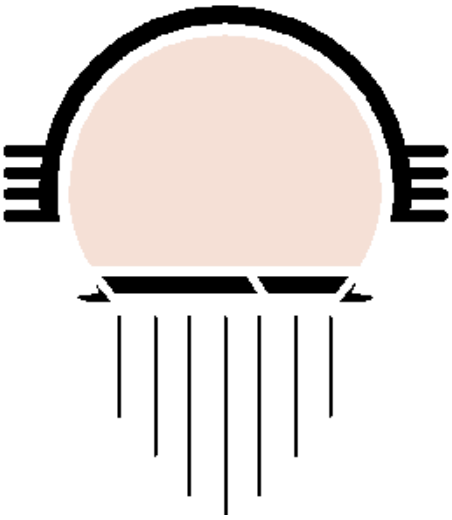
Health Canada Santé Canada

Community-based Reporting:

A Guide for First Nations and Inuit 2015-2016



Canada

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FNIH Regional Offices Contact Information

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

Ontario Region
First Nations and Inuit Health
Health Canada
Emerald Plaza, 3rd Floor
1547 Merivale Road
Ottawa, ON K1A 0K9
1-888-283-8885

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

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

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

Atlantic Region
First Nations and Inuit Health
Health Canada
Maritime Centre, 18th Floor
1505 Barrington Street
Halifax, NS B3J 3Y6
1-800-565-3294

Glossary of Acronyms

Acronym	Description
AA	Alcoholics Anonymous
ADI	Aboriginal Diabetes Initiative
AHSOR	Aboriginal Head Start On Reserve
BF	Brighter Futures
BHC	Building Healthy Communities
BSc	Bachelor of Science
C	Certified
CBRT	Community-based Reporting Template
CBWM	Community-based Drinking Water Quality Monitor
CCC	Clinical and Client Care
CDCM	Communicable Disease Control and Management
CDPW	Community Diabetes Prevention Worker
CHN	Community Health Nurse
CHR	Community Health Representative
CIPHI	Canadian Institute of Public Health Inspectors
COHI	Children's Oral Health Initiative
CPNP	Canada Prenatal Nutrition Program
DTaP-IPV	Diphtheria, Tetanus, Pertussis, Poliomyelitis
DWA	Drinking Water Advisory
DWSP	Drinking Water Safety Program
ECE	Early Childhood Educator
EHO	Environmental Health Officer
e-HRTT	Electronic Human Resource Tracking Tool
EHIS	Environmental Health Information System
e-SDRT	Electronic Service Delivery Reporting Template
FASD	Fetal Alcohol Spectrum Disorder
FNIH	First Nations and Inuit Health
FNIHB	First Nations and Inuit Health Branch
FT	Full Time
FTE	Full Time Equivalent
GCDWQ	Guidelines for Canadian Drinking Water Quality
HC	Health Canada

Acronym	Description
HCC	Home and Community Care
HD	Health Director
HE	Healthy Eating
HiB	Haemophilus influenzae Type B
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV	Human Papillomavirus
IGRA	Interferon Gamma Release Assay
LPN	Licensed Practical Nurse
LTBI	Latent Tuberculosis Infection
MCH	Maternal Child Health
MMR vaccine	Measles, Mumps, Rubella
MOU	Memorandum of Understanding
NAYSPS	National Aboriginal Youth Suicide Prevention Strategy
NIC	Nurse in Charge
NNADAP	National Native Alcohol and Drug Abuse Program
PA	Physical Activity
PCW/HCA	Personnel Care Worker/Health Care Aides
PDH	Professional Development Hours
PT	Part Time
QA	Quality Assurance
QC	Quality Control
RN	Registered Nurse
TB	Tuberculosis
TDG	Transportation of Dangerous Goods
THMs	Trihalomethanes
WHMIS	Workplace Hazardous Materials Information System
WTPO	Water Treatment Plant Operator
YSAC	Youth Solvent Addictions Committee
YSAP	Youth Solvent Abuse Program

Introduction

Purpose of This Guide

This Guide is intended to be used together with the Community-based Reporting Template 2015-2016 (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 2015-2016 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 may require extra space for your responses as indicated in some questions. Use extra sheets of paper (or additional text boxes if using the Adobe version of the CBRT) 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 post-vention 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 is 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 60º 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 60º.* 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. 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 last working day 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, including CHRs, NNADAP Workers, ADI Workers, AHSOR Workers, CPNP Workers, MCH Home Visitors, FASD Community Coordinators and Mentors, HCC Personal Care Workers, Youth Workers, Mental Health Workers, and Other Community-Based Health 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 by the number of hours they typically work.

Definitions:

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.

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 1. 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 2. 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 3, 4, 6 and 7 should be collected for participants in the Canada Prenatal Nutrition Program and the Maternal Child Health Program.

Question 3. 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 breast fed for each of the breastfeeding durations listed.

Question 4. 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 5. 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 6. 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).

High birth weight: Newborns weighing more than 4000 grams (8 pounds, 13 ounces).

Healthy birth weight: Newborns weighing between 2500 grams (5 lb 9 oz) and 4000 grams (8 lb 11 oz).

Question 7. 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, indicate 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 8. 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 9. 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 10. 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 11. 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 12. 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 13. 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 14. 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 <u>not</u> 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 15. 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.

Note: For this question, if your community has more than one AHSOR program, include the total number of children who have been diagnosed, screened, assessed, or referred for special needs in all of the AHSOR programs in your community.

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 16. 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 17. Children's Oral Health Initiative (COHI)

Regardless of agreement type, all communities delivering COHI are expected to continue to use and submit 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, as well as the number of clients participating in prenatal oral health sessions and number of oral health sessions provided, 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 18. 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 19. 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 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 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 20. Mental Wellness Activities

Question 20A. 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 20B. 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 20C. 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 20D. 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 21. 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 22. 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 23. 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.

Question 24. 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 25. Data Tracking Tools and Support

The Mental Wellness Tracking Tool included with the CBRT has two parts, one for the question on Suicide Interventions and one for Question on Interventions of Substance Use, Addictions and Mental Health. The aim of these tools is to simplify the collection of the data required to complete 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

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 26. 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 27. 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).

Question 28. 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 29. 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 30. 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 31. 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 Borne 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 32. 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 33. 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

Worker Type	Description and Certification Type	Certification Code
Community Health Representative	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	CHR
Physician	Certified from the College of Family Physicians and licensed by provincial licensing body.	MD
Licensed Practical Nurse	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.	LPN
Primary Care Nurse	Registered Nurse with a Bachelor's degree in nursing or post graduate studies in clinical practice or nurse practitioner studies.	RN and/or RN (EC)
Public Health Nurse / Community Health Nurse	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).	RN and/or RN (EC)
Tuberculosis Worker	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.	CHR (TB Worker)
Directly Observed Treatment (DOT) Worker	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.	CHR (DOT Worker)
Pandemic Coordinator	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.	N/A

Question 34. 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.

Program and Initiative Area	National	Regional	Local and Community	Total Number of Activities
• Immunization	Posted National Immunization Awareness Week posters in the health facility continuously throughout the year.	Distributed immunization guide developed by the province in October and again in January. Sent 5 community health workers to an immunization training session provided by the FNIH Regional Office in September.	Developed and posted H1N1 posters in the health facility throughout the year. Held a seasonal flu immunization awareness session in October.	5

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 35 and 36. 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 37. 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.

Question 38. 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 39. 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 40. 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 41. 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 42. 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 43. 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 44. 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 45. 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 46. 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

Section F is to be completed only by First Nation managed communities with a Nursing Station and/or Health Centre with Treatment providing Clinical and Client Care (CCC) services which includes access to urgent care twenty-four hours a day, seven days a week (24/7) or five days a week (24/5).

Clinical and Client Care consists of essential health care services directed towards First Nations individuals, living primarily in remote and isolated communities, which enable them to receive the clinical care they need in their home communities. It is provided either directly or through contribution agreements with First Nation Bands or Tribal Councils in locations where these services are not provided by provincial health systems. 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 is inclusive of health promotion and disease prevention at the client/family level in the course of treatment as well as the coordination and integration of care and referral to appropriate provincial secondary and tertiary levels of care outside the community. Physician visits and hospital in-patient, ambulatory and emergency services are components of Clinical and Client Care services provided in some First Nations communities.

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 47. 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 48. 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.

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 49. Total Registered Nurses

This question is asking for the total number of registered nurses employed on the last working day of the fiscal year and who provide primary care services in the community/facility. This includes all Nurse Practitioners (NP), Registered Nurses (RN), and Licensed Practical Nurses (LPN). In Ontario, Licensed Practical Nurses are referred to as Registered Practical Nurses.

Note that this number includes nurses employed in resource pools but does not include Agency nursing services.

Question 50. Course Completion

This question concerns the number of nurses who completed specified training or certification courses during the reporting year by type of training method. .

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.

Use Table 3 below to check descriptions for all of the courses and certifications listed in questions 50A (Primary Care Competency Courses) and 50B (Types of Certifications Held).

Note: The course names or titles may vary by Region. Check with the FNIH Regional Office for the titles used in your region.

Definitions and Examples

Online distance education includes Web based, Webinar, teleconference or videoconference

On-site training is where a trainer is brought to the work in the community/facility for training

Offsite training is where training is held outside of the work community and participant travel is required

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

Table 3: Nursing Courses/Certifications and Descriptions

Courses and Certifications	Description of Course or Certification
Pathophysiology	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.
Advanced Health Assessment	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.
Pharmacotherapeutics *(including a Module or course to meet the upcoming Section 56 Ministerial exemption on Controlled Drugs and Substances Act (CDSA))*.	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.

Courses and Certifications	Description of Course or Certification
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.
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.

Courses and Certifications	Description of Course or Certification
Advanced Cardiac Life Support (ACLS)	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.
Paediatric Advanced Life Support (PALS)	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.
Trauma Nurse Core Course (TNCC)	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.
Immunization Certification	The certification required by provinces that allows nurses to immunize clients for vaccine preventable diseases.
The Transportation of Dangerous Goods (TDG) Course	This certification is to ensure that anyone preparing, packaging, transporting, shipping, and receiving dangerous goods has the appropriate training to do so in a responsible and safe manner that conforms to the conditions outlined in the Transportation of Dangerous Goods Act..
Workplace Hazardous Material Information System (WHMIS) Training	This is a Canada-Wide System which is governed by federal and provincial laws and regulations. Employers must comply with the laws and regulations to ensure that employees obtain training in the safe handling of hazardous materials used in the workplace in order to protect their health and safety.
Safety and Awareness Training (NSAT)	Nurses Safety & Awareness Training (NSAT) was developed in 2003 to meet obligations under the Canada Labour Code. It is designed to give community health nurses (both Health

Courses and Certifications	Description of Course or Certification
	Canada and Band employed) the knowledge, skills and support to develop attitudes about workplace safety, increase awareness and promote strategies for healthy workplaces.