June 30th, 2020 to March 31st, 2021.
- Guidelines and processes for delivery of the service were developed.
- 1/3 of the calls/telehealth assessments were provided directly to the nursing stations such that children did not have to travel out to an Emergency Department.
- Reduced travel in turn has reduced the risk of youth and families being infected with COVID-19 during their travel out to Winnipeg and back.
- Child and adolescent emergent telepsychiatry.
- Over 5 months, 60% of the calls from rural FN/ hospitals managed without bringing the child to Winnipeg.

Workforce Development – Red River College (RRC) Diagnostic Support Worker (DSW) Training Program

- During the Manitoba Keewatinowi Okimakanak's 36th Annual General Assembly held in Norway House Cree Nation, the Chiefs in Assembly passed resolution #2017-07-03 which specifies that the Clinical Care Transformation (CCT) plan must include a training initiative that builds capacity in youth.
- In partnership with Red River College and First Nations and Inuit Health Branch, the DSW training was developed as an applied certificate program and is provided through a blend of online, in class and clinical learning experiences.
- Focused in community, students are provided with the opportunity to learn and practice clinical skills close to home.

The training consists of the following 4 micro-credentials to graduate with a Diagnostic Support Worker applied certificate.



Clinical Partnerships: Jordan's Principle Pediatrician & Clinical Health Psychologist Services

KIM received federal funding for the 2020/21 fiscal year to provide pediatrician and clinical health psychology services to thirteen northern First Nation communities in the MKO region.

The Jordan's Principle initiative delivers pediatrician services to children and youth living in First Nation communities in northern Manitoba. Many were without local pediatric services and some with limited general physician services. This gap led to issues in the care and appropriate referral of children with health and developmental issues.

Through KIM's Jordan's Principle initiative, pediatricians and nurse practitioners help to identify children and youth with previously unattended developmental and chronic health needs, as well as those who may require referral to tertiary care or clinical health psychology services. Pediatric psychology services are often aligned with pediatrician care and provides diagnostic assessments for children who present with developmental anomalies. Psychology services have not been readily accessible to children in smaller or more remote communities.

The clinical partners provide one full-time psychologist position to address the needs in the thirteen communities, in a collaboration with the First Nations' Jordan's Principle Case Managers. The psychologists coordinate with pediatricians to provide needed consultation and direct services to children and youth, primarily in their local communities.

The clinical partners have budgeted one visits of three days per annum in-community for child psychology and three visits of five days per annum for pediatrician services, with follow-up reports to the patient file, or provided via Telehealth where necessary. Upon availability, the partners continue to be flexible in services, providing more service to those communities that present a higher need.

First Nations Served

Nine First Nation communities in the MKO region were initially identified as being under-serviced (i.e. no pediatrician/psychologist and/or limited general practitioner services):

1) God's Lake Narrows First Nation
2) Mosakahiken First Nation
3) Nisichawayasihk Cree Nation
4) Opaskwayak Cree Nation
5) O-Pipon-Na-Piwin Cree Nation
6) Sapotaweyak Cree Nation
7) Shamattawa First Nation
8) Tataskweyak Cree Nation
9) Wuskwi Sipihk Cree Nation

Based on self-identified needs of the First Nations and by their request, four additional MKO First Nations were included in the pediatrician and psychology services, starting April 2020:

1) Barren Lands First Nation (Brochet)
2) Bunibonibee Cree Nation (Oxford House)
3) Pimicikamak Cree Nation (Cross Lake)
4) York Factory First Nation (York Landing)

Project Outcomes

From April 1, 2020 to March 31, 2021, KIM's Jordan's Principle project delivered 22 pediatrician clinics and 8 psychology clinics to 10 of the 13 First Nations. The project provided services to over 374 children and youth. These in-community and virtual appointments are believed to have saved an equal amount of out-of-community medical trips for patients and their escorts to health facilities in such places as Thompson, Winnipeg and other referral sites.

Due to COVID-19, all in-community pediatrician and clinical psychology services were suspended from March until July 2020, however, work was undertaken during that time for the planning of virtual clinics. Communication between the Jordan's Principle program and First Nations remained ongoing throughout the pandemic and starting in July 2020, regular in-person services were able to resume in several communities, with necessary precautions taken.

Referrals

With a focus of identifying children and youth with previously unattended developmental and/or chronic health needs, clinical partners address primary and secondary healthcare issues as presented. As needs are identified, links are established with tertiary health care providers, allied and mental health, and support systems as required. Types of referrals made by physicians to date have included:

Allergy Clinic	Audiology	Cardiology	Child Development Clinic	Dietician	Ears, Nose & Throat (ENT)
FASD Clinic	Gastroenterology	Genetics	Mental Health	Nephrology	Neurology
OT	Orthopedics	PT	Psychology	Radiology	Respirology
Rheumatology	St. Amant	SLP			

Education & Training

Continuing education and on-site workplace development remain integrated in the Jordan's Principle project. Clinical partners offer interdisciplinary education a part of their visits by training the professionals in the community on relevant and current topics in pediatric care. To promote strong relations between healthcare and communities for a future generation of health care professionals, resident doctors have been encouraged and enabled to accompany clinicians, while KIM has made commitment to develop and provide Anti-Racism training for the project's clinical team.

Communications

Immunity Wellness Campaign

In preparation for the 2020-21 influenza season and in support of communicable disease prevention, an immunity wellness campaign was developed to target First Nations in northern Manitoba.

The multi-phased strategy focused on educating, preparing, and protecting northern First Nations on preventative measures, self-care, and building ones' immunity.

The following assets were developed to support the flu vaccination phase:

- Video: "Breathe" video PSA
- Radio: "Breathe" radio PSA
- Posters – Designed and shipped to all MKO health directors
- Digital/Online – Website banners, leader blocks, tall blocks, social media posts

"The KIM Story" video

CoPilot Collective was engaged to pull together clips and to include shots of each participant looking into the lens and saying "wellness" in their Indigenous language. The soundtrack for the video featured Moody x 2, a popular Cree sister duo from Nisichawayasihk Cree Nation, who gave permission to use an instrumental excerpt from their song, *Mahekan*. The youth, elders, health care workers, traditional healers, and drummers whose presence and participation in our KIM film, truly embodied the essence of minoayawin (wellness) and how to live a good life.

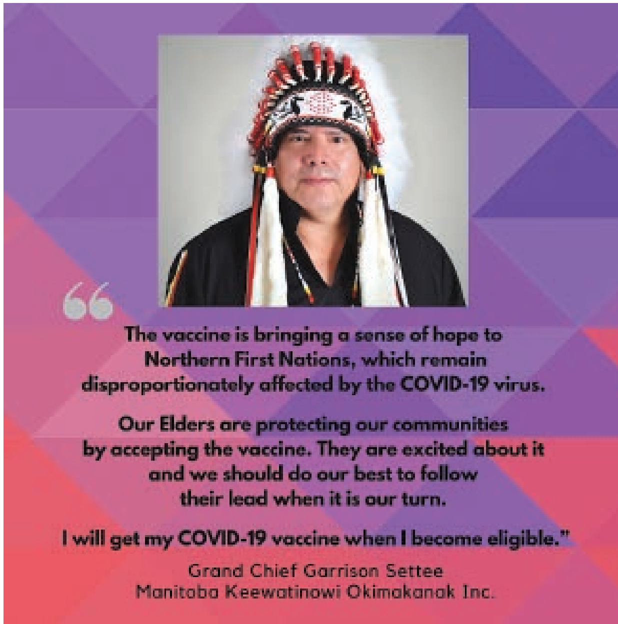
Get Back to Green Video

The two-minute #GetBackToGreen animated public service announcement was funded by the Canadian Red Cross. This video was designed to support First Nations communities in their ongoing efforts to reduce the impacts of the COVID-19 virus, as leadership wanted all citizens to follow public health orders. The overarching message was that if we all work together, we can then return to the safest level – code green – where we can be with our families and friends again, safely.

"We are all about community. Do what you can to stay safe – so we can all get back to green."

The animation video includes a narrative voiced by Indigenous social media influencer, Michelle Chubb, who has ties to both Pimicikamak and Bunibonibee.

Testimonial Poster Series



Inspired by Chief Heidi Cook's presentation during MKO's Live Facebook press conference where she said the following:

"I believe the vaccine will provide protection to our people. Our great-grandparents recognized the value of medical science to our people...that's why healthcare is now in our Treaties. We have a Treaty right to the vaccine...The pandemic they experienced before the time of Treaty is what led to that. We know the impact of that to our community and we need to make it a priority for our people."

KIM reached out to the MKO, SCO and AMC Grand Chiefs and other influencers in health to request testimonials and/or views about the COVID-19 vaccination campaign, addressing vaccine hesitancy, encouraging elders and health care staff to get their vaccines, and what needs to happen in the communities to prevent further outbreaks.

Hope is Stronger than Fear Video

This 60-second animated video was designed to encourage First Nations to connect with their local healthcare providers to learn more about the COVID-19 vaccines, how to access them, and to make informed decisions based on facts from trusted health experts.

Get Back to Green Video

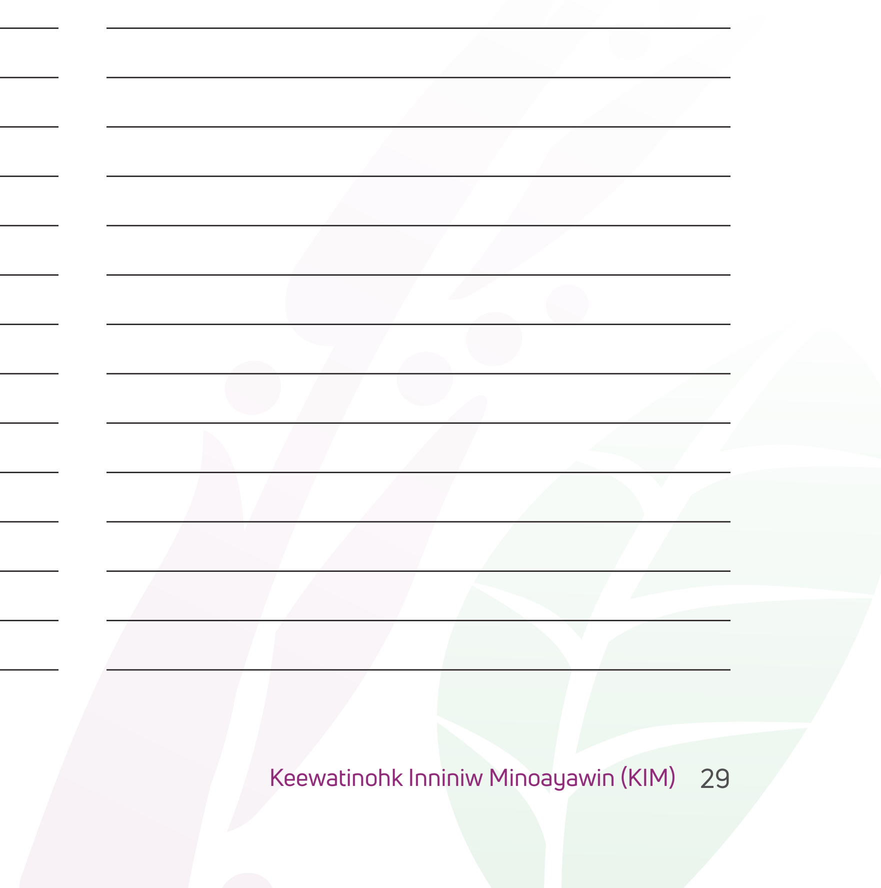
Statement of Earnings

For The Year Ending March 31, 2021

	Current YTD	Unaudited Budget YTD	Variance YTD	
REVENUE:				
Indigenous Services Canada – Health Services Integration Fund	2,181,882	10,800,800	8,618,918	
Indigenous Services Canada – Jordan's Principle	1,824,544	2,069,859	245,315	
The Childrens Hospital Research Institute Of Manitoba	10,000	0	(10,000)	
Indigenous Services Canada – Deferred Revenue Prior Year	9,666,747	9,666,747	0	
	13,683,174	22,537,406	8,854,233	
COSTS AND EXPENSES:				
Clinical Care Transformation Partners	8,761,587	15,339,849	6,578,262	64.0%
Pediatricians And Clinical Psychology Project	1,824,544	2,069,859	245,315	13.3%
Employee Costs (Salary, Benefits, Travel, Etc.)	1,339,591	1,641,650	302,058	9.8%
Governance	168,145	575,549	407,404	1.2%
Operations	509,226	758,281	249,055	3.7%
Administration	1,080,080	1,080,080	0	7.9%
	13,683,174	**21,465,267**	**7,782,094**	
Net Earnings (Loss) For Period		**1,072,139**	**1,072,139**	

Notes:

Notes:



Notes:

Acknowledging the Leadership MKO Health Directors and Nurse Managers Working Group

We acknowledge the northern Health Directors and Nurse Managers Working Group who met with the MKO Clinical Care Transformation leads back in 2019, before the governance model for a new health entity was fully developed.

They provided MKO's Clinical Care Transformation leads with advice and input in many clinical areas as well as the naming of the organization, strategic directions, and overall support for what would become the Keewatinohk Inniniw Minoayawin. They advised that a First Nations led health entity would need to have control of policies and put forward the principle of "all for one, one for all." It was this group of dedicated health leaders who told us that the governance would need clearly differentiated roles, health expertise, and arms-length but still involved political leadership.

The Health Directors and Nurse Managers Working Group

- Anita Crate, Tribal Nursing Officer, Keewatin Tribal Council
- Helga Hamilton, Director of Health, Pimicikamak Cree Nation
- Frances Macklin, Nurse in Charge, Tadoule Lake Nursing Station
- Garry Munro, Executive Director, Cree Nation Tribal Health Centre
- Glen Ross, Executive Director, Opaskwayak Cree Nation Health Authority
- Sarah Samuel, Health Director, Northlands First Nation Health

Health Leadership in Communities

We are grateful to all northern First Nations Health Directors and community health staff who have provided advice and input to the MKO Clinical Care Transformation team, since 2017 when MKO first began to explore the establishment of a new First Nations led health transformation entity. KIM will continue to seek input from these health leaders in the communities.

KIM's governance is meant to be fully inclusive. We encourage health staff to reach out to the caucus coordinator or health director in your community or region, for more information about KIM and how to get involved or provide input at the local level.

Acknowledgement of First Nations and Inuit Health Branch, Indigenous Services Canada

In the spirit of partnership, we acknowledge the Government of Canada for the provision of funding and knowledge resources with respect to Health Transformation via First Nations and Inuit Health, Indigenous Services Canada.

Keewatinohk Inniniw Minoayawin Inc.

Northern Peoples' Wellness

info@kiminoayawin.com

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