Northern BC

Rural and Remote and First Nations Communities

COVID-19 Response Framework

DRAFT

June 09, 2020

RURAL AND REMOTE[1] AND FIRST NATIONS COMMUNITIES COVID-19 RESPONSE FRAMEWORK

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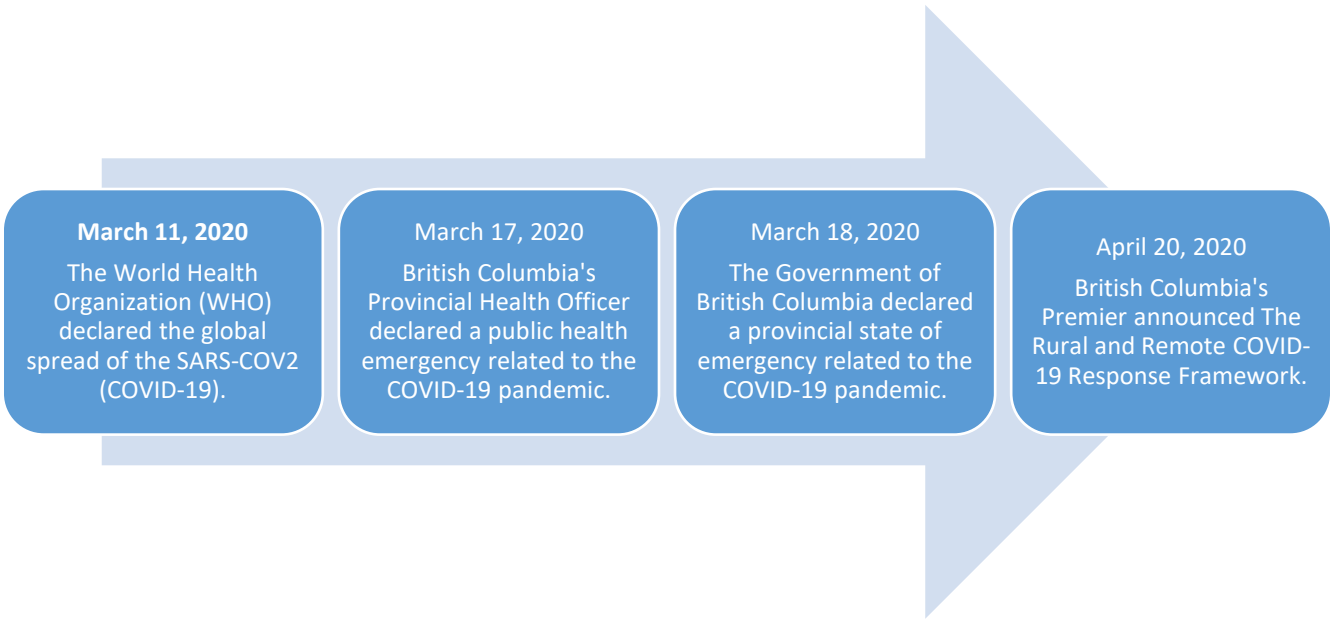
1.0 INTRODUCTION

On March 11, 2020, the World Health Organization (WHO) declared that the global spread of the SARS-CoV2 virus (COVID-19) could be characterized as a pandemic. In British Columbia, Dr. Henry, Provincial Health Officer declared a public health emergency related to the COVID-19 pandemic on March 17, 2020 and the next day the Government of British Columbia declared a provincial state of emergency which was extended further on April 15, 2020. These declarations have led to a series of actions at the society level and health care system level designed to slow the spread of COVID-19 and bend the epi-curve in the province while concurrently preparing and enabling the health care system to respond effectively to the pandemic.



As the BC Health Care System responds to the pandemic, the unique and varied needs of communities across the province are evident. It is important to acknowledge that the challenges revealed as rural, remote, First Nations, and Metis communities respond to the pandemic are longstanding and have an ongoing impact on the quality of care and access to services experienced in these rural, remote and isolated communities.

In advance of a formalized provincial strategy for rural and remote areas, the Rural Coordination Centre of BC (RCCbc) led a process that seeks to surface and co-create innovative solutions to these challenges by bringing together policy makers, educators,

[1] Rural and remote communities encompasses Métis Chartered Communities as well as First Nations, Métis and Inuit peoples living away from home.

health care administrators, researchers and health professionals/service providers. The areas of focus for this partnered work includes:

- Co-creating culturally safe and humble primary health care
- Designing, planning for, and implementing team-based care
- Increasing citizen and community involvement in health care transformation processes
- Improving access and transitions for patients in rural and remote communities with a focus on virtually enhanced care and patient transport.

On April 20th, 2020 the Premier announced the Provincial Rural and Remote COVID-19 Response Framework, a collaborative framework that will provide a permanent and necessary operational framework to better meet urgent and emergent health needs of First Nations and rural and remote communities in BC. The Framework will support people living in rural, remote, and Indigenous communities in BC to have access to critical health care during the COVID-19 pandemic and into the future.
Developed in partnership by First Nations Health Authority (FNHA), Northern Health (NH), and Provincial Health Services Authority (PHSA), the Framework will complement and add to the work underway by RCCbc.

The Framework is a guide for partners to develop the elements necessary to plan and deliver testing services, clinical pathways, patient transport, and other tools in response to the COVID-19 pandemic. Changes that people living in rural, remote, and Indigenous communities will be able to expect include:

- improved medical transportation options to larger centres, including flight and ambulance;
- housing options for people looking to self-isolate near their families while remaining in their home communities;
- new and faster COVID-19 testing technology;
- culturally safe contact tracing that respects privacy in small communities;
- access to Virtual Doctor of the Day; and
- early referral and transport options that will support them being nearer to acute and critical care services, should they so choose.

The Framework is designed to be flexible to ensure local leadership determines how these services and processes will operate in their respective communities. All partners, including local leadership, will work collaboratively to facilitate the necessary and safe deployment of deliverables to meet the diverse population needs. To that end, Northern Health along with the First Nations Health Authority, First Nations communities and local rural and remote leadership developed a Rural and Remote and First Nations Communities COVID-19 Response Framework specific to northern BC.

2.0 NORTHERN BC RURAL AND REMOTE AND FIRST NATIONS COMMUNITIES COVID-19 RESPONSE FRAMEWORK

2.1 Purpose

The purpose of this Northern Response Framework is to provide a guide for Northern Health, northern Municipalities and regional districts, northern First Nations and First Nations Health Authority northern region, Northern Health Emergency Management, BC Emergency Health Services, communities, program administrators, service providers, and policy makers to address the care management needs related to COVID-19 of British Columbians residing in rural and remote British Columbia. The intent is to provide a framework that will support an iterative engagement process between the partners to develop processes and service pathways that help individuals and communities within the specific context of their community and regional network of services. Through the engagement process the partners will gain an understanding of the community and regional context in order to design a response that takes into account the specific community assets and risks that impact health and wellness, particularly in relation to the COVID-19 pandemic.

This document outlines a framework for attending to these challenges in the current pandemic situation. The Framework includes:

- Overarching guiding principles
- Definition/description of rural, remote and First Nations geographies
- Guiding Documents and Planning Tools
  - Understanding the Community Context: A Planning Tool
  - Clinical Pathways
  - Supporting Informed Community and Individual Choices: Guiding Documents
    - Guided Conversation to Support Individual Choice
    - Self-isolation and Cohort Planning Framework
  - Supporting Choice: Transportation Pathways

2.2 Definitions

There is no a single definition of rural or remote. For the purposes of this document **rural** is defined as outlined in the table below which is excerpted from the Northern Health Service Distribution Framework Discussion Report (2017).

Community Profile	Communities	Level of Care
Urban	Prince George	Level 5 Regional Hospital
Rural Centre Large Referral Base	Quesnel, Prince Rupert, Fort St. John, Dawson Creek, Terrace	Level 4 Hospital With Limited Specialty Services
Rural Centre Smaller Referral Base	Vanderhoof, Smithers, Fort Nelson, Kitimat, Hazelton	Level 3 Small Community Hospital

Small Rural Centre	Mackenzie, Fort St. James, McBride, Chetwynd, Massett, Queen Charlotte City, Burns Lake	Level 2 Small Hospital With Capacity for Stable Patients
Rural Community: Less Isolated More Isolated	Fraser Lake, Hudson Hope, Houston Stewart, Dease Lake, Granisle, Atlin, Southside, Valemount, Tumbler Ridge	Level 1 Community Health Centre
Catchment Community		Communities with insufficient critical mass to sustain base services locally. Needs are addressed through natural "consumer" flow patterns and transportation

2.3 Principles

The overarching principles underpinning this framework are consistent with the pandemic response public health measures and take into account the unique realities and context of rural and remote communities. These principles influence both the public health and care management response to COVID-19 and include:

- Evidence-informed decision making – guides decision making based on the best available evidence
- Informed Choice – dialogue that supports informed decision making and choice by individuals or communities
- Flexibility – ensures timeliness and relevance to the community context
- Collaboration – promotes all levels of government and organizations to work together to support the health and well-being of communities and their membership
- Geography – influences decisions critical to clinical and transportation pathways
- Community Networks – recognizes the interconnectedness of rural and remote communities amongst themselves and with other communities
- Local contexts – influence the relevance and effectiveness of specific public health measures
- First Nations rights and entitlement - are recognized and supported
- Culturally safe and respectful – implementation of policies, programs and services
- Collaborative dialogue – occurs between partners in order to maintain clarity of action and sustained relationships

2.4 Assumptions

The assumptions underlying planning for rural, remote and First Nations communities includes recognizing that:

- There will be geographic variability in the intensity and timing of the pandemic.

- There is great diversity in community infrastructure and capacity to address the impacts of the pandemic on communities and its members.
- The impact of the pandemic will differ across community and with some individuals affected more than others.
- The well-being of communities, including individual mental wellness will be affected socially, and economically.
- There is a wide range of opportunities to care for people in community and, if people are confident in their ability to self-isolate and receive care in their community, this will affect their decision to stay or leave community.
- Ensuring appropriate supports and care for people in community will enable the community members to make informed choices regarding their care and when they may choose to leave the community.
- First Nations have distinct historical and contemporary realities that differ from those of non-First Nations British Columbians.

3.0 RURAL AND REMOTE CONTEXT IN BC

A strong sense of place characterizes rural and remote British Columbia and impacts the way in which health care providers carry out their work. The nature of rural service delivery requires partnerships across multiple sectors, innovation and creativity to meet the needs of both communities and the individuals who live in these communities. (BC Ministry of Health, 2015)

3.1 Geography

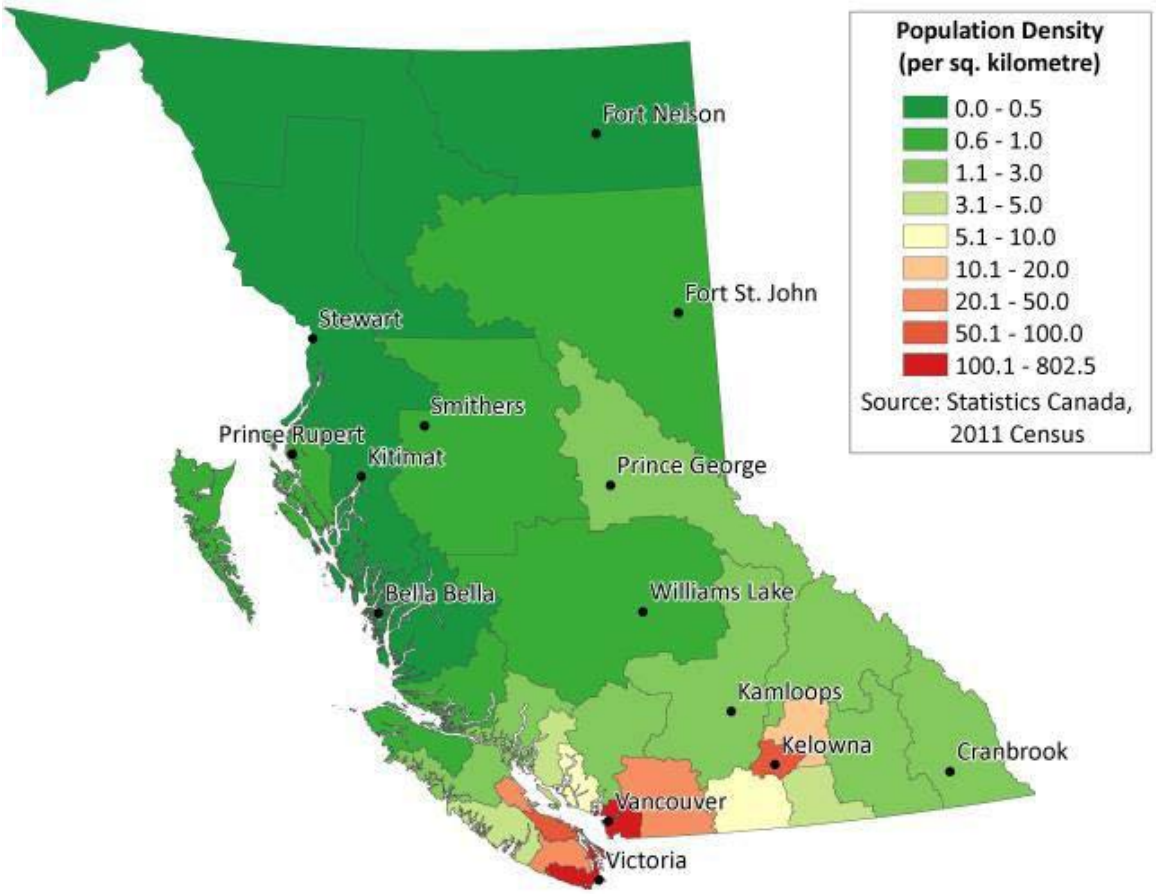
The geography of rural and remote communities in British Columbia is characterized by variation and difference. Almost 95% of British Columbia's land base is rural. The land is home to diverse cultures and rich with natural resources. Rural British Columbia supports the economy through agriculture, mining, forestry, energy development, and tourism. (BC Ministry of Health, 2015)

3.2 Population

The populations of rural British Columbia are often small, dispersed, and fluctuating. Many areas of the province have less than five people per square kilometer (BC Ministry of Health, 2015).

The map below provides population density per square kilometer depicting the rural nature of British Columbia.

Figure 1: British Columbia Population per Square Kilometer

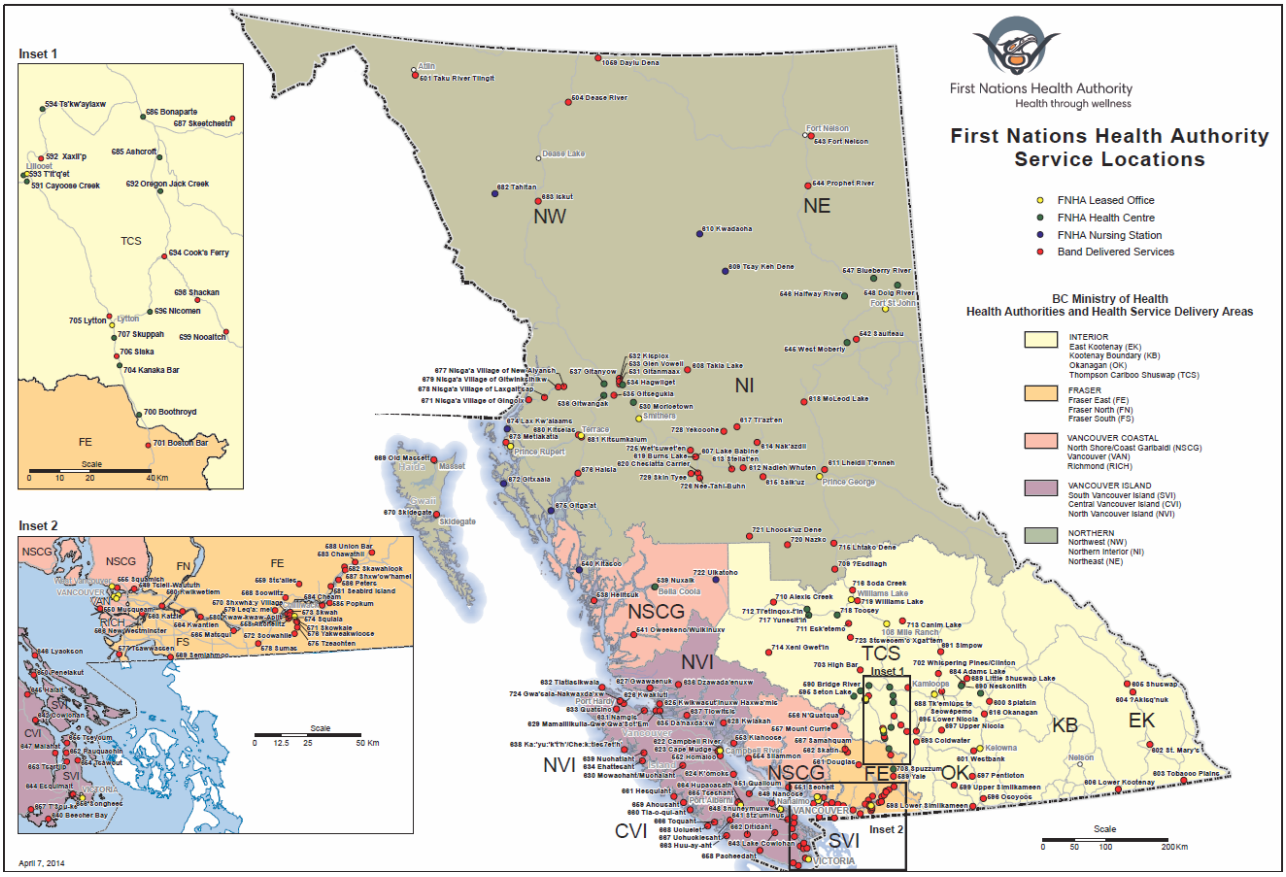


3.3 Rural and Remote Communities

The list of rural and remote communities outlined in the Northern Health Service Distribution Framework by Community (see Appendix A1).

3.4 First Nations

First Nations peoples comprise approximately 200,000 people in British Columbia. There are 198 distinct First Nations in B.C., each with their own unique traditions and history. More than 30 different First Nation languages and close to 60 dialects are spoken in the province (Retrieved April 15, 2020, https://www.welcomebc.ca/Choose-B-C/Explore-British-Columbia/B-C-First-Nations-Indigenous-People).



The First Nations Health Authority (FNHA) is the first province-wide health authority focused on First Nations in Canada. On October 13, 2011, First Nations in BC, the Province of British Columbia and the Government of Canada signed the British Columbia Tripartite Framework Agreement on First Nation Health Governance (cite: https://www.fnha.ca/Documents/framework-accord-cadre.pdf)

FNHA works to transform the way health care is delivered to First Nations through direct services, provincial partnership and collaboration, and health systems innovation, including ensuring that cultural safety and humility and intergenerational trauma informed care are embedded throughout the health system. FNHA collaborates with the federal and provincial governments, regional Health Authorities and other system partners to coordinate and integrate health programs and services to achieve better health outcomes for First Nations in BC.

Additionally, FNHA is responsible for planning, management, service delivery and funding of health programs and services, in partnership with First Nations communities in BC. These services are largely focused on health promotion and disease prevention, and include:

- Primary Health Care
- Children, Youth and Maternal Health
- Mental Health and Wellness
- Communicable Disease Control

- Environmental Health and Research
- First Nations Health Benefits (Non-Insured Health Benefits)
- eHealth and Telehealth
- Health and Wellness Planning
- Health Infrastructure and Human Resources

FNHA is guided by its Seven Directives (cite: https://www.fnha.ca/about/fnha-overview/directives) and Shared Values (cite: http://www.fnha.ca/about/fnha-overview/vision-mission-and-values) and is committed to creating the space for First Nations and Indigenous communities to self-determine their path towards wellness and Nation rebuilding.

Community **isolation** for First Nations communities is considered a factor of remoteness. The table below identifies and defines those categorizations.

Zone 1 Non-isolated	Located within 50 km of the nearest service centre with year-round road access.
Zone 2 Semi-isolated	First Nation is located between 50 and 350 Km from the nearest service centre to which it has year-round road access
Zone 3 Isolated	First Nation is located over 350 Km from the nearest service centre to which it has year-round road access.
Zone 4 Remote isolated	First Nation has no year-round road access to a service centre and, as a result, experiences a higher cost of transportation.

See Appendix A2 for a list of First Nations Communities.

3.5 Métis Nation

The Métis Nation British Columbia (MNBC) represents almost 90,000 (Census, 2016) self-identified Métis peoples of whom 20,000 are registered Métis citizens. MNBC represents 38 Métis Chartered Communities located across the province (Retrieved April 16, 2020, https://www.mnbc.ca/about) See map below.

Métis Chartered Communities within Northern Health are:

- Métis Nation New Caledonia Society – Vanderhoof
- North Cariboo Métis Association – Quesnel
- Prince George Métis Community – Prince George
- Northwest BC Métis Association – Terrace
- Prince Rupert & District Métis Society – Prince Rupert
- Tri-River Métis Association – Smithers
- Ft St John Métis Society – Ft St John
- Moccasin Flat's Métis Society – Chetwynd
- North East Métis Association – Dawson Creek
- River of the Peace Métis Society – Hudson Hope

4.0 GUIDING DOCUMENTS AND PLANNING TOOLS

A series of guiding documents and planning tools have been developed to guide the dialogue necessary between Health Authority staff, service providers, physicians and nurse practitioners, and community leaders to enable informed pandemic response decisions for individuals and communities in the rural and remote community context. These tools and documents are designed to provide guidance to planning and preparation processes, are meant to be used to facilitate dialogue, and will need to be contextualized to the particular community circumstances. Outlined below are three sets of planning tools and guiding documents.

4.1 Understanding the Community Context: A Planning Tool

The purpose of the *Understanding the Community Context* planning tool is to increase the understanding of the current context of individual rural, remote and First Nations communities. Populating the template is best accomplished through a dialogue between the partners involved in the community level response planning and implementation as it is required. Many First Nations communities have developed pandemic plans where some of this information is already available.

The intention in validating and sharing of information between the partners is to facilitate increased understanding of community assets and potential areas of risk facing communities. Hence, the objectives in discussing and completing this planning tool are twofold:

- To collate and validate information about the assets in a community that will contribute to the design of a pandemic response that can be implemented given the community context.
- To enable preplanning between the organizations and services partnering in the pandemic response with the community.

Two variations of the tool are provided. The first is a generic tool applicable to any rural or remote communities and the second provides a more specific set of elements for First Nations communities.

See Appendix B1 for Rural and Remote Communities.
See Appendix B2 for First Nations Communities.

4.2 Clinical Pathways

The purpose of describing clinical pathways is to provide the clinical care team with decision-making guidance as they support individuals who are identified with symptoms consistent with COVID-19. Members of the clinical care team involved in supporting a rural, remote or First Nations community during the COVID-19 response are advised to work through clinical pathways specific to their situation.

The clinical care team will vary dependent on the community context. In some situations, the clinical care team may be present in the community through the services of a nursing station, a community health centre, a diagnostic and treatment centre, or a primary care clinic. In more remote and isolated communities, members of the clinical care team may be itinerant or services may be provided through virtual means. The clinical care team, whether virtual or physically present in the community, may consist of a primary care physician, nurse practitioner, community health nurse/primary care nurse, a community health representative, community paramedic, or other First Responders present in some First Nations communities. In relation to the COVID-19 response, these local clinical care teams are supported by a public health team including the Medical Health Officer and nurses with expertise in communicable disease control, the BC Emergency Health Services patient transfer team, and the acute care specialized services team.

The sample clinical pathways include:

- Clinical pathways guiding decision making for an individual presenting with symptoms consistent with COVID-19. This pathway is targeted to the local clinical care team and/or primary care team.
- Clinical pathways outlining the guidance regarding testing decisions for the clinical care team and/or primary care team.

- Communication pathways between members of the clinical care team and the patient when a patient tests positive for COVID-19. This pathway is particularly important to work through where there are multiple organizations contributing to the clinical care team.
- Community supports identifies broad areas of supports in addition to the clinical supports individuals or groups may need.

The relationship between the clinical care team's response and the broader support network is particularly important to understand in rural and remote and First Nations communities. The clinical response is delivered by the clinical care team and is designed to be patient focused, attend to the individual's clinical care needs including contact tracing and is highly confidential. The broader support network is intended to ensure culturally safe social supports are in place and is focused on the safety and wellness of the individual and family as well as the community.

There are three additional support tools:
- Outpatient Management of Suspected and Confirmed COVID-19 Cases (BCCDC, April 14, 2020)
- Community Cohort Conversation Cue Card COVID-19 (Provincial Patient Transfer Services)
- FNHA/NH COVID-19 Response: Cue Cards for Frontline Providers

Two variations of the clinical pathways were developed. The first is a set of generic tool applicable to any rural or remote communities and the second provides a more specific set of pathways for First Nations communities.

See Appendices C 1-4 and C 9 for Rural and Remote Communities.
See Appendices C 5-11 for First Nations Communities.

4.3 Supporting Informed Community and Individual Choice: Guiding Documents

The purpose of processes that support informed community and individual choice is to enable the care team to work in partnership with the individual and their family in the context of the characteristics of their community and the transportation network. Understanding the context of the community and the clinical pathways available to the individual diagnosed with COVID-19 in a rural, remote, and First Nations community will enable the partners to put in place the infrastructure and supportive processes that enable an informed choice to be made. For example, these choices may include self-isolating at home, self-isolating elsewhere in the community, or self-isolating in a community closer to an acute care hospital or critical care unit with the relevant and appropriate social, physical, and clinical supports in place.

Specifically*, the Self-isolation and Cohort Planning Frameworks*, one for rural and remote communities and one for First Nations communities, are aimed at providing a guide for Northern Health, First Nations Health Authority, northern BC municipalities and regional districts, Métis communities, patient transportation services, individual

communities, program administrators, service providers, and policy makers to address the management of care needs related to COVID-19 in northern, rural and remote and First Nations communities. The Frameworks are intended to support partnerships and engagement that will develop processes and service pathways from within the context of their community's and regional network of services.

4.3.1 Self-Isolation: Considerations for Supporting Individual and Community Choice

Advance planning of the processes and infrastructure necessary to support individual and community choices is guided by the following principles:

- Supporting self-isolation: identifying and creating appropriate spaces and opportunities to self-isolate
- Destigmatizing the practice of self-isolating through education
- Approaches to self-isolate and receive care are appropriate, sustainable, and culturally safe
- Transparency regarding available options and supports
- Enhancing primary care services if needed. This may include bringing a health care team in to community (versus requiring people to leave to seek care)
- Increased access to diagnostics and testing
- Access to appropriate transportation and clinically appropriate response times to transfer people if they are sick
- Understanding and respecting people's wishes. Supporting advance directives and in-community palliation where this is desired
- Ensuring transition to the nearest community is culturally safe and opportunities to self-isolate are safe and supported with appropriate education and health monitoring.
- Awareness that being placed outside of one's community and away from one's established supports can pose hazard and risk to a person.

4.3.2 Supporting Community Cohort Centres

The partners may choose to establish Community Cohort Centres to enable individuals to choose to relocate to a centre in closer proximity to an acute care hospital or critical care unit. The decision to establish Community Cohort Centres should be made based on the community and regional context in dialogue between the partners. If a Community Cohort Centre is to be established the logistics and clinical and social supports must be planned in advance. Considerations in developing a Community Cohort Centre are:

- Acceptable to the person and culturally safe
- Strength based, trauma informed and seek to reduce harm
- Offered as close to home as possible
- Achieved through partnership to provide safe accommodation, housekeeping and food services.
- Supporting appropriate self-isolation practices
- Preserving important relationships, connection and a sense of community
- Holistic and wellness oriented

- Responsive to health and wellness care needs
- Facilitating voluntary participation
- Regularly reviewed for evidence-based effectiveness

4.3.3 Transportation Plan

Transportation services to a Cohort Centre or other similar option need to be pre-determined should the individual choose to self-isolate away from the community. The partners will need to establish a transportation plan to support an individual's right to informed choice as to whether they wish to receive care in their community or to leave and seek care elsewhere. The transportation plan may include personal vehicle, NH transportation support, water transport, community based transportation options for low acuity or asymptomatic, vulnerable individuals.

Higher acuity patient transport will occur through the algorithms established by BC Emergency Health Services. Northern Health and community partners need to finalize regional specific transfer algorithms, transport referral pathways and risk stratification algorithm.

5.0 ASSESSMENT AND EVALUATION

Given the evolving nature of a pandemic it is important to recognize the need for flexibility to take into account conditions of fluidity and uncertainty. An evaluation strategy may include the following areas:

- Type and degree of public health measures implemented
- Differences in approaches to implementation of public health measures within and between communities and health authorities
- Resource availability
- Impact of pandemic on provision of public health and other health services
- Unintended consequences of public health measures and the effectiveness of strategies to mitigate them, including impact on community living settings such as long term care homes, group home and First Nations communities
- Information gaps
- Partnerships and collaborations

These activities will be more successful if there are coordinated and collaborative efforts to ensure partners and or sites to examine specific issues.

For questions or more information, contact Northern Health Pandemic Response (PandemicResponse@northernhealth.ca)

Appendix A1: Northern Health Service Distribution Framework by Community

Community Profile	Communities	Level of Care
Urban	Prince George	Level 5 Regional Hospital
Rural Centre Large Referral Base	Quesnel, Prince Rupert, Fort St. John, Dawson Creek, Terrace	Level 4 Hospital With Limited Specialty Services
Rural Centre Smaller Referral Base	Vanderhoof, Smithers, Fort Nelson, Kitimat, Hazelton	Level 3 Small Community Hospital
Small Rural Centre	Mackenzie, Fort St. James, McBride, Chetwynd, Massett, Queen Charlotte City, Burns Lake	Level 2 Small Hospital With Capacity for Stable Patients
Rural Community: Less Isolated More Isolated	 Fraser Lake, Hudson Hope, Houston Stewart, Dease Lake, Granisle, Atlin, Southside, Valemount, Tumbler Ridge	 Level 1 Community Health Centre
Catchment Community		Communities with insufficient critical mass to sustain base services locally. Needs are addressed through natural “consumer” flow patterns and transportation

Appendix A2: List of Northern BC First Nations Communities

Northeast	**North Cetral**	**Northwest**
- Blueberry River First Nations - Doig River First Nations - Fort Nelson First Nations - Halfway River First Nations - Saulteau First Nations - Tsaa Tse K'Nai First Nations (Prophet River First Nations - West Moberly Lake First Nations	- Burns Lake Band - Cheslatta Carrier Nations - Kwadacha Nations - Lake Babine Nations 1. Old Fort 2. Fort Babine 3. Tachet 4. Woyenne 5. Pinkut Lake/ Donalds Landing - Lheidli T'enneh - McLeod Lake - Nadleh Whuten - Nak'azdli Band - Nasko - Nee-Tahi-Buhn Band - Saik'uz First Nations - Skin Tyee Nations - Stellat'en First Nations - Takla Lake First Nations - Tl'azt'en Nations 1. Tache 2. Binche 3. Dzitl'ainli 4. K'uzche - Tsay Keh Dene - Wet'suwet'en First Nations - Yekooche **Belong to an Interior Regional Hub:** - ?Esdilagh Indian Band - Lhoosk'uz Dene Government (Kluskus) - Lhatko Dene	- Daylu Dena Council - Dease River First Nation - Gingolx - Gitanmaax - Gitanyow - Gitga'at Nation - Gitlaxt'aamiks - Gitsegukla - Gitwangak - Gitwinksihlkw - Gitxaala Nation - Hagwilget Village - Haisla Nation - Iskut - Kispiox - Kitselas Band Council - Kitsumkalum Band - Laxgalt'sap - Lax Kw'alaams First Nations - Metlakatla Indian Band - Moricetown - Old Massett Village Council - Sik-e-dakh Village - Skidegate Band - Tahltan Nation 1. Dease Lake Band - Taku River Tlingit First Nation

Appendix B1: Community Planning Tool – Rural and Remote Communities

This package contains draft COVID-19 Community Profile information. This document has the following purpose:

- Support the ability of the medical system to respond to a positive case of COVID-19 in an efficient and organized manner.
- Prepare critical information in one location that can be added to your pandemic plan (if relevant to your community).
- Validate community information to ensure accuracy.
- Facilitate secure information sharing to prevent duplication.

The confidentiality of your community information is critical. This information is for clinical use only to support planning and response efforts. It is NOT intended for public release. We expect that there will be errors in this information and invite you to join us in ensuring that they information is as accurate as possible. We are committed to work with you as true partners in health and wellness.

COMMUNITY PLANNING TOOL: RURAL AND REMOTE COMMUNITIES	
Community	
Incident Commander	
Health Centre Fax	
Primary Care Team/Provider	
PCT contact:	
Nearest Level 4	
Distance- Level 4 (time/method)	
Nearest 'Urban' Centre	
Distance- Urban Centre (time/method)	
Accessible by Air?	
Transportation Plan? (Y or N)	
PPE Status for Escorts/Responders	
Population	
Self-Isolating Capacity:	
Do you have cohort facilities or options? (separate location for COVID-19 Patients)	
List cohort facilities	
How many people can it accommodate?	
First responders/paramedics in community?	
Other- Virtual Care (# & FTE)	
Pandemic/CD Plan (Y/N)	
Community Testing Capacity & Ability (Y/N)	
Frail and vulnerable Individuals (Y/N) (those of advanced age, and or complex chronic disease)	

Appendix B2: Community Planning Tool – First Nations Communities

NOTICE TO COMMUNITY HEALTH LEADS
Northern Health and the First Nations Health Authority are committed to supporting Northern First Nations communities during the COVID-19 Pandemic. We are working hard to ensure that systems are in place in the event there is a positive case within your community. This package contains DRAFT COVID-19 Community Profile information. This document has a guiding principle of choice for community members & community.

- Support the ability of the medical system to respond to a positive case of COVID-19 in an efficient and organized manner.
- Prepare critical information in one location that can be added to your community pandemic plan.
- Validate community information to ensure accuracy.
- Facilitate secure information sharing to prevent duplication.

The confidentiality of your community information is critical. This information is for clinical use only to support planning and response efforts. It is NOT intended for public release. We expect that there will be errors and/or gaps in this information and invite you to join us in ensuring that the information is as accurate as possible. We are committed to work with you as true partners in health and wellness.

COMMUNITY PLANNING TOOL: FIRST NATIONS COMMUNITIES	
Community	
Health Director/Health Lead	
Primary Care Contact (MRP)	
Incident Commander	
FNHA Comm. Eng. Coordinator (CEC):	
Health Centre/Nursing Station Fax	
Primary Care Team/Provider	
PCT contact	
Nearest Level 4	
Distance- Level 4 (time/method)	
Nearest 'Urban' Centre	
Distance- Urban Centre (time/method)	
Accessible by Air?	
Transportation Plan? (Y or N)	
Local Medical Transportation Options – Health Benefits (all the ways you are currently moving people through FNHA Health Benefits)	
Secondary Medical Transportation Options – (local transportation options unique to your region such as resource company helicopter, ad hoc plane, coast guard etc.)	
PPE Status for Escorts/Responders	

Population	
Self-Isolating Capacity:	
Do you have cohort facilities or options? (separate location for COVID-19 Patients)	
List cohort facilities	
How many people can it accommodate?	
Current Health Care staff	
Regulated	
Non-regulated	
Other- Primary Care (insert # & FTE)	
First responders/paramedics (on reserve)	
Other- Virtual Care (# & FTE)	
Pandemic/CD Plan (Y/N)	
Clinical supplies:	
For FNHA's PPE Status Update- Contact	
Refer to PPE Tracking Tool	
Community Testing Capacity & Ability (Y/N)	
Frail and vulnerable Individuals (those of advanced age, and or complex chronic disease)	