Pinaymootang First Nation
Annual Report on Health 2023-2024

ANNUAL REPORT ON HEALTH

Pinaymootang First Nation

"Promoting Health and Well Being"

Pinaymootang First Nation Health Program

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INTRODUCTION

Aniin, Boozhoo! It is a great honor and privilege to once again present to you, Pinaymootang First Nation Annual Report on Health for fiscal period ending 2023-24.

In this report you will find a year filled with continued service delivery, health programming, information on accomplishments and activities of the past year.

Our highest common goal is to work towards the health and well-being of all through a teamwork, dedication and perseverance approach with many key factors which resulted in accomplishments achieved.

Community health programming main intent is to 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 all 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 care 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.

Sincerely yours,

Chief Kurvis Anderson & Council

MESSAGE FROM THE HEALTH ADVISORY COMMITTEE

This report was prepared under the guidance and approval of the Health Advisory Committee, in accordance with the reporting criteria as outlined in the 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,

Health Advisory Committee

FROM THE DIRECTOR

Director of Health Annual Report

Well another year has come to an end as we provide you to this year's annual report on health for fiscal period ending March 31, 2024. Pinaymootang Health works hard 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.

Governance Structure

The Pinaymootang First Nation Health Advisory Committee responsibilities are to oversee and provide recommendations in health. The Health Advisory Committee meets on a regular monthly basis every last Thursday of each month to review reports, policies, staffing issues and other related concerns. This past fiscal year have altered many of our meetings due to spacing concerns but try our best to make our meetings work. 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.

Health Program Overview

Nursing Treatment & Prevention – the Nursing component in health continues to be challenging in our facility. Pinaymootang has seen such an influx of clientele with a rate of 47% that is way beyond our scope of service as it affects our human resource capacity. Pinaymootang Health Centre is a very active facility and at times becomes difficult to keep up with the workload. The public health program component continues its best to ensure our client needs are met, providing immunizations; flu clinics, encouraging physical activity, education and awareness, and attending to all emergency health needs. The community currently employs 2.5 Registered Nurses, and 4 LPN's who work together through a team-based approach who help out in different capacities in health care.

The First Nation does have two visiting physician services with Dr. Chumber of the IERHA and Dr. Theissen whom provides services in pre-natal and well women's clinic. It has been noted that a total of 650 clients have been seen during this reporting period. In the new fiscal year, we will begin to see a couple of nurse practitioners into our facility, who will assist in care and supports due to the physician shortages in our region.

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 focuses on children, youth and school setting while taking on the CPNP program and

the other CHR focuses on adult and elderly care as well as the ADI program. Both CHR's are committed in ensuring excellent program service delivery in their respective roles.

Support to Nurses – One Administrative Assistant is on hand to help oversee the day-to-day front desk operations of the organization, duties 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. During this reporting period, we required additional supports to meet our demanding service needs.

Operation and Maintenance of Health Facilities – The role of the operations and maintenance is to ensure the upkeep of health facility and with the expanded facility the scope of work has increased significantly. Maintenance continues to be contracted out on a need be basis. We have also hired the services of an infection control within our facility to continue to maintain a safe environment for both the client and staff.

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 does have 3 visiting mental health professionals that provide supports to our community five days a week. We have seen increases in Mental Health during this reporting cycle.

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 to mental health.

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.

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 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.

In Home and Community Care Program – the HCC Program currently employs; 1 HCC Nurse Supervisor, 0.5 EFT in Nursing Support, 3 Health Care Aides. The program currently meets its mandate with 200 clients. This program has been very active in providing basic care supports on a daily basis, assessments, medical equipment, etc.

NIHB Medical Transportation – is administered by one Medical Transportation Coordinator, one part-time Assistant 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 ISC. The program runs a 4-van medical transport system.

Aboriginal Diabetes Initiative – the ADI Program is designed to improve the health status of First Nation 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 services is provided on a bi-weekly schedule.

HIV/AIDS – The HIV/AIDS Program has continued to meet its components of the program, workshops, information sessions, awareness to promote safer activities, available counseling and supporting testing.

Aboriginal Head Start On-Reserve (AHSOR) – the AHSOR Home Visitor Coordinator is available in providing screening of families very early after the birth of a child from 0 to 6 years of age to identify risk factors and assist families with supports such as expanding and enhancing programs and support services for mothers, pregnant moms, caregivers, parents, parents to be, children and their families. The AHSOR Program is active in community and is a participant in the Dolly Parton Imagination Library. The Health Centre have worked to develop on-line forms in child development and have conducted virtual activities to ensure the continuum of

programming.

Accreditation - The Pinaymootang First Nation (PFN) Health Centre made a commitment to continue on with the accreditation process with Accreditation Canada. In September 2022, the organization was awarded with exemplary standing, which is the highest level in the accreditation cycle. We ensure that the highest standard of services is provided in a safe health care environment.

Jordan's Principle, Child First Initiative Program – Niniijaanis Nide (My Child My Heart Program) – This program continues to grow. We have been faced with many challenges such as appropriate office spacing in which we do not have. The role of Jordan's Principle is to ensure that our most vulnerable health needs are met, to help assist with child development, basic care social needs that is reflective around the circle of care model for both the child and the family. Pinaymootang also have taken on services for our off-reserve membership to provide supports.

eHealth – Pinaymootang offers the following eCMR (electronic charting system) with Mustimuhw, Telehealth Services, eChart (electronic health record), and Panorama which is a comprehensive, integrated public health information system designed for public health professionals that helps professionals view and manage more effectively on vaccine inventories, immunizations, investigations, outbreaks and family health. Pinaymootang First Nation received funds to help provide supports that are associated directly to ehealth services. One of the challenges we are facing as an organization is the increase in services that currently ehealth services does not cover such as the increase in eCMRs to meet the needs of staffing.

Over the past year, the nursing team has been working in partnership with FNIHB, FNHSSM, Manitoba Health and PHIMS to become the first pilot community in Manitoba to use PHIMS for entering STI/STBBI into the provincial system. The outlook for this project is to go live in December 2024 and lead the way for other First Nations to have the same access to testing, treatment, and reporting as those in the rest of the Province in Manitoba. It will support our ability to provide informed and comprehensive health care to our community members with diagnoses in this regard. Training and multidisciplinary meetings are in depth and ongoing to ensure success and allow for Pinaymootang Health to lead by example for other Nations.

Maternal Child Health (MCH) – The Strengthening Families Maternal Child Health Program is a program that is implemented in community. We are a home visitation program offered to prenatal moms and families with children from birth to 6 years old. The purpose of this is to enhance child health services. We believe the period from conception to six years of age is the most influential period on brain development, behavior, and health. The effects of maternal health during pregnancy and of childhood experiences on brain development during the first six years last a lifetime. In addition to improving knowledge of preconception and reproductive health among young adults helps to promote a healthy start to pregnancy. It is important to educate parents about further engaging in practices to help benefit their child to reach their fullest potential.

Other Initiatives:
Network Meetings – the Health Centre involves itself in networking meetings with our internal community stakeholders to facilitate partnership building to enhance common goals in service support.

Interlake-Eastern Regional Health Authority (IERHA) – Pinaymootang Health continues to work in partnership with the IERHA. This is one of our biggest partnership arrangements that we associate with in bringing a proposal driven project through the MyHealthTeam. MyHealthTeam is an approach to care that brings health care providers closer to home. MyHealthTeams is made up of a variety of health professionals who complement work that is currently being provided. We offer enhanced services in Addictions, Mental Health, Chronic Disease and most recently virtual physiotherapy in the community.

Southern Chiefs Organization – Like many First Nations in the south, Pinaymootang took an interest in health transformation. The model is a community-led project that brings holistic, physical, spiritual, mental, economic, environmental, social, and cultural wellness by way of policies, creating of wellness plans, identifying evaluation, research and data systems, allocating resources, training and establishing service standards.

University of Manitoba – The university has been a strong partner for several years. This year, we were able to do work in a discussed partnership with the University of Manitoba and the Heart and Stroke Foundation on Best Practice in Four First Nation Communities that includes Pinaymootang. Through the next 3 years we will collaborate with relevant partners to develop a broader dissemination/scale up plan to expand the community-based model of rehabilitation services.

Caring for Adults with Exceptionalities – This one-year pilot project that commenced in April 2023 is intended for young people with complex needs and disabilities who face numerous challenges and barriers during the transition through adulthood. This proposal will provide an opportunity to empower and educate people with disabilities has they face stages of life transitions with personal and professional skills in a supportive environment, which leads to increased self-esteem, confidence and self-reliance. We will build on self-awareness, advocacy and self-knowledge on disabilities and help overcome barriers by promoting an understanding of the impacts of their disability

In closing, I would like to express to the community on all your efforts in following protocols and trusting in your Health Centre for improved well-being and care. We hope you find this report useful.

Gwen Traverse

FROM THE COMMUNITY

Community Health Nurse

This past year has been a year of continued learning and exploring how the future may look for Pinaymootang Health Centre. Each year, Pinaymootang Health Centre continues to expand services to community members. We have seen the staff need to adapt to and make space for new programs and services as well as include those who want to learn from the successes of Pinaymootang.

In 2023, Pinaymootang Health Centre became involved in First Nation Health and Social Secretariat of Manitoba Research study: Learning Where We Are: Clinical Experiential Learning Experiences for Nursing Students in Indigenous Communities. The purpose is to explore the value of having nursing students come to experience health care as it is offered in community and return to school with a new awareness of the barriers experienced by community members while living on Reserve. The hope is to increase this awareness among nurses who will be employed in Manitoba's health facilities with the intent that barriers will be diminished through knowledge and experience.

So far, the students that have completed a rotation at the health centre have been able to participate in a variety of programs and have participated in preparing projects to benefit community members as well as the health staff. We have been grateful for their enthusiasm and the new ideas the students bring to the health centre. We have also been glad to share the barriers experienced by community members and initiate discussions with the students on how they view being part of improving the health system for all Manitobans.

With students from University of Manitoba, Red River College and University of Brandon, the Adults with Intellectual Developmental Exceptionalities (AIDE) Program receiving new funding, the addition of the Heart and Stroke program and the off Reserve Jordan's Principle program, two Nurse Practitioners providing in community services with the possibility of reinitiating virtual Nurse Practitioner services, and more visiting professionals offering services in person, the current health centre building continues to feel cramped!

With the on-Reserve Jordan's Principle program moving forward in the process of an expanded area for office and programming, the health services are looking forward to having a bit more room to breathe while we support the health professionals that come to provide services at the health centre. We hope to improve our use of telehealth as well as inviting more health care providers into the community to meet the needs of Pinaymootang's members.

We nurses acknowledge the trust that is put in us as we work to provide care, and we value the relationships that have been established in the community. We look forward to finding ways to address unmet health needs in the community and we appreciate the feedback we receive from community members about how to improve care within the community's Health Centre.

Activities:

Immunizations given	468	Clinic visits	579
Phone calls	1043	Physician Appointments	358
Virtual Nurse Practitioner Appointments	189	In Person NP Appointments	228

Roxie Rawluk

Community Health Nurse Annual Report

I returned from maternity leave early December 2023. It's been good to be back 2 days a week, providing services at Pinaymootang Health Centre as a community health nurse. My main focus is once again childhood immunizations and postpartum and newborn assessments. New baby and mom assessments can be done either at home or at the Health Centre.

This year, an updated Meningococcal vaccine has been implemented. All children who are eligible to receive it should have received a letter in the mail. Instead of only covering 1 strain of meningococcal bacteria, this updated vaccine protects against 4 different strains. If you have received a letter in the mail and would like your child to receive this, please contact me at the Health Centre and I will be happy to book you an appointment! If you are unsure whether or not your child qualifies, or if your child(ren) are needing immunizations, please contact me and I will be happy to discuss which vaccines your child(ren) may need and also book an appointment.

More information regarding any vaccine can be found on the Manitoba Health website:

HTTPS://WWW.GOV.MB.CA/HEALTH/PUBLICHEALTH/CDC/DIV/VACCINES.HTML

Or you are of course always welcome to call me at the Health Centre for more information also. I am looking forward to continuing providing health services the rest of this year!

Statistics for December 2023:

Health Assessments	14	Blood Work	7
Various Follow-Ups	14	Immunization Visits	7
Women's Health	8	Newborn and Postpartum Assessments	2
Wound Care	6		

FROM THE MCH

Maternal Child Health Annual Report

As Nurse Supervisor for Pinaymootang Strengthening Families Maternal Child Health Program (MCH) it has been my pleasure to watch our program continue to grow and evolve as we adapt to meet the need of those we serve. Maternal Child Health was introduced to community members in June of 2022, to date we have enrolled 63 families to the program.

In Maternal Child Health we promote the physical, emotional, mental and spiritual well-being of women, children and families. This is achieved through education and programing in the areas of nutrition, early literacy / learning, physical, emotional and mental health as well a nurturing the bond between infant and caregiver. The period from conception to six years of age has the most influence of any time period on brain development, behavior and health. This leads us to support efforts that build trusting & supportive relationships between parent and child as well as work to increase a communities' capacity to support one another.

Our areas of focus include prenatal health, postnatal health, newborn care, and the overall wellbeing of young children and women. We work in close partnership with our Canadian Prenatal Nutrition Program and other childhood related initiatives at the Health Center.

The guiding principles in the MCH Program in Pinaymootang are as follows:

- Participation is always voluntary
- Care is grounded in First Nation Culture with land-based teachings incorporated
- Curriculum is family focused and strength based
- Community strengths are highlighted and advocacy to strengthen community capacity is a priority.

Enrollment to Maternal Child Health involves intake, screenings, assessments and further referrals. Families then receive services based on their needs, level of engagement and desire to participate in available community programs, group visits and or home visits. Our Home Visitors office has been designed to accommodate private visits when needed. We have hosted independently or in partnership with other Health Center Programs, a number of community and group activities in which we are able to share our curriculum.

In addition to the work our curriculum supports, we have cultivated the opportunity to improve the knowledge of mental and reproductive health among young adults by hosting

a Young Women's / Teen Clinic at the school. Twice a week as a Community Health Nurse, I visit our clinic at the school and provide care / education as needed. Along with an education platform, bloodwork, medication administration, wound care, referrals, emotional support, and peer capacity building are all things addressed at our clinic. This project has been of great importance to me and it has been rewarding to develop relationships with the younger people of Pinaymootang First Nation. It has also led to various group engagement opportunities to empower the youth regarding their health and wellbeing.

Over the past year time was spent preparing to bring Indigenous Doula Training to the community. This has involved research, proposal writing, organizing and supporting the facilitation of this educational opportunity. Those trained in being Indigenous Birth Helpers will not only be of great support to their own circle of family and friends but to the community as well.

Our prenatal program has continued to be supported by the efforts of Dr. Phoebe Thiessen who visits our Health Center once a month. MCH staff remain actively involved in supporting the care of our prenatal mothers which creates continuity once a child is born. Our CPNP report discusses more in depth our activities in this regard as both programs complement one another and our pre and postnatal population.

MCH and Related Encounters:

- Total enrollment to Maternal Child Health: 63 Families (14 New)
- MCH/ CPNP Group Related Encounters: 49 Events Supported
- Young Women / Teen Clinic: 66 Individuals / 262 Encounters

Community Health Nursing Duties:

As a Community Health Nurse the clinic continues to require a great deal of attention as people with various needs present. Clinic duties include but are not limited to the following: adult and childhood assessments, bloodwork, referrals to other providers, wound care, mental health interventions and treatments. Support for all the Health Centers Programs and attending to emergent needs are two additional ways I allocated my time and services.

STI / STBBI Related Care	**192** Encounters / **102** Clients
Womens Health	**118** Encounters / **56** Clients
Prenatal Care	**412** Encounters / **58** Clients
Infant / Child Health	**99** Encounters/ **57** Clients
Adult Health/Clinic Visits	**535** Encounters / **227** Clients

FROM THE HIVP

HIV Program

Pinaymootang First Nation Health HIV Funding has been allocated primarily towards education and prevention measures in the community. Harm Reduction efforts have also been targeted as a way to address the ongoing health matters related to HIV and AIDS. December was HIV/AIDS awareness month with the slogan "in December we wear RED". Posters were displayed and remain displayed at the Heath Center and education regarding the topic was facilitated at the school during Teen Clinic and are ongoing. In addition, and in partnership with the University of Manitoba we also participated in a study that will help address the impact of HIV diagnoses in Rural and Remote First Nations Communities. The grant we received from this will support ongoing care efforts.

HIV Statistics facing Manitobans:

- **In 2022 in Manitoba, there were 196 newly diagnosed cases of HIV, a 36% increase from 2021**
- In 2022, persons who inject drugs were at greatest risk for transmission
- Individuals 20-39 years of age accounted for the highest proportion of newly diagnosed cases as were women
- Manitoba HIV Program in 2021 reported 73 percent of people referred to the program self-identified as Indigenous.

Sexually Transmitted and Blood Bourne Infections (STI /STBBI Management)

This portfolio and related work, continues to be of great importance and of high need at the Health Center. Incidences of all Sexually Transmitted and Blood Borne Infections continues to be on the rise in Manitoba and in First Nation Communities. Of particular concern is congenital syphilis. Manitoba continues to see alarming numbers of congenital syphilis — a preventable diagnosis and one that can result in a range of debilitating health issues. Managing this and all cases related to Sexually Transmitted and Blood Borne Infections (STBBI) requires proper diagnosing, effective and timely treatment, education and ongoing monitoring. New methods of testing are becoming more accessible which support early diagnosis and treatment accessibility. Nursing staff continue ensure these methods are available and best practices for care are followed. Outreach efforts and supportive actions to support community members in

need and at greater risk lead our work.

It is through our efforts at Teen Clinic and additional workshops that we hope to educate as a means of prevention and have the most impact. Community members are welcome to present to clinic at any time and will receive all services and supports available to them to manage any diagnosis that they face. This care is confidential and we can address concerns quickly, effectively and in a manner that is tailored to each person's specific needs.

STBBI Related Encounters **215** Total Number of Clients Supported **113**

Harm Reduction

The term Harm Reduction refers to a scope of intentional practices along with the development of health-related policies aimed to lessen the negative consequences associated with drug use. It is a holistic approach to care that does not discriminate based on life style and circumstance. It recognizes that people who are unable or unwilling to stop behaviors that may be deemed unsafe can still make choices to protect themselves, others and still have positive life outcomes. Successful Harm Reduction programs are designed to meet people "where they are at", this is meant to encourage the service provider to step away from traditional models of care and see matters related to health through a different lens.

The National Harm Reduction Coalition outlines the following key principles central to successful harm reduction practices that we are mindful of at the Health Center:

- Accepts that illicit drug use exists in communities and works to minimize the harmful effects rather than condemn or ignore the matter.
- Does not attempt to minimize or ignore all matters related to drug use and the adverse outcomes.
- Understands that drug use involves a wide continuum of behavior, some of which are more concerning then others.
- Establishes a holistic approach to care and understands that the criteria for a successful intervention is not always cessation of all drug use and or associated behavior.
- Ensures that the provision of services be nonjudgmental and private.
- Allows for those who use drugs or with a history of drug use be involved in program development for themselves and their peers.
- Empowers the user and empowers the users support network in care.
- Recognizes that poverty, racism, social / geographical isolation, trauma and economical status can affect one's vulnerability and capacity to effectively deal with drug use and potential harm.

Moving forward the goal of the Harm Reduction Program at the Pinaymootang Health Center is to further develop educational programming and build relationships with those in need. As Community Nurses we work hard to ensure that the care provided by all of our health care staff is done so in a nonconfrontational and confidential manner. NARCAN is also available to those who use drugs or LOVE someone who may use drugs. Education can also be organized for individuals or groups and the opportunity to do so is Welcomed.

FROM THE MIDWIFE PROJECT

Midwifery Project Funding – Annual Report

Pinaymootang First Nation Health applied for funding under the Midwifery Project call out for proposals. With funds received during the fiscal reporting year and extending through until July 2024 a series of activities were held and objectives met. The bulk of the funding secured our primary focus of having in community training. Ten community members were successfully trained as Indigenous Doulas/Birth Helpers, facilitated by Wiiji'idiwag Ikwewag and Three Wyndi's Healing.

Beyond this specific opportunity our Maternal Child Health Home Visitors and Canadian Prenatal Nutrition Program Coordinator were offered further education in Winnipeg with Zaagi'idiwin Full Spectrum Indigenous Doula Training.

Additional success was had securing on going Indigenous land-based teaching for our doulas, mothers, their partners and children brought to community by Animikii Miko Ochicahk Lodge. These teachings support newborn / maternal and family wellness. Sessions have included; transferring our traditional knowledge to children, traditional swing teachings, traditional teething toys for newborns along with healthy pregnancy/parenting sessions.

Pregnancy loss training was facilitated in by The DragonFly Support Program and education completed in The PAS by our previously trained Doula.

Prenatal Nurses services were expanded by supporting time devote to clinic, attendance in conferences related to Restoring Indigenous Midwifery and facilitated opportunity to network and build allies with common goals related to Maternal Health.

Doula Care Bags were also purchased and given to our ten Indigenous Doulas/Birth Helpers that will support their future practice.

Over the past 18 months Nursing has worked tirelessly to provide comprehensive prenatal care close to home that is holistic in nature and supports the individual and unique needs of those that seek care. At present there are no local Midwifery Providers. We have prenatal clients that do request midwifery services and are referred accordingly. These referrals at present are to Winnipeg.

What has developed in Pinaymootang's Prenatal Program in relationship to a Midwifery Practice are a multitude of activities. It is through the following actions we undertake that we aim to lay the ground work and develop supporting evidence to support a model of excellence for

future Midwifery Care in Community and Region. Care offered at present includes; monthly appointments in community provided by a visiting Physician with an Obstetrical background, prenatal nurse to provide and organize care, lab services, referrals for diagnostics including but not limited to ultrasounds / fetal assessments, mental health support, prenatal classes and post natal follow up care.

This grant has supported and enhanced the above care by pairing expectant and new mothers with our Maternal Child Health Workers now also trained as Indigenous Doulas. Care can start through out the journey of pregnancy and extend until age six or as needed. Enrollment for supports in our Maternal Child Health programs are voluntary, however we continue to see active engagement and commitment to our efforts. Care strategies by our workers have included: personalized education/resources on all matters through out pregnancy, delivery and in the postnatal and early childhood period, appointment reminders, travel supports, referrals to support services, advocacy and companionship. With the success of our recent training, Indigenous practices in pregnancy, birth and parenting can be part our holistic approach to care.

An unfortunate part of pregnancy is at times the loss of that pregnancy. With the training completed by our Maternal Child Health Home Visitor Lead / Doula our program as expanded to offer appropriate supports and referrals post loss that are led by mother/family. Researched appropriate care bundles to offer as comfort and healing have been gathered. Support is person centered and where desired led with an Indigenous focus. The additional training offered through the Dragon Fly Support Program has been an excellent resource.

In partnership with our nearest Health Authority, the Interlake Eastern Region we support their efforts through referrals to their own Indigenous Doula Caring Project, Giiwijw Bimo'se Maanan Nokoomagk Chi'Mino Bimadiziiyaang (Walking Towards the Good Life with The Grandmothers). Supporting the success and growth of this project along with our own allows us to combine resources, gather evidence and advocate for the use of Midwives/Doulas throughout our Province, Region and in the future our community. This advocacy work will aim to expand the opportunities to train local Indigenous individuals to train as Indigenous Doulas and be supported to bring those services to the communities they call home.

All training concluded to date has been Indigenous led and facilitated. Comprehensive planning is at all times done with input from Indigenous providers that includes; front line workers, health leadership, Chief and Council and respected community Elders. Please refer to the above-mentioned Indigenous Trainers listed in 1d regarding the implementation of our training to date.

One indicator of success to date is by the voluntary involvement by our target population in both past and present learning opportunities. This refers to not only participation in prenatal classes, land-based teaching sessions and grand parent gatherings but also engagement and understanding in their prenatal own care. Our Doula training and our Land Based teaching

sessions are well received and attendees continue to return when opportunity presents.

Outreach efforts by our frontline workers is work has both short- and long-term benefits and the consistency in outreach is proving to be beneficial in building relationships that helps facilitates lifelong learning. These front-line workers have taken their formal training and teachings by our Elders beyond group events into one on one visits to those that are on their caseload.

To further support program sustainability community providers and leaders will continue to advocate and enhance partnerships with our governing bodies at all levels. Advocating for the allocation of funds and resources to the appropriate communities where care can be effectively provided by the right provider in the right manner will promote the community's ability to achieve an excellence in care. This is deserving by all Manitobans but often overlooked to those living in rural, remote and First nation Communities. Providers and leaders in community continue to advocate for this when opportunity is provided. This advocacy has proven to be successful in Pinaymootang First Nation thus far.

Known and Anticipated Challenges:

- Educational Opportunities for training that are achievable and sustainable. Open spots to train Indigenous Midwifes that address more then enrollment in a program are imperative. Candidates need to be able to support themselves, and their families for the length of their program. Classroom learning strategies need to be explored to avoid learners having to relocate great distances and practical learning opportunities need to be welcomed by all facilities offering prenatal / delivery care.
- Confirmed employment opportunities in place and supported by each health authority beyond large urban centers with supportive measures promote success. In addition, to other providers that are committed to success need to be engaged in the process.
- Provider Training. At present beyond community providers there is often a lack of comprehensive education and understanding of the needs faced by Indigenous people related to health and health inequities. Establishing Midwifery Services is directly impacted by this. Health Authorities need for ALL health providers to be trained effectively in Indigenous matters specially those that impact holistic health and wellness. Efforts need to go beyond the understanding of Social Determinants of Health. This education must include commitment to understanding the Truth and Reconciliation: Calls to Action specifically those related to Health matters.

The dollars from this grant allowed for opportunities that would not have been provided otherwise. Pinaymootang First Nation is now home to ten Indigenous Doulas / Birth Helpers. Knowledge has also been gained and is ongoing for those employed in Maternal Child Health Programming. New programming opportunities are being developed to support the maternal population and families because of the training brought to community.

Land based teachings supported our own growth as providers but community members in attendance as well. Teachings from local elders was brought forward in our work plans that has proven to be consistently well received and beneficial with feed back from the Elders being positive.

It is the hope that our successes give us a platform to acquire further funds to continue in the efforts outlined in this report. Investment in Maternal Child Health can support the health of an entire family and community for a lifetime. Through this project and our advocacy efforts we will continue to have consistent quality care close to home and expand service opportunities. During this period a total of 12 doulas were trained.

Sincerely,

Kerri Nickel, Nurse Supervisor

Community Health Nurse Annual Report

Hello, my name is Maegan Anderson. For the past 4 years I have been employed as a Community Health Nurse at the Pinaymootang Health Centre. I also hold a casual nursing position within Lakeshore General Hospital.

My position allows me to provide safe compassionate care to our people but also, I am given the opportunity to work alongside an amazing group of people within the Health Centre and externally as well.

My current roles within the Health Centre include:

- Community Health
- Home and Community care visits
- Wound care
- Diabetes program – Chronic disease/Dietician referrals
- Animal Bites
- Tuberculosis (TB)
- Heart & Stroke Liaison

Being a community health nurse, I am able to ensure that the people of our community and surrounding communities are receiving the upmost respect and dignity, but most importantly receive quality medical care. Some of the medical services include bloodwork, dressing changes, assessments, medication administration, and health education.

Working alongside the Home and Community Care program I am able to provide these services in the homes of our elders. Our elders are the heart of this community and it is my duty as a nurse to provide safe, efficient patient-centered care to all who need it.

Working with the IERHA Chronic disease nurse and Dietician, I am able to send referrals for those who require assistance with the management and prevention of chronic conditions such as diabetes, hypertension (high blood pressure), etc.

The Chronic disease program aims to provide and maintain a high standard of management for patients with chronic diseases, which includes monitoring and development of individual plans that can help slow down the progression of the disease and/or help control the symptoms.

Monthly/Bi-monthly clinics are held within the Health Centre to help those who require/need the service of prevention or management of their chronic disease.

Animal bites – Assessing and treating any type of animal bite or contact to prevent human rabies and sending reports of suspected cases of exposure to Regional public health; Cleaning and disinfecting wounds; administering possible course of rabies vaccine and monitoring the animal.

Tuberculosis (TB) – caused by a bacterium called Mycobacterium tuberculosis, typically it attacks the lungs but can also attack other parts of the body such as kidneys, spine or brain.

Over the past few years I have been working with the University of Manitoba and Heart & Stroke to develop best practice guidelines to reflect the needs for prevention and rehabilitation, which allowed an opportunity for us to bring specialized equipment and services to the community

One of our goals was to have rehabilitation services easily and readily available to community members and with the collaboration from U of M, Heart & Stroke, Riverview Health we are pleased to say this goal has been met – A physiotherapist and rehab assistant will be coming into community for those who require such services.

In closing, I would like to say what a privilege it has been to work for my community, and I look forward to the years to come.

Statistics:

Home care visits	728	General Clinic visits	274
Referrals to CDN/Dietician	59	Phone calls for various concerns	560
Total encounters	1580		

Maegan Anderson LPN - Community Health Nurse

FROM THE FOOT CARE PROGRAM

Foot Care Nurse Annual Report

Hello Pinaymootang, my name is Brenda Henry, I am a Licensed Practical Nurse and have been employed at the Heath Centre as the Foot Care nurse since June 2019. In addition to my role here, I am also a community nurse in Winnipeg. My 20 years of nursing experience has focused on diabetic health and education, lower limb wound care, and preventative health education.

The services I provide at the health centre, and in community are:

- Nail care
- Basic foot and lower limb assessment
- Corn and callus reduction
- Client education on foot health and prevention measures to maintain healthy feet.
- Referrals to Community Nursing, Medical Specialists, and footwear fittings.
- Wound care

Our foot care program helps all community members. Foot Care is provided at the clinic, in community for people who have mobility issues, in hospital during extended stays and at long term care facilities. If you or one of your family members require foot care, please contact the health centre to arrange an appointment.

Each year the foot care program grows, and I am fortunate to meet more of our community members. Over the last five years I have been invited into elders' homes to provide foot care, but while I am there, I get to hear stories from their past, current update on their families, and share some of my own family's stories.

I attended the First Nations Health and Social Secretariat of Manitoba (FNHSSM) Foot Care and Diabetes Integration Program Conference in February 2024. The knowledge I gained from this conference will assist me as I care for our community members.

I continue to enjoy being a part of the Pinaymootang Health Centre team and look forward to the coming year.

Stats:

Home Visits	95	Hospital	20
Long Term Care	12	Clinic Visits	128
Total Visits	255 (Brenda)		
	15 (Nancy)	Total Foot Care Visits	270

FROM THE HEALTH REP

Community Health Representative 1 Annual Report

The Pinaymootang First Nation Health employs two Community Health Representatives who play a major role in the health program. Both CHRs currently oversee additional programs in their job duties, one focuses on school health, baby clinics and youth of the community. 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 done through Panorama and eChart for all children that need immunizations. Immunizations are updated and entered in their personal EMR charts. Panorama, eChart and Mustimuhw are used to get medical information for new families that have moved service area or are from a different band affiliation. Panorama and eChart are also used to search for newborn medical numbers.

MIMS updates are requested for Hep B's, Adacel, Gardasil, Meningococcal, influenza and regular immunizations for babes when they are, 2 months, 4 months, 6 months, 12 months, 18 months, 5 years and Grade 6. Immunizations are an ongoing task. Mustimuhw & Panorama which we constantly use to make sure that the child/ren do not receive repeat immunizations. Immunizations are then entered.

Flu vaccines were given to band members and non- band members in October, November, December and January, February. Charted and recorded in consent forms, personal charts (Mustimuhw), Panorama and in the Seasonal Influenza and Pneumococcal Immunization Data Entry form.

We have held numerous clinics held during this fiscal:

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 as CHR makes all appointment arrangements. Head checks were not done this year due to Covid restrictions.

Triage is done in clinic before patients see the community physician, by CHR, Health Care Aides, mostly by LPN 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, NNADAP, Nurses, Child Health Clinic's, Diabetic clinics, Blood Pressures, Workshops or as needed.

FROM THE CPNP

Canada Prenatal Nutrition Program Annual Report

The goals of the Canadian Prenatal Nutrition Program (CPNP) at Pinaymootang First Nation Health are to achieve optimal health outcomes for mothers and infants, to reduce the incidences of unhealthy birth experiences and to promote and support breast feeding efforts to those able.

This is accomplished with efforts made towards nutritional screening, education, counselling, pre- and postnatal nourishment, breast feeding promotion, education, support or referrals to additional care providers as needed.

There are six guiding principles that help us approach to program delivery:

1. Mothers and Babies First - the health and wellbeing of the mother and baby are most important in planning, developing and carrying out the program.
2. Care is consistently Equitable and Accessible - the program strives to meet the social, cultural and language needs of pregnant women and advocates for accessible and equitable care throughout our province.
3. Community-based - decision making and action in planning, designing, operating and evaluating the program comes from those in the program and involved community partnerships.
4. Strengthening and supporting families – acknowledge that all parts of society share the responsibility for children by supporting parents and families.
5. Partnerships - cooperative partnerships are the key to develop an effective program.
6. Flexibility - the program must be flexible to respond to the different needs in each community and to the changing needs and conditions of every woman.

CPNP has had the opportunity to engage in supports services the following ways:

- Nutrition counseling, prenatal vitamins, and milk coupons
- Referrals to mental health counseling in the prenatal / postnatal time period
- Breastfeeding education and support
- Food harvesting, preparation and storage
- Education and support on infant care and child development
- One on one relationship development with a support worker
- Prenatal Classes that focused on, nutrition, breast feeding, postpartum care, hospital preparedness, SIDS with a focus on relationship building with other expecting women.
- Comprehensive and holistic prenatal care, and

- Referrals to supportive programs such as Maternal Child Health, ASHOR and Jordans Principal

This past year, to increase success and participation in our outreach efforts, involved parties hosted events such as our prenatal series in a strategic manner. We sought out times that worked for participants, provided childcare as an option, supported transportation needs to events, offered nutritional food during sessions, had elder involvement, encouraged father/ partner involvement and resourced relatable resources that ensured needs were met.

Medical related care during pregnancy involves a great deal of planning and supportive actions. Bloodwork is done throughout the gestational time period by the nursing team, referrals for ultrasound and specialist visits are organized by the Prenatal Nurse, Healthy Baby Prenatal Benefit Applications are given and sent on the mother's behalf and expecting mothers are seen on a monthly basis by a Dr. Phoebe Thiessen.

Once a mother and baby have returned to their home a home a visit is arranged by the Public Health Nurse and along with the CPNP worker or an MCH Home Visitor postnatal assessments and ongoing care arrangements are made. At the time of these visits Welcome Home Packages to support newborn care and appropriate educational resources are given, immunization schedule reminders are also provided to families for reference.

Statistics:

Staff Encounters related to Prenatal / Postnatal care	421
Clients receiving care	58
New Community members born to Pinaymootang	19

Moving forward we commit to ongoing excellence in care to our prenatal and postnatal population. Ensuring we are a reliable source of information and support will be something that we continue to strive for.

The ongoing relationships that we have built with primary care providers has been something that has enhanced our program and something that we highly value. Being able to bring care closer to home, advocating for greater access to services and ensuring that the care received is culturally appropriate will continue to guide us.

As we embark on another year, we also look forward to working closely all of the programs available at the Health Center and our visiting professionals. Most importantly we will be there to look after the needs of our expecting families and the newest community members of Pinaymootang.

FROM THE HEALTH REP

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, the role of the 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.

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.

The CHR performs a broad range of duties in the community. Some of the 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 services.

Aboriginal Diabetes Initiative Report

The role of the ADI is to provide an integrated, coordinated diabetes program 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.
- Gardening Project

As many are aware, there 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.

We offer to our clients to:
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.

The Health Program has been very active in implementing the ADI Program.

FROM SUPPORT

Support to Nurses Annual Report

The role of support to nurses at the Pinaymootang Health Centre is Reception and Administration Support.

The main objective to ensure physical and mental health by assisting the professional staff of the Pinaymootang Health Centre, leading to the overall well-being of the members of our community.

The front desk reception organizes and maintains the functions of front desk duties. Also assists in various health departments of our organization when needed. The front desk ensures that every client's needs are being met, by directing them to the appropriate professionals such as doctor, pharmacist, nurse, or any one of our organizations program coordinators.

Pinaymootang is an accredited health facility and is a very fast paced environment with many different programming that ensures and promotes good health.

As the Administrative Support and Front Desk Receptionist my duties have included:

- Booking all appointments for Doctors, Foot care, Mental Health Therapists, and Telehealth
- Greeting & directing all incoming visitors
- Assisting the Doctor and Nursing staff with patient charting
- Storing pharmaceutical deliveries & distribution of prescription medications
- Correspondence with doctor/patient referrals
- Distributing & logging incoming and outgoing faxes/mail
- Help coordinate and organize specialty programming as instructed
- Preparing forms, documents, spread sheets
- Commitment to confidentiality

Throughout the past fiscal year, the number of **650** patients were seen by a visiting physician.

FROM OPERATIONS

Operations and Maintenance Report

The general duties conducted are general cleaning and sanitary services on a daily basis. Both interior and exterior cleaning of premises such as; carpets, furniture, windows, washrooms and floorings.

Removing of litter and garbage to the local landfill is done on a daily basis. The custodian ensures a high confidentiality level. Accurate cleaning is conducted throughout.

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 contract work.

The upkeep to the health facility has been a quite demanding and challenging throughout this fiscal year since the expansion of the Health Centre. During, physician days it is the most-busiest. The health facility as more than doubled its size with overcrowding of staffing which means a drastic workload for both custodian and maintenance.

This position can become quite challenging and we have taken many steps to improve the quality of cleaning.

The Operations and Maintenance personnel has made every effort to ensure the upkeep in good of its health facility in good working order.

Maintenance & Operations

FROM BRIGHTER FUTURES

Brighter Futures Initiative/Building Healthy Communities Annual Report

Hello, my name is Christina Sutherland; I am the coordinator for the Brighter Futures and Building Healthy Communities programs. The Brighter Futures Initiative Program is a community-based health promotion and ill-health prevention program. The program promotes health and prevents ill-health through learning-related activities that strive to increase awareness, change attitudes, build knowledge and enhance skills.

The Program Components:

- *Mental Health* - The goal of this component is to promote the development of healthy communities through community-based mental health programs, services and/or activities. Information and awareness activities on a variety of topics such as family violence, stress management, counseling services and wellness activities.
- *Child Development* - Aims to ensure that children receive the nurturing they need to reach their full potential.
- *Parenting* - The aim of this component is to promote culturally-sensitive parenting skills.
- *Injury Prevention* - The goal of this component is to prevent injuries. Examples of activities funded include first-aid and CPR training, water safety workshops, awareness campaigns and promotion.

The Building Healthy Communities program is designed to develop community-based approaches to youth solvent abuse and mental health crisis. The two main components of the program:

- *Solvent Abuse* - Enables communities to develop local programs aimed at preventing the abuse of solvents and to intervene as needed, which could involve residential treatment.
- *Mental Health Crisis Management* - Is designed to complement the mental health promotion and prevention activities of the Brighter Futures Initiative Program. It enables communities to respond to crisis, such as suicide, as well as to heal from them. It also enables communities to receive crisis-related training, such as suicide prevention training. The objective of the BFI/BHC program is to increase awareness in community mental health, child development, healthy babies, injury prevention and parenting skills; address the health problems affecting children and families in a community-based holistic approach, and support optimal health and social development of infants, toddlers, and pre-school aged children.

The BFI/BHC program works closely with our community network committee, recreation committee, community organizations and other Health Centre programs, providing a variety of different activities for the community members to participate in. The collaboration of the community organizations and Health Programs aids in providing successful and engaging activities and events throughout the year.

Activities throughout the year have included:

▸ Quilt Class	Feb 13-Apr 27, 2023
▸ Springfest, with Pinaymootang Recreation Committee	Apr 11-15, 2023
▸ Health Centre partnered with ACFS to host a breakfast	Apr 13, 2023
▸ Goose Hunt & Harvest, with Jordan's Principle Land-based Program	Apr 17-18, 2023
▸ Duck Hunt & Harvest, with Tim & Elissa, and JP Land-based	Apr 24-25, 2023
▸ 4-Week Ribbon Skirt Class partnering with ACFS-FE Program	May 3-24, 2023
▸ Pinaymootang Health Annual Fishing Derby	May 6, 2023
▸ Community Clean Up	May 18, 2023
▸ Mother's Day BBQ Celebration	May 15, 2023
▸ Community Wellness Week	May 29-Jun 2, 2023
▸ Bicycle Repair Workshop at the School	Jun 13-14, 2023
▸ Swimming Lessons	Jun 26-29, 2023
▸ World Elder Abuse Day, RCMP Presentation	Jun 15, 2023
▸ 2-night Wilderness Camp	Jul 7-9, 2023
▸ Lifejacket Loaner Program	
▸ Traditional Bush Medicine Teachings collaboration with MCH	Jul 25, 2023
▸ ATV Safety Workshop	Aug 9, 2023
▸ Pinaymootang Treaty Days	Aug 14-20, 2023
▸ Pinaymootang Health Fair	Aug 17, 2023
▸ Saskatoon Jam Making	Aug 23, 2023
▸ Back to School Dance, collaboration with the Network committee	Sep 5, 2023
▸ Staff Retreat	Sep 20-22, 2023
▸ Truth & Reconciliation Day Community Event / Every Child Matters Walk	
▸ PAL Gun Safety Certification Course JP-LANDBASED	
▸ Cranberry Canning, with NADAP	Oct 5, 2023
▸ PAL Safety Certification Course collaboration with JP-LANDBASED	Oct 13, 2023
▸ 4-week Prenatal Classes with MCH & ACFS	Oct 19-Nov 9, 2023
▸ Pinaymootang INFO-Session	Oct 24, 2023
▸ ASIST Training	Nov 9-10, 2023
▸ National Addictions Awareness Week	Nov 20-22, 2023
▸ Colouring Contest with Pinaymootang School & SCO	Nov 22, 2023
▸ Wills & Power of Attorney in connection with Elder Abuse	Nov 20, 2023
▸ 4-week Language Classes	Nov 20-Dec 11 2023
▸ Women's Groups with ACFS-FE	Nov 23, 2023

► Christmas Wreath Workshop, with AIDE Program and ACFS-FE	Dec 6, 2023
► Women's Groups	Nov 23-Dec 7, 2023
► Treaty Timeline Presentation	Dec 4, 2023
► 6-Week Anishinaabemowin Class with moccasin-making	Jan 22-Mar 11, 2024
► Nobody's Perfect Parenting training	Jan 11-16, 2024
► 6-Week Anishinaabemowin Class with moccasin-making	Jan 22-Mar 11, 2024
► Women's Group	Feb 15, 2024
► Ice Fishing Derby	Feb 19, 2024
► Valentine's Day Dance	Feb 14, 2024
► 6-Week Anishinaabemowin Class with moccasin-making	Jan 22-Mar 11, 2024
► Network Meeting (ACFS)	Mar 4, 2024
► Generations of Healing Gathering (Elder's Gathering)	
► Winter Fest	Mar 6-9, 2024

Christina Sutherland – BFI/BHC Coordinator

FROM NADAP

Native and Alcohol Drug Abuse Program Annual Report

The Native Alcohol and Drug Abuse Program (NADAP) is one the longest funded program in First Nations communities across Canada. June 19, 2024 will mark the 22 years I have provided my specialized NADAP services to our community. I started in 1988 to 1992 and again from 2006 to the present. I enjoy working in this program and seeing clients succeed in their journey to be free from alcohol and drug abuse lifestyles.

Originally the NADAP Program started in December 1974 as a pilot project to implement and "to support First Nation communities to design and operate programs in the areas of alcohol abuse prevention, treatment and rehabilitation and to reduce the negative physical, mental, social and economic trends occurring on reserves". The programs were to be specific in providing preventative and maintenance models. These were to include activities in alcohol and drug abuse prevention by providing paraprofessional counselling focusing on social and cultural rehabilitation, advocating, educating on either a community wide or on individual basis.

People succeed depending on how much effort they put into becoming addiction free, and enjoying a sober, healthy lifestyle. The decision to be free from an addiction lifestyle has to be made by the person from within. The counselling provides guidance for the clientele who are willing to change. They are encouraged to participate in many events held in the community.

The following list are some of the activities through addictions and land based that have been provided in the community from April 1, 2023 to period ending March 31, 2024:

- Quilt and Sewing Classes (Open to male & female)
- Goose Hunt and Harvest (Land Based Programming)
- Community Clean Up (Taking Pride in our Community)
- Community Wellness Week (Extensive planning and holding events for the community)
- World Elder Abuse Day (RCMP presentation)
- Two-night Wilderness Camping (Open to Youth for Survival Training – Land Based)
- Pinaymootang Health Fair (Awareness & Prevention)
- Dr. Lana Potts Presentation (Aboriginal Health & Alcohol & Drug Abuse)
- Saskatoon Jam making (Teaching & Sharing – Land Based)
- Cranberry Jam Making (Teaching & Sharing – Land Based)
- Truth and Reconciliation Community Event (Every Child Matters Walk)
- Aboriginal History Time Line with Allen Sutherland (Understanding our Paths)
- Generations of Healing Gathering (Healing from the Past)

These events were also open to clientele from Probation Services and Justice Services. However, participation has been low and hopefully the numbers will increase through this information and clientele will attend future events. Our partnership with other programs at the Pinaymootang Health Centre is consistent and valuable.

The following are the numbers for the data collection:

Month	Number of clients	Events	Referrals
April	21		4
May	15	DR. POTTS - 185	6
June	14	WELLNESS CAMP - 180	2
July	15		
August	28	HEALTH FAIR - 325	4
September	26		8
October	26		9
November	15	ADDICTIONS WEEK - 189	
December	3		
January	5		2
February	3		2
March	3	GENERATIONS OF HEALING - 101	
Totals	174	980	37

Yours sincerely,

Alvin Thompson CAC II BSW RSW

FROM TRANSPORTATION

Medical Transportation Annual Report

Hello, my name is Margaret Anderson and I am the 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, one Medical Transportation Assistant and four Medical Driver Personnel.

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:

- To the nearest appropriate facility;
- The most economical and practical means of transportation considering clients condition;
- The use of scheduled coordinated transportation;
- Medical transportation in a non-emergency situation has been prior approved by Coordinator based on eligibility; and
- 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: 2023 – 2024	Recipient: Pinaymootang First Nation	
April 1 – August 31	Contribution Agreement: MB0700072	
# of requests:	# of exceptions requested:	# of appeals:
1092	6	0
# of requests approved:	# of exceptions approved:	# of favorable appeals:
		0

How are the benefits being provided?
One full time/part time Medical Transportation Coordination is currently on hand to provide and assist clientele of appointments bookings, coordinating of transportation and acting as a supervisory capacity to the assistant and the medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow. On-call is often hired when needed.

We provide transport to nearest open facility available

Major accomplishments in the program during the reporting period:
Provided additional PPE to medical vans. The increase in services are slowly opening and vaccinations are being available to front line workers including those that are most vulnerable such as our dialysis clients.

The Medical Transportation private travel has increased.

Major challenges in delivering the program during this reporting period:
We have 6 dialysis clients of which are attending dialysis three times per week Monday-Wednesday-Friday and 3 clients that are every Tuesday-Thursday-Saturday at the Lakeshore General Hospital in Ashern, MB.

The increase in prenatal care, we provide travel at 38 weeks we also provide for high risk pregnancies.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have also diagnosed cancer patients these patients need to attend their treatment via private travel due to compromised immune systems.

Increased and continue safety practices such as disinfecting and supplying and equipment vehicles with continued PPE such as face masks, gloves and sanitizers continues to be on-going.

Medical transportation is picking up discharge clients at various locations within the Interlake such as Eriksdale, Hodgson, Stonewall, St. Rose, Dauphin and Arborg.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7-hour basis, due to many transfers, discharges, or emergency transport services.

Identify the factor (s) that may be impacting the budget:
Increase, in physician travel due to increase in much service from one to two days a week in order to prevent extended trips to Winnipeg, Ashern, Dauphin, Selkirk and Brandon.

The cost of fuel.

Repairs and Maintenance.

Other relevant observations, comments or information to this program:
The need for a FNIHB handbook is required to help clients understand the processes in 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. The program does have this available on its website page, but not everyone utilizes this.

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: 2023 – 2024	Recipient: Pinaymootang First Nation	
Sept 1 – November 30	Contribution Agreement: MB0700072	
# of requests:	# of exceptions requested:	# of appeals:
827	8	0
# of requests approved:	# of exceptions approved:	# of favorable appeals:
835		0

How are the benefits being provided?
One full time and one part time Medical Transportation Coordination is currently on hand to provide and assist clientele of appointments bookings, coordinating of transportation and acting as a supervisory capacity to the assistant and the medical driver personnel currently employed with the First Nation Health Program.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow. On-call is often hired when needed.

We provide transport to nearest open facility available.

Major accomplishments in the program during the reporting period:
Submission of criminal records check, to move into the MTRS system that will help improve reporting criteria.

Pinaymootang FN Health now has access to coordinate hotel stays throughout the NIHB listing. We continue to provide additional PPE to medical vans.

Major challenges in delivering the program during this reporting period:
We have 4 dialysis clients of which are attending dialysis three times per week Monday-Wednesday-Friday and 3 clients that are every Tuesday-Thursday-Saturday at the Lakeshore General Hospital in Ashern, MB.

There is an increase in prenatal care this fiscal year and the program does provide travel at 38 weeks including those who are considered high-risk pregnancy.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have also seen an increase in diagnosed cancer patients. These patients need to attend their treatment and travel by private travel due to their compromised immune system including those with severe wound care complications due to diabetes.

Pinaymootang continues to increase its safety protocol practices such as disinfecting and supplying and equipment vehicles with PPE such as face masks, gloves and sanitizers.

Medical transportation is picking up discharge clients at various locations within the Interlake such as Eriksdale, Hodgson, Stonewall, St. Rose, Dauphin and Arborg.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7-hour basis, due to many transfers, discharges, or emergency transport services. One of the areas we are also facing is the hospital-to-hospital transfers of our clients, especially our dialysis clients who are hospitalized away from their dialyzing site. This is also due to the EMS shortage, not enough hospital beds, lack of staffing in our hospitals and so on.

Identify the factor (s) that may be impacting the budget:
Many hospitals and physician care are slowly catching up in surgeries or appointments. We have seen an increase in heart and stroke clients and increase in cancer care clients.

The cost of fuel in this reporting period.

Repairs and Maintenance have increased due to transport vehicles reaching a certain mileage.

Other relevant observations, comments or information to this program:
The need for an FNIHB book is required to help 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 booklet to hand out as to how decisions are decided. The program does have this available on its website page, but not everyone utilizes this.

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: 2023 – 2024	Recipient: Pinaymootang First Nation	
Dec 1 – Mar 31	Contribution Agreement: MB0700072	
# of requests:	# of exceptions requested:	# of appeals:
875	12	0
# of requests approved:	# of exceptions approved:	# of favorable appeals:
		0

How are the benefits being provided?
One full time/part time Medical Transportation Coordination is currently on hand to provide and assist clientele of appointments bookings, coordinating of transportation and acting as a supervisory capacity to the assistant and the medical drivers currently employed with the First Nation.

Currently employed are 3.5 full time drivers transporting clients to appointments. Each driver works on a rotating basis and are provided with a monthly schedule they are required to follow. On-call is often hired when needed.

4 Vans in use
- Winnipeg – Daily
- Ashern Destinations – Multiple times a day
- Dialysis – 6 days a week 4 trips a day to Ashern
- On-call – 24/7 plus additional appointment to non-Winnipeg destinations

We provide transport to nearest open facility available

Major accomplishments in the program during the reporting period:
Provided additional PPE to medical vans. The increase in services are slowly opening and vaccinations are being available to front line workers including those that are most vulnerable such as our dialysis clients.

Major challenges in delivering the program during this reporting period:
We have 4 dialysis clients of which are attending dialysis three times per week Monday-Wednesday-Friday and 3 clients that are every Tuesday-Thursday-Saturday at the Lakeshore General Hospital in Ashern, MB.

The increase in prenatal care, we provide travel at 38 weeks we also provide for high risk pregnancies.

The major challenges we are currently facing during this reporting period are letters from Physicians that are requested by clients to receive private travel. These letters are not honored. I have taken the initiative to contact these Physicians advising them of our policies and procedures regarding private transportation.

We have diagnosed cancer patients, that need to attend their treatment via private dravel due to compromised immune systems.

Increased and continue safety practices such as disinfecting and supplying and equipment vehicles with continued PPE such as face masks, gloves and sanitizers continues to be on-going.

Medical transportation is picking up discharge clients at various locations within the Interlake such as Eriksdale, Hodgson, Stonewall, St. Rose, Dauphin and Arborg.

Transport coordination continues to be a huge challenge in this fiscal period. Medical Transportation has been on-call to provide services on a 24/7-hour basis, due to many transfers, discharges, or emergency transport services.

Identify the factor (s) that may be impacting the budget:
Increase, in physician travel due to increase in much service from one to two days a week in order to prevent extended trips to Winnipeg, Ashern, Dauphin, Selkirk and Brandon.

Late night discharges; impacts staffing and follow up care.

Complex medical needs from community are increasing.

The cost of fuel.

Repairs and Maintenance.

Private Travel/increased need and requests.

Hotel Accommodation booking and confirmations.

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 booklet to hand out as

to how decisions are decided. The program does have this available on its website page, but not everyone utilizes this.

Submitted by,

Maggie Anderson
Medical Transportation Coordinator

FROM THE HOME

Home and Community Care Annual Report

Hello, my name is Nancy Friesen. I am the Home and Community Care Nurse Supervisor. It is truly an honor to work within the Pinaymootang First Nation and be a part of this dedicated health team! Pinaymootang Home and Community Care staff are devoted to meeting the growing needs of our clients, and community. Our Team consists of 1 full time Nurse Supervisor, 1 LPN part time, and 3 full time Health Care Aides.

The Home and Community Care goal is to assist with maintaining optimal health and mental wellness in home and community. Serving clients living with chronic disease, acute illness, and supporting clients with disability. With assistance, our goals are to preserve and maximize the ability of the client to remain as safe and as independent as possible. Our program is not to replace, but to enhance the care already provided by family members.

Along with the Home Care Program, assistance is often needed with clinic assessments, immunization clinics, visiting professionals, and other external programs and services offered in Community. As a health care team, we strive to provide holistic client centered care to optimize and improve outcomes.

The Home and Community Care Program consists of the services listed below.

Nursing Services:

- Nursing Process; assessment, diagnosis, planning, implementation, evaluation of care.
- Vital Signs include blood pressure, pulse, temperatures, blood sugars and oxygen levels.
- Phlebotomy services, and monitoring results
- Medication administration and monitoring
- Wound Care/Foot Care
- Physical Assessment and Health Education
- Communication and referrals to appropriate Healthcare providers and Specialists.
- Client Care plans and Medication reviews
- Patient advocacy and discharge planning/Lakeshore General Hospital Rounds, Ashern, Tuesday's/EM Crowe Hospital Rounds, Eriksdale, Wednesday's weekly
- Patient advocacy and discharge planning/
- Assistance with the Long-Term Care application process

Personal Care:

- Health Care Aides provide support assisting with activities of daily living.
- Obtaining vital signs/reporting readings to Nurse supervisor

Medical Supplies and Equipment:

- Assessment of client specific needs and ordering equipment to provide a safe home environment, as well as safe client mobility.
- Ordering, assembly, and delivery of safety equipment
- OT/PT outpatient referrals

Home Management/Homemaking Services:

- This is a Pinaymootang First Nation Social Services program; assessments are completed by the Nurse at request of the client and submitted to the social program at the Band Office for further consideration and approval.

In Home Respite:

- Depending on available staff resources, Health Care Aides may be scheduled for a specific time, or at periodic intervals to stay with a client during the time that a caregiver may be away. A request must be submitted in advance to ensure the adequate staff resources are available.

Palliative Care:

- Programing is funded by Health Canada.
- Designed to allow a client to have the resources and support needed for end-of-life care in the comfort of their own home.
- Nurse and Certified Health Care Aides along with a family support system, provide the family with assistance caring for their loved ones at home.

Footcare:

- Home and Community Care in collaboration with the Aboriginal Diabetes Initiative program, offers Foot Care on a biweekly basis by Primary foot care nurse Brenda Henry. Secondary foot care nurse, Nancy Friesen provides foot care assistance when Brenda is not in Community. Foot Care appointments can be made by calling reception at the Health Centre.

Statistics:

Foot Care Services Provided Fiscal Year 2023/2024

Nurse	**Encounters**
Brenda Henry	255
Nancy Friesen	15

Home & Community Care Staff and Fiscal Year April 1, 2023, to March 31, 2024, Encounters
(Encounters include Transportation, Medication delivery, Charting, Establishing Linkages/Liaison, Safety equipment, Consultation, and Hospital discharge planning)

Nancy Friesen	1989	Clinic Encounters <not included in Total>	<276>
Maegan Anderson	1115	Clinic Encounters <not included in Total>	<465>
Various Clinic/Footcare Nurses	300		
Dorothy Sumner	1149		
Jody Sinclair	1580		
Lucille Ross	1286		
Total Fiscal Year Encounters All Staff	7419		

Home & Community Care Direct Service Care Summary (*Direct service care includes assistance with ADLs such as bathing, dressing, medication administration, and all Nursing treatments)*

Month	Active Clients	Homecare Visits	Hours of Service
April 2023	61	295	243.50
May 2023	68	437	395.00
June 2023	74	391	363.25
July 2023	67	316	295.25
August 2023	69	321	288.00
September 2023	70	237	227.00
October 2023	71	271	238.75
November 2023	71	269	262.75
December 2023	81	251	264.00
January 2024	58	272	244.50
February 2024	69	286	256.25
March 2024	71	291	444.75
TOTALS		3637.00 VISITS	3523.00 HOURS

Total Homecare Clients within Reporting Period

Client Summary

Number of Active Clients*	158
Number of Unique Homecare Clients	166

**Client may not be enrolled in Homecare but has received Homecare service encounter*

Description of Training/Meetings/Conferences in the 2023/2024 Fiscal Year:

- Accreditation Film Production
- Foot Care Conference
- Physiotherapy Planning with Riverview Health, University of Manitoba, and Heart and Stroke

- Equipment and Building Preparations for Physiotherapy Space
- Elder Abuse Awareness Walk and Presentation
- Treaty Days Health Fair and Breakfast
- Knowledge & Skills Enhancement Competency Program Immunizations
- Heart & Stroke CPR Training
- FNHMA Conference
- TCIHCC Education/Elder Safety, Mental Health, Ageing Out Occupational Therapy, Wound Care, Foot Care and Traditional Medicine Teaching
- Elder Clinic/Power of Attorney, Health Care Directives and Wills
- Mustimuhw DCI Meeting
- Elder Christmas Come and Go Tea
- Work Plan 2024/2025
- Manager Meeting February 2024 Winnipeg, MB
- FNHSSM Foot Care Conference
- Elder Gathering/Generations of Health
- Quarterly TCIHCC Meetings (Tribal Council and Independent Home & Community Care)
- Lakeshore General Hospital Doctors Rounds/Discharge Planning Tuesdays
- EM Crowe Memorial Hospital Doctors Rounds/Discharge Planning Wednesdays
- Professional Development Planning and Proposal 2024/2025
- Procurement of Physiotherapy Equipment and Supplies as well as Physiotherapy space preparation and Maintenance.

Our Pinaymootang First Nation Health Care team works in collaboration to ensure that each client receives the advocacy and treatment that is specific to their needs.

Thank you!

Nancy Friesen – HCC Nurse Supervisor

FROM THE HOME



Home and Community Care Health Care Aide Annual Report

Hello/Aniin, from the Home and Community Care Program. Reporting for the annual year 2023 – 2024. Our health care aide group wo rks well together as a team.

In our program, there are three HCA's; Dot Sumner, Jody Sinclair and Lucille Ross. We are supervised and guided by the Home & Community Care Coordinator.

As health care aides, we have great respect and honor to help assist our elderly, people living with acute/chronic conditions and individuals with exceptionalities. We will continue to be hard-working, providing care to our Home Care clients and community members.

The Home and Community Care Purposes:

- To provide community care and support to a number of people: in which includes elders and community members with short-term and/or long-term medical conditions and persons with exceptionalities.
- To assist with client care in the home after a hospital discharge.
- To enable clients to remain in their own homes as healthy and independent for as long as safe as possible to delay and prevent admission to a health facility.
- Promoting dignity, independence, preferences, privacy and safety at all times when in the client's home.

Supportive Care:

- Support is provided to various clients according to client's care plan.
- In home assistance is provided for clients after hospital discharge.
- Assist clients with activities of daily living such as bathing, grooming and dressing.
- Refer clients to the foot care nurse.
- Assist with range of motion exercises.
- Home visits are done to monitor client's vital signs in which are checking blood pressure, blood sugars, oxygen levels, respiration and temperatures.
- We provide mobility aides including mechanical beds, safety bed rails, grab bars, commodes, bathing equipment, wheelchairs, canes, walkers and reach extenders to meet the client's needs. We also deliver incontinence products to the 60+ age group, to persons with exceptionalities and to community members who were discharged from hospital.
- Medication delivery is provided for elders in the program.
- One staff member of our HCA team is fluent in the Ojibway language and one of the other HCA staff can understand most Ojibway language when spoken by an elderly person.

Recording and Reporting:

- Each home visit is documented.
- Any concerns are reported to the Home Care Supervisor.
- Initiate client referrals to the Home Care supervisor or refer client to appropriate program area.

Activities:

Community clean up, Elder Abuse Awareness Day Walk/Ride, Annual PFN Treaty Day Health Fair, Health Centre Treaty Day Breakfast, Health Fair at Conference Centre (October 2024), CPP/ Life Inc., Life Insurance Information Session, Wills & Power of Attorneys Information Session and Generations of Healing Gathering (for elders age 60+) at the PFN Conference Centre.

Workshops/Training:

PFN Jordan's Principle Leadership Training Skills (by Zoom), CPP/Life Inc. Life Insurance Information session, Wills & Power of Attorney Workshop, A.S.I.S.T Training (Conference Centre) and a Home & Community Care Educational Gathering Workshop (at Canad Inns – Polo Park Winnipeg).

Statistics:

	Home Visits, H.C Visits & Phone Calls	Baths	Med/Equipment Deliveries/ Transportation	Charting Time	Total
Dot	234	133	209	573	1149
Jody	306	98	428	748	1580
Lucille	262	88	298	638	1286

FROM AHSOR

Aboriginal Head Start Outreach Program Annual Report

Hello everyone! My name is Cherish Sumner. I am the Aboriginal Head Start On-Reserve Home Visitor Coordinator with Pinaymootang Health. My journey began in September of 2017 as the front desk receptionist. I transitioned on to working as the AHSOR Coordinator. As of August 2023, I am a fully certified Early Childhood Educator Level II – after completing full-time studies and receiving my diploma from Robertson College.

The AHSOR program focuses on six main components: Culture and Language, Education and School Readiness, Health Promotion, Nutrition, Social Support, and Parental and Family Involvement. Each component is directed by allowing them to experience each area through home visits, playgroups, day trips, or through the online learning experiences with the Aboriginal Head Start On-Reserve social media posts - as a curriculum-based learning experience with their families (posts that are interactive through the social media page that was created in March of 2021 due to the Covid-19 pandemic).

The AHSOR program strives on having children reach their full potential in life. From the age range of 0-5, this is the time frame of when a child learns the most during their early years. Their brains are still growing after birth and they are making the most neural connections than at any other age in their lifetime. These neural connections are what build the areas of cognitive development, language development, social/emotional development, and physical development. By ensuring that we are helping children be school ready through home visits and group programming, this is what drives me to do what I love to do.

Home visits consist of the Aboriginal Head Start On-Reserve outreach worker to visit the children and parents in the comfort of their home, and conduct a survey called the “Ages and Stages Questionnaire”, which is to be completed by both the parent/caregiver and myself by interacting and engaging with the child – through interacting with the children during the survey. The Ages and Stages Questionnaire’s have a charting system that allows us to see where the children are within the 5 domains of child development and what resources can be offered if needed. Aside from home visits, we engage in playgroups and family programming that includes things such as day trips, playgroups, cooking, and parental information sessions.

The AHSOR program is associated with the Dolly Parton Imagination Library. This is a free book program that mails books to children from birth until their 5th birthday. To date we have 119 children who receive books in the mail from the Dollywood Foundation every month.

It has been an exciting journey to be able to work with such amazing families and wonderful children within our community and I look forward to what the future has in store for our future generations. Thank you for allowing me to be a part of it.

Ages and Stages Questionnaire's	337
Referrals	11
Encounters	389

Respectfully,

Cherish Sumner - AHSOR Coordinator

FROM JORDAN'S PRINCIPLE

My Child, My Heart Program (On) Annual Report

The Pinaymootang Jordan's Principle Niniijaanis Nide Program (My Child, My Heart) continues to evolve as time passes. Jordan's Principle was initially conceived as a child-first principle designed to ensure that First Nation children did not experience denials, delays, or disruptions of needed services as a result of jurisdictional disputes between governments. Over time Jordan's Principle was expanded in order to address gaps in services. We continue to identify the challenges in the complicated patchwork of services, because it conveys the potential for gaps and inequities. We find new ways of working with all our encounters. Change can be challenging but can also be a good thing. We continue to expand in our numbers, therefore we try and create new ways of programming to meet the ever-changing needs of all our children/families.

The back to basic approach has been very demanding with numerous requests on a daily basis from our families. The various requests range from food, furniture, bill payments, vehicle repairs and electronics, etc. We have been trying to put in place basic guidelines on how we determine and submit all the requests that have been coming in. The workers have been assessing the request during home visits. The Jordan's Principle team exercise compassion, common sense, and a reconciliation-first approach when receiving, processing and determining requests.

The Niniijaanis Nide (My Child, My Heart) Program staffing consists at this time of 5 Child Development Workers positions, 1 ASL educator/Youth Transition Coordinator, 1 Land based Coordinator, 1 School Coordinator/Rehabilitation Assistant, 1 Administrative Assistant, 1 Intake Workers, 1 Assistant Case Manager and 1 Case Manager.

The Case Manager and Assistant Case Managers duties consist of but are not limited to, completing Focal Points to cover costs of Orthodontic services, Dental services, prescriptions, home modifications, and other miscellaneous request costs not covered by Treaty Status. These financial requests continue to come in on a regular basis and I do not foresee the requests slowing down. The Case Manager and Assistant Case Manager are also responsible for all intakes, assessments and outgoing referrals. The Case Manager's duty is to manage the Members of the Multidisciplinary team and the operational needs of the program. The Case Manager's duties also consist of ensuring that all the children/family's needs are being met in a timely manner. The Case Manager's liaises with all other Community Programs to ensure a continuity of care for children and their families and avoid duplication of services.

The Team has been working hard on following a Multidisciplinary model of practice and believe they are now seeing the benefits of working from this perspective. The multidisciplinary teams' goal is to provide the most comprehensive care possible. At the right place and time for each participant. They do so by utilizing effective communication and coordination through our weekly team meeting and daily interactions. We are utilizing an assertive approach with the participants in our program, in that we are bringing our services to the participants verses them having to come to us.

During this reporting period we have provided services and resources to 350 plus children and their families utilizing land based and culturally relevant programming that reflects the community's beliefs. These numbers will be higher if we were to include closed or transferred files. We continue to be creative in our approach to reaching participants in our program by using many approaches that may include out-of-town trips, working with other steak-holders, Microsoft teams and phone check-ins, and these approaches boosted our numbers in reaching our children/families. Our programming was developed to encompass a holistic approach and address the Mental, physical, emotional and spiritual needs of our children and families.

We have now added an Intake Worker who covers a lot of our ever-demanding increase in client numbers. The Intake Worker adds our new intakes and completes all information and forms needed. The Intake Worker schedules home visits to meet with the child and family. Once complete they compile information, submit requests and referrals as needed. The Intake Worker works closely with the Case Manager and others within our facility.

Our Child Development workers carry a caseload of 70 plus children, with the numbers increasing on a weekly basis. They work with the Case Manager, Parents, Teachers, School Coordinator, and the visiting Professionals to help identify the children's strengths and needs. They are responsible for doing regular check ins with the children and their families to ensure that all needs are being met in a timely manner. It is strongly encouraged that the workers do home visits and provide services and supports in the home environment. It is imperative that the time is put in to build strong trusting relationships so that families are comfortable with the home-based supports. The Child Development workers also do programs after school and during the day in the summer months.

Our Transition Worker also carries a caseload of children aged 13 plus and she is ensuring that programming to promote transitioning to adulthood is available to all in that targeted group. She also carries the role of our ASL Educator and can deliver those services on an as needed basis and in a 1:1 setting to accommodate any given family situation. The Transition worker receives a lot of requests from families for Back to Basic needs therefore, ensuring all needs are being met in a timely manner.

Our Land-Based Coordinator is working on ensuring that he has programming available to our children and families that supports reconciliation and promotes a sense of community to improve mental, physical, and spiritual wellness. We continue to seek out learning opportunities for our Land based Coordinator to grow in his role. We acknowledge that Land-Based activities empower people by developing a connection to the land and giving tools to protect and fight for it. Our goal is that our Land Based program will develop and deliver programing that is guided by the seasons and that traditionally occurred on the land.

We as a program feel the Traditional language of the First Nations people residing in this community is integral to all of the programming we deliver. Our goal is to ensure that we reach out to Elders in the community who have the gift of the language and provide opportunities for them to share this gift with our children and families. An example of this would be a week-long language immersion camp to be held at Our Wellness camp located by the river. Other examples of how we plan to incorporate Language into our programming is to have an Elder who speaks the language join us during our schedules programs and there they can share the gift of language with participants in the Program. We feel that this interaction would be also beneficial to our Elders by sharing their gifts with the community.

We have been collaborating with the school system. The Child development Workers, work with the children on their caseload providing 1:1 support as needed and as identified by the classroom Teacher/Resource department. We have our School Coordinator in the school that acts as a liaison between the Teachers, School Resource Workers, Parents, Child Development Workers and Case Manager to ensure that no child falls through the cracks and agreed upon services are being delivered. Our program has increased drastically as more children are being seen and being diagnosed, to date we have 350 children enrolled in the program with weekly intakes occurring. We continue to provide supports with specialized services. Specialized services are increasing their visits to the community to accommodate the high needs for SLP, OT and PT. Our Rehabilitation Assistant works very closely with Specialized Services and ensures that all recommended treatment plans are followed up on between community visits from the Specialists. Our Rehabilitation Assistant works closely with our Child Development workers to ensure that they are aware of the plans put forward by the OT, PT and SLP and able to provide adequate support to the families.

As a program we are committed to ensuring our staff receive quality training opportunities to increase their competences in working with the children and families enrolled in the Jordan's Principle Program. We have received training through Seven Feathers consulting on Jordan's Principle Leadership training. There have been other numerous opportunities that have been presented and have been beneficial in increasing our teams' skills. We have been fortunate to work with a Team of Occupational Therapists, Physiotherapists, Speech and Language Therapists who are willing to, and have provided relevant learning opportunities to our team to ensure a continuity of care.

We recently received a new Jordan's Principle activity building. This space will allow us to increase our programming. We look forward to creating a strong Land Based program we will achieve this by investing in training and learning opportunities for our Land Based Educator. We feel a need to increase the Traditional language component into all of our programming, which we will have the opportunity to do with our fluent speaking Land Based knowledge keeper. We will also achieve this by continuing to engage and seek out Elders in our home community who are willing to share their gift during our outings/programming.

We as a program are committed to and honored that we have been given the opportunity to deliver consistent culturally relevant programing to the children and families in Pinaymootang first Nation.

FROM JORDAN'S PRINCIPLE

My Child, My Heart Program (Off) Annual Report

The Jordan's Principle Niniijaanis Nide (My Child, My Heart) Program (est. 2015) of Pinaymootang First Nation has added an extension and expansion of services for our children that live OFF-RESERVE within the Province of Manitoba effective April 2023.

"Our traditional beliefs are "children a gift from the Creator", and for all children, we have a moral and legal obligation and responsibility to care for our children.

Children have a right to feel protected, to be connected to family and to community. They have a right to health, safety and well-being and to be respected when decisions about life are made on their behalf."

Our Jordan's Principle OFF – RESERVE Program had a grand opening for our new sub-office in Winnipeg in April 2024. Located at **UNIT 2 – 1761 WELLINGTON AVENUE – PHONE: 204-691-5786**.

The Jordan's Principle Social Services Coordination for OFF-RESERVE children/families is quite challenging due to demographics. We serve children/families that live in the City of Winnipeg, The PAS, Brandon, Portage La Prairie, Selkirk, Teulon, Niverville, Strathclair, La Broquerie, Ashern, Moosehorn and Wabowden. As demand increases for children being registered in our OFF-RESERVE, the service areas will increase.

From April 2023 to March 31/24, we served **286** children and their families.

The service model is uniquely different from ON-RESERVE Services. Our roles include advocacy with Employment & Income Assistance Program, Manitoba Housing, private landlords, Manitoba Hydro, Winnipeg Water & Waste Department, Indigenous Services, First Nations and Inuit Health Branch, Mental Health Services, Schools, Southern Chief's Organization, AMC, Children's Hospital, Rural Hospitals/Health units, other First Nation communities to ensure we provide service as part of best practice.

In addition, we seek resources for children/families as per request on their behalf for recreational programming, cultural programs in the City of Winnipeg.

Each family's unique situation is assessed, and all participants must be registered in the program. We assist with the following on a Back to Basics, basis:

- Rent
- Utilities
- Food Security
- Transportation
- Clothing
- Furniture

Cultural, medical, and educational needs are also essential services that are needed to ensure the health and well-being of our children and families.

The need is greater for back to basics off reserve due to the high cost of living in Winnipeg and rural areas. Our team works diligently with each family, and we strive to provide satisfactory services for every child.

Our Jordan's Principle OFF-RESERVE Staff:

- Sherri Shorting – Case Manager
- Kathy Hebert – Case Manager
- Cecile Sanderson – Rural Case Manager
- Barbara Sinclair – Intake Worker
- Stefani Traverse – Social Service Coordination Clerk/Administrative Support

The Team has been working hard on following a Multidisciplinary model of practice and I believe they are now seeing the benefits of working from this perspective. The multidisciplinary care teams' goal is to provide the most comprehensive care possible. At the right place and the time for each participant. They do so by utilizing effective communication and coordination through our weekly team meeting and daily interactions. We are utilizing an assertive approach with the participants in our program in that we are bringing our services to the participants versus them having to come to us.

We are committed to ensuring our staff receive quality training opportunities to increase their competences in working with the children and families enrolled in the Jordan's Principle Program. We will continue to grow and build our dynamics by connecting with other programs, medical professionals, and child educators, to ensure the care and security of our children. As we continue to grow, our team will continue to strive by delivering services that apply to each child and their unique circumstances. Under Jordan's Principle, we are ensuring that our children can access the products, services and supports they need, when they need them.

In closure, on behalf of our Jordan's Principle OFF-RESERVE Program, as we increase capacity in services, we are committed to increasing services that deliver comprehensive, consistent community culturally based resources in accordance with community beliefs and practices.

Sincerely,

Sherri Shorting – Case Manager

FROM THE DWSP

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 Kiran Sidhu, 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 town site pump houses.
- Community awareness by way of newsletter information;
- Boil water advisories;
- Well Chlorination;
- Provide Food Safety Course (Food Handlers) to community

Microbiological testing on water samples collected is tested for Total Coli Forms and Escherichia Coli (E-Coli) and is done within the Health Centre. The test detects bacteria in the water sample by using a Coli-sure agent which is provided by FNIHB. The testing process takes 24-28 hours in an incubator with a set temperature at 35 Celsius. After a minimum of 24 hours in the incubator, samples are taken out and results are documented.

Please note: water samples are lower this year due to transfer of old waters system to the new system.

FROM THE AIDE PROGRAM

Adults with Intellectual Developmental Exceptionalities (AIDE) Program Annual Report

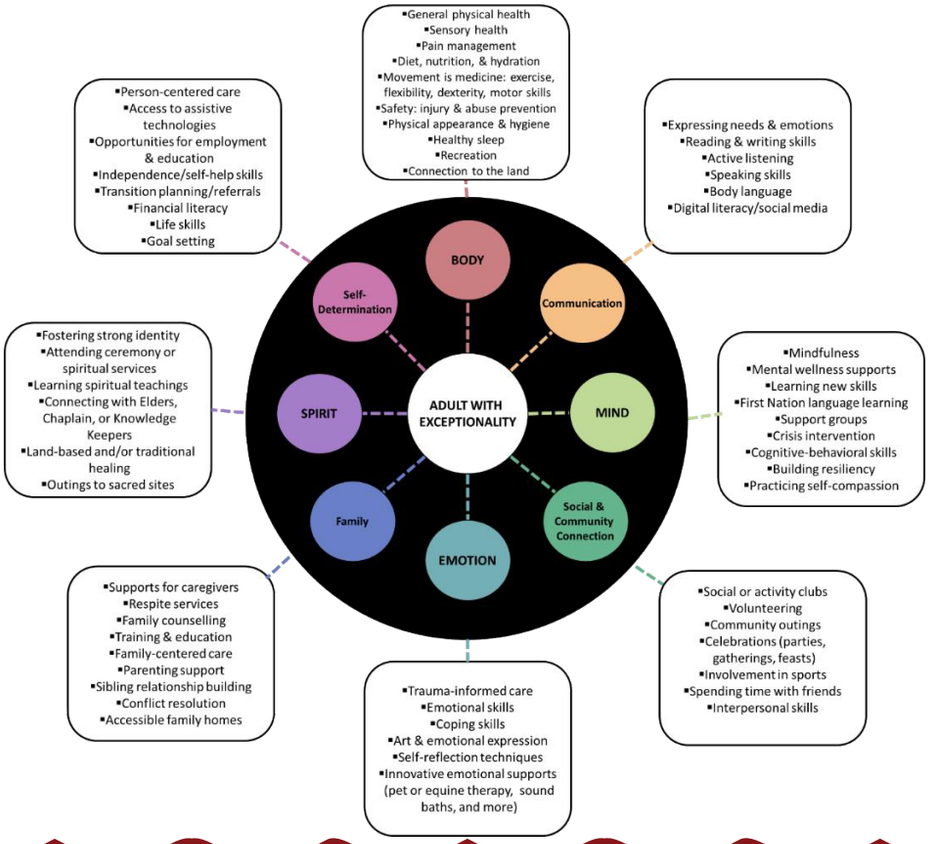
Program Overview

The Adults with Intellectual Developmental Exceptionalities (AIDE) program provides with educational and developmental program services for adults with intellectual or developmental disabilities. Prior to the AIDE program's implementation in April 2023, there was no inclusive on-reserve program that focuses on the specific needs for this targeted group, compared to off-reserve services that are available to all Canadians. As a result, individuals who live with intellectual or physical disabilities often remained at home with little outside stimulation or interaction.

The goal of the Adults with Exceptionalities Program is to support these adults in our community in developing the skills to live fulfilling and rewarding lives, as well as support for the families who care for them. AIDE hopes to continue fostering a sense of community that honors the gifts of our participants and builds each participants' sense of autonomy.

Circle of Care Model

AIDE program staff utilize a Circle of Care model when planning program to ensure all aspects of the participant are considered to provide wholistic support.



Summary of Services

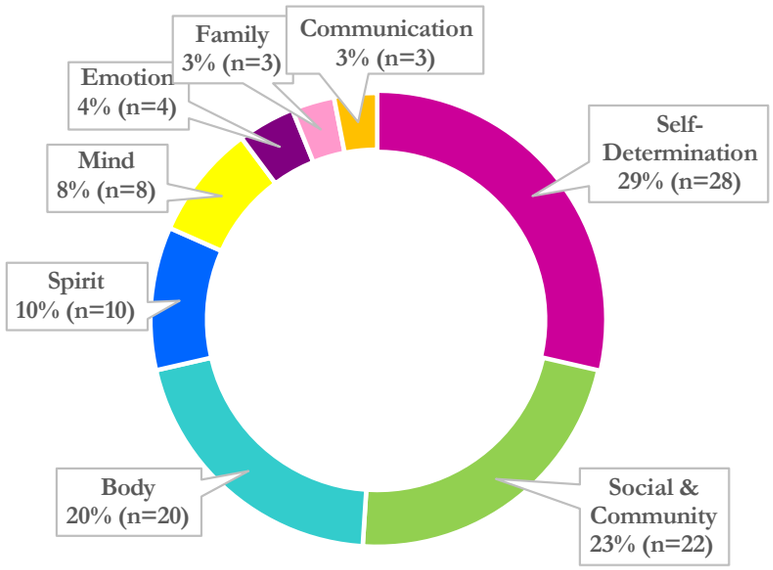
Continued Learning and Development – Education and skill development is the foundation of the Adults with Exceptionalities Program. Workshops focus on providing participants with skills that are relevant, transferrable and valuable to participant life promotion. Program planning utilizes a monthly theme to help guide the learning for the month and to help participants focus on specific aspects of learning. Themes covered over the last fiscal year were: Building Employability, Mental Health Awareness, Healthy Relationships, and Mind, Body & Spirit.

Promoting Structure and Consistency – In addition to the monthly themed events/workshops, program offers a list of health promoting activities that reoccur monthly, such as: physical hygiene and maintenance, Social Club, food security activities, Social Assistance cheque pick-up and grocery shopping, Language Circle, Cooking Class, emotional well-being support and check-ins, land-based cultural activities, and one-on-one supports.

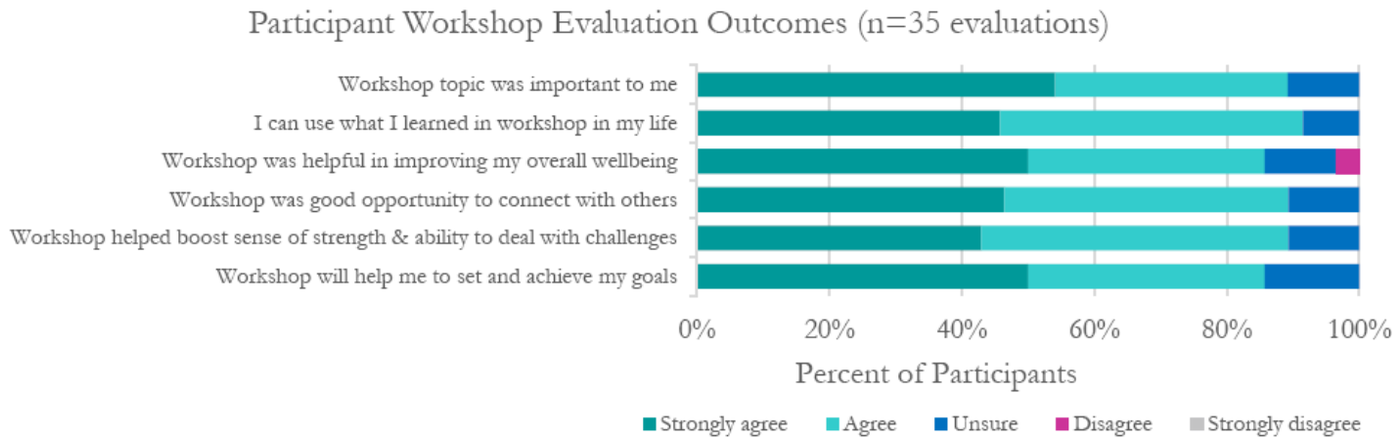
Case Management and Individualized Care Planning – Participants are designated an AIDE support worker with the aim of client-specific services, one-on-one engagement with each participant to support their individualized care plan and ongoing follow-up and navigation of community services. Participants are active collaborators in their care plans that value self determination and a goal-oriented focus. AIDE Staff serve as role models and supports to participants on their case load.

Community Building and Social Engagement – Increasing the community engagement of our Adults with Exceptionalities is central to the vision of the Program, contributing to the overall improvement of participant quality of life. The purpose of regular community engagement and socialization is to maintain and increase participant engagement. Social activities give participants and AIDE staff the opportunity to connect and learn from community.

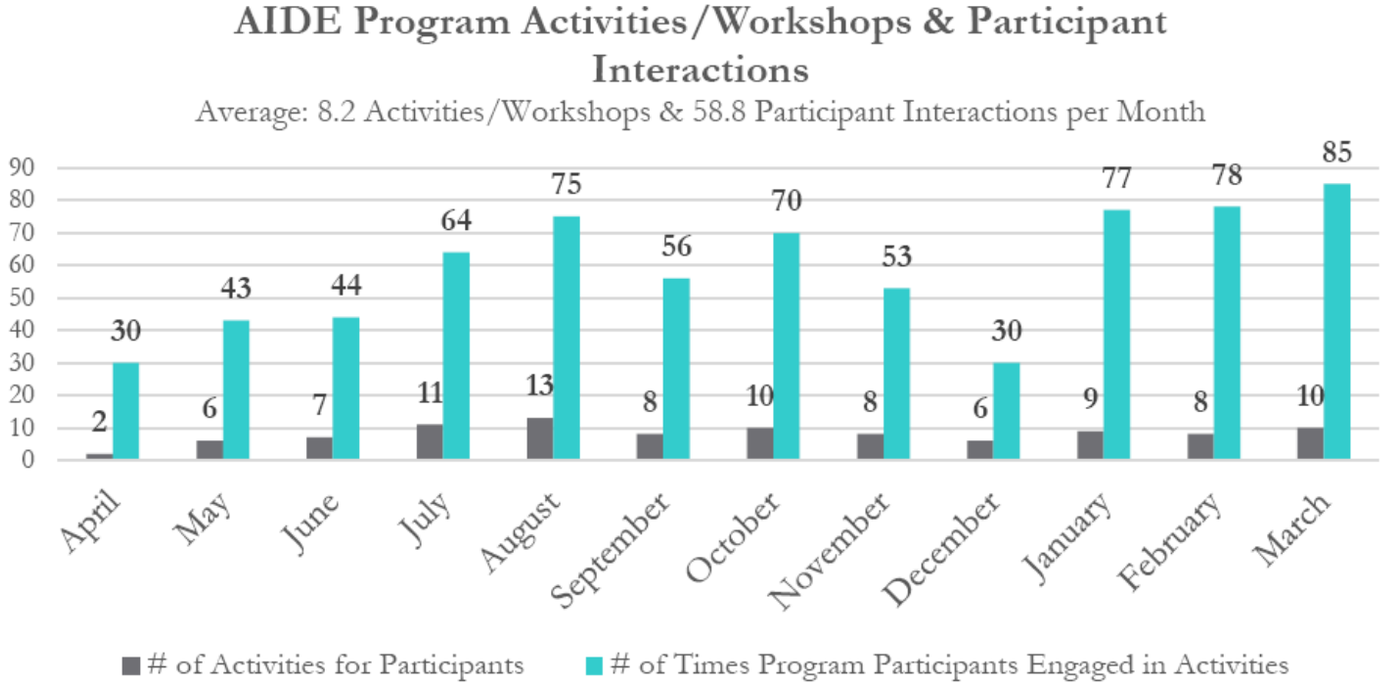
AIDE Program Activities & Workshops for Clients Organized According to Circle of Care Model
98 Activities/Workshops Total from April 2023 to March 2024



From April 2023 to March 2024, AIDE program offered 98 activities. Most activities were either requested by participants or addressed gaps in the community as recognized by participants and their families. This answer to community need is how program acknowledges participant self-determination. Workshops and events actively engage participants in the community, addressing the isolation that occurs for adults with exceptionalities when space is disabling and not conclusive to the needs of those with either intellectual or physical limitations.



Following educational workshops, participant are invited to complete an evaluation form to provide their feedback. Participants are asked to gauge how important the workshop is to them, if they can use what they learned in their life, if the workshop contributes to overall well-being and if the workshop aligns with the participants' goals.



Participant attendance rates are a large focus of AIDE staff as attendance demonstrates participants' commitment to the program and ensures program is meeting the actual needs of the community. Program staff are committed to regular reflection on attendance statistics to ensure participant engagement is on the rise.

Program Staffing and Professional Development

The AIDE staff team consists of a Program Manager, who oversees all program operations, plans and approves of workshops and activities, and connects with community resources and stakeholders to ensure a collaboration of services provided to program participants. The Program Manager supervises an Intake/Administrative Assistant, Case Specialist and three Resource Workers.

This past year, AIDE staff received the following training and professional development:

- ASIST (Applied Suicide Intervention Skills Training)
- Disability Awareness Resource Training (DART)
- Introduction to Autism Spectrum Disorder Training
- Mustimuhw Training (Internal Database utilized by the Health Centre)
- First Aid and CPR Certification

Plan for the Following Fiscal Year

AIDE program will:

- Continue with monthly themes, including World Cultures, Healthy Eating and Diabetes Awareness, Technology and Internet Safety, Substance Use and Harm Reduction Awareness
- Social media engagement
- Staff professional development, including Mental Health First Aid, training on serving those who use substances, non-violent crisis intervention training, PHIA training, and more.
- Increase family involvement
- Continue participation through inclusive programming & assessment
- Set expectations on increased engagement and staff accountability
- Speech Language Pathology and Physio Therapy
- Increase Collaboration Opportunities

The AIDE Team would like to extend a big “miigwetch” to all our participants, community members and stakeholders for their dedication, support, and patience as we roll out this program. The first year was difficult; however, extremely rewarding, as our program participants are a joy to work with and serve. We thank you in advance for your continued support in the following year.

Miigwetch,

Chantell Neff – AIDE Program Manager

FROM THE CHTL

Health Transformation Liaison (SCO) Annual Report

Hello, I am the youth Community Health Transformation Liaison (CHTL) for Southern Chiefs' Organization (SCO) at Pinaymootang Health Centre. Health Transformation is focused on improving the First Nation health system by involving First Nations in decision-making processes.

Through community-driven engagement, SCO works with First Nation partners and governments to build a Southern First Nation health system in Manitoba. This system aims to provide culturally responsive healthcare services, closer to the community. We also aim to strengthen partnerships with the provincial health system for better healthcare, including culturally safe practices.

As Community Health Transformation Liaisons, we organize sessions and events, gather community feedback, and provide support and resources for community involvement. Our mission is to work together with the community to bring positive changes to First Nation healthcare, ensuring that our people's needs and voices are prioritized.

In collaborating with community health stakeholders for programming in Pinaymootang. SCO participated in the following:

The Community Health Fair
Community Gathering Feast
New Community Liaison Worker Training
Jordan's Principle Collaboration Meeting
Pinaymootang Film on Accreditation
Every Child Matters Walk & Talk
Networking Case Management JP CFI
Emergency Planning Meeting
Comprehension Planning Meeting
Wills, Power of Attorney Session
Anishinaabemowin
Staff Meetings
Networking Meetings
Staff Retreat in Health
Back to School Gathering
Weekly Regional Meetings
Addictions Week
Moccasin Teachings
Community Outreach Gathering
MyHealthTeam
IERHA AGM
HIV/AIDS
Heart and Stroke
Harm Reduction
Elders Gathering
Eczema Education
Anti-Racism

In closing, this has been a great year for Pinaymootang Health and I am very proud to be a part of this team. It is a rewarding journey to come to understand what health is truly about and the hard work that my colleagues put in to ensure education and awareness.

Miigwetch,

Stefani Traverse

PINAYMOOTANG FIRST NATION HEALTH PROFESSIONAL SERVICES

JAHNA HARDY is the visiting Mental Health Therapist. Jahna provides counselling services in the community two days per week (every Monday and Tuesday); referrals and appointments can be made through the Health Centre for anyone wishing to utilize.

RANDAL KLAPRAT is the visiting Mental Health Therapist; Randal provides counselling services in the community three days per week (every Wednesday, Thursday and Friday); referrals and appointments can be made through the Health Centre for anyone wishing to utilize.

LUCY DIAZ who originates from Nova Scotia. Lucy is our Dental Therapist; Lucy provides services to the community every Tuesdays for dental care services for school aged children and will book adult emergency by appointment only.

PHYLLIS WOOD is a community member of Pinaymootang. Phyllis provides administrative supports to the Dental Therapist.