Partners in Health “What We Heard” Report

Timmins - October 2025

NISHNAWBE ASKI NATION
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Executive Summary

Timmins Partners in Health Visioning Exercise – What We Heard Report

The Timmins Partners in Health Visioning Exercise brought together representatives from First Nations, Tribal Councils, NAN, Health Service Providers, Health Authorities, and government partners to collectively explore what is working, what barriers persist, and what the path forward looks like toward **Health Transformation by 2030.**

Participants spoke candidly about both progress and frustration. While strong relationships, dedicated staff, and land-based healing programs were highlighted as bright spots, the discussion also revealed deep systemic challenges: from **rigid funding and administrative burdens** to **infrastructure gaps, workforce shortages, and lack of coordination** across jurisdictions.

At the same time, participants expressed optimism. Communities see the transformative potential of **flexibility, autonomy, and multi-year investments.** They emphasized that when funding is unrestricted and communities have control, innovation thrives, land-based youth programs grow, traditional medicine is used alongside clinical care, and families reconnect in healing.

The conversation also centered on the need for accountability, transparency, and trust between partners. Participants called for clearer engagement pathways, data-sharing agreements, and respect for local governance, stressing that standards and strategies must reflect community voices and real conditions on the ground.

Looking forward, participants envisioned a 2030 health system that is **First Nations-led, holistic, and equitable**; one that "meets people where they are at," combines traditional and Western knowledge, and is supported by sustainable infrastructure and a skilled, community-based workforce.

The Journey to 2030 was seen as both a vision and a commitment: to rebuild systems from the ground up, guided by the principles of respect, transparency, flexibility, and co-development.

1. The Journey to 2030: Building a Transformed Health System

1.1 Short-Term Priorities (Immediate Steps to Transformation)

Participants described the **first stage of transformation** as one focused on coordination, clarity, and investment in people and infrastructure. Immediate action is needed to ensure that communities can stabilize services while building the foundation for long-term change.

In the short term, transformation means that **people can make their appointments and receive care when and where they need it,** supported by improved coordination between communities, Tribal Councils, and health partners. To achieve this, participants emphasized the need for:

- **An external review of Non-Insured Health Benefits (NIHB)**, including data-sharing on approval and denial rates, and a commitment from Canada to address administrative barriers that prevent timely access to care.
- **Conversations with ISC and MOH about capital and infrastructure needs,** especially the immediate upgrades required for nursing stations, medical transportation, and home accessibility.
- **Clearer engagement pathways** to ensure community priorities inform policy and funding decisions at every level.
- **Flexible and autonomous funding mechanisms,** reducing administrative burden and empowering communities to design solutions that meet their realities rather than conforming to rigid mandates.
- **Discussions with colleges and universities** to align Health Human Resource (HHR) strategies with community needs, ensuring that training pathways prepare people for positions in their own Nations.

Short-term success will be measured not by new programs alone but by **how well existing systems are made to work for the people they serve** — through coordination, accountability, and respect for community-driven priorities.

1.2 Five-Year Milestones: Laying the Foundation for a New System

The **five-year journey (2025–2030)** represents the bridge between today's fragmented system and the fully transformed model envisioned by communities. Participants described this phase as one of **integration, innovation, and empowerment** — shifting from multiple "mini-systems" to one coherent, community-driven network of care.

Key milestones for this period include:

- **Health Human Resources (HHR) Strategy:** Training people in their own communities through micro credentialing and at-home learning programs, ensuring the workforce is local, stable, and culturally competent.
- **Financial Control and Decision-Making:** Strengthening local authority over health funding to ensure transparency, accountability, and equitable distribution of resources.
- **System and Infrastructure Planning:** Mapping health facilities, technology, and transportation needs to create equitable access to care across the territory — with the guiding principle that "housing is health."
- **Policy Reform:** Advancing legislative and regulatory changes that remove barriers to community control — especially within NIHB, ISC program mandates, and Ontario's jurisdictional limitations.
- **Governance Integration:** Moving from isolated Health Director structures to integrated models of Health Director–to–Health System leadership, ensuring alignment between community delivery and regional governance.
- **Cross-Jurisdiction Collaboration:** Strengthening partnerships between Ontario, Manitoba, Nunavut, and Quebec to reflect the lived geographies and care pathways of northern peoples.
- **Evaluation and Accountability:** Embedding continuous evaluation into all transformation work to ask the central question — "Is this making a difference?"

This stage also requires addressing inter-jurisdictional coordination and **clarifying governance roles and responsibilities** — the "five W's and the money" (who, what, where, when, why and how resources flow).

By 2030, participants said, communities should no longer be navigating between multiple disconnected systems. Instead, **they will own and operate an integrated, culturally safe, and data-driven health system that reflects their values and priorities.**

1.3 Innovations and Immediate Needs

Innovation, in the words of one participant, means *"doing what works — and being allowed to do it."*

Participants identified a range of innovations and immediate needs essential to sustaining progress toward transformation:

- **Administrative Streamlining:** Reducing the reporting and compliance burden so staff can focus on care, not paperwork.
- **Digital and Data Integration:** Moving from fax-based communication to secure electronic systems; improving medical records management and implementing interoperable Electronic Medical Record systems (EMRs) that respect **data sovereignty.**
- **Ethical Artificial Intelligence (AI) and Virtual Care:** Exploring how technology can expand access — with designated providers, translation services, and improved scheduling — while ensuring that **digital tools enhance, not replace, relationships.**
- **Intersectoral Partnerships:** Encouraging collaboration between health, education, and economic sectors — for example, community-owned information technology (IT) firms supporting telehealth, or local enterprises operating health transport.
- **Cultural Processes and Traditional Healing:** Integrating local medicine, fish-camp healing, and traditional practitioners as recognized components of care.
- **Equity in Workforce Compensation:** Achieving **parity in salaries and benefits** across First Nations and non-Indigenous health systems to retain skilled staff.
- **Expanded and Flexible Mandates:** Allowing programs to respond to emerging community needs rather than fixed federal or provincial categories.
- **Enhanced Emergency Response Capacity:** Investing in fully equipped emergency medical service (EMS) teams and ensuring equitable access to first responders in remote regions.

Together, these innovations represent a **shift in mindset** — from reacting to crises to designing systems that anticipate needs, enable wellness, and value Indigenous knowledge as central to effective healthcare.

1.4 Vision for 2030: What the Transformed System Looks Like

Participants' vision for 2030 was clear and hopeful. The transformed system is:

- **Community-led and culturally grounded**, built upon the Treaties and guided by the seven teachings.
- **Equitable and barrier-free**, ensuring consistent access to care regardless of geography or jurisdiction.
- **Interconnected and coordinated**, with seamless navigation between community, regional, and specialized services.
- **Transparent and accountable,** where data, decisions, and outcomes are shared openly with communities.
- **Holistic and preventative**, addressing the social determinants of health — such as housing, water, food, language, and culture — as integral to wellness.
- **Empowered and self-sustaining,** supported by legislation, funding, and governance structures that recognize First Nations as Health Service Providers in their own right.

1.5 What Does Care Look Like Now?

When participants were asked what care looks like in their communities today, the response was brief but powerful: **No consistent funding.**

This single phrase captures both what exists and what is missing. Where funding is stable, communities are able to plan, retain staff, and deliver care that meets local needs. Where it is not, services are fragmented, and energy is spent on survival rather than improvement.

"Consistent funding" was not only identified as a characteristic of effective care, but as the **foundation upon which transformation depends.** Participants noted that reliable, multi-year investments allow programs to grow from short-term crisis management to long-term wellness planning. It enables communities to focus on outcomes, not reporting cycles.

In other words, when funding is consistent, **care becomes predictable, relationships strengthen, and communities can finally plan for health instead of reacting to illness.**

As one participant summarized, "Everything we're talking about — *training, infrastructure, cultural care, transformation — starts with consistency. Without that, nothing lasts.*"

1.6 How Are Decisions Made?

Participants described today's decision-making environment as **overly political, inconsistent, and often disconnected from community realities.** Many expressed that progress in Health Transformation requires a deliberate shift, away from reactive, personality-driven decisions toward **structured, transparent, and values-based governance.**

A central theme was the need for **succession planning** across all levels of the system. Participants stressed that long-term progress cannot rely on individuals alone. Instead, organizations must build continuity through leadership development, mentorship, and knowledge transfer. This ensures that institutional memory and relationships are preserved even as people move between roles.

As one participant noted, *"We've seen too much start over every time someone new steps in. Real transformation needs consistency in leadership, not just in funding."*

Another key message was the call to **"leave the politics behind."** Communities want decision-making processes that focus on outcomes, not political cycles or competing mandates. Decisions about programs, staffing, and funding must prioritize health, wellness, and community-defined goals, not short-term administrative convenience.

Participants also urged leaders and partners to **"be bold."** Boldness, in this context, means moving beyond cautious pilot projects and incremental changes. It means creating policies that genuinely empower communities, even when that challenges conventional structures of government control.

Finally, participants highlighted the importance of **Indigenous prioritization in long-term planning and investment.** They emphasized that every major decision, whether about capital infrastructure, workforce expansion, or funding distribution, should begin by asking: How does this advance the health and wellbeing of First Nations?

In a transformed system, decisions will be:

- **Predictable and transparent,** guided by community-determined principles;
- **Grounded in Indigenous leadership and long-term succession;**
- **Free from short-term political interference;** and
- **Driven by courage and innovation rather than compliance.**

This, participants agreed, is what real shared governance will look like on the path to 2030.

1.7 What Are the Signs That Health Transformation Is Working?

Participants identified several clear and practical indicators that would signal Health Transformation is truly working, not just as a policy framework, but as a lived experience in communities. These signs focus on **innovation, accessibility, equity, and respect for choice,** showing that transformation will be measured in both outcomes and everyday realities.

Innovation and Modernization

Transformation will be visible when northern communities have access to **state-of-the-art technology and tools** at the same standard as urban centres in Canada. Participants envisioned diagnostic and digital health systems that are **modern, integrated, and responsive**; for example, x-ray machines located in regional hubs, consistently operational and staffed with trained personnel.

As one participant noted, *"Innovation isn't about the newest gadget — it's about making sure our communities have what everyone else already takes for granted."*

The introduction of reliable technology will mean less medical travel for routine diagnostics and greater confidence in local care delivery. Innovation, in this context, reflects **equity and modernization**, not experimentation.

Predictable, Proactive Infrastructure Planning

Another sign of success will be when infrastructure needs are **anticipated and planned for, not discovered in crisis.** Participants described a system where the expansion of facilities, staff housing, and clinical equipment is forecasted years in advance, supported by community data and population trends.

"Reasonable plans to expand infrastructure," one participant explained, means investing in readiness, not recovery. Health Transformation will be working when there **is a coordinated plan to grow capacity before the gaps appear.**

Choice and Accessibility

Health Transformation will also be evident when **choice becomes a standard, not an exception.** Families will no longer have to navigate inflexible systems or justify basic requests.

One participant shared a simple but telling example:

"If I want to take all my kids at once to see the dentist, I should be able to."

This vision reflects a shift from rigid service models to **family-centered, culturally grounded, and community-driven care,** where peoples' time and needs are respected.

Responsive and Flexible Benefits

Participants underscored that NIHB must evolve alongside Health Transformation. A transformed system will ensure that NIHB **reflects community realities,** supporting freedom of choice, preventative care, and local service access.

Medical travel, for instance, should no longer only exist for emergencies or specialist visits, it should be **a tool for prevention and wellness,** allowing families to maintain continuity of care close to home.

Respect for Local Voice and Autonomy

Transformation will also be evident when people's **choices for core health service locations are respected.** Communities want the ability to determine whether services are best delivered in community, regionally, or through urban partnerships, and to have governments honour those decisions.

Participants described a future where jurisdictional boundaries no longer limit access, and where **equity of service is tied to geography, not policy.**

In Summary:

Health Transformation will be working when care in NAN territory is predictable, modern, and accessible; when infrastructure grows before it breaks, when technology supports rather than replaces relationships, and when people see their choices, culture, and freedom respected in every part of the system.

2. What Is Working Well

Participants acknowledged that despite immense systemic barriers, there are **pockets of strength, innovation, and perseverance** within the current health landscape. What is working well today reflects the **commitment of people, the flexibility of communities,** and the **relationships that have grown through shared challenges**. These examples serve as the foundation on which Health Transformation must continue to build.

2.1 Community Strength, Leadership, and Collective Action

At the heart of what's working are **the people**. Participants consistently recognized the dedication of staff, health directors, and community members who continue to deliver care under extraordinary circumstances. They described workers as *"creative, committed, and willing to go above and beyond."*

Many spoke about the power of **collective action**, especially during crises such as COVID-19, when communities, Tribal Councils, and service providers came together quickly to protect residents, share supplies, and coordinate care. This spirit of cooperation demonstrated what's possible when bureaucratic barriers are removed and **decisions are made locally.**

2.2 Culturally Grounded and Land-Based Healing

When **funding is flexible and community-controlled,** programs flourish. Participants highlighted how **land-based care** allows communities to deliver holistic healing that addresses mental, emotional, physical, and spiritual needs simultaneously.

Land-based youth gatherings, healing camps, and family activities not only strengthen cultural identity but also provide trauma-informed spaces for wellness and prevention. These approaches bridge traditional knowledge and contemporary health practice, this ensures that **culture is not a program add-on, but a core element of care.**

The emphasis on **local medicines** and **traditional practitioners** reflects growing recognition of the need to value Indigenous healing practices alongside non-Indigenous medical models.

2.3 Partnerships, Relationships, and Political Will

Strong and consistent **relationships** emerged as another clear success. Participants cited **regular check-ins and collaboration** among NAN, Ontario, and ISC as examples of growing coordination and mutual accountability.

Relationships between **Health Directors, First Nations Councils, and Tribal Councils** have also improved, allowing for greater alignment across regions and organizations. This networked approach to problem-solving has led to faster crisis responses, better information sharing, and a growing sense of **shared purpose.**

Participants also noted a shift in **political will**, with more openness from government partners to engage in co-development and dialogue. This goodwill must now be sustained and translated into long-term commitments and flexible policies.

3. Barriers and Challenges

While participants identified many areas of strength, they were equally direct about the **systemic barriers** that continue to prevent equitable, effective, and culturally grounded healthcare in the North. The discussions in Timmins reflected both **frustration and fatigue**, but also clarity about what must change for transformation to succeed.

3.1 Fragmented Systems and Complex Governance

Participants emphasized that the current health system is **fragmented, confusing, and layered with overlapping jurisdictions.** There are multiple mandates, accountability structures, and governance models that do not align, resulting in duplication, exclusion, and missed opportunities for collaboration.

Communities often *"can't see the process"* — meaning that key decisions and standards are developed without transparency or clear communication about who is responsible for what.

Concerns were raised that **national or provincial "standards"** often fail to reflect lived realities or community priorities. Participants questioned whether these standards are meaningful, given the lack of engagement with key partners and the disconnect between policy and practice.

Many called for a **clear engagement pathway** that ensures decisions are made with, not for, communities, and that senior government representatives, including Deputy Ministers and Ministers, are directly involved in ongoing dialogue.

3.2 Funding Models and Resource Inequities

Current funding models were described as **rigid, restrictive, and inequitable.** Participants criticized the practice of allocating funding **based on population size rather than need**, noting that this approach fails to account for the high costs of service delivery in remote and fly-in communities.

Applications for funding are often overly bureaucratic and **too narrow to address the true scope of Nations' needs.** Participants expressed frustration that even successful programs are forced to operate on short-term cycles, with no guarantee of renewal.

"We're told to build systems, but we're funded like we're running pilot projects."

Participants stressed that sustainability depends on **multi-year, flexible funding** that allows communities to plan, hire, and retain staff — not constantly reapply or justify their existence.

3.3 Infrastructure, Geography, and Access

Many of the barriers identified were **structural and geographic.** The lack of adequate infrastructure — from nursing stations and housing to technology and roads — continues to limit access and strain health workers.

Communities spoke of delays and backlogs in care due to poor communication systems *("we're still using fax"),* inadequate transportation options, and inequitable access to diagnostic tools.

The **disconnect between the North and South,** both physically and administratively, remains one of the most persistent challenges. Southern-based service models often do not fit the realities of remote communities, leading to gaps in coordination and care continuity.

Participants linked these barriers directly to declining outcomes: *"Health outcomes and accessibility have worsened, not improved."*

3.4 Health Human Resources (HHR) and Burnout

Participants identified **HHR shortages** as a major limiting factor in the stability of the system. Recruiting and retaining nurses, personal support workers (PSWs), and allied health staff is increasingly difficult, especially when salaries and benefits in remote communities are not competitive.

Even when staff are hired, **burnout and turnover** are high due to isolation, workload, and the emotional toll of crisis-based work. Communities also struggle to **keep PSWs employed year-round** when funding streams are fragmented or unpredictable.

Participants called for **comprehensive workforce strategies** that include equitable pay, professional supports, and mental health resources for staff — as well as long-term investments in **training community members** to fill health roles locally.

3.5 Administrative Burdens and Communication Breakdowns

Participants described the administrative side of the current system as **overwhelming and counterproductive.** Excessive reporting requirements, siloed programs, and inconsistent communication across agencies drain capacity and divert energy away from patient care.

There is a **lack of transparency, accountability, and trust** — with poor coordination between ISC, MOH, and communities. Several participants cited the Auditor General's report as evidence that **systemic inefficiencies** persist at all levels.

The Non-Insured Health Benefits (NIHB) program was frequently mentioned as an example of these issues. Denials, missed appointments, and inconsistent communication cause significant stress for clients and staff alike. Participants noted that **operational bulletins are often issued without consultation**, creating confusion rather than clarity.

"We spend more time explaining the system than delivering care," one Health Director observed.

3.6 Cultural and Jurisdictional Barriers

Participants stressed that existing systems still **privilege non-Indigenous medicine and models of care**, marginalizing traditional practices and community authority. There is a growing desire to **integrate local medicine and healers** more fully — but policy, regulation, and funding frameworks have not adapted to support this.

The lack of cultural safety and trauma-informed care also continues to cause harm. Historical trauma, lateral conflict, and mistrust remain significant barriers to collaboration. Participants said that true transformation must start by rebuilding trust — not only between communities and government, but within the system itself.

At the same time, **jurisdictional complexity** — between ISC, MOH, and other partners — creates constant tension. As one participant put it, *"No one knows who to go to for what, and by the time we find out, it's too late."*

3.7 Service Disruptions and Declining Outcomes

Participants reported that **continuity of care is often lost**, especially for children and those requiring long-term support. Years of underfunding and poor coordination have led to backlogs, missed appointments, and worsening health outcomes in many communities.

Medical travel remains one of the most significant barriers. Communities still **do not control the system,** leading to delays, denials, and preventable crises.

Sustainable funding gaps — combined with years of deficits and poor communication between partners — have left many communities struggling to maintain even basic service levels.

3.8 Environmental and Land-Based Challenges

Some participants connected the erosion of community health directly to **environmental disruption and resource extraction**. Protecting the land was identified as both a health and sovereignty issue. *"You can't heal people if the land is sick,"* one participant said.

Environmental degradation and lack of consultation on development projects were seen as direct barriers to community wellness, reinforcing the need for policies that respect **land-based rights and health connections.**

3.9 Trust, Relationships, and Capacity

Finally, participants identified **relationships themselves** as both a strength and a challenge. While there is growing goodwill among NAN, Tribal Councils, and government partners, the system still struggles with mistrust, limited capacity, and **unresolved internal conflicts.**

There is also a pressing need for **knowledge-sharing and training in governance, funding processes, and grant writing,** especially for capital and infrastructure projects. Without this, communities risk being left behind in competitive or bureaucratic funding environments.

In Summary:

The barriers identified in Timmins point to a health system that is **overly complex, under-resourced, and structurally colonial,** yet also full of people determined to make it work. Addressing these challenges will require **transparency, legislative reform, funding redesign, and genuine co-development** — but most of all, the political courage to act on what communities have already said for decades.

4. Opportunities and Solutions

While participants spoke candidly about barriers and systemic inequities, the tone of the discussion shifted noticeably when focusing on **opportunities**. The Timmins session reflected a deep optimism that transformation is achievable — that communities already hold the knowledge, relationships, and experience to build something better.

Participants emphasized that transformation will not come from external reform alone, but from **reconnecting with traditional laws, strengthening relationships, and creating space for co-development.** As one participant said, *"We already know how to build a good system. We just need the room to do it."*

4.1 Returning to Natural Laws and Treaty Principles

The foundation of opportunity lies in returning to **natural laws and Treaty-based principles**. Participants spoke of the importance of recognizing that the Treaties define enduring relationships, not transactions, between Nations and governments.

Health Transformation, they said, should be guided by these natural laws: respect, reciprocity, balance, and responsibility to the land and people. This perspective reframes transformation as not just system redesign, but **restoration**.

Recognizing Treaty rights within all planning, funding, and policy frameworks ensures that transformation reflects the original intent of Nation-to-Nation relationships and honors First Nations sovereignty in health governance.

4.2 Strengthening Relationships and Coordination

Participants identified **coordination and relationship development** as central opportunities for progress. A recurring theme was the need to **flatten processes** so that everyone, from community members to national partners, has a voice in shaping the new system.

Building stronger coordination mechanisms among **Health Directors (HDs), First Nations Councils (FNCs), Tribal Councils (TCs), and Health Service Providers (HSPs)** will allow decisions to move more efficiently and transparently. Regular, accessible meetings were proposed to ensure information sharing, alignment, and consistent engagement.

Participants also suggested improved **communications strategies** to ensure clarity, consistency, and understanding across jurisdictions. Translation, both linguistic and cultural, was recognized as essential to ensure all partners can fully participate and contribute.

4.3 Building Trust and Shared Leadership

Trust remains the most critical currency of transformation. Participants emphasized the importance of **building trust with the Health Transformation leadership,** suggesting that it must "come from the people" to maintain legitimacy and accountability.

Trust is built through **transparency and co-development.** Participants recommended that transparency be explicitly defined in the **Relationship Charter**, outlining shared commitments to information sharing, decision-making, and financial openness.

There was also a strong call for **agreement to make change** — to move from dialogue to tangible actions that demonstrate trust in practice.

"Every step we take together, we need to prove this is different from before."

4.4 Alignment, Collaboration, and Cross-Sector Innovation

Participants saw enormous opportunity in **aligning existing work and building cross-collaborative teams** across systems and sectors. This includes deeper partnership between health, education, housing, and economic development — recognizing that wellness depends on more than clinical care.

Opportunities include:

- Developing cross-sector partnerships with organizations like Ontario Health and Indigenous Services Canada, as well as regional examples such as Nuk Health (Alaska) to learn from Indigenous-led models abroad.
- Aligning ongoing projects to reduce duplication, share data, and streamline reporting.
- Establishing cross-collaborative teams with clear roles and responsibilities across HDs, TCs, HSPs, and government partners.
- Promoting knowledge exchange across communities to reduce competition and reinforce mutual support.

"We should be learning from each other, not competing for the same dollars."

Participants also highlighted **systems partners and the trilateral between Nishnawbe Aski Nation (NAN), Indigenous Services Canada (ISC) and Ministry of Health (MOH)** as essential vehicles for advancing this alignment — ensuring each partner is accountable for its role in transformation.

4.5 Needs-Based, Flexible, and Remoteness-Focused Funding

A major opportunity lies in **shifting from population-based to needs-based funding models**, where remoteness and cost of service delivery are explicit factors.

Participants argued that equitable funding should reflect the **true cost of health care in remote and isolated communities,** including travel, staffing, housing, and infrastructure. Flexible funding will allow communities to respond to needs as they emerge, rather than fitting into restrictive program categories.

Innovative financial strategies — such as **cost-sharing arrangements, creative Non-Insured Health Benefits (NIHB) savings models,** and community-based resource reinvestment — were also suggested. Participants proposed training **dedicated NIHB workers** within communities to navigate benefits efficiently and advocate for clients.

4.6 Expanding Access and Technology

Participants highlighted technology and connectivity as critical enablers of equitable access. The **ongoing improvements in broadband and growing access to the Ontario Telemedicine Network** represent opportunities to expand virtual care, telehealth, and data integration.

Direct flights, improved medical transport logistics, and expanded regional services were also noted as practical ways to reduce travel burdens and increase local access.

Participants recommended that technology investments prioritize **accessibility, reliability, and local staffing**, ensuring that tools like x-ray machines and diagnostic systems are not only purchased but consistently operational and maintained.

4.7 Cultural Integration and Workforce Recognition

Participants emphasized the opportunity to **hire and recognize traditional practitioners as health professionals**, granting them equal respect and status within the health system.

This integration must go beyond cultural "add-ons" — it should embed traditional healing, ceremony, and local medicine into **program design and delivery,** balanced with clinical care.

"Culture-based services aren't a supplement — they are the system."

Participants also identified opportunities to reduce **language barriers**, develop trauma-informed approaches, and create **culturally safe service models** grounded in both Indigenous knowledge and modern medicine.

4.8 Economic Development and Self-Determination

Communities see Health Transformation as an opportunity not only to improve care but to **build economic sovereignty**. Participants pointed to **First Nations entrepreneurship, urban reserve development,** and **local business partnerships** as tools to generate revenue and sustain health infrastructure.

These economic drivers can also reduce reliance on short-term funding and support **self-determination** through community-owned health services, infrastructure, and enterprises.

Participants stressed that **mandates need to be redefined** to reflect this independence. For example, the ability for Tribal Councils or Health Service Providers to **control NIHB administration** was raised as a major step toward real autonomy.

4.9 Governance Renewal and Policy Reform

Finally, participants identified opportunities to clarify **roles, responsibilities, and authorities** across all levels of governance. Authority mapping, joint evaluation, and clearer policy frameworks will strengthen coordination and accountability.

There is also an opportunity to **modernize policies** such as Jordan's Principle and NIHB to ensure they are **updated, efficient, and reflective of current realities.**

By redefining mandates, aligning systems, and empowering local leadership, Health Transformation becomes not a single reform but a **comprehensive realignment of power, responsibility, and accountability.**

In Summary:

The opportunities identified in Timmins reveal that communities are not waiting for transformation — they are already building it. By grounding the system in natural law, strengthening relationships, and committing to needs-based funding and cultural integration, partners can turn opportunity into action.

"The solutions are here. What we need now is the will to act on them — together."

5. Shared Principles and Commitments

Participants across all partner groups — First Nations, Tribal Councils, Health Service Providers, Ontario Health, ISC, and MOH — agreed that meaningful transformation can only happen when everyone operates from a **common foundation of principles.**

These shared values are not theoretical; they are practical standards for how partners will communicate, make decisions, and hold one another accountable on the path to 2030.

5.1 Guiding Values

Respect and Reciprocity

All partners committed to approaching Health Transformation with respect for each person, community, and Nation. Decisions must honour local priorities, community expertise, and the Treaties that define the relationships between First Nations and the Crown.

Trust and Transparency

Transformation requires open sharing of information, funding data, and decision-making. Transparency will be defined collectively in the Relationship Charter, establishing clear expectations for reporting, communication, and accountability.

Integrity and Accountability

Participants stressed the need to "live up to our commitments." Integrity means following through, reporting honestly, and acknowledging when systems fall short. Accountability applies to everyone — from community leadership to federal and provincial partners.

Collaboration and Co-development

Health Transformation will succeed only if it is **co-developed**, not imposed. Partners agreed to work together through coordinated planning tables, joint evaluations, and shared communications. Flattened structures and regular dialogue will keep voices at every level connected.

5.2 Cultural and Community Foundations

First Nation Leadership

The process must remain First Nations-led. Communities determine priorities, define success, and guide evaluation. Government and institutional partners act as enablers, not gatekeepers.

Cultural Safety and Trauma-Informed Practice

Every program and policy must be grounded in cultural safety, humility, and trauma-informed approaches. This includes space for ceremony, traditional healing, and the use of Indigenous languages.

The Seven Teachings and Natural Law

Participants reaffirmed the Seven Grandfather Teachings — Love, Respect, Bravery, Truth, Honesty, Humility, Wisdom — as the moral compass for all transformation work. These teachings guide conflict resolution, communication, and long-term relationship building.

Community and Patient Centeredness

Services must be community-driven and patient-centered, designed "from the heart." This includes dedicating space to consult **youth and Elders** in all planning processes.

5.3 Equity, Flexibility, and Wholistic Wellness

Equitable Resources

Equity means fairness — ensuring resources are distributed based on need, remoteness, and social determinants of health, not population formulas. Health Transformation must reduce gaps rather than replicate them.

Flexibility and Proactive Planning

Partners agreed to avoid rigidity: no shortcuts, no rushing, no one-size-fits-all templates. Transformation should be deliberate, evidence-informed, and adaptable to local realities.

Wholistic Wellness Model

Health cannot be separated from housing, water, food, language, and safety. A wholistic wellness approach ensures every investment and policy connects to the broader determinants of health.

5.4 Relational Commitments

- **Communications:** Clear, consistent, and timely two-way communication between all partners.
- **Conflict Resolution:** Mechanisms grounded in the Seven Teachings and respect for differences.
- **Knowledge Building:** Continuous learning, evaluation, and shared capacity development.
- **Gratitude and Humility:** Remembering who we are, being thankful for the work, and approaching transformation *"from the heart."*

In Summary:

These shared principles form the ethical and operational backbone of Health Transformation. They reaffirm that transformation is not only a technical process but a **relational and moral undertaking.** By committing to respect, trust, transparency, co-development, and cultural integrity, partners can ensure that every step toward 2030 is taken together and grounded in shared purpose.

6. One Thing Each Partner Can Do Better

As partners reflected on the work ahead, each group acknowledged that transformation requires not only structural change but **personal and institutional growth.**

Participants identified one area where every party — NAN, Health Service Providers, ISC, MOH, and all together — can focus to strengthen collaboration and accelerate progress toward 2030.

6.1 Nishnawbe Aski Nation (NAN): Be Proactive and Coordinated

Participants recognized NAN's role as the political and coordination hub for Health Transformation. The one area for improvement is to move from reaction to **proactive, consistent coordination.**

NAN can:

- Convene regular trilateral and partner meetings to share updates and lessons learned since 2018.
- Ensure adequate preparation time and clear timelines for engagement.
- Factor **remoteness** into all funding programs and planning frameworks.
- Provide more training and support for community-based NAN workers.

"Be less reactionary, more attentive, and always ahead of the next step."

This shift from crisis response to proactive planning will demonstrate NAN's leadership in stabilizing and guiding the transformation process.

6.2 Health Service Providers (HSPs): Strengthen Relationships and Local Presence

For HSPs, the greatest opportunity lies in **deepening relationships with communities** and embedding services closer to home.

HSPs can:

- Create **knowledge-exchange sessions** across agencies to share promising practices.
- Build relationships among HSPs and First Nations partners through joint participation.

- Provide **more cultural training** for staff to ensure culturally safe and trauma-informed care.
- Establish **discharge liaisons** in all regions and improve communication when patients return to communities.
- Send specialists to communities more frequently and for longer durations, based on community-identified needs.

"Show up more, stay longer, and listen first."

By focusing on relationship-building and continuity of care, HSPs can transform service delivery from transactional to relational.

6.3 Indigenous Services Canada — ISC: Demonstrate Flexibility and Good Faith

Participants called on ISC to model flexibility and trust.

The one thing ISC can do better is to **modernize its internal systems and funding approach** to match the realities of NAN communities.

ISC can:

- Revisit programs to allow flexibility and reduce administrative burden.
- Demonstrate **good faith** through consistent engagement and follow-through.
- Undertake **internal change management** to empower middle managers and improve cross-branch coordination.
- Advance the **10 policy changes** already developed in support of Health Transformation.
- Shift to **outcome-based funding** with reduced reporting and compliance requirements.
- Work collaboratively with provinces on **client-focused medical travel** and **discharge planning** within **First Nations and Inuit Health Branch (FNIHB)**.

"Trust communities with the flexibility you expect from yourselves."

6.4 Ministry of Health — MOH: Engage and Integrate

For Ontario, the key area for improvement is **meaningful engagement and integration.**

The province can:

- Revisit and revitalize the **Indigenous Healing and Wellness Strategy** to align with current realities.
- Create a **policy table** to identify and remove legislative and regulatory barriers (e.g., Public Hospitals Act, Mental Health Act).
- Increase engagement with First Nations communities and leaders.
- Improve access to provincial funding programs and simplify application processes.
- Reform **PHIPA** to support ethical data-sharing and Indigenous data sovereignty.
- Collaborate more effectively with the federal government on shared responsibilities.
- Expand **on-reserve services** while respecting community sovereignty and local governance.
- Provide **travel subsidies** similar to Quebec's regional air-access program to reduce the cost of care for remote communities.

"Health Transformation won't succeed without Ontario at the table — listening, enabling, and integrating."

6.5 Together: Commit to Continuous Dialogue and Co-development

Collectively, all partners agreed that the greatest improvement lies in **how they work together.**

They committed to:

- Maintain continuous dialogue and co-development through trilateral and regional tables.
- Strengthen communication at all levels — from policy to front-line operations.
- Ensure all processes are appropriately resourced and inclusive.
- Dedicate consulting spaces for youth and Elders in all planning and evaluation processes.
- Anchor every decision in the shared principles of trust, respect, transparency, and collaboration.

"Transformation happens at the speed of trust. The more we communicate, the faster we move together."

7. Final Thoughts – One Takeaway

The final discussion of the Timmins Partners in Health Visioning Exercise ended not with policy language, but with words that carried feeling — **communicate, commit, co-develop, collaborate, and trust.**

Participants agreed that transformation is not a project or a program; it is a s**hared responsibility and a generational undertaking.**

At its core, everyone reaffirmed a single truth:

"Nothing about us without us."

This guiding principle reminds all partners that transformation will succeed only when communities lead and every voice is heard with respect.

Participants summarized the collective takeaway in a single idea — **we already agree on the outcomes.** Health Transformation brings people together around the same goals:

- equitable access to care;
- sustainable systems;
- cultural safety, and;
- wellness rooted in community.

The path forward will require:

- Open communication at every level;
- Commitment to co-development and long-term collaboration;
- Consistency in engagement and follow-through;
- Transparency and candor in all decisions;
- Consensus-based action, and
- Trust in the relationships that make this work possible.

Participants recognized that this is an **enormous undertaking** — one that demands patience, humility, and sustained effort. But they also emphasized that the foundation is already here: **partnership, culture, and community.**

"If we hold to our values — trust, respect, communication, and accountability — we'll get there together. That's the real meaning of Health Transformation."


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