Community-based Reporting:
A Guide for First Nations and Inuit
2011-2012
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FNIH Regional Offices Contact Information (to be updated)

Regions and Programs Branch – BC Region
First Nations and Inuit Health
Health Canada
Sinclair Centre – Federal Tower
757 West Hastings Street, 6th Floor
Vancouver, BC V6C 3E6
1-888-321-5003
Fax: 604-666-5815

Regions and Programs Branch – Manitoba Region
First Nations and Inuit Health
Health Canada
Stanley Knowles Building, 3rd Floor
391 York Avenue
Winnipeg, MB R3C 4W1
1-877-505-0835
Fax: 204-984-5798

Regions and Programs Branch – Alberta Region
First Nations and Inuit Health
Health Canada
Canada Place, 7th Floor
9700 Jasper Avenue
Edmonton, AB T5J 4C3
1-888-495-2516
Fax:

Regions and Programs Branch – Saskatchewan Region
First Nations and Inuit Health
Health Canada
South Broad Plaza, 1st Floor
2045 Broad Street
Regina, SK S4P 3T7
1-877-780-5458
Fax:

Regions and Programs Branch – Québec Region
First Nations and Inuit Health
Health Canada
Guy-Favreau Complex – East Tower, 2nd Floor
200 René-Lévesque Boulevard West
Montréal, Québec H2Z 1X4
1-877-483-5501

Regions and Programs Branch – Ontario Region
First Nations and Inuit Health
Health Canada
Emerald Plaza, 3rd Floor
1547 Merivale Road
Ottawa, ON K1A 0K9
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Regions and Programs Branch – Atlantic Region
First Nations and Inuit Health
Health Canada
Maritime Centre, 18th Floor
1505 Barrington Street
Halifax, NS B3J 3Y6
1-800-565-3294
Fax: 902-426-8675
## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
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<tr>
<td>ADI</td>
<td>Aboriginal Diabetes Initiative</td>
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<tr>
<td>AHSOR</td>
<td>Aboriginal Head Start On Reserve</td>
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<tr>
<td>BF</td>
<td>Brighter Futures</td>
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<tr>
<td>BHC</td>
<td>Building Healthy Communities</td>
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<tr>
<td>BSc</td>
<td>Bachelor of Science</td>
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<tr>
<td>C</td>
<td>Certified</td>
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<tr>
<td>CBRT</td>
<td>Community-based Reporting Template</td>
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<tr>
<td>CBWM</td>
<td>Community-based Drinking Water Quality Monitor</td>
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<tr>
<td>CCC</td>
<td>Clinical and Client Care</td>
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<tr>
<td>CDCM</td>
<td>Communicable Disease Control and Management</td>
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<tr>
<td>CDPW</td>
<td>Community Diabetes Prevention Worker</td>
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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
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<tr>
<td>CHR</td>
<td>Community Health Representative</td>
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<tr>
<td>CIPHI</td>
<td>Canadian Institute of Public Health Inspectors</td>
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<tr>
<td>COHI</td>
<td>Children's Oral Health Initiative</td>
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<tr>
<td>CPNP</td>
<td>Canada Prenatal Nutrition Program</td>
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<tr>
<td>DTaP-IPV</td>
<td>Diphtheria, Tetanus, Pertussis, Poliomyelitis</td>
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<tr>
<td>DWA</td>
<td>Drinking Water Advisory</td>
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<tr>
<td>DWSP</td>
<td>Drinking Water Safety Program</td>
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<tr>
<td>ECE</td>
<td>Early Childhood Educator</td>
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<tr>
<td>EHO</td>
<td>Environmental Health Officer</td>
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<tr>
<td>e-HRTT</td>
<td>Electronic Human Resource Tracking Tool</td>
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<tr>
<td>EHIS</td>
<td>Environmental Health Information System</td>
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<td>e-SDRT</td>
<td>Electronic Service Delivery Reporting Template</td>
</tr>
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<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
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<td>FNIH</td>
<td>First Nations and Inuit Health</td>
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<td>FNIHB</td>
<td>First Nations and Inuit Health Branch</td>
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<tr>
<td>FT</td>
<td>Full Time</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
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<tr>
<td>GCDWQ</td>
<td>Guidelines for Canadian Drinking Water Quality</td>
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<tr>
<td>HC</td>
<td>Health Canada</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>HCC</td>
<td>Home and Community Care</td>
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<tr>
<td>HD</td>
<td>Health Director</td>
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<td>HE</td>
<td>Healthy Eating</td>
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<td>HiB</td>
<td>Haemophilus influenzae Type B</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<td>IGRA</td>
<td>Interferon Gamma Release Assay</td>
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<td>LPN</td>
<td>Licensed Practical Nurse</td>
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<td>LTBI</td>
<td>Latent Tuberculosis Infection</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<tr>
<td>MMR vaccine</td>
<td>Measles, Mumps, Rubella</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>NAYSPS</td>
<td>National Aboriginal Youth Suicide Prevention Strategy</td>
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<td>NIC</td>
<td>Nurse in Charge</td>
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<td>NNADAP</td>
<td>National Native Alcohol and Drug Abuse Program</td>
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<td>PA</td>
<td>Physical Activity</td>
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<td>PCW/HCA</td>
<td>Personnel Care Worker/Health Care Aides</td>
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<tr>
<td>PDH</td>
<td>Professional Development Hours</td>
</tr>
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<td>PT</td>
<td>Part Time</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>QC</td>
<td>Quality Control</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TDG</td>
<td>Transportation of Dangerous Goods</td>
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<tr>
<td>THMs</td>
<td>Trihalomethanes</td>
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<tr>
<td>WHMIS</td>
<td>Workplace Hazardous Materials Information System</td>
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<td>WTPO</td>
<td>Water Treatment Plant Operator</td>
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<tr>
<td>YSAC</td>
<td>Youth Solvent Addictions Committee</td>
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<tr>
<td>YSAP</td>
<td>Youth Solvent Abuse Program</td>
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Introduction

Purpose of This Guide

This Guide is intended to be used together with the Community-based Reporting Template 2011-2012 (CBRT). Contribution Agreement (CA) recipients are required to complete the CBRT for reporting on performance of health programs and services for each community covered by their Contribution Agreement. The Guide provides information that you will need to complete the CBRT.

The CBRT is not for reporting financial and audit information. For information on financial reporting requirements, refer to your Contribution Agreement.

This Guide provides:

- Instructions and guidance for completion of each section of the CBRT;
- Explanations of why specific information is being collected and how it will be used;
- Definitions specific to each question and examples to illustrate response requirements;
- Additional information such as a glossary of acronyms, and FNIH Regional Office contact information.

How This Guide Is Organized

The Guide is organized based on the CBRT:

- **Part 1 – Identification Information** asks for information that identifies the community and recipient.
- **Part 2 – Common Information** asks what programs and services are delivered in your community, as well as the types and numbers of health care workers.
- **Part 3 – Program Component Reporting** is divided into Sections A. to G., one for each program component covered in the CBRT. Each section asks questions about your programs and services related to the program component.

Important Reference Documents

- First Nations and Inuit Program Compendium 2011-2012 provides detailed program descriptions that will assist you in completing the CBRT.
- Program Component Performance Measurement Strategies, available from your FNIH Regional Office.
Context

Treasury Board Canada requires each government department to periodically review and renew the authorities it has to operate programs and allocate funds. Health Canada is required to renew its Contribution Program Authorities every 5 years. In April 2011, the renewed Authorities for First Nations and Inuit programming and services came into effect.

To fully benefit from funding flexibility in the new Contribution Program Authorities, Health Canada continued to improve its program structure by grouping First Nations and Inuit (FNIH) programs into program components. This was accomplished by putting similar and comparable programs into the same program component. Grouping similar programs and services provides the flexibility to First Nations and Inuit to identify and address their own health needs and priorities.

The FNIH program components are now as follows:
- Healthy Child Development
- Mental Wellness
- Healthy Living
- Communicable Disease Control and Management
- Home and Community Care
- Clinical and Client Care
- Environmental Public Health
- Non-Insured Health Benefits*
- Health Planning and Quality Management*
- Health Human Resources*
- Health Facilities*
- System Integration*
- e-Health Infostructure*
- Nursing Innovation*

The program components identified with an asterisk (*) are not included in the CBRT.

Contribution Agreement recipients can use the performance information that they collect and provide in the CBRT for their own planning, decision-making and health promotion.

Health Canada will use the performance information to develop reports at the regional or national level. This allows Health Canada and funding recipients to identify strengths and weaknesses in programming and to adjust programming to better serve the needs of First Nations and Inuit communities. National level reports may also be shared with Treasury Board to comply with reporting requirements of Health Canada authorities.

In order for Health Canada to assess program success and to compare its program results from year to year, the information gathered through the CBRT must be provided by every community.
General Instructions for Completing the CBRT

• Information obtained from completed CBRTs will be aggregated by community. Consequently, if your Contribution Agreement covers more than one community, you must submit a completed CBRT for each community included in your agreement.

• Programs that currently report to Health Canada using other tools, processes or electronic systems, such as the HCC e-SDRT and e-HRTT, and COHI dental database, are required to continue to input into these processes and systems within the agreed upon time frames, in addition to answering the related questions in the CBRT.

• The reporting year is April 1st to March 31st except for certain questions under Communicable Disease Control and Management, which has differing reporting periods depending on program requirements and provincial schedules.

• Do not provide personal information (names or other information) in the CBRT. Information pertaining to individual members of the community is not requested.

• The information communities provide in the CBRT on program performance can help them to know if their program activities are achieving what they want them to achieve. Recipients need processes and tools to manage that information. In order to gather, organize, and monitor program performance information, use simple tools when available, such as activity record sheets, client files, intake forms, and information systems.

• Certain data tracking tools are provided along with the CBRT. These tools can support your collection of data but should not be submitted to Health Canada.

• As much as possible, try to be consistent throughout the CBRT in your use of terms, e.g., how you categorize different types of health care workers, etc.

• You will require extra space for your responses as indicated in some questions. Use extra sheets of paper and be sure to label the sheets with the question numbers and submit them as part of your completed template.

• The due date for submitting the completed CBRT is specified in your Contribution Agreement. Submit the completed CBRT to your FNIH Regional Office by e-mail, mail or fax.

If you have any questions about the CBRT or this Guide, contact your FNIH Regional Office. Contact information for all FNIH Regional Offices is provided at the beginning of this Guide.
Part 1 – Identification Information

Part 1 is mandatory.

Accurate identification is necessary in order to confirm that the recipient has met the performance reporting requirements of the contribution agreement. It also facilitates the accurate compiling and reporting of performance information at the Regional level.

Indicate the number on the appropriate Contribution Agreement; the highest type of funding model used by the contribution agreement; whether the contribution agreement is for multiple communities, and if so, for how many communities; the community name; the organization or recipient name as indicated in the contribution agreement, the name of the health facility where community members access services; the reporting period; and the contact name and position with signature and date. Be sure that the CBRT is authorized and signed by the recipient before submitting the completed CBRT to your FNIH Regional Office.

Note: You must complete a separate CBRT for each community covered in your Contribution Agreement.

Part 2 – Common Information

Part 2 is mandatory.

Part 2 consists of two sections. The first section asks you to identify the programs and services that are delivered in the community that you identified in Part 1. The second section asks about the type and number of health care workers serving the community.

This information will be analyzed to assess the level of programs and services regionally and nationally.

1. Programs and Services Delivered

Indicate which programs and services were provided for the reporting year by putting a check mark in the boxes for all programs or services that apply. For each of the programs and services you indicate here, you must complete the questions in the corresponding section in Part 3.

The programs and services provided in your community through your Health Canada contribution agreement may have a different name than those provided in the CBRT, or programs may be combined. If that is the case, short program descriptions (A to G) are provided below to help you decide where your program fits best.

If you need more details on programs, see the full program descriptions in the FNIH Program Compendium.
A) Healthy Child Development

The Healthy Child Development component funds and supports community-based and culturally relevant programming, services, initiatives and strategies that aim to improve health outcomes associated with First Nations and Inuit maternal, infant, child, and family health. The areas of focus include prenatal health; nutrition, early literacy and learning; physical, emotional and mental health; and children’s oral health.

Programming provides increased access to a continuum of supports for women and families with young children from preconception through pregnancy, birth, and parenting. Funding also supports knowledge development and dissemination, monitoring and evaluation, public education and outreach, capacity building, program coordination, consultation, and other health promotion and disease prevention activities related to healthy child development.

B) Mental Wellness

The Mental Wellness program component funds and supports programming for communities, families and individuals to maintain and improve their mental health through a number of mental health and addictions programs. These programs promote mental health, increase awareness of mental health issues and addictions, and offer prevention programs, counselling, treatment and aftercare for people with mental health issues and addictions. Other programs work to improve community response to mental health crises and aftercare.

Mental Wellness programs include Brighter Futures, Building Healthy Communities, the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS), and the community-based delivery of the National Native Alcohol and Drug Abuse Program (NNADAP). Other programs in the component, i.e., the Youth Solvent Abuse Program (YSAP), NNADAP residential treatment centres, and the Indian Residential Schools Resolution Health Support Program, all report their activities using separate reporting formats in accordance with their contribution agreements. Brighter Futures includes community-based mental health, child development, parenting skills, healthy babies, and injury prevention. Building Healthy Communities assists communities to respond to crisis by providing funding to address gaps in mental health crisis management, and to develop solvent abuse prevention and early intervention programs. The National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) reduces risk factors and enhances protective factors against youth suicide including prevention, intervention and postvention activities. The National Native Alcohol and Drug Abuse Program (NNADAP) provides community-based addictions prevention, counseling, and aftercare.
C) Healthy Living

The Healthy Living component funds and supports a suite of community-based programs, services, initiatives and strategies that aim to improve health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families and communities. Initiatives promote healthy behaviours and supportive environments, particularly in the areas of healthy eating, food security, and physical activity. They also address chronic disease prevention, screening, and management; and injury prevention. Funding also supports knowledge development, dissemination and exchange; research; monitoring and evaluation; public education and outreach; capacity building; program coordination; consultation; and other health promotion and disease prevention activities related to Healthy Living.

D) Communicable Disease Control and Management

Programs in the Communicable Disease Control and Management component aim to reduce the incidence, spread, and human health effects of communicable diseases, as well as improve health through disease prevention and health promotion activities for on-reserve First Nations and Inuit living south of the 60th parallel. Communicable disease control and management programs and initiatives support public health measures to mitigate these underlying risk factors by: preventing, treating and controlling cases and outbreaks of communicable diseases; promoting public education and awareness to encourage healthy practices; strengthening community capacity; conducting data collection, surveillance and identifying risks; and working collaboratively with other jurisdictions and FNIH program and policy areas.

E) Home and Community Care

Home and Community Care is a coordinated system of health care services that enable First Nations and Inuit people of all ages with disabilities, or chronic or acute illnesses, as well as the elderly, to receive the care they need in their homes and communities. Home and Community Care services are provided primarily through contribution agreements with First Nations, Inuit communities, and territorial governments. The program strives to provide services equivalent to those offered to other Canadian residents in similar geographical areas. Home and Community Care is delivered primarily by home care registered nurses and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process. Essential service elements include client assessment; home care nursing; case management; home support (personal care and home management); in-home respite; linkages and referrals to other health and social services, as needed; provision of and access to specialized medical equipment and supplies for care; and a system of record keeping and data collection. Additional supportive services may also be provided depending on the needs of the communities and funding availability. Supportive services may include, but are not limited to rehabilitation and other therapies; adult day care; meal programs; in-home mental health; in-home palliative care; and specialized health promotion, wellness and fitness.
F) Clinical and Client Care

Clinical and Client Care consists of essential health care services directed toward First Nations individuals living primarily in remote and isolated communities, enabling them to receive the clinical care they need in their home communities. Clinical and Client Care is the first point of individual contact with the health system and is delivered by a collaborative health care team, predominantly nurse led, providing integrated and accessible assessment, diagnostic, curative and rehabilitative services for urgent and non-urgent care. The continuum of Clinical and Client Care includes health promotion and disease prevention at the client or family level in the course of treatment, as well as the coordination and integration of care and referral to appropriate provincial secondary and tertiary care providers outside the community.

G) Environmental Public Health

The Environmental Public Health Program is delivered in all First Nations communities south of 60° by Environmental Health Officers (EHOs) employed by Health Canada or individual Bands or Tribal Councils in accordance with the National Framework for the Environmental Public Health Program in First Nations Communities South of 60°. Objectives of the program are to identify and prevent environmental public health risks that could affect the health of community residents, and to recommend corrective action and health promotion to reduce these risks. Key programming includes environmental public health assessments (e.g., public health inspections, investigations, monitoring of drinking water quality), training, and public education and awareness. Activities are delivered in core areas such as: Drinking Water, Food Safety, Health and Housing, Wastewater, Solid Waste Disposal, Facilities Inspections, Environmental Communicable Disease Control, and Emergency Preparedness and Response.

2. Health Team

Health Care Worker is a generic term used in the CBRT for the different types of health related workers providing programs and services. The purpose of this section is to gather information on the numbers and types of health care workers in the community, and whether they are full time, or part-time or visiting. This information sheds light on the human resource capacity of the community to provide health programming and services. No individual’s names or personal information should be provided in this section. Recipients should report only on those positions that are occupied as of the end of the reporting period.

The categories of health care workers specified are:

- Health Managers
- Registered nurses employed by the Band, including nurse practitioners, registered nurses and licensed practical nurses.
- Registered nurses employed by Health Canada, including nurse practitioners, registered nurses and licensed practical nurses.
- Other licensed or regulated health professionals
• Community-based health workers, e.g., CHRs, NNDAP, ADI, AHSOR, CPNP, MCH Home Visitors, FASD Community Coordinators and Mentors, HCC Personal Care Workers
• Administrative, janitorial, and housekeeping staff working in health facilities and for health programs.

Note: In Ontario, Licensed Practical Nurses are referred to as Registered Practical Nurses.

Be sure to provide the numbers for each category of health care workers under full or part-time, and the totals for each column.

Indicate whether you have an arrangement with a medical officer of health or a medical health officer to provide public health services to your community, and if so, who they work for.

Definitions:
Full time and part-time are defined by the recipients who report the information. No standard has been established in this respect.

Licensed or regulated refers to the health care worker who is required by provincial legislation to obtain a licence or certification related to their field of work from a recognized professional association or government body. For example, in Ontario, nurses are licensed through the College of Nurses of Ontario. Environmental Health Officers are certified by the Canadian Institute of Public Health Inspectors.

Part 3 – Program Component Reporting
Part 3 is mandatory.
Each section of Part 3 pertains to a program component. Complete the information for the program component sections that apply to the programs and services managed in your community under your Contribution Agreement with Health Canada, and as you indicated in Part 2 of the CBRT. Sections must be completed unless specified otherwise at the beginning of a section.

Part 3 of the CBRT requests specific performance information for each program and service. The information collected from all communities will be compiled and used to:
- assess health programs and services (e.g., Have targeted populations been reached?);
- inform program development (e.g., Are there better ways to reach target populations?);
- improve programs and services (e.g., who, where, how); and
- assess the need for further investments.

This information is essential to evaluate the quality, efficiency and effectiveness of programs and services, such as changed behaviour or accessibility.
To help you complete Part 3, it is important that you have basic information management processes in place. In order to gather, organize, and monitor information on program performance, use simple tools such as activity record sheets, client files, intake forms, and information systems.

Note: Programs that currently report to Health Canada using other tools, processes or electronic systems, such as the HCC e-SDRT and e-HRTT, and COHI dental database, are required to continue to input into these processes and systems within the agreed upon time frames, in addition to answering the related questions in the CBRT.

Question 1. Worker Information and Training

Definitions

Job title means the employee’s actual job title in the community.

Certification type is the type of certification or accreditation the employee has, if any. In your response to this question, use the appropriate letter codes for certification or accreditation types provided in Table 1 in the CBRT.

Note: Enter only those codes included in Table 1. Multiple certifications and accreditations for a single worker should be separated by commas.

Training completed means training completed during the reporting year. The training types are defined as:

- **Certified Training**: worker acquired diploma or certificate through training and completion of an educational program of at least one academic year in length.
- **Continuing Education**: short-term courses that upgrade or maintain skills.
- **Short Course Training**: courses between 1 week and 3 months that are not recognized with classes in a certification program.

As much as possible, use consistent titles for members of your health team throughout the CBRT to ensure that information collected in all communities is comparable.
A. Healthy Child Development

Introduction

This section is for reporting on all programs, services and activities that contribute to achieving the objectives and outcomes of the Healthy Child Development program component. Healthy Child Development programs are designed to collectively improve the cultural, emotional, intellectual and physical growth and development of infants, children and youth. It includes programs that aim to improve maternal, infant and child health outcomes, increase children’s knowledge of language and culture, and increase their readiness for school. Programs in this component include Aboriginal Head Start On Reserve (AHSOR), Canada Prenatal Nutrition Program (CPNP), Fetal Alcohol Spectrum Disorder Program (FASD), and Maternal Child Health (MCH).

A Healthy Child Development Tracking Tool is included with your CBRT package to aid you in tracking information required to complete this section. Use of the tool is not mandatory, but it is recommended if you have no other tracking tool to collect the information. The tracking tool is especially useful because the data is organized to correspond directly to the CBRT questions. See Questions 3-5, 7, 8, and 10-17.

Question 2. Pre and Postnatal Nutrition Activities

This information is required to identify the types of pre- and postnatal nutrition activities that are being offered to pregnant women and mothers of infants up to one year of age.

Note: These activities fall under the elements of the Canada Prenatal Nutrition Program (CPNP) and the Maternal Child Health program (MCH). Examples of activities are provided in Question 2 in the CBRT and are defined under each of the program elements in the Definitions and Examples below.

For Supportive Elements, indicate whether your community offers any of the supportive activities (see definition below) to pregnant women and mothers with infants up to one year of age.

Definitions and Examples

Activities are defined as any program or service element that is funded through the contribution agreement for the purpose of achieving a program or service objective.
Pre and Postnatal Nutrition Activities fall under the following CPNP elements:

- **Nutrition Screening, Education and Counselling** involves talking to a pregnant women or mother to determine if she would benefit from nutritional education or counselling. A screening tool is used to determine how a woman eats, what she needs to learn about nutrition, and how to help her set goals for healthy eating. The screening, education, and counselling are done by a program worker or other qualified worker.

- **Maternal Nourishment** activities involve providing healthy foods to pregnant and breastfeeding women. This can be done by giving women healthy food directly, giving them healthy snacks when they meet for groups, or giving them food hampers or vouchers.

- **Breastfeeding Promotion, Education, and Support**: Breastfeeding promotion encourages women to breastfeed, and encourages communities and families to support women who breastfeed. The education and support elements aim to teach women and their families about the benefits of breastfeeding, how to breastfeed, and how to maintain breast milk supply if separated from their infant, and to support them during breastfeeding.

- **Supportive Elements** are not related to nutrition but can contribute to the improved health of mothers and infants. There are two types of supportive activities. The first includes activities that help women to access nutrition programming, such as transportation and childcare. The second includes non-nutrition activities that help to improve the health of mothers and infants. Examples include, but are not limited to, exercise programs for women of childbearing age or programs that help women quit smoking.

**Question 3. Reach of Pre and Postnatal Nutrition Programming**

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 3-8” columns D-H to complete this question.

This question provides Health Canada with information that is necessary to calculate the program reach by providing the number of participants who receive CPNP program services. The table asks that you identify the total number of participants grouped according to when they first joined CPNP. For the purposes of reporting in the CBRT, it is not necessary to keep a record of how many activities any of the participants attended or how often, but simply to provide the number of participants who took part in any pre and postnatal (CPNP) activities offered in your community during the reporting year.

For the reporting year, provide the number of participants who first received pre or postnatal nutrition services during in their first, second or third trimester of pregnancy, or postnatal. Count each participant only once. If you add the numbers you provide for all of the four possible time frames (first, second or third trimester of pregnancy, or postnatal), that total should equal the total number of participants in your program for the reporting year.

Note: The information requested in Questions 4, 5, 7 and 8 should be collected for participants in the Canada Prenatal Nutrition Program and the Maternal Child Health Program.
Question 4. Breastfeeding for participants with infants six months or older

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 3-8” columns I-M to complete this question.

Health Canada promotes breastfeeding as the best method of feeding infants because it provides optimal nutritional, immunological and emotional benefits for the growth and development of infants. One of the objectives of CPNP and MCH is to increase breastfeeding initiation and duration among participants.

Information collected on the numbers of CPNP and MCH participants who have initiated breastfeeding, and on the number who have breastfed for the specified durations, will help Health Canada to track and report on the overall, national breastfeeding rates among participants.

In this question, for participants with infants 6 months or older, indicate the number who breastfed for each of the breastfeeding durations listed.

Question 5. Risk Factors

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 3-8” columns N-V to complete this question.

Note: This question refers to all pregnancies concluding in the reporting year. If more than one risk factor is present in a single pregnancy, count the pregnancy for every risk factor that applies.

The information collected on risk factors will help to determine whether Health Canada is reaching its program target populations. When risk factors are identified, Healthy Child Development programs can provide women with the education, support and resources to reduce high-risk behaviours and promote healthy, full term births.

In the MCH program, comprehensive first level screening and assessments are crucial for early identification of pregnant women and families with infants and young children who may be at risk for poor health outcomes and require comprehensive support and interventions for healthy pregnancy and child development outcomes.

Screening can identify risk factors or conditions that may negatively affect the mother’s health and the health of her baby. Research shows that women with risk factors benefit more from frequent support during pregnancy and show improved health and well-being before and after the birth of their baby.
Definitions and Examples

Risk factor is a condition or excessive stressor that is likely to increase the chances for unhealthy birth outcomes.

Health Canada has identified the following risk factors to report: pregnancy when the woman is younger than 20 and older than 35; smoking; drug, alcohol, or solvent use; diabetes diagnosed before or during pregnancy; and diagnosis of post partum mood disorders diagnosed during previous pregnancies.

Question 6. Total Number of Births

The total number of births gives a base count of infants up to one year of age in the community during the reporting year. Together with the numbers you provided in Question 3, this base count allows your community and Health Canada to determine the percentage of the target population being reached by pre and postnatal nutrition programming. This question asks for the total number of births to mothers who resided in the community during the reporting year.

If the total number of births in your community is not available in your program sources, your Band Office, or other sources in your community, try the INAC website. However, INAC data may be slightly inaccurate due to lag time in acquiring status for infants and young children. INAC also does not account for non status infants born to mothers in the community. Census Canada may provide more details.

Question 7. Birth Weight

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 3-8” columns W-Z to complete this question.

Good maternal nutrition is a major factor contributing to healthy birth weight. Information from this question will allow communities to track the progress of their prenatal nutrition programming in increasing the numbers of infants with healthy birth weights. Information on the number of pre-term newborns accounts for premature infants whose lower birth weight may be attributed to an early birth rather than poor maternal nutrition.

For this question, indicate the number of low birth weight infants, high birth weight infants, and infants who were born at a healthy birth weight. The response “birth weight unknown” should be used if you are unaware if a participant’s infant was full term or pre term.
Definitions

Low birth weight: Newborns weighing less than 2500 grams (5 pounds 8 ounces). Low birth weight babies have a greater risk of dying as infants, and are more likely to develop serious lifelong disabilities and illnesses.

High birth weight: Newborns weighing more than 4000 grams (8 pounds, 13 ounces). These babies have a greater risk of developing diabetes later in life. Delivery can be more difficult for the mother.

Healthy birth weight: Newborns weighing between 2500 grams (5 lb 9 oz) and 4000 grams (8 lb 11 oz). These babies have the lowest risk of poor birth outcomes.

Full term: [to be completed]

Question 8. Solid Food Initiation

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 3-8” columns AA-AD to complete this question.

The period from conception to six years of age is the most important time for brain development and has a crucial impact on behaviour and health. In an infant’s first year, appropriate introduction of solid foods supports healthy development. One of the objectives of post-natal nutrition programming is to increase the number of infants fed age-appropriate foods in their first 12 months.

Information on solid food initiation will help determine how effectively programs are achieving this outcome. It also allows a comparison to current Health Canada infant feeding guidelines which state that at six months, infants need complementary foods along with continued breastfeeding to meet their nutrient needs.

For infants in your program seven months or older, Health Canada would like to know when solid food was introduced into their diet (before the age of two weeks, between 2 weeks and 6 months or after 6 months).

Definitions

Solid food: At about six months, infants are ready for foods with more semi-solid texture. Refer to Eating Well with Canada’s Food Guide: First Nations, Inuit, and Métis for more information and examples.

Solid food initiation is the first time that an infant is given food other than liquids.
Question 9. Maternal Child Health Screening and Assessment

Screening and assessment services offered by Community Health Nurses and Home or Family Visitors help to identify the needs of families and to determine the appropriate level and types of services to provide to the family. Comprehensive first level screening and assessments are beneficial for early identification of pregnant women and families with infants and young children who may be at risk for poor health outcomes.

Screening can identify risk factors and excessive stresses that may negatively affect a mother’s health and the health of her baby.

Definitions and Examples

Activities are any program or service element that is funded by the contribution agreement for the purpose of achieving a stated program or service objective.

Question 10. Maternal and Child Health Home Visiting and Case Management

Programming Reach

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 10-11” columns B-G to complete this question.

This section provides Health Canada with information that is necessary to calculate the program reach by providing the number of participants who receive home visiting and case management services in your community during the reporting year.

Women can be receiving home visiting and case management at the same time. Therefore women can be counted in both columns for this question.

Definitions and Examples

Home Visiting, as part of maternal and child health services, is a type of service delivery model that is provided in a home setting by a trained service provider. Services under home visiting include prenatal and post partum support; infant development activities; identification of parents or families at risk through screening and assessment tools; education and support; and, when appropriate, referrals and case management.

Case Management is the linking of an individual or family to health or social services. The key case management components are screening, comprehensive assessment, service planning, service coordination, on-going monitoring, and reassessment or evaluation of needs. Within the context of maternal and child health services, case management builds on the strengths of the individual or family and provides them with long-term support from pre-pregnancy through post-partum, infancy and early childhood.
Participant for this question is defined as the primary contact for the home visiting and case management services, including services for their family and dependants.

Family The definition of family is determined by communities. For example, a family could include extended family members and other community members.

Caregiver is an individual over the age of 18 other than the biological parents, who cares for the child and may or may not have guardianship of the child. For example, a caregiver could be the grandmother in a household.

**Question 11. First Home Visit**

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Questions 10-11” columns H-K to complete this question.

The earlier in a pregnancy that the first home visit takes place, then the earlier that risks can be assessed and appropriate supports or interventions can be delivered to the family. Information on the stage of pregnancy when women access maternal and child health programming helps the community and Health Canada to determine whether more efforts are needed to reach families earlier.

**Definitions and Examples**

First home visit is the point of first contact with the MCH program to support pregnant women and families with young children.

First trimester of pregnancy is 0 to 12 weeks.

Second trimester of pregnancy is 13 to 26 weeks.

Third trimester of pregnancy is 27 to 40 weeks.

**Question 12. Fetal Alcohol Spectrum Disorder**

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 12” columns B-C to complete this question.

FASD services are directed toward First Nations on-reserve and Inuit individuals, children from age 0 - 6, and women of child bearing age. The main focus of the program is pregnant, at-risk women.
Definitions and Examples

The FASD has three elements:

**FASD capacity building** activities support First Nations and Inuit communities to build knowledge and skills (capacity) on FASD and healthy child development issues, in order to increase the number of healthy babies and to help prevent FASD. Examples of capacity building activities include FASD awareness and prevention activities and development of action plans. **You do not need to report the number of participants in capacity building activities.**

**FASD community coordination and FASD case management** A community coordinator is a community-based liaison person who acts as an advocate for the child and the family. **For the number of participants receiving FASD community coordination services, a participant is defined as the parents or caregivers and a child who is suspected of being affected by or diagnosed with FASD.**

**FASD mentoring** The mentor helps a woman to identify her strengths and challenges and links her to appropriate services and supports that can help to reduce her risk of having a baby affected by FASD. **The number of participants receiving mentoring services is the number of clients who work with a mentor.**

**Question 13. Aboriginal Head Start On Reserve (AHSOR)**

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 13” to complete this question.

AHSOR programming can be delivered at the community level in a variety of ways, such as Centre-based, Outreach/Home-visiting, or a combination of the two (see definitions below).

The information from this question helps to give a picture of how programming is delivered and better illustrates how AHSOR meets the needs of the children and families it serves.

*Note: Some communities, due to their size, may have more than one AHSOR program. If this is the case for your community, choose only one of your AHSOR programs for completing this question.*

*In some circumstances, AHSOR may provide partial funding to another early childhood development (ECD) program in a community. Include any ECD program(s) receiving AHSOR funding in your answers to this question.*
Definitions and Examples

Number of communities In some cases an AHSOR program can serve multiple communities. If this is the situation for your AHSOR program, then indicate the total number of other communities served, including your own community.

Outreach/Home-visiting Outreach is also known as Home-visiting. This type of programming is implemented in a child’s home, or in a home environment, with the intent to include the entire family. Outreach/Home-visiting may be delivered because of geographical distances (e.g., the centre-based program is too far to travel) or because a centre-based delivery approach is not practical or possible.

Centre-based program is programming that happens in a building or facility, also referred to as a “site”.

Licensing is done by the province or territory and shows that a preschool, daycare or early childhood education centre has met minimum health, safety and teacher training standards set by the province or territory.

Full day programs operate in both the morning and afternoon. Half day programs operate in either the morning or the afternoon. For this question, indicate the number of full days and half days that your Centre-based program operates only.

Co-located An AHSOR program is co-located if it shares space in a building or facility with another program or service, such as a daycare or school, health centre, community centre, or Band office.

Co-located in a school or daycare facility An AHSOR program is co-located in a school or daycare facility if it shares space in a building or facility with a school or daycare.

Question 14. AHSOR Activities

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 14” columns B-E to complete this question.

The activity types listed in this question support AHSOR’s six components: culture and language, health promotion, nutrition, education, social support, and parental/family involvement. The information from this question will provide a better understanding of how the AHSOR program can support a child’s health and development.

Definitions and Examples

Activities are any program or service element that is funded by the contribution agreement for the purpose of achieving a stated program or service objective.
Question 15. Number of Children in AHSOR Programming

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 15” columns C-F to complete this question.

A child’s early years (from birth to age six) are the most influential of any time in the life cycle for brain development and for future learning, behaviour and health. The AHSOR program supports children from birth to six years of age. However, similar to a preschool program, AHSOR typically serves children from ages 3-6 before they enter school.

Note: For this question, if your community has more than one AHSOR program, include the total number of children attending all of the AHSOR programs in your community.

Definitions and Examples

Children younger than 3 years old means children who were younger than 3 years old during the reporting period.

Children 3 to 6 years old means children who were between the ages of 3 and 6 years old during the reporting period.

Waiting list: The number of children on a waiting list means the number for each age group on a waiting list at the end of the reporting year.

Note: If you do not keep a waiting list, indicate N/A (not applicable) for the number of children in each age group. If you keep a waiting list but no children in a specific age group were on the list at the end of the reporting period, use 0 (zero) for that age group.

Question 16. Children with Special Needs

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 16” columns G-K to complete this question.

All children are recognized as having unique abilities and gifts, including children who have special needs. ECD programs like AHSOR can help to identify children who may be in need of extra supports and ensure their needs are met. If children with special needs are identified and diagnosed early, it can help them throughout their lives.
Definitions and Examples

Children with special needs require ongoing additional support(s) or service(s) for healthy development in order to interact with their peers in day-to-day living. Special needs may include physical, sensory, cognitive and learning challenges, and mental health issues. In this question, a single child may be counted in more than one category of special needs, if applicable.

Diagnosis is the identification of a disease, disorder, or syndrome through a method of consistent analysis by a health care professional(s). In this question, count only those children who have received a formal diagnosis, including those who were diagnosed before entering AHSOR.

Screening and assessment can be used by parents or staff to determine if a child’s development is progressing as expected, or if there is cause for concern and a need for further follow up. An example of a screening tool is Ages and Stages.

Referral means a child has been referred to a health care professional or professionals, (nurses, doctors, specialists, etc.) for further special needs assessment or diagnosis.

Question 17. Frequency of Parent/Family Participation

If you are using the Healthy Child Development Tracking Tool, refer to the totals in spreadsheet “Question 17” columns L-O to complete this question.

Programs, such as AHSOR, that involve parents or other primary caregivers of young children, can influence how they relate to and care for children in the home, and can vastly improve children's behaviour, learning and health in later life.

Note: For this question, if your community has more than one AHSOR program, include the total number of parent/family participants for all of the AHSOR programs in your community.

Definitions and Examples

Parent or family participants, for the purposes of determining parental or family involvement, parent may include the extended family, e.g., grandparents, aunts/uncles, siblings, and also a caregiver.
Question 18. Children’s Oral Health Initiative (COHI)

Regardless of agreement type, all communities delivering COHI are expected to continue to use the Dental Service Daily Record and the Dental Service Forms according to the frequency and terms outlined in the contribution agreement program plan. These communities must also complete this question in the CBRT.

By collecting information on the total number of children in the community and the total number of children accessing the COHI program, the reach of the program can be measured. This will illustrate successes and gaps in making the program accessible.

Note: Information on population numbers by age groups may be available from your Band Office or, if not, from the INAC website or Census Canada.

Question 19. Healthy Child Development Service Linkages

Healthy Child Development programs, more specifically MCH and FASD, have a case management component which means helping clients to access resources, programs and services in or outside of the community. This question is aimed at determining the types of services and programs outside the community that have been relevant to program clients.

Definitions and Examples

Service linkages refer to the connections and relationships that have been established outside the community with other service providers, i.e., hospitals, provincial clinics, education organizations, or non-profit organizations.

Types of organizations and agencies for service linkages include:

The Regional Health Authority and the Health Service Zone are the provincially funded health services (such as those delivered in hospitals or clinics) that serve the primary health care needs in your community.

Educational organizations means schools, Aboriginal Head Start, adult education upgrading and colleges that serve your community.

Non-profit organizations include district, provincial or territorial organizations including Aboriginal organizations such as Tribal Council, etc. that serve your community.

Province means provincial or territorial programs or services that members of your community may access.
Question 20. Data Tracking Tools and Support

The Healthy Child Development Tracking Tool included with the CBRT has two parts, one for AHSOR and other for FASD, CPNP, MCH and COHI. The aim of these tools is to simplify the collection of the data required to complete by the CBRT. The tools are organized to correspond directly to CBRT questions. The goal of asking this question is to find out if these data tracking tools are easy to use and helpful for filling out the CBRT.

Definitions and Examples

Data tracking tools assist in the compilation of information. They may be used to track a variety of administrative or client level data, and are important supports for program planning and case management.
B. Mental Wellness

Introduction

This section of the CBRT is for reporting on all programs and services that directly contribute to achieving outcomes of the Mental Wellness program component. These programs provide culturally appropriate counselling services, addiction prevention services, health promotion services, and mental wellness services. Programs in this component include: Building Healthy Communities (BHC); Brighter Futures (BF); National Native Alcohol and Drug Abuse Program (NNADAP) – community-based prevention; Youth Solvent Abuse Program (YSAP); and National Aboriginal Youth Suicide Prevention Strategy (NAYSPS).

The National Native Alcohol and Drug Abuse Program (NNADAP) - Residential Treatment and the Youth Solvent Abuse (YSAP) Treatment Centres are not included in the CBRT.

This information is being collected to demonstrate accountability to our stakeholders and to highlight the various activities that are undertaken at the community, family and individual level to improve mental wellness. Your community has chosen specific types of mental wellness activities according to your needs and your level of funding. Health Canada is interested in what types of mental health promotion, prevention, intervention, and aftercare activities you offer, and in some cases, how many people you reach. For example, over time we will know whether more communities are able to offer more ‘upstream’ prevention programs that focus on keeping people well rather than treating mental health and addictions issues later.

Question 21. Mental Wellness Activities

Question 21A. Suicide Prevention
Suicide prevention activities are designed to prevent suicide by: reaching out to youth, families and communities; increasing the protective factors; and decreasing risk factors for youth suicide. Health Canada collects this information in order to better understand what you do in the area of youth suicide prevention activities. Although there are many activities aimed at preventing youth suicide, the question is specifically about those activities that use a prevention approach with groups of youth (e.g., skill development) or others in the community, such as increasing knowledge of how to intervene with a suicidal person.

Note: Activities that involve direct interventions with individuals or families are covered in Question 22, Suicide Interventions.
Definitions and Examples
All suicide prevention activities are aimed at the following: increasing awareness that suicide is preventable; increasing awareness of how to prevent suicide; increasing protective factors; and decreasing the risk factors for youth (through recreation, skill development, connecting to culture and community). Other types of suicide activities are interventions and post-ventions, which are covered in Question 22, Suicide Interventions.

Question 21B. Mental Wellness Promotion and Support
Mental Wellness promotion and support can be a part of several of the Mental Wellness programs. Health Canada will use the information from this question to assess what supports and activities communities are providing as part of the continuum of mental wellness services. Wellness activities teach and promote ways to increase well being, focusing on positive choices for all, regardless of risk for mental health issues and addictions.

Definitions and Examples
Mental Wellness Promotion and Support includes those activities that enhance mental wellness by teaching mental health skills or providing a health enhancing environment. Examples include: classes, workshops and community activities that promote and support mental wellness, such as effective parenting skills and positive stress management techniques, as well as activities that increase social connectedness, such as social groups and community celebrations. In the question, indicate whether your community offered any of these types of activities during the reporting year.

Question 21C. Substance Abuse, Addictions, and Mental Health Activities
This category includes a number of activities that might take place to increase awareness of mental health issues and substance abuse and addictions, and to support people dealing with these issues. Health Canada will use the information from this question to determine whether communities support these types of activities with their Mental Wellness funding.

Definitions and Examples
Mental wellness activities can be awareness raising sessions, such as presentations and workshops, cultural events that raise awareness, support groups, or school-based programs to raise awareness and prevent mental health issues and substance abuse.

Question 21D. Crisis Intervention
Mental health crisis interventions address gaps in mental health services that the community may experience. Crisis intervention activities include local plans or strategies to enable a community to respond effectively to a local crisis, such as suicide, cluster suicide, and violent crimes.
Definitions and Examples

Crisis intervention activities may include developing relationships or protocols with outside parties, such as provincial governments or health authorities, or establishing service agreements with external service providers to enhance community capacity in a time of crisis; and developing or actively maintaining or improving mental health crisis intervention plans and protocols.

Question 22. Suicide Interventions

Information on suicide interventions helps Health Canada to understand the work that communities are doing specifically for youth at risk of suicide.

Definitions and Examples

Suicide intervention refers to outreach, assessment, treatment planning, counselling, support, or referrals to other services that are provided through your community health services to an individual or individuals thought to be, or known to be, at risk of suicide.

In the question, the first row concerns interventions for youth who are at risk of suicide. The second row is refers to interventions for youth who have attempted suicide and for those affected by a suicide attempt. The third row is for those people affected by a completed suicide by a loved one or a community member.

Number of interventions means the number of times your health service workers intervened during the reporting year, not the number of individuals (i.e., multiple interventions might occur for a single individual).

Number of clients refers to the total number of youths with whom interventions have taken place during the reporting year.

Number of clients where the family was involved in the intervention means the number of clients with whom interventions involving their family have taken place.

Family may include a parent or parents, and may also include the extended family, such as grandparents, aunts or uncles, siblings, or other caregivers, such as step-parents.

Question 23. Interventions for Substance Abuse, Addictions and Mental Health

The information from this question will help Health Canada to identify the types of services communities offer, the age groups they serve, and how often families are involved in interventions for substance abuse, addictions and mental health issues. For youths and adults, indicate the number of clients who were reached with each type of interventions listed, and the number of clients where the family was involved in the intervention.
Use the number of clients, **not** the number of interventions. A client can be counted more than once if they have been in interventions of different types. The numbers for “where the family was involved” are a sub-set of the number of clients.

**Definitions and Examples**

**Interventions for substance abuse, addictions and mental health issues** can include interventions for people who are at risk of developing substance abuse, addictions or mental health issues; for people who are coping with substance abuse, addictions or mental health issues; and for people who require care after they have been treated. For those at risk there are screenings, brief interventions, and referrals to services. For those experiencing substance abuse, addictions issues, or mental health issues, there are counselling, support groups, and community based treatment, such as day treatment and evening sessions.

**Note:** Referrals to residential treatment services (NNADAP or YSAP) are not included here but are covered in Question 24, **Referrals to Treatment Centres.**

**Family involvement** The family may include a parent or parents, and may also include the extended family, such as grandparents, aunts/uncles, siblings or other caregivers such as step-parents. To determine the number of family-based clients for youth under 18, for example, count the number of clients in the first column of the first row and then count the number of those clients where the family was involved in the second column. For example, if you did a screening and basic assessment for seven clients under the age of 18 and three of these individuals participated in this intervention with their family, indicate seven in the first column and three the second column.

**Question 24. Referrals to Treatment Centres**

The information collected with this question provides a picture of the number of clients referred to NNADAP residential treatment or YSAP treatment centres. The numbers of referrals should be presented by age and gender, so that Health Canada can track trends in referrals over time. The age information is also important because children attend separate programs from adults. **Count only completed referrals.**
Definitions and Examples

**Referrals** involve connecting clients or families with appropriate services and supports based on their needs and strengths. For instance, when it is clear that a client’s substance use problem requires more intensive care, the client may be referred directly to NNADAP or YSAP residential treatment programming.

**Completed referral** is a referral for which the client ..... [to be completed]

**Question 25. Service Linkages for Mental Health and Addictions**

This information will be used by Health Canada to determine the extent and types of service linkages used by communities in the course of offering mental wellness programs. For example, if you use the services of a regional health authority for detoxification of clients, or if you perform many of your suicide prevention activities within schools in your community or area, or with the local police or RCMP, check the appropriate boxes. This information will be used to measure change over time in the extent of service linkages with other organizations that can increase the effectiveness of mental wellness programming.

**Definitions and Examples**

Types of service linkages include:

- **Regional Health Authority or Health Service Zone** are the provincially funded health services (such as those delivered in hospitals or clinics) that serve the primary health care needs in your community.

- **Educational organizations**: Schools, Aboriginal Head Start, Adult Education Upgrading and Colleges in your community or that serve your community.

- **Non-profit organizations** include provincial or territorial organizations, including Aboriginal organizations and Tribal Councils that serve your community.

- **Police** includes any policing services that serve the community, for example, Band or Tribal police services, the RCMP, or local, city or provincial services.

- **Provincial services** are those programs and services that members of your community may access from the province.
Question 26. Data Tracking Tools and Support

Mental Health and Addictions (MHA) does not provide communities with any data collection tools at this time.

Definitions

Data tracking tools assist in the compilation of information. They may be used to track a variety of administrative or client-level data, and are an important tool in program planning and case-management.
C. Healthy Living

Introduction

This section in the CBRT is for reporting on all program activities that contribute to achieving the outcomes of the Healthy Living program component. The programs in this component support the development and implementation of community-based activities that promote healthy lifestyle choices and support active living. Over the long term, these programs will contribute to the prevention of chronic disease and injuries across Canada. This component includes the Aboriginal Diabetes Initiative (ADI) and Injury Prevention.

Question 27. Chronic Disease and Injury Prevention

The Healthy Living information collected will be used to inform program development, program and services improvement and the need for further investments in programs by Health Canada. Information related to the types of activities delivered is essential to evaluate the quality, efficiency and effectiveness of Healthy Living programs and services.

Definitions and Examples

Chronic Disease Prevention Activities include awareness and education activities relating to diabetes. These types of activities contribute to increased knowledge among community members about the risk factors for developing Type 2 diabetes, what Type 2 diabetes is, how it can be prevented, and who can provide support.

Question 28. Diabetes Screening

Collecting information on the number of individuals screened for diabetes in communities and the types of screening activities will help inform program development and guide improvements to diabetes programming and services and is essential to evaluate the quality, efficiency and effectiveness of Healthy Living programs and services.

Definitions and Examples

Diabetes and pre-diabetes diagnostic screening refers to glucose testing in collaboration with a primary care worker.

Fasting glucose test is administered to determine how much glucose is in a blood sample taken after an overnight fast.
OGTT, the Oral Glucose Tolerance Test, measures the body’s ability to use glucose. The test is commonly used to diagnose pre-diabetes and diabetes, and is also used to check for diabetes in pregnancy (gestational diabetes).

Non-diagnostic diabetes awareness/prevention screening refers to....[to be completed]

**Question 29. Diabetes Management**

Collecting information on how diabetes is managed after diagnosis helps to inform program development and to guide improvements in diabetes programming and services. Information related to the types of activities delivered is essential to evaluate the quality, efficiency and effectiveness of Healthy Living programs and services.

**Definitions and Examples**

**Screening for complications** is screening for limb, eye (retinal), cardiovascular, and kidney (renal) complications according to the Canadian Diabetes Association’s clinical practice guidelines.

**Referrals to health professionals or services** are referral activities such as: working with the province or territory and other health care providers to improve the coordination of services for those accessing care outside the community; referral to hospitals or other treatment and management services for people with diabetes complications; and communication with community health nurses to ensure home care is provided after hospitalization is no longer required.

**Question 30. Diabetes Clinics and Training**

Collecting information on the type of education, training and care clinics offered to people in the community living with diabetes will be used to inform program development and guide improvements to diabetes programming and services. Information related to the types of activities delivered is essential to evaluate the quality, efficiency and effectiveness of Healthy Living programs and services.

**Definitions and Examples**

**Diabetes education and training clinics** include diabetes self-management sessions, or workshops, that are intended to support individuals, groups and families living with diabetes.

**Foot care and foot screening clinics** are delivered to assist individuals or groups with proper foot care, and are provided through Aboriginal Diabetes Initiative funding.
Question 31. Healthy Living Service Linkages

Information collected regarding the types of services and support available outside the community to help people in the community manage their health will be used to inform program development and guide improvements to health programming and services.

Definitions and Examples

Service linkages refer to the connections and relationships that have been established outside the community with other service providers (i.e., hospitals, provincial clinics, education organizations or non-profit organizations).

Types of service linkages include:

Regional Health Authority or Health Service Zone are the provincially funded health services (such as those delivered in hospitals or clinics) that serve the primary health care needs in your community.

Educational organizations include Schools, Aboriginal Head Start, Adult Education Upgrading and Colleges in your community or that serve your community.

Non-profit organizations include provincial or territorial organizations, including Aboriginal organizations and Tribal Councils that serve your community. [to be completed]

Provincial services are those programs and services that members of your community may access from the province.

Question 32. Tracking Tools

Information of the usefulness of tracking tools will assist Health Canada in tool development and improvements.

Definitions and Examples

Data tracking tools assist in the compilation of information, allowing administrators to maintain an inventory of appointments, referrals and results that are pertinent to each individual or group.
D. Communicable Disease Control and Management (CDCM)

Introduction

This section is for reporting on all program activities that contribute to achieving Communicable Disease Control and Management outcomes. Communicable Disease programs are designed to protect First Nations and Inuit communities from preventable diseases, and to implement measures to manage, contain, and control risks of outbreaks. Programs within the Communicable Disease Control and Management component are: Vaccine Preventable Diseases and Immunization; Blood Bourne Diseases and Sexually Transmitted Infections (HIV/AIDS), Communicable Disease Emergencies, and Respiratory Infections (Tuberculosis). For more information on these programs, see the FNIH Program Compendium.

Data on these programs are required to evaluate progress being made in the areas of: service delivery; public health education and awareness; capacity development; and surveillance, data collection and evaluation. Information collected includes vaccines administered, number of communicable disease cases identified and treated (e.g., TB), number and type of awareness activities conducted, number of training sessions held, and ongoing surveillance activities being conducted within the community. This information assists community health workers and decision makers at the community, regional and national levels in the design, delivery and monitoring of communicable disease-related health programs and services. This leads ultimately to more responsive communicable disease control and management services for on-reserve First Nation communities.

Note:

- For the Communicable Disease Control and Management section, the reporting period is April 1 to March 31, unless otherwise indicated for a specific question.
- All mandatory Public Health reporting must continue to be reported to the proper authorities as specified in the Contribution Agreement.

Question 33. Number of Health Care Workers in CDCM in Your Community

As indicated, provide the number of people who work directly in CDCM in your community.

Question 34. Worker Information and Training

This question applies to health care workers in your community who work directly on Communicable Disease Control and Management activities and who are supported in whole or in part by funds received from FNIHB.
Information on training is required to determine who has been trained, what they have been trained on, and who still requires training. This information not only helps to ensure that the right courses are provided to the right people, but also is the first step in measuring the impact training has on the capacity, knowledge, and skills of community health staff. It also helps to identify ways training activities can be improved.

Note: To answer this question, use the information provided in Table 1: Health Care Worker Type and Certification Type below.

The following are definitions for the headings in the columns in Question 34 in the template.

**Definitions and Examples**

**Job Title** means the actual job title of the health care worker in your community.

**Worker Type**: Use the descriptions in the second column in Table 1 below to find the best match for worker type based on the role of the worker in the community. This should be seen as a ‘best fit’ scenario, that is, fit each health care worker into only one type.

**Hours per week** means the average number of hours per week worked by the employee.

**Certification Type**: Use Table 1 below for certification and accreditation types and the corresponding letter codes. Indicate, by letter code only, the type of certification or accreditation the worker has, if any. Enter only those codes included in the table. If a worker has more than one certification or accreditation, separate the codes by commas.

**Training** means courses, classes or other training opportunities provided to health care workers on topics such as transport of dangerous goods, outbreak control, HIV/AIDS counselling, etc.

**Certified Training** means that a worker acquired a diploma or certificate through training and completion of an educational program of at least one academic year in length.

**Continuing Education** means short-term courses that upgrade or maintain skills.

**Short Course Training** means courses between 1 week and 3 months that are not recognized with classes in a certification program.

Note: As much as possible, try to use the terminology used in Table 1 for Worker Type and for Certification Type. This will ensure that information collected from different communities across the region and country is comparable.
Table 1: Health Care Worker Type and Certification Type

<table>
<thead>
<tr>
<th>Worker Type</th>
<th>Description and Certification Type</th>
<th>Certification Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Representative</td>
<td>CHR is an integral part of the Public Health Team. While some CHRs receive training, they are unregulated health care workers and must be supervised by a community or public health nurse. CHRs are hired by local health boards</td>
<td>CHR</td>
</tr>
<tr>
<td>Physician</td>
<td>Certified from the College of Family Physicians and licensed by provincial licensing body.</td>
<td>MD</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>Licensed Practical Nurse can provide primary care and home care types of services. A LPN is required to complete a two-year educational program and is licensed by the provincial or territorial licensing body (also called registered practical nurse in some jurisdictions). LPN may refer to Registered Nurse for consultation.</td>
<td>LPN</td>
</tr>
<tr>
<td>Primary Care Nurse</td>
<td>Registered Nurse with a Bachelor’s degree in nursing or post graduate studies in clinical practice or nurse practitioner studies.</td>
<td>RN and/or RN (EC)</td>
</tr>
<tr>
<td>Public Health Nurse / Community Health Nurse</td>
<td>Registered Nurse with a Bachelor’s degree in nursing or post graduate studies in Public Health/Population Health. Registered nurse who works in the community (health centres and nursing stations).</td>
<td>RN and/or RN (EC)</td>
</tr>
<tr>
<td>Tuberculosis Worker</td>
<td>A CHR responsible for implementing various aspects of the tuberculosis program such as community awareness, health promotion, etc. Some Tuberculosis Workers may receive specialized training relating to tuberculosis.</td>
<td>CHR (TB Worker)</td>
</tr>
<tr>
<td>Directly Observed Treatment (DOT) Worker</td>
<td>A CHR responsible for supporting adherence to treatment for those identified with active disease or TB infection. Some DOT workers may receive some specialized training relating to active disease or tuberculosis infection.</td>
<td>CHR (DOT Worker)</td>
</tr>
<tr>
<td>Pandemic Coordinator</td>
<td>Supports on-reserve First Nation communities in developing, testing, and revising a pandemic plan. The pandemic coordinator also helps communities strengthen linkages with key partners such as provincial and regional health authorities.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Question 35. Awareness and Education Activities

Information on the types of awareness and education activities helps your community and Health Canada to determine where gaps exist and to better plan future activities. It is also the first step toward measuring the effect that awareness and education initiatives have on community knowledge, as well as identifying areas for improvement.

This question asks for the number of awareness and education activities conducted in your community or organization for five different program and initiative areas. It also asks you to provide a brief description of each activity and to categorize the activity as national, regional or local. See the Immunization example below for clarification.

Note: You will need extra space to provide descriptions of the activities for this question. Use an extra sheet of paper and be sure to label it with the question number and submit it as part of your completed template.

Definitions and Examples

The following example for Immunization shows how to complete this question in the template. For each column of your response, provide a very brief summary of what was done and when it occurred. The final column is the total of national, regional and local/community activities for the specific program.

<table>
<thead>
<tr>
<th>Program and Initiative Area</th>
<th>National</th>
<th>Regional</th>
<th>Local and Community</th>
<th>Total Number of Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Immunization</td>
<td>Posted National Immunization Awareness Week posters in the health facility continuously throughout the year.</td>
<td>Distributed immunization guide developed by the province in October and again in January.</td>
<td>Developed and posted H1N1 posters in the health facility throughout the year.</td>
<td>5</td>
</tr>
</tbody>
</table>
Awareness and education activities include social marketing campaigns, education sessions and other initiatives or activities designed to increase awareness and knowledge of communicable diseases, their prevention and how to appropriately manage them. Awareness and education activities will typically be targeted toward First Nation community members; however, in certain instances they can include health workers.

If an awareness or education activity involved more than one topic, choose the program and initiative area that is the “best fit” for that activity and count it only once. List the other topics involved in that activity in the brief description. For example, if an awareness session talked about HIV/AIDS and Tuberculosis, it should not be counted twice. Choose either HIV/AIDS or Tuberculosis, and then make a note that the session talked about both.

Use your discretion on how many times an activity should be counted. For example, if the same education session is provided six times throughout the year to six different groups of people, it will likely make sense for your community to count it as six activities. However, if you put up a poster in the health facility and had to replace it twice during the year, it likely will not make sense to count this as three activities.

National refers to activities involving participants or targeting audiences living in multiple communities across two or more provinces, e.g., posting National Immunization Awareness Week posters. However, for communities in the Atlantic provinces, national activities are defined as those that include participants or audiences from outside Nova Scotia, New Brunswick, Newfoundland and Labrador, and Prince Edward Island.

Regional refers to activities involving participants or targeting audiences living in multiple communities within a province. This includes activities conducted by regional First Nations organizations for multiple communities within their constituency.

Local/community refers to activities involving participants from a single community.

Questions 36 and 37. Health Status Reports

These questions concern health status reports specifically on communicable disease.

The information you provide in your response to these questions will allow Health Canada to determine what communicable disease information is being received by communities from the organizations listed in the question. Information on First Nations communicable disease control and management should not flow only one way, i.e., from First Nations communities and organizations. It is important that organizations, such as the First Nations and Inuit Health Branch and the FNIH Regional Offices, and the provinces, districts, and regional health authorities, send information back to support the work of First Nations communities. Then First Nations can use this information to improve community health planning and programming.
This question also assists FNIH Regional Offices in determining if there are gaps in the dissemination of information (i.e., if information is being sent out from the Regional Office but is not reaching the intended recipients).

**Definitions**

**Health Status Reports** provide an overview of the incidence and prevalence of reportable communicable diseases.

**Questions 38. Pandemic Plans**

The information from this question is needed to identify what has been done in terms of community pandemic planning and what areas require additional work to ensure First Nation communities are well prepared for possible pandemics.

**Definitions**

**Pandemic Plan** identifies and documents activities for prevention or mitigation, preparedness, response, and recovery that are critical for the well-being of a community during a pandemic event. The goal of a pandemic plan is to reduce the health and social impacts of influenza on individuals and the community. A pandemic plan should include, at a minimum, specific plans or directives for: surveillance, vaccination, use of antivirals, health services, public health measures, communications, and human and material resources. A community pandemic plan should be adaptable and scalable to different pandemic scenarios.

**Last updated** refers to the date that the last set of revisions were made, whether minor or substantial, to ensure your pandemic plan is fully up-to-date. Provide the day, month and year of the update.

**All hazards emergency plan** refers to a program, arrangement or other measure for dealing with emergencies regardless of cause. The plan documents the people, procedures, resources, communications, and organizational structures required to avoid or lessen the impact of an emergency.

**Questions 39 and 40. Population Numbers and Vaccine-Preventable Disease Cases**

Question 39 asks for your community population numbers broken down by age groups and for the source of the population numbers. Question 40 concerns the number of vaccine-preventable disease cases for the same age groups.

This information allows communities and Health Canada to identify community demographics and to track vaccine-preventable communicable cases by type and age. Communities and Health
Canada can then use this information to guide vaccination activities, including vaccine awareness and education initiatives, and to improve the overall vaccination program.

Note: Age breakdowns for these questions are consistent with those used by the Public Health Agency of Canada to ensure data comparability.

Definitions and Examples

Population means the number of people living on-reserve, including both First Nations and non-First Nations. For question 39, provide the population for each of the specified age groups.

Population data source means where the population information came from, for example, Indian and Northern Affairs Canada, your community health centre, or the Band Office. For question 40, use the same population data source as in question 39. There is no need to re-state the source in question 40.

Question 41. Vaccine Dose Numbers

Wasted and lost vaccine doses are costly both financially and in terms of supply. Information on the number of doses wasted due to any cause and the number of doses lost to cold chain breakages will be used to identify opportunities for better guidelines or training to improve best practices and to minimize wasted and lost doses.

Question 42. Immunization Coverage Report

Complete the applicable immunization coverage report form received from the FNIH Regional Office and submit it with your completed template. If you have already completed and submitted an immunization coverage report form to your Regional Office, there is no need to complete the form again. Contact your Regional Office if you are unclear about whether or not you have already completed such a form.

Note: When completing the immunization coverage report form, be sure to use the reporting period specified in the form, e.g., calendar year, school year, or other period.

The information from this question will be used to determine which vaccines have been administered to what percentage of the target population. With this information, immunization activities can be targeted appropriately to segments of the population and for specific communicable diseases requiring greater coverage.
Definitions and Examples

**Outbreak** means the occurrence in a community or region of cases of an illness with a frequency clearly in excess of what one would normally expect. The status of an outbreak is relative to the usual frequency of the disease in the same area, among the same population, during the same season of the year. As a result, each region or community will determine what qualifies as an outbreak at any given time.

**HPV Cohort** means the grade level where the publicly funded HPV program was announced by the province, for example, Grade 8 for Ontario.

**Question 43. TB Testing**

This question asks for the number of clients, by age and gender, who were screened or tested for TB, as well as the result of screening or testing. It also asks for your community’s total population and the source of the population data.

### Note: Use a calendar year reporting period (January 1 to December 31) when completing this table and include all people living on-reserve.

Information from this question is intended to improve the understanding of how TB affects your community by determining how many cases of LTBI and active TB are present in the community each year. Through annual assessments, insight can be gained into how TB changes over time and whether interventions are working.

Assessing TB over different age groups provides an opportunity to better understand the patterns of transmission in your community and consequently, lead to a greater ability to develop effective targeted approaches to reduce the incidence and burden of the disease. Also, understanding the number of cases within a given total population helps to provide context to the TB situation within your community and to further refine your targeted approach. For example, approaches for TB prevention and control will possibly be more complex and labour intensive if there are 2 males aged 20-25 years diagnosed with active infectious pulmonary TB in a community of 1000 versus in a community of 50.

Measuring LTBI will demonstrate to what extent TB in its latent form is present in a community. Given LTBI can become active TB over time, the number of cases of LTBI found within a community can help determine whether a community is at risk of future outbreaks and whether proactive approaches, such as prophylaxis or enhanced surveillance, are needed to prevent these cases from becoming active TB. Alternatively, measuring LTBI can indicate whether there is a need to enhance vigilance for active TB through early detection in order to prevent transmission of TB when LTBI becomes active TB.
All columns must be filled out. Where no cases are identified, indicate this with a zero ('0'). Where data are not available, indicate this with a N/A (i.e., not available).

**Note:** The age breakdowns for immunization are consistent with those used by the Public Health Agency of Canada to ensure data comparability.

### Definitions and Examples

**Active TB** means the presence of current active tuberculosis (TB), most often on the basis of positive bacteriology but in approximately 15-25% of cases, on the basis of appropriate clinical, radiological, or pathological presentation, as well as treatment response (Canadian Tuberculosis Standards, 6th ed., page 375).

The **Number of clients further assessed for active TB** includes anyone who is assessed for (or to rule out) active TB disease through a skin test or other tests including chest x-rays or based on suspicious clinical symptoms.

The **Results of assessment for active TB** includes the numbers of those diagnosed with active disease, with LTBI, or with neither active disease nor infection (No TB).

**Latent Tuberculosis (TB) Infection (LTBI)** means the presence of latent or dormant infection with *Mycobacterium tuberculosis* with no evidence of clinically active disease. Subjects deemed to have LTBI are by definition non-infectious (Canadian Tuberculosis Standards, 6th ed., page 382).

- For the number of clients screened for LTBI, include any clients assessed for LTBI through either routine screening or contact tracing. Indicate the results of the screening by providing the number of clients testing either positive or negative.
- For LTBI, the number of positive or negative results is based on the clinical assessment of the Mantoux skin test or other equivalent such as IGRA testing.

**Screening** is examination of a group of usually asymptomatic people to detect those with a high probability of having a given disease (TB in this situation), typically by means of an inexpensive diagnostic test, i.e., Mantoux skin test or IGRA for TB (Stedman’s Medical Dictionary, 28th ed., page 1737).

**Routine Screening** is screening relating to, or being in accordance with, established procedure.

**Contact Screening** is screening a person who is known to have been exposed to a contagious disease (Stedman’s Medical Dictionary, 28th ed., page 435).

**Population data source** means where the population information came from, for example, Indian and Northern Affairs Canada, your community health centre, or the Band Office.
Question 44. Use of Provincial or Territorial TB Prevention and Control Programs

Partnerships are essential in diagnosing, managing and preventing TB within a community. The purpose of this question is to understand whether community TB programs are collaborating with provincial or territorial counterparts and if so, for which elements of their TB programs.

The following are examples to help you answer this question:

If your TB program accesses the provincially funded services to support only diagnosis and treatment, you would indicate that you work with the provincial TB program (i.e., choose ‘Yes’) and the program element for the expertise and resources would be Program Implementation (i.e., choose ‘Program Implementation’).

If your community regularly meets with its provincial partners (i.e., Regional Health Authorities or Agencies, depending on the provincial TB system) to discuss TB program challenges or review case management, you would indicate that you work with the provincial TB program (i.e., choose ‘Yes’). This example could include program development, implementation, and evaluation (i.e., choose ‘Program Development’, ‘Program Implementation’ and ‘Program Evaluation’, as applicable).

Definitions and Examples

For the purposes of completing the question:
Clinical expertise refers to a licensed physician who can diagnose and recommend treatment against tuberculosis.

Public health expertise refers to a licensed health care practitioner who has expertise in preventing and controlling tuberculosis in a community.

Question 45. Access to Referrals and Services for HIV Testing and Treatment

Information on access to referrals and services for HIV testing is required to measure the level of access to HIV/AIDS-related care, treatment, and support. Knowing the current level and type of access is the first step in determining where improvements can be made.

Definitions

Near the reserve means close enough to the reserve that travel is not a significant barrier for community members to get tested.
Question 46. HIV/AIDS Support Groups

Information on HIV/AIDS support groups in your community is used to identify where support groups are already in place, where they have not been identified as needed, and the reasons they are not in place in communities that wish to have them. This information is the first step in identifying and addressing barriers to the creation of support groups.

Question 47. Collection of Other Information

Information about other data being collected in your community on blood borne pathogens and sexually transmitted infections, e.g., rates of HIV infection, number of counselling sessions conducted, gives a general sense of the type of HIV/AIDS-related information being collected in communities. Together with information collected from Question 46, it provides a useful indication of the HIV/AIDS priorities in communities delivering HIV/AIDS programs and services.

Use the box provided in the template to respond to this question. You do not have to provide actual data, just the types of information collected.
E. Home and Community Care

Home and Community Care (HCC) is a coordinated system of health care services that enable First Nations and Inuit people of all ages with disabilities, or chronic or acute illnesses, as well as the elderly, to receive the care they need in their homes and communities. HCC is delivered primarily by home care registered nurses and trained and certified personal care workers. Essential elements include client assessment; home care nursing; case management; home support (personal care and home management); in-home respite; linkages and referrals to other health and social services, as needed; provision of and access to specialized medical equipment and supplies for care; and a system of record keeping and data collection. HCC can arrange for certain additional supportive services depending on the needs of the communities and available funding.

Question 48. Collaborative Service Delivery

As well as answering the related questions in the template, communities with a First Nations and Inuit HCC program are expected to use the Electronic Service Delivery Reporting Template (e-SDRT), which includes the Electronic Human Resource Tracking Tool (e-HRTT). They should continue to input information according to the “Other Reporting Requirements” schedule.

Collaborative service delivery arrangements with external providers for HCC services and supports, enhance access and timeliness of care, and improve communication between health organizations to ensure continuity of client services that will lead to improved client health outcomes. Collaborative working relationships with hospitals, regional health authorities, or health service organizations, such as home health and social agencies or therapeutic services, make it easier to meet client needs as they arise.

Information from this question will be used to identify gaps the types of collaborative service delivery arrangements that are in place for community HCC programs and where gaps exist.

Definitions and Examples

Collaborative service delivery arrangements may be formal, with a written Memorandum of Understanding, protocol, agreement, contract, etc. or informal, with a non-written agreement to provide supportive services or information to HCC client services in your community. For example, a First Nation organization wants to partner with a local hospital to assist with discharge planning. A formal agreement and discharge protocol are developed between the hospital and community requiring that contact between HCC and the hospital’s discharge unit be established, and that discharge plans, physician orders, and prescriptions for HCC supplies be determined before a client leaves the hospital and returns to the community.
Question 49. Complaints and Appeals

It is important for community HCC programs to have a process in place to manage complaints and appeals from clients, health workers, and service delivery partners. A standardized, consistent method to collect information and resolve related complaints or appeals enhances the quality of the home care program.

Your response to this question simply determines whether or not your community has a process in place for complaints and appeals. The HCC policies and procedures manual includes a form, available to all HCC clients, that requests information on complaints and appeals. Communities that do not have a process in place are encouraged to refer to the manual and prepare a complaints and appeals process to ensure a consistent approach to resolving such issues.

If many communities lack a complaints and appeals process, then Health Canada and the HCC program can support communities in developing one.

Definitions and Examples

HCC complaint is a grievance or criticism related to the way care was provided to a client. A legal, ethical, cultural or moral issue may also be at the heart of the complaint. For example, a weekly task list is provided to all home health aides. One aide does not adhere to the list and so his or her client places a complaint with the HCC nurse.

HCC appeal process is a process requesting a formal change to an official decision. For example, the nurse completes a client assessment and finds that the client is not eligible to receive HCC services. The client does not agree with the decision. The HCC nurse provides the client with the policy and process for determining client eligibility to receive care and services. If still not satisfied, the client can file an appeal with the nurse manager or director. A meeting is held between the HCC nurse manager and the HCC nurse to review the decision. The HCC nurse manager meets with the client to review the decision and will also help find an alternative solution.

Question 50. Incident and Occurrence Reporting

It is important for community HCC programs to have a process in place for reporting on incidents or occurrences affecting client safety, such as adverse or sentinel events, violence, harassment, falls, medication errors, emergency preparedness, coroner’s reports, or litigation status updates. The objective of the process is to decrease client, staff and program risk and minimize liability. Risk may relate to client or staff safety or the quality of services, finances or programs, as well as emergencies and disasters.

Information in incident and occurrence reports can be used to make improvements to the HCC program, thus ensuring clients and staff remain safe and the quality of health care is maintained. The aim is to anticipate and mitigate risk and lessen exposure or frequency and severity of illness, injury or death. The HCC program takes responsibility for managing and reducing incidents and accidents.
Your response to this question simply determines whether or not your community has an incident reporting process in place. If many communities lack an incident and occurrence reporting process, then Health Canada and the HCC program can support communities in developing one.

Definitions and Examples

Incident and occurrence reporting process refers to the standardized procedures that a HCC health care worker, the program nurse and the nurse manager follow when an incident occurs.

Question 51. Accreditation

Accreditation by a recognized accreditation organization ensures that First Nation and Inuit HCC services to community members are based on the same rigorous standards as provincial and territorial services. The accreditation process helps the community’s HCC program to identify program or service gaps and also helps measure how well quality improvements are being achieved. Other benefits include a sense of accomplishment that First Nations and Inuit health services have for achieving standards of excellence used by health services nationwide; a culture of empowerment; and shared accountability and decision making at all levels within health organizations.

Information from this question is being collected to assess the extent to which the promotion of continuous quality improvement through accreditation is being done within First Nation and Inuit HCC services.

Definitions and Examples

Accreditation involves to meeting performance standards that examine all aspects of health care, from patient safety and ethics, to staff training and partnering with the community. Health care personnel devote time and resources to learn how to improve what they are doing so they can provide the best possible care and service to their patients and clients.

Accreditation provides a measure of the quality of your HCC Program, and helps the community to identify current strengths and areas that may require additional effort to improve the program and its management. It is important to consider the goal of accreditation when program standards and policies are created.
F. Clinical and Client Care

This section is to be completed only for organizations or communities with a Nursing Station or Health Centre with Treatment, providing primary care clinical and treatment services, twenty-four hours a day, seven days a week (24/7), or five days a week 24/5. If these services are provided by Health Canada (FNIH), this section must be completed by the FNIH Regional Office.

Clinical and Client Care (CCC) services are defined as essential health care services directed toward First Nations individuals living primarily in remote and isolated communities, enabling them to receive the clinical care they need in their home communities. CCC provides assessment, diagnostic, curative and rehabilitative services for urgent and non-urgent care. It also includes health promotion and disease prevention provided at the client and family level in the course of treatment, as well as referral to care facilities outside the community. CCC does not include any services provided for communicable disease control, including immunization and group or community health promotion activities.

Note: In responding to questions in Section F, include encounters and services provided by all members of the CCC team, including physicians and nurses.

Question 52. Community Members Accessing CCC Services

This question is asking for the number of community members who accessed CCC services at least once during the reporting year.

The information provided by this question will determine the overall utilization rate of CCC services in your community or organization. For example, if there were 1000 people living on-reserve and eligible for CCC services and 700 of them received services at least once during the reporting year, then the utilization rate is 70%.

Question 53. Service Encounters

This question is being used to calculate the service utilization rate in your community or organization and to distinguish between encounters for urgent (emergency) and non-urgent clinical services. Having these numbers by age group will assist you in determining differences in service demand by different age groups and also gives an indication of the workload by age group to assist in improving service planning.
Definitions and Examples

Service is defined as the provision of assessment and diagnostics, treatment, follow-up, rehabilitation, or monitoring. More than one service can be provided in an encounter.

An encounter is considered to be one visit to the nursing station. A number of services could be provided in one encounter. One community member may have multiple service encounters in the reporting year.

Urgent service encounters means CCC services provided to individuals for conditions that are a potential immediate threat to life, limb or function. Examples include cardiac arrest, accidental trauma, respiratory arrest, etc.

Non-Urgent service encounters means CCC services provided to individuals for the treatment or assessment of chronic, acute or other conditions that are not threats to life, limb or function. Examples include respiratory tract infection from influenza or a cold, diabetic follow-up and counselling, non-life threatening injuries, etc.

Question 54. Classification of Primary Care

This question asks for numbers of CCC encounters broken down by primary reason for the encounter.

The classification of reasons for encounters focuses on data elements from the patient's perspective. In this respect, the classification is patient oriented rather than disease or provider oriented. The reason for encounter, or demand for care, given by the patient has to be clarified by the nurse, physician, or other health worker before there is an attempt to interpret and assess the patient's health problem in terms of a diagnosis, or to make any decision about the process of management and care.

Table 2 below provides examples of the types of care and services included in encounters for each of the classifications of primary reason for encounters.

Definitions and Examples

Encounter means a professional interchange between the patient and health care provider and is characterized by three elements:
1. Patient reason for encounter (why has he/she come?)
2. Diagnosis (what is the patient’s problem?)
3. Process (what is being done?)
### Table 2: Examples of Encounters for Classifications of Primary Reasons

<table>
<thead>
<tr>
<th>Classifications: Primary Reasons For Encounters</th>
<th>Types of Care and Services in this Encounter Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic, Screening and Preventive procedures</td>
<td>Services related to diagnostic screening and prevention activities for an individual. It is useful when there is no underlying pathology for the problem under management, e.g., check up (partial or full); advice and health instruction.</td>
</tr>
<tr>
<td>Medication provision and clinical procedures</td>
<td>The processes involved in patient care including the provision of treatment for urgent and non-urgent conditions. This classification will be the one most often used when you have sufficient information to arrive at a diagnosis in the medical record or problem list, and treatment is provided at the time the patient presents him/herself for service. It does not include the provision of vaccines.</td>
</tr>
<tr>
<td>Symptoms and complaints</td>
<td>Used when a patient presents with symptoms that are ill-defined, and are valuable for describing the problem under management in a problem list or the medical record, e.g., general ill-feeling: feeling tired.</td>
</tr>
<tr>
<td>Provision of test results and follow-up</td>
<td>Used when a patient is given the results of diagnostic or screening tests and receives follow-up treatment or counselling.</td>
</tr>
<tr>
<td>Referrals</td>
<td>Used when after assessment, diagnosis or treatment, it is determined that the patient must be referred to another health professional either internally, e.g., home care, addictions and mental health, or outside the community or organization.</td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>Used for the variety of planned activities related to chronic disease management of individuals including: follow-up, screening, treatment, and counselling or education. For example, scheduled visits for diabetics, but not the treatment of a diabetic who presents at the clinic with a leg ulcer that must be treated immediately.</td>
</tr>
<tr>
<td>Other reasons</td>
<td>Use only when the service provided does not fit into any other classification.</td>
</tr>
</tbody>
</table>
Question 55. Full-Time Equivalent (FTE) Nursing Positions

This question concerns the number of allocated FTE nursing positions, the actual number employed, and the breakdown for Band-employed nurses, agency nurses, and contract nurses, i.e., provided by Health Canada. Details for parts A), B), and C) follow:

A) This information is being collected to determine the number of funded, permanent full-time Registered Nurse (RN) positions or Full-time Equivalent (FTE) positions delivering care in your community during the reporting year. For example, if you received funding for 4 permanent full-time RN positions, your response would be 4. N.B. The question is about number of positions, not number of RNs.

B) This information is being collected to determine the actual number of RN FTEs that delivered the services during the reporting year. For example, if you received funding for 4 FTE RN positions and but in fact you required 5 FTE positions to deliver the care, this would indicate changes in service delivery, such as an unexpected increase in emergency visits or higher health care demands for services.

C) This information is being collected to determine the nursing vacancy rate and the percent of Staff and Agency/Contract nurses. For example, if your nursing station was allotted funding for 6 full-time nurses and if on March 31st, 4 positions were filled by nurses employed by your organization and 2 positions were filled by Agency nurses, the vacancy rate would be 33% (2/6). The percent of positions filled by staff nurses is 66% (4/6).

The information is a component of the total staffing complement required for delivery of health services. The number of FTEs staffed by RNs represents the largest staffing requirement in the provision of Client and Clinical Care. This information reflects overall staffing needs.

The data will be used to compare the funded staff positions to the actual staffing requirements in order to identify any shortfalls.

Definitions and Examples

Registered Nurse (RN) includes all RN classes including Nurse Practitioners (NPs). It does not include Licensed Practical Nurses (LPNs), Registered Practical Nurses (RPNs), or Registered Psychiatric Nurses.

Full-Time Equivalent means a full-time permanent position. For Registered nurses it equates to 1950 paid hours per year. For example, if you have a .5 FTE RN position, the nurse is employed for 975 hours (i.e., 0.5 times 1950 hours).

Band employed nurse (or staff nurse) is a Registered nurse employed by the Band who is not a contract/agency nurse.
**Agency/contract nurse** is a Registered nurse who is under contract to provide the hours of work for payment as defined by the contract. An agency nurse is not an employee.

**Staffing complement** means the number and type of personnel employed by an organization to deliver the required services.

**Question 56. Nursing Overtime Hours**

Indicate the total number of overtime hours worked by nurses during the reporting year.

This information will provide data on the amount of overtime hours worked by Registered nurses on a daily basis in nursing stations and health centres where RNs are on call to cover emergencies after regular hours, twenty-four hours a day, either 7 or 5 days a week. Indicate the number of hours worked by Registered nurses after regular business hours, including on-call and call-back hours worked.

The total amount of overtime hours worked by nurses to provide emergency services after regular business hours will increase the understanding of the amount of after-hours care required in the community due mostly to emergencies.

**Question 57. Nursing Contract Hours**

This question concerns the total contract hours worked by agency nurses during the reporting year. Exclude overtime hours worked.

This information is being collected to determine the total number of Registered nurse hours that were filled by Agency nurses during the past year. It is also used to determine the number of vacant nurse positions.

**Question 58. Course Completion**

This question concerns the number of nurses who completed specified training or certification courses during the reporting year and also the total training hours for all nurses completing each course during the reporting year.

Use Table 3 below to check course descriptions for all of the courses listed in question 58.

**Note:** The course names or titles may vary by Region. Check with the FNIH Regional Office for the titles used in your region.
This information is used to determine the number of nurses in your community requiring education and training, including annual certification. For example, Registered nurses may be required by legislation in the province where they practise to maintain annual certification in Basic Cardiac Life Support (BCLS) competencies. This information will allow you to track how many nurses completed various types of training and certification each year.

Table 3 provides examples of training and certification courses and course descriptions to assist you in responding to this question.

### Table 3: Nursing Courses/Certifications and Descriptions

<table>
<thead>
<tr>
<th>Courses and Certifications</th>
<th>Description of Course or Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathophysiology</td>
<td>Examine theoretical and practice related concepts in pathophysiology as a basis for advanced nursing practice. Explore alterations in physiological function with an emphasis on age-related, acute, episodic, and chronic conditions found in primary health care practice.</td>
</tr>
<tr>
<td>Advanced Health Assessment</td>
<td>Analyze and critique concepts and frameworks essential to advanced health assessment and diagnosis using clinical reasoning skills. Apply clinical, theoretical and research knowledge in comprehensive and focused health assessment for the individual client’s diagnostic plan of care.</td>
</tr>
<tr>
<td>Pharmacotherapeutics (including a Module or course to meet the upcoming Section 56 Ministerial exemption on Controlled Drugs and Substances Act (CDSA))</td>
<td>Critically appraise and interpret concepts and frameworks integral to pharmacotherapy, advanced counselling, and complementary therapies for common conditions across the lifespan. Develop, initiate, manage, and evaluate therapeutic plans of care that incorporate client values and acceptability, goals of therapy, analysis of different approaches, and pharmacotherapeutic principles. CDSA module introduces the therapeutic application of narcotics and controlled substances along with the legal and professional competencies and responsibilities for prescribers and those who support care of patients when conditions are managed with these therapeutic agents.</td>
</tr>
<tr>
<td>Courses and Certifications</td>
<td>Description of Course or Certification</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Basic Trauma Life Support (BTLS)                | BTLS Basic - Designed for the Emergency Medical Technician (EMT)-Basic and First Responder, this hands-on training course offers basic Emergency Management System (EMS) providers complete training in the skills necessary for rapid assessment, resuscitation, stabilization and transportation of the trauma patient. The course provides education in the initial evaluation and stabilization of the trauma patient.  

BTLS Advanced - This comprehensive course covers the skills necessary for rapid assessment, resuscitation, stabilization, and transportation of the trauma patient for the advanced EMT, paramedic and trauma nurse. The course teaches the correct sequence of evaluation and the techniques of critical intervention, resuscitation and packaging a patient.                                                                 |
| International Trauma Life Support (ITLS)       | ITLS is accepted internationally as the standard training course for pre-hospital trauma care. It is used as a state-of-the-art continuing education course, and as an essential curriculum in many paramedic, EMT and first-responder training programs.  

ITLS courses combine classroom learning and hands-on skill stations. Scenario assessment stations enable participants to learn by working in simulated trauma situations. ITLS courses are designed, managed and delivered by course directors, coordinators and instructors experienced in EMS, pre-hospital care and the ITLS approach.                                                                 |
<p>| Advanced Trauma Life Support (ATLS)            | Advanced Trauma Life Support (ATLS) is a training program for doctors and paramedics in the management of acute trauma cases, developed by the American College of Surgeons. The program has been adopted worldwide in over 40 countries, sometimes under the name of Early Management of Severe Trauma (EMST), especially outside North America. Its goal is to teach a simplified and standardized approach to trauma patients. |
| Basic Cardiac Life Support (BCLS/BLS/CPR)      | The BLS for Healthcare Providers course contains updated content and science from the 2005 Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care. The course addresses core material such as adult and pediatric CPR (including two-rescuer scenarios and the use of a bag mask), foreign-body airway obstruction, and Automated External Defibrillator (AED) use. |</p>
<table>
<thead>
<tr>
<th>Courses and Certifications</th>
<th>Description of Course or Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Cardiac Life Support (ACLS)</td>
<td>The ACLS for Healthcare Providers course is designed to teach the skills needed to assess and administer care within the first 10 minutes of an adult VF/VT (ventricular fibrillation/ventricular tachycardia) arrest. Students will learn the skills needed to manage 10 advanced cardiac life support scenarios: respiratory emergency, 4 types of cardiac arrests: simple VF/VT, complex VF/VT, PEA (Pulseless Electrical Activity) and asystole, 4 types of pre-arrest emergencies (bradycardia, stable tachycardia, unstable tachycardia, and acute coronary syndromes), and stroke.</td>
</tr>
<tr>
<td>Paediatric Advanced Life Support (PALS)</td>
<td>The PALS for Healthcare Providers course is designed to teach health care providers to recognize the indicating factors for infants and children at risk of cardiopulmonary arrest; to help students learn the strategies to prevent arrests in infants and children; and to provide students with the skills to safely and effectively apply cognitive and psychomotor skills to resuscitate and stabilize infants and children in respiratory failure, shock or cardiopulmonary arrest. A strong emphasis is placed on bag-mask ventilation, management of airway, defibrillation and cardioversion, use of Automated External Defibrillators (AEDs) for children older than one year, and rhythm management.</td>
</tr>
<tr>
<td>Trauma Nurse Core Course (TNCC)</td>
<td>Trauma nursing as a discipline refers to the process and content of all the different roles nurses have in the care of the trauma patient. Knowledge is the core of any discipline. The purpose of TNCC is to present core-level knowledge, refine skills, and build a firm foundation in trauma nursing.</td>
</tr>
<tr>
<td>Immunization Certification</td>
<td>The certification required by provinces that allows nurses to immunize clients for vaccine preventable diseases.</td>
</tr>
</tbody>
</table>

**Question 59. Referrals**

Provide the numbers of referrals (scheduled and non-scheduled) to the listed health care provider groups outside the community.
Question 60. Collaborative Service Delivery

A collaborative service delivery arrangement is used to ensure that a system of continuous client-centred care is in place and functions effectively and efficiently between the community and other health systems or organizations, such as hospitals, health authorities, and therapeutic services. Collaborative service delivery arrangements (either formal or informal) enhance access and timeliness of care, and improve communication between health organizations to ensure continuity of services that will lead to improved client health outcomes. It is important to have established linkages with essential CCC service elements according to the CCC program framework.

To meet client needs, it also helps to establish working relationships with non-health organizations such as social agencies and housing services, to better integrate a continuum of services.

Data from this question are used to track effectiveness and efficiency between two health systems, thus helping foster continuity of client care, communication and linkages that are functioning well, and timely and accessible care and services.

Definitions and Examples

Collaborative service delivery arrangements may be formal, with a written Memorandum of Understanding, protocol, agreement, contract, etc. or informal, with a non-written agreement to support CCC client services in your community. For example, a First Nation organization wants to partner with a local hospital in the area of discharge planning. A formal agreement and discharge protocol are developed between the hospital and community requiring that contact between the nursing station and the hospital’s discharge unit be established, and that discharge plans, physician orders, and prescriptions for CCC supplies be determined before a client leaves the hospital and returns to the community.

Memorandum of Understanding (MOU) is a type of agreement between two health systems such as a community or First Nation Health organization and a provincial health institution. A policy and process is then put in place that ensures that the communication between the organizations is consistent and that client discharge processes are followed.

A Contract may be in place for an external organization to provide services to your community. Such a contract may be used if your community sometimes has difficulty staffing positions or if a service needed by community members is not available in your organization. Generally, if a contract is in place, your organization pays the second organization for the services.
Question 61. Complaints and Appeals

It is important for community CCC programs to have a process in place to manage complaints and appeals from clients and service delivery partners. A standardized, consistent method to collect information and resolve related complaints or appeals enhances the quality of clinical and client care.

Your response to this question simply determines whether or not your CCC program has a process in place for complaints and appeals. Communities that do not have a process in place are encouraged to prepare a complaints and appeals process to ensure a consistent approach to resolving such issues.

If many communities lack a complaints and appeals process, then Health Canada and the CCC program can support communities in developing one.

Definitions and Examples

**Complaints:** A grievance or criticism related to the way care was provided to the client. A legal, ethical, cultural or moral issue may also be at the heart of the complaint.

**Appeals:** An appeal is a process for requesting a formal change to an official decision. For example, if a complainant does not agree with a CCC nurse’s decision on delivery of care, then he or she may seek to appeal that decision.

Question 62. Incident and Occurrence Reporting

It is important for your community’s CCC program to have a process in place for reporting on incidents or occurrences affecting client care. The objective of the process is to decrease client, staff and program risk and minimize liability. Risk may relate to client safety or the quality of services.

The information in incident and occurrence reports can be used to make improvements to CCC services, ensuring that the quality of health care is maintained. The aim is to anticipate and mitigate risk and lessen the frequency of adverse events.

Your response to this question simply determines whether or not your community has an incident reporting process in place. If many communities lack an incident and occurrence reporting process, then Health Canada and the CCC program can support communities in developing one.

Definitions and Examples

**An occurrence or adverse event** covers three kinds of adverse (harmful) events:
1) An unexpected or undesirable incident that is directly linked to the care or services that the CCC program delivers to its clients or staff;
2) An incident that happens while the CCC delivers care, resulting in the client’s illness, injury or death; and
3) An adverse outcome for a client that includes an injury or a complication.

**Incident:** An event not usually part of delivering care or services. It may have a negative impact on the client, staff, community or organization. Incidents should always be measured in terms of the degree of risk.
G. Environmental Public Health

Introduction

The Environmental Public Health Program is delivered in First Nations communities south of 60° by Environmental Health Officers (EHOs) employed by Health Canada or individual Bands and Tribal Councils, in accordance with the National Framework for the Environmental Public Health Program in First Nations Communities South of 60°.

Objectives of the program are to identify and prevent environmental public health risks that could affect the health of community residents, and to recommend corrective action and health promotion to reduce these risks. Key programming includes environmental public health assessments (e.g., public health inspections, investigations, drinking water quality monitoring), training, and public education and awareness. Activities are delivered in core areas such as: Drinking Water, Food Safety, Health and Housing, Wastewater, Solid Waste Disposal, Facilities Inspections, Environmental Communicable Disease Control, and Emergency Preparedness and Response.

Data compiled from this section of the CBRT will be used by Health Canada staff to complete regional and national level analyses of environmental public health activities and to determine trends in First Nations communities. This will allow Health Canada and funding recipients to identify strengths and weaknesses in programming and adjust programming accordingly in order to better serve First Nations’ needs. Results will also be aggregated into national environmental public health performance reports and evaluations, and may be shared with the Treasury Board of Canada Secretariat in order to comply with the reporting requirements of Health Canada’s Authorities.

Note: If the EHO who works in your community is an employee of Health Canada, you do not have to fill out section G. Environmental Public Health in the Community-based Reporting Template.

Questions 63 and 64. Availability of EHO Reports

All EHOs working in First Nations communities south of 60°, including EHOs employed directly by Bands and Tribal Councils, should use EHIS. If all inspections, assessments, investigations, training, and other activities are entered in EHIS, and Health Canada can generate aggregate reports for your community directly from the system, then do not fill out the first part of this section, i.e., questions on the work of EHOs.

However, if EHOs have not entered all activities in EHIS, or communities do not provide access to Health Canada to aggregate reports directly from the system, then this section of the CBRT must be completed.

If you are not sure, verify with the Regional Environmental Health Manager at the FNIH Regional Office.
**Question 65. EHO Professional Training**

This information on EHO training is collected to verify that all EHOs working in First Nations communities across Canada are able to maintain their professional competencies according to the Canadian Institute of Public Health Inspectors (CIPHI) Continuing Professional Competencies Program. Information on professional training is required to determine what types of training have been completed, but also what training gaps exist so that provision of professional training activities can be improved. This is one step to ensuring community capacity, knowledge and skills in Environmental Public Health.

**Question 66. Environmental Public Health Inspections**

Data on environmental public health inspections are required to evaluate progress being made in the following areas: service delivery; capacity development; and surveillance, data collection, and evaluation. This ultimately leads to more responsive Environmental Public Health programming for on-reserve First Nation communities.

This question gathers information on the following for the reporting year: number of routine inspections; number of request inspections; the total number of each type of facility in your community.

*Note: Do not count inspections more than once. Each inspection should correspond with one of the facility types listed.*

**Definitions and Examples**

**Routine public health inspections** are inspections delivered at pre-set intervals, such as annually or quarterly, as agreed by First Nations authorities and the EHO, based on Health Canada and provincial guidelines, as well as public health risks. Routine inspection intervals may be defined in your Health Plan.

**Request public health inspections** (or on-request inspections) are inspections provided at the request of or in agreement with First Nations authorities in response to a public health complaint or potential public health risk.

**New onsite sewage disposal systems** are systems with fewer than five connections, located on a property but not yet connected to a house or a facility, to dispose of or treat wastewater. This includes, but is not limited to: (i) composting toilet systems, (ii) disposal fields, (iii) greywater pits, and (iv) septic tanks.

**Existing onsite sewage disposal systems** Are systems (with fewer than five connections) connected to a house or facility. These inspections are usually conducted during the course of a housing or facility inspection and are completed on request only. They may be requested when
part of the system, or the system as a whole, fails to function normally or adequately and requires repairs or reconstruction in order to function properly.

**Community wastewater (sewage) systems** are wastewater systems, including both treatment and collection systems, that service five or more connections and use different levels of treatment (primary, secondary, or tertiary) to reduce the amount of pollutants discharged to a surface water body. Examples of community wastewater treatment systems include lagoons and mechanical treatment plants.

**Housing units** are units inspected only upon request. A housing unit is any building where a person ordinarily eats and sleeps. Examples include houses, apartments, duplexes, mobile homes, nursing station residences, etc.

**Permanent food facilities** are establishments where food is prepared and served (e.g., a restaurant, community care facility, health facility, or school) or where food is grown, processed, sold, or stored. Permanent facilities are those that operate continuously six months a year or longer, or they operate intermittently for more than 50% of the days of the year. Permanent food facilities may include service, retail, and manufacturing facilities such as restaurants, institutional food services, convenience and grocery stores, food storage and warehouses, meat and fish plants, dairy or livestock enterprises, and other establishments.

**Seasonal food facilities** are establishments where food is prepared and served or where food is grown, processed, or sold, but are open only part of the year. A seasonal food facility operates for a continuous period of up to six months, or operates intermittently for no more than 50% of the days of the year. Seasonal food facilities could include hot-dog stands, ice cream shops, or seasonal canteens.

**Special event food facilities** are establishments where food is prepared and served or where food is grown, processed, or sold. Special event food facilities are temporary and are associated with community gatherings such as fairs, pow-wows, or sporting events.

**Health facilities** include ambulance bases, health centres, health offices, health stations, hospitals, medical centres, and nursing stations. For certain health facilities, inspections are done only on a request basis, including dental clinics, laboratories, pharmacies, and physiotherapy centres.

**Community care facilities** include schools, daycares, group homes, Head Starts, long-term care facilities, private home daycares, recovery houses, shelters, nursing homes, senior homes, retirement homes, youth drop in centres, treatment centres, and wellness centres.

**General facilities** include offices, animal shelters, barber shops, bed and breakfasts, fire stations, funeral homes, gas stations, hair salons, hotels, industrial sites, lodges, massage centres, motels, pet stores, and tattoo parlours. General facilities may include any other facilities not defined in this list that require public health inspections routinely or upon request.
Recreational facilities include arenas, billiard halls, bingo halls, bowling alleys, campgrounds, casinos, community centres, curling rinks, fitness centres, golf courses, parks, recreation centres, and sports fields. Recreational facilities also include playgrounds, play spaces and equipment intended for use by children.

Recreational water facilities include beaches, marinas, swimming pools, wading pools, water parks and whirlpools.

Solid waste disposal sites are sites where residential and commercial solid waste generated within a community can be accepted for disposal. This includes dump sites, collection-only sites, transfer stations, sanitary engineered landfills, hazardous waste depots, trenches, pits, burning barrels, compost facilities, recycling plants, incinerators, and industrial waste sites.

Question 67. Environmental Communicable Disease Investigations

Environmental communicable disease investigations occur in response to a suspected or confirmed environmental communicable disease case or outbreak (i.e., foodborne, waterborne or vectorborne) or “other” cases or outbreaks where the source of the case or outbreak is unknown or there are multiple sources in one or more First Nations communities. The EHO may lead the investigation or participate by providing advice and assistance on request, taking samples, conducting additional public health inspections, and delivering additional training sessions.

Data on environmental communicable disease investigations are required to evaluate progress being made in the areas of service delivery; capacity development; and surveillance, data collection, and evaluation. This ultimately leads to more responsive environmental public health programming for on-reserve First Nations communities.

Note: You will require extra sheets of paper for your responses to this question. Be sure to label the sheets with the question number and submit them as part of your completed template.

a) Foodborne Illness Investigations
For each foodborne illness investigation during the reporting year, provide details about the type (e.g., listeriosis, salmonella, unidentified) and scope (e.g., duration, location of investigation, number of suspected or confirmed cases, if known) of the outbreak, as well as the EHO’s role and the outcomes or results of the investigation.

Note: When a foodborne illness investigation leads to or includes a public health inspection, also be sure to record this inspection under Question 66. If additional food handler training is required during an investigation, also be sure to record this training under Question 73.
b) Waterborne Illness Investigations
For each waterborne illness investigation, please provide the details about the type (e.g., e coli, giardia, unidentified) and the EHOs’ role and the outcomes/results of the investigation.

Note: When a waterborne illness investigation leads to or includes a public health inspection, also be sure to record this inspection under Question 66. Any water samples taken must also be entered in your regional water database and/or in Question 76.

c) Vectorborne Illness Investigations
For each vectorborne illness investigation, please provide the details about the type (e.g. animal bite/rabies, West Nile virus, unidentified) and scope (e.g. duration; number of suspected or confirmed cases) if known, of the outbreak, as well as the EHOs’ role and the outcomes/results of the investigation.

Note: When a vectorborne illness investigation leads to or includes a public health inspection, also be sure to record this inspection under Question 66.

Question 68. Other Environmental Disease Investigations

Other investigations are those for which the source is unknown or there are multiple sources.

Note: You will require extra sheets of paper for your responses to this question. Be sure to label the sheets with the question number and submit them as part of your completed template.

For each “other” investigation during the reporting year, provide details about the type, if known, and scope (e.g., duration; location(s) of investigation; number of suspected or confirmed cases of the outbreak, if known, as well as the EHO’s role and the outcomes or results of the investigation.

Note: When an investigation leads to or includes a public health inspection, also be sure to record this inspection under Question 66.

Question 69. Zoonotic Surveillance and Intervention Activities

Data on zoonotic surveillance and intervention activities are required to evaluate progress and trends in surveillance as well as the effectiveness of different types of zoonotic interventions. This ultimately leads to more responsive environmental public health programming for on-reserve First Nations communities.
a) **Zoonotic Surveillance Activities**

Zoonotic surveillance activities are the on-going systematic collection and analysis of data and the provision of information that could lead to action to prevent and control zoonotic diseases. This includes passive surveillance (e.g., submitting or receiving submissions of ticks or dead birds for testing) and active surveillance (e.g., mosquito trapping and testing, planned tick collection).

For each zoonotic surveillance activity, provide details about the type (e.g., West Nile virus mosquito or bird, Lyme disease/tick, rabies/wildlife) and scope (e.g., duration, number of sampling sites, number of suspected or confirmed human disease cases, if known, etc.) of the surveillance, as well as the EHO’s role and the outcomes or results of the surveillance.

b) **Zoonotic Intervention Activities**

Zoonotic intervention activities are operations designed to prevent or reduce zoonotic diseases. Examples include mosquito larviciding, mosquito adulticiding, dog control, and rodent control.

For each zoonotic intervention activity, provide details about the type (e.g., mosquito larviciding or adulticiding, dog control, rodent control) and scope (e.g., duration, number of sites or instances) of the intervention, as well as the EHO’s role and the outcomes or results of the intervention.

**Questions 70-72. Emergency Planning, Response and Recovery**

Data on emergency planning, response and recovery activities are required to evaluate progress in service delivery, capacity development, surveillance, and collaboration with other health workers before, during and after emergencies. This ultimately leads to more responsive environmental public health programming for on-reserve First Nation communities.

For each emergency planning, response, and recovery activity, provide details about the emergency event, the EHO’s role, others involved, the type of activities undertaken, duration, and outcomes or results.

Note: You will require extra sheets of paper for your responses to questions 70-72. Be sure to label the sheets with the question numbers and submit them as part of your completed template.
Definitions and Examples

Emergency planning activities are measures taken prior to an event to be ready to respond to an emergency and manage its consequences. Examples include: participation in table-top sessions; public education; assisting a First Nation community in the development of its community emergency planning, response and recovery plan; and providing advice and guidance to the community and other stakeholders on environmental public health considerations for emergency planning.

Emergency response activities are actions during or immediately after an emergency to manage its consequences. Examples may include assessing the site of an emergency, inspecting sites/facilities affected by an emergency, communications, providing advice, and guidance during an emergency event, etc.

Emergency recovery activities are actions taken to repair and restore conditions to an acceptable level after an emergency. Examples include: the provision of advice and guidance after an emergency; follow-up assessment of a site affected by an emergency; public education; and follow-up inspections.

Question 73. EHO Training Sessions for Community Members and Staff

Information about EHO training sessions for community members and staff is required to determine what types of training have been completed at the community level, and to identify training gaps so that activities can be improved. This is one step to ensuring community capacity, knowledge and skills in Environmental Public Health.

Question 74. Educational and Training Materials

Information about environmental public health educational and training tools developed in your community is required to determine the types of tools available at the community level. This helps to identify tools that could be useful in other Regions or communities. The information also shows where gaps exist so that other tools can be developed or improved. This is part of ensuring community capacity, knowledge, and skills in Environmental Public Health.

For each environmental public health educational or training item developed, provide details about the type of materials developed, the EHO’s role and the role of other partners in its development, the intended audience, distribution, and observed results.

Note: You will require extra sheets of paper for your responses to this question. Be sure to label the sheets with the question number and submit them as part of your completed template.
Definitions and Examples

Public health training materials are tools developed by the EHO for use during training sessions with community staff and workers, or as references for trainees, aimed at guiding them to carry out a specific work or volunteer task, or an environmental public health or environmental health research activity. Examples include hand-outs and binders used during training sessions, training guides and how-to manuals, posters and pamphlets, and videos.

Public health educational materials are materials, developed by the EHO or an Environmental Public Health staff member, containing environmental public health information or program information aimed at increasing community members’ awareness of services available, health risks, and steps to take to prevent, mitigate or adapt to these risks. Examples include pamphlets, leaflets, websites, posters, booklets, videos environmental health guides, and media releases and announcements.
The remaining questions in the Environmental Public Health section concern Drinking Water information.

All EHOs working in First Nations communities south of 60° are encouraged to use the same drinking water database as their respective FNIH Regional Office. If drinking water data is entered in the FNIH Regional Office database, performance reports can be generated directly from the database. However, if EHOs, communities, or Tribal Councils choose not to use the database used by their respective FNIH Regional Office or choose to use the database but not to share aggregate performance reports directly with the Regional Office, then the following questions on drinking water are mandatory.

If you are not sure, verify with the Regional Environmental Health Manager at the FNIH Regional Office.

Note: Do not complete this part of the CBRT if you receive the services of an EHO employed by Health Canada.

**Question 75. Availability of Drinking Water Data**

If your answer to this question is “Yes”, you do not have to complete the remaining questions.

**Question 76. Drinking Water**

Through the Drinking Water Safety Program (DWSP), Health Canada works in partnership with more than 700 First Nations communities south of the 60th parallel in Canada to ensure that drinking water is monitored according to the Guidelines for Canadian Drinking Water Quality (GCDWQ).

In communities where it is difficult or impossible to test drinking water samples for microbiological contamination on a regular basis or to deliver microbiological water samples to a laboratory in a timely manner, Health Canada, through its Community-based Drinking Water Quality Monitor program, helps First Nations communities establish drinking water quality sampling and testing capabilities to verify the overall quality of drinking water at tap.

Health Canada provides funds to Chief and Council to employ Community-based Drinking Water Quality Monitors (CBWMs) in the community who can provide a final check on the overall safety of the drinking water. Health Canada trains these monitors to sample and test the drinking water for potential bacteriological contamination.
If a community does not have a CBWM, then an EHO, a Certified Public Health Inspector employed by Health Canada or a First Nations stakeholder samples and tests drinking water quality, with the community’s permission.

The information collected for the Drinking Water Safety Program provides health information on reducing public health risks, meeting capacity needs in First Nations communities to address drinking water quality, and increasing the confidence of First Nations in the quality of their drinking water. This information is used by Health Canada to assess program delivery.

**Definitions and Examples**

**Community-based Drinking Water Quality Monitors** are responsible for sampling the treated drinking water within the community and testing the samples for bacteriological quality only. The CBWM is responsible for giving test results to the community’s EHO, who is responsible for the interpretation of the test results. The CBWM may also be a Community Health Representative (CHR), Water Treatment Plant Operator (WTPO), or another individual identified by Chief and Council. If a community does not have a CBWM, the monitoring activities are carried out by the community’s EHO.

The activities of CBWMs include, but are not limited to, the following:

- Sampling and testing the quality of drinking water in distribution systems and cisterns, as detailed in the sampling procedures developed in collaboration with the EHO, according to the GCDWQ;
- Recording all results on water quality data sheets each week and sending monthly reports to the EHO, Chief and Council, and WTPO;
- Performing quality assurance tests on testing media, according to the quality assurance plan developed in collaboration with the EHO;
- Notifying the EHO for interpretation of the results and further action immediately upon determining that Escherichia coli or total coliforms exceed the latest guidelines or when there are unusual changes in disinfectant residuals;
- Meeting regularly with Chief and Council, the EHO, the Health Director, the Nurse in Charge, the Community Health Nurse, and the CHR, and reporting orally on program activities.

**Number of samples** refers to the number of samples collected for bacteriological parameters for each water distribution system (piped, public, trucked, and individual) during the reporting period.

**Bacteriological monitoring** of drinking water at tap by the CBWM is conducted as a final check on the overall safety of the system. The chemical, physical, and radiological monitoring of drinking water is the EHO’s responsibility.
**Number of Water Distribution Systems** means the number of distribution systems (piped water systems with five connections or more, public water systems, trucked water systems, individual water systems) monitored for bacteriological, protozoa, chemical, THMs, and radiological parameters.

**Quality Assurance** (QA) is defined by the International Organization for Standardization as “a set of activities whose purpose is to demonstrate that an entity meets all quality requirements”. The objective of the QA program for the DWSP is to ensure the adequacy of water sampling and the reliability of test results. The quality assurance questions relate to the percentage of samples submitted to an accredited laboratory bacteriological analysis.

**Drinking Water Illnesses** are illnesses that result from consuming contaminated water. The three main types of microorganisms that can be found in drinking water are: bacteria, viruses, and protozoa. Common waterborne illnesses include Salmonellosis, Shigellosis, Cholera, Giardiasis, and Cryptosporidiosis.

**Public Awareness** activities provide an opportunity to inform community members about drinking water quality issues, public health risks, water disinfection, and drinking water systems. Public awareness sessions include workshops, health fairs, community meetings, presentations, and training sessions for community members. Do not include training or capacity building activities directed at staff, such as CBWMs and EHOs.