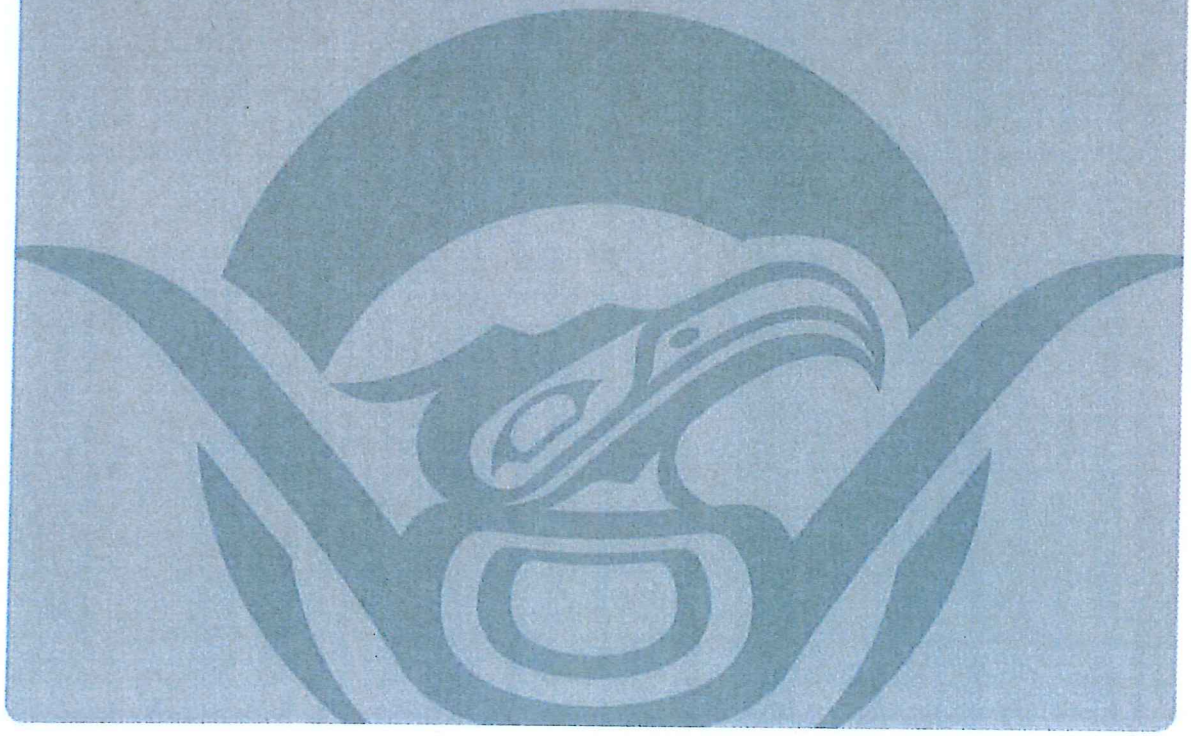
completion of the CBRT." (Mark your level of agreement with this statement in the appropriate box.)	Disagree	☐
	Neutral	☐
	Agree	☐
	Strongly agree	☐
26E) "The tracking tool(s) has (have) been useful across activity areas." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	☐
	Disagree	☐
	Neutral	☐
	Agree	☐
	Strongly agree	☐

C Healthy Living



C. Healthy Living

Question 27. Chronic Disease and Injury Prevention: Use check marks (√) to indicate which activities and services were provided. If an activity you provide could fit under more than one category provided below, choose whichever one is the 'best fit', and identify it only once.

Chronic Disease and Injury Prevention Activities	Activity Offered (√)
Physical Activity	**Check (√)**
Awareness activities related to physical activity (e.g., Diabetes Walks, Healthy Living Awareness Days)	☑
Walking clubs	☑
Sport/recreation activities (e.g., soccer, basketball, etc.)	☑
Traditional physical activities (e.g. jigging, dancing, games, snowshoeing, canoeing)	☑
Nutrition	**Check (√)**
Cooking sessions or classes (including community kitchens)	☑
Traditional harvesting, food preparation, food preservation (e.g., berry picking, cleaning fish, canning, etc.)	☑
Healthy eating awareness and education (e.g., health fairs, radio shows, etc.)	☑
Grocery tours	☑
Community gardens	☑
Good Food Boxes	☑
Food Vouchers	☑
School-based feeding programs	☑
Additional	**Check (√)**
Diabetes information sessions or workshops	☑
Development of resource materials (e.g., posters, cookbooks, displays, guides, etc.)	☑
Injury prevention training and awareness raising (e.g., safety committees, tool kits, "A Journey to the Teachings" training, etc.)	☑

Question 28. Diabetes Screening: Indicate which activities and services were provided during the reporting year by checking (√) **Yes** or **No**. If an activity could fit under more than one category provided below, choose whichever one is the 'best fit' and identify it only once.

Do you conduct diabetes diagnostic screening in your community? (e.g., fasting glucose, OGTT. See Guide for definitions.)	**Yes** ■	**No** ❑
If **Yes,** how many individuals were screened in the reporting year?	84	
Do you conduct non-diagnostic diabetes awareness/prevention screening in your community? (e.g., non-diagnostic screenings at schools, workplaces, sporting events, health fairs, etc)	**Yes** ■	**No** ❑
If **Yes**, provide an estimate of how many non-diagnostic screenings were conducted during the reporting year.	67	

Question 29. Diabetes Management: Use check marks (√) to indicate which activities and services were provided. If an activity could fit under more than one category provided below, choose whichever one is the 'best fit' and identify it only once.

Diabetes Management Activities	Activity Offered Check (√)
Diabetes support or healthy living groups	☑
Screening for complications, e.g., retinal screening	☑
Screening for complications, e.g., renal screening	☑
Referrals to health professionals or services	☑
Diabetes self-management sessions	☑

Question 30. Diabetes Clinics and Training: Indicate which activities and services were provided by checking (√) **Yes** or **No**.

Do you provide or support diabetes education clinics and training for clients to support their self-management (e.g., blood sugar testing, foot care, diet and exercise advice, traditional activities)?	**Yes** ■	**No** ❑
If **Yes,** how many individuals were served in the reporting year?	67	
Do you provide foot care clinics?	**Yes** ■	**No** ❑
If **Yes**, how many individuals were served in the reporting year?	32	

Question 31. Healthy Living Service Linkages: Use a check mark (√) to indicate where service linkages occurred between community health staff external organizations and agencies during the reporting year. Service linkages can be formal or informal

arrangements, collaborations, or processes with external individuals and organizations to facilitate the delivery of health services. See Guide for details and examples.

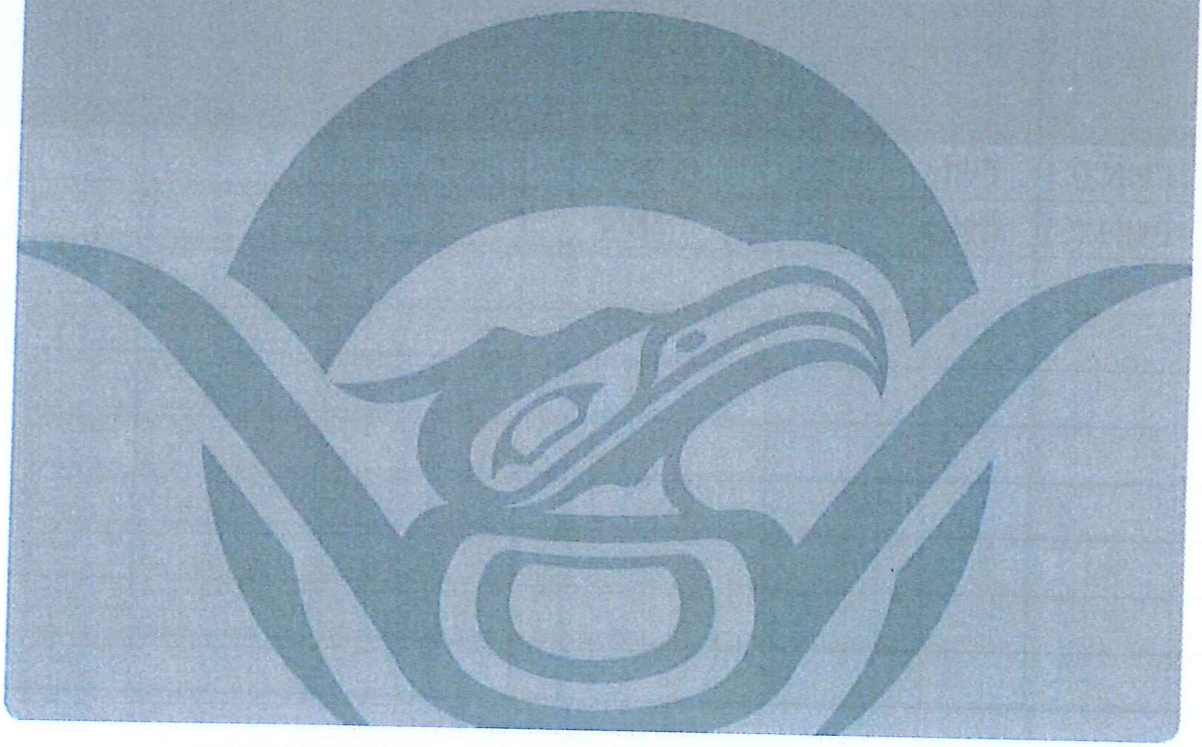
Type of Service/Service Linkage	Regional Health Authority/Health Service Zone	Educational Organizations	Non-Profit Organizations	Provincial Services
Healthy eating/nutrition	√		√	√
Physical activity/recreation	√		√	√
Specialist care	√		√	√
Injury Prevention	√		√	√
Treatment/management	√		√	√
Diagnostics/screening	√		√	√

Question 32. Tracking Tools: Use check marks (√) to indicate your responses to the following questions, unless otherwise indicated.

32A) Do you use a diabetes tracking tool, chronic disease registry, or other tracking system in the community to track clients living with type 1 and type 2 diabetes or other chronic diseases?	**Yes** ■	**No** ❑
If **No**, go to question **33** in the next section. If **Yes**, go to question **32B).**		
32B) According to your tracking system, how many individuals in your community are living with diabetes type 1 and diabetes type 2?	**Type 1** 3	**Type 2** 34
32C) Was your tracking tool supplied by First Nations Health Authority?	**Yes** ■	**No** ❑
If **No**, go to question **33** in the next section. If **Yes**, go to question **32D).**		
32D) Provide the name of the tracking tool(s) being used. Mustimuhw		
In questions **32E) to 32G),** rate your level of satisfaction with the tracking tool(s) by indicating your level of agreement with the following statements:		
32E) "The tracking tool(s) is (are) useful for tracking work in Healthy Living." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	❑
	Disagree	❑
	Neutral	❑
	Agree	❑
	Strongly agree	❑
32F) "The tracking tool(s) has aided in the completion of the CBRT." (Mark your agreement with this statement in the appropriate box.)	Strongly disagree	❑
	Disagree	❑
	Neutral	❑
	Agree	❑
	Strongly agree	❑
32G) "The tracking tool(s) has been useful across activity areas" (Mark your level of agreement with this statement in	Strongly disagree	❑
	Disagree	❑

the appropriate box.)	Neutral	☐
	Agree	☐
	Strongly agree	☐

D Communicable Disease Control and Management (CDCM)



D. Communicable Disease Control and Management (CDCM)

The reporting period for Section D is April 1 to March 31 unless otherwise indicated for a specific question.

Programs/initiatives included under CDCM are:

- Vaccine Preventable Diseases and Immunization;
- Blood Borne Diseases and Sexually Transmitted Infections (HIV/AIDS)
- Communicable Disease Emergencies; and
- Respiratory Infections (Tuberculosis)

Question 33. Number of Health Care Workers in CDCM in Your Community: How many people work in CDCM in your community? 3

Question 34. Worker Information and Training: In the table, provide the worker information and indicate the training the CDCM health care workers completed during the reporting year.

Worker Information				***Training completed during the reporting year**		
Job Title	**Worker Type** (Base on the descriptions in the Guide)	**Hours Per Week**	**Certification Type** (Use letter codes provided in the Guide for certification type)	**Completed Certified Training** (Indicate completion with a check mark)	**Continuing Education Training** (Indicate completion with a check mark)	**Short Course Training** (Indicate completion with a check mark)
CHN (C)	CHN	35	RN			
CHN (S)	CHN	28	RN			

***Certified Training:** Educational program at least one academic year in length.
***Continuing Education Training:** Short-term courses that upgrade or maintain skills.

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

Question 35. Awareness and Education Activities: For each of the program and service areas listed, indicate the number of related awareness and education activities conducted in your community or organization, and provide a brief description of the activities. You will need extra space for this question. Refer to the Guide for definitions and examples of national, regional and local/community and further details on how to complete this table.

Program and Initiative Areas	National	Regional	Local/community	Number of Activities
HIV/AIDS-Blood Borne and Sexual Transmitted Infections	0		5	5
Tuberculosis	0		4	4
Immunization	0		23	23
Pandemic Planning	0		1	1
Infection Prevention and Control	0		4	4

Question 36. Health Status Reports: Use check marks (√) to indicate if you received a health status report with data on communicable diseases from each of the following organizations during the reporting year.

Organization	Received Health Status Report on Communicable Diseases from Organization	
First Nations Health Authority	**Yes** ■	**No** ❑
Province	**Yes** ❑	**No** ■
District/Regional Health Authority	**Yes** ❑	**No** ■
First Nations and Inuit Health Branch (national office)	**Yes** ❑	**No** ■
Other (please specify)	**Yes** ❑	**No** ■

Question 37. If you answered **No** to **all** organizations in **question 36**, go to **question 38**. Otherwise, answer the two questions below.

a) Did any report you received contain information specific to your community?

Yes ☐ **No** ■ If **No,** go to **question 38.**

b) Did you use this report for programming decisions in your community?

Yes ☐ **No** ☐

If you answered **Yes** to part b), provide a very brief description below of how the report was used. If you answered **No** to part b), provide a very brief description of why you didn't use the report for programming decisions.

Question 38. Pandemic Plans

38A) Does your community have a Pandemic Plan?	**Yes** ■ **No** ☐ (If **No**, go to **question 39)**
38B) When was your community Pandemic Plan last updated?	**Day/Month/Year** 05/08/2009
38C) Has your community tested its Pandemic Plan engaging the appropriate stakeholders as identified in the Plan?	**Yes** ☐ **No** ■ (If **No,** go to **question 38e)**
38D) When was your community plan last tested?	**Day/Month/Year** 2010
38E) Does your community have an all hazards emergency plan?	**Yes** ■ **No** ☐ (If **No**, go to **question 39)**
38F) Has your community Pandemic Plan been integrated with the Emergency Management Plan?	**Yes** ☐ **No** ■

Question 39. Immunization Coverage Report: Complete the applicable immunization coverage report form for your region/province according to your provincial immunization schedule. The form will be provided to you by the First Nations Health Authority. Follow the instructions provided in the form and submit it with this completed template.

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).

Immunization coverage report form completed and submitted with reporting template?

Yes ■ **No** ☐

Question 40. Use of Provincial or Territorial TB Prevention and Control Programs: Does your community make use of TB clinical, treatment, health promotion, and public health expertise and resources from the provincial or territorial TB prevention and control programs? Indicate your response with check marks (√) below.

- ☐ **Not applicable** because no provincial TB prevention and control programs are available. If not applicable, go to **question 45.**
- ■ **Yes,** our community makes use of the available expertise and resources.
- ☐ **No**, our community does not make use of the available expertise and resources.

If **No**, go to **question 45**.
If **Yes**, use check marks (√) to indicate the program elements for which the expertise and resources are being used.

Program Development	☑
Program Implementation	☑
Program Evaluation	☑
Research	☑
Clinical advice	☑

Question 41. Access to Referrals and Services for HIV Testing and Treatment: Indicate your responses with check marks (√). For a definition of "near", see the Guide.

Is HIV testing accessible on or near the reserve? **Yes** ☐ **No** ☐

Is HIV treatment accessible on or near the reserve? **Yes** ■ **No** ☐

Question 42. HIV/AIDS Support Groups: Are there any HIV/AIDS support groups in your community? Use check marks (√) to indicate your responses.

Yes ☐ **No** ■

If **No**, indicate all of the reasons why no HIV/AIDS support groups exist in your community.

- ☐ Limited funding
- ☐ Insufficient capacity to establish and lead support groups (e.g., sufficient funding is available but there is a lack of training opportunities, venues, or human resources)
- ■ Need for support groups not identified (e.g., very low rates of HIV/AIDS infection so HIV/AIDS is not an issue needing support groups)
- ■ Individuals with HIV prefer not to involve health centre staff in their follow-up
- ■ Individuals with HIV prefer to access services off-reserve, especially for HIV/STIs
- ☐ Other reasons (please specify) (e.g., stigma associated with HIV/AIDS)

_____

Question 43. Collection of Other Information: Does your community collect any additional information on blood borne pathogens and sexually transmitted infections? **Yes** ❑ **No** ■

If **Yes,** briefly list in the box below, the **types** of information collected (e.g., rates of HIV infection, number of counselling sessions conducted, etc.).

Note: You do not have to provide the actual data, just the types of information collected.

E Home and Community Care

E. Home and Community Care

All communities with a Home and Community Care (HCC) Program are expected to use the Electronic Service Delivery Reporting Template (e-SDRT), which includes the Electronic Human Resource Tracking Tool (e-HRTT), and should continue to input information according to the "Other Reporting Requirements" schedule. **In addition, please answer the questions in this section.**

Question 44. Collaborative Service Delivery: Does your community or organization have a collaborative service delivery arrangement for HCC services or supports with external providers such as hospitals (including discharge information agreements), Regional Health Authorities, client care access centres, etc.?

Note: Collaborative arrangements may be formal with a written agreement in the form of a Memorandum of Understanding, protocol, agreement, contract, etc. or informal with a non-written agreement to provide services or information to support HCC client services in your community.

Yes ■ **No** ❑

If **Yes**, please complete the following table.

Collaborative Agreement with:	**Number of Agreements** (in place at the end of the reporting year)
District or Regional Health Authority	Informal with IHA-HCC
Hospitals	
Client Care Access Centres	
Other (Please specify)	

Question 45. Complaints and Appeals: Do you have a process in place to manage HCC complaints and appeals?

Yes ■ **No** ❑

Question 46. Incident and Occurrence Reporting: Do you have a HCC incident and occurrence reporting process in place?

Yes ■ **No** ❑

Question 47. Accreditation: Has your HCC program been accredited by Accreditation Canada or other recognized accreditation organization?

Yes ❑ **No** ■

F Clinical and Client Care (CCC)

F. Clinical and Client Care (CCC)

Section F is to be completed only by communities with a Nursing Station and/or Health Centre with Treatment providing primary care clinical and treatment services twenty-four hours a day, seven days a week (24/7) or five days a week (24/5). If these services are provided by the First Nations Health Authority, this section should be completed by the First Nations Health Authority.

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

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 48. Community Members Accessing CCC Services: How many community members accessed CCC services at least once during the reporting year? 357

Question 49. Service Encounters: Indicate the number of service encounters for urgent (emergency) and non-urgent clinical services. One community member may have multiple service encounters.

	Number of CCC Service Encounters During the Reporting Year	
	Urgent	**Non-Urgent**
Total Encounters		1301

Question 50. Total Registered Nurses: Please indicate the total number of registered nurses employed on the last working day of the fiscal year and who provide primary care services in this facility (headcount) 3 from IHA.

Note: This includes nurses employed in resource pools but does not include Agency nursing services. Full-Time Equivalent (FTE) Nursing Positions: Indicate numbers at the end of the reporting year.

Question 51. Course and Certification Completion: Of the nurses in Question 49 above, indicate the number of registered nurses who have completed the following courses and certifications by type of training method. Refer to the Guide for course descriptions.

Note: The names of courses or certifications may vary by Region. Check with the Region for the names used.

50A. Primary Care Competency courses

Courses	Total number of nurses who completed the course	Number of nurses who completed the course through online distance education	Number of nurses who completed the course through onsite training	Number of nurses who completed the course through offsite training
Advanced Health Assessment (AHA), or equivalent college/university recognized course				
Pharmocotherapeutics (Pharmacy) or equivalent college/university recognized course				
Pathophysiology, or equivalent college/ university recognized course				

All three primary care core courses These are: Advanced Health Assessment (AHA), Pharmacotherapeut ics(Pharmacy), and Pathophysiology or equivalent college/university recognized courses	3	[redacted]		
Other equivalent additional Practice Competency course: **Add title**				

51B: Type of Certifications Held

Certifications	Total number of nurses who hold a valid certificate	Number of nurses who completed the certification through online distance education	Number of nurses who completed the certification through onsite training	Number of nurses who completed the certification through offsite training
Basic Trauma Life Support (BTLS)		NA		
International Trauma Life Support (ITLS)		NA		
Advanced Trauma Life Support (ATLS)		NA		

Basic Cardiac Life Support (CPR) for Health Professionals Level 5	5	NA		
Advanced Cardiac Life Support (ACLS)		NA		
Pediatric Advanced Life Support (PALS)		NA		
Trauma Nurse Core Course (TNCC)		NA		
Immunization Certification (IC)	3			
Nursing Education Module on Controlled substances in First Nations Health Facilities (CS Module)			NA	NA
Workplace Hazardous Materials Information System (WHMIS)	5			
Transportation of Dangerous Goods course	5			
Nurse Safety and Awareness Training (NSAT)				

Other certification (please add title of training /certification here)				