2017 - 2018

Pinaymootang First Nation Annual Report on Health

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Annual Report on Health 2017-2018

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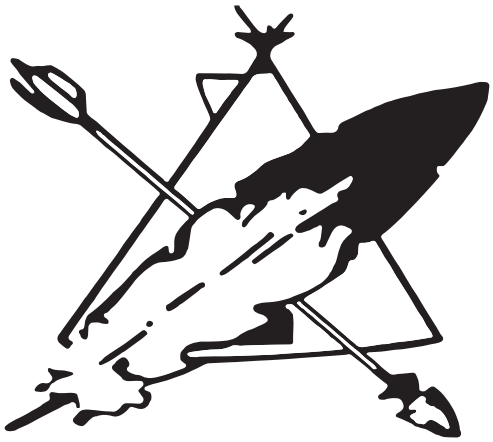
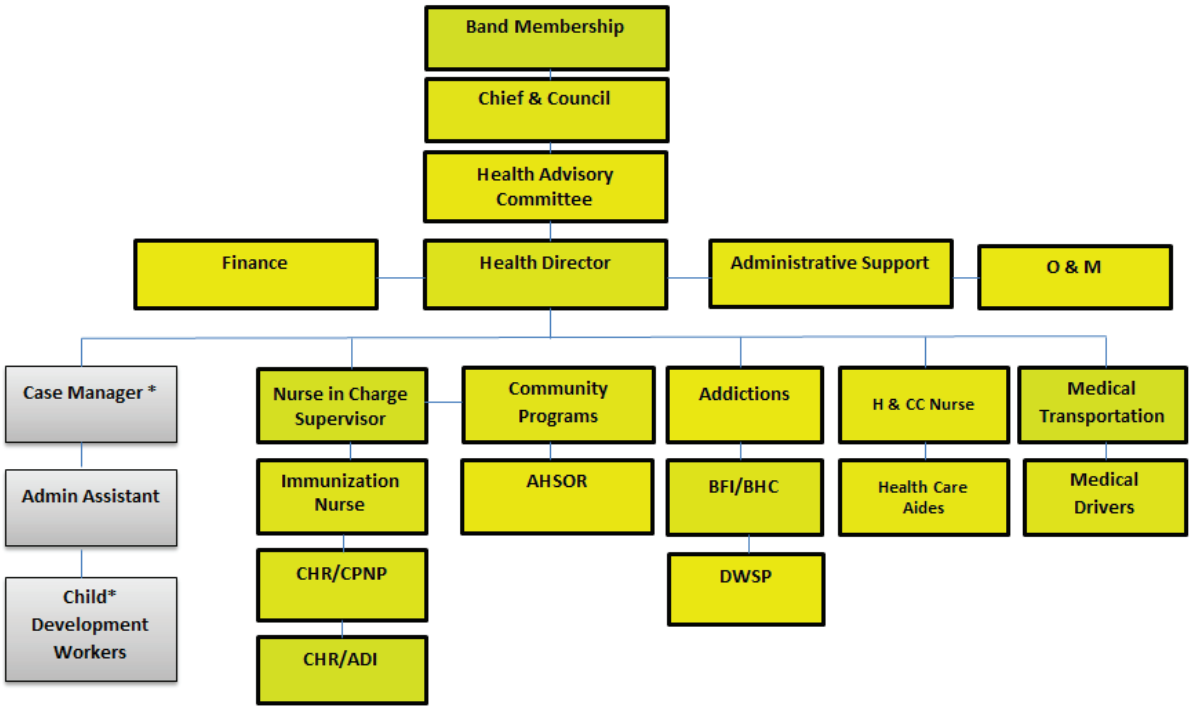


Pinaymootang First Nation Health Program
824 Main Market Road
Fairford, Manitoba R0C 0X0

Phone: (204) 659-5786
Fax: (204 659-5841
www.pfnhealth.com

Pinaymootang First Nation Health Centre Organizational Chart



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Introduction

As leader of the community, it is an honor and privilege to once again present to you the annual report on Health for fiscal period 2017 – 18. As leader of the community, I am privileged to be involved in an organization that plays such an active role in the lives of our community members. The health and well-being of each one of us is a gift, a treasure that we have been blessed with, something that we must protect.

In this report you will find a year filled with continued service delivery, information on the accomplishments and activities of the past year as we work towards common goals for the benefit and well-being of health. Teamwork, dedication and perseverance have always been the key, which have resulted in accomplishments achieved. Our community health programming intent will continue to:

- Provide open communication efficiently and effectively;
- Be guided by principles of fairness and equity;
- Encourage and support participation in activities;
- Actively grow in unity; and
- Be transparent and accountable to the general public to whom we serve.

The mission and vision of Pinaymootang Health Centre is to advance health knowledge, build capacity by promoting awareness, self-care, develop tools and processes in health education.

I thank the Health Centre Staff for their hard working efforts in making our health programs a success. Without their care and dedication, it would be impossible to sustain and improve health in our community.

In closing, I thank you for this opportunity as we are here to ensure that the future in health is prosperous and filled with hope and determination.

Respectfully yours,

Chief Garnet Woodhouse

Message from Health Advisory Committee

We have the honor and privilege to present to you once again the Annual Report on Health on behalf of Pinaymootang First Nation Health Program for fiscal period ending March 31, 2018.

This Annual Report was prepared under the guidance and approval of the Health Advisory Committee, in accordance with reporting criteria as outlined in Health Transfer Agreement.

All material and fiscal implications have been considered in preparing the Annual Report on Health.

On behalf of the Pinaymootang First Nation Health Advisory Committee we hope that you find this information useful.

Sincerely,

Chairperson

Director of Health Report

Well another fiscal year to an end, as we once again provide you to this year's annual report on health for fiscal period ending March 31, 2017. Each year in health brings many new challenges and our hands-on approach allows us to quickly direct resources to where they are most needed.

Pinaymootang Health works to ensure that patient rights for safe and adequate health care needs are met. We strive to prevent and reduce risks to individual health and community health.

As we move along to this year's report, I am so happy to report that one of the community's long desires has been fulfilled in regards to the expansion of the Health Centre facility after 9 long years.

I wish to personally thank health staff for being such great champions in health programming and going through this journey this year, I know we faced many challenges to ensure health programming continued as we faced construction but without you and your hard work and dedication you made it all possible.

Governance Structure

The Pinaymootang First Nation established a Health Advisory Committee to oversee and ensure the proper operation and management of the Pinaymootang Health Program.

The Health Advisory Committee meets on a regular monthly basis every last Tuesday of each month to review reports, policies, staffing issues and other related concerns. The role of the committee is to represent Chief and Council to whom it is accountable, in that role the committee is responsible for providing recommendations on health and management. Through the terms of reference the committee defines the parameters within which the organization will carry out its work.

Health Program Overview

Nursing Treatment & Prevention – the Nurse in Charge continues to demonstrate her nursing abilities. The Health Centre is becoming a very active facility and at times difficult to keep up with the work load. The public health program meets its criteria; visiting new parents, providing well women's care, facilitating baby care; providing immunization; flu clinics, encouraging physical activity, facilitating community education sessions, and attending to all emergency needs. The community currently employs 3 Registered Nurses and 3 LPN's in different capacities. Jennifer Gould is the charge nurse, Roxie Rawluk is the immunization nurse, Janice Lowry who recently came out of retirement helps provide support 6 days a month on diabetes care, Brenda Halchuk is the HCC Nurse Supervisor and provides foot care, Nancy Tindall is the

community health program coordinator (school nursing, helps out in clinics, homecare and foot care) and April Sanderson is our case manager for the Jordan's Principle Child First Initiative Program. One of the new programming in this fiscal is the foot care, changes have occurred within health nationally which now all First Nations receive funding to provide foot care at the community level.

Physician services still continue with Dr. Kashur every Thursday and a new physician in our community Dr. Le who provides services every Tuesdays through LifeSmart. We recently, also opened up a satellite pharmacy within the clinic.

Community Health Representative – The CHRs continue to play a major role in health programming both employees oversee additional programs within their scope of work. One CHR Carol Woodhouse focuses on children, youth and school setting while taking on the CPNP program and the other CHR Alfred Pruden focuses on adult and elder care as well as the ADI program. Both CHR's have committed themselves in ensuring excellent program service delivery in their respective roles.

Support to Nurses – One Administrative Assistant Cherish Sumner helps oversee the day to day secretarial operations of the organization, her activities include but not limited to the following; support services to nurses, physician's and visiting professionals; provide support to program managers, booking all specialty visits, organizing meetings, and all general required duties.

Operation and Maintenance of Health Facilities – The role of the custodian is to ensure the upkeep of health facility and with the expanded facility her hours have increased significantly.

National Native Alcohol and Drug Abuse Prevention – the goal of the NNADAP is to support our membership and the community to establish and operate programs aimed at stopping high levels of alcohol, drug and solvent abuse. Most of the NNADAP activities focus on the four areas of emphasis: prevention, treatment, training, research and development. The NNADAP program continues to support community designed and operated projects in alcohol prevention, treatment and rehabilitation in order to arrest and reverse the present destructive physical, mental, social and economic trends. The coordinator continues to provide the needed support and works closely with the visiting professionals in the area of mental health. Pinaymootang Health have received a much needed increase in service with Jahna Hardy providing service every Tuesday and Randal Klaprat providing service 4 days per month. Since the repatriation we have seen such increases happen.

Brighter Futures Initiative/Building Healthy Communities (Mental Health; Home Care Nursing; Solvent Abuse) – the Health Program currently employs one person to oversee the roles in the BFI and BHC program. The purpose of the BFI is to improve the quality of and access to culturally sensitive wellness services in the community. These services help create healthy family and community environments which support child development. The components and objectives of the BFI are mental health, child development, injury prevention, healthy babies

and parenting skills. A variety of projects have been held throughout the year aimed specifically in these areas.

The role of the BHC program is to address gaps in the range of mental health services and activities related to crisis intervention and post-vention on reserve. A common area identified was to improve the First Nations capacity to address crisis and we have been working diligently in creating an external crisis plan with community stakeholders.

Environmental Health Drinking Water Safety Program – The Health Program currently employs an individual on a half time level. The Drinking Water Program continues to meet its components as outlined in the agreements, such as sampling, testing drinking water, recording results on water quality, providing monthly reports to Environmental Health Officer, Jennifer Hughes of First Nations and Inuit Health Branch - Health Canada, for interpretation and recommendations in determining E. Coli and total coliforms, inspecting and reporting on general sanitation, providing public awareness, develop contents for school, supports action on health status inequalities affecting members according to identified priorities and ensuring all pertinent procedures are followed, maintained and updated.

Canada Prenatal Nutrition Program (CPNP) - this program is designed to improve the health of pregnant women and their babies, the objective is to improve the adequacy of diet of prenatal, to promote breast feeding, to increase the access to nutritional information, to increase the number of infants fed aged appropriate foods in the first twelve months of life. Some of the activities have included; mommy and me programs, milk programs, prenatal clinics, traditional teachings, building skills in preparing nutritious foods, group sessions, parenting, cooking demos and providing information and promotion of the CPNP program.

In Home and Community Care Program – the H & CC Program currently employs; 1 HCC Nurse with an LPN assisting when possible and 2 Health Care Aides Pam Sumner and Dot Sumner. The program currently meets its mandate with 89 clients. This program has been so busy and would like to see an increase human resource that is much needed. Home visits are conducted on a daily basis, assessments completed, medical equipment purchased based on needs and most importantly getting our elderly involved into programs.

NIHB Medical Transportation – is administered by one Medical Transportation Coordinator and 3.5 medical drivers. The purpose of the Medical Transportation Program is to provide transportation benefits to eligible First Nation members to the nearest access to medically required services that cannot be obtained in community. The program continues to intake medical appointments, verifying, scheduling in coordination of transportation based on the guidelines of FNIHB. A policy handbook has been completed and will be distributed at the upcoming health fair. The program runs a 4 van medical transportation system.

Aboriginal Diabetes Initiative – the ADI Program is designed to improve the health status of First Nations individuals, families and communities through actions aimed at reducing prevalence and incidence of diabetes and its risk factors. Diabetes is the biggest health

challenge currently facing First Nations and this is one area we focus on, is the preventative measures that diabetes can be prevented. Diabetic awareness activities continue to take place, foot care is held bi-weekly, risk factors, assessments, surveys, physical activities, prevention and awareness, healthy eating habits, and gardening projects all have been implemented.

HIV/AIDS – The HIV/AIDS Program has continued to meet its components of the program, workshops, information sessions, awareness to promote safer activities, counseling, testing and health education classes have been conducted.

Aboriginal Head Start On-Reserve (AHSOR) – the AHSOR Home Visitor Coordinator is available to provide screening of all families pre-natal or very early after the birth of a child from 0 to 6 years of age to identify risk factors and assist these families with supports such as expanding and enhancing programs and support services for mothers, pregnant women, caregivers, parents, parents to be, children and their families. The AHSOR Program is active in community and has become a participant in the Dolly Parton Imagination Library.

Accreditation - The Pinaymootang First Nation (PFN) Health Centre made a commitment in 2010 to complete the accreditation process with Accreditation Canada, to ensure that the highest quality of services are provided to community members in a safe health care environment. Accreditation Canada is an independent, not-for-profit organization that sets standards for quality and safety in health care and accredits health organizations in Canada and around the world.

The Pinaymootang First Nation Health Centre received full Accreditation in 2014 and every 4 years a renewal process begins and will take place in September 2018. Our goal is to ensure that Health Centre team work diligently to meet the system-wide and service excellence standards set out in specific areas related to health services and supports including:

- Leadership for Aboriginal Health Services
- Home Support Services
- Aboriginal Community Health and Wellness
- Customized Infection Prevention and Control

The Accreditation process is long and detailed.

Jordan's Principle Child First Initiative Program – In moving forward in funding from the Health Services Integration Funding to JP CFI in April 2017, Pinaymootang seen an increase in its funding to provide increase service. Our program currently has a Case Manager, Administrative Assistant/ASL Trainer and 4 Child Development Workers. The intent of this program is to provide service to children on reserve for families with children with complex medical needs. Our program has been highlighted as a best practice model with the Canadian Home Care Association and many other communities have visited to see the operations of the program we know as Ninijaanis Nide – My Child My Heart Program.

In the new fiscal, we had been advised by Health Canada, that Pinaymotoang was one of 3 programs selected to undergo an evaluation process, this is something that we will look forward to in hopes for the continuation of this program. In July 2017 in working with McGill University the "Honouring Jordan's Principle" research project concluded and shared. This is a research project that validated the need of challenges First Nation members faced when accessing service for their child.

Other Initiatives:
Network Meetings – the Health Centre is involved in community network meetings with internal stakeholders and meet on a monthly basis to facilitate partnership building.

Interlake-Eastern Regional Health Authority (IERHA) - the Health Program continues to work with the IERHA in partnership in dealing with issues and concerns to ensure improved health care of service. Over the course of the year, we had worked with surrounding communities including First Nations Social Secretariat of Manitoba and developed the Comprehensive Quality Service plan and provided recommendations with the intent of improving service for the Interlake area. The recommendations are:

1) To provide Culturally Safe and Respectful Services;
2) To broaden the scope and Mandate of Health Centers in First Nations;
3) Ensure Retention of Health Care Provides in IERHA;
4) Improve Access to comprehensive Mental Health and Addiction services;
5) Improve Access to Emergency Care; and
6) Improve access to dialysis services.

Our hope is that we continue moving forward in partnership to improve access to health care and service.

Respectfully yours,

Gwen Traverse
Director of Health

Nurse in Charge Annual Report

What a year this has been at the Health Centre! It started out knowing that the construction was on its way but not knowing exactly how we would get through it all. With the nurses having to take the clinic to the Wellness Centre and seeing clients there for over 6 months and working with construction noises everyday it finally came to an end. We have now seen the light at the end of the tunnel and have enjoyed watching the finishing touches being made and now are able to work in a wonderful new facility. It has been a tough year for all of us but with all the challenges I think we have grown as a team and we are stronger together.

With the expansion we will now have three clinic rooms and continue to have six Nurses to assist the community members with their health care needs. Myself and the Home and Community Care Nurse work Monday to Friday, our Immunization Nurse working Monday to Wednesday, our Community Health Program Coordinator working Monday to Thursday and our JP-CFI Case Worker working Monday to Friday. Janice is also continuing to be here 6 days a month for diabetic screening/education and also to assist in the clinics. We, along with the rest of the staff will continue to treat your health care needs as quickly as possible.

During the past year we have had Dr. Kashur continue to support us here at the Health Centre with referrals and prescriptions as needed. He was also able to start his clinic here again but at times we continue to have shortages with vacation and educational leaves. For appointments in Ashern, there is now 2 other physicians working in the Medical Clinic which brings the total to 3 in the clinic and 1 in the pharmacy. In Eriksdale they have brought another female physician bringing their total to three physicians. There are still times of shortages but the physicians have been working with us and we will continue to strive for the best possible care for the community members.

We continue to deliver the same services in the clinics as before for the health care needs of the community. We provide phlebotomy (blood draw), pregnancy testing, testing for sexually transmitted infections and treatment, pre-natal and post-partum care, PAP tests, monitoring your chronic diseases such as blood pressure and blood sugars, dressing changes for your wounds so community members do not have to travel to Ashern with a wait in the Emergency Room and everything else in between.

With all of the changes in the last year at the Health Centre we continue to want to grow and make changes to improve the health and well-being of the community members. We want you

to come in and feel welcome and treated with respect and know that your health needs are being looked after by caring staff who strive for the best possible care that can be provided. We are also here to be your advocates to make sure that the other health care providers in the region meet your medical needs.

With all the changes in the past year as well as still learning what my role is as nurse in charge and keeping up with the clinic it has been a challenging one. With that, I have enjoyed my first full year here and still have so much more to learn and have more room to grow. I want to make sure that the clinics are running smoothly and have enough supplies for the needs of our patients and that our machines are functioning to continue the best possible care that a Health Centre can provide. We also continue to maintain our standards as we are an accredited facility and this next year will again be challenging as accreditation is coming up this year in September.

The following are the stats from April 1, 2017 to March 31, 2018:

- **Adult Health** **238**
- **Infant/Child Health** **230**
- **Women's Health** **133**
- **Communicable Diseases** **51**
- **Pre-Natal/Post- Partum** **121**
- **Home & Community Care** **329**

Total encounters with community members 1579

Number of members served 1120

Now that the construction has come to an end and more new challenges to come in this new year at the Health Centre I know that I can build on what I have already learned and continue to grow in the position as Nurse- in- Charge and my work in the clinics. I hope to find new ways to bring education/workshops to the community regarding chronic diseases now that we have a community room where we can book telehealth sessions and have educators teach from a distance. I would again like to thank you for the opportunity to work in this community as it has brought me great joy.

Jennifer Gould
Nurse in Charge

Immunization Nurse Coordinator Annual Report

This past year has been an exciting (and exhausting) year of development and change. Our facility has grown. We have added more staff. We have made a more useful space for the Niniijaanis Nide program; a restful space for the Mental Health Therapist; a pharmacy room and we have a new community room too! It is so encouraging to work with an organization that continues to seek new ways to meet the health needs of the community. As we are coming to the end of the renovations, it seems as though we are looking into this new fiscal year with optimism and new ideas, seeking ways to bring improved health and new opportunities into the heart of Pinaymootang First Nation.

I recently attended a meeting that was a discussion with the University of Manitoba. We were looking at ways to bring a wider variety of services into the community of Pinaymootang. It was a fascinating discussion, but also circular. We kept ending up back at encouraging the children of the community to graduate from High School and continue their education to become Physiotherapists, Occupational and Speech Therapists, Rehabilitation and Health Care Aides that the community needs. The community would also thrive with more business people, entrepreneurs, doctors, electricians, plumbers, carpenters…

And it all keeps coming back to the future.

The children of Pinaymootang *are* the future of the community, the province and the country. Who knows if the next MLA, MP or Prime Minister is being cuddled in the arms of your neighbours or even *your* arms? To reach these goals, it is important, yes, to send children to school for the formal part of their education; the standardized part.

Even more important is the education they receive at home. Where do children look to see how to serve their community, how to take care of their neighbour in need, how to lift up their brothers and sisters when they fall, how to gaze in wonder at the creation around them? Where do they learn to distinguish between what is right and wrong, what is to be treasured and what is to be thrown away? They look to their parents, their aunts, uncles, grandmas and grandpas, foster parents, siblings.

We as adults need to look at our lives to see what we are showing the children; what kind of role models we are. Are we encouraging the children of Pinaymootang to dream big, bigger than the dreams already dreamt?? Are we showing the children how to be strong and make the

choices that will improve not just our physical health, but our emotional, spiritual, and mental health??

The expansion of the Pinaymootang Health Centre was not intended to just focus on physical health, but on emotional, mental and community health as well. The healthier Pinaymootang is as individuals, the healthier the community will be. We hope, as a Health Centre, to support both the individuals and the community on a journey to improved health and well-being through the services we offer.

And then we come full circle: a healthier community leads to healthier families with confident, bright babies and children which leads to young people who soak up knowledge, experience and education in order to return home to keep building up the community. Pinaymootang is filled with bright, adventurous children, the future of the community, the province, the nation. Thank you for allowing me to participate in their health care!

Immunization Coordinator Stats:

- 614 immunizations: 475 various vaccines; 139 flu vaccines.
- 786 clinic visits: 438 adults; 348 children.
- 33 dressing changes: 27 adults; 6 children.
- 32 injections of various medications for adults.
- 5 home visits: 4 adults; 1 children.
- 55 blood draws: 50 adults; 5 children.
- 48 referrals: 28 adult; 20 children.
- 10 preoperative assessments: 0 adults; 10 children.
- 198 phone consults for various concerns: 107 adults; 91 regarding children.

In the coming year, I look forward to continuing to share my knowledge and experience with you. I hope to also continue learning so that each year I can serve the families of Pinaymootang better, supporting you all in your pursuit of happy, healthy lives and bright futures!

Roxie Rawluk
Immunization Nurse

Diabetes Nurse Annual Report

Hi everyone—yes I am back in Pinaymootang as I found it too difficult to be away so since May 2017 I have been coming to the community 6 days a month with a focus on diabetes as well as doing some clinic work.

I cannot express how happy I am to still be in the community and working at the Health Center, over the years getting to know each one of you has been an honor and to be able to continue to work with you in a smaller capacity is great.

I am here every Tuesday and every second Wednesday and this year I saw 185 clients in clinic. I focus on diabetes and prevention and have been in the school and done some community educational session, as well as promote gardening and healthy eating.

Diabetes continues to spread in the community and every year we have a few more community members' diagnosed and a few more continue down the path of complications and start dialysis. It has always been my dream that one year we will eradicate diabetes from Pinaymootang and I feel as a community this can happen. Our youth are more informed as to diabetes and its complications and they are the ones that need to change the future.

So please drop in and see me if you are experiencing diabetes and I would love to discuss some of the ways to try to improve the condition and help prevent complications from this disease. Diabetes needs to be taken seriously and anyone who has a diagnosis needs to become well informed so as individuals you can ensure that complications do not arise.

I also work in the clinic and will see community members for any health issues and as I said it is an honor to be able to work at the Health Center on a 6 day a month basis and still have contact with the community and its members

Thank-you

Janice Lowry RN/PHN

Community Health Program Coordinator Nurse
Annual Report

Hello everyone, what a busy year this has been! Exciting things have been happening at the Health Centre this past year as you may have noticed; working through construction has been a bit of a struggle at times but it was all worth it in the end! It is wonderful to be employed by such a progressive community; I look forward to many more years in Pinaymootang.

As a Community Health Program Coordinator Nurse, I cover many areas within my scope by providing nursing care for the Community Health and the Home & Community Care programs when the program Nurses are unavailable. I also provide assistance to the visiting Doctor by setting up referrals, completing lab requisitions, collecting lab samples and wound care if needed. There is never a dull moment with my role as I like to keep busy whether it is by helping out other programs with their activities or restocking supplies in the clinics and storage when necessary.

As a foot care nurse I provide basic foot care to elders and diabetics within the community. Foot care clinics are held weekly by appointment only; clients are seen every two to three months or on an as needed basis. If you or someone you know in the community is in need for foot care please contact the Health Centre to set up, an appointment. Keep an eye out for information sessions related to foot care; topics will include information on easy seated exercises to increase blood flow to extremities, tips on what to look for when purchasing foot wear and how to self-care for your feet.

Part of my role is to focus on the Pinaymootang School throughout the school year to provide workshops; Nursery to Grade 12 students are informed on a wide variety of health related topics. Some examples of topics that have been discussed in the past are hand washing, cough & cold etiquette, puberty, growth & development, STI awareness & contraceptive options. The information discussed is age appropriate and does not go beyond the students' developmental level. Due to shortages and changes with Doctors in our area this past year I found an increase in community members seeking medical assistance at the Health Centre which made it difficult to be present in the school for programming.

As Supervisor to the Aboriginal Head Start On-Reserve program I provide support and assistance when needed to the Home Visitor/Head Start Worker. This is an out-reach program for families in the community with young children aged 6 and under. Through arranging home visits and programming out of the home, a Home Visitor provides support and educational resources to the children and their families while focusing on culture and language; education and school readiness; health promotion; nutrition; social support; and parental and family involvement. Part of Head Start program incorporates a playgroup for families which is held one afternoon a week in the Multi-purpose room at the Pinaymootang School; this offers a safe

environment for young families to socialize and learn outside the home. Educational activities that were held this past year during playgroup were; cooking, baking, crafts, homemade baby food making, and sewing projects. In addition to Playgroup the Head Start program is always busy holding a variety of other programming too; such as nutrition workshops, parenting programs, grandparents outdoor tea and bannock making, sewing classes, fish filleting and soup making. I strongly encourage all families and children that fall within the age category to participate in the Aboriginal Head Start On-Reserve program it is a great way to increase knowledge and skills for a brighter and healthier future.

Each spring I like to incorporate some sort of program for community members to become more active and make better choices when it comes to food. Over the past couple years I have organized Pinaymootang's Biggest Loser. This program was based on weight loss over a period of 8 weeks and the top 3 participants with the most weight lost win prizes. In the future I am hoping to somehow make clients more accountable for their health by shifting the focus of this program from weight loss to healthy living and being active. I look forward to holding this event annually and help provide community members with the support they need to live a healthier lifestyle.

HIV/AIDS Annual Report

The purpose of the HIV/AIDS program is to develop initiatives to control and prevent the spread of HIV infection on-reserve, to reduce the health, social and economic impacts of HIV/AIDS, to encourage and support the active involvement of community, to identify option and strategies for the provision of treatment, care and support programs that will facilitate knowledge that will provide timely and comprehensive education and preventative programs, to increase knowledge and educate to ensure that skills exist at the community level to develop a coordinated approach.

The HIV/AIDS program continues to grow and threaten the lives of our First Nation people as no one is immune from HIV/AIDS. The Pinaymootang First Nation Health program has come to realize that this disease with the infection rate is amongst communities where poverty, family violence and drug/alcohol abuse are present. The indicator of unprotected sexual activity, a very high sexually transmitted disease rate and a high teen pregnancy rate prove that we are at risk of HIV infection.

During the course of the year, we have been promoting that HIV/AIDS as well as Hepatitis C are preventable diseases. We have been educating that in order to prevent transmission we must practice safe precautions.

The following activities were conducted;

- Information drives targeting the youth ages 15 – 21;
- Awareness during community events;
- Health Sex Education Classes;
- Video and Power Point Presentations;
- Promotion of World AIDS Day;
- Providing contraceptives, condom talk demos;
- Testing and Counseling.

I would like to thank Pinaymootang community members, Chief and Council and my co-workers for their continuous support. I look forward to many more years of employment at the Pinaymootang Health Centre.

Nancy Tindall LPN, Foot Care Nurse
Community Health Program Coordinator Nurse

Community Health Representative Report

The Pinaymootang First Nation Health Centre employs two Community Health Representatives who play a major role in health programming. Each CHR oversees additional programming in their job descriptions. My role focuses on school health, baby clinics, and youth of the community while taking on the Canada Pre-Natal Program (CPNP).This position is responsible for the delivery of high standard community health surveillance programs and to provide quality health prevention and treatment in community.

Updates of immunizations are requested from Manitoba Immunization Monitoring System for all children that need immunizations. Sometimes requests are made daily as mom brings in their child for immunization, to make sure that they haven't received same. Immunization cards are updated and in their personal charts. Mims requests are done for new families moving back to the reserve or if they are from a different band affiliation. MIMS requests are also used for newborns to get medical numbers.

Preschool list is made and a copy is faxed over to the school for the teacher. A preschool clinic is set up for the kids to get a Denver Development Test and immunization is given to preschoolers before school starts and this is done by Nurse and CHR.

Head checks are done by CHR's as per request by school principal and shampoo given out as needed. Chronic Disease Register is checked through by Nurse's, CHR's and Health Care Aides to ensure we are meeting client needs.

Pre-checks are done on clients before seeing the community physician by CHR or Health Care Aide such as blood pressures, blood sugars, weights and are then recorded on personal chart.

Transportation is always provided for clients wanting to come in for Doctor's clinics, Dental, Addictions, Nurse, Child Health Clinic's, Diabetic clinics, Blood Pressures, Workshops or as needed.

Canada Prenatal Nutrition Program Annual Report

The Canada Prenatal Nutrition Program (CPNP) is designed to improve the health of prenatal and postnatal women and their babies. We strive for well-nourished pregnant women, more women breastfeeding, and for as long as possible, greater access to nutrition information, services, increased knowledge and skill-building opportunities and the best infant feeding practices to ensure health babies.

Three main program areas in the program are Nutrition Screening, Education and Counselling, Maternal Nourishment (providing pregnant women and breastfeeding moms with health foods), Breastfeeding Promotion, Education and Support.

Pregnancy tests are done by nurse at the request of clients and if found that they are pregnant they are put on a prenatal list card for follow up. All bloodwork is done by the nurse and Healthy Baby Prenatal Benefit Application is given and mail out to Health Baby Manitoba, which in return they receive a supplement. Baby's Best Chance books are given out to every prenatal.

Prenatal clients are seen according to the weeks they are pregnant:

- 12 Weeks - Pre & Post Natal Testing Blood work
- 18 Weeks - Maternal Serum Screening & Ultrasound
- 20 Weeks - Referral to Obs. (Fax Letter & Blood work)
- 28 Weeks - 50 gm Glucose Test
- 38 Weeks - Leave to Winnipeg to deliver

Nurse and CPNP home visit newborns and moms as soon as they return to the community and Welcome Home Packages are given. Assessments are done to baby and mom, to see if there are any concerns that need to be addressed.

This fiscal year 37 Welcome Home Packages were given (receiving blankets, wipes, nose bulbs, socks, bibs, mittens, t-shirts, nail clippers sets, shampoo, body wash, baby lotion, sleepers, thermometers) and information packages were also made up and fridge magnets with immunization schedule. Ultrasounds are booked at Eriksdale Hospital and at times second ones are needed. Most prenatal are found in their first trimester, odd one will be found in last trimester.

We have had 5 miscarriages in this annual reporting year.

Prenatal clients are given a milk coupon, in which they get a 4 liter jug of 1% milk from the community store, once a week.

Manual Breast pumps are given to mom at her request as she will be breastfeeding, usually a couple of months for some and some past 9 months. Star blankets are also given to breastfeeding moms, if they have breastfed 9 months or over. The CPNP has incentive for mother to have their child immunizations they are at 6 months - baby wraparounds, 12 months-t-shirt, and 18 months- water bottle, ball and puzzle.

Successes:

- Among the 43 prenatal mothers who consented to the program 41 have participated; there are still a total of 21 prenatal clients currently enrolled in the program.
- None of the prenatal mothers do prohibited drugs;
- Booklet developed on Growing Healthy Together Baby and Me which facilitates bonding between mother and baby even during prenatal stages;
- Mommy and Me Support Gatherings;
- Milk program;

2017 - April –Dec 2018 – 17 Boys & 10-Girls
2018- January – March-2018 - 2-Boys & 8- Girls were born
Total babies born (37)
New Year's Baby is a boy Born February 12, 2018

Submitted by,

Carol Woodhouse – CHR/CPNP

Community Health Representative 2 Annual Report

The Pinaymootang First Nation Health Program currently employs two Community Health Representatives (CHR's) were one CHR oversees adult and community health care while the other takes on the responsibility of school health, children and youth.

And as part of the health care team, my role as your community health representative is responsible in liaising between patients, families and health care providers to ensure patients and families understand their conditions and are receiving appropriate care. I have been working as a CHR for many years now and I really enjoy what I do.

The scope of the CHR Program directly impacts individuals and the community as a whole and by working with health care providers and the community to provide education, information and support on the health and well-being to individuals, families and communities based on a holistic approach to health and health care. The CHR supports services that encourage prevention, intervention and provide up to date information and resources to promote healthy living lifestyles through education, immunization, and clinics.

As a CHR, I also perform a broad range of duties in the community. Some of my duties throughout the fiscal year have included but not limited to the following:

- Acting as liaison and coordinator for the community, residents and professional staff;
- Providing information about childcare, nutrition, sanitation, communicable disease and other health matters;
- Conducting home visits to teach and demonstrate family health care and referring medical health problems to health professionals;
- Assisting with immunization consent forms;
- Translation;
- Participating in health information drives;
- Assisting in Health Education;
- Assisting with community health events (cleanup, health fair, workshops, etc.);
- Participated in the Accreditation Process;
- Monthly reporting and attending staff meetings;
- Nutritional and Physical Activity

And over the course of the fiscal year we have seen an increase in all of our services. Other than the CHR role I also take on the ADI Programming.

Aboriginal Diabetes Initiative Report

The role of the ADI is to provide an integrated, coordinated diabetes program in the community in the area of diabetes prevention, health promotion, lifestyle support, care and treatment. As the ADI Coordinator my role is to reach the short term and long term goals which include;

- Raising awareness of diabetes;
- Risk factor assessments;
- The value of healthy lifestyle practices;
- Supporting the development of a culturally appropriate approach to care and treatment;
- Diabetes prevention;
- Health promotion; and
- Building capacity and linkages in the components of the program.

They are three types of diabetes;

- Type 1 is where the body makes little or no insulin;
- Type 2 is where the body makes insulin but cannot use it properly; and
- Gestational diabetes is where the body is not able to properly use insulin.

Diabetes is a lifelong condition but one that can easily be managed and maintained by eating healthy and getting physically active.

During the course of this fiscal year report, the ADI Program provided the following:

- Cooking Classes on proper nutrition
- No sugar promotion
- Smoking and canning white fish
- Physical Activity Challenges
- Mobile Wellness Clinic
- 6 days month Diabetes nurse
- Workshop activities on the value of nutrition
- Food Label reading
- One on One counseling on diabetes and nutrition
- World Diabetes Day Initiatives
- Diabetes and Risk Factor Management;
- Wellness Fitness Centre Promotion;
- Traditional Harvesting, Food Preparation, Food Preservation;

- Learn How to Prevent Diabetes: Learn when and how to screen for diabetes, importance of a healthy diet including reading nutrition labels and carbohydrate counting, as well as making healthy lifestyle choices

- Learn what diabetes is, how to test and control your blood sugar, treatments for diabetes, what to eat with diabetes, and how to read food labels. We will also talk about staying healthy from your eyes to your toes by making healthy lifestyle choices, modifying recipes, managing stress, physical activity, and understanding your blood sugar results!

- Diabetes Class Learn how to stay healthy from your eyes to your toes by making healthy lifestyle choices, modifying recipes, stress management, physical activity, and understanding your blood sugar results!

- Eating for Heart Health: Love your heart! Learn about dietary changes to help you improve your blood pressure and cholesterol, medications to protect your heart, activity and stress management, and monitoring your blood pressure at home.

- Diabetes Class 1 & 2 Learn what diabetes is, how to test and control your blood sugar, treatments for diabetes, what to eat with diabetes, and how to read food labels. We will also talk about staying healthy from your eyes to your toes by making healthy lifestyle choices, modifying recipes, managing stress, physical activity, and understanding your blood sugar results.

The Health Program has been very active in implementing the ADI Program to the community as well as my role in CHR. I look forward to another year filled with new programming.

Meegwetch!

Alfred Pruden
CHR/ADI Coordinator

Support to Nurses Annual Report

My name is Cherish Sumner and I have been with Pinaymootang Health Centre for a total of 6 months. The position I currently hold is to assistant the public health nurse, health professionals and program supervisors with their roles and responsibilities. I also provide front desk administration to the organization.

Throughout the months, I have watched it grow to where it is at today. Many hard working hours have been put in with all health employees to ensure that we provide effective and efficient health care to our community members.

My duties include the following tasks:

- All appointment bookings; Tele-health Appointments
- Assist the NIC on charting;
- Preparing health correspondence;
- Distributing copies of incoming and outgoing mail, correspondence or reports accordingly;
- Help coordinate and organize specialty programming as instructed;
- Maintaining a high level of confidentiality at all times;
- Prepare various forms and documents;
- All required front desk duties;

During the course of this fiscal year a total of 668 clients have been seen by the visiting physician and since the expanded facility increased service have risen drastically. I believe, we are providing more of a primary health care service than anything else in order to provide services closer to home for our community members.

RECOMMENDATIONS

- Require more training in clinical management;
- Additional Administrative Support Worker due to the increase workload in health services;

Cherish Sumner

Operations and Maintenance Report

The general duties conducted are; general cleaning and sanitary services, on a daily basis, both indoor and outdoor cleaning of premises including; carpets, furniture, windows, washrooms and floors. Waxing and buffing are conducted twice per year and the restocking of cleaning and washroom supplies are ordered as needed.

Removing of litter and garbage to the local landfill is done, daily. The custodian ensures a high confidentiality level.

Other maintenance that is required such as lawn maintenance, HRV cleaning, lighting fixture change, snow removal, drainage, door fixtures, grading of parking lot are conducted through a need be basis by short term contract work.

The upkeep to the facilities has been a demanding and challenging throughout the year ever since the expansion process began. The health facility as almost doubled its size which means a drastic increase in workload. Changes will need to be made as we work through the facility's infection control standards based on the Accreditation renewal coming this fall.

The Health Program has made every effort to maintain the upkeep of the facility.

Phyllis Wood

Brighter Futures Initiative/Building Healthy Communities
Annual Report 2017-2018

Hello, my name is Stephen Anderson; I am the Brighter Futures and Building Healthy Communities coordinator. The objective of the BFI/BHC program is to increase awareness in mental health, child development, healthy babies, injury prevention and parenting skills; improve the knowledge and skills of community members in the areas of mental health, child development, healthy babies, injury prevention and parenting skills; address the health problems affecting children and families in a community-based holistic and integrated manner and support optimal health and social development of infants, toddlers and pre-school aged children.

To increase awareness in these different areas the BFI/BHC program, in partnership with various community agencies and other Health Centre programs, provides a variety of different activities for community members to participate in. These are just some of the events/programming held in the past year:

- The BFI program once again assisted in the Gardening program, 70 community members took part in this year's Garden Project. The Gardening project is done in partnership with the ADI and BFI programs. Clients are given several different types of seeds to plant along with seed potatoes in their own garden; community members in this program should take pride in growing and gathering their own food.
- Kid's Health Fair. This program was held in partnership with other Health Centre programs, clients took part in various games and activities with their children aged 0-6. Over 200 parents and kids took part in this event. We look forward to continuing this event in the coming year.
- Swimming lessons at Steep Rock Beach. These lessons are an annual activity in the summer months. The Pinaymootang Health Centre partners up with the Manitoba Life Saving Society to organize the lessons for the week. This year 28 participants took part in this annual activity.
- First Aide/CPR & AED training. This training was also bought to community members with the help of the Manitoba Life Saving Society. Fourteen (14) participants completed the 16 hour course that was held over 4 evenings. All that took part passed and received their Red Cross Level C- First Aide/CPR & AED certificates.

- The community Health Fair, held during annual community Treaty Day celebrations, showcases all Health Centre programs and gives community members a chance to interact with health staff. Over 200 people took part in this event.
- Pinaymootang Health Centre hosted a workshop in partnership with Sport Manitoba. The Fit Kids Healthy Kids workshop showed front line workers on how to utilize different types of games when working with limited space. This workshop was attended by other community front line workers as well as some workers from other communities.
- Family Day Snowmobile Ride/Weiner roast. This was a first time event that we tried and while not knowing how much community members would attend but we were pleasantly surprised when we had over 80 people show up. Community members had the option to come on the ride or to meet up at the community cabin on Fisher Island on Lake St. Martin. We hope to continue this event in the coming winter season.

Attendance at monthly community networking meetings and quarterly Brighter Future Coordinator meetings that are held with other communities are also just some of the ways the program looks to continue building partnerships with other stakeholders. The sharing of new and different ideas with these partners is a great way to further our awareness with what clients want to see in certain areas.

In closing, I would like to thank everyone that has taken part in the past year's programming. It is because of the community member's participation that we have enjoyed success in the programs we have offered. We will continue to strive to bring the most relevant and up to date programming available to the community members.

Thank you

Stephen Anderson

NATIVE ALCOHOL AND DRUG ABUSE ANNUAL REPORT

My name is Alvin Thompson and I have been employed as the Addictions Coordinator/Counsellor for the last twelve (12) years. I previously held this position from 1988 to 1992. My training at the time consisted of specialized training from the Addictions Foundation of Manitoba and from Community Health Program training through Yellowquill College.

I started training through University of Manitoba and graduated from a Counselling Skills Certificate Program in that year. Later, I started the Aboriginal Community Wellness Diploma Program and graduated in 2008. A few years passed and I embarked on a Bachelor of Social Degree Program and graduated in 2016. I have taken many other training programs in various training segments and am always thankful that I returned to this type of work. It is indeed gratifying to be in this field of work and though there are many challenges, the successes are paramount in bringing satisfaction to this career. I am able to use my own experiences and the training I have received to help people that find themselves in quandary with various types of social problems.

Trauma has been found to be the main factor which leads to addictive behaviour(s). Since the 2011 flood, many were traumatized and had to leave the serene surroundings of where they grew up and where many fond memories were created. Because of the flood, and the displacements that occurred, the majority of the people have moved to urban centres and have had an easier access to alcohol and drugs, gangs, and many other detrimental factors have been brought into their lives. Once repatriation commences many new forms of addictions will happen they did not have before they were displaced.

This will result in many challenges and various types of other problems that will be brought back into the area. For this reason, Pinaymootang Health Centre has played a leading role in preparing for the repatriation. We have had many meetings with the Ashern and Eriksdale hospitals, the Interlake Eastern Regional Health Authority to prepare for the increase of the populace and the presenting circumstances. To this end, the Pinaymootang Health Centre has prepared in designing a policy and on the development of Crisis teams to deal with the influx. This has not been an easy task as there are many unforeseen situations that will present themselves and we have to be well prepared to deal with all facets of problems. The Crisis Team policy will have to be a living document as there will be unforeseen circumstances to deal with.

On a brighter note, Pinaymootang Health Centre thrives on improving its services which include visiting physicians, 6 nurses on staff, 2 mental health Therapists, dental health therapist and many other professional services such as tele-health and counselling.

My program has seen an increase of clients and the members that require services are receiving them and I am prepared to collaborate and work with the other staff from the communities to ensure the best possible care is always being provided.

It is essential that the circle of care includes having a Crisis Service Procedures Manual in place and to Pinaymootang Health Centre will work diligently in achieving the goal of having this component of care available.

This past year has been challenging in working at the Pinaymootang Health Centre due to the construction. However, where there is a will, there is always a way of achieving goals and providing the services that the membership requires.

The following is statistical information from April 1, 2017 to March 31, 2018:

Month	**New Clients**	**Referrals**	**Other FN Members**
April	25	10	05
May	09	09	04
June	05	03	03
July	15	09	02
August	21	06	01
September	21	08	05
October	25	09	09
November	24	05	06
December	14	06	05
January	31	07	09
February	18	07	11
March	25	13	07
Totals	233	92	76

In addition, this past fiscal year I attended several meeting where plans for the evacuees were discussed as well as attending other meetings/workshops to keep myself apprised of the cases requiring case management and other training that I can use to benefit the clientele;

- Bridging Indigenous Knowledge – Winnipeg Manitoba
- Elders Gathering – Fairford House of Prayer
- Flood Repatriation Meetings – Winnipeg Manitoba
- Smoking Cessation Program – Winnipeg Manitoba
- Transporting Dangerous Goods – Pinaymootang First Nation

- Treaty Day Health Fair – Pinaymootang First Nation
- BFI/BHC/NADAP Conference – Winnipeg Manitoba
- Creation of Support Systems – University of Manitoba
- Improving Quality of Life Conference – Assembly of Manitoba Chiefs
- Brighter Futures Gathering – Cree Nations – Winnipeg Manitoba
- Professional Development Workshop – Winnipeg Manitoba
- Harm Reduction Conference – Winnipeg Manitoba
- Case Management Workshop – Winnipeg Manitoba
- Networking Meetings – Pinaymootang First Nation

Respectfully Submitted,

Alvin Thompson CAC II BSW RSW
Addictions Coordinator/Counsellor

Medical Transportation Annual Report

My name is Margaret Anderson and I am employed as the new Medical Transportation Coordinator for the Pinaymootang First Nation Health Program.

The Medical Transportation Program provides transportation benefits to eligible clients with access to required services that cannot be obtained within the community. This program is administered by one Medical Transportation Coordinator and four Medical Drivers.

Medical Transportation is provided only to access health services approved by Non-Insured Health Benefits (NIHB) – FNIHB Health Canada. Requests for Medical Transportation to access services that are not provincially insured or which do not fall under the parameters of (NIHB) will be denied except for Medical Transportation to Traditional Healers and Medical Transportation to Treatment Centers.

Client's Off-Reserve will need to contact FNIHB – 1-877-983-0911 regarding travel for their appointments if they are not eligible through the Medical Transportation Program On-Reserve.

MEDICAL TRANSPORTATION OVERVIEW

Assistance with Medical Transportation services are provided to members who live On-Reserve for medical travel and associated services for the following:

1) To the nearest appropriate facility; 2) The most economical and practical means of transportation considering clients condition; 3) The use of scheduled coordinated transportation; 4) Medical transportation in a non-emergency situation has been prior approved by Coordinator based on eligibility; and 5) Services not available in the home community.

DAILY ACTIVITIES

- Performing administrative duties and maintaining client files;
- Providing services to eligible Members living on reserve;
- Booking, verifying and rescheduling of appointments coordination;
- Recording and providing meal tickets for clients with Winnipeg appointments;
- Accommodations are provided with either private home or hotel, according to eligibility of client (Surgery preps or post op care);
- Preparing OCA forms for private travel and appointment verification slips for clients;
- Recording all returned private travel forms;
- Preparing daily passenger logs for medical driver for Winnipeg log.

APPENDIX NIHB/MT-A NIHB Program Reports, Progress Activity Reports due Dates and Progress Activity Report Requirements

Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2017 – 2018** **April 1 – August 31**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **1561**	# of exceptions requested: **10 clients reimbursed**	# of appeals: **0**
# of requests approved: **1571**	# of exceptions approved: **10**	# of favorable appeals: **0**

How are the benefits being provided:

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time driver transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow. The program also as an on-call driver for relief driving should existing drivers are away on vacation, sick, training or if an additional vehicle is required when transport is at its full capacity then an additional vehicle is then utilized. Medical Drivers provide transport to various locations such as Eriksdale Hospital for ultra sounds as well as Selkirk, Hodgson and Dauphin area.

Major Accomplishments in the program during the reporting period:

Increased coordination with medical appointments in Selkirk and Dauphin runs and being able to schedule clients on the same day to appointments.

Based on last year's numbers there has been an increase in private travel and meal tickets.

Medical van has shown an increase of usage in transportation to Winnipeg, Selkirk, Dauphin due to doctor shortage in Ashern and Eriksdale district.

Increase of prenatal, which do provide for high risk pregnancies.

In July of this report, two additional doctors have been acquired at the Lakeshore General Hospital, this has helped reduce the travel to several General Practitioners in Winnipeg and the usual contract for physicians at the hospital is a three year contract.

Major Challenges in delivering the program during this reporting period:

We now have an increase of 12 dialysis clients, 11 of which are attending dialysis three times per week at the Lakeshore General Hospital in Ashern, MB. One client is currently going three times per week to the Seven Oaks Hospital dialysis unit a spot opens up at the Lakeshore Hospital.

With the Provincial systems changing many of our clients that are transported from Pinaymootang via ambulance to the nearest hospital (Lakeshore GH) are transported further out to communities such as Arborg, Pine Falls and sometimes Pinawa, MB., with these types of transfers our clients are usually left in the previously mentioned community hospitals with no way to get home this leaves the Pinaymootang Medical Transportation Program with additional costs not accounted for in the yearly budget.

The Lakeshore General Hospital still faxes out physician shortages/nurse managed care info sheets during weekend hours or evening hours when they do not have a physician on call and has become a struggle to ensure our clients have a good pathway to care.

Identify the factor (s) that may be impacting the budget:

Increase in meal tickets and accommodations.

The increase in surgeries has become a strain in our reporting period as well a the ambulance diversions with our area.

Other relevant observations, comments or information to this program:

The need for better communication methods in evolving change.

The need for handbook on community policies and guidelines that the coordinator must follow. As the coordinator of the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a book to hand out as to how decisions are decided and how process is followed.

APPENDIX NIHB/MT-A NIHB Program Reports, Progress Activity Reports due Dates and Progress Activity Report Requirements

Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2017 – 2018** **Sept 1 – November 30**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **996**	# of exceptions requested: **5 clients reimbursed**	# of appeals: **0**
# of requests approved: **996**	# of exceptions approved: **0**	# of favorable appeals: **0**

How are the benefits being provided:

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time driver transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow and they provides services on a need be basis, if the medical transport is at full capacity then an additional van is required, this worker also provides transport to the Eriksdale Hospital for ultra sound as well as Selkirk and Dauphin areas.

Major Accomplishments in the program during the reporting period:

Increased coordination with medical appointments in Selkirk and Dauphin runs and being able to schedule clients on the same day to appointments.

One dialysis client received a transplant and no longer receives dialysis.

Major Challenges in delivering the program during this reporting period:

We now have an increase of 11 dialysis clients, 9 of which are attending dialysis three times per week at the Lakeshore General Hospital in Ashern, MB.

Major challenges during this report would be the on-going hospital emergency closures and diversions and we find that our Medical Transportation Program is picking up discharge clients to various locations at times it is very difficult to keep up.

Identify the factor (s) that may be impacting the budget: We found that during this period that there has been an increase in surgeries whether it is for child dental surgery, minor surgery as well as the concern on the hospital closures and diversions.
Other relevant observations, comments or information to this program: The need for the community to find funds to print off its transportation booklet as it reflects the Medical Transportation Program to help clients understand the policies, procedures and guidelines that the Medical Transportation Coordinator must follow. As the Coordinator for the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a book to hand out as to how decisions are decided.

APPENDIX NIHB/MT-A NIHB Program Reports, Progress Activity Reports Due Dates and Progress Activity Report Requirements

Program Activity Report

1st	2nd	3rd Final
For Period Apr 1 to Aug 31	**For Period Sept 1 – Nov 30**	**For Period Dec 1 – Mar 31**
Due Oct 15	**Due Jan 15**	**Due June 30**
Fiscal Year: **2017 - 2018** **December 1 – March 31**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **1247**	# of exceptions requested: **10**	# of appeals: **0**
# of requests approved: **1247**	# of exceptions approved:	# of favorable appeals: **0**

How are the benefits being provided:

One full time Medical Transportation Coordinator is currently on hand to provide and assist clientele of appointment bookings, coordinating of medical transportation, and acting as a supervisory capacity of medical drivers currently employed with the First Nation.

Currently employed are 3.56 full time drivers transporting clients to appointments, each driver works on a rotating basis. Each driver has a monthly schedule they follow and they provides services on a need be basis, if the medical transport is at full capacity then an additional van is required, this worker also provides transport to the Eriksdale Hospital for ultra sound as well as Selkirk and Dauphin areas.

Major Accomplishments in the program during the reporting period:

Increased coordination with medical appointments in Selkirk and Dauphin runs and being able to schedule clients on the same day to appointments.

Two dialysis clients received a transplant and no longer receive dialysis.

Major Challenges in delivering the program during this reporting period:

We have 9 dialysis clients of which are attending dialysis three times per week at the Lakeshore General Hospital in Ashern, MB, and 1 dialysis client attending dialysis three times per week to Selkirk Regional Health Centre in Selkirk, MB.

Major challenges during this report would be the hospital emergency closures. We find that our Medical Transportation Program is picking up discharge clients to various locations. The IERHA has been experiencing major physician shortages within the Interlake Region.

Identify the factor (s) that may be impacting the budget: We have found that during this period that there has been an increase in surgeries. As well as the concern on the hospital closures.
Other relevant observations, comments or information to this program: The need for an NIHB booklet is required to help the clients understand the policies and guidelines that the coordinator must follow. As the coordinator of the program, I find that having to say no to clients based on the criteria of private travel and other areas within the program, I feel that it would be beneficial to the program if there was a book to hand out as to how decisions are decided.

Submitted by,

Maggie Anderson – Medical Transportation Coordinator

Home and Community Care Nurse Supervisor
Annual Report

Hello! My name is Brenda Halchuk and I am a License Practical Nurse with 30 years of experience working with elders. I started working here in Pinaymootang on September 21, 2016. I want to thank the community for welcoming me and making me feel like part of the community. I enjoy working for the community and serving community members. I really admire how the health center is so progressed and feel very proud to be part of the health team.

It has been a trying time this past year due to the expansion of the Health Center. The Health Center was very chaotic but well worth the sacrifices! The health center is very modern and well equipped. We now have a tub room with a large bath tub for members use.

The Program Goal I work in is: ***"To assist clients to live in the community as independently as possible, preserving and encouraging enhancement of the support provided by the family and community"***

The Home & Community & Care Program supports community members living with chronic and acute illness and disabilities by providing services that help maintain optimum health, well-being, and safely in their homes and community.

Available resources in the Home Care Program:

- **Nursing Services:** Vital Signs checks (blood pressure, pulse, blood sugars, etc.), collect blood work, wound care, provide education, advocate, liaison, and interpret in the comfort of the elders homes.
- **Personal care:** HCA have their regular clients that require personal care. HCA are trained to check vital signs. The HCAs' bring the readings to the nurse, and if readings are high the nurse will conduct further assessments.
- **Medical Supplies and Equipment:** Home care nurse assesses homes and makes appropriate recommendations of equipment required to continue living at home safely. Letters for wheel chair ramps are sent to Chief and Council.
- **Home Management/homemaking services:** This program is under Social Services. I do an assessment on client and make recommendations to Social Services.
- **In-Home Respite:** HCA worker could be assigned to stay with the client for a period of time, or could be scheduled to come in periodic intervals during the time the caregiver is away from home, depending on ***resources*****.**

- **Palliative Care:** New program now funded by Health Canada. This allows clients the option of dying at home in comfort and dignity. Certified Health Care Aides and Nurse provide family and care givers assistance in caring for loved ones at home.

Stats:

Number of Home Visits	387
Number of Clients seen in Clinic	375
Number of Hospital Visits	9
Number of Foot Care Provided	124
Number of Baths Provided	31
Total Number of Clients Served	683
Total Number of Client Encounters	1241
Total Number of Activities	7
Total Number of Attendees	216

The Home and community Care program currently has 121 clients including those of Jordan's Principal. There are **9** clients in for Ashern dialysis.

Description of trainings/conferences as follows:

- June 15th and 16th: Staff Development
- September 14th and 15th, 2017: I attended workshop "Palliative Care"
- February 1st, 2nd, and 3rd, 2018 I attended "Pallium Training"

Submitted by,

Brenda Halchuk. LPN – Nurse Supervisor

Health Care Aide Annual Report

Hello my name is Pamela Sumner, and I am a certified Health Care Aide here at the Pinaymootang Health Centre. I have been working as a Health Care Aide for many years now. I enjoy working for the elder's in our community, and learning from them as well. I work to the best of my abilities, and always strive to do the best I can for the people in the community.

The Home and Community Care's Objectives are: To provide holistic and personal care services with respect and compassion in order to allow individual community members to remain healthy & live independently in their own home as long as possible.

Assist clients and their families to participate in the development and implementation of the client's care plan to the fullest extent and to utilize available community support services where available and to provide the appropriate care for the clients.

Assisting community members living with chronic and acute illness and disabilities by providing service that help them maintain optimum health, well-being and independence in their homes and community.

Supportive care:

- Making home visits, and visiting elders.
- Activities of Daily Living; Bathing, grooming, toileting. Basically, getting clients ready for the day.
- Taking vitals which include; blood pressures, temperatures, blood sugars, respirations, pulse.
- During home visits, making sure the clients are taking their medication, and documenting any changes to medication to our Home Care Nurse.
- Assisting clients with equipment when needed to make life easier. Example; mobility aides, wheelchairs, walkers, canes, shower heads, bath seats, etc.

Recording and Reporting:

- After each home visit, report to the nurse for any assistance needed for the client, or if any concerns that need to be addressed.
- Chart on any home visits made or done, after reporting to the supervisor.
- Make referrals for clients to the right program area, or to the Home Care Nurse.

Activities

Total Home Visits	**857**	
Activities	**7**	**231**
Meetings and Training	**First Aide/CPR** **Respectful Workplace Practices** **Monthly Staff Meetings** **Transportation of Dangerous Goods Workshop**	

Pamela Sumner – Health Care Aide

Health Care Aide Annual Report

Hello my name is Dorothy (Dot) Sumner I am a health care aide. I have been employed at Pinaymootang Health Centre since January 2012. I work with the Home and Community Care Program, under the supervision of the HCC Nurse Coordinator. I work with elders and persons living with acute or chronic conditions and persons with special needs. I enjoy working here and I take great pride in helping people and value what I do. It is a pleasure serving the people of my community.

The Home and Community Care's Objectives are:

- To provide care for clients who need assistance in the home after hospital discharge.
- To provide community care and support to a range of people: including elders, families and individuals with special needs and people with short term and long term medical conditions.
- To enable clients to remain in their own homes as healthy and as independent for as long as possible and also to delay and prevent admission to a health care facility.
- To promote dignity, independence, preferences, privacy and safety at all times when in the clients home.

Supportive Care:

- We provide personal care services, such as bathing, grooming and dressing; to help prepare clients get on with their day.
- We make daily homes visits to various clients' homes, to provide support for clients who may have concerns.
- I communicate with the elders in their language.
- We check and record vital signs this includes: blood pressures, temperatures, pulse and respirations and also do blood sugars and oxygen levels.
- We assist with range of motion exercises.
- We provide mobility aides to meet the client's needs with wheelchairs, canes and walkers. Other equipment provided includes: shower heads, bath seats, bath mats, safety toilet rails, raised toilet seats, commodes, reachers, mechanical beds and bed safety rails.

Recording and Reporting:

- Following a home visit, I report and direct any concerns or changes to the HCC supervisor.
- Charting and documentation is done after a home visit.
- Report foot care referrals to the foot care nurse

Activities:

Total Home Visits	**730**	
Activities	**7**	**231**
Meetings and Training	**Falls & Risk Prevention** **Conflict Resolution Training** **Improving Quality of life** **Respectful Workplace Practices** **Monthly Staff Meetings** **Transportation of Dangerous Goods Workshop**	

Aboriginal Head Start Outreach Program (AHSOR)
Annual Report

Hello, my name is Sheila Sinclair I am the Aboriginal Head Start Outreach Home Visitor Coordinator. I had transitioned over to the program in December 2017.

The AHSOR program is designed to meet needs of children and their families. This program focuses on children from the ages of 0-6 years. This program consists of 6 components that are required: 1) Culture and Language, 2) Education and School Readiness, 3) Health Promotion, 4) Nutrition, 5) Social Support and, 6) Parental and Family Involvement.

The AHSOR program engages children and their families to participate in various activities in addition to the home visits conducted. The home visits consist of the home visitor, the child, and the parent/s or guardian. Educational resource tools are bought into each home visit to focus on the mandated program such as the Ages and Stages questionnaire which is a survey that sees where the child's developmental skills are at. In these questionnaires, we see the different developmental skills that each child has such as gross motor skills, fine motor skills, communication, personal /social skills and problem solving. If we see a delay in any of the children we are obligated to make referrals to programming whether it be to the JP CFI, O/T, P/T and Speech. These therapists will help enhance the child's developmental skills needed at their level.

Activities through the year have included:

- Playgroup held on a weekly basis. Various activities are held during this program such as arts, crafts, sewing, nutritional teaching, parenting training.
- Nutrition Workshops held allows families to learn on nutritional facts and to promote healthy eating.
- Cultural and Traditional teachings such as bannock making.
- Promoting Activity.
- Weekly home family visits to children to address any child development issues and conduct appropriate referral processes.
- Promotion of the Dolly Parton lending library.
- Parenting Classes (ALAPS).
- Injury prevention (car seat safety).
- Monthly Staff Meetings ;

- Monthly Community Networking Meetings ;
- Home Visits to provide ASQ assessments

Sheila Sinclair

Niniijaanis Nide – My Child, My Heart Program

Hello, my name is April Sanderson, I am a Licensed Practical Nurse and a certified Foot Care Nurse. I joined the team at Pinaymootang Health Centre in December 2015 as the Case Manager for the "Niniijaanis Nide Program" – which in Ojibway translates to "My Child, My Heart" in the English language.

The purpose of this program is to support families living with children with complex needs and to help enhance the child's life and facilitate timely health care interventions, developmental stimulation, provide support, address gaps in service, avoid jurisdictional disputes and improve needed care.

We assist families who have children with developmental and/or physical disabilities with some of the additional needs they may have. The object is to engage families and the community in working together to improve access to health services. Our goal is to contribute to quality of life ensuring that children, young people and their families are enabled to experience a life that is as full and as normal as possible. We strive to provide a fun and enjoyable atmosphere in order to encourage client participation in programs. We assist in their physical, social, emotional and daily life skills development, increasing their independence and allow them to function in the community.

The program is staffed with Child Development Workers who are certified Health Care Aides. The Child Development workers provide respite, work with the parents to identify their child's strengths and goals, and together we find ways to assist the child to develop and learn new skills. We also have an American Sign Language Educator who provides services to our community and she comes to us with 25 years of experience of American Sign Language (ASL); she continues to provide ASL Classes at the Pinaymootang School and provides one-on-one supports to the children in our Program.

Some of the programming that has been undertaken this fiscal year;

- "Healthy Child, Happy Child Workshop" – Telehealth;
- eSDRT Training – Telehealth;
- "Dynamic Intelligence and the Guiding Relationship" 2-day hosted by Rehabilitation Centre for Children – Telehealth;
- "2017 Manitoba Pediatric Health Conference"
- Parent Support Group;

- 2017 Annual Children's Health Fair hosted by Pinaymootang Health Centre;
- Eagle Urban Transition Centre site visit;
- IRTC – Josie Kent, Rachel Fair site visit;
- 2017 Annual Treaty Days Health Fair hosted by Pinaymootang Health Centre;
- "Corn Roast" Fall Celebration with Families hosted by Pinaymootang Health Centre;
- Meeting with MFNERC/MFNSS and introduction hosted by Pinaymootang School;
- EAGLE Urban Transition Centre 3-day Workshop;
- St. Amant site visit and introduction;
- "Building Blocks – Helping Your Children Grow" - RCC
- 2017 Canadian Home Care Association – "Home Care Summit 2017" (Edmonton);
- Treaty 8 - "Western Canada Jordan's Principle Gathering 2017" (Calgary)
- "9th Annual First Nation Caring Society Workshop & Gala" (Winnipeg);
- "Fit Kids, Healthy Kids" Workshop;
- "Parent's Valentine's Day Party" hosted by Pinaymootang Health Centre;
- "2017 First Nations Health Managers Association" (Toronto);
- "Foot Care & Chronic Disease" – Diabetes Initiative Program;
- "Jordan's Principle Case Management Forum" – AMC (Winnipeg);
- "Jordan's Principle Case Manager's Gathering" (Winnipeg);
- MATC (Manitoba Adolescent Treatment Centre) Introduction meeting hosted by Pinaymootang School;
- Food Handling for Niniijaanis Nide (My Child, My Heart) Program staff;
- "Canadian Home Care Association Webinar: Niniijaanis Nide (My Child, My Heart) Program;
- "Power to Parent II – Helping Our Children Grow" workshop over 8 weeks and completed January 2018;

Due to the success of the Program we developed in Pinaymootang our Health Centre was tasked to develop a Tool Kit and 5 Modules were developed to assist the other 63 First Nations in Manitoba to assist in the development of their programs in their home communities. To date we have had 22 communities, 5 Tribal Service Coordinators and 1 out of Province program (Fort McMurray, AB) visit our Health Centre to observe the Program operations.

We attended meetings in Edmonton, Toronto, Calgary and Ottawa to do our Presentation to delegates regarding the "Niniijaanis Nide Program – (My Child, My Heart)". Our Program was highlighted by the Canadian Home Care Association as a "High Impact Practice" from their "2016 Home Care Summit" in Vancouver in October 2016 and was published on their website. We were invited to their "2017 Home Care Summit" in Edmonton and we were able to provide an update on what has transpired over the year since we first presented our program.

This fiscal year we are working in partnership with the University of Manitoba for the development of the transition phase for the "age out process" for the children who are currently in the Niniijaanis Nide (My Child, My Heart) Program and other youth in the community.

Some of the programming that is being provided to the children are: Reading Club; Moe the Mouse; Movie Night; Activity/Gym Night; Baking Night; Oduminoh Group; Nagamon Club/Music Fun; Gardening – Get Set Grow; WII Night; ASL Class; ASL Lunch-time Signing Club.

Total Fiscal year New Intakes 17/18: 8 children
Home-visits/1-1 Visits Total: 765 Home Visits
(Case Manager/Child Development Workers/ASL Educator)

Outdoor activities and Field Trips were scheduled throughout the summer (Goldeyes Baseball Games, Assiniboine Park Zoo, Children's Museum, Prairie Dog Express, Foxhole Farms, Manitoba Museum, and Steep Rock). Our Program was able to purchase a 10 passenger van to enable us to transport the children to the programming that is scheduled regularly and other group activities planned throughout the year. I would like to express my gratitude to the Pinaymootang School for allowing us to use their facilities for our continued Programming.

I look forward to continuing to work with the children and their families in the community and continue to enrich their lives to the best as we possibly can. I would like to extend my thanks to the Community for their support and Pinaymootang Health Centre for giving me the opportunity to share my knowledge as a nurse and as parent of a child with special needs.

Respectfully,

April Sanderson, LPN/Case Manager

Drinking Water Safety Program Annual Report

The Drinking Water Safety Program falls under the jurisdiction of FNIHB. The Health Program receives funding for a part time Community Based Water Monitor (CBWM). The purpose of this program is to ensure safe drinking water and proper services are provided to the Community.

The Drinking Water Safety Program is important in exposing potential risks that may be present in drinking water supplies and are identified through testing of public wells and private well supplies. With the guidance of the Environmental Health Officer from First Nations Inuit Health Branch (FNIHB) has set up a sampling plan that is unique to the community and its environmental situations.

The Pinaymootang First Nation, Drinking Water Safety Program conducts the following:

- Sampling frequencies twice a year for private wells;
- Conducts weekly testing to public building wells and distribution systems;
- Chlorine residual testing is done at four (4) locations once a week in the community; two (2) at the school distribution system and two (2) at the townsite pump houses.
- Community awareness by way of newsletter information;
- Boil water advisories;
- Well Chlorination;

Microbiological testing on water samples collected is tested for Total Coli Forms and Escherichia Coli (E-Coli) and is done within the community Health Center. The test detects bacteria in the water sample by using a Coli-sure agent which is provided by FHIHB. The testing process takes 24-28 hours in an incubator with a set temperature at 35 C (+/-.5C). After a minimum of 24 hours in the incubator, samples are taken out of the incubator and results are documented on forms using Water Trax numbers and are submitted monthly to the Environmental Officer (EHO).

TABLE 1 - TOTAL NUMBER OF BACTERIOLOGICAL SAMPLES BY WATER SOURCE
FIRST NATIONS DRINKING WATER SAFETY PROGRAM

COLISURE (QUANTI-TRAY) AND ETL MONTHLY RESULTS
APRIL 1, 2017 - MARCH 31, 2018

MONTH	WTP/DS	WDT	SPWS	C/B	PRIVATE-WELLS	TOTAL
April						
May	8		48	6	56	6
June	32		10		42	
July	24		27	6	51	6
August	28		28	5	56	5
September	36	4	13	1	49	5
October	40	3	13	2	53	5
November	32	2	16		48	2
December	8		10		18	
January	17	2	10	1	27	3
February	32		10		42	
March	24	1	10		34	1
TOTALS	**281**	**12**	**182**	**21**	**476**	**33**

WTP: Water Treatment Plant
WDT: Water Truck Delivery
(Raw & Treated: Sampling recommended Weekly)
(Monthly sampling recommended)

PWS: Distribution System

(Weekly sampling as per sampling strategy)

WELL: Private Wells
(1-2 timers per year sampling recommended)

CSPWS: CISTERN/BARREL
(Twice per year sampling recommended)

COMMUNITY: Pinaymootang First Nation

Pinaymootang First Nation Health Professional Services

Jahna Hardy is the visiting Mental Health Counselling Services expert, Lenore provides counselling services in the community one day per week (every Tuesdays) referrals for services can be made through the Health Centre for anyone wishing to utilize.

Lucy Diaz who originates from Nova Scotia, Lucy is our Dental Therapist and is currently based out of Peguis First Nation, Lucy, provides services to the community once a week every Tuesdays for dental care for school aged children and will book adult emergency by appointments.

Dr. Kashur is our visiting physician who provides care and service to the community every Thursdays. Dr. Kashur is based out of the Ashern General Hospital through the Interlake Eastern Regional Health Authority.

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2017 - 2018

Pinaymootang First Nation Annual Report on Health