DIABETES INTEGRATION PROJECT ANNUAL REPORT F/Y 2017/2018

Contents

1.0 Introduction

On behalf of the Nanaandawewigamig (FNHSSM) Board of Directors, staff and management, we are pleased to present the Diabetes Integration Project Annual Report for the 2017/2018 fiscal year.

2.0 FNHSSM - Location

The FNHSSM- Diabetes Integration Project sub office is located at 600 – 275 Portage Avenue, Winnipeg, Manitoba.

The Thompson Mobile Health Care Service Delivery Team is housed at the Keewatin Tribal Council located in Thompson, Manitoba.

The Dauphin Mobile Health Care Service Delivery Team is housed in the Federal Building, 317 Main Street, Dauphin, Manitoba.

3.0 First Nation Communities Served

Provision of mobile secondary prevention screening and education to adult clients to prevent/and or delay the complications of type 2 diabetes in 20 First Nation communities as follows:

Winnipeg Team	Dauphin Team	Thompson Team
Hollow Water	Pine Creek	God's River
Peguis	Skownan	God's Lake
Roseau River	Ochichakkosippi	Oxford House
Long Plain	Ebb & Flow	Tataskweyak (Split Lake)
Sandy Bay	Keeseekoowenin	Nisichawayasihk (Nelson House)
Swan Lake	Rolling River	Chemawawin
	Gambler	
	Tootinaowaziibeeng (Valley River)	

4.0 The Mobile Health Care Service Delivery

4.1 Clinical Services

Given the high incidence, prevalence rates and complications of type 2 diabetes in the Indigenous population, the FNHSSM - Diabetes Integration Project is a mobile diabetes care and

treatment service model intended to address the care and treatment needs for adult First Nations people who have been diagnosed with type 2 diabetes. A number of clinical services are provided to assess the health status of each client and the provision of client centered care, diabetes education and support.

The DIP Model of Care utilizes a one to one patient to provider model. The one patient to one provider model allows DIP to work with each client individually to meet the needs of each client and allows for the development of a therapeutic relationship. Utilizing an anti-racist, anti-oppressive approach to client care, trust is developed usually over two to three clinical visits and clients are open to discussing sensitive areas during the clinical assessment.

The Diabetes Canada Association Clinical Practice Guidelines for the Prevention and Management of Diabetes (2013) are utilized as the "Gold Standard of Care" and provides a framework for the diabetes care and treatment activities provided by the Mobile Diabetes Health Care Service Delivery Teams.

4.2 Secondary Screening for Complications - Clinical Assessment of Clients

A comprehensive clinical assessment of new clients takes approximately 1 – 1.5 hours for the service teams to complete and includes the following assessments:

- Referral Source – tracking of whom is referring clients to DIP
- Client Demographic Information – Name, date of birth, age, gender, physician, marital status, ethnicity, language, employment status, Client file – open/closed, length of diabetes, allergies
- Physical Activity
- Traditional Health/Spiritual support
- Medication Review – listing of all medications reviewed with clients
- Immunization Assessment – influenza/pneumococcal vaccine
- Risk Factor Assessment – lifestyle, tobacco use, alcohol, drug use, over the counter drug use and herbal medication, family history, comorbidity, client history of diabetes risk factors
- Clinical Assessment
    - Height, weight, waist circumference, blood pressure, body mass index
    - Point of Care Testing
        - ACR – albumin-creatinine ratio (assess kidney damage)
        - HgbAlc – finger poke blood sample – measures the client management of diabetes and treatment effectiveness
        - e-GFR – estimated glomerular filtration rate – finger poke blood sample used to assess kidney function

- Eye Assessment – basic questions asked about glasses, dilated eye exam, changes in vision; referral to optometrist who will then refer to an ophthalmologist
- Sleep Apnea Assessment
- Oral Assessment – dentures, assess for gum disease, bad breath
- Autonomic Assessment – questions around sweating, issues with the client's stomach, dizziness, problems with going to the bathroom, low blood sugar, sexual dysfunction
- Foot Assessment (Neuropathy) – monofilament testing for protective sensation, assess for visible signs of foot issues – nail inspection, redness, swelling, foot ulcer or deformity, condition of the skin between the toes and use of mobility aids. Foot Risk assigned based on findings.
- Footwear assessment – inspection of the client's footwear, foot care education and teaching on proper fitting footwear and overview of signs and symptoms of when to see the doctor

4.3 Point of Care Testing

The point of care testing analyzers produce quick results in 6 - 12 minutes. Client education is provided based on the individual client results, which creates an opportunity for diabetes education at the point of care. The opportunity allows the mobile teams to support clients and to increase awareness of their condition and to support clients to manage their health. Clients have advised they like the fact that results are obtained immediately and the education is tailored to the individual client.

DCA Vantage Analyzer

Piccolo Express Analyzer

Hemoglobin Alc - Hemoglobin Alc (HgbAlc) is assessed through a finger poke blood sample using the DCA Vantage analyzer. The HgbAlc is a measure of the average blood sugar over a period of three months. The HgbAlc is used as an indicator of treatment effectiveness in the overall management of type 2 diabetes.

Kidney Damage Assessment - The Albumin to Creatinine Ratio (ACR) is assessed through the DCA Vantage analyzer and conducted through a random urine sample to assess for kidney damage.

Kidney Function Assessment - A finger poke blood sample can provide information on the estimated glomerular filtration rate (EGFR) to assess kidney function. This is done through the Piccolo Express Analyzer.

4.4 Follow up Assessments

Follow up assessments are completed following the initial assessment in the second and each subsequent clinical visit. Follow up assessments take approximately 30 minutes to complete and are based on the initial assessment findings. Client goals and medication changes are reviewed, Point of Care Testing completed (Alc) and a urine sample may be obtained if the results were abnormal in the previous visit. Ongoing care and treatment, education, referral and supportive activities are conducted to ensure clients are receiving care as outlined in the Diabetes Canada Clinical Practice Guidelines (2013).

5.0 Human Resources

There are a number of human resources currently employed to carry out the mandate of the Diabetes Integration Project. Many of the nurses employed are First Nation/Metis nurses that can speak the language, share the same cultural background and are the bridge between western medicine and traditional health and healing practices. The ability to speak the language puts the nurses in a unique position in terms of working directly with Indigenous clients who may or may not be able to speak English. A registered dietitian also provides nutritional services to support the clients seen by the mobile teams.

6.0 Quality Assurance Program

A Quality Assurance Program is an essential component that sets the performance standards in the accuracy and precision of point of care testing results. The Diabetes Integration Project

contracts internal quality control services from CEQAL based out of Vancouver, British Columbia. The role of the Quality Assurance Contractor is to:

- Provide products and professional consulting services to support the clinical assessment and lab testing at the "point of care" using the DCA Vantage Analyzers and the Piccolo Express analyzers.
- The contractor ensures the quality, monitors the performance of the point of care testing analyzers and promotes the standardized operation. The contractor provides professional consulting services and the provision of the internal quality control (IQC) testing materials.

7.0 Information Management – DIP Database

Information management and technology has been and will continue to be a huge part of the Diabetes Integration Project. Data collection and analysis provides the evidence to monitor and track client progress over successive visits. Data analysis assists in determining the effectiveness of the clinical services being provided by the mobile teams. Components of the database were established from the Diabetes Canada Clinical Practice Guidelines. Information collected on each client is entered into the database which allows the DIP Team nurses to monitor and track client progress over successive visits.

At the end of each fiscal year (April – March), all data entered is analyzed to identify the numbers of clients seen, and clinical data is broken down into the following categories:
1) Diabetes Management – measured by finger poke blood sample
2) Kidney Damage – measured by urine sample
3) Kidney Function – measured by finger poke blood sample
4) Foot Inspection – each client is risk stratified
5) Medications – a listing of all meds the client is on are reviewed with each client
6) Body Mass Index data is collected
7) Client Care Plan
8) Diabetes Education provided
9) Referral Pathways – all referrals to primary care or specialists are tracked to monitor each client

8.0 Meetings with Tribal Councils/First Nations/Health Authorities

A number of meetings/presentations have been held to provide information on the DIP Project, discuss issues/concerns and to collaborate on the coordination of diabetes care and treatment services as follows:

8.1 Tribal Council/First Nation Meetings

- May 23, 2017 – God's Lake Narrows
- May 25, 2017 FARHA

- June 30, 2017 FARHA
- July 21, 2017 – Split Lake, Health Director
- September 27, 2017 – West Region Treaty 2 and 4 Health Services - Yorkton
- October 4, 2017 – FARHA
- January 24, 2018 - West Region Treaty 2 and 4 Health Services – ADI Workers
- March 15, 2018 - FARHA

8.2 Manitoba First Nations Diabetes Leadership Council

- July 5 – 6, 2017
- September 7 – 8, 2017
- December 2017
-February 24, 2018

8.3 First Nations Inuit Health Branch FNIHB

- January 4, 2018
- February 8, 2018

8.4 FNHSSM Nursing Advisory Meetings

- April 20, 2017
- May 29, 2017 Peachey Report
- July 24, 2017
- September 25, 2017
    - October 23, 2017
    - November 27, 2017
    - January 22, 2018

8.5 Foot Care Program

- June 8, 2017 Dauphin River and Lake St. Martin
- July 10, 2017 – Dakota Ojibway Health Services
- July 20, 2017 – FNIHB, Glenn Howell
- August 25, 2017 – Regional Foot Care Coordinator Interviews
- September 11, 2017 – Foot Care Workshop Planning Committee
- September 19, 2017 – Foot Care Announcement, FNHSSM AGM
- September 26, 2017 – Assiniboine Community College, Brandon
- October 4, 2017 – Foot Care Training (North)
- October 7, 2017 – Foot Care Media Event, FNHSSM
- October 12, 2017 – Foot Care Workshop Planning Committee
- October 13, 2017 – Foot Care Inventory Review
- December 1, 2017 – Assiniboine Community College, Brandon

8.6 Research Project Meetings

SPOR – DIABETES AND ITS RELATED COMPLICATIONS

- April 13, 2017 – Goal Group
- May 26 – 27, 2017 SPOR Meeting - Toronto
- August 21, 2017 – Dr. Jon McGavock

SPOR CAN-SOLVE CKD - OPTIMAL APPROACHES TO CKD CASE FINDING IN INDIGENOUS COMMUNITIES

- April 21, 2017
- May 3 – 4, 2017 CAN-Solve CKD Meeting (Montreal)
- Meetings are held on a biweekly basis on Fridays from 12: 00 – 1:00 PM

IMPROVING RESPONSIVENESS ACROSS THE CONTINUUM OF KIDNEY HEALTH CARE IN RURAL AND REMOTE MANITOBA FIRST NATION COMMUNITIES (IK-Health) - Dr. Josie Lavoi

- Held monthly meetings in preparation for proposal submission

TYPE 2 DIABETES IN MANITOBA (Dr. Chelsea Ruth/Dr. Liz Sellers)

- Meetings are held bi-weekly on Wednesdays from 1:30 – 3:00 PM

8.7 Other

- June 9, 2017 – U of Manitoba – Opiod Addiction
- June 19 – 20, 2017 – Manitoba First Nations Health Technicians Meeting
- June 22, 2017 – Auditor General's Meeting
- July 12, 2017 – Canadian Footwear, Brian Scharfstein
- July 27, 2017 – Manitoba First Nations Health Technicians Network – MRSA Webinar #1
- August 1, 2017 – FNHSSM Organizational Review
- August 16, 2017 - Manitoba First Nations Health Technicians Network – MRSA Webinar #2
- August 28 – 31, 2017 FNHSSM Board and Staff – Strategic Planning Exercise
- September 19 – 20, 2017 – FNHSSM AGM

9.0 DIP Meetings

- July 4, 2017 North Team Interviews
- August 9, 2017 – Healthier Together Proposal Review
- October 3, 2017 – Diabetes Service Coordination Meeting – NRHA
- October 16, 2017 – DIP North Team MB Telehealth

- October 17, 2017 – Anti-Racism Workshop Planning
- Manitoba Health – E-chart
  - June 6, 2017
  - October 12, 2017

9.1 Continuing Competency

May 19, 2017 - College of Registered Nurses of Manitoba
June 28, 2017 - Advancing In Module 1 – Pathophysiology and Prevention of Diabetes
June 28, 2017 Advancing In Module 2 - Diagnosis and Targets
July 26, 2017 – Advancing In Module 3 – Lifestyle Modifications
December 19, 2017 - Advancing In Module 4 – Pharmacology for Type 2 Diabetes
January 29, 2018 - Advancing In Module 5 – Intensive Insulin Therapy

9.2 Presentations

- May 8, 2017 University of Manitoba – DIP Nursing Presentation
- September 27, 2017 – West Region Treaty 2 & 4 – Yorkton
- November 16, 2017 – DREAM Symposium, University of Manitoba
- November 23, 2017 Physiotherapy Students, University of Manitoba
- January 24, 2018 – West Region Treaty 2 and 4 Health Services – ADI Workers

9.3 Training and Capacity Development Sessions

June 26 – 30, 2017 – DIP Quarterly Admin Week Session
September 27 – 29, 2017 DIP Quarterly Admin Week Session
December 6 – 8, 2017 DIP Quarterly Admin Week Session
March 20 – 22, 2018 DIP Quarterly Admin Week Session

10.0 Research Projects

10.1 SPOR CAN-SOLVE CKD - OPTIMAL APPROACHES TO CKD CASE FINDING IN INDIGENOUS COMMUNITIES

The First Nations Community Based Screening to Improve Kidney Health and Prevent Dialysis (FINISHED) Project ran in 11 Manitoba First Nations communities from 2012-2015 as an active Screen, Triage and Treat model for chronic kidney disease (CKD), hypertension and diabetes. The FINISHED Project led to the successful 5 year Strategies for Patient Oriented Research (SPOR) proposal entitled, "**CAN-SOLVE CKD - OPTIMAL APPROACHES TO CKD CASE FINDING IN**

INDIGENOUS COMMUNITIES is co-lead by Dr. Adeera Levin, University of British Columbia and Dr. Paul Komenda, Manitoba Renal Program.

Currently supported by The Aboriginal Diabetes Initiative (First Nations Inuit Health Branch) to provide culturally safe care and screening for diabetes related complications to Indigenous people in Manitoba. Through a joint initiative across British Columbia, Alberta, Saskatchewan, Manitoba and Northwestern Ontario, the plan is to expand and train primary care providers across Canada on this successful model of culturally safe, community-based care for Indigenous and non-Indigenous persons living with diabetes.

The Diabetes Integration Project will lead the training and capacity development activities of screening, triage and treatment activities of Renal Screening Teams across the country. The DIP provides a culturally safe and appropriate model for research to use in overcoming the barriers to comprehensive, coordinated and integrated intervention for limb, eye, cardiovascular and kidney complications.

10.2 SPOR – DIABETES AND ITS RELATED COMPLICATIONS

The FNHSSM - Diabetes Integration Project lead by Dr. Barry Lavallee, has partnered with the University of Toronto on the Canadian Institutes for Health Research on a grant entitled, “Strategies for Patient Oriented Research (SPOR) – Diabetes and Its Related Complications.

By 2020, over 10% of Canadians (3M) will have diabetes. Type 1 and 2 diabetes are a major cause of vision loss, amputations, heart and kidney failure. There is an urgent need to establish effective patient centred, evidence based and primary care focused models of early detection and targeted interventions to prevent and better manage diabetes complications.

The SPOR Diabetes Network has partnered with a number of academic researchers across Canada in the following areas:

1) Recognizing Risk for all diabetes complications and customizing interventions
    a. Launching of diabetes complications screening pilot studies
    b. Development of a comprehensive diabetes registry for communities screened
    c. Design a diabetes complications “Risk Calculator”
2) Biological Risk Analysis – comparison of clients with low and high risk complications
    a. Discovery of an application of new biomarkers to detect risk before clinical signs develop
3) Precision Tools – Empowering clients to achieve diabetes management using insulin pumps and/or external pancreas
    a. Use of technology assisted prevention of diabetes complications
4) Targeted Interventions – diet, lifestyle, and physical activity

DIP will be involved in one of the many projects through the SPOR Network. Principle investigator is Dr. Barry Lavallee through the University of Manitoba, in a joint application to the Canadian Institutes for Health Research (CIHR) has been approved.

The Diabetes Integration Project will be involved in the development of a "National Training in Culturally Safe Diabetes Education" project.

The project will be jointly funded by the SPOR Network and Research Manitoba for a total of $575K ($115/YR X 5 Years). $287,500 from the SPOR Network and $287,500 from Research Manitoba.

10.3 TYPE 2 DIABETES IN MANITOBA (Dr. Chelsea Ruth/Dr. Liz Sellers)

In June 2015, the Provincial Minister of Health approved three research project deliverables - Tuberculosis, Diabetes in Manitoba and the First Nations Atlas. The Minister requested that FNHSSM be collaborators on the project.

The Diabetes in Manitoba deliverable would provide an analysis of major trends in type 2 diabetes trends, prevalence, incidence, complications and mortality in Manitoba from 1979 – 2015. The Manitoba Health database will be linked to the Indian Registry file and will include the following data for Registered First Nations in Manitoba:

- Health service use
- Physician visits
- Hospitalization
- Prescription drug use
- Changes over time, income quintiles and regions of the province
- Early onset of type 2 diabetes
- Diabetes in Pregnancy

The Final Report is expected to be completed in the fall of 2018 and provide a "snapshot" of diabetes within the Manitoba Region.

10.4 IMPROVING RESPONSIVENESS ACROSS THE CONTINUUM OF KIDNEY HEALTH CARE IN RURAL AND REMOTE MANITOBA FIRST NATION COMMUNITIES (IK-Health) - Dr. Josie Lavoi

"Improving responsiveness across the continuum of kidney health care in rural and remote Manitoba First Nation communities" (I-KHealth) builds on the success of the FINISHED project with a partnership-based program of research which brings together community-based

researchers from the *Nanaandawewigamig* FNHSSM/Diabetes Integration Project, First Nation patients with lived experience of kidney disease, University of Manitoba (UM) university-based researchers and the Manitoba Renal Program. The project will receive $1.5 million over 5 years in funding from the Canadian Institutes of Health Research.

The project has four components including:

- Mapping patient journeys for First Nations people living in rural and remote areas
- Assessing primary health care's role in kidney health
- Evaluating and developing appropriate kidney health education
- Exploring alternative models of dialysis treatment delivery.

While a diagnosis of kidney disease is life-changing, a diagnosis in an earlier stage of chronic kidney disease (CKD) can lead to interventions that help manage the disease and reduce the possibility of progressing to later stages and the need for dialysis.

11.0 Reports

11.1 Director – Diabetes Integration Project

One of the priorities of the Diabetes Integration Project is the successful implementation of the secondary prevention diabetes care and treatment services in the twenty First Nation communities currently being served. A regular review of the mobile diabetes care and treatment services provided in the three regions, what works, what doesn't and making improvements based on data analysis, best practice research has given the DIP Project satisfaction of making a difference in the lives of type 2 diabetes clients.

The DIP Model of Care has demonstrated its success and has gained national attention through the various collaborative networks. As new information/data analysis, best practice become available, the DIP Senior Management Team works collectively with Dr. Barry Lavallee, Program Medical Consultant to ensure capacity development activities continue to build on the skills, knowledge and reinforcement of the anti-racist, anti-oppressive approach to care and treatment.

Capacity development sessions are held during Administration Week on a quarterly basis when the teams were not travelling to the communities. The Program Medical Consultant directly supports the DIP Team nurses in their application of Diabetes Canada Clinical Practice Guidelines through a number of "Case Management" discussions. Each DIP Team nurse presents specific client information including lab values (no names). This process enhances the knowledge base of the teams in terms of diabetes care and treatment options. These discussions were found to be particularly useful in ensuring the DIP Team nurses are applying the Diabetes Canada Clinical Practice Guidelines in the provision of diabetes care and treatment services.

The Quality Assurance Program is a very important component in the overall diabetes care and treatment services provision. Results obtained from point of care testing must be accurate and precise as clinical decisions and diabetes education are based on the results provided. Protocols are in place to ensure all internal quality control testing processes are followed. The Province Wide Coordinator works collaboratively with CEQAL in ensuring the POCT testing process is conducted appropriately and the necessary steps are taken when issues arise.

One of the challenges is the ongoing retention of the North Team nurses as wage parity directly impacts on our ability to successfully recruit and retain nurses. DIP is unable to compete with the Regional Health Authority or federal wage scales. A Wage Parity Business Case was submitted to FNIHB, MB Region in October 2016 but was unsuccessful.

The DIP database information management system contains very valuable information on the health status of all clients currently served by the DIP Team nurses in all twenty First Nations

communities. All client data is inputted into the database with the ability to generate reports on a quarterly basis and annually.

E-chart is a valuable tool that DIP had prior to the merge with the First Nations Health and Social Secretariat of Manitoba. E-chart has now been set up with each of the DIP Teams. E-chart is available in This is a work in progress to get e-chart installed in our Winnipeg office as well as in our Thompson and Dauphin office locations. E-chart is currently available in 8/20 First Nations currently being served. Having access to e-chart in sixteen (16) out of twenty (20) First Nation communities will enable the nurses to check lab and medication data prior to visits to the communities. E-chart will reduce the duplication of lab tests being completed out in the field.

The client caseload has tripled since inception but the funding has remained essentially the same since 2013. DIP management is looking at streamlining the assessment process, as well as reducing the weight of the clinical equipment and supplies, which would allow the DIP Team nurses to see more clients within the time allowed. This review process will continue into the next fiscal year as more data becomes available.

In the next fiscal year, FNHSSM/DIP will continue to participate in a number of research projects that will benefit all Manitoba First Nations communities. The evidence obtained in the FINISHED Kidney Screening Project conducted in 2012 – 2015 has led to the SPOR Projects and the IK-Health project DIP is currently involved in. The research will lead to potentially changing clinical practice in both adults and children with respect to diabetes and kidney screening.

Overall, it has been a very busy and successful year. Future plans include a review of operational policies and procedures, and improving communication with key stakeholders to improve the services provided. We are definitely looking forward to another busy year ahead.

Thank you to the FNHSSM Board, staff, management and to the First Nations communities and the clients we serve. We make every effort to benefit the First Nation communities and to all individual clients we serve.

Respectfully prepared by;

Caroline Chartrand, RN/BN
Director, Diabetes Integration Project
First Nations Health and Social Secretariat of Manitoba

11.2 Province Wide Coordinator Report

The overall goal of the Diabetes Integration Project (DIP) is to enhance diabetes care and support for adults living with type 2 diabetes. The PWC responsibilities include: assisting in the implementation and evaluation of the DIP project and collaborating with and providing support to three DIP nursing teams to promote the delivery of quality services. This report highlights activities carried out by the PWC throughout this past fiscal year.

Communication

The PWC communicates and collaborates with First Nation communities, Manitoba First Nations Diabetes Leadership Committee (MFNDLC), health technicians, heath care providers, researchers, First Nations and Inuit Health Branch (FNIHB), and Regional Health Authorities. Communications efforts include face-to-face meetings, teleconferences, telehealth sessions, orientation, and conferences/workshops throughout the year to address regional issues, health inequities, and to enhance existing services for care related to diabetes and related complications. The PWC attended the following meetings/conferences/workshops:

- Provided orientation on the DIP for the new ADI worker from Nelson House April 26, 2017
- Harm Reduction meeting re: potential project on the use of marijuana to address opioid addictions
- Northern Regional Health Authority (NRHA) Diabetes Service Coordination meetings held in April, June, and October
- Manitoba First Nation Diabetes Leadership Council (MFNDLC) Meeting June and July re: Foot Care proposal implementation
- Met with the DIP dietitian to provide feedback for the national review of Canada's Food Guide
- FNHSSM staff meeting held on June 22,2017 to provide feedback related to climate/environment and health to staff from the Auditor General Office
- Assembly of Manitoba Chiefs Annual General Assembly in Nelson House July
- Royal College of Physicians and Surgeons, Indigenous Health Advisory Committee (IHAC) members and guests, met in September to provide feedback on previous work completed specific to developing educational and practice resources in cultural safety, creating a cultural safety knowledge hub, establishing an Indigenous led process in project management and promoting Indigenous culture and spirituality
- Met with the Spirit Meter representative in October
- Devotion partnership meeting in October
- NRHA Northern Health Summit – “Building Bridges for Bridging Gaps” Diabetes in the North on October 24
- Health Information Management meeting October 30th

- National Collaborating Center for Aboriginal Health - Indigenous Social Determinants of Health Conference in Ottawa held in November27-29th
- Anti-racism workshop held in Winnipeg on November 30th & December 1st
- Manitoba First Nations Health Technicians (MFNHTN) – Meeting Jan 23 & 24, 2018
- Meeting with Youville clinic (diabetes center) on January 30th
- MFNDLC Meeting Feb 21 & 22, 2018
- Manitoba First Nations Health Directors meeting held on March 27-29, 2018

Human Resources

The PWC participates in activities related to Human Resources (HR) such as: staff recruitment and retention, nursing orientation, HR planning, employee development (workforce training), job description review, and performance management. The PWC participated in the following HR activities throughout the fiscal year:

Recruitment

- Thompson Team 2 full-time (2.0 FTE) nurse positions - interviews were held on May 10, July 7 & 10th
- Regional Foot Care Coordinator full-time (1.0 FTE) nurse position - Interviews July 10th
- Thompson Team 2 full-time (2.0 FTE) nurse positions - interviews were held on August 25th
- Winnipeg Team 1 part-time (0.5 FTE) nurse position – interviews held on November 2nd
- Dauphin Team 1 full-time term (1.0 FTE) nurse position – interviews held February 22, 2018.

Nursing Orientation

All new nursing staff are provided with a two-week orientation session and in the third week they are required to shadow an existing team during clinic in the community. The PWC typically accompanies the nurse on their first visit to a community. This fiscal year the PWC provided orientation for 4 new nurses and a brief session was provided to the Regional Foot Care Coordinator.

Overtime management

- The DIP PWC was responsible for the approval of nursing staff overtime claims until the end of February 2018, as of March 2018 the DIP Director assumed this responsibility.

DIP Continuous Quality Improvement

The PWC collaborates with and provides consultative support to the DIP mobile teams and facilitates the development and implementation of program processes and tools to support smooth, consistent and quality clinic operations.

Capacity Building

Quarterly meetings are held in Winnipeg to provide staff with an opportunity to share knowledge, to learn from each other and to discuss challenges and successes of the community clinics. During these meetings the teams provide feedback and suggestions for strategies to address existing and potential challenges and ideas for project improvements. Client case studies are also presented by each team and provide an opportunity for staff to share and discuss client care and treatment. The case studies are a means to inform and enhancing staff knowledge specific to client care and treatment. This past fiscal year the DIP quarterly meetings were held on the following dates:

- June 27-29, 2017 - face-to-face meeting
- September 18-22, 2017 face-to-face meeting
- December 5-7, 2017 - face-to-face meeting
- March 20-22, 2018 face-to-face meeting

Field Visits

- The PWC attempts field visits at least once per year and accompanies DIP teams to communities to observe community clinic operations, nursing care, and to complete the orientation process. During field visits the PWC takes the opportunity to communicate information on the DIP with community health staff including Health Directors and/or the Nurse-In-Charge/Community Health Nurse and the ADI Worker.
  - May 2 & 3, 2017 Peguis
  - October 7 & 9, 2017 Nelson House
  - January 17 & 18, 2018 Hollow Water

Program forms are refined/revised as required, to facilitate DIP nursing documentation and database operations.

- Revised the initial and follow-up client assessment forms.
- Inserted the FNHSSM Logo on all project and client forms.
- Update DIP clinic operations guidelines to support the delivery of standardized care, clinic operations and nursing documentation practices.

Database

Client data gathered during the assessment process is entered into the DIP electronic database on a weekly basis, ideally this should be done in the community however, internet connectivity

in the community continues to be a challenge and teams resort to entering data when they return to home office. Ongoing work on the database continues and glitches that are discovered during use are reported to the Information Technology Consultant and repaired.

Point of Care Testing (POCT)

The DIP continues to contract CEQAL to support the POCT Quality Management program, CEQAL is a reference method laboratory specialized in delivering accuracy assessment solutions for improving the quality of testing in health care. According to CEQAL,

> *"IQC testing prior to patient testing at point of care is the only way to ascertain that all equipment, reagents and user techniques are performing in accordance with performance goals that meet the requirements for monitoring patient diabetes and renal status…In this contract year, POCT continued with the Kidney Check panel on the Piccolo as well as HbA1c and urinary Albumin/Creatinine ratios (ACR) on the DCA devices. Thompson site resumed POCT testing in November 2017. The reduced amount of IQC testing scheme went well and will be continued. The nurses and quality coordinators are diligent in following process and repeating failed IQC. "*[1]

All DIP nurses receive training on the operation, testing and maintenance of analyzers prior to using instruments in the field. The PWC assists teams with troubleshooting any issues related to analyzer operations and POCT quality control and maintenance excel spread sheets are forwarded to CEQAL for analysis. CEQAL provides a Quality Management Report of POCT results on a monthly and annual basis. The DIP team's compliance to POCT protocols continues to support excellence in Point of Care Testing.

FNHSSM Nursing Advisory

The PWC participates in FNHSSM monthly Nursing Advisory meetings to support and/or address regional issues that arise impacting nursing services and overall health services for First Nations.

Regional Foot Care Program

The PWC participated in face-to-face and teleconference meetings with the MFNDLC, FNIHB, and DIP in preparation for the implementation of the Regional Foot Care Proposal. Initial meetings were held in June and July to plan implementation, the PWC assisted with the development of the initial implementation budget and work plan, recruitment and orientation of the Regional Coordinator.

[1] CEQAL Report to the First Nations Health and Social Secretariat of Manitoba (FNHSSM)
Quality Management of Point of Care Testing (POCT) Contract Year April 1, 2017 – March 31, 2018

Research Projects

Throughout the fiscal year the PWC participated in various meetings (face-to-face and teleconferences) to discuss, provide feedback and guidance for the following research proposals and research projects:

- ***Kidney Project - First Nation Community Based Screening to Improve Kidney Health & Prevent Dialysis (FINISHED)*** – This three-year screening project was completed in 2015 and was conducted in partnership with the Manitoba Renal Program, Winnipeg Regional Health Authority and the DIP. The PWC has participated in project team meetings to discuss and plan the data linkage with the administrative database at the Manitoba Centre for Health Policy to track clients that were screened and examine data to explore what type of follow-up care was received post-screening.

- ***NorWest Mobile Diabetes and Kidney Screening and Intervention Project*** – provides screening clinics for diabetes and kidney disease where they triage and refer clients for appropriate treatments. Screening is conducted amongst populations identified as high risk for disease within the city of Winnipeg. The project works in partnership with the DIP, Manitoba Renal Program, and Chronic Disease Innovation Center (CDIC) researchers. The PWC participates in the project steering committee meetings when available and reviewed and provided feedback for the journal article entitled: *Remote Dwelling Location Is a Risk Factor for CKD Among Indigenous Canadians* published February 10, 2018 in the Kidney International Reports Journal.

- ***Strategies for Patient Oriented Research (SPOR) Can-SOLVE Chronic Kidney Disease (CKD): Identifying Diabetes and CKD in Indigenous Communities*** – this project proposes to identify disease early so that early care and treatment can prevent or halt the progression of CKD. This project is in partnership with the Manitoba Renal Program, CDIC researchers, the DIP, Four Arrows Regional Health Authority (FARHA) and First Nation communities yet to be identified.
    - Renal capacity development training for two staff from the FARHA was held in August 2017 in preparation for kidney screening in one community.

- ***Strategies for Patient Oriented Research (SPOR) Diabetes Action Canada*** - this project proposes to provide National Training in Culturally Safe Diabetes Education for health care providers.

- ***I-KHealth: Improving responsiveness across the continuum of kidney health care in rural and remote First Nation communities*** - this proposal was submitted in September 2017 to the Canadian Institute of Health Research. In January 2018 it was announced that this five-year research project will receive funding from the Canadian Institute of Health Research.

The I-KHealth project will complete four studies to evaluate and strategize kidney health approaches and will be led by DIP, First Nations Health & Social Secretariat of Manitoba, Ongomiizwin Research, the University of Manitoba and the Manitoba Renal Program.

Future Planning

Participate in review and development of the DIP and in research projects to advance the care and treatment of type 2 diabetes. Work collaboratively with the provincial, federal and First Nations to improve access and enhance care for First Nations individuals and communities.

Respectfully submitted,

Lorraine McLeod BN, RN

11.3 Program Medical Consultant

The Diabetes Integration Project remains one of the most successful primary care based intervention project aimed at addressing the secondary complications associated with type 2 diabetes among those at risk and affected in the First Nation communities. This program is funded to deliver in community care to twenty First Nation communities in three regions of Manitoba. The remaining 42 or so communities various primary care systems, many unable to contend with the most prevalent chronic disease and its complications, and some communities have inconsistent primary care. Many cases of type of 2 diabetes remain undiagnosed in communities and we see late presentations of complications across Manitoba. (Unpublished data)

The focus of this program is secondary prevention for those already living with the disease, residing in communities and, as such, are known to contend with several barriers to addressing their condition. Reducing vascular disease such peripheral vascular disease (often associated with below or above knee amputations), prevention of chronic kidney disease or its progression to end stage renal disease, supporting good eye health and stroke reduction are couched within standard medical and nursing practices and protocols.

The ensuing years and experiences, however, drew attention to the need to incorporate an understanding of the historical and continuing impact of colonization on the ability of many First Nation people living with the disease to care for self and family. The alarming number of cases with proteinuria, as an example, was discovered in our data base and we realized such emerging health trends like this requires our leadership to engage with other stakeholders, health care providers, medical scientists and health systems to work towards solution based interventions.

Working with the Manitoba Renal program, nephrologists from the Winnipeg Regional Health Authority and two Tribal Council area leads and communities, the First Nation Community Based Screening to Improve Kidney Health and Prevent Dialysis program (FINISHED) received funding to test a new method of delivering care and treatment to First Nation communities. This successful intervention cemented our theory about the need for a two-pronged approach to address the epidemic of chronic diseases within First Nation communities. It involved direct patient care and support along with a population based intervention employing an analysis of data delivered by point of care technology. The first rested upon a therapeutic engagement with qualified and well-skilled nurses in which participants were supported on the spot and the other a team of non-Indigenous and Indigenous medical practitioners and scientists who examined and theorized about population trends comparing data from across the world.

These key interventions led to several publications in high impact journals and the dissemination strategy included feedback to the communities and their participants. The intention is to change the culture of health care for First Nation communities.

Further research agendas stem from this work and include two national awards from the SPOR arms of Canadian Institutes of Health Research aimed at differentiating population education versus point of care testing to elucidate and reduce the need for end stage treatments of CKD in First Nation communities in four western provinces. The other intends to support culturally safe care for First Nation participants of the health care systems in Canada.

Care of the Person Living with Diabetes in Community

The care of First Nation people affected by type 2 diabetes is no different than any other. The context under which many First Nation people live, however, demarcates and crosses race and disease lines. DIP has had to develop an anti-racist and anti-oppressive model of care to deliver effective care and treatment to the communities served.

When First Nation people are approached with respect and the therapeutic engagement harnesses hope, positive expectations and embraces human capacity and community strength, patients' self-efficacy is uncovered and thus improves. The result is patients take their medications, stop smoking, and their self-efficacy improves. Functionally, the nurse providers are trained and supported to engage with their patients from an anti-racist, anti-colonial and strength based approach. Taking direction from the patients and being literate to cues invite the co-creation of narratives, strengthening patient experiences through supportive listening and reflection. This therapeutic relationship is hinged upon the First Nation person as human. It is armed in a space free of colonial shame and a space where healing occurs through employment of silence and word as interventions.

The Population Approach

The costs of primary care interventions such as ours outweighs, according to experts, the well described benefits to the individual patient. A few First Nation people living with diabetes whose biological indicators change for the better has little effect on the larger community.

The upstream risk factors associated with chronic diseases are racialized and it is important to consider their impact in context. As addressed earlier, poverty affects diabetes, racism both individual and structural in origin, limit access to supports and the continuing impact of the intergenerational genocidal state supported programs all serve to platform failure, suffering and early death from this preventable disease. While the current health narrative aims at weight reduction and smoking cessation as two strong risk factors to eliminate to prevent diabetes and its complications, the social exclusion of First Nation communities within Canada has more deleterious effects along the same disease progression and development.

As such, DIP/FNHSSM may require as much as $50-100 million dollars annually to reduce complications associated with diabetes along with elimination of indigenous specific racism and equitable plus resources to bring down the rates of poverty. Yet, paradoxically, without

addressing this critical pathway based on socially constructed poverty with its racial specificity, the amount of resources and monies needed to curb the impact on community will skyrocket in the downstream complications. An argument for a population based approach to addressing chronic disease in community stands as one of the most effective ways to address the epidemic.

Workforce Development

The intense nature of practice within the DIP model can limit the lifespan of the workforce. Historically, and as part of current administrative practice, DIP employs ways to improve retention rates and these include but are not limited to opportunities for professional development, regular team activities, case reviews, networking and sponsoring an environment of reflective practice. The practice, however, can inflict vicarious trauma upon the nurses. Many come from community and may have undergone their own challenges and experiences of oppression. The effect on provider is recognized as part of practice but within the context of DIP, a differing level of trauma occurs when the DIP Team nurses are confronted with situations where they may see themselves or their families. It becomes an emotional and spiritual paradox; western medicine does not offer solutions here and our workforce are aware of this on many levels. Our sessions are one means to mitigate the impact of vicarious trauma on workforce health and wellness and lend support in the form of group dynamics.

Students

DIP continues to participate as a site for medical students mostly when there are opportunities to have them involved in our work. We have had rehab, nursing and pre-professional students as well. Mentorship of researchers from other institutions is sought out frequently.

Research

DIP is lead on two Canadian Institute of Health Research sponsored projects. One centers on diabetes and the other on chronic kidney disease. They are five years in duration and both have a national scope to address Indigenous health in context. To date, we have yet to receive any of the funds to move forward on our agendas.

Dr. Barry Lavallee
Program Medical Consultant

11.4 Registered Dietitian Annual Report

Introduction

Kayla Farquhar is a Registered Dietitian with the Diabetes Integration Project who started her position on July 11, 2016. She is a member of Rolling River First Nation. She is a recent graduate (June 2015) from the MB Partnership Dietetics Education Program (MPP). Previous to this position, she worked in Garden Hill First Nation as the Clinical Dietitian. Kayla plans to write her Certified Diabetes Educator examination in May 2019.

Community Visits

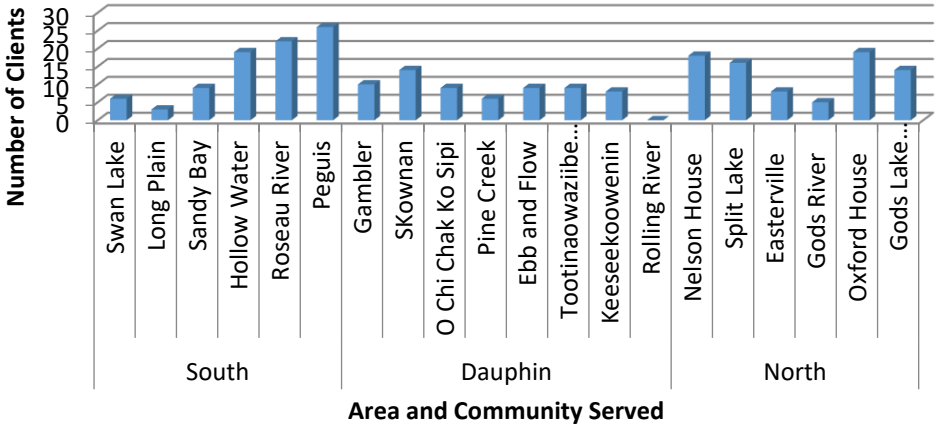
The Registered Dietitian provided direct nutrition services to 20 First Nation communities in Manitoba. In the 2018/2018 fiscal year a total of 48 community visits were provided. 11 of these visits were provided via telehealth and a few clients were provided services via telephone. In total, 11 visits were cancelled, mostly related to communities' having other scheduled events/activities at the same time. Diabetes-specific adult group education was provided ten times at community visits. Four other group presentations on diabetes were requested and provided at an Elders Gathering, a Rolling River Diabetes Gathering, West Region Tribal Council Aboriginal Diabetes Initiative training, and one conference presentation conducted three times at the Foot Care and Chronic Disease Conference. Diabetes information booths were set up at a Peguis health fair and Aboriginal Diabetes Day Event put on by the National Aboriginal Diabetes Association.

Service Provided to Clients

This past fiscal year, the Registered Dietitian provided individual service to 230 clients; 102 new client files were opened and 128 were follow-up appointments. A total of ten group sessions were also provided to eight communities, with approximately 150 participants (5-80 participants per group).

Clients in the North comprised 35% of the total (80), clients in the South comprised 37% (85), and clients in the Dauphin region made up 28% (65) of the total clients seen. The number of clients seen in each community is shown in Figure 1.

Figure 1. Individual Nutrition Services in 2017-2018 by Area and Community



Some other activities that the Dietitian has initiated this year include a Brown Bag Lunch Series for the Nanaandawewigamig staff and First Nation communities held through telehealth. Six presentations were conducted from June 2017 to January 2018 including:

- How to Make a Healthy Lunch
- Diabetes and Healthy Eating
- Sneaking Physical Activity into your Life
- Yoga Session presented by a guest
- Tips for Eating Smart During the Holidays
- Common Diets

A three-month Workplace Healthy Living Challenge was also created by the Dietitian to help promote healthy living activities in the workplace.

The Dietitian attended the following national meeting/conference:

- Indigenous Diabetes Health Circle Conference in Niagara Falls in Sept 2017.
- Canadian Food Policy meeting in Ottawa as the MB representative.

The Dietitian participates on the following committees:

- Health and Safety Committee (as co-chair)
- "FUN Committee"
- FNHSSM Nursing Advisory

Successes

The DIP gained access to e-chart this year in December 2017, which has been helpful in preparing for client visits. The Dietitian is able to assess the client information, current bloodwork and medications to support diabetes management.

A dietetic intern was recruited from the Manitoba Partnership Dietetic Education Program and completed a three-week diabetes placement under the preceptorship of the DIP Dietitian.

There have also been multiple client's making excellent positive changes in their lives to better manage their diabetes such as exercising more often; self-monitoring blood glucose; eating regular meals; eating more fibre; smoking cessation and some who are even carbohydrate counting.

Challenges

The high turnover rates of ADI workers in community is a challenge, as sometimes there are periods of time with little or no support in the community. Having a designated staff member to contact clients, book appointments, arrange for transportation, etc. is crucial to a successful community visit.

The Registered Dietitian is only able to visit each community approximately every 6 months for a short period of time. Many clients do not have the opportunity to be seen each visit due to the large number of clients. This frequency is insufficient for proper follow-up. There are close to 800 clients on the Dietitian's client lists; however the list still has to be updated with inactive clients taken out to get an accurate number. The increasing number of clients for the sole dietitian on the DIP project has made it very difficult to provide timely, frequent service to all DIP communities.

Clients faced multiple challenges this fiscal year. Many struggled with financial challenges with limited income, poor quality of foods, and limited availability of foods not permitting adequate healthy food intake. Many had no access to gym facilities, dusty roads, stray dogs in the community, and cold weather preventing adequate physical activity. Others had either limited resources or limited direction of clients through resources causing clients to be uninformed of the basic diabetes education and possession of a glucometer.

Status and Linkages

Nutrition services will continue to be provided by the Registered Dietitian to the 20 communities that DIP services. The dietitian will also continue to connect with Dietitians within the Regional Health Authorities to prevent and close gaps in nutrition services in First Nation Communities.

Next Steps

The TRCC call to action to help *"close the gaps in health outcomes between Aboriginal and non-Aboriginal communities"* as the Dietitian works to help First Nations people manage type 2 diabetes and prevent complications. Next steps include:

- Telehealth will be utilized more frequently in the next year, decreasing time and cost associated with travel to communities and therefore increasing the number of client's that the Dietitian can visit.

- Work on a proposal to increase the EFT of a Registered Dietitian at FNHSSM to increase the capacity and frequency of nutrition services to clients. This may link to both TRCC action number 19 and number 23: *"increase the number of Aboriginal professionals working in the health-care field".*

Conclusion

I would like to thank the DIP staff for their guidance and support throughout this year as I learned about the organization and communities we serve. I want to thank the FNHSSM staff and the board of directors for their support to the DIP project and learning opportunities throughout the year.

I also want to thank Barbara Thompson; Debbie Stucky; Stacey McIvor and Vanessa Hamilton; Jeff LaPlante; Jocelyn Bruyere and Darlene Spence for inviting me to present at their workshops/meetings. Lastly, I want to thank the 20 communities that I have visited over the year, especially the ADI workers, CHRs, Medical Drivers, Admin staff, Health Directors, Nurses in Charge and any other staff who have assisted in coordinating community visits, scheduling clients, arranging transportation for clients, provided nourishments for clients, and encouraged clients to participate in the DIP program.

Respectfully,

Ms. Kayla Farquhar
Registered Dietitian

11.5 DIP Dauphin Team

Dauphin Team Members

Pat Currie RN Team Lead

Alice Asham LPN

Introduction

We strive to build a working relationship with the First Nation Communities we serve. In these communities we address the complex needs of clients with type 2 diabetics by providing support, education and clinical testing.

Our goal is to assist our clients in the self-management of their disease and provide service within their community where many clients have difficulty accessing health services. We help them navigate through the complex health care system by providing their Diabetes team with updates and referrals as needed.

The Dauphin Team travels to 8 First Nation Communities within our area. Our rotation takes us to each community every 8-9 weeks. We hold one, two or three day clinics depending on the community size and need.

Community Activity Report

Pre-visit

One to two weeks prior to our community visit a client priority list and blank schedule is sent to the community. Clients are prioritized according to abnormal lab results, length of time since previous visit, medication changes and follow ups from previous clinic. Any new client referrals are also added as top priority. Contact is made with the ADI worker the Friday or Monday prior to the clinic. Supplies are checked and prepared for the community visit.

Visit

The Dauphin team drives to all communities on a daily basis (Tuesday/Wednesday/Thursday) except during the winter months. We now travel on work time and arrive at 10:30 am and set up our clinic and test equipment. Appointments are set up by the ADI worker and walk-ins are accommodated if at all possible.

Post Visit

After the clinic, a verbal report is given to the CHN on the clients seen, lab results, follow up and any referrals that are being made. Copies of the client visit summaries are provided to be inserted in the clients' charts.

Clinic Visits – Number of Visits by Community				
Community	**Number of Clients**	**Total number of Clinical Visits**	**Number of clinics cancelled by team**	**Number of clinics cancelled by community**
Pine Creek	64	4	0	0
Skownan	44	5	0	0
Ochichakkosippi	31	4	0	0
Ebb & Flow	88	5	0	0
Rolling River	48	5	0	0
Keeseekoowenin	48	4	0	0
Gambler	12	4	0	1
Tootinaowaziibeeng	53	4	0	1

Communication

Communication with the community is usually with the ADI worker, the CHN and the Home and Community Nurse and on occasion the Health Director. In each Community the ADI worker, CHN and Health Director were given copies of the schedule for 2017-2018. The ADI worker is contacted prior to the clinic to confirm the clinic. Upon arrival to the clinic there is a brief meeting with the ADI worker to review the appointment schedule. At the end of the clinic report is given to the CHN.

Successes/Accomplishments

The number of clients coming to the clinics has been increasing. There have been improvements to some clients A1C's and have seen clients that have not been seen for several years. We have been trying to establish trust and build a relationship with our clients. Overall health centre staff has been supportive and the ADI workers and staff work hard at filling in the appointment schedule. We have met with ADI workers and CHNs in the communities in regards to increasing our turnout.

Challenges

Getting appointment lists prior to clinics has been a challenge. Several communities have had ADI workers change so they are also learning their roles. The high number of no show or cancelled clients. Inclement weather was a problem during some of clinics.

Future Plans

- To continue to build on working relationships with the communities we serve.

- To continue to work with our clients to help them manage their diabetes and help them cope with chronic disease. To help our clients prevent the complications of type 2 diabetes so they can live a full life in spite of their diabetes.
- To continue to find ways to encourage attendance at our clinics by doing draws, possibly group sessions, presentations. Discussing ideas with CHN and ADI workers and FNHSSM management.

To continue to collaborate and have a working relationship with the medical teams, West Region Treaty 2& 4 Health Services, Prairie Mountain Regional Health Authority, pharmacists and physicians working in some of the communities.

Respectfully,

Patricia Currie
Dauphin Team Lead

11.6 DIP Winnipeg Team

Reporting Period: April 1, 2017 – March 31, 2018

1. Introduction

The Winnipeg Team consist of:
Nurse #1: Sharon Flett, LPN, Team Lead, St. Theresa Point First Nation has been with DIP since June 2009
Nurse #2: Belinda Harper, LPN, Tataskweyak Cree Nation has been with DIP since June 2013.

a. The communities DIP served are as follows:

- Peguis First Nation
- Long Plain First Nation
- Swan Lake First Nation
- Hollow Water
- Sandy Bay First Nation
- Roseau River

2. Community Activity Report:

Clinic Visits – Number of Visits by Community				
Community	**Number of Clients**	**Total number of Clinical Visits**	**Number of clinics cancelled by team**	**Number of clinics cancelled by community**
Peguis	167	7	0	2
Long Plain	40	4	0	0
Swan Lake	40	4	0	0
Hollow Water	79	8	0	0
Sandy Bay	101	8	0	0
Roseau River	53	6	0	2

3. Communication Patterns

Community Contacts			
Community	**Contact Name**	**Address**	**Communication Contact**
Peguis	Diane Bear, ADI	Peguis Health Center	Ph: 204-645-2169
Long Plain	Winona Meeches, ADI	Long Plain Health Center	Ph: 204-252-2369
Swan Lake	Stephen Martin, CHN/PHN	Swan Lake Health Center	Ph: 204-836-2424
Hollow Water	Sandra Monias, CHR	Adam Hardisty Health Center	Ph: 204-363-7364

Sandy Bay	Melva Spence, ADI	Sandy Bay Health Center	Ph: 204-843-2304
Roseau River	Debbie Alexander, ADI	Ginew Wellness Center	Ph: 204-427-2384

Communication Patterns

Pre-visit communication is usually done by phone or email from the team to the Aboriginal Diabetes Initiative Worker (ADI) or CHN to inform him/her of the upcoming clinic. The ADI/CHN confirms the clinic scheduled and also provides information whether the timing is appropriate as some community events or issues arise which may impede the clients ability to attend clinic.

On-site – most of the communication is face to face contact with clients and health care staff.

Post-visit- a verbal report is provided to the ADI or CHN about the clinical summary. As part of the trip reports, we review our nursing concerns and/or client health issues we assessed during clinics. Further to the discussions, we also review client referrals that need to occur. A copy of the reporting tool, trip report and client list is left or forwarded to ADI/CHN.

Information packages are mailed to the communities containing the follow:

- DIP Background information
- 2017-2018 Community Visit Schedule
- Referral Form
- Community Capacity & Activity Pathway
- DIP Client Eligibility & Prioritization
- DIP Community Capacity & Activity Pathway
- DIP Visit Posters
- DIP Blank Appointment Schedules

Successes

- 76 new clients were admitted
- Improved HgbA1c or targets met in large numbers of clients
- Improved blood pressures once referred to physicians
- Clients demonstrating improvements in glycemic control
- Referrals to in-house/visiting physicians for clients to receive immediate care
- Collaborating with other community health programs i.e. foot care, visual & retinal screening, dental for the well being of clients
- Staff are accommodating in transporting clients to and from their DIP appointments

"I like the DIP Program because you get the results immediately and the nurse goes over the results with you" – Testimony of Swan Lake Client

Challenges

- High turnover of staff - ADI workers

- High turnover of physicians which compromises clinical care of clients. Clients identified they were in need of a primary care family physician for optimal long term-care, treatment and follow-up services.
- Decreased attendance of clients during poor weather conditions, death in the community and cheque days, i.e. social assistance days, child tax, GST.
- During the absence of ADI, there is low attendance due to no shows or cancellations, or clients not aware of the DIP clinic
- Experience difficulties accessing internet services in some communities for DIP database entries.
- Swan Lake and Long Plain are quarterly visits

4. Future Planning/Goals/Recommendations

- Encourage community members with Type 2 Diabetes to attend DIP clinic.
- With the new Foot Care Program, we can refer clients to basic foot care services within the community
- Continue ongoing care to support current clients, lowering their A1C and blood pressure levels within target ranges
- Expand DIP team to services more First Nation communities.

Respectfully

Sharon Flett, Winnipeg Team Lead

11.7 DIP North Team

Reporting Period: April 1, 2017 - March 31, 2018

DIP Thompson Team Staff

In the 2017/18 fiscal year the DIP Thompson Team experienced a number of challenges in the recruitment/retention of nurses. The positions were vacant until September 2017.

The Thompson Team consist of:
Nurse #1: Glenda Gray, RN Team Lead, hired October 3, 2017
Nurse #2: Ardith Hatley, LPN, hired September 26, 2017

Introduction

The Diabetes Integration Project (DIP) Thompson team provides care and treatment services in six First Nation communities in the region. These services were developed to improve diabetes care and support for adults living with Type 2 Diabetes. Services provided by the mobile teams include assessments for monitoring diabetes status/control, screening for complications, diabetes education that encourages and supports client self-management practices, and referrals to physicians, specialists, and community providers. The overall all goal of the DIP is to prevent or delay the onset of diabetes related complications

Sub Office Location

The DIP Thompson Team works out of the Keewatin Tribal Council office in Thompson and travel to communities within the northern region on a rotational basis, holding a community clinic approximately every eight weeks. Teams typically travel to the community on the Tuesday and return to office Thursday afternoons.

Communities Served

The DIP Thompson Team provides services to the following six communities in the northern region:

- Bunibonibee Cree Nation (Oxford House)
- Chemawawin (Easterville)
- God's Lake
- Manto Sipi (God's River)
- Nisichawayasihk (Nelson House)
- Tataskweyak Cree Nation (Split Lake)

Linkages to Communities

At the end of each two or three day clinic the DIP team provides a community visit report to the Nurse-In-Charge (NIC)/Community Health Nurse and/or ADI Worker and advises of client referrals and any client follow-up that may be required. If the ADI Worker is unavailable during clinic operations the Community Health Representative (CHR) and/or receptionist provide support to the DIP team during clinic days. Referrals are made to community health providers, physicians, foot care and retinal screening programs of the Northern Regional Health Authority and to specialists.

Status of Activities for 2017-2018

Community Activity Report

Pre-visit

- The DIP team contacts the ADI Worker to confirm the schedule for the next community visit one month in advance and one to two weeks prior to scheduled visit they confirm clinic space and accommodations.
- The DIP team sends a list of clients requiring a follow-up visit and new client visits along with a blank appointment schedule to assist the ADI worker with scheduling appointments.
- The ADI Worker books client appointments, calls clients to remind them of their appointment and advertises the upcoming clinic (posters/radio).
- The DIP Team prepares client files, restocks clinical supplies and educational resources in preparation for the community visit. When air travel is required the DIP Administrative support staff book flights for the team well in advance of travel.

Day of Visit

- The DIP Team reviews the client appointment schedule with the ADI worker so that they may arrange client transportation and contact clients if an appointment becomes available due to no-show or cancellations during clinic hours.
- Reporting - At the end clinic a meeting is held with the Nurse-In-Charge/Community Health Nurse/ADI Worker and/or Health Director to discuss/review outcome of clinic, client follow-up or referrals and to plan next scheduled clinic.

Post Visit

- The DIP Team completes database entries, sends referral letters to community providers, and physicians and/or specialists upon return to home office.

DIP Clinics

Community	Number of			
	Clients	Community visits	Visits cancelled by team	Visits cancelled by community
Bunibonibee Cree Nation (Oxford House)	146	1	See Note	0
Chemawawin (Easterville)	44	2	See Note	0
God's Lake	88	2	See Note	0
Manto Sipi (God's River)	69	1	See Note	0
Nisichawayasihk (Nelson House)	101	3	See Note	0
Tataskweyak Cree Nation (Split Lake)	158	2	See Note	0

Note: No DIP services were provided from April – September 2017 due to the challenges with successful recruitment and retention of the DIP Team Nurses.

Communication Patterns

The community Aboriginal Diabetes Initiative (ADI) Worker is the primary contact in the community and is instrumental in preparing for DIP clinics and supporting the DIP teams when they are in the community.

Community Contacts

- Belinda Muskego, ADI Worker, Bunibonibee
- Dianne Constant, ADI Worker, Chemawawin
- Robert Ogemow, ADI Worker, God's Lake
- Gloria Yellowback, ADI Worker, Manto Sipi
- Eleanor Erickson, ADI Worker, Nisichawayasihk
- Elsie Morris, ADI Worker, Tataskweyak

The DIP team communicates by telephone, email and facsimile with the Nurse-In-Charge, ADI Worker, and/or CHR in regards to clinic set-up, clinic results and client follow-up and referrals. At the beginning of each fiscal year the community receives an annual schedule of visits and background information of the project. Information packages are sent by email and/or facsimile to community in advance of the clinic with a letter identifying date of the clinic, posters for advertising, blank appointment schedule and a list of clients to be seen.

Successes/Accomplishments

- Number of clients with improved HgbA1c, with clients reaching target.
- Having access to client charts in communities where the team provides clinic enables the DIP team to review relevant lab results and current list of medications.
- Downsizing number of cases required to transport clinic supplies and equipment
- Community staff helpful i.e. maintenance person helps with unloading equipment, CHR/Receptionist help call clients to schedule appointments or to fill cancellation when ADI worker unavailable.
- Having adequate clinic space (2 rooms) to conduct client assessments when in the community makes it possible to see more clients.

Key Issues/Challenges

- Clinic operations are challenging when the ADI worker is away from the community
- Clients not showing for appointment or cancellations because of competing priorities makes it challenging to fill the appointment slot on short notice.
- Clients forgetting to bring in medications or list of medications.
- Appointment schedule not completed and received in advance of clinic.
- Difficulty accessing the internet or experience intermittent connectivity, makes it a challenge to complete database entries on site
- In some communities the small clinic space or only having access to one clinic room to hold the clinic makes it difficult to see more clients.

- Interruptions when clinic located in spaces other than a clinic room.
- Accommodations for DIP Team are unavailable or cancelled on short notice.
- Unloading and loading equipment when only one nurse is available is challenging.
- Road conditions, flight delays or cancellations, and inclement weather. The team makes every effort to reschedule the visit.
- Nursing staff retention and recruitment has been a huge challenge this fiscal year.

Future Planning/Goals

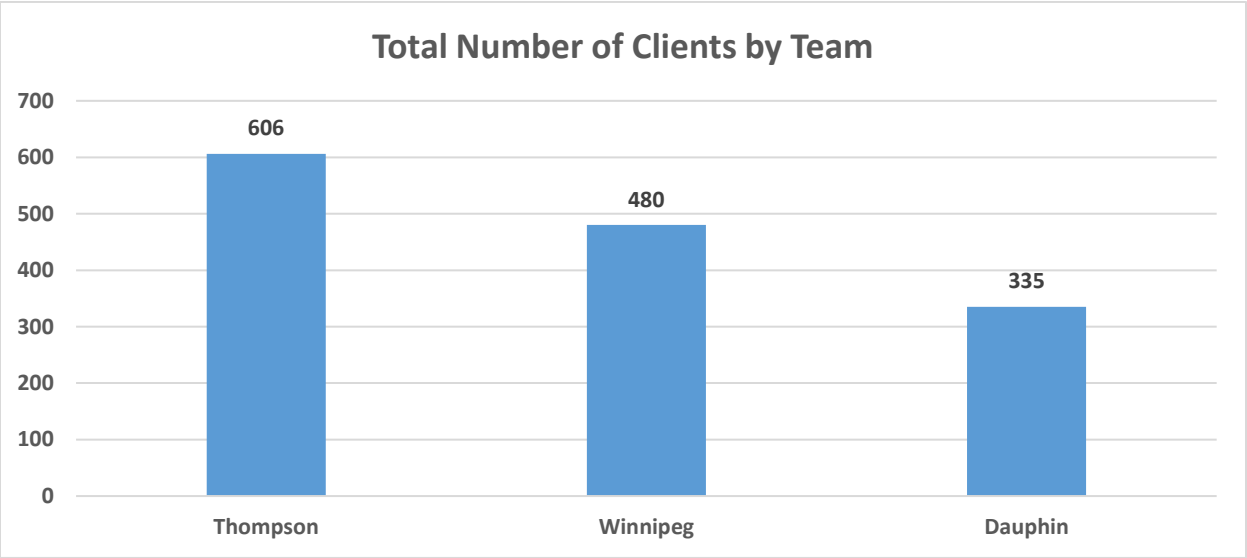
- Successful recruitment of nursing staff to provide services in community.
- Advertise DIP clinics, call clients to schedule appointments.
- Continue to work with community staff to develop strategies to support individuals living with type 2 diabetes.

Respectfully,

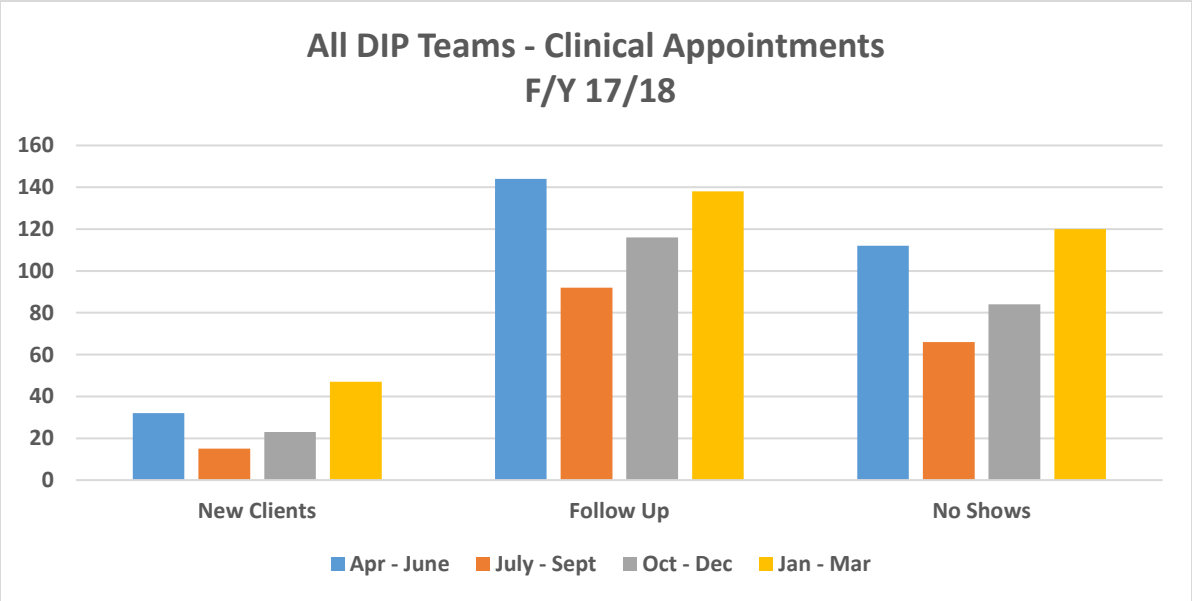
Glenda Gray, RN
DIP Thompson Team.

12.0 Statistical Highlights

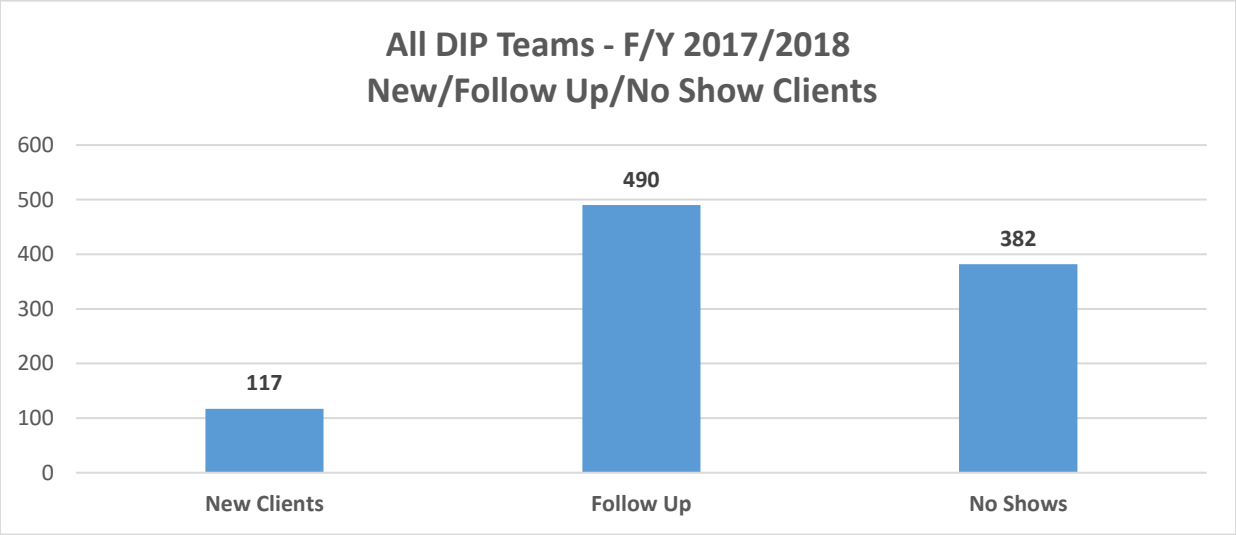
12.1 All DIP Teams – Number of Clients



The data provides valuable information on the number of clients seen by each of the DIP Teams. The highest numbers of clients are serviced by the Thompson Team (42%), Winnipeg Team (34%) followed by the Dauphin Team (24%). Issues with recruitment and retention of the Thompson Team has had an impact on the clients seen within the 6 First Nations communities currently served.

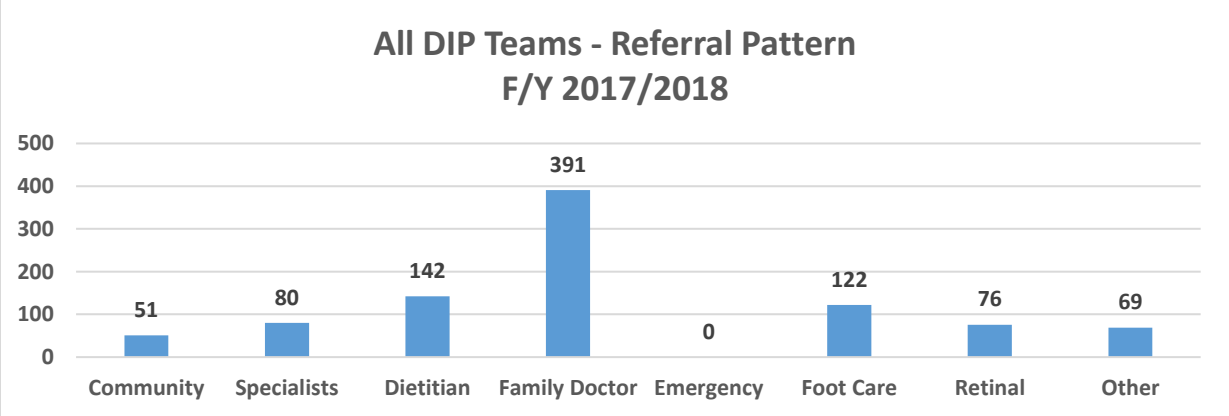


The data evidence shows the months where no nurses were available (April – September Thompson Team) and February – March Dauphin Team). The number of no shows/cancellations/rescheduled visits remains problematic for all teams. This is evident during the absence of the Aboriginal Diabetes Initiative workers, Social Services days, Family Allowance days, a death in the community or other issues such as accommodations.



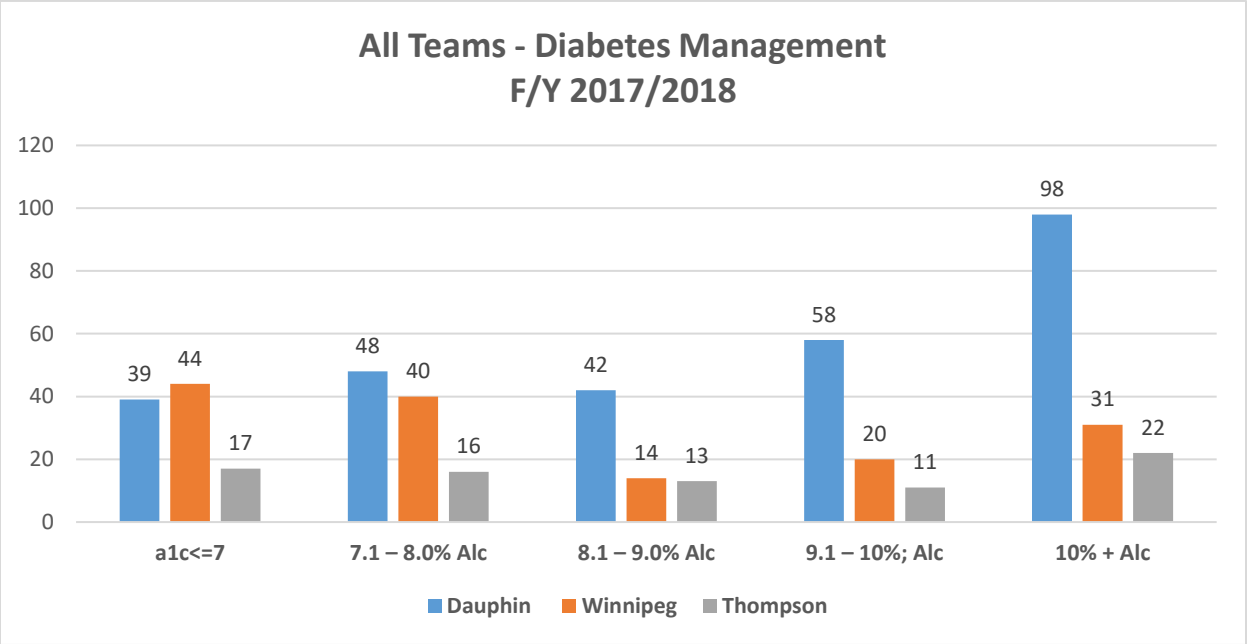
As with previous years, this fiscal year had 117 new clients introduced into the program. The number of follow up clients decreased slightly this year due to the DIP North Team vacancy. The number of no shows or cancelled visits remains problematic for all teams.

12.2 All DIP Teams – Referral Patterns



As in previous years, the highest number of referrals has been to the primary care physician for follow up care and treatment in all sites. More referrals are submitted to the DIP/Regional Health Authority dietitian as well as foot care and retinal vision screening services which clearly shows care is required in all First Nation communities.

12.3 Type 2 Diabetes Management

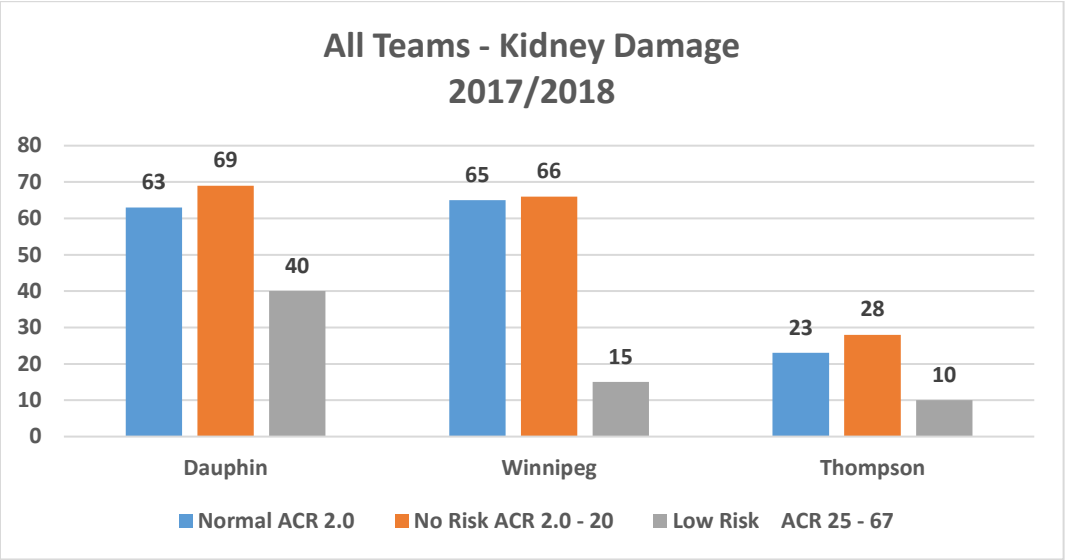


Self-management of diabetes is measured by a finger poke HgbA1c blood sample. The HgbAlc is a measure of the average blood sugar over a period of three months. The HgbAlc result is used as an indicator of treatment effectiveness in the overall management of type 2 diabetes. A target value of equal to or less than 7% is normal.

For the (513) clients tested this year, the data suggests that 19 of clients have reached the target value of 7%; 20% are less than 8.0% showing these clients are almost at target.

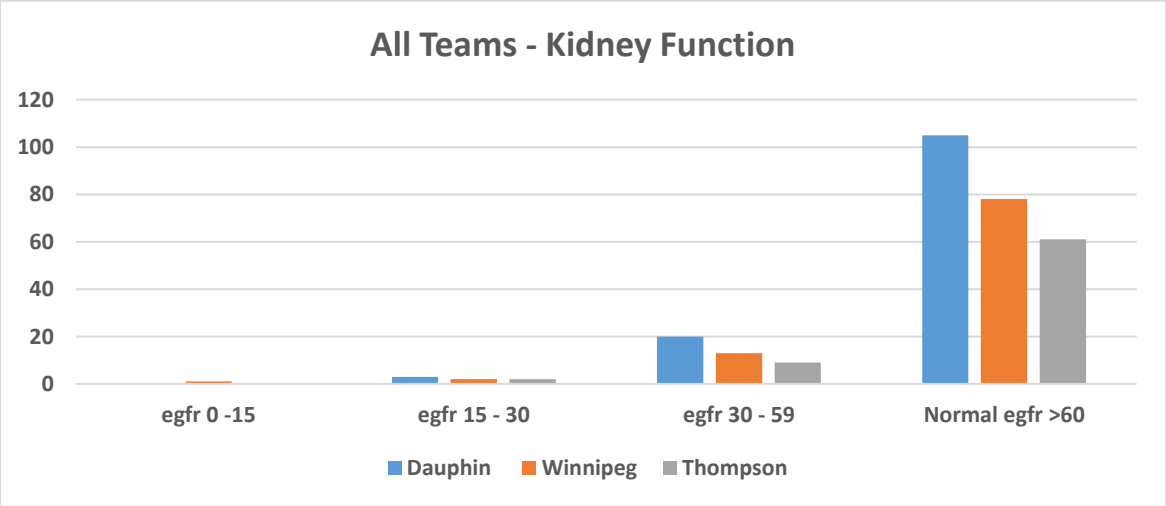
Clients who have Alc of over 10% are struggling with uncontrolled diabetes. 29% of all clients seen have uncontrolled diabetes and are at higher risk for complications in the future. The Dauphin Team have the highest numbers of clients with uncontrolled diabetes. These clients need additional support to manage their diabetes. Poverty is a huge factor that creates additional challenges as there are competing priorities for clients.

12.4 Kidney Damage (Protein in Urine)



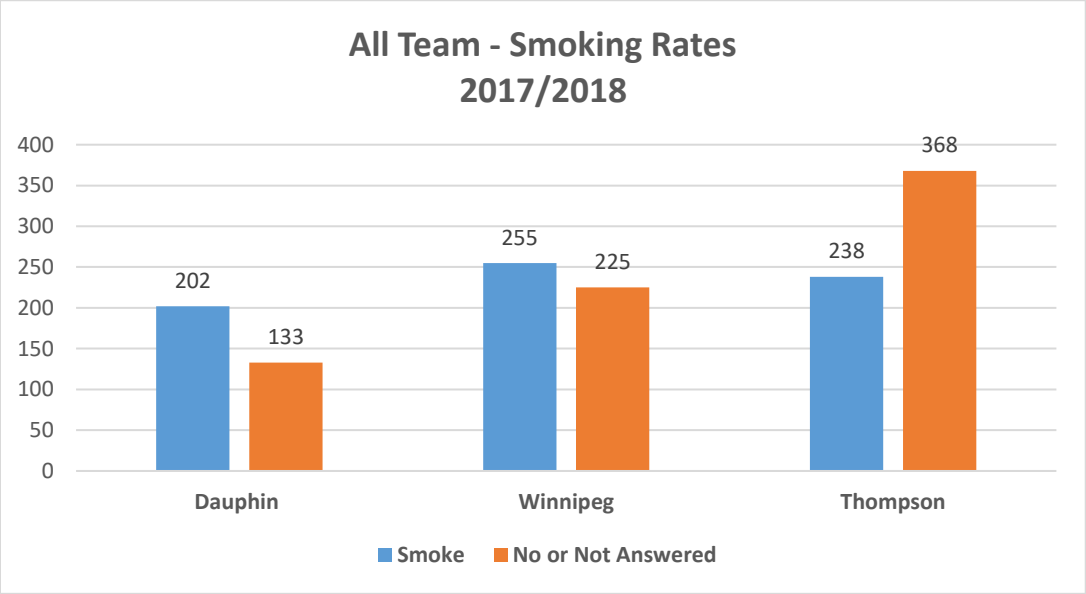
Protein in urine is a sign of kidney damage and is measured through a urine sample. 2.0 mg/mmol is considered normal and are not retested for another year. Of the 379 clients that were tested for kidney damage, 86% had normal/no risk kidneys. Only 16% of clients tested have evidence of kidney damage (61 clients) and will require monitoring over the next few years.

12.5 Kidney Function (eGFR)



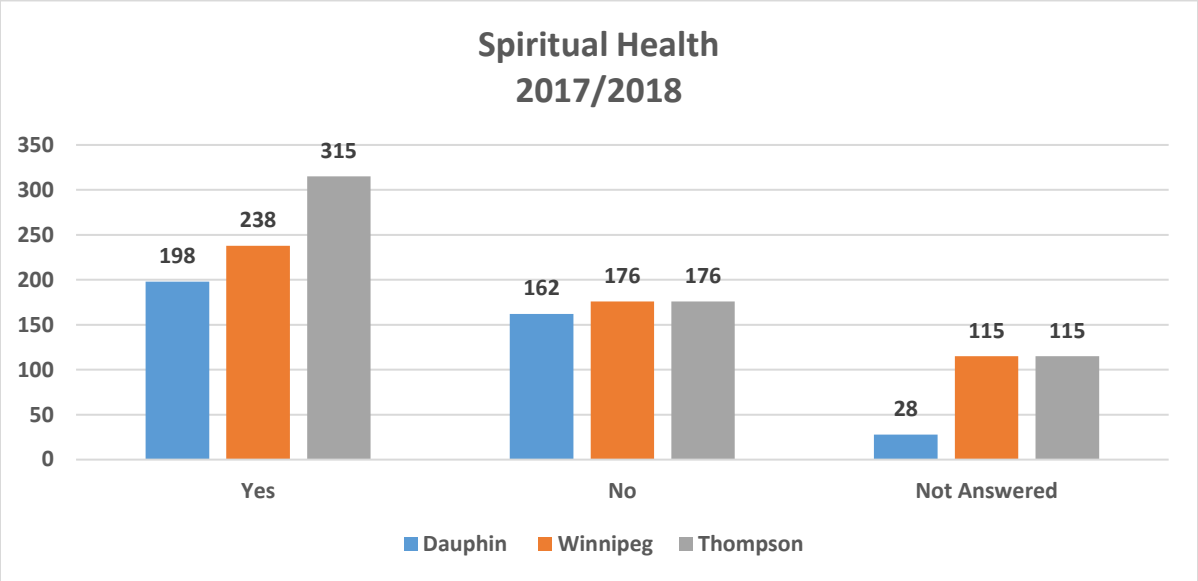
The eGFR is used to monitor kidney function and is measured through a finger poke blood test that is done annually for every client. An eGFR >60 ml/min is considered within normal range and the majority of clients are over the 60 ml/min. There are a few clients from the Dauphin Team who will require further monitoring to assess declining kidney function who are more at risk for dialysis.

12.6 Number of Clients Who Smoke by Region



Thompson Team has the lowest number of clients who smoke (238/606) while 60% of the Dauphin Team clients smoke; and 53% of the Winnipeg Team clients smoke. Moving forward, the evidence suggests more emphasis is needed on smoking cessation and to support the clients in their attempts to quit smoking.

12.7 Spiritual Health



In terms of spiritual health, only 55% of the clients seek spiritual help whether it is Christian based or Traditional Health.

13.0 Conclusion

Thank you to the First Nations Health and Social Secretariat of Manitoba, Board of Directors, Senior Management Team, DIP Team nurses, Tribal Councils, and First Nations communities health staff who work tirelessly for the benefit of First Nations diabetes clients. We will continue to work to improve the health of the clients we serve as it has been very rewarding to hear clients' state they are making changes in their lives, improving self-management practices and the positive feedback received from the community health staff and other primary care professionals.

Should you have any questions regarding the Nanaandawewigamig - Diabetes Integration Project, please do not hesitate to contact us at (204) 942-9400 or email: cchartrand@fnhssm.com. We look forward to another productive fiscal year ahead.

Respectfully,

Caroline Chartrand
Director, Diabetes Integration Project
First Nations Health and Social Secretariat of Manitoba