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Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

Annual Report 2017-2018
NWT Health and Social Services System

Best *health* | Best *care* | Better *future*

Rapport annuel 2017-2018
du système des services de santé et des services sociaux des TNO

Le présent document contient un résumé en français

Une santé *optimale* | Des soins *optimaux* | Un avenir *prometteur*

OCTOBER | OCTOBRE 2018

Message from the Minister

I am pleased to present the Northwest Territories (NWT) Health and Social Services System Annual Report for the 2017-18 fiscal year. This report presents the 2nd year of reporting operations and progress under our strategic priorities as outlined in the *2017-2020 Health and Social Services System Strategic Plan* and highlights actions and progress towards our vision of Best Health, Best Care, for a Better Future. The 2017-18 fiscal year marked the first full year of the NWT Health and Social Services system operating post-integration of six regional health and social services authorities into the Northwest Territories Health and Social Services Authority (NTHSSA).

Consistent with other Canadian health systems, the NWT Health and Social Services system continues to experience expenditure growth, requiring a concerted effort and a focus on effective and efficient delivery of services.

In 2017-18, the Department spent $445.6 million; $283.6 million went directly to the Health and Social Services Authorities to administer and deliver programs and services. The Department's total expenditures increased $4.5 million over the prior year. The increase was due mainly to investments in long term care and homecare, as well as the increased costs associated with southern residential care. In addition, the Department spent over $110.5 million on capital infrastructure projects and $41.6 million to perform work on behalf of others. This resulted in a 2017-18 operating deficit of $10.1 million for the system. At March 31, 2018, the accumulated deficit for the system was $81.8 million.

Ensuring the ongoing sustainability of the health and social services system while continuing to provide equitable access that best meets the needs of our residents will require significant change to the way we currently do business. As the system absorbs the necessary changes that occurred in our organizational and governance structures, system-wide efficiencies will be realized. Through a focus on primary health care and upstream interventions we can begin to change the cost trajectory of our system. The efficiencies gained by our moving to a territorial model of service delivery will further support our strategic priority of being an effective and efficient system for years to come.

Accountability Statement

This Annual Report fulfills the obligation to report to the Legislative Assembly on the preceding year's operations and financial position of the Department of Health and Social Services. As Minister of Health and Social Services, I ensured that this Annual Report was prepared with respect to the implementation of the Territorial Plan. This report is used to review and analyze the progress of the health and social services system on financial activities and strategic areas of priority conducted in the 2017-18 fiscal year as part of the commitment of the Department of Health and Social Services to sustain and strengthen performance and accountability across operations and to ensure transparency on an ongoing basis. This report also meets the obligation to annually table a report on the operations of the Medical Care Plan.

Glen Abernethy
Minister of Health and Social Services

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Executive Summary

The NWT Health and Social Services System 2017-2018 Annual Report presents the second year of reporting progress on the 2017-2020 HSS System Strategic Plan: Caring for Our People. This Annual Report fulfills the obligation to report to the Legislative Assembly on the preceding year's operations and financial position of the Department of Health and Social Services (hereafter referred to as the Department), as outlined in the Government of the Northwest Territories Planning and Accountability Framework and in accordance with the *Financial Administration Act*. As per the *NWT Hospital Insurance and Health and Social Services Administration Act*, the Minister of Health and Social Services prepared this Annual Report with respect to the implementation of the Territorial Plan. This report also meets the obligation to annually table a report on the operations of the Medical Care Plan.

Strategic Priorities

The Department and the Authorities continued to implement the ten year Right from the Start Framework in a joint effort with the Department of Education, Culture and Employment to achieve better outcomes for children aged 0-5 and their families.

Over the 2017-18, initiatives were taken to foster healthy families including audits of regional offices with an eye to provide learning opportunities to meet our goal of not only maintaining but also improving the quality of services provided.

As part of *Mind and Spirit: Promoting Mental Health and Addictions Recovery Strategic Framework 2016-2021*, the Department released an action plan in fall 2017 on Child and Youth Mental Wellness, and is currently developing a final action plan on Mental Health and Addictions Recovery. In line with our commitment to provide effective mental health and addictions services, the following ongoing services were provided: community counselling program, facility based addiction treatment, on the land healing, and suicide awareness and prevention.

Other significant areas of work carried out were aimed at reducing the burden of chronic disease and promoting healthy lifestyles. Initiatives included: an increased focus on encouraging cancer screening through education and promotion; promoting breastfeeding and discouraging pop consumption; and community health fairs that help to share health and wellness ideas.

Actions were taken so that seniors can age in place, such as increasing the home care workforce by 11 positions, as well as working to expand palliative care services.

Consistent with other Canadian health systems, the NWT health and social services system continues to experience significant expenditure growth, requiring a concerted effort and a focus on effective and efficient delivery of services.

Financial Highlights

In 2017-18, the Department spent $445.6 million; $283.6 million went directly to the Health and Social Services Authorities to administer and deliver programs and services. The Department's total expenditures increased $4.5 million over the prior year. The increase was due mainly to investments in long term care and homecare as well as the increased costs associated with southern residential care. In addition, the Department spent over $110.5 million on capital infrastructure projects and $41.6 million to perform work on behalf of others. This resulted in a 2017-18 operating deficit of $10.1 million for the system. At March 31, 2018, the accumulated deficit for the system was $81.8 million.

Performance Measures

Public reporting on the performance of the NWT Health and Social Services system is a key part of fulfilling the Government of the Northwest Territories' commitment to improving accountability and transparency in an environment of growing expenditures and limited resources.

Some positive long term trends include: decreases in rates of potentially avoidable mortality due to preventable causes, as well as those due to treatable causes; an increase in the screening rate for colorectal cancer; a decrease in the proportion of visits to the emergency department that were non-urgent; a decrease in the proportion of mental health hospitalizations due to alcohol or drugs; and, an increase in the percentage of child welfare placements in the child's home community.

Résumé

Le rapport annuel 2017-2018 du système des services de santé et des services sociaux des TNO résume les progrès réalisés au cours de la deuxième année de mise en œuvre du plan stratégique 2017 à 2020 intitulé « Votre bien-être, notre priorité ». Ce rapport remplit l'obligation de rendre compte devant l'Assemblée législative des activités et de la situation financière du ministère de la Santé et des Services sociaux (le Ministère) pour l'exercice écoulé, conformément au cadre de planification et de responsabilisation du GTNO et à la Loi sur la gestion des finances publiques. Le présent rapport annuel a été préparé par le ministre de la Santé et des Services sociaux en vertu de la *Loi sur l'assurance-hospitalisation et l'administration des services de santé et des services sociaux*. Il répond également à l'obligation de déposer annuellement un rapport sur les activités du régime d'assurance-maladie.

Priorités stratégiques

Le Ministère et les administrations ont poursuivi la mise en œuvre du cadre décennal « Partir du bon pied » en collaboration avec le ministère de l'Éducation, de la Culture et de la Formation pour améliorer la situation des enfants de 0 à 5 ans et de leurs familles.

Au cours de l'exercice 2017 2018, différentes initiatives ont vu le jour pour favoriser la santé des familles, notamment l'audit des bureaux régionaux afin de leur offrir des occasions de formation pour atteindre notre objectif, qui est non seulement de maintenir, mais aussi d'améliorer la qualité des services que nous assurons.

Pour respecter le cadre stratégique 2016 à 2021 intitulé « Tête et esprit : Encourager le rétablissement de la santé mentale et la lutte contre les dépendances aux Territoires du Nord-Ouest », le Ministère a publié, à l'automne 2017, un plan d'action sur la santé mentale des enfants et des jeunes et élabore actuellement le plan d'action final sur le rétablissement de la santé mentale et la lutte contre les dépendances. Pour faire suite à notre engagement de fournir des services de santé mentale et de traitement des dépendances efficaces, nous avons offert les services continus suivants : programme de counseling communautaire; traitement des dépendances en établissement; guérison dans la nature; sensibilisation au suicide et prévention.

D'autres efforts considérables ont été déployés pour réduire le fardeau des maladies chroniques et promouvoir les modes de vie sains. Voici quelques-unes des initiatives prises dans ce domaine : encourager le dépistage du cancer par l'éducation et la promotion; encourager l'allaitement; déconseiller la consommation de boissons gazeuses; organiser des salons sur la santé communautaire pour faire connaître différentes idées favorisant la santé et le bien-être.

Des mesures ont été mises en place pour que les personnes âgées puissent vieillir chez elles, par exemple en créant 11 emplois dans le secteur des soins à domicile, ainsi qu'en travaillant à élargir les services de soins palliatifs.

À l'instar d'autres systèmes de santé et de services sociaux canadiens, le système ténois continue d'enregistrer une augmentation considérable des dépenses. Nous devons donc concerter nos efforts et nous concentrer sur une prestation efficace des services.

Finances : faits saillants

En 2017-2018, le Ministère a dépensé 445,6 millions de dollars. De ce total, 283,6 M$ sont allés directement aux ASSSS pour l'administration et la prestation de services et de programmes régionaux et territoriaux. Les dépenses totales du Ministère ont augmenté de 4,5 M$ par rapport à l'exercice précédent. Cette augmentation s'explique principalement par des investissements dans les soins de longue durée et les soins à domicile, ainsi qu'une augmentation des coûts associés au recours à des établissements de soins dans le Sud. De plus, le Ministère a dépensé plus de 110,5 M$ sur des projets d'infrastructures et 41,6 M$ pour accomplir du travail en sous-traitance. Il en a résulté un déficit d'exploitation de 10,1 M$ pour le système en 2017-2018. Au 31 mars 2018, le déficit accumulé s'élevait à 81,8 M$.

Mesures de rendement

La publication de rapports publics sur le rendement du système de santé et de services sociaux est un élément clé dans la réalisation de l'engagement du gouvernement des Territoires du Nord-Ouest à améliorer la responsabilisation et la transparence dans un contexte de dépenses croissantes et de ressources limitées.

Parmi les tendances positives à long terme, mentionnons : la diminution de la mortalité attribuable à des causes évitables ou traitables; l'augmentation des taux de dépistage du cancer colorectal; la diminution du pourcentage de visites aux urgences pour des causes non urgentes; la diminution de la proportion d'hospitalisations en santé mentale attribuables à l'alcool ou aux drogues; l'augmentation du pourcentage de placements en protection de l'enfance dans la communauté d'appartenance de l'enfant.

Introduction

The purpose of this Annual Report is to provide an overview of the performance of the NWT health and social services system (HSS). This Annual Report does not intend to comprehensively outline the operations of each Authority. Details on the operations of each Authority can be found in their individual Annual Reports.

This Annual Report fulfills the obligation to report to the Legislative Assembly on the preceding year's operations and financial position of the Department, report on the operations of the Medical Care Plan, and report on significant strategies and initiatives under departmental action plans. This Annual Report is also used to review and analyze the progress of the health and social services system on strategic areas of priority, financial activities, and performance measures for the 2017-18 fiscal year.

The NWT, like other Canadian jurisdictions, is taking a proactive approach to improving accountability for the delivery of publicly funded health and social services. The NWT HSS budget makes up 25 per cent of the overall Government of the NWT's budget. Decision makers and the public want to know if HSS funding is being spent effectively, how the system is performing relative to its peers, and if it is achieving its intended outcomes.

Public reporting on the performance of the NWT HSS system is a key part of fulfilling the GNWT's commitment to improving accountability and transparency in an environment of growing expenditures and limited resources.

Structure of Our System

On August 1, 2016, six regional Health and Social Services Authorities were consolidated into the Northwest Territories Health and Social Services Authority (NTHSSA). The Hay River Health and Social Services Authority (HRHSSA) remain outside of the NTHSSA, as does the Tłı̨chǫ Community Services Agency (TCSA) as per the terms of the Tłı̨chǫ Land Claims and Self-Government Agreement.

The NTHSSA, HRHSSA, and TCSA, collectively referred to as the Authorities, are one integrated territorial health and social services system, functioning under a one-system-approach and under a single governance structure.

[1]Based on 2017-2018 Revised Estimates. Government of the Northwest Territories, *Main Estimates 2018-2019*, p. ix.

What We Do

The role of the Department is to support the Minister of Health and Social Services in carrying out the Government of the NWT's mandate by: setting the strategic direction for the system through the development of legislation, policy and standards; establishing approved programs and services; establishing and monitoring of system budgets and expenditures; and evaluating and reporting on system outcomes and performance. The Department remains responsible for ensuring that all statutory functions and requirements are fulfilled, ensuring professionals are appropriately licensed and managing access to health insurance and vital statistics services.

The Authorities are agencies of the GNWT governed by the Northwest Territories Leadership Council. Regional Wellness Councils provide advice to the Leadership Council and valuable input on the needs and priorities of the residents in their regions. The Territorial Leadership Council is responsible to the Minister of Health and Social Services for governing, managing and providing the following health and social services in accordance with the plan set out by the Minister:

- Diagnostic and curative services;
- Mental health and addictions services;
- Promotion and prevention services;
- Long term care, supported living, palliative care and home and community care;
- Child and family services;
- In-patient services;
- Critical care services;
- Diagnostic and therapeutic services;
- Rehabilitation services; and,
- Specialist services.

More specialized diagnostic and treatment services are accessed outside of the NWT through contractual arrangements with Alberta Health Services.

In addition, the Department is responsible for providing access to facility based addictions treatment services outside of the NWT, and holds contracts with four southern facilities, located in Alberta and British Columbia, to provide specialized treatment to residents of the NWT.

Non-governmental organizations (NGOs), and community and Indigenous governments, also play a key role in the delivery of promotion, prevention and community wellness activities and services. The Department and the Authorities fund NGOs for activities such as:

- Prevention, assessment, early intervention, and counselling and treatment services related to mental health and addictions;
- Early childhood development;
- Family violence shelters and awareness;
- Long term care;
- Dementia care;
- Tobacco cessation;
- In-home and in-facility respite services for caregivers of seniors or children and adults with special needs; and
- Health promotion activities.

Vision

Best Health, Best Care, for a Better Future

Our Mission

Through partnerships, provide equitable access to quality care and services and encourage our people to make healthy choices to keep individuals, families and communities healthy and strong.

Our Values

Caring

We treat everyone with compassion, respect, fairness and dignity, and we value diversity.

Accountable

System outcomes are measured, assessed and publicly reported on.

Relationships

We work in collaboration with all of our residents, including Indigenous governments, individuals, families and communities.

Excellence

We pursue continuous quality improvement through innovation, integration and evidence based practice.

Our Strategic Priorities

As outlined in the *2017-2020 Health and Social Services System Strategic Plan: Caring for Our People*, the high level objectives of the HSS system are represented through the following strategic priorities: Early Childhood and Development, Child and Family Services, Mental Health and Addictions, Chronic Disease, Seniors and Elders, and System Sustainability. This Annual Report allows for reporting on the activities carried out under the Strategic Plan

Reporting Progress on our Strategic Priorities

PRIORITY 1: EARLY CHILDHOOD DEVELOPMENT

The following activities occurred in support of the Priorities of the 18th Legislative Assembly, namely "Supporting quality early childhood development in collaboration with existing organizations".

EARLY CHILDHOOD DEVELOPMENT ACTION PLAN

The Department and the Authorities continued to implement the ten year *Right from the Start Framework* in a joint effort with the Department of Education, Culture and Employment to achieve better outcomes for children aged 0-5 and their families. The action plan supports equitable access to a continuum of inclusive, culturally relevant early childhood programs and services for children, parents, families and communities.

Work continued to improve outreach, promotion, and education in the areas of pregnancy, breastfeeding, parenting, and mental health to support families in all regions of the NWT.

Initiatives included:

- Continuing to offer midwifery services in Hay River and Fort Smith.
- Developing the NWT Midwifery Practice Framework to enhance access to birthing services and care.
- Working to achieve the Baby Friendly Initiative (BFI) designation across NWT facilities to promote, protect and support breastfeeding. This included piloting a BFI training package for all health care practitioners.
- Partnering with the Aurora Research Institute to identify barriers to breastfeeding in the NWT, and sharing Indigenous practices around infant feeding. This involved holding sharing circles and interviews in each region of the Northwest Territories.
- Supporting community organizations to establish peer support groups by developing a Breastfeeding Peer Support Volunteer Train the Trainer Program and facilitating four training sessions for mothers from across the NWT.
- Delivering the Healthy Family Program in 16 communities.
- Steps have also been taken to improve access to early childhood assessment, intervention and responses. Nine age-specific forms of the NWT Well Child Record were implemented and are being used to assess children ages 0-5. These forms were integrated into the Electronic Medical System last October.
- Continuing with year 2 of the Early Childhood Intervention Pilot projects in the Tłı̨chǫ, Beaufort Delta and Dehcho regions.
- Holding focus groups with parents and caregivers to help inform the development of a public awareness campaign on Early Childhood Development programs. The focus groups took place in five communities: Yellowknife, Behchokǫ̀, Fort Simpson, Inuvik, and Norman Wells. The focus groups helped identify information needs as well as the best ways to communicate about Early Childhood Development programs and services with parents and caregivers.

ORAL HEALTH STRATEGY

The Early Childhood development framework, Right from the Start, commits the government to improving oral health outcomes for children aged 0-5. The Oral Health Action Plan is being developed and that will bring oral health prevention services to people in their home communities and decrease the burden of oral disease through the NWT. A Senior Nursing Consultant, Oral Health was employed by the Department in February and March to further support the development of oral health initiatives. In addition, draft NWT Oral Health Program Standards have been developed by the Canadian Dental Hygienists Association and will be finalized in 2018-19.

PRIORITY 2: CHILD AND FAMILY SERVICES

BUILDING STRONGER FAMILIES

As part of the Mandate of the 18th Assembly, the Department continued the implementation of the Building Strong Families Action Plan to transform and enhance how child and family services are delivered across the NWT.

A key part of this transformation that took place in 2017-18 was the auditing of all regional offices. The purpose of the audits is to: improve the quality of services for children and families; improve accountability for service delivery; to inform child and family services professional development training; and, to identify the need for updating and/or amending the Child and Family Services Act and the Child and Family Services Standards and Procedures Manual. Regional audits extract and measure a point in time of child and family and foster care services information and provide a learning opportunity to review, maintain and/or enhance the delivery of quality services to children and families across the territory.

Central to the delivery of services for children and families is a strong information system. In 2017-18, a new improved information system, Matrix NT was launched. Matrix NT improves how regional and departmental staff manage, track and report on children and families receiving services by allowing for the electronic collection of Structured Decision Making (SDM®) Assessment Tools. SDM® is an evidence-based proprietary risk assessment, decision support and case management structure promoted by the Children's Research Center specifically for child protection services.

SERVICES FOR CHILDREN WITH DISABILITIES

The ECD Framework outlines actions to improve how we identify and support children with disabilities and developmental needs. The Department continued to provide a range of services for children with disabilities, including: Speech Language Pathology, Occupational Therapy, and Physiotherapy, available through regional rehabilitation teams; Audiology services available at the territorial level; and the Stanton Territorial Hospital Child Development Team and Fetal Alcohol Spectrum Disorder (FASD) Family and Community Support Program. The Department also continued to fund non-government organizations to provide a number of disability-related services. The Department's Out-of-Territory program continued to offer support services to aid in individuals with complex needs being met within the NWT. The Department hired an external contractor to assist with a Disability Program Review. The Department has also developed the *GNWT Programs and Services for Persons with Disabilities Inventory*. This inventory is available on the GNWT website.

PRIORITY 3: MENTAL HEALTH AND ADDICTIONS

The following activities occurred in support of the Priorities of the 18th Legislative Assembly, namely "Focusing on mental health and addictions by ensuring that services are delivered locally with culturally appropriate methods".

The Department is committed to providing effective mental health and addictions services in the NWT. Ongoing services include:

- Community Counselling Program;
- Facility Based Addictions Treatment Centres and Related Programs;
- On The Land Healing Programs; and,
- Suicide Awareness and Prevention.

COMMUNITY COUNSELLING PROGRAM

The Community Counselling Program offers free counselling and referral services to all NWT residents, including children and youth. It also provides individualized aftercare support for clients returning from addictions treatment. The Community Counselling Program served an average of 883 clients per month in 2017-18.

FACILITY BASED ADDICTIONS TREATMENT PROGRAMS AND RELATED SERVICES

The Department continues to offer facility based treatment addictions programs through the contracts it holds with four southern facilities. In 2017-18, over 200 people attended addictions treatment – with a completion rate of almost 74%.

The Department worked collaboratively with other GNWT Departments and community partners to address the needs of NWT residents who are impacted by homelessness and related issues. The Department received $750,000 in new funding in the 2017-18 budget. In July 2017, the DHSS partnered with the City of Yellowknife to open a temporary sobering centre location, in conjunction with a mobile outreach unit, based out of the Yellowknife Community Arena. While the temporary location closed September 2017, the Salvation Army housed the Sobering Centre until a permanent location could be readied. A permanent location for the Sobering Centre was identified and renovations are being made to prepare the new site for occupancy in September 2018.

Furthermore, as part of the *Mind and Spirit: Promoting Mental Health and Addictions Recovery Strategic Framework 2016-2021*, the Department released an action plan in fall 2017 on Child and Youth Mental Wellness, and is currently developing the final action plan on Mental Health and Addictions Recovery.

ON THE LAND HEALING PROGRAMS

The Department worked with Indigenous governments to deliver On the Land healing programs in support of the Mandate of the 18th Assembly that aims to enhance access to culturally-appropriate programs and services. This work is the Department's response to a recommendation made in the Healing Voices report (2013) from the Minister's Forum on Addictions and Community Wellness to adopt and increase the availability of culture based approaches to providing treatment and aftercare for people with addictions.

In 2017-18, the On the Land Healing Fund contributed $1 million to 12 regional and community programs: Inuvialuit Regional Corporation, Dehcho First Nations, NWT Métis Nation, Gwich'in Tribal Council, Acho Dene Koe First Nation, Salt River First Nation, Kátł'odeeche First Nation, Akaitcho Territorial Government, Délı̨nę Got'ı̨nę Government, Sahtú Dene Council, Tłı̨chǫ Government and K'asho Got'ine Charter Community. In support of the GNWT's commitment to community wellness, the Department committed to allocating a minimum of $200,000 annually to the NWT On the Land Collaborative Fund to provide easier access to funding and other resources for on-the-land initiatives.

SUICIDE AWARENESS AND PREVENTION

The Department has developed multiple crisis response and awareness campaigns surrounding suicide awareness and prevention, including:

- holding of Applied Suicide Intervention Skills Training ("ASIST") and Mental Health First Aid workshops in all regions, to reduce the stigma associated with suicide and increase awareness and skills at the community level; and,
- delivering of the Talking About Mental Illness (TAMI) program to grade 8 students in a number of NWT communities. The primary goal of TAMI is to reduce the stigma around mental illness so that youth are more likely to seek help for mental health related issues.

PRIORITY 4: CHRONIC DISEASE

The following activities occurred in support of the Priorities of the 18th Legislative Assembly in "Reducing the burden of chronic disease and promoting healthy lifestyles".

CANCER INITIATIVES

The most common cancer diagnoses among NWT males are colorectal, prostate and lung cancer. For NWT females, breast, colorectal and lung cancers are the most frequent diagnoses. The Let's Talk about Cancer campaign encourages learning and discussion about cancer prevention, screening, early detection, and support as a means to contribute to individual and community-level health and wellness. The Department is currently developing resources to inform NWT residents about cancer screening, care and support services, as well as risk factors that can be reduced through healthy lifestyles. In 2017, we developed a series of videos on cancer screening, diagnosis, and treatment that are aimed at helping individuals make healthier lifestyle choices. From September 2017 to March 2018, a series of radio jingles related to colorectal cancer screening were launched territory-wide. In addition, the Department created a video and digital/print media campaign with Francois Rossouw to promote colorectal cancer screening.

Other activities included:

- on World Cancer Day, public awareness materials related to cancer were distributed by the community health representatives;
- the NTHSSA's *Navigating your Cancer Journey: A Resource for Cancer Patients in the Northwest Territories* was sent out to all frontline healthcare providers, hospitals and community health centres;
- a large inflatable Giant Colon was used in regional centres, Yellowknife and small communities to emphasize the importance of colorectal cancer screening;
- the Department has collaborated with the K'asho Got'ine Charter Community, the Tulita Dene Band, and the Goba Group to develop a glossary of approximately 50 cancer terms in North Slavey dialects to help improve understanding about the disease, prevention, and treatment;
- a multi-disciplinary team from Alberta Health Services visited Yellowknife in November 2017 to review Stanton's chemotherapy program. Formal recommendations from the review were implemented; and,
- a new Territorial Specialist in Cancer Care position was created in the NTHSSA.

DIABETES INITIATIVES

About 200 new cases of diabetes are diagnosed each year in the NWT, with Type 2 diabetes comprising the majority of cases. In the NWT, non-Indigenous males have the highest rate of diabetes, while non-Indigenous females have the lowest rate. Indigenous females have a higher rate of diabetes than Indigenous males. In 2017-18, the Department continued to approach diabetes through surveillance, prevention, screening and monitoring. This was facilitated by several initiatives, such as breast feeding and baby-friendly initiatives that focus on reducing obesity and diabetes through healthy infant feeding and the annual Drop the Pop campaign that aims to reduce drinking sugary beverages.

Diabetes analytics using the Electronic Medical Record (EMR) first implemented in Yellowknife as a pilot project, in 2016, was expanded to other communities in order to ensure those diagnosed with diabetes are being monitored adequately.

COMMUNITY HEALTH FAIRS

From September 2017 to March 2018, Community Healthy Living Fairs (Fairs) were held in 18 Indigenous communities.

The primary goals of the Fairs are to raise awareness on healthy living, focus on community wellness, and expand health networks. This was the third year that these Fairs have been held throughout the territory. The Fairs are community driven with local champions making the decisions on who presents and what the areas of focus will be. GNWT Departments and agencies then provide support and information.

The Fairs are for the whole community with a focus on sharing health and wellness ideas, along with promotion of fitness, nutrition and traditional living.

Department staff attended these Fairs to share resources and raise awareness of chronic disease prevention and management through interactive engagement.

PRIORITY 5: SENIORS AND ELDERS

The following activities occurred in support of the Priorities of the 18th Legislative Assembly in "Taking action so that seniors can age in place".

CONTINUING CARE SERVICES ACTION PLAN

The *Continuing Care Services Action Plan* was released in September 2017. This Action Plan aims to address the relevant goals and commitments set forth by three guiding documents: the strategic framework *Our Elders: Our Communities*; the Department of Health and Social Services' strategic plan *Caring for Our People*; and the Mandate of the Government of the Northwest Territories – 2016-2019. Goals include: improve home and community care services; provide equitable access and high quality long term care; and enhance palliative care services.

HOME AND COMMUNITY CARE SERVICES

A well-resourced home and community care system is central to allow seniors to age in place. In 2017-18, we increased our homecare workforce by 11 positions in communities across the NWT through GNWT Home and Community Care funding. 2017-18 was the first year of a 10 year bilateral funding agreement, totaling $7.4 million to support home and community care services.

LONG TERM CARE SERVICES

Investments in our long term care (LTC) facilities system are important to keep up with the growing demand for LTC beds. In 2017-18 investments resulted in the grand opening of the 18-bed Jimmy Erasmus Seniors Home in Behchokǫ̀. During the year, construction took place on a new 18-bed LTC facility in Norman Wells.

The timely offering of a LTC bed to a client who needs one is a key goal of our LTC system. The median number of days a client waited to receive an offer of a placement in a long term care facility in 2017-18 was 13 days. The median is the number of days at which 50% of clients have been offered a first placement since the time of their application.

The average age of all applicants admitted to Long Term Care, Dementia, and Extended Care during 2017-18 are as follows:

PALLIATIVE CARE

Palliative care is about caring for people and their families as they approach death. The Department is working to support elders to live in their own homes for as long as possible and to ensure adequate supports are available for those who can no longer do so. Part of these efforts includes expanding palliative care.

Work continued this year on developing and implementing actions related to expanding palliative care services. The Department released the *Palliative Approach to Care Service Delivery Model* in January 2018; this document describes the Palliative Approach to Care and how it is delivered across the NWT. To support the development of policies, care pathways, and protocols, the Department worked with the NWT Seniors' Society and the Authorities to engage seniors, elders and Health and Social Services providers in a focus group. Information shared in the focus group will be used to support the development of policies and tools related to advanced care planning and palliative care in 2018-19.

The Department collaborated with the Authorities to establish a Territorial Specialist-Palliative Care position within the NTHSSA for a 3-year term to lead training and policy work to achieve actions related to expanding palliative care services. Support was provided for front line staff to participate in palliative care training sessions delivered in the NWT and in western Canada. Together, these activities assist the Department and the Authorities to make the best use of existing resources in the provision of palliative care.

Long Term Care		Dementia		Extended Care		Total	
# of Residents Admitted	Average Age	# of Residents Admitted	Average Age	# of Residents admitted	Average Age	# of Residents admitted	Average Age
43	78	1	74	3	79	47	78

PRIORITY 6: EFFECTIVE AND EFFICIENT SYSTEM

The following activities supported the goal of building a sustainable HSS system through: appropriate and effective use of resources, innovative service delivery and improved accountability. This is consistent with the 18th Legislative Assembly's commitment to continue the integration of the HSS system.

SYSTEM TRANSFORMATION

The activities associated with System Transformation are ongoing and will continue over the next number of years. To best support the ongoing transformation, HSS adopted a learning approach to evaluation. The following elements form the basis of the HSS System Transformation Learning Evaluation approach:

- continuous Quality Improvement (QI) approach to enable system learning from each program area as they transition. QI tools are available to all program leads and the Department's senior management team to assist in organizational restructuring and achieving operational efficiencies;
- a Legislative Audit to ensure the Authorities are complying with legislative reporting and accountability requirements outlined in *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act*. The Department completed the legislative audit for the first 18 months of the NTHSSA and tracked compliance throughout that period;
- public reporting on the progress/achievements of System Transformation. These achievements are captured in the NTHSSA's 2016-17 Annual Report; and,
- ongoing monitoring will include results from the Employee engagement Survey and the Patient/Client Experience Questionnaires to establish a baseline and to identify and track ongoing trends as a result of System Transformation in addition to the ongoing monitoring of system performance measures.

The Department is working with the Authorities on the design of a case study to evaluate mid-term and long-term outcomes of system transformation. The program areas tentatively selected for study are endoscopy and colorectal cancer screening.

MEDICAL TRAVEL

In 2017-18 the Department conducted an internal assessment of the Medical Travel Ministerial Policies. The goals of the assessment are: to improve customer service; to provide better information to medical travel staff, providers and patients; and to streamline business processes to become more efficient. Actions here included work on: updating the medical travel appeals process; clarifying nearest and approved centers for treatment; updating escort criteria to reflect the recent addition of prenatal escorts; and developing criteria to allow for escorts for patients with serious illnesses; and, reviewing the low-income threshold (the amount of income below which patients do not have to pay a copayment).

CULTURAL SAFETY

The Department is working to address systemic racism by embedding cultural safety practices throughout the health and social services system.

In 2017-18, the Department allocated $976,013 from the federal Health Services Integration Fund to support commitments identified in *Building a Culturally Respectful Health and Social Services System*. This includes establishing the Indigenous Advisory Body and the development of a cultural safety action plan.

ORGAN AND TISSUE DONATION

The *Human Tissue Donation Act* came into effect in June 2015. This established a legislative framework allowing NWT residents to consent to donate organs and tissues, streamlining the process and easing the burden of family decision making. Work continued in 2017-18 to finalize agreements with Alberta health to allow for the inclusion of NWT residents in the Alberta Organ and Tissue Donation Registry.

LEGISLATIVE PROJECTS IN SUPPORT OF A MODERN HEALTH AND SOCIAL SERVICES SYSTEM

The Department of Health and Social Services moved forward on a number of legislative initiatives in 2017-18.

LEGISLATION

Health and Social Services Professions Act (Bill 18)

A new *Health and Social Services Professions Act* (Bill 36) was passed in the Legislative Assembly in March 2015. On June 2, 2017, Bill 18, *An Act to Amend the Health and Social Services Professional Act* received ascent. Bill 18 addressed continuing competency requirements; information maintained in registers and what information can be shared with the public; and the Minister's authority to approve standards. The Act will regulate several health and social services professions under one legislative model, allowing the Department to modernize the existing outdated professional legislation in a more efficient and consistent manner. The new Act is expected to come into force in 2018-19 with the introduction of the first set of profession specific regulations, and an application process for professions to request regulation.

Vital Statistics Act (Bill 5)

An Act to Amend the *Vital Statistics Act* came into force July 1, 2017. The Act makes the process for amending gender on birth registrations more consistent with legislation in other jurisdictions and with human rights regarding gender identity, and removes the requirement for both a given name and surname, thereby providing for identification using a single name based on traditional culture. The Act also provides for future registration of names in fonts other than the Roman alphabet. This portion of the Act will come into force at a later time. Bill 5 also outlines consequential amendments that will be required to the *Change of Name Act* and Regulations.

Cannabis Smoking Control Act (Bill 6)

The proposed federal Cannabis Act was passed on June 8, 2017 and will come into force October 17, 2018. The Government of the Northwest Territories' omnibus *Cannabis Legalization and Regulation Implementation Act* (Bill 6) received first reading February 28 and second reading March 1, 2018. It will come into force at the same time the federal Cannabis Act comes into force. Under Bill 6, the regulation of smoking cannabis in public is set out under a new enactment the *Cannabis Smoking Control Act*.

The new *Cannabis Smoking Control Act* is intended to protect residents, particularly children and youth, from second hand cannabis smoke exposure, and to reduce the risk of normalization by restricting public areas where cannabis can be smoked. The Act will prohibit the smoking of cannabis in places where tobacco cannot currently be smoked, in addition to areas that are frequented by children, youth and crowds such as playgrounds, sporting fields, and public parks when in use for a public event. To ensure that legal cannabis users are informed of the risks and harms associated with cannabis use, the Act sets out signage requirements for cannabis retail outlets.

INTERIM GUIDELINES

Medical Assistance in Dying Interim Guidelines

On June 6th, 2016, Medical Assistance in Dying became legal in Canada as a result of amendments to the Criminal Code. In 2017-18, the Northwest Territories (NWT) Interim Guidelines were developed to ensure the requirements set out in the federal government's amendments to the Criminal Code are followed, as well as to provide additional safeguards for patients and practitioners in the NWT. With the Guidelines in place, ongoing work was required to prepare for amendments to reflect the recent amendments to the *Coroner's Act*, and to comply with the coming into force of federal monitoring regulations on November 1, 2018.

The amendments will set out information that practitioners and pharmacists must provide to the NWT Medical Assistance in Dying Review Committee. The Review Committee will be responsible for reporting this information to Health Canada on a quarterly basis.

The GNWT has committed to developing a legislative framework for Medical Assistance in Dying. This work will begin after the federal government makes decisions regarding extending access to Medical Assistance in Dying to: mature minors, persons whose sole medical condition is a mental illness, and those who have given advance consent. Reports on these issues are expected in December 2018.

REGULATIONS

Health and Social Services Professions Act (HSSPA) Regulations

Work on profession specific regulations under the Act continued throughout 2017-18, for:

- Emergency Medical Service Providers;
- Psychologists;
- Licensed Practical Nurses; and
- Naturopathic Doctors.

Other professions currently unlicensed in the Northwest Territories could also be regulated under the Act in the future.

Mental Health Act Regulations

Bill 55, an Act to Amend the Mental Health Act received assent on October 8, 2015. The new Act includes a substantial enhancement of patient rights, and the establishment of a new model of community-based treatment. Much of the detail of these changes needed to be addressed in the accompanying regulations. Work on the regulations required to bring the Act into force was completed in 2017-2018, specifically:

- Assisted Community Treatment regulations;
- Apprehension, Conveyance, and Transfer regulations;
- Designation of Facilities regulations;
- Forms regulations;
- Review Board regulations; and,
- General regulations;

The Act is scheduled to come into force September 1, 2018, following the delivery of training for health and social services professional, Review Board Members, and other impacted parties.

Public Health Act Regulations

Work continued on the Public Pool Regulations under the Public Health Act. The amendments to the Public Pool Regulations will reflect changes in water treatment technology and update the standards to be consistent with newer regulations in other jurisdictions.

The GNWT is putting in place appropriate processes and regulatory frameworks to support growing the commercial agricultural sector. As part of this work, the NWT's Food Establishment Safety Regulations under the Public Health Act are being updated to ensure the safety of food preparation, distribution and sale, of low-risk foods sold directly by the grower to the consumer in the NWT. These changes will allow local producers to meet the inspection requirements for low-risk foods, such as whole fruits and vegetables. Regulatory changes for low-risk foods are anticipated to be completed and implemented in 2018-19.

STRATEGIC INVESTMENTS IN INFRASTRUCTURE

Significant work was undertaken in 2017-18 on infrastructure projects throughout the NWT HSS system.

APPROVED PROJECTS

Community	Project Type	Status
Hay River	48 Bed LTC development	Site Survey and building siting in progress
	72 Bed LTC facility in legacy Stanton Building	72 Bed LTC Design in progress
Inuvik	48 Bed LTC facility	Planning, Site Selection and Design for a new 48 Bed LTC facility in progress
Yellowknife	AVENS Kitchen and Laundry	Replacement / Expansion of AVENS Kitchen and Laundry Facility siting options in progress
Tulita	Health and Social Services Center	Development of a new Health Center on a New Site, Land use permit for geotechnical in progress.

EXISTING PROJECTS

Community	Project Type	Status
Behchokǫ̀	Long Term Care - Replacement of 8 bed facility with 18 bed facility	Completed Grand Opening was in April 2017
Hay River	Health Center Replacement – Currently in First year of operation	Sterilizer installation in 2018
Norman Wells	Replacement and new long term care facility	Facility to be operational summer 2018.
Fort Resolution	Replacement Health and Social Services Centre	Facility to be operational spring 2018.
Hay River	Woodland Manor Renovation / Expansion	Facility to be operational in fall 2018.
Yellowknife	Stanton Territorial Hospital New P3 Hospital	To be operational in 2019-20
Sambaa K'e	Replacement of existing leased HSS facility with a GNWT facility	Contract Awarded – Materials were shipped on the 2018 Winter Road Construction summer 2018
Yellowknife	Extended care facility to be developed on the Yellowknife Health Campus in Legacy Stanton Building	Design in progress, construction proposed to start mid to late 2019

FUTURE PROJECTS

Community	Project Type	Status
Fort Simpson	Health and Social Services and LTC facility Replacement	Feasibility Study in process – Contract awarded
Jean Marie River	Health and Social Services Center	Project need identified waiting for capital funding Critical project to be identified as a priority during next capital planning cycle

STRATEGIC INITATIVES/OTHER PROJECTS

Community	Project Type	Status
Hay River	Offsite Services – Clinical Lease Acquisition	Determination of leasing requirements for HRHSSA Acquisition of new leased space
Yellowknife	Jan Stirling – Clinical Lease Acquisition	Determination of leasing requirements for HRHSSA Acquisition of new leased space
Yellowknife	Sobering / Day Shelter	Building undergoing renovations Occupancy in September 2018

INVESTMENTS IN E-HEALTH AND TECHNOLOGY

Electronic Medical Records (EMR) enables health care practitioners to better capture and share client medical information leading to better quality of care, improved patient safety and improved outcomes.

The EMR has been instrumental in transforming care to be client-centered. It has improved the continuity of care especially when a client has received care at various NWT locations or by different care providers. Patient information is available for practitioners where and when it is needed, and the EMR has enabled care closer to home. It has resulted in efficiencies in service delivery and more time spent with the client rather than tracking down results. Test results are included in the client's chart and can be flagged for follow up and reviewed in the EMR, reducing the need to request and fax information or re-order tests. Prior visit details are accessible and legible. The EMR provides medication decision support tools that have helped to provide safe and consistent care by including drug allergy alerts, medication interactions and clinical practice guidelines. This has led to quality improvement of services delivered and improved client outcomes.

The deployment of EMR in the NWT continued in 2017-18 with almost all communities (98% of residents) now connected. The remaining 2 communities are expected to be using the EMR in 2018-19.

A Digital Care Strategic Framework is being developed to guide digital investments for the next 3-5 years. The framework will help ensure HSS technology investments continue to align with HSS and GNWT strategic priorities, further enabling improvements in quality care and outcomes.

Partnering to Improve Health Outcomes

The Department partners with other GNWT Departments and NWT organizations on actions to improve health outcomes.

Anti-Poverty

The Department works with other GNWT Departments, Indigenous and community governments, NGOs, and other community partners with the aim of reducing poverty in NWT by fulfilling the commitments made by all partners in the Territorial Anti-Poverty Action Plan. An example of our collaborative work is the Territorial Anti-Poverty Fund. Funding goes to non-government organizations, Indigenous organizations, and community-based organizations to advance specific priorities of the Anti-Poverty Action Plan. In 2017-18, funding was increased by $1 million and 27 projects were supported in communities across the NWT.

Disabilities Framework

In support of the GNWT commitment to "work with all relevant stakeholders, including non-government organizations from the disabilities sector, to complete the NWT disability review and develop a strategic framework and five-year action plan to ensure effective supports and programs are in place for persons with disabilities" the Department tabled the following documents:

- *Equity, Accessibility, Inclusion and Participation: The NWT Disability Strategic Framework: 2017-2027;*
- *Disability Matters: A Companion to the NWT Disability Strategic Framework; and*
- *GNWT Programs and Services for Persons with Disabilities Inventory.*

These documents are the product of ongoing collaboration between the GNWT and disability partners. In 2018-19 a five-year Action plan will be released that will focus on: the strengths in our system; improving communication and collaboration; increasing access to disability related programs and services; and, addressing the social determinants of health and disability.

Family Violence Prevention

The Department continued to work with the Authorities, the Department of Justice, the Status of Women Council and the Coalition Against Family Violence to reduce family violence in the NWT through emergency shelter services and prevention and intervention initiatives. The Department currently provides funding for five family violence shelters to the Authorities who then enter into contribution agreements with NGO's to operate the shelters. In 2017-18, the Department undertook a review to determine an appropriate funding model for family violence shelters through consultations with Shelter Executive Directors.

The Department funds the Territorial Family Violence Shelter Network which enables shelter staff across the territory to collaborate and build capacity to serve women and children fleeing violence.

We are continuing our work on a new funding model for family violence shelters, in partnership with the Shelter Network.

Office Of The Public Guardian

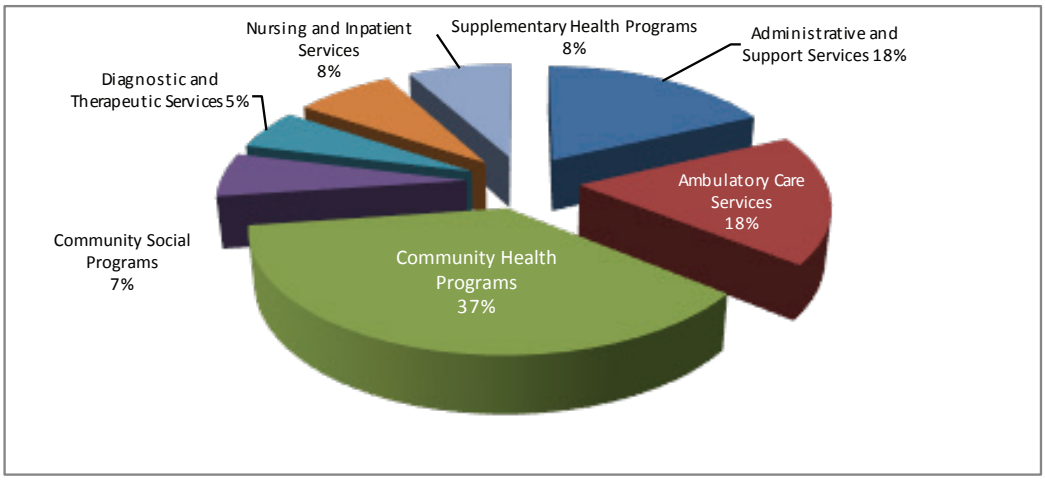
In 2017-18 a work plan was developed and steps have been taken to address the recommendations of the 2016 review of the Office of the Public Guardian (OPG). The OPG has begun addressing these recommendations by:

- recruiting additional psychiatrists and psychologists to complete specialized capacity assessments for individuals with complex needs;
- identifying an individual to train NWT psychologists and HSS health professionals to conduct capacity assessments;
- reviewing the delivery model of the Office of the Public Guardian in the regions; and
- working to update and modernize the Office of the Public Guardian's Standards and Procedure Manual.

Financial Highlights

In 2017-18, the Department spent $445.6 million; $283.6 million went directly to the Health and Social Services Authorities to administer and deliver programs and services. The Department's total expenditures increased $4.5 million over the prior year. The increase was due mainly to investments in long term care and homecare as well as the increased costs associated with southern residential care. In addition, DHSS invested $110.5 million on capital infrastructure projects and spent $41.6 million on projects funded by third parties.

2017-18 Department of Health and Social Services Proportion of Actual Expenditures by Activity



2017-18 Health and Social Services Actual Expenditures by Activity (in thousands)

	2017-18	2016-17
Activity	**Actual**	**Actual**
Administrative and Support Services	80,327	82,263
Ambulatory Care Services	78,897	78,222
Community Health Programs	165,384	159,285
Community Social Programs	26,682	27,108
Diagnostic and Therapeutic Services	24,535	23,989
Nursing and Inpatient Services	34,148	33,902
Supplementary Health Programs	35,669	36,359
Total	**$445,642**	**$441,128**

2017-18 Health and Social Services Actual Expenditures by Authority (in thousands)

Authority	Revenue	Expenses	Operating Surplus (Deficit)	Accumulated Surplus (Deficit)
Northwest Territories Health and Social Services Authority	307,491	320,159	(12,668)	(77,226)
Hay River Health and Social Services Authority	33,588	30,541	3,047	(2,386)
Tłı̨chǫ Community Services Agency	17,082	17,558	(476)	(2,160)
Total	**358,161**	**368,258**	**(10,097)**	**(81,772)**

In 2017-18, the Authorities received approximately 79% of their revenue from the Department. Expenditures were $368.3 million and total revenue was $358.2 million, resulting in an operating deficit of $10.1 million. At March 31, 2018, the accumulated deficit was $81.8 million.

2017-18 System Pressures

Human Resources continue to be the most significant cost pressure for the Authorities, particularly costs associated with staff turnover and the impacts of operating in 24/7 environments and requirements for service continuity. Compensation and benefits accounted for 63% of total expenditures, in 2017-18 – with Authorities spending $230.5 million on staff.

Other pressures continue to include the costs associated with NWT residents receiving services outside the NWT, when those services are not available in the NWT. The Department spent $30 million for residents to access hospital and physician services outside the NWT. Annual expenses are driven by both the volume of residents accessing services and the rates charged for those services, which are set nationally and updated annually. The Department spent $30 million in adult and youth residential care placements in southern facilities. This includes services for residents with specialized cognitive or physical care needs. The number of residents requiring these services has increased, as has the complexity and subsequent cost of services accessed.

Performance Measures

This section organizes indicators under the three categories of best health, best care and better future and is informed by the NWT Health and Social Services Performance Measurement Framework. The indicators under best health are focused on the overall health and wellness of the population. Under best care, indicators presented look at access, quality and responsiveness of care and services provided to children, individuals, families and communities. Under better future the indicators focus on measuring the efficiency of the system as it relates to the future sustainability of the overall health and social services system.

Statistical Summary

The following summary of performance indicators provides a snapshot of the current status of NWT HSS system performance and overall population health and wellness, including long-term trends and short-term changes. The full report on Public Performance Indicators follows this summary.

The long-term trend is based on seven or more years of data, whereas the short-term change is the difference between the most recent year of data available and the previous year. Where possible, a trend or change is determined to have occurred through statistical significance testing. This testing allows one to rule out changes that may have occurred by chance. Coloured arrows are used to mark the direction of the change or trend and to indicate whether the direction was positive (green) or negative (red). In some cases it is not possible to determine whether a change is positive or negative (i.e., the nature of the change is uncertain).

Data Sources and Limitations

The data for this report primarily came from the NWT HSS system, as well as the Canadian Institute for Health Information, Statistics Canada, the NWT Department of Education, Culture and Employment, the NWT Department of Human Resources, the Workers Safety and Compensation Commission and the NWT Bureau of Statistics. Depending on the source of data, there can be delays of up to a year or more for when the data are available for use.

Unless stated otherwise, all rates are population based (e.g. number of discharges per 10,000 population or 1,000 cases per population etc).

The numbers and rates in this report are subject to future revisions and are not necessarily comparable to numbers in other tabulations and reports. The numbers and rates in this report rely on information systems and population estimates that are continually updated and often revised. Any changes that do occur are usually small.

The quality of data available varies across the HSS system and is dependent on the mechanism available to collect data. Some information systems are paper based and others are electronic. Some have long histories and others are relatively new. Some collect a lot of detail and others do not.

Arrow colour (Trend)

Positive | Negative | Uncertain

Best Health Indicators	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Population Rating their Overall Health As Very Good or Excellent	54.3%	n/a	n/a	n/a
Population Rating their Mental Health as Very Good or Excellent	66.4%	n/a	n/a	n/a
Population Rating their Daily Life Stress as Extreme or Quite a Bit	17.9%	n/a	n/a	n/a
Population with a Somewhat or Very Strong Sense of Community Belonging	79.4%	n/a	n/a	n/a
Population that are Current Smokers	34.0%	n/a	n/a	n/a
Population that are Heavy Drinkers	31.8%	n/a	n/a	n/a
Population that are Overweight or Obese	39.8%	n/a	n/a	n/a
Population that are Moderately Active or Active	61.3%	n/a	n/a	n/a
Potentially Avoidable Mortality due to Preventable Causes (Deaths per 10,000)	20.2	21.0	No	↓
Mental Health Hospitalization Rate (Discharges per 1,000)	14.0	12.7	No	↑
Hospitalizations Entirely Caused by Alcohol (Discharges per 1,000)	17.2	14.6	↑	↑
Opioid Related Hospitalizations (Discharges per 10,000)	6.7	8.1	No	↑
Population Hospitalized for Self-Harm (Patients per 10,000)	17.2	19.3	No	Stable
Sexually Transmitted Infections (Cases per 1,000)	26.6	31.0	↓	↑
Early Development Instrument - Proportion of Children Vulnerable in One or More Domains	38.1%	n/a	n/a	n/a

Best Care Indicators	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Potentially Avoidable Mortality due to Treatable Causes (Deaths per 10,000)	9.8	10.3	No	↓
Screening for Colorectal Cancer (% of Target Population)	22.9%	24.8%	↓	↑
Screening for Breast Cancer (% of Target Population)	53.7%	53.6%	No	↓
Screening for Cervical Cancer (% of Target Population)	47.3%	48.6%	↓	↓
Childhood Immunization (% Fully Immunized by Second Birthday)	62.7%	63.4%	No	n/a
Seniors receiving the Flu Shot	55.5%	n/a	n/a	n/a
Hospitalizations for Lower Limb Amputations (Per 1,000 Persons with Diabetes)	3.2	3.7	No	Stable
Long Term Care Placement Wait Times (Days)	13	58	No	Stable
Patient/Client Satisfaction - Satisfied or Very Satisfied	90%	92%	No	n/a
Hospital Deaths within 30 Days of Major Surgery	0.6%	0.8%	No	n/a
Inpatients Injured by Falling in NWT Hospitals (per 10,000 Discharges)	9.4	6.5	No	Stable
Nursing-Sensitive Adverse Events - Medical (per 1,000 Discharges)	11.4	14.5	No	n/a
Nursing-Sensitive Adverse Events - Surgical (per 1,000 Discharges)	34.8	42.4	No	n/a
In Hospital Sepsis (Cases per 1,000 Hospital Stays of 2 Days or More)	0.5	1.3	No	n/a
Repeat Mental Health Hospitalizations (% with 3 or More in a Year)	10.5%	14.0%	No	n/a
Community Counselling Utilization (Monthly Average # of Clients)	883	871	No	n/a
Proportion Completing Residential Addictions Treatment	73.7%	75.8%	No	n/a
Family Violence Shelter Utilization - Women (Monthly Average)	27.7	25.8	No	Stable
Family Violence Shelter Utilization - Children (Monthly Average)	17.2	21.3	No	Stable
Family Violence Shelter Re-Admission Rates	73.0%	68.3%	No	↑
Child Welfare - % of Placements in Home Community	79.1%	76.5%	No	↑
Child Welfare - % with One Placement per Year	67.3%	62.8%	No	Stable
Child Safety - % Repeatedly Maltreated within a Year	27.4%	29.9%	No	Stable

Best Future Indicators	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Hospitalizations for Ambulatory Care Sensitive Conditions	5.7%	5.9%	No	Stable
Median Length of an Alternative Level of Care Stay	12.5	28	No	Stable
Proportion of Mental Health Hospitalizations due to Alcohol or Drugs	46.3%	46.1%	No	↓
Emergency Department Visits that are Non-Urgent	8.9%	12.1%	↓	↓
No Show Rates - Family/Nurse Practitioners	11.8%	12.0%	No	↑
No Show Rates - Specialists	12.0%	11.8%	No	↑
Vacancy Rates - Family Practitioners	29.8%	37.1%	No	Stable
Vacancy Rates - Special Practitioners	11.0%	30.0%	No	Stable
Vacancy Rates - Nurses	4.7%	5.4%	No	n/a
Vacancy Rates - Social Workers	4.5%	6.4%	No	n/a
Workplace Safety Claims - NWT HSS System (per 100 Employees)	14.2	16.0	No	n/a
Administrative Staffing - NWT HSS System (% of Positions)	27.3%	27.9%	No	n/a
Administrative Expense - NWT Hospitals (% of Expenditures)	4.2%	5.7%	↓	n/a

Notes

The "most recent time period" refers to the indicator results for the latest year, or point in time, of data available. "Previous time period" refers to the year, or point in time, one year before the most recent time period (e.g. if the most recent period is 2017-18 then the previous time period is usually 2016-17). Short term change is the difference between the two. The long term trend is the direction the numbers are heading over a time period of several years (seven or more). In some cases there are not enough years of comparable data to determine the direction of the trend.

A green arrow means the short or long term change is positive. A red arrow is a negative change. An arrow that is outlined in black means it is not clear if the change was positive or negative. For example, a decrease in the number of community counselling clients may be due to a shortage of available services (e.g. staff vacancies) but also could be an indication of a drop in the demand for the service. "Stable" means that the long term trend is neither up nor down (i.e., flat).

"n/a" means that there is not sufficient information available (e.g., not enough years of data to establish a trend or there are substantial inconsistencies in what is being measured over time).

The directions of the short-term change and the long term trend have been determined by statistical significance testing where possible. When results are based on a small population and/or a few events (e.g. cases of hospital deaths following surgery), as is often the case in the NWT, numerical differences between two numbers may have occurred by chance. When a numerical difference is said to be statistically significant (e.g., arrows in the summary above) it means that any apparent difference between two numbers, or the direction of the trend, was unlikely to have occurred by chance. In contrast, it is important to note that with large numbers (e.g. no shows), even a very small percentage change between two numbers (e.g. a three percent change from one year to the next year) can be statistically significant.

Best *health*

- Support the health and wellness of the population
- Promote healthy choices and personal responsibility through awareness and education
- Protect health and prevent disease
- Provide targeted access to services for high risk populations
- Reduce disparties in health status and impacts of social determinants

Best Health – Health Status and Well-Being

What is being measured?

Four measures of health status and well-being where the proportion of the population surveyed (age 12 & over) rated/reported: their overall health as very good or excellent; their mental health as very good or excellent; perceived that most days in their life were quite a bit or extremely stressful and having a strong or somewhat strong sense of community belonging.

Why is this of interest?

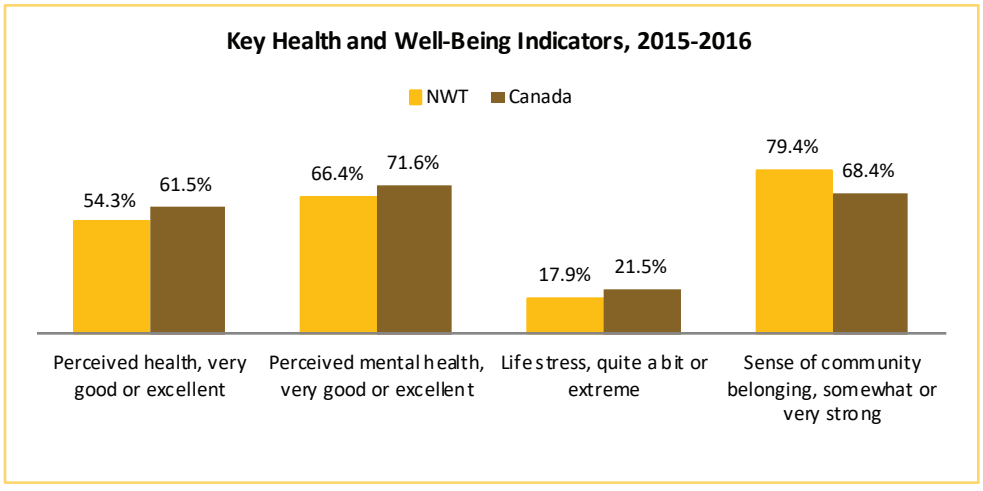
Self-reported health relates to how healthy a person feels, and is an important predictor of future health care use and mortality rates. Perceived mental health gives a general sense of the population afflicted from some sort of mental or emotional disorder or issue. Stress can negatively affect one's physical and mental well-being as well as influence negative behaviours such as substance abuse and poor dietary choices. There is a strong link between sense of community belonging and physical and mental health.

How are we doing?

Compared to Canada results were mixed with NWT residents being less likely to rate their overall health or mental health as being very good or excellent. NWT residents, compared to national rates, were less likely to report experiencing a quite a bit or extreme levels of stress and NWT residents were more likely to report having a somewhat or very strong sense of community of belonging.[2]

Source

Statistics Canada, Canadian Community Health Survey (National File).



[2]In 2015, Statistics Canada changed the content and the design of the Canadian Community Health Survey. Because of these changes, historical trending (comparisons to pre-2015 results) has not been included in this report.

Best Health – Determinants of Health and Well-Being

What is being measured?

Four measures of behaviours that have a strong influence on health and well-being: the proportion of the population who are current daily or occasional smokers (age 12 and over); the proportion who are heavy drinkers (age 12 and over); the proportion that are obese (age 18 and over); and the proportion who are physically active (age 18 and over).

Why is this of interest?

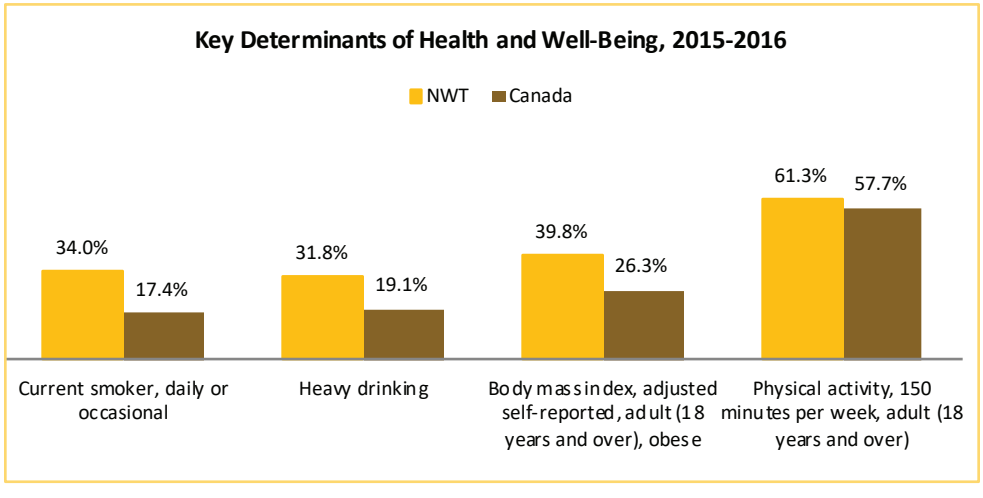
Smoking is a largely preventable factor in a number of chronic diseases, including lung and other cancers, chronic lung problems, Type II diabetes, and cardiovascular diseases (heart attacks and strokes). Not only can smoking increase the risk of acquiring Type II diabetes, it can also increase the risk of severe complications of diabetes (such as lower limb amputations). Heavy drinking is a factor in family violence and injuries. Heavy alcohol consumption, over many years, can contribute to a number of chronic diseases, including cardiovascular diseases (heart attacks and strokes), liver failure and some cancers. Regular heavy drinking can also lead to dependency, and is often a co-factor in other mental health issues. Obesity is a largely preventable factor in a number of chronic diseases, including Type II diabetes, cardiovascular diseases (heart attacks and strokes), and some cancers. Regular physical activity can be a role in preventing chronic disease, maintaining a healthy weight and help with one's overall sense of well-being.

How are we doing?

The NWT population have higher rates of smoking, heavy drinking, and obesity than the national averages. When it comes to physical activity, there is not a statistically significant difference between the NWT and Canada.[3]

Source

Statistics Canada, Canadian Community Health Survey (National File).



[3]In 2015, Statistics Canada changed the content and the design of the Canadian Community Health Survey. Because of these changes, historical trending (comparisons to pre-2015 results) has not been included in this report.

Best Health – Avoidable Death due to Preventable Conditions

What is being measured?

The age-standardized rate of deaths due to preventable conditions (deaths per 10,000 population, under the age of 75 years)..

Why is this of interest?

This indicator focuses on premature deaths due to conditions that are considered preventable. These deaths could potentially be avoided through improvements in lifestyle (e.g., smoking cessation and healthy weights) or health promotion efforts (e.g. injury prevention).

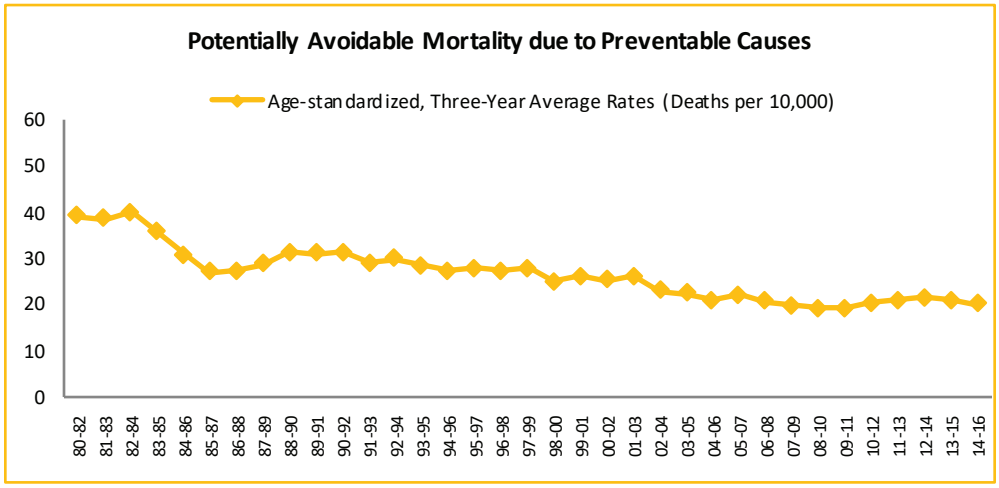
How are we doing?

The rate of avoid mortality due to preventable conditions has decreased over the last thirty years – from an average of 33 deaths per 10,000 in the 1980s to 21 deaths per 10,000 in the last ten years.

The rate of avoidable death is higher in the NWT than in Canada – at 20.2 versus 13.0 per 10,000 (2014-2016).

Source

NWT Department of Health and Social Services, Statistics Canada, and NWT Bureau of Statistics.



Best Health – Mental Health Hospitalizations

What is being measured?

The annual age-standardized rate of mental health hospitalizations, overall and by diagnostic category, for NWT residents.[4]

Why is this of interest?

Mental health hospitalizations, while unavoidable at times, are often preventable through the treatment of issues in other venues (e.g., counselling and outpatient psychiatric services, and treatment programs for addiction).

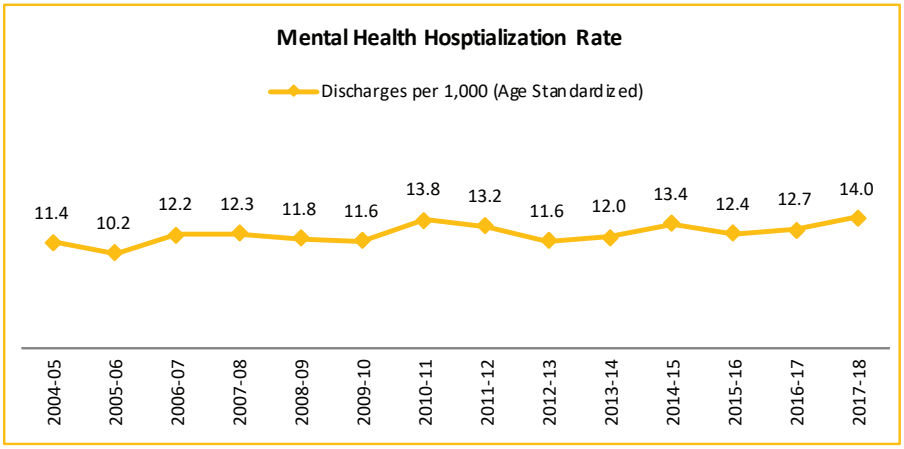
How are we doing?

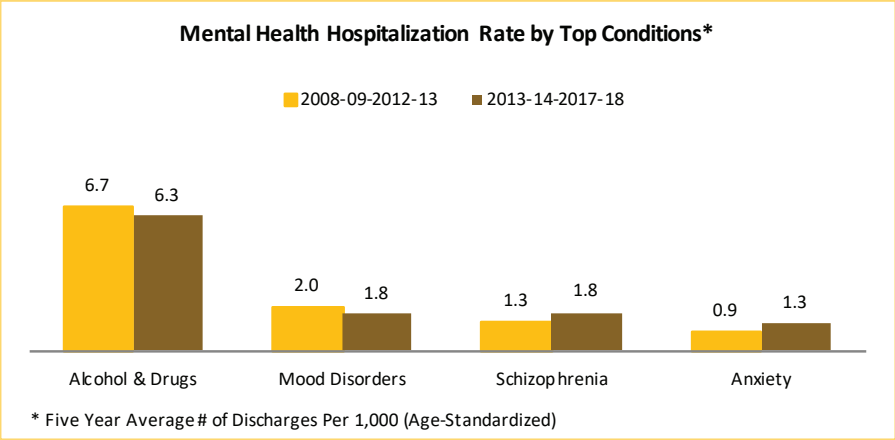
Over the last 14 years, the rate of hospitalizations has been trending upwards. Alcohol and drug issues (dependency/abuse) represented just under half of all mental health hospitalizations. Together with the three next largest categories (mood disorders, schizophrenia/psychotic disorders, and anxiety disorders), they accounted for 9 out of 10 mental health hospitalizations between 2013-14 and 2017-18.

The NWT's overall mental health hospitalization rate, between 2013-14 and 2017-18, was on average, over twice the national average (2015-16). Compared to national rates, the NWT has especially higher rates of alcohol/drug hospitalizations (over five times) and anxiety disorder hospitalizations (over three times).

Sources

NWT Department of Health and Social Services, Canadian Institute for Health Information, NWT Bureau of Statistics and Statistics Canada.





[4]Only hospitalizations of NWT residents where the primary reason for the hospitalization was a mental health issue are included in the measure.

Best Health – Hospitalizations Entirely Caused by Alcohol

What is being measured?

The age-standardized rate of hospitalizations due to conditions caused by alcohol (discharges per 1,000, age 10 years and over). Conditions included can range from alcohol abuse and dependency to alcoholic cirrhosis of the liver and alcoholic gastritis.

Why is it of interest?

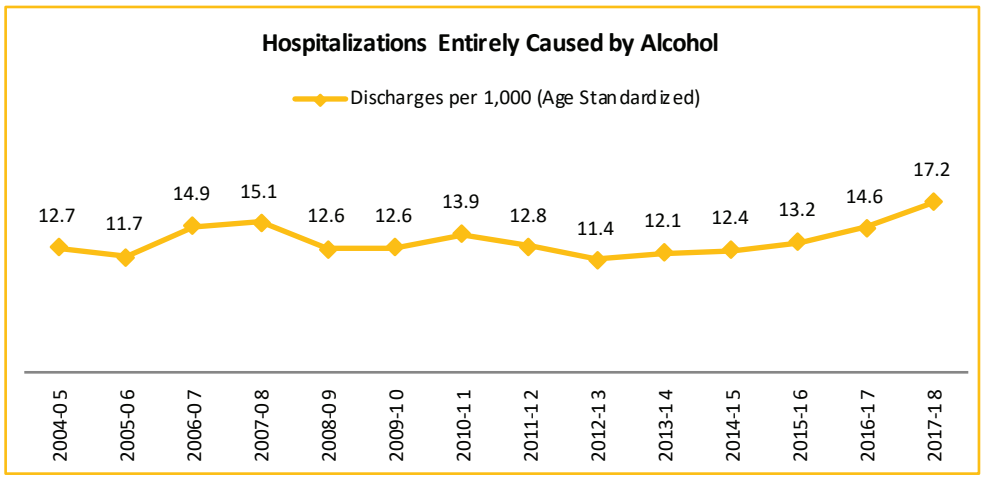
The abuse of alcohol is a cause or a contributing factor in a number of health conditions and is a leading factor in preventable death and disease. In addition, the harmful use of alcohol puts an unnecessary strain on the health, social services and justice systems.

How are we doing?

The rate of hospitalizations entirely caused by alcohol has increased between 2004-05 and 2017-18 from 12.7 to 17.2 discharges per 1,000. In 2016-17, the NWT rate of hospitalizations caused by alcohol was six times the national average (14.6 versus 2.4 per 1,000).

Sources

NWT Department of Health and Social Services, Canadian Institute for Health Information, NWT Bureau of Statistics and Statistics Canada.



Best Health – Opioid Hospitalizations

What is being measured?

The rate of hospitalizations for opioid abuse and poisoning (discharges per 10,000).[5]

Why is this of interest?

Across the country, opioid addiction is a public health crisis. Fentanyl overdoses have resulted in a record level of deaths due to opioids.

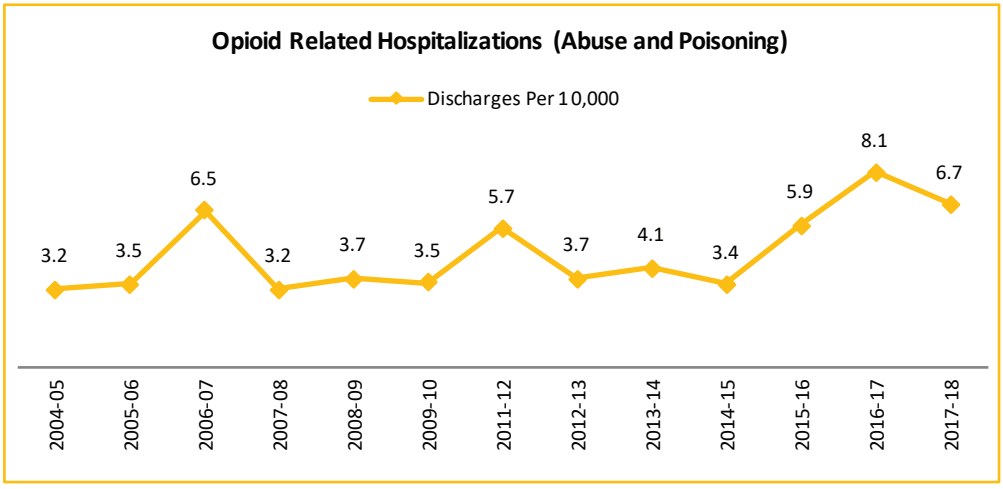
How are we doing?

The rate of opioid abuse and poisoning hospitalizations has increased between 2004-05 and 2017-18 – with most of the increase coming since 2014-15.

Compared to national rates, the NWT is not significantly different. The NWT age-standardized rate of 7.9 opioid hospitalizations per 10,000 was not significantly different than the national rate of 5.8 (2015-16 to 2017-18).[6]

Sources

NWT Department of Health and Social Services, Canadian Institute for Health Information and NWT Bureau of Statistics.



[5] The hospitalization rate includes any diagnosis (primary or secondary) of an opioid poisoning or abuse.

[6] Canadian rate excludes Quebec.

Best Health – Population Hospitalized for Self-Injury

What is being measured?

The age-standardize rate of the population hospitalized one or more times for a self-injury per year (patients per 10,000).[7]

Why is it of interest?

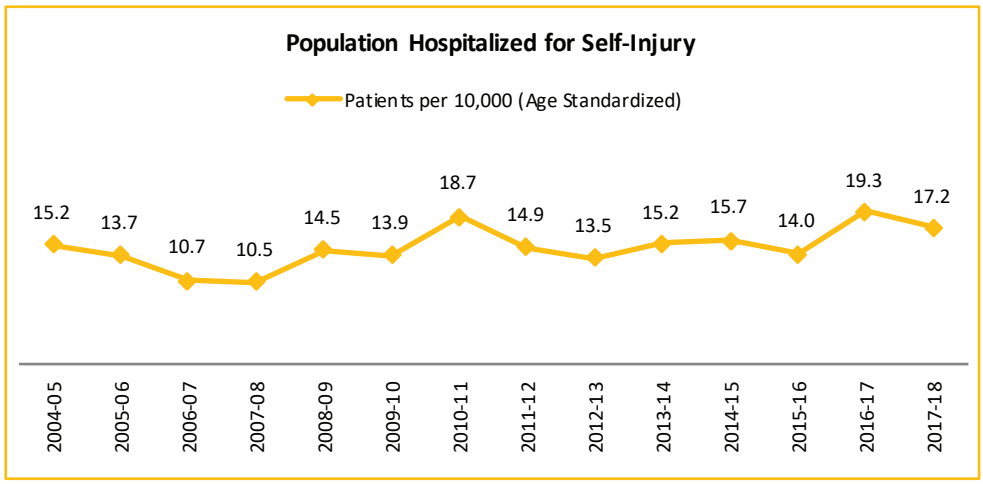
Self-injury can be the result of self-harming behaviours and/or suicidal behaviours. "Self-injury can be prevented, in many cases, by early recognition, intervention and treatment of mental illnesses. While some risk factors for self-injury are beyond the control of the health system, high rates of self-injury hospitalization…" may be attributed to a lack of appropriate programs and supports aimed at preventing self-injury hospitalizations.[8]

How are we doing?

The rate of the population hospitalized for a self-injury has fluctuated since 2004-05 ranging a low of 10.5 to a high of 19.3. A direct comparison to a national average is not available but when examined by total hospitalizations, the NWT rate than is higher than the national rate at 25.2 versus 6.8 per 10,000 (2016-17).

Sources

NWT Department of Health and Social Services, Canadian Institute for Health Information, NWT Bureau of Statistics and Statistics Canada.



[7]Any diagnosis (primary or secondary) for a self-injury is included.

[8]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=1114197

Best Health – Sexually Transmitted Infections

What is being measured?

The incidence of Sexually Transmitted Infections (STIs): the number of STIs per 1,000 population per year. STIs include chlamydia, gonorrhea and syphilis.

Why is this of interest?

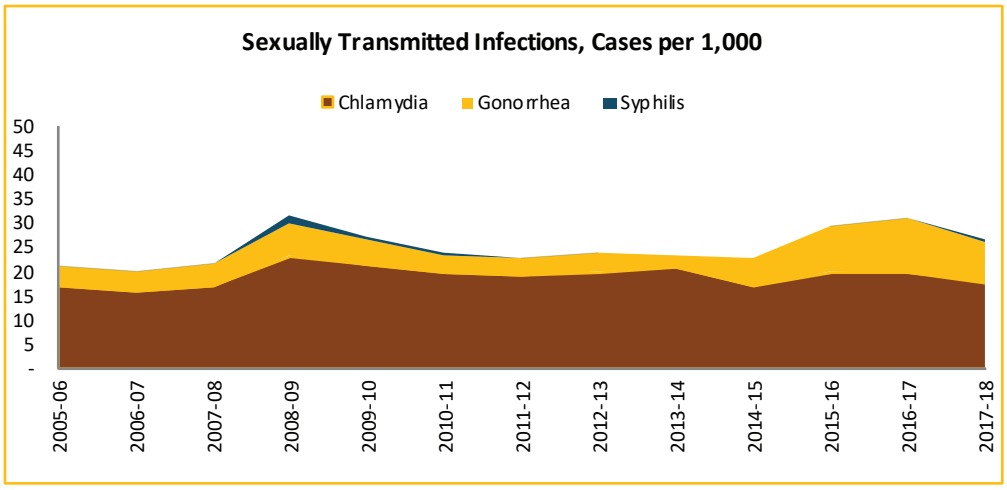
STIs are spread through practicing unsafe sex, and can cause infertility, ectopic pregnancies, premature births and damage to unborn children. The rate of STIs can provide a proxy of the degree to which unsafe sex is being practiced.

How are we doing?

Over the last 13 years, the rate of STIs peaked both in 2008-09 (32 cases per 1,000), primarily due to an increase in the rate of chlamydia, and in 2016-17 (31 cases per 1,000), primarily due to an increase in the rate of gonorrhea. The rate has declined in 2017-18 to 26.6 cases per 1,000 but still remains high relative to the national average of just over 4.1 cases per 1,000 (2016).

Sources:

NWT Health and Social Services, Public Health Agency of Canada, and NWT Bureau of Statistics.



Best Health – School Readiness

What is being measured?

The proportion of kindergarten students who are vulnerable in one or more areas (domains) of their development as measured by the Early Development Instrument (EDI).

The EDI is a kindergarten teacher-completed checklist that measures five areas of a child's development: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge.

Why is this of interest?

This indicator is an important measure for a number of reasons. It is a determinant of how well a child will do in school, as well as health and well-being in later life. It may also be used as a high level measure of the collective success of interventions into improving the early development of children.

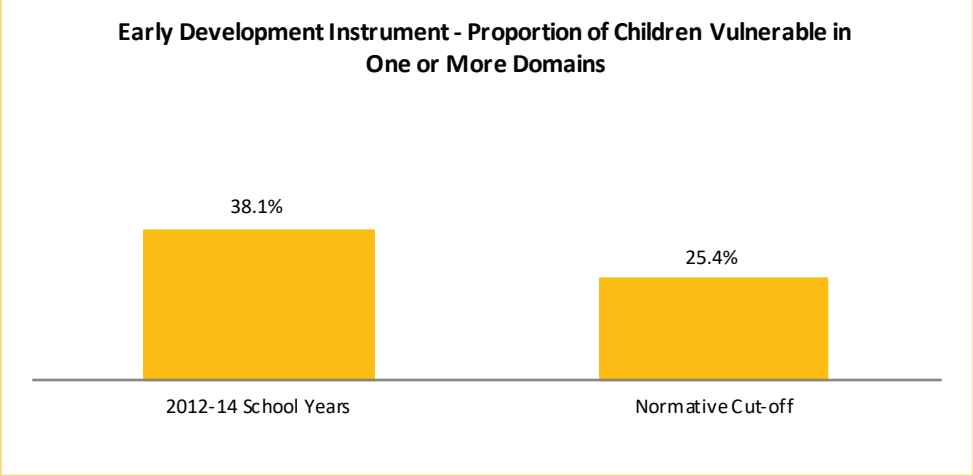
How are we doing?

The proportion of NWT kindergarten students who are vulnerable in one or more developmental areas was 38.1% in 2012-2014 school years - higher than the normative cut off of 25.4% (based on a national cohort).

For the same time period, 22.0% of children were found to be vulnerable in the domain of physical health and well-being, 18.8% were found to be vulnerable in the domain of communication skills and general knowledge, 17.3% were vulnerable in the domain of language and cognitive development, 16.8% were vulnerable in terms of emotional maturity and 13.6% were vulnerable in terms of social competence.

Sources

NWT Department of Education, Culture and Employment, Offord Centre for Child Studies, McMaster University, and Canadian Institute for Health Information.



Best *care*

- Care and services are responsive to children, individuals, families and communities
- Provide equitable access to safe, quality, care and services that are appropriate for our residents' needs
- Reduce gaps and barriers to current programs and services
- Enhance the patient/client experience
- Ensure programs and services are culturally sensitive and respond to community wellness needs

Best Care – Avoidable Mortality due to Treatable Causes

What is being measured?

The age-standardized three-year average rate of potentially avoidable deaths due to treatable conditions (deaths per 10,000 population, under the age of 75 years).

Why is it of interest?

"Mortality from treatable causes focuses on premature deaths that could potentially be avoided through secondary and tertiary prevention efforts, such as screening for and effective treatment of an existing disease."[9]

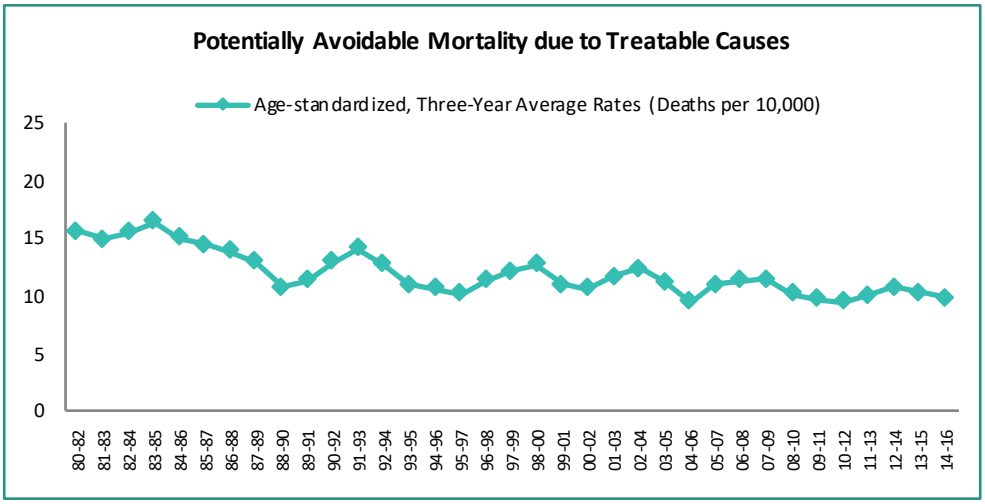
How are we doing?

The rate of avoidable death due to treatable causes has significantly decreased over the last three decades – dropping from an average of around 14 deaths per 10,000 in the 1980s, to an average of around 10 deaths per 10,000 in the last ten years.

The NWT has a higher rate of avoidable deaths due to treatable conditions than the national average – 9.8 versus 6.8 per 10,000 (2014-2016).

Sources

NWT Department of Health and Social Services, Statistics Canada and NWT Bureau of Statistics.



[9]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=1114185

Best Care – Cancer Screening

What is being measured?

The proportion of the target population who have been screened for colorectal cancer (age 50 to 74), breast cancer (females, age 50 to 74) and cervical cancer (females age 21 to 69) within a two-year period. The population targeted for screening is based on the age group found to be effective in testing specific to each cancer type.

Why is it of interest?

In general, screening allows for early detection of cancer. Early detection of cancer (i.e. finding it in the early stages) provides the best chance for the patient at avoiding death and significant illness by way of early interventions. For example, colorectal cancer cure rates are almost 90% when detected early; when detected in later stages, the cure rate drops to 12%.[10] In the NWT colorectal cancer is the second leading cause of cancer death. Breast cancer is second most common diagnosed cancer in NWT females. While cervical cancer is not a leading cause of cancer in the NWT, a large proportion of cervical cancers are caused by certain types of the human papiliomavirus (HPV) – a disease that can be screened for and treated.

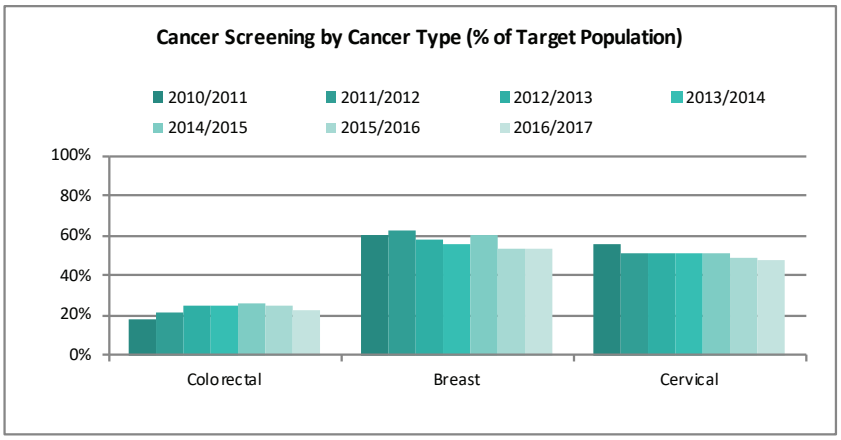
How are we doing?

Between the two-year periods 2010/2011 and 2016/2017 the proportion of the population who received a fecal immunochemical test (designed to detect blood in one's stool) has varied from a low of 18% to a high of 26%. Over the same time period, the rate of women receiving a mammogram varied from a low of 54% to a high of 62%. And, between 2010/2011 and 2016/2017, the proportion of women receiving the Papanicolaou test (Pap test), has ranged from a low of 47% to a high of 56%.

The NWT does not meet the national minimum screening targets for colorectal cancer screening (60%), breast cancer (70%) and cervical cancer (80%).

Source:

NWT Department of Health and Social Services.



[10]Ontario Ministry of Health and Long Term Care, *Colon Cancer Check* (2013). http://www.health.gov.on.ca/en/pro/programs/coloncancercheck/pharmacists_faq.aspx#1

Best Care – Childhood Immunization

What is being measured?

The proportion of the population born in a given year (e.g. 2012) having received full immunization coverage by their second birthday.

Why is this of interest?

Immunization has been shown to be one of the most cost effective public health interventions available. Maintaining high vaccine coverage is necessary for preventing the spread of vaccine preventable diseases and outbreaks within a community. The recent outbreaks of measles in Canada, as well as the United States highlight the importance of achieving and maintaining high vaccination rates.

How are we doing?

For children born in 2012, the latest immunization coverage study in 2015 revealed an immunization coverage rate of 62.7% by the child's second birthday for six vaccines in total. In comparison, the last study of children born in 2011, found that the coverage rate was 63.4%.

As seen in the table, NWT coverage rates are much higher per vaccine. For four out of five vaccines, the NWT does not meet national goals. The one exception is the vaccination for varicella (chickenpox).

Source

NWT Department of Health and Social Services.

Vaccine by Diseases Protected Against and Coverage Rate (By 2nd Birthday)	NWT 2015*	National Goal	Meet National Goal
DaPT IPV-HIB Diphtheria, pertussis, tetanus, polio and haemophilus influenza type b	74%	95%	No**
Hep B Hepatitis B	81%	n/a	n/a
Meningococcal C conjugagte Meningitis, meningococcemia, septicemia	83%	97%	No
MMR Measles, mumps and rubella	85%	97%	No**
Pneumococcal conjugate Streptococcus pneumoniae	73%	90%	No
Varicella Varicella (Chickenpox)	88%	85%	Yes

n/a = Not applicable.
*Children born in 2012.
** National goal only includes pertussis and rubella respectively.

Best Care – Influenza Immunization for Seniors

What is being measured?

The proportion of the population age 65 and over surveyed who reported that they had a flu shot within the past year.

Why is it of interest?

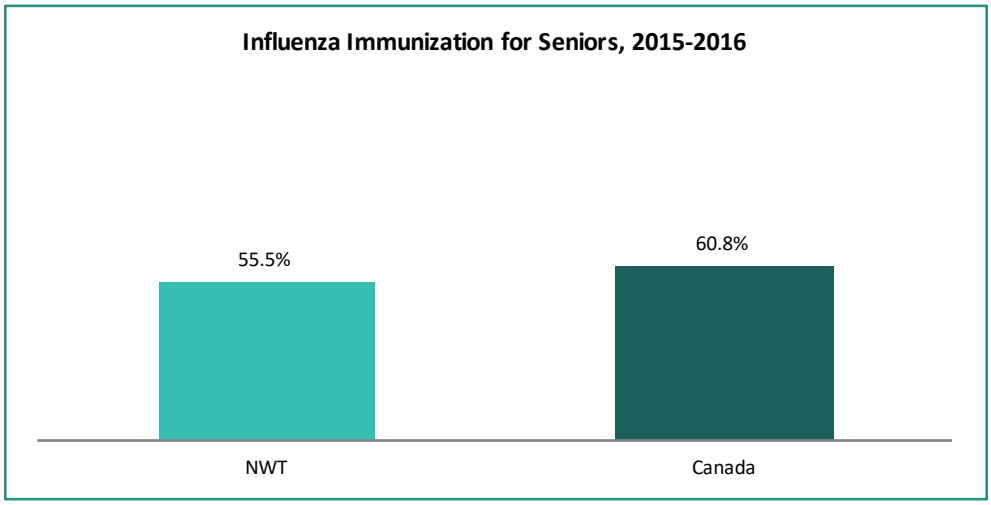
As immune defences become weaker with age, the senior population is of greater risk for serious complications from the flu. The flu shot can be effective in preventing the flu.

How are we doing?

Just over half of NWT seniors reported receiving the flu shot for 2015-2016 – not significantly different from the national rate.[11]

Source

Statistics Canada, Canadian Community Health Survey (National File).



[11]In 2015, Statistics Canada changed the content and the design of the Canadian Community Health Survey. Because of these changes, historical trending (comparisons to pre-2015 results) has not been included in this report.

Best Care – Lower Limb Amputations

What is being measured?

The three-year average rate of the population with diabetes hospitalized one or more times a year for a lower limb amputation (patients age 40 and over per 1,000).

Why is it of interest?

Lower limb amputations (non-injury related) are often preventable in diabetes patients. People with diabetes are more prone to foot ulcers and infections. Ulcers and infections if not successfully treated can lead to amputation.

How are we doing?

Since 2004-05 to 2006-07 the three-year average rate of the population with diabetes hospitalized for a lower limb amputation has ranged from 0.9 to 3.7 patients per 1,000.

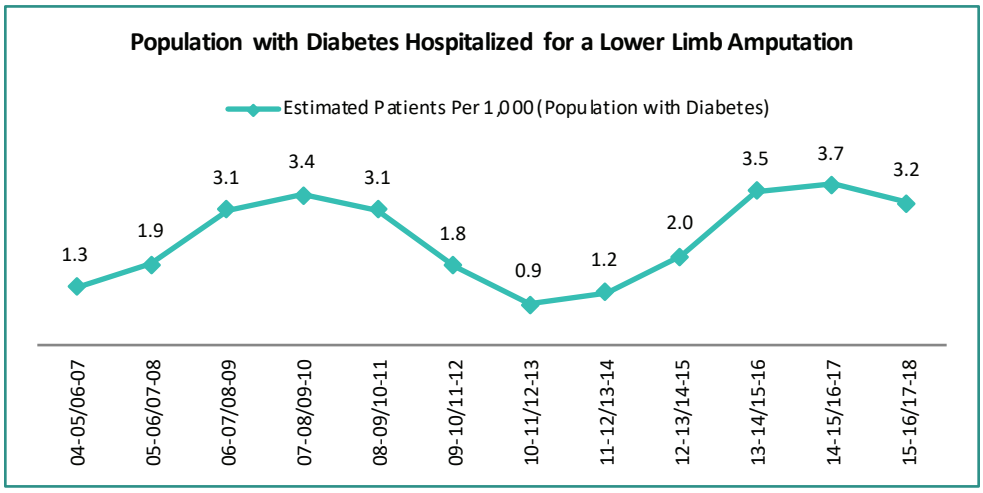
It is important to point out that the actual number of patients is small, ranging from 1 to 12 in any given single year. A direct comparison to a national average is not available but when examined by the rate of hospitalizations for lower limb amputations, the NWT had a significantly higher rate at 3.7 versus 2.0 per 1,000 (2015-16-2017-18).[12]

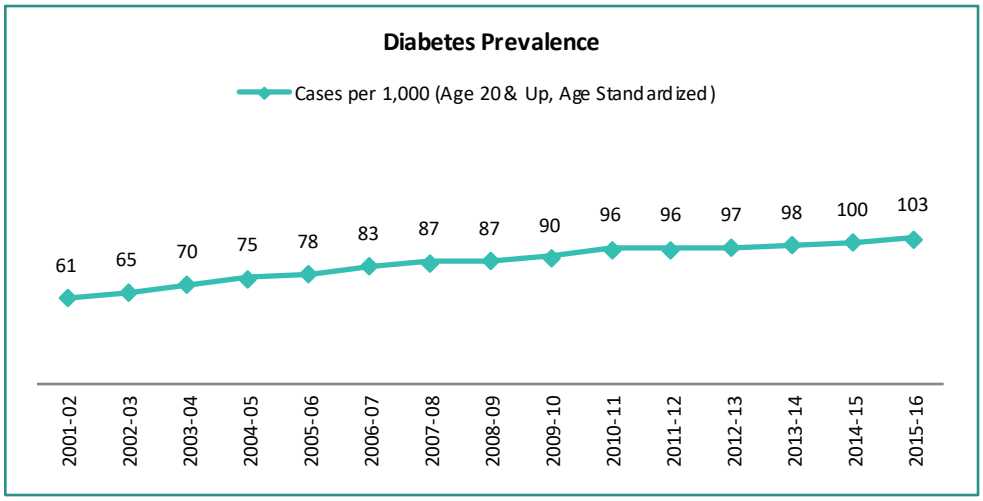
Other Information

The prevalence of diabetes, in general, continues to increase each year by an average of 3.8%.

Sources

NWT Department of Health and Social Services, Canadian Institute for Health Information, and Public Health Agency of Canada.





[12]Canadian rate is an estimate and excludes Quebec.

Best Care – Long Term Care Placement Wait Times

What is being measured?

The median number of days a patient waits to receive an offer of a placement in a long term care facility.[13] The median is the number of days in which 50% of the clients have been offered a placement.

Why is this of interest?

While providing timely access to long term care services is a priority for the NWT HSS system, it is also a goal to use system resources as efficiently as possible. People awaiting long term care are sometimes placed in expensive acute care beds.

How are we doing?

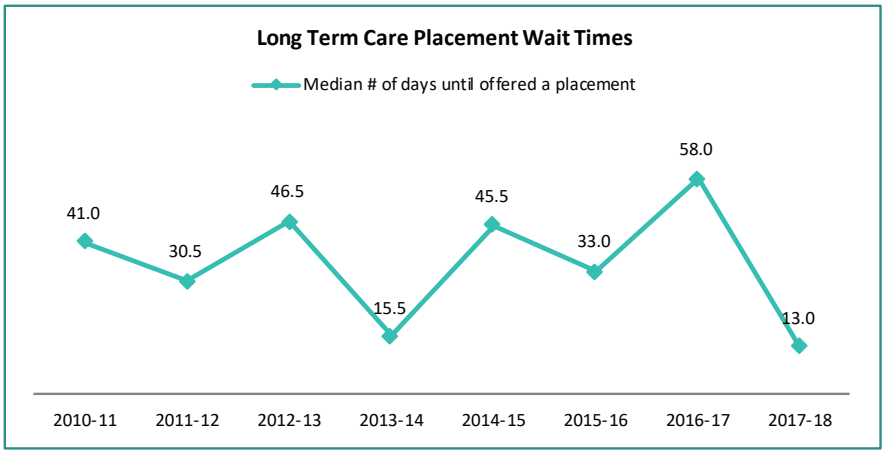
Long term care facilities have been running near full occupancy in recent years and demand for long term care services has been increasing. Between 2013-14 and 2017-18, the number of new clients - those still waiting from the prior year plus those applying in the current year - increased by 11% from 74 to 82.

Over the last eight years, the median wait time to be offered a placement in a long term care facility was 34 days and has ranged from 13 days to 58 days.

While around 46% of clients have been offered a placement within four weeks, over two-thirds of clients have been offered a placement within three months.

Source

NWT Department of Health and Social Services.



Long Term Care Wait Times									
	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	8 Years
Placements offered	63	36	34	46	38	40	55	41	353
Average (Days)	66	55	112	59	98	82	120	76	83
Median (Days)	41	31	47	16	46	33	58	13	34
Proportion of Clients by Number of Days before Placement Offer									
<8	13%	25%	18%	26%	8%	15%	18%	49%	20%
8 to 14	14%	22%	3%	20%	16%	18%	11%	7%	14%
15 to 21	8%	0%	12%	11%	8%	5%	5%	5%	7%
22 to 28	6%	3%	6%	9%	5%	8%	0%	2%	5%
29 to 92	25%	25%	24%	15%	29%	23%	29%	15%	23%
93 to 182	30%	19%	15%	9%	11%	18%	15%	10%	16%
183 & Up	3%	6%	24%	11%	24%	15%	22%	12%	14%

[13]The wait time is the time between the date when it is determined that an individual requires placement in a LTC facility to the date they are offered a placement. When a client refuses a placement, they end up starting over in the wait list queue. .

Best Care – Patient/Client Satisfaction

What is being measured?

The percentage of NWT residents who report that they were satisfied or very satisfied with the health and/or social service care received in NWT.[14]

Why is this of interest?

Assessing the level of satisfaction with the care patients/clients have received can provide a means for the NWT HSS system to improve the delivery of services.

How are we doing?

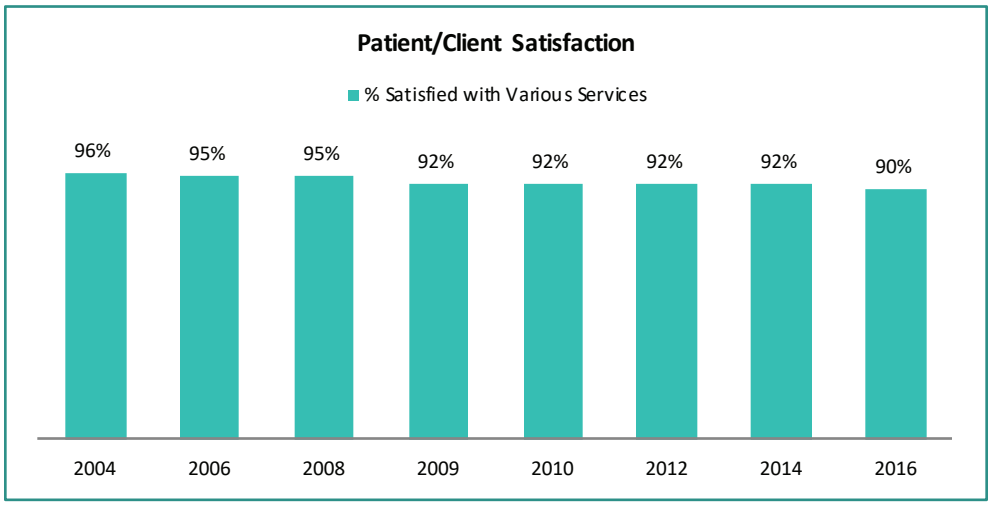
Patient and client satisfaction questionnaires have been delivered across the NWT HSS system over the last few years. Results have been favourable – with 90% to 96% of those filling out the questionnaires reporting that they were satisfied with the services they received.

Long term trends are difficult to measure currently, as the last eight questionnaires have varied in terms of which service areas were surveyed.

For the three questionnaires with the widest HSS system coverage (hospitals, health centres clinics and public health offices), the results have ranged between 90% and 92%.

Source

NWT Department of Health and Social Services.



[14]Question used to ascertain satisfaction varies from survey to survey (% satisfied/very satisfied, % quality of service excellent/good, % agree/strongly agree service was of high quality etc.).

Best Care – Hospital Deaths Following Major Surgery

What is being measured?

The proportion of patients dying within 30 days of a major surgery.

Why is it of interest?

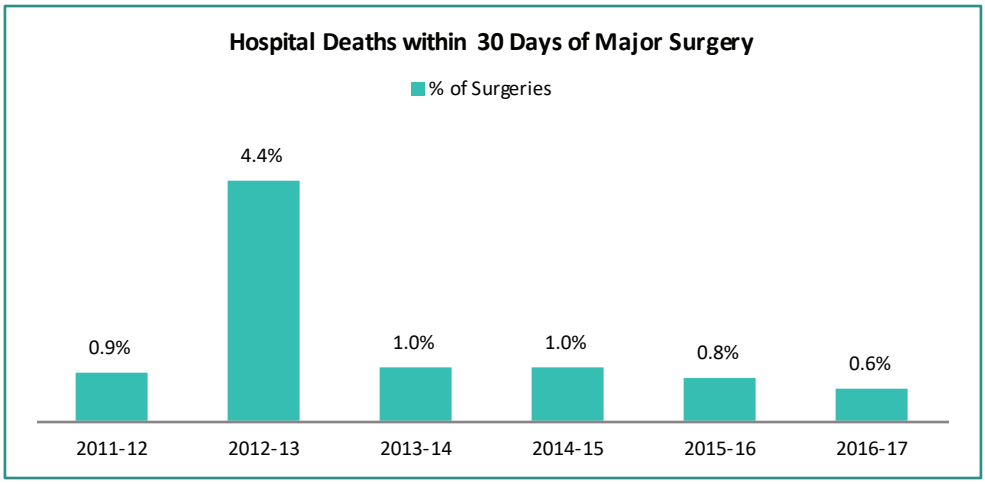
"Although not all deaths are preventable, reporting on and comparing mortality rates for major surgical procedures may increase awareness of surgical safety and act as a signal for hospitals to investigate their processes of care before, during or immediately after the surgical procedure for quality improvement opportunities."[15]

How are we doing?

With the exception of 2012-13, one percent or less of major surgeries resulted in a patient death in NWT hospitals (within 30 days). In 2016-17, the rate of deaths following major surgery was not significantly different from the national average (0.6% versus 1.6%).

Source

Canadian Institute for Health Information.



[15]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=5111812.

Best Care – Inpatient Falls in NWT Hospitals

What is being measured?

The number of inpatients per 10,000 discharges (hospital stays) who experienced an injury due to a fall while they were in an NWT hospital.

Why is this of interest?

Hospitals are expected to treat and care for patients with serious conditions. The effectiveness of the treatment and care received by patients should not be lessened by an injury sustained during a hospital stay. Falls are preventable, and as such, preventing them from happening is an important part of patient-centered quality care.

How are we doing?

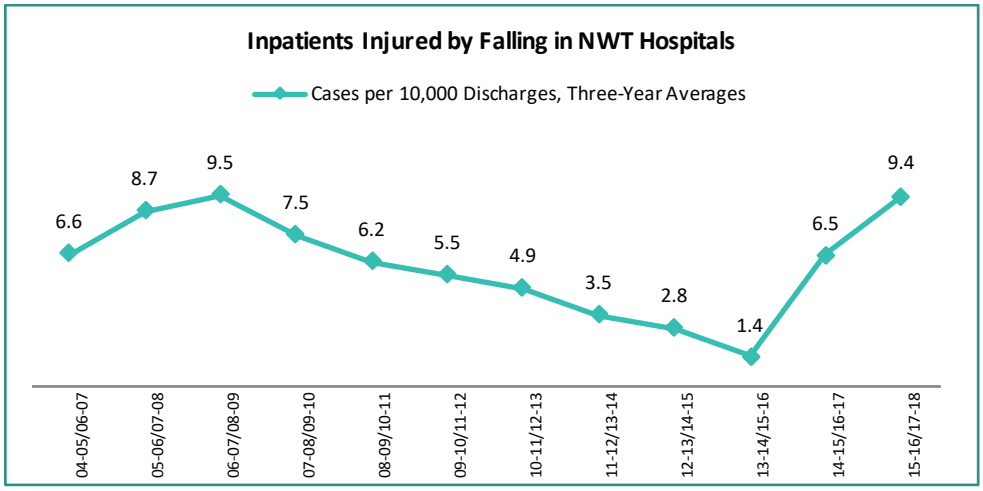
In time period shown, the annual number peaked at 9.5 injured per 10,000 discharges, on average, between 2006-07 and 2008-09, and then dropped down to an average of less than two per 10,000 between 2013-14 and 2015-16.
The average rate has since increased in recent years to 9.4 per 10,000 between 2015-16 and 2017-18. In terms of counting actual patients, the numbers vary widely from zero to seven cases per year.

Notes

The rate of inpatients experiencing falls only includes those patients where the fall resulted in an injury serious enough to be documented on their chart.

Sources

NWT Department of Health and Social Services and Canadian Institute for Health Information.



Best Care – Nursing-Sensitive Adverse Events

What is being measured?

The number of medical and surgical hospitalizations where the patient experienced one or more adverse events during their stay, age 55 years or over, per 1,000 discharges (hospital stays). Adverse events measured by this indicator are: urinary tract infections, pressure ulcers, in-hospital fractures and pneumonia.

Why is this of interest?

Hospitals are expected to treat and care for patients with serious conditions in a safe and effective manner. The effectiveness of the treatment and care received by patients should not be lessened by an injury or infection sustained during a hospital stay. "While nurses are not solely responsible for adverse events that occur in hospital, many believe that there is a strong relationship between nurse staffing and patient outcomes. This indicator can help hospitals identify potential issues in nursing care."[16]

How are we doing?

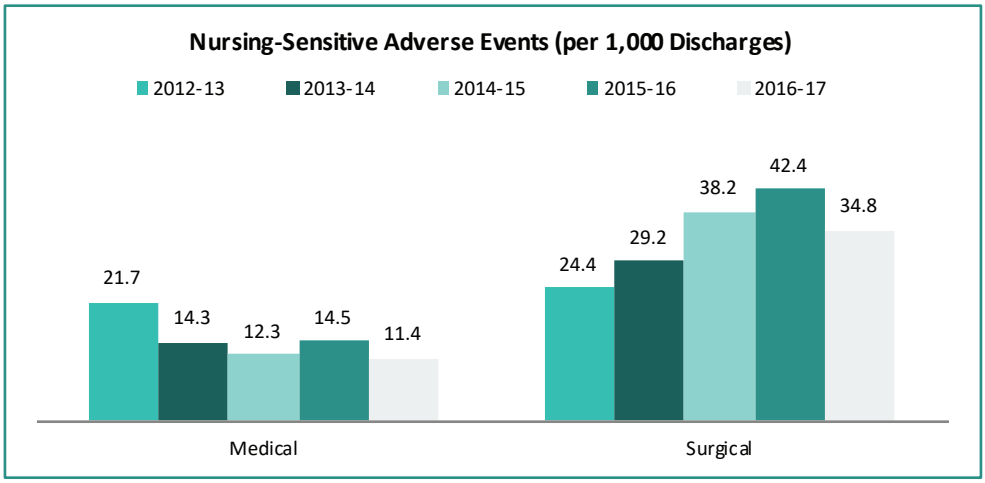
The annual number medical hospitalizations where the patient experienced an adverse event ranged from 11.4 to 21.7 per 1,000 discharges between 2012-13 and 2016-17. During the same four years, the annual number of surgical patients where a patient experienced an adverse event ranged from 24.4 to 42.4 per 1,000 discharges. The NWT had a significantly lower rate of nursing-sensitive adverse events for medical patients in 2016-17 compared to the national average (11.4 versus 27.0). The NWT's rate of nursing-sensitive adverse events for surgical patients in the same year was not statistically different from the national average (34.8 versus 32.6). It important to point out that the actual number of surgical hospitalizations at NWT facilities, where an adverse event occurred, can be small (e.g., between 4 and 8 surgical cases per year), and thus increases or decreases are often not meaningful.

Notes

High or low rates for this indicator must be interpreted with caution as they may be a consequence of inconsistent coding practices by hospitals when reporting post-admission adverse events.

Source

Canadian Institute for Health Information.



[16]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=10977350.

Best Care – In-Hospital Sepsis Rate

What is being measured?

The rate of sepsis occurring during a patient's stay in a NWT hospital (cases per 1,000 hospital stays of two days or longer). Sepsis is a systemic inflammatory response that occurs as a complication of an infection.

Why is it of interest?

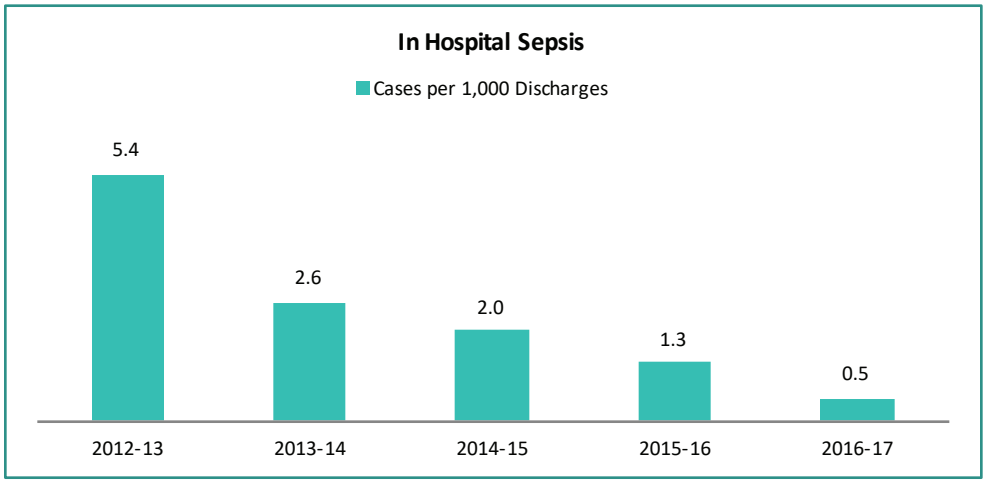
"Sepsis is a leading cause of mortality and is linked to increased hospital resource utilization and prolonged stays in intensive care units. Appropriate preventive and therapeutic measures during a hospital stay can reduce the rate of infections and/or progression of infection to sepsis. The indicator addresses the extent to which acute care hospitals are effective in preventing the development of sepsis."[17]

How are we doing?

With the exception of 2012-13, NWT hospitals have averaged below 2 cases per 1,000 discharges (hospital stays). The NWT rate is significantly lower than the national rate – 0.5 versus 3.9 (2016-17).

Source

Canadian Institute for Health Information.



[17]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=5111838.

Best Care – Repeat Hospital Stays for Mental Illness

What is being measured?

The proportion of patients who had three or more hospital stays for a mental illness among all those patients who had at least one hospital stay for a mental illness within a given year.

Why is it of interest?

This measure can point to a problem of frequent users and may indicate a problem with the appropriateness of care in both the hospital and in the community at large.

How are we doing?

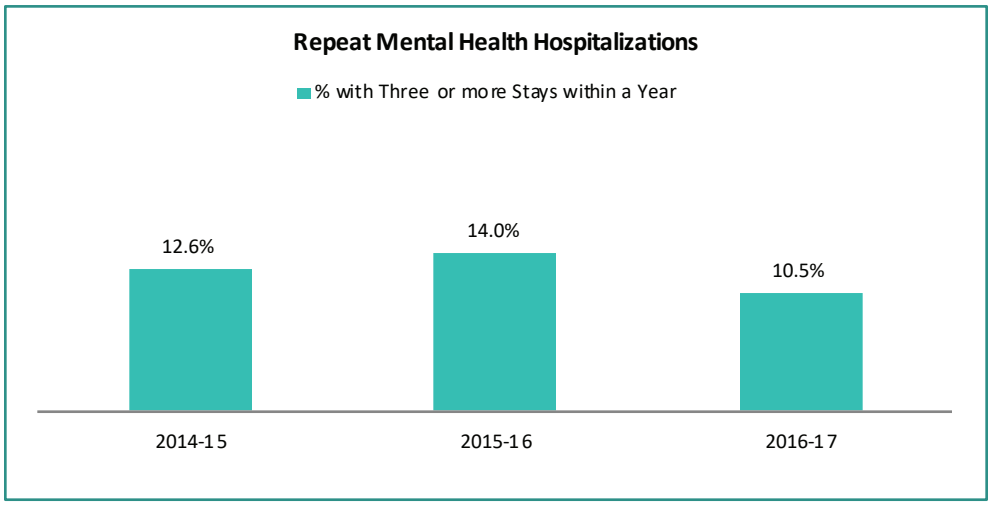
For 2016-17, the proportion of patients with repeat mental health related hospitalizations was 10.5% in the NWT compared to the national average of 12.1%. For the time frame examined, the rate of repeat hospitalizations has fluctuated between 10.5% and 14.0% per year.

Other Information

The NWT has a mental health hospitalization rate approximately twice the national rate. Almost half of NWT hospitalizations for mental illness were primarily due to alcohol and drugs – over five times the rate of hospitalizations nationally. The NWT's readmission rate for mental health hospitalizations has not been significantly different from the national average over the last three years.

Source

Canadian Institute for Health Information and NWT Department of Health and Social Services.



Best Care – Community Counselling Utilization

What is being measured?

The average number of community counselling clients seen per month.

Why is this of interest?

The basic descriptive measure allows for tracking changes in the utilization of the Community Counselling Program (CCP) that provides us with an indication of the appropriateness of services being delivered.

How are we doing?

Over the course of three years, there have been an average 926 clients seen per month by the CCP.

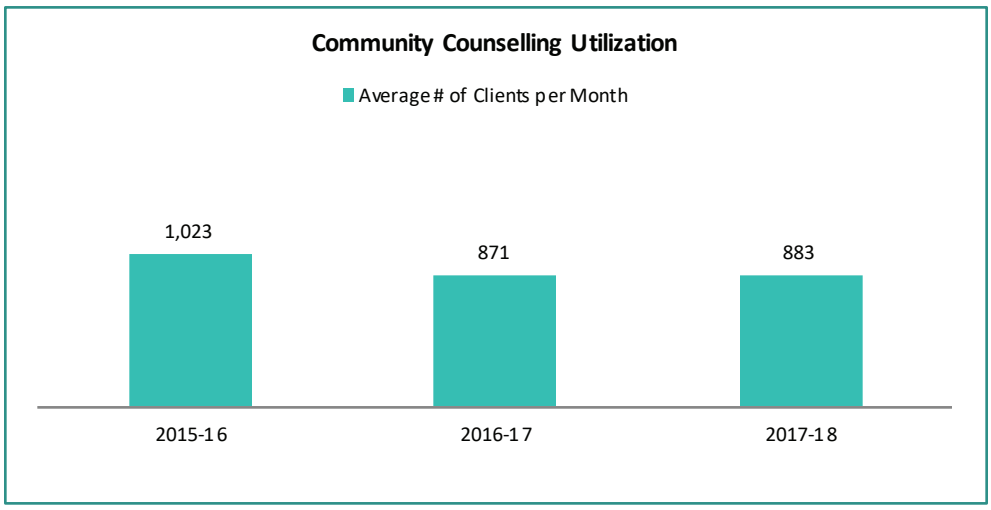
Other information

In 2017-18, the top five documented primary reasons (issues the client presented with) for counselling were addictions (24%), a diagnosed mental illness (11%), trauma (8%), relationship issues (6%) and undiagnosed mental health issues (6%). The remaining reasons for presenting included such issues as difficulty managing stress, family conflict, bereavement, anger, and issues around basic needs.

Every effort is made to get a client into see a CCP counsellor in as short of time as possible. Residents in an immediate crisis, or at immediate risk, do not have to wait. For other clients, wait times vary from community to community. Some communities do not have a wait list while others the wait can be up to two or more months – depending on the type of counselling in question.

Source

NWT Department of Health and Social Services.



Best Care – Residential Addictions Treatment

What is being measured?

The proportion of people who start and complete a full session of residential addictions treatment.

Why is this of interest?

This measure is an indication of how well the system is meeting client needs by ensuring those clients wanting treatment have access to appropriate programs in a timely manner.

How are we doing?

Over the last four years, on average, three-quarters (75%) of those who began treatment completed treatment.

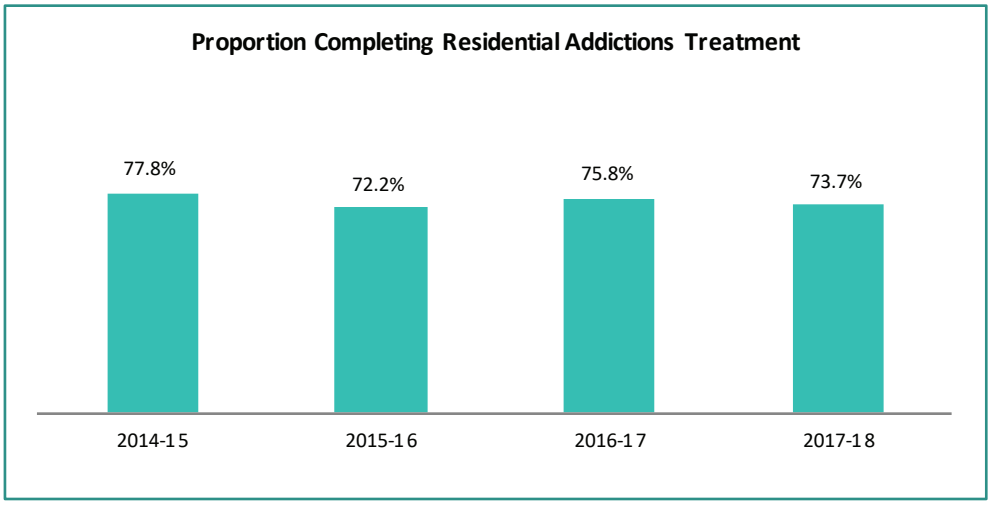
Other information

NWT residents have access to a variety residential treatment programs, including gender specific treatment, culturally based treatment (First Nations, Metis and Inuit), and treatment for trauma as well as concurrent (co-occurring) disorders.

There is no waitlist for accessing treatment. Most clients are admitted within two to three weeks of being approved by the facility.

Source

NWT Department of Health and Social Services.



Best Care – Family Violence and Safety

What is being measured?

The average monthly number of admissions to family violence shelters in the NWT, and the proportion of women and children having stayed at the shelter before.

Why is this of interest?

The average monthly shelter admission count allows for the ability to track changes in client uptake over time. Shelter re-admission rates track the re-victimization of women.

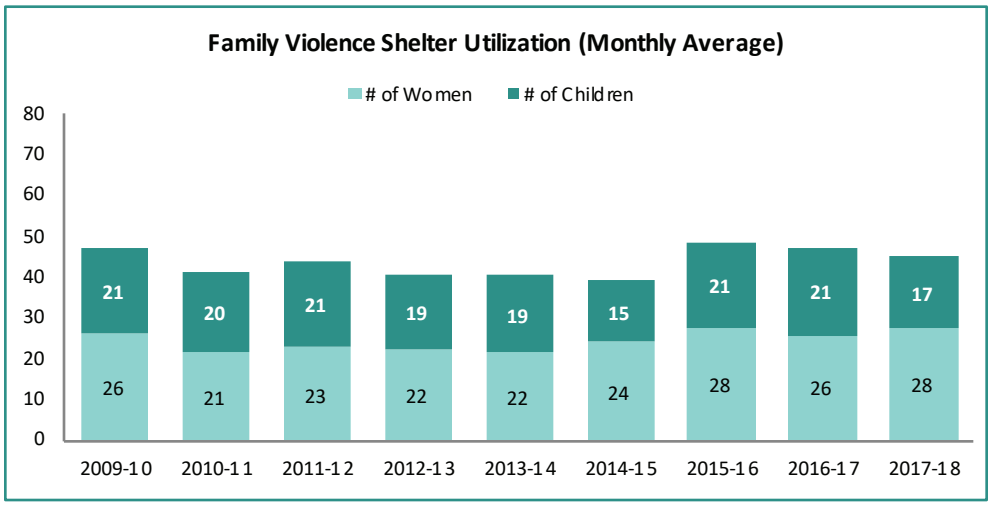
How are we doing?

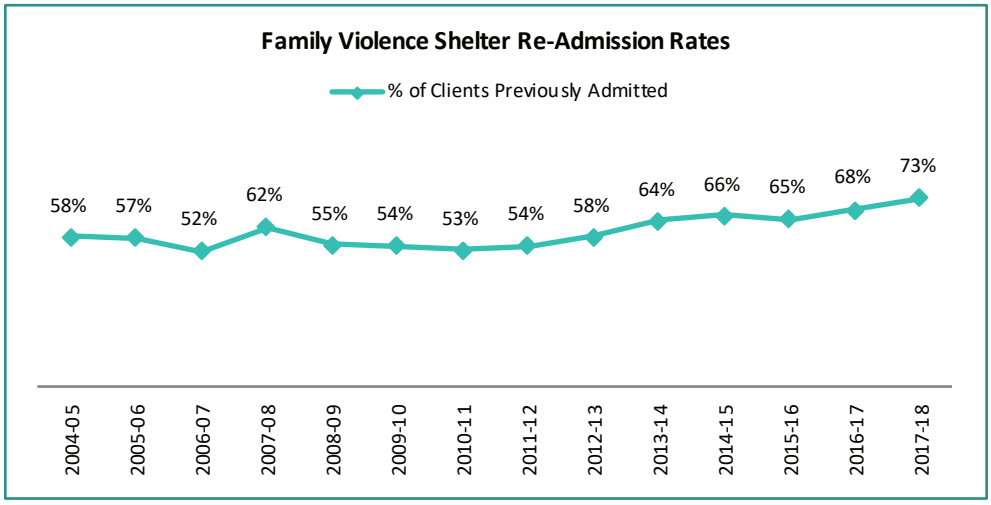
Over the last nine years, shelter usage has remained relatively consistent – averaging around 24 women and 19 children admitted per month.

Over the last 14 years, the proportion of re-admissions to shelters has been increasing - from 58% (2004-05) to 73% (2017-18).

Source

NWT Department of Health and Social Services.





Best Care – Home Community Placements

What is being measured?

The proportion of placements in the child's home community.

Why is this of interest?

When a child must be placed outside of the parental home, it is in the best interest of the child to be placed within their home community. Living in their home community provides the child the best chance of contact with their relations and friends.

How are we doing?

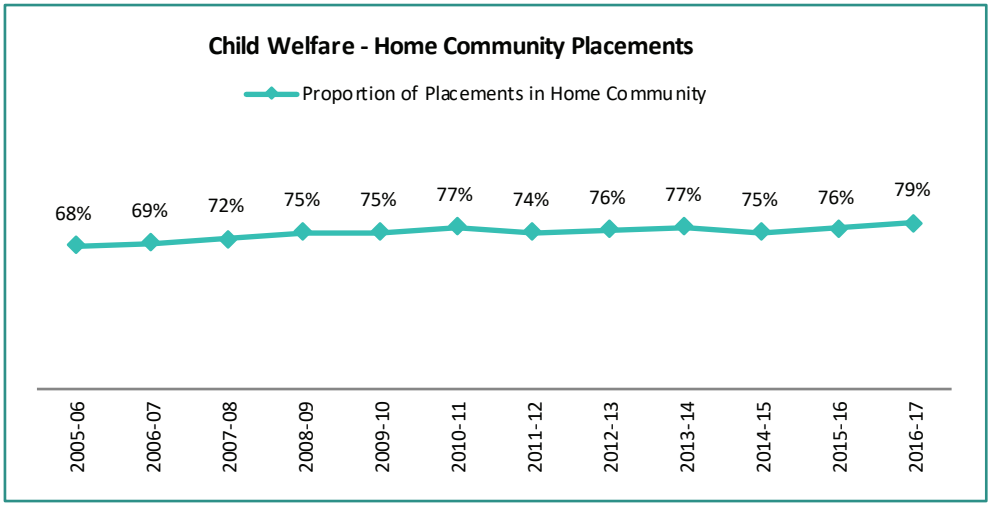
The proportion of placements in the home community has increased since the mid-2000s, going from 68% in 2005-06 to 79% in 2016-17.

Note

A child may have more than one placement within a year.

Source

NWT Department of Health and Social Services.



Best Care – Placement Change

What is being measured?

The proportion of children in care with one placement per year.

Why is this of interest?

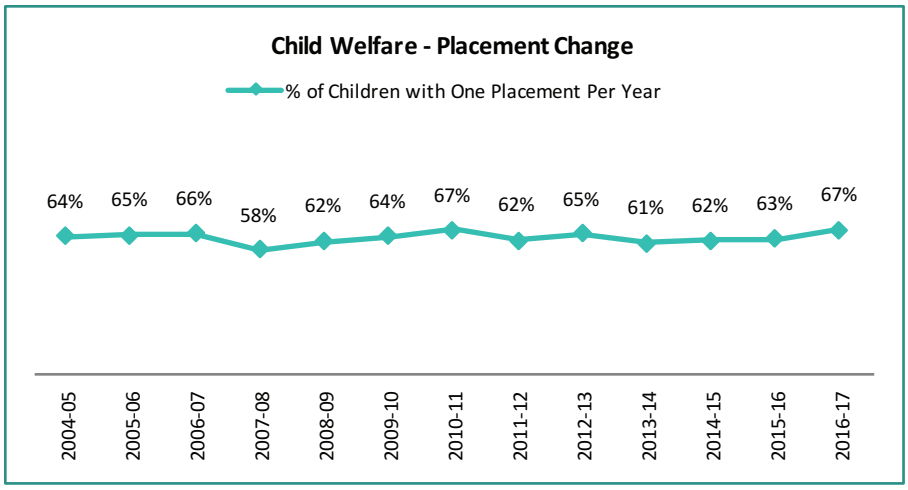
Multiple placement changes are not in the best interests of children. For younger children multiple placements can lead to attachment disorders which may have life-long negative consequences.

How are we doing?

The proportion of children having one placement per year has changed little in the time period considered – averaging 64% (ranging from 58% to 67%). When examined by age group, the proportion of children with one placement per year varies insignificantly between the two time periods.

Source

NWT Department of Health and Social Services.



Children in Care % of Children with One Placement per year			
Age	Average		Change
	07-08/11-12	12-13/16-17	
Total	63%	64%	1.8%
Under 3	58%	58%	-0.7%
3 to 5	60%	60%	1.0%
6 to 11	65%	63%	-4.1%
12 to 15	59%	62%	4.3%
16 & Up	70%	75%	7.1%

Best Care – Child Safety

What is being measured?

The percentage of children found to be maltreated (neglect, abuse, or parent's behaviour) within a year of the last substantiated case of maltreatment.

Why is this of interest?

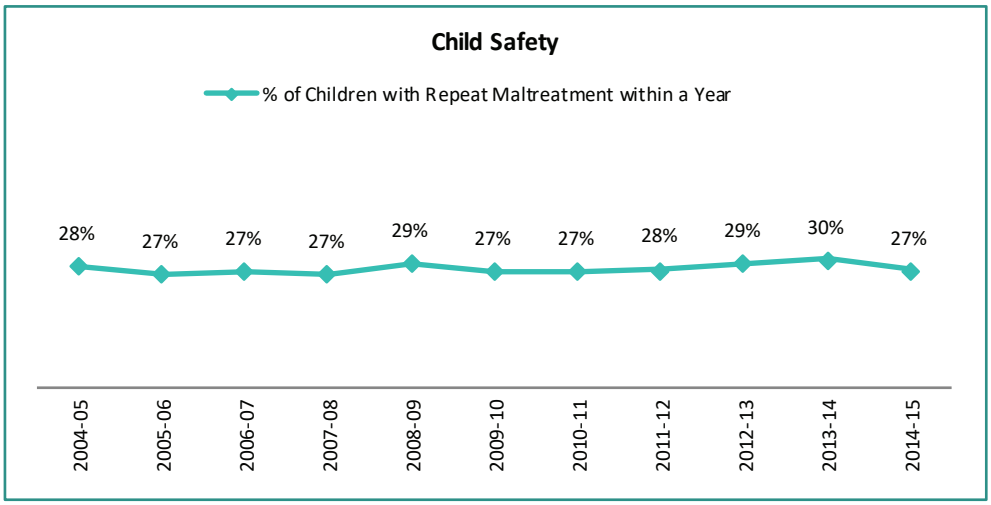
This measure focuses on the safety of children by tracking how well the child welfare system "… protect[s] children from further maltreatment."[18]

How are we doing?

Since 2004-05, the proportion of children found to have been maltreated again (within one year) has remained relatively unchanged - ranging from 27% to 30%.

Source

NWT Department of Health and Social Services.



[18]Nico Trocme et al, *National Child Welfare Outcomes Indicator Matrix* (September 2009), p. 2.

Better *future*

- Build a sustainable health and social services system
- Enhance the skills, abilities and engagement of the HSS workforce
- Support innovation in service delivery
- Improve accountability and manage risk
- Appropriate and effective use of resources

Better Future – Ambulatory Care Sensitive Conditions

What is being measured?

Hospitalizations for ambulatory care sensitive conditions (ACSC) as a proportion of overall hospitalizations. An ACSC hospitalization is where the primary (most responsible) diagnosis for the hospitalization (under age 75 years) is one of the following conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, angina, heart failure and pulmonary edema, or hypertension.

Why is this of interest?

A hospitalization where the primary diagnosis is an ACSC represents "… a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care."[19]

How are we doing?

The proportion of total hospitalizations for ambulatory care sensitive conditions has remained steady for most of the period under review – fluctuating between 4.5% and 6.1% between 2004-05 and 2017-18.

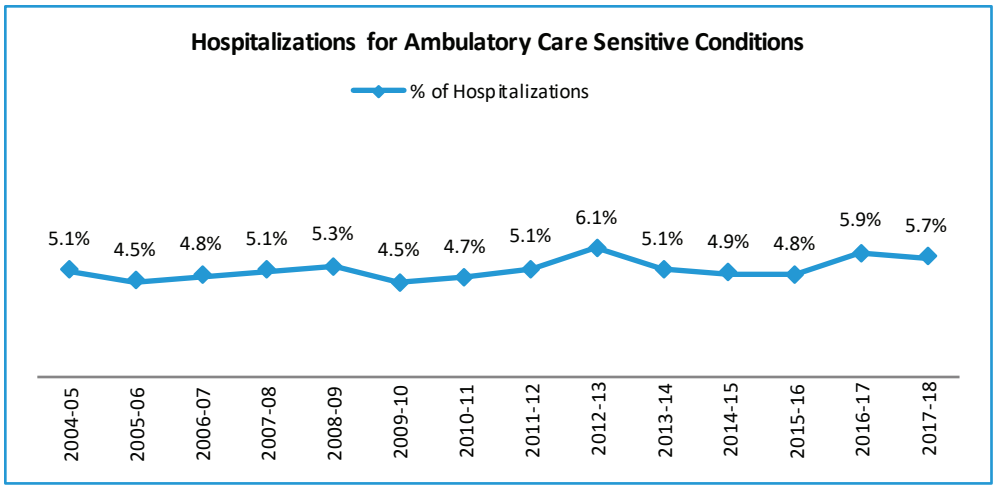
The NWT ACSC hospitalization rate (age-standardized) is almost twice the rate nationally at 78.9 per 10,000 (population) versus 32.5 per 10,000 (2016-17).

Notes

This indicator tracks NWT residents at NWT hospitals.

Sources

Canadian Institute for Health Information and NWT Department of Health and Social Services.



[19]Canadian Institute for Health Information, http://indicatorlibrary.cihi.ca/pages/viewpage.action?pageId=1114181

Better Future – Alternative Level of Care

What is being measured?

The median number of days for an alternative level of care stay at NWT hospitals.

Alternative level of care (ALC) refers to the status of a patient who no longer requires inpatient care but still occupies an acute care hospital bed. The ALC patient cannot be released from the hospital because there is no alternative care available (e.g. home care, long-term care, etc.). The median number of days is the half-way point where 50% of the patients have stayed less than and 50% have stayed more than.

Why is this of interest?

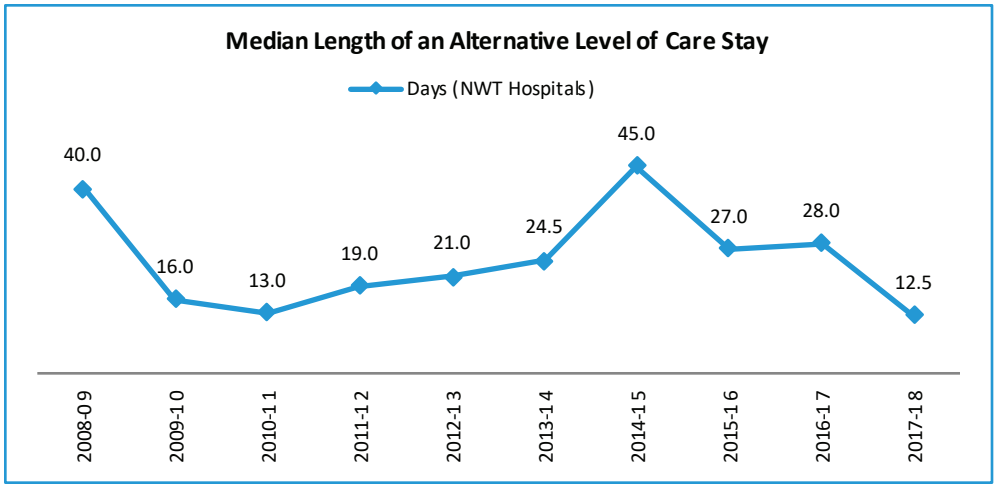
Acute care is the most expensive cost area in the health care system. ALC patients result in inappropriately used acute care beds, reducing the availability of space for patients who actually require acute care. The sooner a patient requiring non-acute care is able to be discharged the better it meets the patient needs and the greater the appropriateness of the use of health care resources.

How are we doing?

Between 2008-09 and 2017-18 the median length of stay has fluctuated between 12.5 and 45 days.

Sources

NWT Department of Health and Social Services and Canadian Institute for Health Information.



Better Future – Alcohol and Drug Hospitalizations

What is being measured?

The proportion of mental health hospitalizations for alcohol and/or drug (A&D) abuse related issues.

Why is this of interest?

Acute care is the most expensive cost area in the health care system. Treating addiction issues in a hospital setting may be viewed as an inappropriate use of hospital resources and may indicate that existing programs are not effective in supporting patients that have a history of excessive substance abuse.

The increasing rate of hospitalization for A&D issues is also reflective of a wider problem of A&D abuse in NWT communities. The NWT's mental health hospitalization rate is on average approximately over twice that of the national average (2014-15) – primarily due to a high rate of A&D hospitalizations – at over five times the national average.

How are we doing?

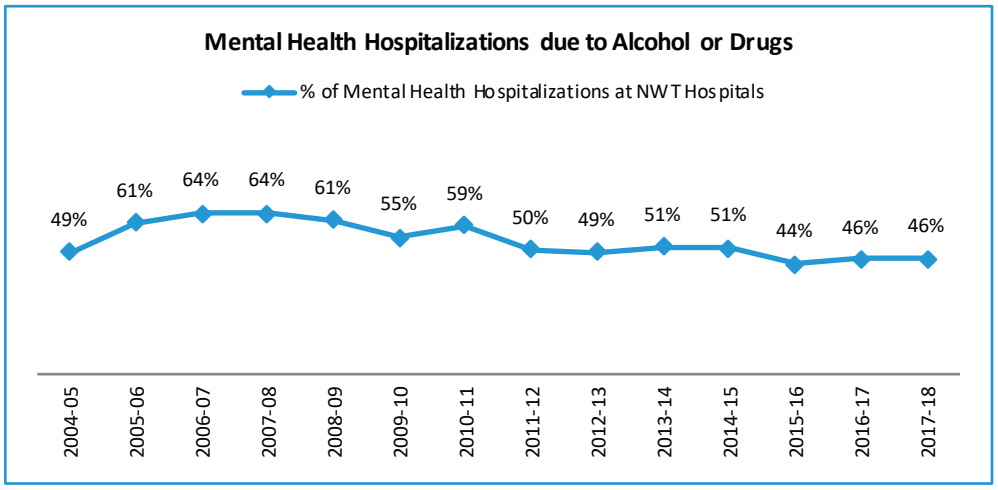
In the time period shown, the proportion of mental health hospitalizations due to A&D issues has decreased from a peak of 64% in the mid-2000s to a low of 44% to 46% in recent years.

Notes

This indicator only tracks hospitalizations, at NWT hospitals by NWT residents, where the primary reason for hospitalization was an A&D issue. Patients with A&D issues could also have a secondary mental health issue(s) and/or a secondary physical issue(s) that have contributed to their hospitalization. This indicator does not track hospitalizations due to other types of damage resulting from long term alcohol and drug abuse (e.g. alcohol induced liver disease).

Sources

NWT Department of Health and Social Services and Canadian Institute for Health Information.



Better Future – Non Urgent Emergency Department Visits

What is being measured?

The proportion of emergency department visits that are non-urgent - as defined by the Canadian Triage and Acuity Scale (CTAS).[20]

CTAS categorizes the seriousness of a patient's condition in terms of the level of urgency required for their care. Level 1 is the highest urgency and level 5 (non-urgent) the lowest.

Why is this of interest?

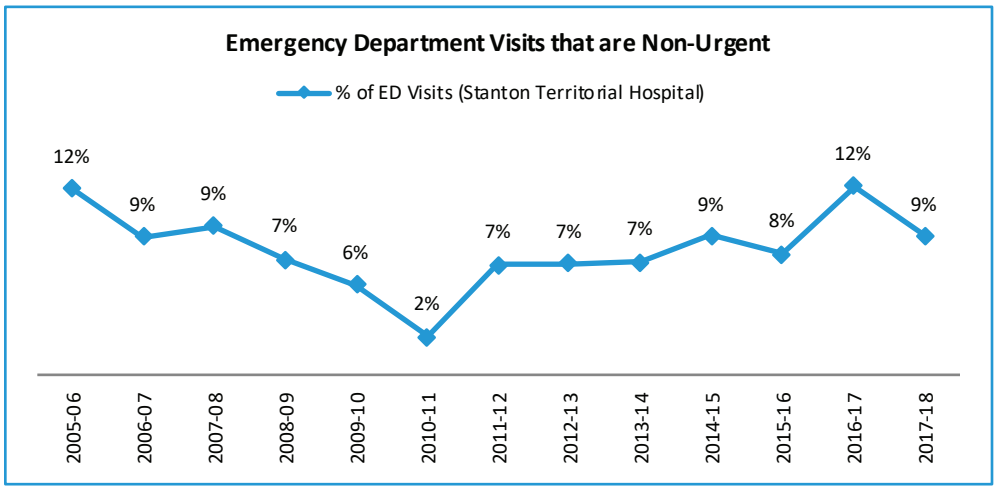
Patients who access emergency department services for health issues that could be seen at a primary care clinic (level 5 – non-urgent), that day or in the next day or two, are taking up limited resources that could be made available to higher priority patients.

How are we doing?

After decreasing to 2% in 2010-11, the proportion of emergency visits considered non-urgent has increased to 8.9% in 2017-18.

Source

Northwest Territories Health and Social Services Authority.



[20]Emergency department visits that did not have a CTAS scored were excluded.

Better Future – No Shows

What is being measured?

The no show rate for family/nurse practitioners and specialist practitioners: the proportion of scheduled appointments where the patient does not show up.

Why is this of interest?

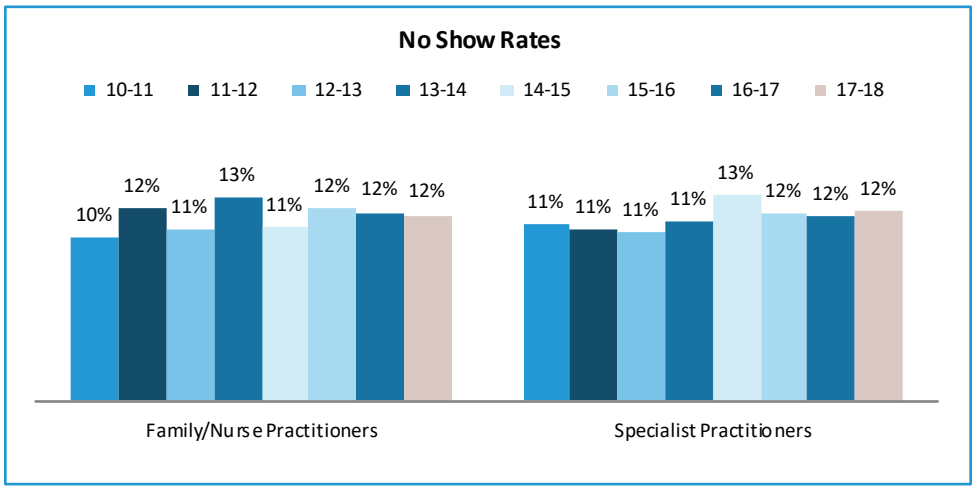
No shows to appointments with these professionals can represent a significant waste in their time as well as needlessly delaying other appointments. These no shows can result in lost appointment slots that cannot be readily filled. To maintain the sustainability of the NWT HSS system, while maximizing timely access, waste in the system must be minimized.

How are we doing?

In the last eight years, patients did not show up to approximately 10 to 13% of scheduled appointments to family and nurse practitioners.[21] For specialists, the no show rate was also ranged between approximately 11 to 13% over the last eight years.[22]

Source

NWT Health and Social Services Authorities.



[21]No show rates for family and nurse practitioner appointments came from data provided by the current HSSAs and their historical counterparts. Reporting has not been consistent over the years. Nurse and family practitioners cannot be separated in all cases, and thus have been lumped together for the purposes of this report. No show rates are estimated for family/nurse practitioners in 2017-18.

[22]No show rates are estimated for specialists in 2011-12. Specialist no show rates exclude Ophthalmologists.

Better Future – Physician Vacancies

What is being measured?

The vacancy rate for family practitioners and specialist practitioners.[23]

Why is this of interest?

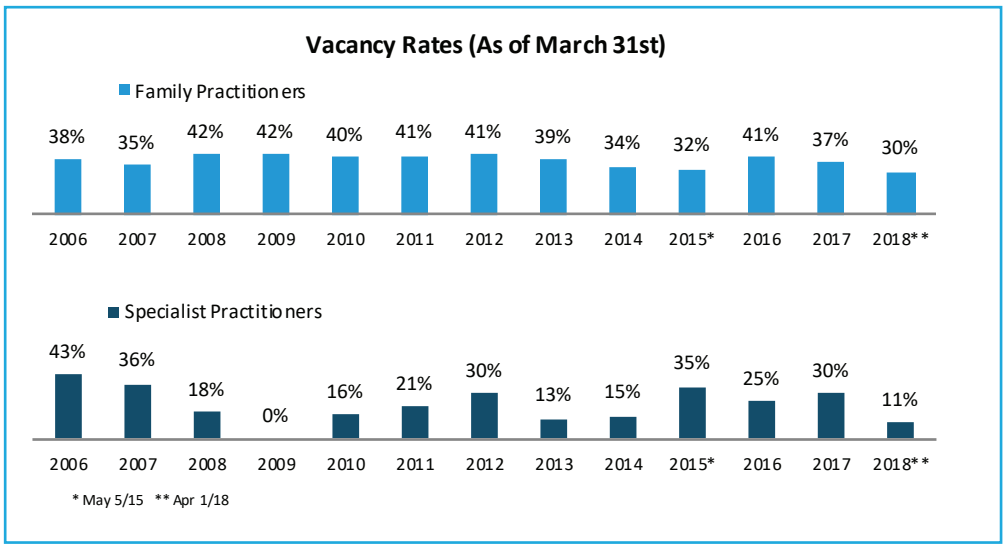
Physicians are key components of the NWT HSS system. Vacancies in these positions significantly impact the capacity of health and social services system.

How are we doing?

Since 2006, vacancy rates have fluctuated between 30% and 42% for family practitioners and between 0% and 43% for specialists. Recent vacancy rates for family practitioners and specialist practitioners are 30% and 11% respectively.

Source

Department of Health and Social Services.



[23]Vacancy rates for physicians include positions staff by locum or temporary physicians. .

Better Future – Nurse and Social Worker Vacancies

What is being measured?

The vacancy rate for nurses and social service workers.

Why is this of interest?

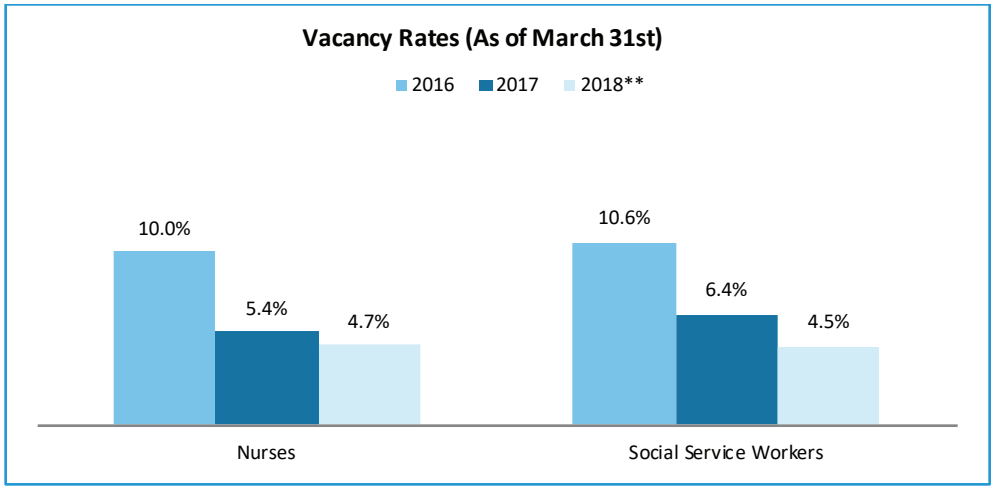
Nurses and social workers are key components of the NWT HSS system. Vacancies in these positions significantly impact the capacity of health and social services system.

How are we doing?

As of March 31, 2018, the vacancy rates for nurses and social service workers were 4.7% and 4.5%, respectively. Due to a change in methodology, historic vacancy rates for nurses and social service workers are not available.[24]

Sources

Department of Finance and Department of Health and Social Services.



[24]Vacancy rates for nurses and social service workers exclude positions vacant but not staffed due to operational reasons. Vacancy rates for nurses also exclude relief nurses. March 31, 2016 rates are estimated.

Better Future – Staff Safety

What is being measured?

The number of workplace safety claims per 100 health and social services employees.

Why is this of interest?

Ensuring staff safety is very important in any workplace but especially in health care and social services where front-line employees are relatively more vulnerable to injury in performing their daily tasks than most other GNWT employees.

How are we doing?

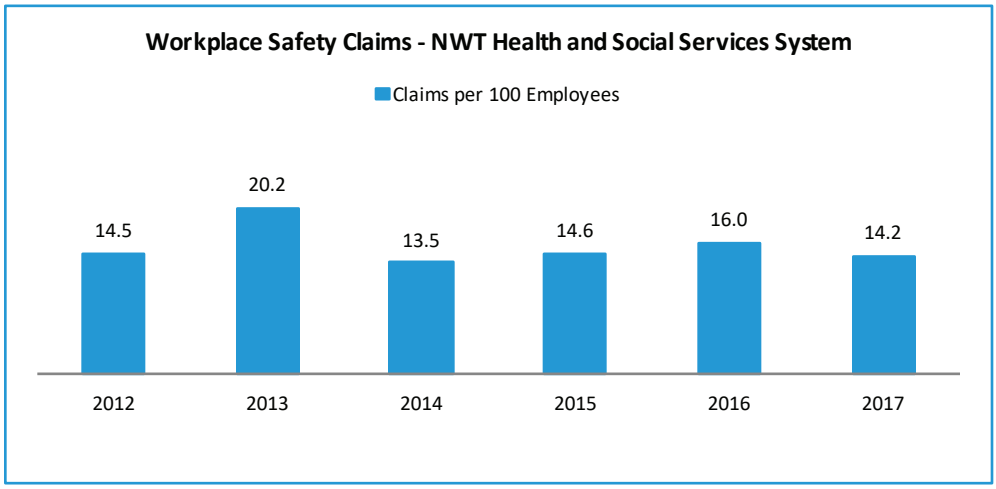
Excluding 2013, the overall rate of safety claims have remained relatively unchanged, fluctuating between 13.5 and 16.0 claims per 100 employees. In the last five years, the rate for the HSS system has been over twice that of the rate for the rest of the GNWT.

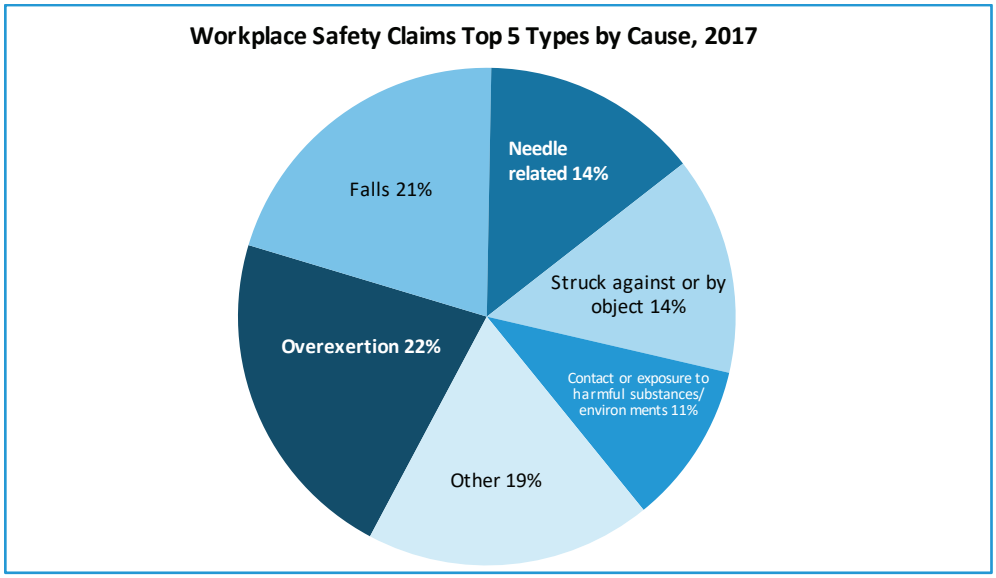
Other Information

In 2017, the top five causes for workplace safety claims were the worker had overexerted themselves (22%), falling (21%), needle punctures and scratches (14%), where the worker was struck by or struck against an object (14%), and contact/exposure to harmful substances such as infectious diseases and chemicals (11%).

Sources

NWT Department of Finance, Workers Safety and Compensation Commission of the NWT and Nunavut, and Hay River Health and Social Services Authority.





Better Future – Administrative Staffing

What is being measured?

The proportion of overall staff in the HSS system that are in administrative roles.

Why is it of interest?

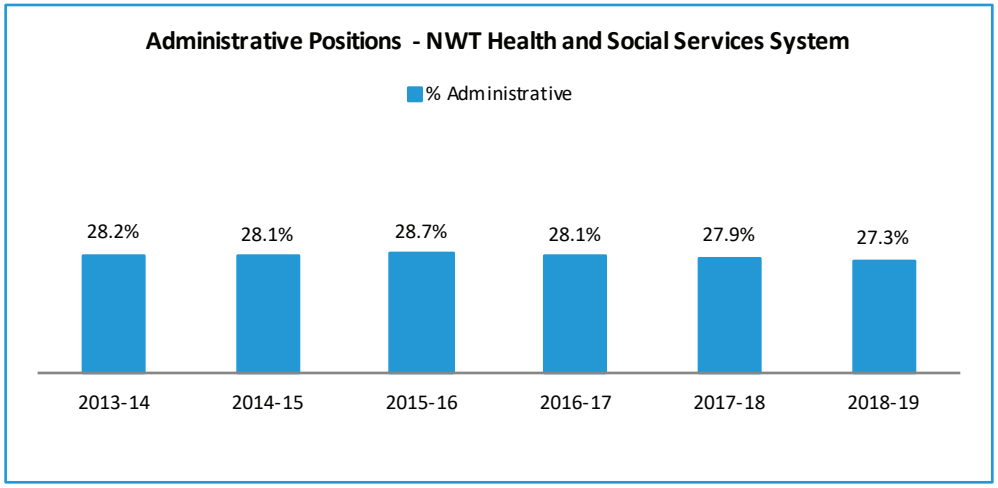
A goal of the health and social services system is to provide the best care as efficiently as possible in order for the system to be sustainable into the future. Increases in the proportion of administrative staff may reflect inefficiencies in the system that need to be investigated.

How are we doing?

The proportion of staff that administrative has averaged around 28% over the last six years.

Source

NWT Department of Health and Social Services.



Better Future – Administrative Expense (Hospitals)

What is being measured?

The proportion of overall hospital expenditures spent on administrative purposes.

Why is it of interest?

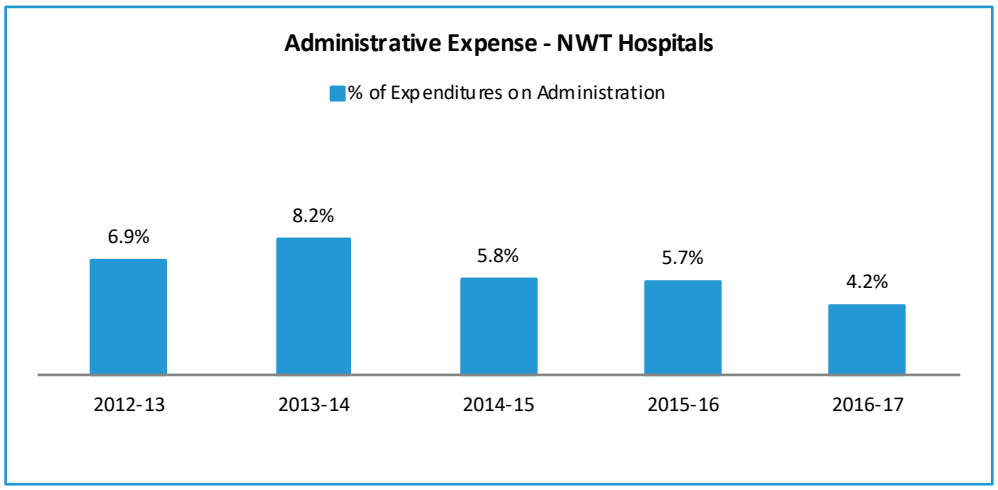
A goal of the health and social services system is to provide the best care as efficiently as possible in order for the system to be sustainable into the future. Increases in the proportion of money spent on administration may reflect inefficiencies in the system that need to be investigated.

How are we doing?

The proportion of hospital expenditures dedicated to administration in the NWT was 4.2% in 2016-17 – lower than the national average of 4.5%. Between 2012-13 and 2015-16, the NWT rate was higher than the national average.

Source

Canadian Institute for Health Information.



Appendices

Appendix 1: Reporting on the Medical Care Plan

Under the *Medical Care Act* (MCA), the Minister of Health and Social Services is obligated to table a report on the operations of the Medical Care Plan. This appendix fulfills this reporting obligation. Although there is no similar legislative requirement to report on the Hospital Insurance Plan, information on this plan is included as it contains important medical services that residents may receive.

NWT Health Care Plan

Residents registered with the NWT Health Care Plan (NWTHCP) are eligible for:

- insured hospital services under the Hospital Insurance Plan established under the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA); and
- insured physician services under the Medical Care Plan established under the MCA.

The Department administers both of these Acts in accordance with the program criteria required by the *Canada Health Act*. The plan is publicly administered, benefits are universal and comprehensive, and residents are able to move freely (are portable) to access services that are medically required. The GNWT Medical Travel Policy provides assistance to residents who require insured services that are not available in their home community.

Eligibility for the NWTHCP is assessed in accordance with guidelines that are consistent with interprovincial agreements on eligibility and portability. As of March 31, 2018 there were 43,632 individuals registered under the NWTHCP.

Insured Physician Services

Services provided under the MCA are medically necessary services provided by a physician in an approved facility. Some examples include:

- diagnosis and treatment of illness and injury;
- surgery, including anaesthetic services;
- obstetrical care, including prenatal and postnatal care; and,
- eye examinations, treatment and operations provided by an ophthalmologist.

Physicians must be licensed under the *Medical Profession Act* in order to practice in the NWT. On March 31, 2018, there were 512 physicians, mostly locums, licensed to practice in the NWT.

The Minister appoints a Director of Medical Insurance to administer the MCA and its regulations. The Director prepares a tariff of insured services which itemizes benefits payable for services provided on a fee-for-service basis for the Minister's approval. The Director also has the authority to enter into agreements for the delivery of insured services that are not on a fee-for-service basis. Almost all physicians in the NWT provide their service by contract rather than by fee-for-service. The Director is required to prepare an annual report on the operations of the medical care plan for the Minister.

During the reporting period, almost $56.5 million was the amount for physician and clinic expenses for insured physician services provided to residents within the NWT.

Insured Hospital Services

Authorities are responsible for delivering inpatient and outpatient services to residents in hospitals and health centres. Contribution agreements between the Department and the Authorities fund the services they provide. Allocated amounts are determined through the GNWT budgetary process.

During the reporting period, insured hospital services were provided to inpatients and outpatients in four acute care facilities, eighteen health centres, and one primary care clinic throughout the NWT.

The *Hospital Insurance and Health and Social Services Administration Ac*t's definition of insured inpatient and outpatient services are consistent with those in the *Canada Health Act*.

The NWT provides the following:

a)Insured inpatient services, meaning:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures together with the necessary interpretations;
- drugs, biological and related preparations when administered in the hospital;
- use of operating room, case room and anaesthetic facilities;
- routine surgical supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities;
- services rendered by persons who receive remuneration from the hospital; and,
- services rendered by an approved detoxification centre.

b)Insured out-patient services, meaning:

- laboratory, radiological and other diagnostic procedures together with the necessary interpretations (not including simple procedures done in a doctor's office);

- necessary nursing services;
- drugs, biological and related preparations when administered in the hospital;
- use of operating room, case room and anaesthetic facilities;
- routine surgical supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities; and
- services rendered by persons who receive remuneration for those services from the hospital.

Reciprocal billing arrangements with Canadian jurisdictions are in place so that NWT residents with a valid NWTHCP do not have to pay out of pocket if they access medically required inpatient or outpatient services in these jurisdictions. During the reporting period, $30 million was paid to approved inpatient and outpatient facilities and physicians outside the NWT for the treatment of NWT residents.

Appendix 2: Publications

Reports and Strategic Documents

- Accountability Requirements for Health and Social Services
- Annual Report of the Director of Child and Family Services, 2016-2017
- Child and Youth Mental Wellness Action Plan 2017-2022
- Continuing Care Services Action Plan 2017/18 – 2021/22
- Disability Matters
- Early Childhood Development Action Plan 2017-2020
- Equity, Accessibility, Inclusion, and Participation - NWT Disability Framework: 2017 to 2027
- GNWT Programs and Services for Persons with Disabilities Inventory
- Midwifery Stakeholder Engagement Report
- Moving Forward: NWT Health and Social Services System 2015-2016 Annual Report
- NWT Disability Program Review and Renewal Project Public Engagement Questionnaire
- NWT Health and Social Services Annual Report 2016-2017
- NWT Health Services Patient Experience Report 2016
- Operational Review of the Northwest Territories Public Guardian Office (Executive Summary)
- Palliative Approach to Care Service Delivery Model for the NWT
- Process Evaluation of the Anti-Poverty Fund Allocation
- Seniors' Information Handbook
- Status Report on the Implementation of the Health Information Act

Brochures and Facts Sheets

- Arsenic Compounds
- Facts about Mould
- Information on NWT Health Coverage of Tobacco Quit Aids
- Métis Health Benefits
- Moose Organ Consumption Notice
- My Tobacco Quit Plan
- Navigating Your Cancer Journey: A Resource for Cancer Patients in the Northwest Territories
- NWT Help Line
- NWT Help Line (Info Card)
- NWT Mental Health and Addictions Resource List
- Pack Travel Insurance Every Time You Travel
- Protecting Your Privacy within Electronic Health Information Systems
- Sahtu Glossary - Cancer Terminology
- Seniors Program Extended Health Benefits
- Smoking Cessation Aids
- Specified Disease Conditions Program Extended Health Benefits
- Studying Outside the NWT?
- Travelling Outside Canada?
- Travelling Within Canada? What you should know
- Vaccine Information Sheets
- Your Health Care Benefits

Infographics and Posters

- Chlamydia Rates in the NWT
- Gonorrhea Rates in the Northwest Territories
- Know Your Privacy Rights
- NWT Help Line (Poster)
- NWT Immunization Schedule - General Public
- Population of the NWT
- Satisfaction with Life in the NWT
- Self-Perceived Health in the NWT
- Self-Perceived Mental Health in the NWT
- Sense of Community Belonging in the NWT
- Socio-Economic Status in the NWT
- Syphilis Rates in the Northwest Territories
- Tuberculosis Rates in the NWT
- We share because we care

Videos

- A fecal immunochemical test (FIT)
- A Warning from the Chief Coroner
- Ann Firth's Cancer Journey
- Back To The Trail 2017
- Breast Cancer Screening
- Cancer Diagnosis
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Donald Prince
- Dr. Andre Corriveau on the Fentanyl Crisis
- Elliot Michael Brown
- Five Ways to Prevent Cancer
- France's Cancer Journey
- Francois Rossouw
- How Does Cancer Treatment Work
- How to Use a Naloxone Kit
- It's A Community Issue - A 'What will it Take?' family violence rant series
- Love Shouldn't Hurt - A 'What will it Take?' family violence rant series
- NWT Help Line
- Shining a Light - Jacey Firth-Hagen
- What is Cancer?

If you would like this information in another official language, call us.

English

Si vous voulez ces informations en français, contactez-nous.

French

Kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.

Cree

Tłı̨chǫ yatı k’ę̀ę̀. Dı wegodı newǫ dè, gots’o gonede.

Tłı̨chǫ

ʔerıhtł’ís Dëne Sųłıné yatı t’a huts’elkër xa beyáyatı theɔą ɔat’e, nuwe ts’ën yółtı.

Chipewyan

Edı gondı dehgáh got’ı̨e zhatıé k’ǫ́ǫ́ edatł’éh enahddhę nıde naxets’ǫ́ edahłí.

South Slavey

K’áhshó got’ı̨ne xədə k’é hederı ɔedı̨htl’é yerınıwę nídé dúle.

North Slavey

Jii gwandak izhii ginjìk vat’atr’ijąhch’uu zhit yinohthan jì’, diits’àt ginohkhìi.

Gwich’in

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.

Inuvialuktun

ᑖᒃᑯᐊ ᑎᑎᖅᑲᐃᑦ ᐱᓕᒍᐅᕐᓂᑦ ᐃᓄᒃᑎᑐᑦᓯᒪᓕᑐᑎᒃ, ᐅᕙᑦᑎᓐᓄᑦ ᐅᖃᒃᑕᓕᕆᓇᖅᑐᑎᑦ.

Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.

Inuinnaqtun

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