PINAYMOOTANG
HEALTH CENTRE

ANNUAL REPORT ON HEALTH 2025-2026

Prepared By
PFN HEALTH

Annual Report on Health 2025-2026

Pinaymootang First Nation
Annual Report on Health 2025-2026

Annual Report on Health

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Introduction

The past year has highlighted both the strength and the ongoing challenges within our health systems. As we present this Annual Health Report, we offer a comprehensive overview of the key trends, priorities, and accomplishments that have influenced the well-being of our community over the past 12 months. This report outlines important data related to healthcare access, service delivery, and public health initiatives, providing valuable insights to help inform decision-making and guide future planning.

Our shared goal remains to promote the health and well-being of all through teamwork, dedication, and perseverance. These guiding values, along with several key contributing factors, have supported the progress and achievements realized throughout the year.

Kurvis Anderson
Chief

Community health programming continues to focus on:

- Ensuring clear, timely, and effective communication
- Upholding principles of fairness and equity
- Encouraging and supporting community participation
- Strengthening unity and collaboration
- Maintaining transparency and accountability to the community we serve

We extend our sincere gratitude to the healthcare professionals and community partners whose commitment and collaboration make this work possible. Together, we move forward with a shared vision of fostering a healthier and more equitable future for all.

It is with great pleasure to present the Pinaymootang First Nation Annual Health Report for fiscal period ending 2025–2026.

In closing, I thank you for the opportunity to serve. We remain committed to ensuring a future in health that is strong, hopeful, and guided by determination.

Sincerely yours,

Chief Kurvis Anderson

Message from the Health Advisory Committee

On behalf of the Health Advisory Committee, we are pleased to present the Annual Health Report for the year 2025–2026. This report reflects our continued commitment to monitoring, evaluating, and supporting the delivery of effective and culturally responsive health services in Pinaymootang First Nation. It offers a comprehensive overview of key health indicators, program performance, and policy implementation, while also highlighting the challenges and opportunities encountered throughout the year.

We extend our sincere appreciation to all contributors, healthcare staff, and community partners for their ongoing dedication and support. Your efforts are essential to the progress we continue to make together.

On behalf of the Pinaymootang First Nation Health Advisory Committee, we hope you find this report informative and valuable.

Sincerely,

Health Advisory Committee

Director of Health Annual Report

Gwen Traverse
Director of Health

It is my privilege to present the Pinaymootang First Nation Health Annual Report for the fiscal year ending 2025–2026. This report provides an overview of the health services delivered throughout the year, highlights our accomplishments, acknowledges the challenges we have faced, and reflects our continued commitment to improving the health and well-being of our community.

The past year has been one of growth, resilience, and continued adaptation. Like many First Nations communities across Canada, Pinaymootang First Nation has experienced increasing demands for healthcare services while navigating ongoing workforce shortages, evolving federal policies, and the growing complexity of community health needs. Despite these challenges, our Health department has remained committed to delivering accessible, culturally appropriate, and compassionate care to every member of our community and to those that enter our facility.

Health extends far beyond the treatment of illness. It encompasses prevention, education, mental wellness, cultural identity, environmental health, family supports, and the social determinants that influence quality of life. Our programs continue to evolve in response to community needs while maintaining a strong focus on prevention, early intervention, and holistic wellness.

As Director of Health, I would like to acknowledge the dedication and professionalism of our healthcare team. Their compassion, resilience, and commitment to serving our community are evident every day. I also extend my appreciation to Chief and Council, the Health Advisory Committee, Elders, community partners, and funding agencies whose ongoing support has strengthened our ability to provide comprehensive health services. Most importantly, I thank the members of Pinaymootang First Nation for the trust you continue to place in our care.

Governance
The Pinaymootang First Nation Health Advisory Committee continues to provide valuable oversight and strategic guidance in Health. Throughout the year, the Committee worked collaboratively with Health Administration to review programming, identify emerging priorities, and support informed decision-making. Their recommendations have helped ensure accountability, transparency, and continuous quality improvement while maintaining a community-driven approach to health service delivery.

Director of Health Annual Report

Health Services

The Health Centre continues to be one of the busiest facilities within the community. Nursing services experienced another year of high demand as community members accessed primary care, emergency treatment, immunizations, chronic disease management, prenatal services, communicable disease monitoring, and health promotion programming. Although staffing pressures continue to challenge healthcare systems throughout Manitoba, our nursing staff have remained committed to providing safe, high-quality care while responding to increasing service demands.

The community continues to benefit from the expertise of visiting physician Dr. Phoebe Theissen, who provides prenatal care and well-women clinics services, while visiting Nurse Practitioners Marco Buenafe and Brindy Bishop have continued to improve access to primary healthcare through routine assessments, chronic disease management, diagnosis, treatment, and preventative care. Their contributions have significantly reduced barriers to accessing medical services close to home.

Community Health Representatives remain at the forefront of health promotion and disease prevention within Pinaymootang First Nation. Through home visits, community education, school programming, and family outreach, they continue to support individuals across all stages of life. One representative focuses primarily on maternal and child health initiatives, including the Canada Prenatal Nutrition Program, while the second concentrates on adult wellness, diabetes education, and elder programming. Together they promote healthy lifestyles, encourage preventative care, and strengthen community awareness through ongoing education and engagement.

Behind every successful clinical program is a dedicated administrative team. The Health Centre's administrative staff ensure the efficient operation of daily services by managing appointments, coordinating visiting specialists, maintaining client records, supporting healthcare providers, and assisting with financial administration and reporting. Their work provides the foundation that allows frontline healthcare professionals to focus on patient care.

Maintaining a safe, welcoming, and functional Health Centre continues to be a priority. Facility maintenance, repairs, equipment servicing, and environmental safety measures have been managed throughout the year to ensure the building remains fully operational and responsive to the needs of both staff and community members.

Director of Health Annual Report

Mental wellness and addictions programming continues to evolve through the National Native Alcohol and Drug Abuse Program (NNADAP). Increased funding has allowed the program to expand culturally grounded land-based programming that incorporates traditional teachings, elder involvement, cultural activities, and community healing opportunities. These initiatives recognize that healing is strengthened through connection to culture, language, and the land while supporting prevention, recovery, and long-term wellness.

The Brighter Futures Initiative and Building Healthy Communities programs continue to provide comprehensive mental wellness programming that supports individuals and families across the lifespan. Services include crisis intervention, parenting supports, child development, injury prevention, suicide awareness, violence prevention, and community wellness initiatives. Together these programs contribute to healthier families and stronger communities by addressing many of the social factors that influence health.

Environmental Public Health programming remains essential to protecting the safety of our community. Regular water sampling, testing, monitoring, and reporting continue to meet federal requirements and ensure that drinking water remains safe. Collaboration with Environmental Public Health Officers and Indigenous Services Canada allows for ongoing surveillance and prompt responses should concerns arise.

The Canada Prenatal Nutrition Program continues to support healthy pregnancies and positive early childhood outcomes by providing nutrition education, breastfeeding support, healthy food supplements, parenting education, and prenatal programming. These services strengthen families by ensuring expectant parents have the knowledge and resources necessary to promote healthy childhood development from the earliest stages of life.

Demand for Home and Community Care services continues to increase as more elders and individuals with chronic illnesses choose to remain in their homes for as long as possible. The program provides nursing support, personal care, home assessments, medical equipment coordination, chronic disease management, and assistance with activities of daily living. Through these services, community members are able to maintain their independence while receiving care within familiar surroundings.

Medical Transportation remains one of the Health Centre’s largest operational responsibilities. Throughout the year, staff coordinated transportation for hundreds of medical appointments outside the community while ensuring services complied with the Non-Insured Health Benefits program guidelines. Managing vehicle scheduling, accommodation arrangements, escort approvals, and travel logistics requires ongoing coordination, and the department continues to meet these demands.

Director of Health Annual Report

The Aboriginal Diabetes Initiative remains an important component of chronic disease prevention within the community. Education, healthy lifestyle promotion, nutrition counselling, awareness campaigns, and regular foot care clinics continue to support individuals living with diabetes while encouraging preventative measures that reduce long-term complications.

Education and prevention continue to guide the HIV/AIDS and Harm Reduction Program. Through workshops, community awareness activities, and culturally appropriate education, the program encourages informed decision-making, reduces stigma, and promotes healthier lifestyles while supporting individuals and families affected by substance use and communicable diseases.

The Aboriginal Head Start On Reserve Program continues to provide culturally based early childhood programming that promotes school readiness, language revitalization, nutrition, family involvement, developmental screening, and cultural learning opportunities. The program remains an important investment in the future of our children by strengthening healthy development during the critical early years.

Accreditation

Quality improvement remains central to every aspect of Health Centre operations. Following the achievement of Exemplary Standing during Accreditation Canada in 2022, preparations have continued for the upcoming accreditation survey scheduled for September 2026. Staff have continued reviewing policies, strengthening quality improvement initiatives, updating procedures, and ensuring compliance with national standards to maintain the level of care for our community.

Jordan's Principle – Niniijaanis Nide Program

The Niniijaanis Nide Program experienced one of its most significant years of transition since its establishment. Jordan's Principle funding has, for many years, allowed Pinaymootang First Nation Health to provide comprehensive services for children with complex health, developmental, educational, and social needs. These services have included specialized therapies, respite care, cultural programming, behavioural supports, developmental interventions, case management, transportation assistance, adaptive equipment, and individualized care planning.

Director of Health Annual Report

During the 2025–2026 fiscal year, Indigenous Services Canada introduced significant changes to the administration of Jordan's Principle nationally. New funding directives, revised eligibility requirements, and changes to approval processes resulted in fewer approved requests and the discontinuation of many supports that communities had previously relied upon. These changes created uncertainty for families while presenting operational challenges for service providers across the country.

Despite these challenges, Pinaymootang First Nation Health remained committed to advocating for children and families. Staff dedicated countless hours to reviewing files, assisting families with new applications, appealing decisions where appropriate, coordinating services with other agencies, and exploring alternative funding sources to minimize disruptions in care. The Jordan's Principle Team continued working closely with healthcare professionals, educators, therapists, and caregivers to ensure children with developmental delays, autism spectrum disorder, disabilities, behavioural challenges, and complex medical conditions continued receiving coordinated services.

The continued growth of children's programming has also highlighted the need for additional space within the Health Centre. Staff have demonstrated remarkable flexibility by maximizing available facilities, coordinating services across multiple locations, and adapting programming to ensure children continue receiving essential supports. Although the future of Jordan's Principle programming continues to evolve, our commitment remains unchanged. Every child deserves equitable access to the services they need to thrive, and Pinaymootang First Nation Health will continue advocating for the rights of First Nations children while pursuing sustainable approaches to preserve critical services.

eHealth Services

Technology continues to transform healthcare delivery within our community. The continued expansion of electronic medical records, telehealth services, virtual care, secure digital communications, and public health reporting systems has improved efficiency while increasing access to healthcare professionals. Pinaymootang First Nation remains committed to embracing innovative technologies that improve client care while strengthening collaboration among healthcare providers.

Maternal Child Health

The Maternal Child Health Program continues to provide comprehensive supports for expectant parents and families with young children. Through home visits, education, developmental screening, parenting support, nutrition counselling, and referrals to specialized services, the program promotes healthy pregnancies and positive childhood development while strengthening family capacity during the earliest years of life.

Director of Health Annual Report

Partnerships and Community Collaboration

Strong partnerships remain essential to delivering comprehensive healthcare services. Throughout the year, Pinaymootang First Nation Health continued working collaboratively with the Interlake-Eastern Regional Health Authority through the MyHealthTeam initiative, improving access to mental health services, chronic disease management, addictions supports, virtual physiotherapy, and other specialized healthcare services. The Health Centre has maintained strong relationships with the University of Manitoba and other academic institutions to support research, community-based rehabilitation initiatives, and student learning opportunities that contribute to advancing Indigenous health.

During the 2025–2026 fiscal year, Pinaymootang First Nation received funding through the Indigenous Health Equity Fund (IHEF), administered by Indigenous Services Canada and disbursed through the Southern Chiefs' Organization (SCO). This flexible funding supports First Nations in addressing community-identified health priorities and advancing equitable, culturally safe healthcare. The funding has provided opportunities to strengthen health programming, enhance service delivery, and respond to the evolving health needs of our community in accordance with local priorities. The community had utilized the funding to support areas in equine therapy, gardening and mental health initiatives.

The Adults with Intellectual Development Exceptionalities also known to us has the AIDE Program continues to provide essential supports to adults with intellectual, developmental, physical, and complex disabilities within Pinaymootang First Nation. The program is designed to promote independence, dignity, inclusion, and meaningful participation in community life while recognizing the unique strengths and abilities of each participant.

Throughout the year, staff worked closely with participants and their families to provide person-centred supports that encouraged the development of daily living skills, social connections, self-confidence, and community involvement. Programming included opportunities for recreational, cultural, educational, and life skills activities that foster personal growth and help participants achieve their individual goals.

The program also plays an important role in coordinating services by working collaboratively with healthcare providers, social service agencies, educational institutions, and community organizations. Through these partnerships, participants are better able to access the supports and resources they require while reducing barriers to care and community participation.

As the demand for services continues to grow, the program remains committed to adapting to the evolving needs of participants and advocating for sustainable resources that will strengthen supports for adults with exceptional disabilities. Pinaymootang First Nation Health recognizes the importance of providing inclusive programming that empowers individuals to live fulfilling lives while remaining active members of the community.

Director of Health Annual Report

Emergency Response Planning

Emergency preparedness remains an important priority for Pinaymootang First Nation. Throughout the later 2025–2026 fiscal year, the Health Program in partnership with community stakeholders continued to review and strengthen the community emergency response plan to ensure essential health services can continue during emergencies such as severe weather, power outages, flooding, public health events, and other unforeseen situations.

The Health Centre worked collaboratively with Chief and Council, community departments, and regional partners to support coordinated planning and effective communication. Efforts focused on maintaining continuity of care for community members while ensuring staff are prepared to respond quickly and effectively when emergencies arise.

Pinaymootang First Nation Health remains committed to ongoing emergency preparedness planning to protect the health, safety, and well-being of our community.

Closing Remarks

As I reflect on the past year, I am proud of the dedication demonstrated by every member of the Pinaymootang First Nation Health team. Together, we have continued to strengthen services, respond to emerging healthcare challenges, and advocate for the needs of our community. While much work remains, we continue to move forward with optimism, guided by our commitment to culturally safe, accessible, and community-driven healthcare.

On behalf of Pinaymootang First Nation Health Centre, I sincerely thank Chief and Council, the Health Advisory Committee, our staff, community partners, Elders, and the members of Pinaymootang First Nation for your continued trust, support, and collaboration. Together, we will continue building a healthier future for our Nation.

Respectfully submitted,

Gwen Traverse

Community Health Nurse Report
Roxie Rawluk

I am pleased to provide this annual report highlighting emergency preparedness activities, public health initiatives, and nursing services supported through Pinaymootang First Nation Health during the 2025–2026 fiscal year.

As communities continue to witness increasing emergency situations around the world, Pinaymootang First Nation Health remains committed to strengthening preparedness and ensuring our community is better equipped to respond to a variety of emergencies. These may include communicable disease outbreaks, flooding, wildfires, extended power outages, hazardous material incidents, and other situations that may impact the health and safety of community members.

Over the past year, the Health Centre has continued to focus on emergency preparedness by increasing awareness, strengthening response planning, and supporting training opportunities for staff and community members. Several staff and community members have participated in emergency response, safety, and preparedness training to build knowledge, confidence, and capacity to respond effectively during times of crisis.

Emergency preparedness is an ongoing responsibility that requires the participation of the entire community. While not every household may have the ability to create a complete emergency kit, there are many steps individuals and families can take to reduce risks and improve readiness. Community members are encouraged to identify important items that would be required during an evacuation and keep these items easily accessible. Important documents such as identification, birth certificates, passports, and other records should be stored safely and kept together. Maintaining an updated list of important phone numbers is also recommended in case electronic devices are lost or unavailable during an emergency.

Community members are also encouraged to ensure that current contact information is provided to the Health Centre and Band Office so they can be reached quickly during evacuations or community-wide emergencies. Households should maintain access to emergency supplies, including drinking water and non-perishable food items. Emergency planning recommendations generally encourage having enough supplies available to support each household member for a minimum of 72 hours.

Home safety and fire prevention continue to be important areas of emergency preparedness. Community members are encouraged to maintain working smoke detectors, remove debris and fire hazards around their homes, safely store flammable materials, maintain grass and brush areas, and follow FireSmart practices to reduce wildfire risks.

Community Health Nurse Report
Roxie Rawluk

Preparedness also includes building knowledge and skills that support community safety. The Health Centre continues to encourage participation in available training opportunities, including CPR, First Aid, water safety, road safety, ATV safety, and other community-based education initiatives. These programs provide individuals and families with practical skills that can reduce risks and improve response during emergencies.

Communicable disease prevention remains an important component of emergency planning and public health. The COVID-19 pandemic highlighted the importance of community preparedness and the role that prevention measures play in protecting vulnerable individuals. Maintaining up-to-date immunizations, practicing proper hand hygiene, following cough etiquette, and staying informed about public health recommendations continue to be important strategies for reducing the spread of illness.

The Health Centre continues to support emergency communication and community awareness by providing updates, information, and reminders through available communication channels, including the Pinaymootang Community App. Community members are encouraged to remain informed, understand emergency plans, and discuss preparedness within their households.

In addition to emergency preparedness responsibilities, I continue to support nursing services within the areas of public health, maternal child health, primary care, and Home and Community Care. It remains an honour to contribute to ensuring that members of Pinaymootang First Nation continue to receive quality healthcare services close to home.

Throughout the fiscal year, nursing and healthcare services continued to experience significant demand. The following services were provided:

2025-2026 Stats:

Primary Care Clinic Visits: 827

Phone Consultations: 2298

Nurse Practitioner Visits: 788

Physician Visits: 166

Immunizations & Public Health Services

- **Flu Vaccinations: 90**
- **Covid-19 Vaccinations: 59**
- **Routine Immunizations: 289**
- **Prophylactic Rabies Treatments: 2**

I look forward to continuing my own learning and development in emergency preparedness and healthcare so that I can continue supporting the community of Pinaymootang through both everyday healthcare needs and unexpected challenges. Through collaboration, awareness, and preparation, we can continue building a safer and healthier community for all members.

Roxie Rawluk - Community Health Nurse

Community Health Nurse Report
Dudley Landon

Hello Pinaymootang, my name is Dudley Landon, and I am a Registered Nurse who relocated to your community and commenced employment with the Pinaymootang Health Centre in March 2026.

This report outlines my professional activities and contributions as a Community Health Nurse (CHN) and Registered Nurse working within a multidisciplinary First Nation Health Centre. Throughout my practice, I have focused on delivering culturally safe, holistic, and client-centred care that respects the values, traditions, and unique health needs of the community.

My role has included supporting community wellness through chronic disease management, health promotion, disease prevention, immunization programs, and client education. I have worked collaboratively with interdisciplinary team members, community leadership, and external healthcare partners to improve access to quality healthcare services and promote positive health outcomes for individuals, families, and the community as a whole.

This report highlights my key responsibilities, accomplishments, and contributions since joining the Pinaymootang Health Centre, while reflecting my commitment to providing compassionate, evidence-informed nursing care and fostering respectful relationships within the community.

Nursing responsibilities:

- Comprehensive health assessments
- Medication administration and management
- Immunization services
- Maternal and child health support
- Communicable disease surveillance
- Mental health referrals
- Health education and promotion
- Urgent care interventions
- Home visits
- Supporting continuity of care for clients with complex health needs.
- Performing laboratory testing and medical related referrals.

Immunization and Communicable Disease Prevention

- Administration of routine childhood and adult immunizations.
- Surveillance and reporting of communicable diseases.

Maternal, Child, and Family Health

- Prenatal and postnatal support.
- Infant growth and developmental monitoring.
- Health teaching for parents and caregivers.

Community Health Nurse Report
Dudley Landon

Community Health Promotion
I actively participated in health promotion activities focused Diabetes education and Healthy lifestyle education.

Cultural Safety and Indigenous Health
Supporting patient self-determination and informed decision-making.
Participating in education and reflection related to Indigenous health and cultural safety.

Professional Development
Continued enhancement of clinical skills.
Indigenous cultural safety training.
Emergency response and certification updates.

Challenges
High demand for healthcare services.
Complex chronic disease burden.
Limited specialist access in rural and remote settings.
Social determinants of health affecting patient outcomes.

Conclusion
The reporting year was marked by strong collaboration, community engagement, and a continued commitment to delivering high-quality, culturally safe nursing care. Through partnerships with interdisciplinary team members, Elders, community leaders, and healthcare organizations, I contributed to improving access to care, promoting wellness, managing chronic disease, and supporting the overall health of community members. I remain committed to advancing holistic, client-cantered care that reflects the values, strengths, and priorities of the First Nation community we serve.

Encounter Stats (March 9, 2026 – July 10, 2026)

Total clients 241
Total unique encounters 374

Dudley Landon, RN

Community Health Nurse Report
Kerri Nickel

It has been six years that I became a member of the Pinaymootang Health Care Team.My role has changed and evolved over the years which has allowed for a great deal of professional and personal growth. The work I am engaged with at present has been some of the most rewarding experiences I have had in my career. My supervisory role plays large part of what I do, and allows for programs to collaborate, provide a wide range educational programing and resources and offer comprehensive health care services to our targeted population.

Very important work continues to be accomplished by the Maternal Child Health, CPNP and Head Start Programs. Our group sets goals that aim to benefit our targeted audiences while still meeting each of our program standards. This allows us to grow in the delivery of services to meet the needs of Pinaymootang Families and engage in new opportunities. I would like to take this opportunity to once again acknowledge the staff of our MCH, CPNP and AHSOR programs for their tremendous efforts, hard work, commitment and willingness to adapt to changing circumstances in order to help our families succeed.

HIGHLIGHTS

Young Women/ Teen Clinic

It has been our experience that creating healthy habits in young people leads to an increase in positive health outcomes throughout adulthood. Twice a week I support Health outreach efforts at the school for a young women's / teen clinic. Time spent there has included, classroom education, well being visits in partnership with our Mental Health Therapists, referrals to additional providers, medication administration, nursing assessments and promoting awareness on topics including but not limited to reproductive health, healthy relationships, and harm reduction. It as been extremely rewarding to spend time with the youth and watch as they become young adults, building their trust and seeing them feel more comfortable to seek out care for themselves.

Prenatal Program

Maternal Child Health Program began in Pinaymootang in April of 2022. It was identified early on, a need to concentrate efforts towards our Prenatal and Postnatal Program. The goal in Pinaymootang with our Prenatal / Maternal population is to ensure that each pregnant woman and her family however that may look, feels supported, has access to care and that her pregnancy, birth and postnatal time is healthy, positive and memorable.

Community Health Nurse
Kerri Nickel

The prenatal program in Pinaymootang supports care of the expectant mother / family by:

- establishing a personalized care plan with the expecting parent / family
- connects mother with a Home Visitor, allowing for the family to have a support person follow them throughout their pregnancy journey and postnatal period
- nursing services to coordinate all of the different aspects of care, including phlebotomy services, and direct access to physicians
- connects to additional services such as Canadian Prenatal Nutrition Program
- advocates with external providers to ensure care is received timely and appropriately

Our success has been in large part due to the care provided by our visiting Physician Dr. Phoebe Thiessen. Dr Thiessen is the Obstetrical Lead with Interlake Eastern Regional Health Authority, and we are tremendously grateful to have her here once a month to facilitate prenatal care. Dr. Thiessen joined our program in January of 2023 allowing us to keep care closer to home for expectant families and to support women's health needs. In that time, 222 women have had prenatal care or women related health concerns addressed by Dr Thiessen and our team with 2208 encounters recorded. This fiscal year we supported 45 women and 47 pregnancies in some capacity. Our efforts within this portfolio have led us to be part of conversations regarding Restoring Indigenous Midwifery to First Nation Communities. It is an honor to be engaged in this work.

Harm Reduction, STI/STBBI Management and Clinic Care
Under the STI/STBBI and Harm Reduction portfolio I allocate time to a variety of tasks. These include but are not limited to; developing and providing education as requested, participation in the Manitoba Harm Reduction Network, and providing or addressing the needs of community members using a wholistic approach to care. With HIV being on the rise in Manitoba I plan to continue to increase time and resources that support community education, prevention and access to care moving forward.

Strengthening Families ~ Mental Health Partnership with University of Manitoba
Due to our successes, Pinaymootang MCH program was approached by Strengthening Families; First Nation Inuit Health Services to partner with the University of Manitoba Hearts Minds and Research Lab. The purpose of this working group is to improve the mental health and wellbeing of families living in Pinaymootang First Nation with a focus on the Maternal population. The project is a collaborative initiative recognizing the disparities that exist in community and will aim to help bring change and healing through relevant strength-based approaches specific to our members. This is a promising partnership, and it is always a pleasure

Community Health Nurse
Kerri Nickel

Personal Health Information Management System (PHIMS)
Pinaymootang Nursing Team collaborated with multiple external partners to become the first, First Nation Community to use PHMIS regarding Communicable Disease Control alongside the Province. Many hours of planning, preparation and training went into the deployment of this project to ensure we were successful. It allows for providers to improve health services through collaborative and secure sharing of health information. A comprehensive healthcare picture related to these diagnoses is now accessible to nursing and supports us with ongoing care.

Encounter Stats

Childrens Health Visits: 130

Womens Health: 266

School Visits: 229

Prenatal / Postnatal Visits: 870

Adult Health / Clinic Visits: 266

STI / STBBI Visits: 318

MCH / CPNP Related: 330

Maternal Child Health Annual Report

The primary goal of Maternal Child Health is to improve holistic health outcomes for our maternal, infant, and child population with attention paid to the family. Our areas of focus include prenatal health, postnatal health, newborn care, and the overall health of young children. This is achieved through education and programing in the areas of nutrition, early literacy / learning, physical, emotional and mental health as well as nurturing the bond between infant and caregiver. In addition to this we have cultivated the opportunity to improve the knowledge of reproductive health among teens and young adults by hosting a teen clinic at the school and offering a variety of workshops.Along with the sharing of our curriculum, we have hosted independently or in partnership with other Health Programs, a number of community activities to meet the needs of the population we serve. Our strengths continue to be teamwork, cultural involvement, community and family engagement, and adaptable outreach efforts; all to support and empower those we serve.

During this fiscal year the MCH Program successfully collaborated with the University of Manitoba regarding a project focused on supporting the development of culturally safe community-led wellness initiatives regarding Mental Health. Three themes emerged during this work. They include but were not limited to; navigating adversity and the stigmas that exist regarding Mental Health, addressing current challenges/barriers within health care systems that that compromise access to care, and how to move forward together so that while we address the needs for improvement, we create an environment that allows for members to thrive.

I have held the role of Home Visitor Lead with the Maternal Child Health Program for four years as of April 2026. In this role I have dedicated my efforts to nurturing healthy, comfortable, and well-rounded relationships with parents and families to ensure they feel supported and cared for. I do one-on-one home and office visits with families, facilitate and collaborate small and large group activities, as well as providing support as needed for families in the program. This role has cultivated opportunity for me to utilize my doula training in the work we do with our prenatal families and helped expand the services we offer regarding pre and post-natal care.

During home visits and groups, I do my best to provide relevant information and resources for families and ensure that they understand how and what they would use these resources for, whether it is just for their information, to strengthen their familial relationships with one another, or to continue learning together at home. One of my favorites is providing a printed book about big emotions that are sometimes harder to explain to younger children but made easier with the story.

Moreover, for the Maternal Child Health program I help to coordinate monthly events and small groups, some of these events are in collaboration with other community programs or with facilitators, that bring land-based knowledge and teachings to our families. For some of the small groups we like to build on information for parents about physical, mental, emotional, and social health that relates to their child’s growth. Within this role I have seen the importance of

Maternal Child Health Annual Report

encouraging families to be more engaged not only in community programming but also to be active in their own health as well as their children's health. I find health to be important as it affects and helps our daily lives, and to encourage healthy habits and relationships and to learn together, this has been a very enjoyable part of my job!

Training Highlights:
First Aid & CPR Level C
Babies are Sacred- Safe Sleep Practices
Prime Research Conference Panelist on Indigenous Centered Community Engagement in Research

Plans for the year ahead:
This year I look forward to hosting a Land-Based event in collaboration with other programs and in partnership with University of Manitoba and PRIME, and continuing to promote healthy families, overall health and mental health wellness and connection to our community and to the land through land-based activities and learning. I also look forward to seeing families flourish and grow together in healthy environments.

Gichi Miigwetch,
Alannah Woodhouse, Home Visitor Lead

Statistical Information 2025-2026

Home Visits: 220

Group Activities: 58

Outreach: 251

Families Enrolled: 103

A Note from Kerri Nickel, LPN / Community Health Nurse
Pinaymootang Maternal Child Health Program will continue to build on our success and seek out opportunities for individualized visits either in homes or in our office, host both small and large groups events and grow our program to reach more families in need. Our work will aim to celebrate parents, encourage learning in different ways, strengthen the parent-child bond, be relationship focused and preserve Indigenous sustainability and cultural knowledge. We will collaborate with other community programs, leaders and Indigenous facilitators for community driven and land-based events where families learn skills that they can use at home and be able to continue to teach their children for generations. It is through these supportive and meaningful actions that we can best support our families to benefit and thrive.

Community Health Nurse Annual Report
Meagan Anderson

The past five years working at the Pinaymootang First Nation Health Centre have been both rewarding and professionally fulfilling. During this time, I have had the privilege of providing safe, compassionate, and client-centred care to members of our community while contributing to the continued growth and development of our Health Centre.

Working alongside a dedicated team has allowed us to strengthen the quality of care we provide and continually improve the services available to our community.

My primary responsibilities continue to focus on Community Health Nursing, with an emphasis on the Home and Community Care Program. Through both clinic-based and home-based services, I strive to support individuals in maintaining their health, independence, and overall well-being.

Within the Health Centre, I provide a variety of nursing services including health assessments, medication administration, wound care, blood collection, referrals to specialized healthcare providers, and health education. These services are delivered in a safe, ethical, and culturally respectful manner while supporting clients in achieving their individual health goals.

Home and Community Care remain a significant component of my role. Home visits allow clients to receive nursing care within the comfort of their own homes while promoting independence and reducing unnecessary hospital visits. Services provided include health assessments, medication management, wound care, chronic disease monitoring, and client education. In addition, I coordinate access to essential medical equipment and supplies such as walkers, wheelchairs, canes, bathroom safety equipment, bed rails, toilet rails, and incontinence supplies. These supports help improve safety within the home while enhancing clients' quality of life.

Supporting individuals living with chronic diseases continues to be an important priority. By working collaboratively with physicians, nurse practitioners, dietitians, and other healthcare professionals, referrals are coordinated to ensure clients receive comprehensive care. Ongoing monitoring, education, and individualized care planning assist clients in managing chronic conditions while encouraging healthy lifestyle choices that may slow disease progression and improve overall health outcomes.

Public Health responsibilities also include responding to animal exposure incidents. This involves assessing injuries, cleaning and disinfecting wounds, administering tetanus immunizations when indicated, coordinating follow-up with Manitoba Public Health regarding potential rabies exposure, and monitoring clients throughout treatment. Prompt assessment and intervention help reduce the risk of serious infection and ensure appropriate follow-up care.

Community Health Nurse Annual Report
Meagan Anderson

One of the highlights of the past year has been the continued success of our Elder Programming. Throughout the year, Elders participated in a variety of activities including cooking classes, arts and crafts, wellness sessions, and community outings such as strawberry picking at Boonstra Farms. These activities not only encourage healthy lifestyles but also foster social connections, reduce isolation, and promote emotional well-being. Witnessing the positive impact these programs have on our Elders continues to be one of the most rewarding aspects of my role.

Tuberculosis prevention and treatment remain ongoing public health responsibilities. Through Directly Observed Therapy (DOT), medications are administered and monitored within clients' homes to ensure adherence to prescribed treatment while reducing the risk of transmission. I am pleased to report that there were no active tuberculosis cases within our community during this reporting period.

During the year, I also continued participating in the Heart & Stroke Foundation and University of Manitoba community rehabilitation pilot project. This initiative focused on increasing awareness of cardiovascular disease prevention while supporting clients through pre- and post-rehabilitation services within the community. Although the pilot project concluded in August 2025, it provided valuable experience and strengthened partnerships with the University of Manitoba and the Heart & Stroke Foundation. We remain optimistic about future opportunities to collaborate on initiatives that improve community health outcomes.

Throughout the reporting period, nursing services continued to experience steady demand. A total of 248 Home and Community Care visits and 243 clinic visits were completed. Fifty-five blood collection appointments and 204 wound care treatments were provided, while 375 telephone consultations addressed a wide range of health concerns and client follow-up needs. Twenty-one referrals were made to Chronic Disease services and dietitians to support clients requiring specialized care. Overall, a total of 907 client encounters were recorded during the year, reflecting the ongoing need for accessible nursing services within our community.

As I reflect on another successful year, I would like to express my sincere appreciation to the community members who continue to place their trust in our healthcare team. Building meaningful relationships with our clients remains one of the most rewarding aspects of my profession. We value the feedback we receive, as it allows us to continually improve our knowledge, skills, and the quality of care we provide. I also extend my gratitude to my colleagues for their teamwork, professionalism, and commitment to delivering exceptional healthcare services.

Community Health Nurse Annual Report
Meagan Anderson

I look forward to another year of serving the community and continuing to promote health, wellness, and quality care for all members of Pinaymootang First Nation.

Annual Statistics 2025-2026

Home and Community Care Visits: 248

Community Health Clinic Visits: 243

Blood Collection Appointments: 55

Wounded Care Treatments: 204

Telephone Consultations: 375

Chronic Disease Network / Dietician Referrals: 21

TOTAL CLIENT ENCOUNTERS: 907

Maegan Anderson - LPN

Foot Care Annual Report

Hello Pinaymootang, my name is Brenda Henry, and I am a Licensed Practical Nurse who has been proudly serving the Pinaymootang First Nation Health Centre as the Foot Care Nurse since June 2019.

In addition to my role within the Health Centre, I continue to work as a community nurse in Winnipeg. With over 22 years of nursing experience, my practice has focused primarily on diabetic health and education, lower limb wound care, and preventative health education.

Foot care plays an important role in maintaining overall health and preventing complications, particularly for individuals living with diabetes, mobility challenges, and chronic health conditions. The foot care services provided through the Health Centre are available to all community members and are designed to promote healthy feet, early identification of concerns, and timely access to additional healthcare supports when needed.

Services provided through the Foot Care Program include routine nail care, basic foot and lower limb assessments, corn and callus reduction, wound care, client education related to foot health and prevention, and referrals to Community Nursing, medical specialists, and appropriate footwear services. Foot care services are provided in a variety of settings to ensure accessibility for community members. Appointments are available at the Health Centre clinic, through home visits for individuals experiencing mobility challenges, during extended hospital stays, and within long-term care facilities. This approach allows clients to receive consistent care regardless of their circumstances or location.

Over the past year, the Foot Care Program has continued to grow, allowing me the privilege of meeting and supporting more members of our community. Over the past seven years, I have been welcomed into the homes of many Elders to provide foot care services. These visits have become much more than healthcare appointments; they have provided opportunities to listen to stories from the past, learn about family histories, share experiences, and build meaningful relationships with community members. These connections are one of the most rewarding aspects of my role.

The continued growth of the Foot Care Program reflects the importance of preventative healthcare and the positive impact that accessible services can have on improving quality of life. Early identification and treatment of foot concerns can help prevent more serious complications and support individuals in maintaining independence and wellness.

Foot Care Annual Report

I continue to be grateful for the opportunity to be part of the Pinaymootang First Nation Health Centre team and appreciate the trust community members have placed in me. I look forward to continuing to provide compassionate, preventative care and supporting the health and wellness of our community in the coming year.

Professional Development

Continued education remains an important part of providing current and evidence-based foot care services. Upcoming professional development opportunities include participation in the Canadian Foot Care Nurse Association Annual Conference, scheduled for May 22–24, 2026, in Toronto, Ontario, and the Manitoba Association of Foot Care Nurses Conference, scheduled for October 16–17, 2026, in Winnipeg, Manitoba.

Foot Care Program Statistics (2025–2026)

Throughout the reporting period, the Foot Care Program provided a total of 292 visits to community members. Services were delivered through clinic appointments, home visits, and care provided in hospital and long-term care settings.

Annual Statistics 2025-2026

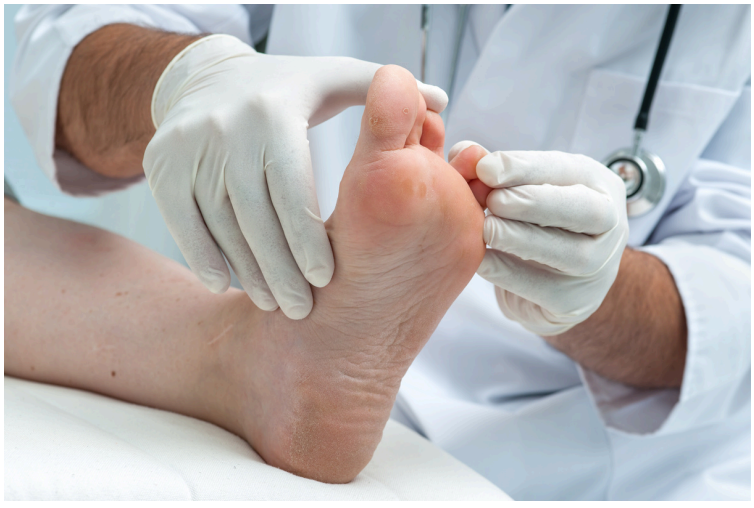
Clinic Visits: 141

Home Visits: 101

Hospital and Long Term Care Visits: 60

TOTAL FOOT CARE VISITS: 292

Brenda Henry, LPN Footcare Nurse



Community Health Representative 1 / Canadian Prenatal Nutrition Program

Aniin, my name is Heather Anderson. I am a wife and a mother to 5 beautiful children. I was born and raised in Pinaymootang. This report outlines the activities, accomplishments, and observations from my time as the Maternal / Youth Wellness Worker at the Pinaymootang Health Centre. I have been in this role since August 2024; my main areas of focus are the Canadian Prenatal Nutrition Program and the Immunization Program. My main tasks are to focus on community outreach, health promotion, and establishing strong relationships with both clients and colleagues. It has been a valuable tool that I am able to understand Anishinaabemowin as it helps to meet the needs of many community members.

This fiscal year I continued to familiarize myself with various reporting/charting programs that are used within the Health Centre. Inputting immunizations on the provincial Public Health Information Management System (PHIMS) is of great benefit to the Nursing team as it supported data entry and coordinated appointments so that our children and youth were up to date on their immunizations. Another initiative we have resumed are in school vaccinations for those that are of age that require Men-C-ACYW (Meningococcal Conjugate Quadrivalent), Hepatitis B (HB), Human Papillomavirus (HPV) and Tetanus, Diphtheria Pertussis (Tdap) which are the grades 6 and 7/8.

As the Canadian Prenatal Nutrition Program Coordinator, I continue to spend time engaging in the services that the program can provide. 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.

As part of the Prenatal Care Team, I ensure completion of the Health Baby Forms, coordinate appointments and provide transportation, communicate with nurses and Dr. Thiessen on any needs of the prenatal mothers not previously noted, collaborate with other programs to facilitate Prenatal Classes, create our Welcome Baby packages, and attend the Postnatal visits with the nurses.

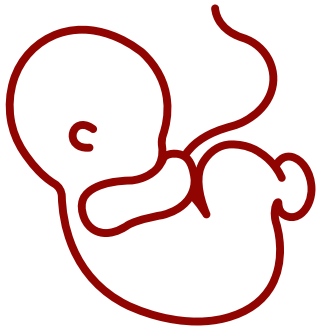
In the role of Maternal/Youth Wellness Worker, some of the other programs and services that I have partnered and worked with from the Health Centre include; Jordan’s Principle, Maternal Child Health, Nursing, and Aboriginal Head Start On-Reserve programs. Collaboration is key when it comes to providing services to community members as it helps spread resources and

Community Health Representative 1 / Canadian Prenatal Nutrition Program

allows programs to reach more people. To help promote a healthy community, another initiative in the CHR program is transportation to and from the Health Centre. This ensures clients attendance for their appointments or programs and access to resources needed.

In the past fiscal year, I participated in the following training opportunities:

- Maternal Child Health Workshop
- CPNP Conference/Training
- PHIMS Gathering
- CHR Gathering/Training
- Milk Mentors Training
- Excel Training



Future Goals

Some of the goals for the year ahead include continuing to work with the community of Pinaymootang and offer help where I can such as immunizations. I plan to expand our outreach at the school regarding immunizations including the preschool age. Participating in the Children's Health Fair -providing information on immunizations, booking, and gathering consents.

As a CPNP Coordinator, I plan to develop positive relationships with our prenatal families. I will be guided by the following principles:

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 comes from those in the program and community partnerships.
4. **Strengthening and supporting families** – we all share the responsibility for children by supporting parents and families.
5. **Partnerships** - cooperative partnerships are the key to developing an effective program.
6. **Flexibility** - the program must be flexible to respond to the different needs of each family.

Community Health Representative 1 / Canadian Prenatal Nutrition Program

Encounters:

Prenatal/Postnatal Encounters: 248
School Visits: 60
Immunization Entries: 252
Data Entry: 1276
Transportation for Clinic Visits: 313
Group Participation and Collaboration: 143

In conclusion, I am deeply honored to serve the community of Pinaymootang and grateful for the support of the Health Centre staff and leadership. These first months have laid a strong foundation, and I look forward to continuing to build relationships and deliver health programming that reflects the strengths, values, and needs of our people.

Meegwetch,

Heather Anderson - Maternal/Youth Wellness Worker

Community Health Representative 2/ Aboriginal Diabetes Initiative Annual Report

I am pleased to provide this annual report outlining the activities, services, and contributions of the Community Health Representative (CHR) Program and the Aboriginal Diabetes Initiative (ADI) Program within Pinaymootang First Nation Health for the 2025–2026 fiscal year.

The Pinaymootang First Nation Health Program currently employs two Community Health Representatives who work collaboratively to support the health and wellness needs of our community. One CHR focuses primarily on adult and community health programming, while the other provides support for school health, children, and youth initiatives. Together, we work as members of the healthcare team to strengthen community-based services, improve access to health education, and promote healthy lifestyles.

As a Community Health Representative and Aboriginal Diabetes Initiative (ADI) Worker, my dual role is to serve as a link between community members, families, healthcare providers, and community services. Through education, advocacy, outreach, and relationship building, I support individuals in understanding their health needs, accessing appropriate healthcare services, and making informed decisions that promote lifelong wellness.

The CHR and ADI programs take a holistic approach to health by recognizing the importance of physical, mental, emotional, social, and spiritual well-being. Through prevention, early intervention, health promotion, and collaborative partnerships, these programs continue to make a positive impact on the health of individuals, families, and the community.

Community Health Representative Program

Throughout the fiscal year, I provided health education and support related to childcare, nutrition, sanitation, communicable diseases, chronic disease prevention, and healthy lifestyle practices. I assisted community members in navigating healthcare services, accessing available resources, and connecting with healthcare professionals when additional care or referrals were required.

Community wellness remained a key focus through participation in health fairs, workshops, community events, nutrition initiatives, physical activity programs, and community clean-up activities. These initiatives encouraged healthy living while providing opportunities for community members to learn, connect, and engage in health promotion activities.

I also contributed to the continued improvement of Health Centre services by participating in the accreditation process, completing monthly program reporting, attending staff meetings, and supporting quality improvement initiatives. These activities help ensure programs continue to meet community needs while aligning with healthcare standards and best practices.

Community Health Representative 2/Aboriginal Diabetes Initiative Annual Report

Aboriginal Diabetes Initiative Program

The Aboriginal Diabetes Initiative (ADI) Program continues to play an important role in diabetes prevention, education, and chronic disease management within the community. The program promotes healthy lifestyles while supporting individuals living with diabetes through education, self-management, and coordinated care.

Throughout the year, diabetes education focused on:

- Diabetes prevention and risk reduction
- Healthy eating and nutrition
- Blood sugar monitoring
- Medication management
- Physical activity
- Stress management
- Healthy meal planning
- Prevention of diabetes-related complications

Education also included information on the three types of diabetes—Type 1, Type 2, and gestational diabetes—and emphasized the importance of regular screening, healthy food choices, reading nutrition labels, carbohydrate awareness, and maintaining active lifestyles.

The ADI Program continued to promote overall wellness through education on foot care, vision health, cardiovascular health, blood pressure, cholesterol management, and healthy lifestyle modifications. Community members were encouraged to take an active role in managing their health through regular monitoring and preventative care.

An important component of the program continued to be the Gardening Project, which promotes healthy eating, physical activity, food security, and connection to the land. The project encourages community participation while increasing access to fresh, nutritious foods and supporting overall wellness.

Program Collaboration

The CHR and ADI programs work closely with Health Centre staff and community partners to deliver coordinated health promotion initiatives and improve access to services. Collaboration with nursing staff, community programs, schools, and external healthcare providers strengthens preventative care, chronic disease management, and health education throughout the community.

Community Health Representative 2/Aboriginal Diabetes Initiative Annual Report

Looking Ahead

Community engagement and demand for services continued to increase throughout the fiscal year, demonstrating the importance of accessible, community-based health programming. Building trusting relationships with community members remains essential in promoting early intervention, disease prevention, and healthier lifestyles.

I am grateful for the opportunity to serve the members of Pinaymootang First Nation and remain committed to supporting individuals and families through education, advocacy, prevention, and collaboration. Together, the Community Health Representative and Aboriginal Diabetes Initiative programs continue to promote healthier living, strengthen community wellness, and improve health outcomes for present and future generations.

Jethro Woodhouse – CHR, ADI Worker

Support to Nurses Annual Report 2025–2026

I am pleased to provide this annual report outlining the activities, responsibilities, and contributions of the Support to Nurses role within Pinaymootang First Nation Health for the 2025–2026 fiscal year.

The Support to Nurses role at the Pinaymootang Health Centre provides essential reception and administrative services that contribute to the efficient operation of the Health Centre. This position plays an important role in supporting healthcare providers and ensuring community members have timely access to programs and services. Through administrative coordination, client support, and collaboration with the healthcare team, this role contributes to the delivery of safe, accessible, and client-centred care.

As the first point of contact for clients, families, and visitors, front desk reception provides a welcoming and supportive environment while ensuring individuals are connected with the appropriate healthcare provider, including physicians, nurse practitioners, nurses, and program staff. Maintaining a professional and compassionate approach at the front desk is essential in supporting positive client experiences and strengthening relationships with community members.

As an accredited and busy healthcare facility, the Pinaymootang Health Centre provides a wide range of programs and services that support the overall health and wellness of the community. Administrative support is critical in coordinating these services and ensuring the Health Centre operates effectively and efficiently.

Throughout the fiscal year, responsibilities within this role included coordinating appointments for visiting physicians, nurse practitioners, foot care services, mental health providers, and telehealth appointments. Additional duties included greeting and assisting clients and visitors, supporting healthcare providers with patient charting and documentation, receiving and assisting with the distribution of pharmaceutical deliveries and prescriptions, and managing communication related to referrals and healthcare services. Confidentiality and privacy remain a priority in all aspects of the role, ensuring that client information is handled appropriately and in accordance with healthcare standards.

Throughout the year, the Health Centre continued to experience a high demand for healthcare services. Our statistics have shown 788 Nurse Practitioner visits between Brindy and Marco, 248 Dr. Thessien that includes rounds and calls made and 329 from a Chronic Disease Nurse.
The Support to Nurses role continues to be an integral part of the Pinaymootang First Nation Health team. By providing reliable administrative coordination and front-line client support, this position helps ensure the smooth operation of the Health Centre and contributes to the delivery of accessible, efficient, and compassionate healthcare services for the community.

Rose Anderson

Operations and Maintenance Report

The Operations and Maintenance function continues to play a vital role in ensuring the Health Centre remains clean, safe, and fully operational. Daily responsibilities include comprehensive cleaning and sanitation services for both the interior and exterior of the facility. This includes maintaining carpets, furniture, windows, washrooms, and flooring to a high standard of cleanliness.

Waste management is conducted on a daily basis, including the removal of litter and garbage to the local landfill. All duties are carried out with a strong commitment to confidentiality, accuracy, and attention to detail.

Additional maintenance tasks are addressed as needed through contracted services. These include lawn care, HRV system cleaning, lighting fixture replacements, snow removal, drainage maintenance, door repairs, and parking lot grading.

This fiscal year has presented increased demands due to the expansion of the Health Centre. With the facility more than doubling in size, there has been a significant increase in both foot traffic and staffing levels, resulting in a heavier workload for custodial and maintenance personnel. Peak activity, particularly during physician clinic days, has further intensified these demands.

Despite these challenges, continuous efforts have been made to enhance cleaning practices and improve overall maintenance standards. Adjustments and improvements have been implemented to ensure the facility remains a safe and welcoming environment for staff, clients, and visitors.

Operations and Maintenance staff remain committed to maintaining the Health Centre in good working order and ensuring that all areas meet the required standards for health and safety.

Community Wellness Annual Report

Land-based activities were very well attended, with events reaching or exceeding their anticipated participant capacity. Activities offered throughout the year included fish harvesting and filleting, jam making and cranberry canning, floral and wreath workshops, medicine picking and processing, a language camp, and a variety of Indigenous games for participants of all ages.

Total attendance across all programs and events reached 4,099 participants over the course of the year. Program expectations were met, and community interest remained consistently high. Attendance was especially strong at community-wide events such as the Easter Egg Hunt, Community Clean-Up, women's groups, Children's Health Fair, Splash Pad Grand Opening, Treaty Days, Golf Tournament, Health Fair, Back-to-School and Halloween dances, Every Child Matters Walk, Community Craft Sale, Christmas Parade, and the on-reserve Christmas Dinner.

National Addictions Awareness Week, held from November 17–19, 2025, was a significant success. The event was delivered in partnership with PCFS, API, School & IRTC, and featured a community feast and Gospel Jam. Each day saw participation from approximately 100 youth and adults. One ongoing challenge continues to be last-minute cancellations, which limits opportunities for other community members who are interested in attending. Overall, the activities supported balance within the Medicine Wheel by addressing mental, physical, emotional, and spiritual wellness. The primary objective was to promote equilibrium across all four areas.

We remain committed to meeting the needs of our community and will continue to deliver and expand programming in response to community requests.

The following are numbers from the data collection:

Type of activity	Populations Served			Method of Delivery			Total # activities	Total # participants
	Adults	Youth	Children	Virtual	On-the-land	Other		
Substance Use	361	198	3	0	3	2	5	361
Mental Health/Wellness	541	90	370	1	12	5	18	1001
Life Promotion/Suicide Prevention	79	24	22	1	3	4	8	125
Crisis Response	2	0	0	0	0	0	0	0
Other (please specify) Ex: community events	1334	170	1108	0	9	5	14	2612

Christina Sutherland – BFI/BHC Coordinator

Addictions Program Annual Report

My name is Alvin Thompson, and I was born and raised in Pinaymootang. This year marks my 24th year working as an Addictions Counsellor with the NNADAP Program. I am grateful for the opportunity to begin and end each workday with prayer, which guides me in the work I do.

I am committed to advocating for individuals who find themselves in difficult or unwarranted situations. My services extend beyond my own community to other communities, and I strive to provide everyone with the same level of professional, respectful, and compassionate care. Throughout my career, I have remained dedicated to supporting individuals on their journey toward healing, wellness, and hope.

In today's society, we continue to face many challenges, including illness, family dysfunction, and the lasting impacts of colonization. The effects of Indian Residential Schools, Indian Day Schools, Boarding Home Schools, Child and Family Services (CFS), the Indian Act, and other government policies have created intergenerational trauma that continues to affect First Nations individuals, families, and communities.

Trauma often leads to unhealthy coping strategies, including addictions. While alcohol and drugs are common concerns, addictions can take many forms. Family violence, emotional abuse, and sexual abuse also contribute to the challenges faced by children, youth, adults, Elders, women, and men.

The NNADAP Program works with community partners to provide workshops, counselling, training, and culturally grounded, land-based mental health activities that promote healing and healthier lifestyles. Although these programs have positive outcomes, limited funding restricts the number of participants who can benefit from them.
The following chart summarizes data collected through the NNADAP Program. One of the assessment tools used is the Substance Abuse Subtle Screening Inventory (SASSI), a specialized screening tool that helps identify individuals who may be at risk for substance use disorders and supports treatment planning.

Addictions Program Annual Report

The following chart summarizes data collected through the NNADAP Program. One of the assessment tools used is the Substance Abuse Subtle Screening Inventory (SASSI), a specialized screening tool that helps identify individuals who may be at risk for substance use disorders and supports treatment planning.

Month	Number of clients	SASSI	Referrals
April	25	9	13
May	29	14	21
June	21	10	21
July	20	4	9
August	29	8	28
September	28	12	16
October	23	10	10
November	26	10	17
December	10	5	2
January	13	0	0
February	7	3	6
March	11	0	4
Totals	**229**	**82**	**141**

In our community, alcohol remains the most commonly used substance, followed by crack cocaine, methamphetamine, and cocaine. Other substances of concern include inhalants, opioids, and benzodiazepines obtained through prescriptions or the illicit drug market.

Illicit drugs pose significant risks because their contents and potency are unknown. Many may be contaminated or mixed with fentanyl or other synthetic substances, greatly increasing the risk of overdose and death. While fentanyl is a legitimate prescription medication used to manage severe pain under medical supervision, illegally manufactured fentanyl is a major contributor to the current overdose crisis.

Cannabis sold through licensed retailers is regulated to meet established safety standards. However, cannabis obtained through the illicit market is unregulated, and its contents cannot be verified, increasing potential health and safety risks.

Recovery from addiction is a process that occurs in stages. Understanding these stages helps individuals, families, and service providers support long-term healing.

- **Pre-contemplation:** The individual is not yet ready to seek treatment and may deny or rationalize their substance use.
- **Contemplation:** The individual recognizes there is a problem but has not yet committed to making changes.
- **Preparation:** The individual is ready to seek help and begins planning for treatment.
- **Action:** The individual actively participates in treatment, counselling, and recovery supports.
- **Maintenance:** The individual works to maintain sobriety and strengthen long-term recovery.
- **Termination:** The individual has achieved sustained recovery and continues to support a healthy lifestyle.

These stages form a continuum of care that supports individuals throughout their recovery journey. It is important to recognize that relapse can occur and should not be viewed as failure. Instead, it can provide valuable learning opportunities that strengthen long-term recovery. Ongoing support, encouragement, and professional guidance remain essential throughout the healing process.

Sincerely,
Alvin Thompson CAC II BSW RSW
Addictions Coordinator

Medical Transportation Program Annual Report

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

The Medical Transportation Program plays a vital role in ensuring eligible community members have access to medically necessary healthcare services that are not available within Pinaymootang First Nation. The program helps reduce barriers to healthcare by coordinating safe, timely, and cost-effective transportation in accordance with the Non-Insured Health Benefits (NIHB) Medical Transportation Policy. The program is delivered by a dedicated team consisting of one Medical Transportation Coordinator, one part-time Medical Transportation Assistant, and four Medical Drivers, who work together to coordinate travel, support clients, and ensure access to essential medical services.

Medical Transportation benefits are available to eligible First Nations members residing on reserve who require medically necessary services that cannot be provided within the community. Transportation is coordinated in accordance with NIHB guidelines and supports travel to the nearest appropriate healthcare facility using the most economical and practical means of transportation based on the client's medical needs.

Eligible services include travel to: Physician and specialist appointments, diagnostic testing and medical imaging, hospital services and surgical procedures, allied health services, medical treatments and follow-up care and traditional Healers and recognized Treatment Centres, where eligible under NIHB.

The Medical Transportation team coordinates a wide range of services to ensure clients can safely access healthcare appointments and treatments. Responsibilities include:

- Coordinating and scheduling medical transportation for eligible clients.
- Booking, confirming, and rescheduling medical appointments.
- Maintaining accurate client files and transportation records.
- Preparing travel authorizations and required documentation for private vehicle reimbursement.
- Issuing meal vouchers for eligible clients travelling for medical appointments.
- Coordinating accommodation for eligible clients requiring overnight stays due to surgery, medical treatment, or post-operative care.
- Preparing daily transportation schedules and passenger manifests for Medical Drivers.
- Verifying appointment attendance and processing travel documentation for reimbursement.
- Providing information and assistance regarding NIHB Medical Transportation policies and eligibility.

Medical Transportation Program Annual Report

Through careful coordination and collaboration with healthcare providers, hospitals, clients, and families, the Medical Transportation Program continues to improve access to healthcare services while ensuring transportation resources are used efficiently and responsibly.

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: 2025 – 2026 April 1 – August 31	Recipient: Pinaymootang First Nation Contribution Agreement: MB0700072	
# of requests: 1707	# of exceptions requested: 6	# of appeals: 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 (Multiple times per day)
- Dialysis (6 days a week, 4 trips a day)
- On-Call 24/7 plus additional appointments to non-Winnipeg destinations

We provide transport to nearest open facility available

Major Accomplishments in the program during the reporting period:

The program received much needed replacement vehicles.

Medical Transportation Program Annual Report

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 2 clients that are every Tuesday-Thursday-Saturday at the Lakeshore General Hospital in Ashern, MB and we have 2 additional dialysis clients in Winnipeg doing their treatment until a spot becomes available to them in Ashern MB.

With 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 they Physicians advising them of our policies sand procedures regarding private transportation.

We have also diagnosed cancer patients who 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 Ashern, 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 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 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.

Medical Transportation Program Annual Report

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

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: **2025 – 2026** **Sept 1 – November 30**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **1071**	# of exceptions requested: **4**	# of appeals: **0**
# of requests approved:	# of exceptions approved:	# of favorable appeals: **0**

How are the benefits being provided?
Medical Transportation benefits are delivered through a coordinated transportation program operated by the First Nation.

One full-time and part-time Medical Transportation Coordinator is currently employed to support clients by booking medical appointments, coordinating transportation, schedules and providing supervisory oversight to both the Medical Transportation Assistant and the medical drivers.

The program employs the equivalent of 3.5 full-time drivers who are responsible for transporting clients to and from medical appointments. Drivers work on a rotating schedule and are provided with a monthly work schedule and additional on-call drivers are hired as required to meet service demands.

4 Vans in use:
- Winnipeg (Daily)
- Ashern (Multiple times per day)
- Dialysis (6 days a week, 4 trips a day)
- On-Call 24/7 plus additional appointments to non-Winnipeg destinations

Transportation is provided to the nearest open medical facility, ensuring timely access to required healthcare services.

Medical Transportation Program Annual Report

Major Accomplishments in the program during the reporting period:

- Continued to provide reliable and consistent medical transportation services, ensuring community members could access essential healthcare appointments, including specialist care, dialysis, and emergency services.
- Maintained daily transportation to Winnipeg and multiple daily trips to Ashern, improving access to regional healthcare services.
- Provided dialysis transportation six days per week with four trips daily, ensuring uninterrupted access to life-sustaining treatment.
- Maintained an efficient scheduling system with monthly driver rotations and 24/7 on-call coverage to meet urgent transportation needs.
- Coordinated medical appointments and transportation logistics, helping reduce missed appointments and improve continuity of care.
- Effectively managed a four-vehicle fleet to meet community transportation needs while minimizing service interruptions.
- ·Ensured clients were transported to the nearest appropriate healthcare facility with available services.
- Strengthened program operations through effective coordination and communication among drivers, support staff, clients, and healthcare providers.

Major Challenges in delivering the program during this reporting period:

- Demand for Dialysis Transportation:
  The program continues to support nine dialysis clients, including:
  - Six clients attending dialysis three times per week (Monday–Wednesday–Friday) at Lakeshore General Hospital in Ashern, MB
  - Two clients attending dialysis every Tuesday–Thursday–Saturday at the same facility
  - One additional dialysis client currently receiving treatment in Winnipeg until space becomes available in Ashern

These schedules place significant and ongoing pressure on transportation resources, driver availability, and vehicle usage.

- Increase in Prenatal and High-Risk Pregnancy Travel:
  - There has been an increase in transportation requests for prenatal care, particularly for clients at 38-week gestation and for those with high-risk pregnancies, requiring more frequent, time-sensitive, and long-distance travel.
- Rising Meal Costs for Clients Traveling to Winnipeg:
  - The increase in food prices, particularly at Salisbury House, has resulted in higher meal costs. The current meal ticket is becoming insufficient, requiring the program to issue two meal tickets per day for clients who remain in Winnipeg for extended periods, increasing program expenditures.

- Private Travel Authorization Challenges:
  - A major challenge has been the submission of physician letters requesting private transportation for clients, which do not align with program policies and therefore cannot be honored. The Medical Transportation Coordinator has proactively contacted facilities to explain program policies and procedures regarding private travel, though this remains an ongoing issue.
- Private Transportation for Immunocompromised Clients:
  - Several cancer patients requires private transport due to compromised immune systems, limiting the ability to use shared transportation and increasing costs and scheduling complexity.
- Expanded Geographic Service Area for Discharges:
  - Medical Transportation is increasingly required to pick up discharged clients from multiple locations across the Interlake region, including Ashern, Eriksdale, Hodgson, Stonewall, St. Rosé, Selkirk, Dauphin, and Arborg, placing additional strain on drivers, vehicles, and scheduling.
- Ongoing Transportation Coordination Pressures:
  - Transport coordination remains a significant challenge during this fiscal period. The program operates on a 24/7 on-call basis to accommodate frequent hospital transfers, discharges, and emergency transportation, leading to increased workload, scheduling difficulties, and staff fatigue.

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

- Late-Night Hospital Discharges:
  - Late-night discharges create additional staffing pressures, including overtime, on-call requirements, and increased follow-up care coordination.
- Rising Complexity of Medical Needs:
  - An increase in clients with complex and chronic medical conditions has led to more frequent and specialized transportation services, driving up program expenses.
- Fuel Cost Increases:
  - Rising fuel prices continue to significantly impact transportation-related expenditures.
- Vehicle Repairs and Maintenance:
  - Noticed a slight increase in repair and maintenance costs.
- Increased Demand for Private Travel:
  - There has been a growing need and number of requests for private travel, increasing both transportation and administrative costs.
- Hotel Accommodation Bookings and Confirmations:
  - Increased travel has led to a higher volume of hotel bookings and confirmations, adding administrative workload.
- Hotel Accommodation Reimbursement Challenges:
  - Reimbursement delays and increased costs have occurred due to NIHB-approved hotels being occupied by evacuees, limiting availability, and increasing accommodation expenses.

Medical Transportation Program Annual Report

Other relevant observations, comments or information to this program:
There is a strong need for a printed FNIHB policy and guidelines booklet to support client understanding of the Medical Transportation Program. While program policies and criteria particularly those related to private travel approvals are available on the website, not all clients access or utilize online resources.

As the program coordinator, having to deny requests based on established eligibility criteria can be challenging and often leads to misunderstandings. Providing clients with a clear, easy-to-understand booklet outlining program policies, decision-making criteria, and client responsibilities would improve transparency, reduce confusion, and support consistent communication.

A physical booklet would serve as a valuable reference for clients, help manage expectations, and strengthen trust in the program by clearly explaining how decisions are made and what services are covered.

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

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: **2025 - 2026** **December 1 – March 31**	Recipient: **Pinaymootang First Nation** **Contribution Agreement: MB0700072**	
# of requests: **1124**	# of exceptions requested: **7**	# of appeals: **0**
# of requests approved:	# of exceptions approved:	# of favorable appeals: **0**

How are the benefits being provided?
The Medical Transportation Program is staffed by one full-time/part-time Medical Transportation Coordinator who is responsible for booking medical appointments, coordinating client transportation, and providing supervision and support to the transportation assistant and medical drivers.

Medical Transportation Program Annual Report

The program currently employs 3.5 full-time drivers who transport clients to medical appointments on a rotating schedule. Drivers follow monthly schedules, and additional on-call drivers are utilized as needed to ensure uninterrupted service.

The program operates four vans and provides:

- Daily transportation to Winnipeg.
- Multiple daily trips to Ashern.
- Dialysis transportation to Ashern six days per week, with four trips each day.
- 24/7 on-call transportation, including appointments outside of Winnipeg when required.

Medical transportation is provided to the nearest appropriate health care facility with available services, ensuring clients have timely access to essential medical care.

Major Accomplishments in the program during the reporting period:
During the reporting period, the Medical Transportation Program continued to provide reliable and consistent transportation services, ensuring community members had access to essential healthcare appointments, including specialist care, dialysis, and emergency services. The program maintained daily transportation to Winnipeg and multiple daily trips to Ashern, improving access to regional healthcare facilities. Dialysis transportation was provided six days per week with four trips daily, ensuring clients received uninterrupted access to necessary treatment.

The program maintained an efficient scheduling system with monthly driver rotations and 24/7 on-call coverage to respond to urgent transportation needs. Medical appointments and transportation logistics were coordinated to help reduce missed appointments and improve continuity of care. The four-vehicle fleet was effectively managed to meet community transportation demands while minimizing service disruptions. Clients were transported to the nearest appropriate healthcare facility with available services, and program operations were strengthened through effective communication and coordination among drivers, support staff, clients, and healthcare providers.

Major Challenges in delivering the program during this reporting period:
During the reporting period, the Medical Transportation Program supported six dialysis clients attending treatment three times per week at Lakeshore General Hospital in Ashern, MB. Two clients attend Monday-Wednesday-Friday, two attend Tuesday-Thursday-Saturday, and two clients continue to receive treatment in Winnipeg until space becomes available in Ashern.

With increased prenatal care needs, transportation is provided for clients at 38 weeks of pregnancy, as well as for high-risk pregnancies requiring specialized care.

Medical Transportation Program Annual Report

A major challenge during this reporting period has been requests for private travel supported by physician letters. These requests are reviewed according to program policies, and communication with physicians has been initiated to clarify transportation guidelines. The program also continues to support cancer patients requiring transportation due to compromised immune systems.

Medical Transportation continues to provide discharge transportation from various locations throughout the Interlake region, including Eriksdale, Hodgson, Stonewall, St. Rose, Dauphin, and Arborg. Coordination remains a significant challenge due to the ongoing need for 24/7 on-call services to respond to transfers, discharges, and emergency transportation needs.

Identify the factor (s) that may be impacting the budget:
The Medical Transportation Program continues to face increasing demands as the need for services grows.

Late-night hospital discharges continue to affect staffing, scheduling, and follow-up care, while the growing number of clients with complex medical needs requires more frequent and specialized transportation.

Rising fuel costs, along with slow increased vehicle repairs and maintenance, place a financial pressure on the program. In addition, requests for private have increased, and the growing need to coordinate hotel accommodations for medical appointments has added to the administrative workload. Despite these challenges, the program remains committed to providing safe, reliable, and timely transportation services that ensure community members have access to essential healthcare.

Other relevant observations, comments or information to this program:
There is a strong need for a printed FNIHB policy and guidelines booklet to support client understanding of the Medical Transportation Program. While program policies and criteria particularly those related to private travel approvals are available on the website, not all clients access or utilize online resources.

As the program coordinator, having to deny requests based on established eligibility criteria can be challenging and often leads to misunderstandings. Providing clients with a clear, easy-to-understand booklet outlining program policies, decision-making criteria, and client responsibilities would improve transparency, reduce confusion, and support consistent communication.

A physical booklet would serve as a valuable reference for clients, help manage expectations, and strengthen trust in the program by clearly explaining how decisions are made and what services are covered.

Submitted by,

Maggie Anderson
Medical Transportation Coordinator

Home and Community Care Health Annual Report

It is hard to believe that another year has so quickly come and gone. I am honored to continue building relationships and caring for the members of the community. I am working on my sixth year of serving the people of Pinaymootang. Over the years I have been blessed with many opportunities for growth and professional development. I have continued to learn and be mentored by leadership and our fearless and dedicated Director of Health, who has taught me how to navigate Health Systems as well as advocate for improved care and bringing services to the Nation for the betterment of the people. Along with my primary roles as Home and Community Care Nurse Supervisor, and Foot Care, I also assist in the clinic, public health and support other programs in the Health Centre. Together we continue to work as a fierce Health Care Team.

Our Home and Community Care Team and Mission

1 Full time LPN Nurse Supervisor, Nancy Friesen
1 Part time LPN, Maegan Anderson
3 Full time Health Care Aides, Dorothy Sumner, Jody Sinclair, and Lucille Ross.

The Home and Community Care team is committed to serving clients living with chronic disease, acute illness, and supporting clients with disability. Assistance with preserving and maximizing the ability for community members to remain in their homes safely for as long as possible.

Our program is not to replace, but to enhance the care already provided by family members.

The Home and Community Care Program Available Services
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, monitoring results and Physician consults.
- Medication administration and monitoring
- Wound Care/Foot Care
- Physical Assessment
- Providing various health education.
- Communication with and referrals to appropriate Healthcare providers and Specialists.
- Client Care plans and Medication reviews
- Patient advocacy and discharge planning/Ashern Lakeshore General Hospital Rounds Tuesday's weekly
- Patient advocacy and discharge planning/Eriksdale EM Crowe Hospital Rounds Wednesday's weekly
- Assistance with the Long-Term Care and Supportive Housing application process
- Homemaking (PFN Social Program) Referrals Only

Home and Community Care Health Annual Report

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 PFN 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 as long as safely possible.

Foot Care:

- 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 also provides foot care when needed.Foot Care appointments can be made by calling reception at the Health Centre.

Home and Community Care Statistics:

Foot Care Services Provided Fiscal Year 2025/2026

Nurse	Encounters
Brenda Henry	262
Nancy Friesen	30
Total Encounters	292

Home and Community Care Health Annual Report

Home & Community Care Staff Encounters April 1, 2025, to March 31, 2026

STAFF	ENCOUNTERS
Nancy Friesen	1791
Maegan Anderson	979
Jody Sinclair	1990
Dorothy Sumner	1243
Lucille Anderson	1731
Brenda Henry	274
Other Nursing	40
Total Fiscal Year Encounters	**8048**

Nancy Friesen Nurse Supervisor Encounter Breakdown

Home Visits	732
Clinic Visits	539
Hospital Visits	22
School Visits	2
Advocacy/Consults/Other	495
Total Encounters	**1791**

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

Month	Year	Active Clients	Homecare Visits	Hours of Service
April	2025	77	283	264.5
May	2025	59	267	355.25
June	2025	72	265	269.5
July	2025	74	374	480.25
August	2025	69	364	382.5
September	2025	85	425	449
October	2025	71	364	374.5
November	2025	72	318	298.5
December	2025	70	273	313.25
January	2026	74	357	361.25
February	2026	70	274	300
March	2026	72	334	347.5
Totals			**3898.00 Visits**	**4196.00 Hours**

Home and Community Care Health Annual Report

Total Homecare Clients within the Reporting Period

Client Summary

Number of Active Clients* **153**

Number of Unique Homecare Clients **133**

*Clients may not be enrolled in Homecare but can receive Homecare service.

Meetings/Training/Conferences in the 2025/2026 Fiscal Year:

- Tribal Council and Independent Home and Community Care Quarterly Meetings (Nancy)
- Foot Care Conference May 22-26, 2025 (Brenda/Nancy)
- Physiotherapy Tele Rehab Work with The University of Manitoba (Nancy)
- Emergency Medical Services Meeting to Advocate for Improved Ambulance Services and Delivery of Care (Nancy)
- Hospital Discharge Planning/Doctors Rounds Lakeshore General Hospital, Tuesdays (Nancy)
- Hospital Discharge Planning/Doctors Rounds EM Crowe Hospital, Wednesdays (Nancy)
- Strawberry Picking July 3, 2025 (Maegan and Dot)
- Community Breakfast/Health Fair/Treaty Days, August 2025 (Home Care Team)
- Jordan's Principle Service Coordinator Gathering "Rooted in Support, Rising in Strength," September 2025 (Nancy)
- On going Jordan's Principle Supports for Group Report Submissions and Indigenous Services Canada Meetings. (Nancy)
- IERHA/EMS Capacity Building and Improved Delivery of Care Meeting, October 2025 (Nancy)
- Mustimuhw Champion and continued staff supports /Upgrade Lead (Nancy)
- University of Manitoba Physiotherapy Evaluation Framework Working Group Lead. (Nancy)
- Elder Christmas Tea, December 2025 (Home Care Team)
- Collaboration and Advocacy for Services/Supplies Meeting with Shared Health Lab Services
- Community Resource Symposium, January 2026
- Professional Development Anti-Indigenous Racism in Health Care Conference, February 18/19, 2026 (Home Care Team)
- Elder Gathering "Roots of Strength, Hearts of Wisdom", March 9/10/11, 2026 (Home Care Team and Michelle)
- Gardening with Elders (Home Care Team, Jody Lead)
- First Aid and CPR Training (Home Care Team)
- Splash Pad Grand Opening (Jody, Dot, and Lucille)
- Smart Work Ethics Training (Jody)
- Staff Professional Development
- Annual Education Gathering Tribal Council and Independent Home and Community Care (Home Care Team)

Respectfully.

Nancy Friesen – HCC Nurse Supervisor

Aboriginal Head Start Outreach Program Annual Report

Aboriginal Head Start Outreach Program Annual Report

Aneen! My name is Cherish Sumner, and I am a Level II Early Childhood Educator serving as the Aboriginal Head Start On-Reserve (AHSOR) Outreach/Home Visitor Coordinator with Pinaymootang Health. This is my fifth year as the AHSOR Coordinator, and I have proudly been employed with Pinaymootang Health for the past nine years.

I am truly grateful for the opportunity to work alongside the children and families in our community and to build meaningful, trusting relationships that support healthy child development and family wellness.

The Aboriginal Head Start On-Reserve (AHSOR) program serves children from birth to six years of age and is built around six key components: Culture and Language, Nutrition, Health Promotion, Education and School Readiness, Social Supports and Parental and Family Involvement.

The early years of a child's life are critical to lifelong learning and development. Research shows that children learn more between the ages of 0 and 5 than at any other stage of life. During this time, the neural connections in a child's developing brain grow rapidly, making early experiences essential to healthy development. The goal of the AHSOR program is to provide positive, nurturing, and interactive learning experiences that strengthen these developing neural connections. Children learn best through play and developmentally appropriate environments that encourage exploration, creativity, and confidence. Every interaction with children and families is designed to help each child reach their full potential while fostering healthy growth and development.

As the Outreach/Home Visitor, I provide home visits within the community where parents or caregivers and their children complete the Ages and Stages Questionnaires (ASQ) in the comfort of their own homes using hands-on learning materials and interactive activities. Families also have the option of completing the ASQ at the Health Centre or during Mom/Dad & Tot programming.

The Ages and Stages Questionnaire is a developmental screening tool that evaluates five key areas of child development: Communication and Language, Cognitive Development, Fine Motor Skills, Gross Motor/Physical Development and Social and Emotional Development. Once completed, the questionnaire provides a general overview of a child's developmental progress according to their age. If concerns are identified in any developmental area, referrals are made to appropriate services to ensure children receive early intervention and support.

Aboriginal Head Start Outreach Program Annual Report

Mom/Dad & Tot programming is offered bi-weekly and provides opportunities for families to learn, play, and connect. Activities include Playgroups with fine and gross motor activities, Cooking classes, Baby food preparation classes, Arts and crafts, Outdoor play, Gardening, Sewing classes, "Nobody's Perfect" parenting program, Car seat safety education, Cultural teachings, Seasonal celebrations, and Family-focused educational activities. These programs encourage positive parent-child interactions while supporting healthy development, school readiness, and family well-being.
The AHSOR program currently serves: 116 enrolled children, 71 families.

Through our ongoing partnership with the Dollywood Imagination Library, approximately 94 children receive one free book each month until their fifth birthday, encouraging early literacy and a lifelong love of reading.

The AHSOR program works closely with several community programs and partners, and together we organize community programming, events, and family-centered activities. One of the year's greatest accomplishments was leading the planning and coordination of the 2025 Children's Health Fair. The event was highly successful and brought together numerous community services, that included; Program enrollment, Childhood immunizations, Status card applications, Mental health supports, Child development resources and Family health education. The Children's Health Fair strengthened collaboration among community partners while improving access to services that support the overall health and well-being of children and families.

Ages and Stages Questionnaire's/Home Visits	132
AHSOR Encounters	632
Referrals	4
Overall Programming and Event Encounters	1442

Challenges
Limited program space and last-minute cancellations make it difficult to offer available spots to families on the waitlist. Seasonal illnesses during the fall and winter also reduce attendance at programming and home visits. Despite these challenges, the program remains flexible and committed to providing quality support and services to families throughout the year.

Aboriginal Head Start Outreach Program Annual Report

Professional Development

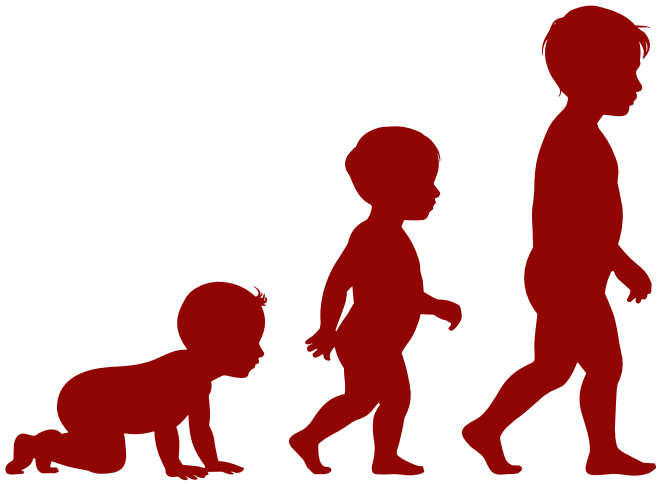
Throughout the year, I participated in ongoing professional development and collaborative meetings, including:

- Monthly AHSOR Meetings
- Pinaymootang Health Staff Meetings
- First Nations Early Learning and Child Care (FNELCC) Directors and Coordinators Meetings
- FNELCC Conferences
- University of Manitoba Food Security Project in partnership with Protein Industries Canada
- Nutrition Training

Continued learning and collaboration strengthen my ability to provide current, evidence-informed programming that meets the evolving needs of children and families.

I welcome feedback from families as we continue to strengthen our programming. It is an honour to support our children during these important early years and help build a strong foundation for their future success.

Cherish Sumner, AHSOR Coordinator



Jordan's Principle, Child First Initiative - My Child, My Heart Program Annual Report

My name is Sheri Gould, and I am the Lead Case Manager for the Niniijaanis Nide (My Child, My Heart) Program. I have had the privilege of serving in this role since May 1, 2023. I hold a Bachelor of Social Work degree from the University of Manitoba and have worked in a variety of positions supporting both children and adults within our community. My passion is working alongside children and families to ensure there are no gaps in services. Through both my professional and lived experience, I understand the importance of ensuring First Nations children receive the supports they need without denial, delay, or disruption

Program Overview

The Jordan's Principle, Child First Initiative was established in Pinaymootang First Nation in December 2015. Since then, the program has continued to expand following the historic decisions of the Canadian Human Rights Tribunal, ensuring that all First Nations children can access the health, educational, social, and cultural services they require.

Jordan's Principle is founded on the belief that First Nations children should receive public services without delay or denial simply because of jurisdictional issues. Through this child-first approach, our program works to eliminate barriers and ensure children and families receive timely, equitable, and culturally appropriate supports.

The Niniijaanis Nide (My Child, My Heart) Program continues to grow each year. During the 2025–2026 fiscal year, 691 children were enrolled in the Jordan's Principle Program, demonstrating the increasing need for community-based supports and services.

Program Team

The Jordan's Principle Program employs a multidisciplinary team dedicated to meeting the diverse needs of children and families. The team currently includes:

- 1 Lead Case Manager
- 4 Case Managers
- 1 Intake Worker
- 1 Youth/Family Therapist
- 1 Rehabilitation Assistant
- 2 Medical and Dental Navigators
- 1 Administrative Assistant
- 1 Cultural Wellness Facilitator/Knowledge Keeper
- 7 Land-Based Workers

Jordan's Principle, Child First Initiative - My Child, My Heart Program Annual Report

Together, the team works collaboratively to provide coordinated, child-centred, and culturally responsive services that support the health, development, and well-being of children throughout the community.

Program Services

Case Managers work directly with families to coordinate services, advocate for children's needs, develop care plans, and collaborate with healthcare professionals, educators, therapists, and service providers to ensure children receive appropriate supports.
The Administrative Assistant provides essential administrative and organizational support that allows services to be delivered efficiently while maintaining timely communication with families and service providers.

The Rehabilitation Assistant coordinates appointments for children ages 0–4 years with visiting rehabilitation professionals, ensuring continuity of care and communication between families and healthcare providers.

The Intake Worker is responsible for receiving and processing new referrals, completing intake assessments, maintaining accurate client records, and coordinating the collection of required documentation. This role serves as the first point of contact for families, helping to ensure timely access to services while supporting efficient communication and coordination within the program.

Medical and Dental Navigators assist families in accessing specialized healthcare services by coordinating appointments, navigating healthcare systems, advocating for children's needs, and reducing barriers to medical and dental care.
The Youth/Family Therapist provides trauma-informed, culturally safe counselling and therapeutic support to children, youth, and families. Services focus on promoting emotional well-being, strengthening coping skills, supporting healthy family relationships, and addressing mental health concerns through individual, family, and group interventions.

The Cultural Wellness Facilitator and Land-Based Workers provide culturally grounded programming that promotes healing, identity, connection to the land, language, traditional knowledge, and community belonging. Programming is guided by the seasons and supports the mental, emotional, physical, and spiritual wellness of children, youth, and families.

Collaborative Care

The Jordan's Principle Program continues to work closely with Mental Health Services within the Health Centre and external service providers to ensure children and youth have access to comprehensive supports.

Jordan's Principle, Child First Initiative - My Child, My Heart Program Annual Report

Our program collaborates regularly with Occupational Therapists, Physiotherapists, Speech-Language Pathologists, Dietitians, Social Workers, Rehabilitation Specialists, and St. Amant's Jordan's Principle team. These partnerships strengthen continuity of care while increasing access to specialized assessments, therapies, and family supports.

Professional Development

- Providing quality services begins with investing in our staff. Throughout the fiscal year, team members participated in a variety of professional development opportunities, including:
- Technical Advisory Group meetings
- Occupational Therapy, Physiotherapy, and Speech-Language Pathology education sessions
- St. Amant workshops
- Smart Work Ethics Training
- "Nobody's Perfect" Parenting Program training
- Ongoing mentorship and interdisciplinary learning opportunities
- First Aid and CPR

These educational experiences continue to strengthen staff knowledge, improve service delivery, and enhance supports provided to children and families.

Community Programming

The Niniijaanis Nide (My Child, My Heart) Program delivers comprehensive, child-centred programming that reflects the principles of Jordan's Principle by ensuring First Nations children have equitable access to services that support their physical, emotional, mental, social, cultural, and spiritual well-being. Programming is designed to remove barriers, address unmet needs, strengthen family relationships, and promote healthy child development through culturally relevant and inclusive experiences.

Throughout the fiscal year, programming focused on the following key areas:

Health Promotion and Wellness

Programs encouraged healthy lifestyles through nutrition education, physical activity, mental wellness initiatives, grief supports, walking clubs, cooking classes, dietitian services, rehabilitation supports, wellness camps, and access to allied health professionals.

Cultural Identity and Land-Based Learning

Children and families participated in land-based activities and traditional teachings that strengthened cultural identity, connection to the land, and intergenerational learning. Activities included trapping, fishing, ice fishing, traditional harvesting, deer skinning demonstrations, gardening, kayaking, and seasonal teachings led by Elders and Knowledge Keepers.

Jordan's Principle, Child First Initiative - My Child, My Heart Program Annual Report

Family Strengthening
Recognizing that strong families support healthy children, the program provided opportunities for parents, caregivers, and children to participate together through family gatherings, parent planning meetings, holiday celebrations, community feasts, virtual programming, and seasonal events that fostered connection, resilience, and community belonging.

Recreation and Social Inclusion
Recreational programming promoted social development, confidence, and positive peer relationships through sports days, boys' and girls' groups, camping experiences, cultural outings, community celebrations, youth events, and educational excursions.

Community Partnerships
The Jordan's Principle team collaborated with Health Centre programs, schools, rehabilitation professionals, mental health providers, Elders, Knowledge Keepers, and community organizations to ensure children and families received coordinated, wraparound supports that reflected their individual strengths and needs.

By providing accessible, culturally safe, and responsive programming, the Jordan's Principle team continues to uphold the Child First Initiative by ensuring children receive the services and opportunities they need without delay or disruption. Through collaboration, prevention, early intervention, and meaningful engagement with families, the program continues to build stronger foundations for healthy children, resilient families, and a thriving community. These activities continue to strengthen cultural identity, encourage healthy lifestyles, build resilience, and create opportunities for children and families to connect with one another and their community.

As demand for Jordan's Principle services continue to increase, our program remains committed to expanding opportunities for children and families. Future priorities include strengthening our land-based programming, increasing traditional language learning opportunities, and continuing to work alongside Elders and Knowledge Keepers to ensure cultural teachings remain at the heart of our services.

We remain committed to delivering comprehensive, culturally safe, and community-driven programming that responds to the unique needs of every child and family. It is an honour to serve the children of Pinaymootang First Nation, and we look forward to continuing this important work together.

Respectfully submitted,
Sheri Gould, BSW - Lead Case Manager
Niniijaanis Nide (My Child, My Heart) Program
Jordan's Principle – Child First Initiative

Drinking Water Safety Program Annual Report

The Drinking Water Safety Program is funded through the First Nations and Inuit Health Branch (FNIHB) and supports a part-time Community-Based Water Monitor (CBWM). The program is dedicated to protecting the health of community members by monitoring drinking water quality and ensuring safe drinking water practices.

Working in collaboration with Kiran Sidhu, Environmental Health Officer with FNIHB, a community-specific water sampling plan has been developed to address local environmental conditions and identify potential risks in both public and private water systems.

Program Activities

The Drinking Water Safety Program includes:

- Semi-annual sampling of private wells.
- Weekly microbiological testing of public building wells and distribution systems.
- Weekly chlorine residual testing at four community locations, including two school distribution system sites and two townsite pump houses.
- Community education through newsletters and public awareness initiatives.
- Boil Water Advisory notifications and follow-up.
- Well chlorination support.
- Delivery of Food Safety (Food Handlers) training for community members.

Water samples are tested at the Health Centre for Total Coliforms and Escherichia coli (E. coli) using the Colilert/Colisure testing system provided by FNIHB. Samples are incubated at 35°C for 24–28 hours, after which results are recorded, and any required follow-up actions are completed.

Brady Traverse - DWS

Adults with Intellectual Developmental Exceptionalities (AIDE) Program Annual Report

The Adults with Intellectual Developmental Exceptionalities (AIDE) program provides educational, advocacy and goal-orientated support services for adults with intellectual or developmental disabilities living on-reserve in Pinaymootang First Nation. The AIDE program has been recognized across the country as the first on-reserve program to address the gap in services for adults with lifelong physical and intellectual disabilities. Staff are excited to share that Indigenous Services Canada has agreed to continue funding this growing program for the next fiscal year. AIDE hopes to continue fostering a strong sense of community that honors the gifts of our participants and builds each participants' sense of autonomy, confidence and motivation.

Summary of Services

Circle of Care – 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. [See Figure 1.0]

Learning and Development – Education and skill development are the foundation of the AIDE Program. Programming focuses on providing participants with skills that are relevant, transferrable and valuable to each participant's life. The AIDE program is thankful for all the knowledge and heart put into programming from our facilitators, valued elders and local knowledge keepers.

Promoting Structure and Consistency – The AIDE program offers a list of health promoting activities that reoccur monthly, including food security solutions, prepping easy cooking class, grocery shopping, monthly hamper delivery, language circles, hygiene care, emotional well-being support, and land-based cultural activities.

Case Management and Individualized Care Planning – Participants also receive individualized support and one-on-one services offered by the AIDE Case Specialist, Resource Workers and Program Manager. The aim of client-specific services is for one-on-one engagement with each participant to support their individualized care plan, 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.

Adults with Intellectual Developmental Exceptionalities (AIDE) Program Annual Report

Some goals we achieved this year were:

- Physiotherapy
- Speech Language Pathology for Indigenous adults who were unable to access these supports earlier in life.
- Successful completion of disability credit applications
- Psychologist assessment and diagnosis
- Advocation for secured housing and renovations
- Personal banking, Dental, Crisis Support, Harm Reduction, and more!

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 with the community and represent a positive glimpse of what it looks like to thrive with disabilities.

Program Statistics

Population Served – Rather than primarily utilizing the term “disability”, AIDE’s philosophy is to highlight the strengths and gifts those living with disabilities have. This is the reason for the use of the term “exceptionality”. AIDE hopes to continue reducing the stigma surrounding disability and special needs in the community through advocacy, education and representation. During the 2025-2026 fiscal year, AIDE received 11 new referrals resulting in 7 new regular participants. See Figure 2.0 for the visual chart.

Programming – 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.

This fiscal year, the AIDE program offered 136 group activities and/or educational workshops for program participants and their family members. In 2025/2026, most activities were Social and Community Connection (24%), highlighting the desire program participants have to reduce social isolation and continue building strong social connections together. The visual of the program wheel for this year is helpful to demonstrate the balance of all activities and to show staff where we can improve when planning programs and workshops. See Figure 3.0 for the visual image of this years Circle of Care.

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 Administrative Assistant, Case Specialist and a team of Resource Workers.

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AIDE staff attended a total of 12 days in professional development over the last fiscal year (this number does not include time spent in team or health centre meetings, which does include training opportunities). Providing staff with training opportunities will ensure culturally competent, relevant and skilled service delivery. Some trainings received this year included:

- Disability Awareness Resource Training (DART)
- Mental Health First Aid
- Beyond Limits: Canada's Conference for Diversity and Accessibility 2025
- Excel Level 1 Training
- First Aid and CPR

Again, the entire AIDE Team would like to thank all our participants, families, community members, stakeholders and leadership for their dedication and support of the AIDE Program. Together we will continue to foster a positive sense of community and increase opportunity for our relatives with exceptionalities.

Kichii Miigwetch,
Chantell Neff - AIDE Program Manager

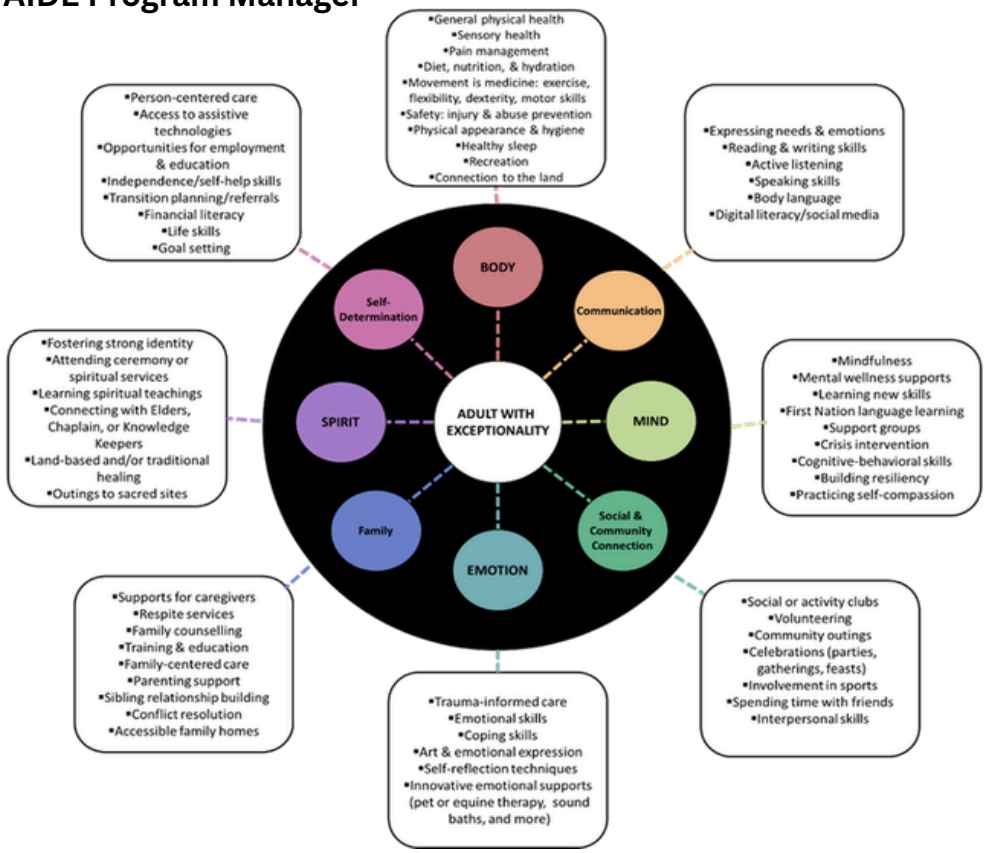

Figure 1.0 - AIDE program staff utilize a Circle of Care model when planning program to ensure all aspects of the participant are considered to provide wholistic support.

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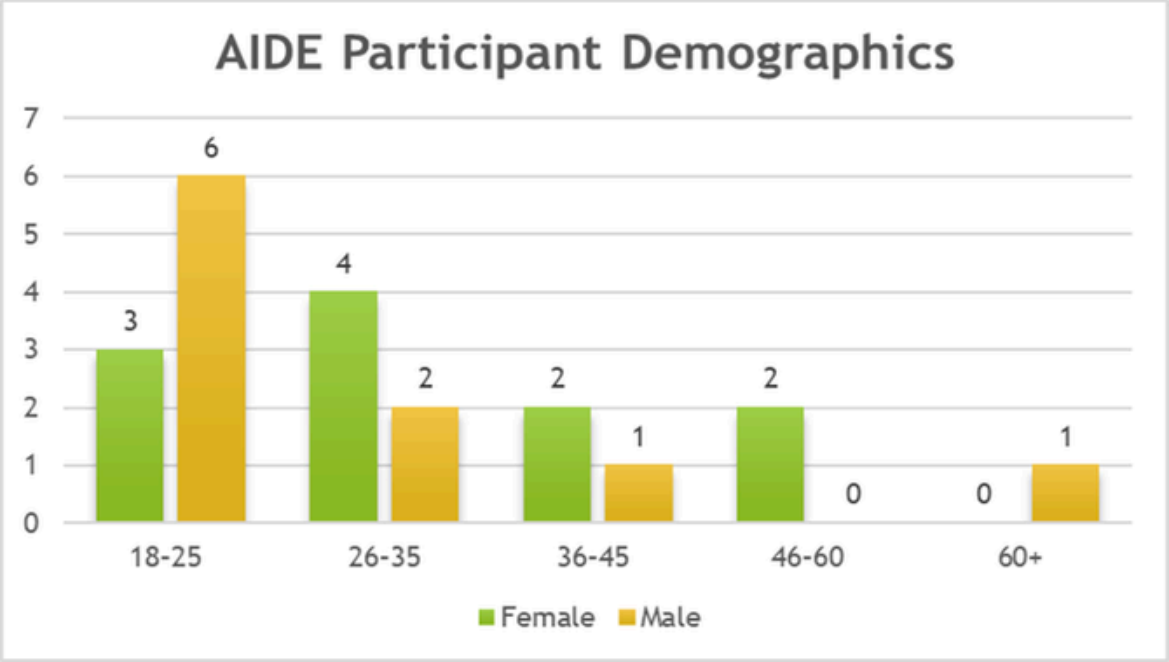

Figure 2.0 – Visual chart of the age and gender demographics of the AIDE Program Participants.

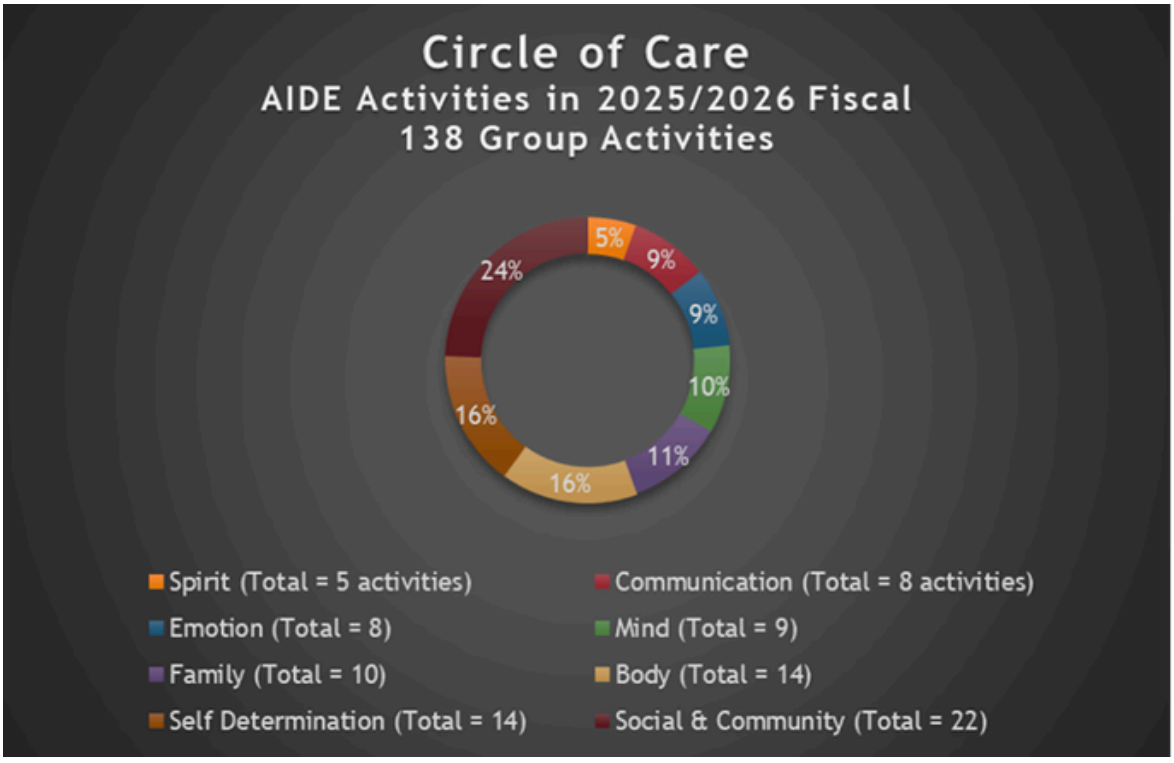

Figure 3.0 – Visual representation of this years wholistic programming.

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.