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Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

NWT Health and Social Services System

Annual Report

2016-2017

Best health | Best care | Better future

Rapport annuel 2016-2017 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

MARCH | MARS 2018

Message from the Minister

I am pleased to present the Northwest Territories (NWT) Health and Social Services System Annual Report for the 2016-2017 fiscal year. This report presents the 1st 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 2016-2017 fiscal year was a year of transition for the NWT Health and Social Services system, with the integration of six regional health and social services authorities into the Northwest Territories Health and Social Services Authority (NTHSSA). The Hay River Health and Social Services Authority (HRHSSA) and the Tłı̨chǫ Community Services Agency (TCSA) will remain outside of the NTHSSA at this time. These three organizations, referred to as the Authorities, will function together under a one-system-approach improving efficiencies. This organizational change included the creation and appointment of members to six Regional Wellness Councils. These councils ensure that people from each region of the NWT have a representative voice in the Health and Social Services system. The Chair of each of these Regional Wellness Councils sits on the NTHSSA Leadership Council, as well as the Chair of the TCSA.

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

In 2016-2017, the Department of Health and Social Services spent $441 million; $281.5 million went directly to the Health and Social Services Authorities to administer and deliver territorial and regional programs and services. The Department's total expenditures increased $16 million over the prior year. The increase was due mainly to higher volumes of residents accessing physician and hospital services outside the NWT; and increased prices and utilization of southern residential care facilities. In addition, the Department spent over $140 million on capital infrastructure projects and $37 million to perform work on behalf of others. This resulted in a 2016-2017 operating deficit of $14 million for the system. At March 31, 2017, the accumulated deficit for the system was $62.7 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. The changes in our organizational and governance structures were the necessary first steps that will enable system-wide change and the realization of efficiencies. Through a focus on primary health care and upstream interventions we can begin to change the cost trajectory of our system. The efficiencies that can be gained by moving to a territorial model of service delivery will further support our strategic priority of being an effective and efficient system.

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 2016-2017 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 2016-2017 Annual Report* presents the first 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 revised *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 2016-2017 fiscal year, a number of initiatives were undertaken in the area of Child and Family Services aimed at providing prevention and protection services to children and youth and their families. The Department continued implementation of the *Building Stronger Families Action Plan* and work continued with the Authorities, the Department of Justice, the Status of Women Council and the Coalition Against Family Violence on various prevention and intervention projects to reduce the impacts of family violence in the NWT.

In 2016-2017, the Department released the *Mind and Spirit Mental Health and Addictions Strategic Framework* to ensure future work aligns with the needs of our residents and that services are delivered locally with culturally appropriate methods.

Other significant areas of work carried out were aimed at reducing the burden of chronic disease, promoting healthy lifestyles and taking action so that seniors can age in place.

Consistent with other Canadian health systems, the NWT health and social services system continues to experience significant growth in expenditures, requiring a concerted effort and a focus on effective and efficient delivery of services. A significant accomplishment and first step towards reforming the health and social services system is the integration of six regional health and social services authorities into a Territorial Health and Social Services Authority.

Financial Highlights

In 2016-2017, the Department spent $441 million; $281.5 million went directly to the Health and Social Services Authorities to administer and deliver territorial and regional programs and services. The Department's total expenditures increased $16 million over the prior year. The increase was due mainly to higher volumes of residents accessing physician and hospital services outside the NWT; and increased prices and utilization of southern residential care facilities. In addition, the Department spent over $140 million on capital infrastructure projects and $37 million to perform work on behalf of others. This resulted in a 2016-2017 operating deficit of $14 million for the system. At March 31, 2017, the accumulated deficit for the system was $62.7 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 potentially avoidable mortality due to preventable causes (cases per 10,000); potentially avoidable mortality due to treatable cause (cases per 10,000); the proportion of mental health hospitalizations due to alcohol or drugs; as well as increases in the percentage of child welfare placements in one's home community.

Sommaire

Le rapport annuel 2016-2017 du système des services de santé et des services sociaux des TNO résume les progrès réalisés au cours de la première année de mise en œuvre du plan stratégique 2017-2020 intitulé *Votre bien-être, notre priorité*. Ce rapport remplit l'obligation de rendre compte à l'Assemblée législative des activités et de la situation financière du ministère de la Santé et des Services sociaux (MSSS) pour l'exercice précédent, conformément au cadre de planification et de responsabilisation du GTNO et à la nouvelle version de 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 MSSS et les administrations ont poursuivi l'implantation du cadre décennal Partir du bon pied en collaboration avec le ministère de l'Éducation, de la Culture et de la Formation pour améliorer le sort des enfants de moins de cinq ans et de leurs familles.

Au cours de l'exercice 2016-2017, plusieurs initiatives ont été entreprises dans le domaine des services à l'enfance et à la famille fournir des services de prévention et de protection aux enfants, aux jeunes, et à leurs familles. Le Ministère a poursuivi la mise en œuvre du plan d'action *Bâtir des familles plus* fortes et a continué de collaborer avec les administrations, le ministère de la Justice, le Conseil sur la condition de la femme et la Coalition contre la violence familiale sur différents projets de prévention et d'intervention en vue de réduire les conséquences de la violence familiale aux TNO.

En 2016-2017, le Ministère a publié le cadre stratégique *Tête et esprit* portant sur la santé mentale et la toxicomanie pour veiller à ce que les actions futures correspondent aux besoins de nos résidents et à ce que les services soient offerts localement selon des méthodes adaptées à la culture.

D'autres efforts considérables ont été déployés en vue de réduire le fardeau des maladies chroniques, de promouvoir les modes de vie sains et d'aider les aînés à vieillir chez eux.

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 et efficiente des services. Chose certaine, la fusion de six administrations régionales en une Administration territoriale des services de santé et des services sociaux a constitué une première étape importante dans la réforme du système.

Finances : faits saillants

En 2016-2017, le Ministère a dépensé 441 M$. De ce total, 281,5 M$ sont allés directement aux ASSSS pour l'administration et la prestation de services et programmes régionaux et territoriaux. Les dépenses totales du Ministère ont augmenté de 16 M$ par rapport à l'exercice précédent. Cette augmentation s'explique principalement par le plus grand nombre de résidents ayant accédé à des services médicaux et hospitaliers à l'extérieur des TNO, ainsi que par l'augmentation des tarifs et de l'occupation des établissements de soins dans le Sud. De plus, le Ministère a dépensé plus de 140 M$ sur des projets d'infrastructures et 37 M$ pour accomplir du travail en sous-traitance. Il en a résulté un déficit d'exploitation de 14 M$ pour le système en 2016-2017. Au 31 mars 2017, le déficit accumulé s'élevait à 62,7 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 GTNO 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 (cas pour 10 000); de la mortalité potentiellement évitable attribuable à une cause traitable (cas pour 10 000); de la proportion d'hospitalisations en santé mentale attribuables à l'alcool ou aux drogues. On s'attend aussi à une augmentation du pourcentage de placements en protection de l'enfance dans la collectivité même 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 2016-2017 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.[1] 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 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 2016-2017 Revised Estimates. Government of the Northwest Territories, *Main Estimates 2017-2018*, p. ix

What We Do

The role of the Department is to support the Minister of Health and Social Services in carrying out the mandate by: setting the strategic direction for the system through the development of legislation, policy and standards; the establishment of approved programs and services; the establishment 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 NTHSSA, HRHSSA and the TCSA (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. Several initiatives were administered by the Department and the Authorities as part of core service delivery under the Early Childhood Development (ECD) Action Plan for 2016-2017. The Department and the Authorities:

- Continued to support facilities to obtain the Baby Friendly Initiative designation to protect, promote and support breastfeeding in all health care facilities while supporting community-based breastfeeding support. Funding was allocated to Moms, Boobs and Babies to develop and implement peer support training for mothers in Yellowknife, Hay River, and Inuvik.
- Funded the Authorities for training and support for the effective delivery of the Healthy Family Program in all regions in the NWT.
- Completed the evaluations of Tele-Speech and Rehabilitation Services to enhance access to early intervention services for children with exceptionalities or experiencing developmental delays aged 0-5.

The Department's role is to outline legislation, policies, and professional standards for providing health care and services to residents of the NWT including children aged 0-5 years and their families. ECD is a shared responsibility among families, the education system, the health and social services system, and communities. As such, the Department continuously engaged with communities across the NWT to update as needed policies, processes and standards. In 2016-2017, the Department led a number of initiatives that will improve early childhood development in the NWT, including having:

- Engaged with a wide range of stakeholders to assess the perceived gaps in the current maternity care system and to explore ways in which maternal health services could be enhanced by a Territorial Midwifery Program and continued to develop the Hay River Midwifery Monitoring and Evaluation plan.
- Revised and standardized the NWT Prenatal Record form to facilitate the assessment and documentation of pertinent information about the woman's health and pregnancy care for use in all NWT health facilities. Training and support on the *NWT Prenatal Record* forms will be completed when the form is integrated into the EMR.
- The *NWT Well Child Record* has been implemented and is being used to assess children aged 0-5.
- Continued to implement the priority referral process for pregnant mothers with addictions issues. Through the existing contract with treatment facilities, pregnant women with addictions have priority access to treatment when they request it and based upon bed availability. Health Care Practitioners are informed annually of the priority referral process.
- Developed a new oral health approach and continued to provide support for sustainable nutrition strategies. Projects included the development and testing of oral health promotion and prevention programming, and targeting prenatal and infant/child health programs during the Healthy Living Fairs and with licensed child day care facilities.
- Supported three early childhood intervention pilot projects operating in the Tłı̨chǫ, Dehcho, and Inuvialuit Settlement regions.
- Continued to collaborate with ECE to support community wellness initiatives focusing on early childhood funding and expertise to include ECD components of the plans.

Despite the many successes in implementing the ECD Action Plan for 2016-2017, much work remains to be completed to improve outcomes for children and their families. ECD initiatives are important in promoting the health and wellbeing of children in the NWT. ECD is also recognized as a critical determinant associated with mental health, addictions and chronic disease outcomes in adolescence and adulthood. According to available information from the Early Development Instrument, for the period of time between 2012 and 2014, the proportion of children vulnerable in one or more domains was 38.1% for children in the NWT - higher than the normative cut-off of 25.4% (based on a national cohort).

An Implementation Review was conducted with the purpose of generating evidence and background information from the first three years of implementing the Framework and the first two Action Plans (Action Plan for 2014-2016 and the

Bridged Action Plan for 2016-2017). The development of the new three-year Action Plan for 2017-2020 was shaped by priorities set by the 18th Legislative Assembly and guided by the findings from the review. The renewed action plan will continue to ensure that every child, family and community in the NWT, including those most at risk, have access to high quality, comprehensive, and integrated ECD programs and services that are community driven, sustainable and culturally relevant.

EARLY CHILDHOOD INTERVENTION PILOT PROJECTS

Work on three early childhood intervention pilot projects continued to move forward in the Tłı̨chǫ, Dehcho, and Inuvialuit Settlement regions. The Department has been working with the Indigenous governments and relevant authorities in each region to respond to regional issues and to generate information on service delivery models for early childhood development intervention services. Each of the three projects was implemented during the 2015-2016 fiscal year with monitoring and evaluation plans developed for each project. In the spring of 2016, data was collected on the first year of these pilot projects and a report was published later that year. Findings from the pilot projects will inform the future design of territorial early childhood intervention services.

HEALTHY FAMILY PROGRAM

The Department continued to support the 18th Legislative Assembly priority of fostering healthy families through the continued delivery of the Healthy Family Program, an early intervention program that strives to promote a positive and nurturing parent-child relationship in at-risk families. The program was offered in all regions of the NWT, servicing 16 communities and remained a major component of both the ECD Action Plan and the Building Stronger Families Action Plan. In 2016-2017, the Healthy Family Program focused on voluntary home visitation, offered group activities for families, provided referrals to other community services, and established partnerships with other community-based organizations. It also continued to promote healthy eating through the Collective Kitchen, a program funded by the Anti-Poverty Strategy offered at all sites. Feedback from Healthy Family Program staff from the NTHSSA and the HRHSSA was gathered through focus groups at six sites to inform the reframing of the Healthy Family Program. Practitioners attended regional training sessions, and program staff from the NTHSSA and HRSSA attended a territorial workshop in March 2017. The Department organized the Period of PURPLE Crying training and the Relationship Based Practice Training for home visitors. The total 2016-2017 operating budget for this program was approximately $2.5 million.

ORAL HEALTH STRATEGY

Oral health continues to be a concern in communities across the NWT. With funding from Health Canada, the Department has committed to improving oral health outcomes for children aged 0-5 through the Oral Health Strategy, which supports the ECD Framework. With the goal of improving the use of existing resources and integrating oral health preventative care into primary care service delivery, work continued in the following areas:

- Inventory and assessment of dental equipment and infrastructure in the NWT,
- Development of program standards and protocols for preventative care delivery including fluoride varnish application, and
- Supported access to oral health resources, including toothbrushes, toothpaste and informational materials, to over 30 day/child care centres and preschools.

PRIORITY 2: CHILD AND FAMILY SERVICES

The following activities occurred in support of the Priorities of the 18th Legislative Assembly, namely "Fostering healthy families by focusing on wellness, prevention, and improved nutrition" and "Taking action on the crisis of family and community violence".

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 is delivered across the NWT.

To support case management in child prevention and protection services and interventions, the Department deployed the Structured Decision Making (SDM®) system, an evidence-based proprietary risk assessment, decision support and case management structure promoted by the Children's Research Center (CRC) specifically for child protection services. This structured assessment system is composed of a suite of six assessment and decision support tools to help child protection workers and child protection supervisors make decisions at critical points when dealing with child protection concerns, and ensure decisions are being made in the best interests of the child and family. The six (SDM®) tools are: Screening and Response Priority Assessment; Safety Assessment; Risk of Future Harm Assessment; Household Strengths and Needs Assessment; Family Reunification Assessment; and Risk Re-assessment.

Each assessment tool will improve efficiencies in child protection work by identifying and addressing child protection concerns of neglect and abuse more effectively, identify strengths, inform resource allocation, reduce disruptions and avoid unnecessary decision delays to children, youth and families. In collaboration with CRC, the Department adapted and tested the tools to reflect the NWT child protection practices, which led to training opportunities for all child protection staff. Training and territory-wide implementation of the first three SDM® assessment tools were completed. The development of the fourth tool began in September 2016 and was implemented by April 2017 as a guide for staff.

SDM® information will be collected in the new child and family services information system (Matrix NT) which will provide the Department with data for analysis and service improvement purposes. User acceptance testing for Matrix NT was completed by the end of the 2016-2017 fiscal year.

In 2016-2017, the Department examined and defined permanency planning to ensure that child protection practice is culturally relevant and supportive of family and community. Permanency planning is based on the principle that every child has the right to a permanent family, with the child's family of origin as the first option. Permanency Planning was incorporated into the Child Protection Worker Supervisors training curriculum.

IMPROVE RESPONSE TO FAMILY VIOLENCE

The Department continued to work with the Authorities, the Department of Justice, the Status of Women Council and the Coalition Against Family Violence on various prevention and intervention projects to reduce family violence in the NWT. In 2016-2017, funding continued for the Territorial Family Violence Shelter Network allowing for the continued collaboration of shelter staff to better serve those fleeing family violence. In regions without shelters, the Department continued to support the development of family violence response teams and protocols.

FAMILY VIOLENCE PREVENTION

The Department also continued to expand on its "What Will it Take?" social marketing campaign releasing four rant videos "Violence is a Choice", "Stop Blaming the Victim", "No Excuse" and "It's a Community Issue". The Department also continued to promote "What Will it Take?" workshops throughout the NWT as well as support the inclusion of "What Will it Take?" messaging into FOXY/SMASH programs for young men and women. The Department continued to support and participate in activities of the Network to Prevent the Abuse of Seniors and Older Adults, through collaboration with the NWT Seniors' Society.

SERVICES FOR CHILDREN WITH DISABILITIES

The ECD Framework outlines actions that are needed to improve services and supports for children with disabilities. The Department provided 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. If the services an individual needed were not available in the NWT, the Department's Out-of-Territory program offered support services to aid in those needs being met elsewhere. In 2016-2017, the Department completed an evaluation of TeleSpeech and finalized an evaluation of the Rehabilitation Services delivery model for children aged 0-5 in order to identify opportunities for improvement in service delivery. These evaluations will allow us to identify gaps in service and improve where necessary.

The Department initiated the Disability Review and Renewal Project in 2016-2017 with engagement of other GNWT Departments and NGOs that deliver services on the GNWT's behalf. The Project will identify gaps in disability programs and services and opportunities for improvement, and through this work with other departments the Department began to draft an inventory of existing programs and services for individuals with disabilities.

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".

MENTAL HEALTH AND ADDICTIONS STRATEGIC FRAMEWORK

The Department released the 'Mind and Spirit' Mental Health and Addictions Recovery Strategic Framework (2016-2021) in support of the priority set by the 18th Legislative Assembly to foster wellbeing and safety through a focus on mental health and addictions recovery and to ensure delivery and access to culturally-appropriate programs and services. The Framework set the stage for the development of three specific action plans in the following key areas: Child and Youth Mental Wellness, Addictions Recovery, and Mental Health Services.

The Framework built on existing strengths of connectedness to culture and community, which are some of the strongest preventive foundations against mental health and substance abuse. The Framework focuses on four key directions: A Focus on Prevention and Early Intervention, A Recovery-Oriented System, Personal Experience and Outcomes, and A Whole of Government Approach.

MENTAL HEALTH PROGRAMS

The Department is committed to providing effective mental health and addictions services in the NWT. Ongoing services continued in 2016-2017 including:

- The Mental Health First Aid – Northern Peoples Program is a program designed to create an awareness of mental illness and to give participants safe and effective support and intervention skills for aiding in an individual's mental health crisis. Funding was provided to the Authorities to deliver training in each region twice in the 2016-2017 year.
- The Applied Suicide Intervention Skills Training (ASIST) is a two day workshop that trains participants to recognize if someone is at risk for suicide and respond appropriately. Like the Mental Health First Aid program, the Department provided funding for the training to be delivered in each region twice in the 2016-2017 year.
- Talking About Mental Illness is a school-based program/intervention currently offered to Grade 8 students in Yellowknife, Inuvik, Fort McPherson and Fort Resolution. It is aimed at raising awareness and reducing the stigma of mental illness.
- •The NWT Helpline is a 24-hour toll-free phone service that assists callers experiencing mental health problems or crisis. In 2017, the Department expanded this program to include telephone group sessions and a Facebook page.
- The Community Counselling Program offers free counselling, and referral services to all NWT residents. In 2016-2017, the program served an average of 871 clients per month.
- Residential treatment services for youth are offered through Northern Specialized Treatment Resources based in Yellowknife and Fort Smith; or Southern Specialized Residential Placement Resources for more significant developmental and physical disabilities, genetic disorders, acquired brain injuries, psychiatric illness, psychological disorders, and complex behaviour problems secondary to trauma.
- Stanton Territorial Hospital offers psychiatric assessment and treatment for youth and adults. Monthly psychiatric services are also offered in the Beaufort Delta and Sahtu Regions
- Individuals requiring withdrawal management can receive medical detox services at Inuvik Regional or Stanton Territorial Hospitals. Withdrawal management not requiring medication are offered in a non-hospital setting, such as the Salvation Army Resource Centre.

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 availability of culture based approaches to providing treatment and aftercare for people with addictions. In 2016-2017, the On the Land Healing Fund contributed $980,000 to seven regional programs and four community programs: Inuvialuit Regional Corporation, Gwich'in Tribal Council, Sahtu Dene Council, Akaitcho Territory Government, NWT Metis Nation, Tłı̨chǫ Government, Dehcho First Nations, K'asho Got'ine Charter Community, Tłı̨chǫ Leagia Ts'iili Ko – Behchokǫ̀, Katlodeeche First Nation, and Deline Got'ine Government.

The Department initiated work with on the land leaders to develop an evaluation approach for on the land programs. This evaluation approach will propose to use community-based research and Indigenous ways of knowing to evaluate programs such as Project Jewel, an on the land wellness program that targets specific groups of residents in the Beaufort Delta Region who struggle with a particular issue (e.g. addictions, poverty, violence, emotional trauma) and aims to build resilience within participants. The Department is supporting a research project that is underway with the University of Ottawa that will inform the evaluation approach for land based programs. Other Departmental work that occurred in 2016-2017 aimed at informing an evaluation approach for land based programs included: the Department meeting with members of the On the Land Funders' Collaborative; the Department co-facilitating a training workshop hosted by NWT Recreation and Parks Association on evaluating land based programs; the Department commissioning a shared research synthesis on land based programs; and the On the Land Summit that was held in March 2017 that included engagement with programs from across the country that are embarking on evaluating land based programs.

SAHTU MENTAL HEALTH PILOT

The NTHSSA – Sahtu Region worked with the Deline Got'ine Government to establish a two-year pilot project which will see a Traditional Counsellor in the community. In March 2017, meetings were held in Deline to gather information and feedback from community members around what a traditional counselling program could look like, what it should include and how it should integrate with other, existing services in the community.

PRIORITY 4: CHRONIC DISEASE

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

YOUTH ANTI-SMOKING INITIATIVES

Currently, 32.5% of NWT residents over the age of 12 are daily or occasional smokers, significantly higher than the national rate of 18.5%. In an effort to reduce the number of NWT smokers the Department has committed to reducing the number of youth who take up smoking through preventative youth anti-smoking programs. In order to understand what motivates youth to start using tobacco, how to best engage youth in tobacco prevention and cessation, and how to develop key messages about healthy living, the Department held focus group discussions with NWT youth aged 13-24. These discussions concluded in July of 2016 and over 70 NWT youth participated.

TAXATION OF SUGAR-SWEETENED BEVERAGE, JUNK FOOD AND TOBACCO

One of the key elements of the tobacco reduction strategy in the NWT, and other jurisdictions, has been the taxation of products. An increase on the taxes applied to both loose and packaged tobacco products took effect as of April 1, 2017.

The Department continues to examine the use of a similar strategy to reduce the consumption of sugar-sweetened beverages. While there is currently no province or territory in Canada with a "junk food" or "soda" tax, the Department is reviewing literature and monitoring the impact such initiatives have had in other jurisdictions to investigate if such a policy would be an effective way to reduce the prevalence of obesity and of dental disease.

HEALTHY LIVING FAIRS

The Department continued to promote healthy living and community wellness to help reduce the burden of chronic disease. To support this promotion, the Department hosted Community Healthy Living Fairs in 18 communities across the NWT in the 2016-2017 fiscal year. The fairs featured booths with resources from regional and territorial programs and activities that focused on health, wellness, fitness, nutrition and traditional living.

DIABETES INITIATIVES

The prevalence of diabetes continues to rise in the NWT and across Canada. In 2016-2017, the Department continued to approach diabetes through surveillance, prevention, screening and monitoring, as well as promoted initiatives targeting these areas, such as infant feeding and Baby Friendly Initiatives and Drop the Pop. Work to finalize the Chronic Disease Prevention and Management (CDPM) Framework was done in 2016-2017 with the framework expected to be released in 2018. This framework will facilitate the continued treatment and management of diabetes in the NWT.

PRIORITY 5: SENIORS AND ELDERS

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

OUR ELDERS, OUR COMMUNITIES FRAMEWORK

The *Our Elders, Our Communities Framework* outlines seven priorities that will be used to guide program design for older adults to assist them to remain in their communities for as long as possible. During 2016-2017, the Department engaged with Indigenous governments, Members of Legislative Assembly, NGOs and community members to inform the development of an Action Plan for Continuing Care Services to support elders to age in place, and ensure that services are available for those who are no longer able to live in their own homes. The engagement allowed the Department to obtain valuable input on priority actions and opportunities for aligning with new initiatives.

ADMISSIONS TO LONG TERM CARE

The average age of all applicants admitted to Long Term Care, Dementia, and Extended Care from April 1, 2016 to March 31, 2017 are as follows:

Long Term Care		Dementia	
# of Residents Admitted	Average Age	# of Residents Admitted	Average Age
45	79	7	79
Extended Care		**Total**	
# of Residents admitted	Average Age	# of Residents admitted	Average Age
3	77	55	77

The median number of days a patient waited to receive an offer of a placement in a long term care facility in 2016-2017 was 58 days, where the median is the number of days at which 50% of clients have been offered a first placement since the time of their application.

HOME AND COMMUNITY CARE SERVICES

NWT residents continued to have access to a range of home and community care services that promote independence, a healthier and active lifestyle, and enable them to remain living at home longer.

On January 16, 2017, a new bilateral health care funding agreement was agreed to between the federal government and the NWT. The NWT will receive $7.4 million over the next 10 years for home and community care services, beginning in 2017-2018.

LONG TERM CARE PROGRAM REVIEW

The Long Term Care Program Review was completed in the 2015-2016 fiscal year, and the Report identified a need to expand Long Term Care capacity across the NWT. In response to the Review, the Department began working with Departments of Finance, Public Works and Services, Justice, and the NWT Housing Corporation to assess options in the report, specifically regarding:

- Reviewing updated capital projections for LTC care and dementia beds;
- Developing financing options for LTC care facilities;
- Proposing a regulatory framework for LTC;
- Developing an action plan for enhanced home and community care services;
- Building more Seniors' Supported Independent Living units; and
- Marketing preventative maintenance, renovation and mobility upgrades.

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, improved accountability, and an engaged and skilled HSS workforce. This is consistent with the 18th Legislative Assembly's commitment to continue the integration of the HSS system.

EFFECTIVE AND EFFICIENT HSS SYSTEM

Integrated Health and Social Services System

The Department is committed to the continued integration of the HSS system to improve the quality of care for people across the system. On August 1, 2016 six regional health and social services authorities were consolidated into a single healthy and social services authority - the NTHSSA. The HRHSSA and the TCSA will remain outside of the NTHSSA at this time. These three organizations will function together under a one-system-approach allowing for a more consistent and efficient system.

In response to the creation of the NTHSSA, members were appointed to six Regional Wellness Councils. These councils ensure that people from each region of the NWT have a representative voice in the HSS system. The Chair of each of these Regional Wellness Councils sits on the NTHSSA Leadership Council, as well as the Chair of the TCSA. Training and orientation for Wellness Council members were provided in Yellowknife from August 10 to 12, 2016.

Clinical Standards

The NWT Clinical Standards Steering Committee continued to oversee the development of territorial clinical standards and clinical practice guidelines, including performance and compliance indicators. The development of such clinical standards and clinical practice guidelines contributes to the delivery of quality care and consistent access to care for patients. In collaboration with the NTHSSA, the four initiatives that were updated though not yet finalized included:

- Community Health Nursing Administrative Policies
- Community Health Nursing Clinical Practice Guidelines
- Community Health Nursing Program Standards
- NWT Guidelines for the Care of Survivors of Sexual Assault

Health Services Administration

The Health Services Administration (HSA) office in Inuvik manages vital statistics, health care registration, supplementary health benefits and insured services. As part of HSA modernization, the HSA Business Process Review Report was completed by a Contractor in July 2016. The Report included maps, narratives, findings and recommendations. The Report defined the current state of business processes, identified gaps and enabled detailed evaluation for streamlining of business processes using modern technology.

Business processes for HSA work provided the basis for building a new HSA ticketing tool for target implementation in September 2017. The ticket tool is used by staff to record and track client interactions and service delivery. Business processes will also provide orientation for new staff on HSA work, step by step.

Medical Travel

Significant steps have been made towards modernizing the program, including:

- The revision of the GNWT Medical Travel Policy and associated Ministerial Policies came into effect April 2015.
- The publication "NWT Medical Travel: A Step-by-Step Guide" was released in early 2017 as a resource for patients requiring travel for medical services. (https://www.nthssa.ca/sites/www.nthssa.ca/files/medical-travel-guide-final.pdf)
- Training for medical travel staff to become certified service professionals as well as an internal review of Medical Travel Ministerial Policies continues into 2017-18.

IMPROVED ACCOUNTABILITY

As part of System Transformation as well as the Department of Finance's new reporting requirements under the revised Financial Administration Act (2016), the Department updated the HSS system Accountability Framework.

The updated HSS Accountability Framework and new Accountability Requirements document outline the roles, responsibilities, and all legislated reporting requirements under the new Hospital Insurance and Health and Social Services Administration Act, revised Financial Administration Act, the Canada Health Act, the Medical Care Act, and the Child and Family Services Act. The roles and responsibilities outlined for the Department and the Authorities are in the areas of planning, budgeting, reporting and auditing.

As a result of these updates, 2016-2017 marked the first year that the Authority Operating Budgets were tabled in the Legislative Assembly.

In support of the Mandate of the 18th Legislative Assembly that highlights the importance of accountability to be an effective, responsible and transparent government, the Department released and tabled the following reports:

- the NWT Public Performance Measures Report; and
- a report based on the 2016 results of the Community Counselling Program Client Satisfaction Questionnaire.

The reports contained information on the health and wellness of NWT residents and their experience with the HSS system. Public reporting of performance indicators allowed for an open and transparent assessment of the effectiveness of the HSS system, as well as promoted continuous quality improvement.

In addition to this, the 2016 NWT Health Services Patient Experience Questionnaire was administered across the health care system with a report tabled in June 2017.

ENGAGED AND SKILLED HSS WORKFORCE

To support and sustain a skilled and engaged HSS workforce the Department maintained initiatives to support the training and development of employees in the HSS system. These initiatives included:

- The Executive Leadership Development Program (ELDP) provides individuals with opportunities to develop leadership skills and core competencies that prepare them for leadership roles in senior management in the HSS system. In 2016-2017, the Department supported two individuals in this program.
- The Graduate Entry-Level Internship Program (GEIP) offers northern post-secondary graduates work experience related to their education in the field of health and social services. In 2016-2017, the Department supported eight individuals in this program.
- The Targeted Academic Support Program (TASP) provides financial support to eligible employees who wish to receive academic or technical training to expand on their scope of practice. In 2016-2017, the Department supported twenty-one staff members through this program.
- The Post-Graduate Certificate in Remote Nursing is a program that prepares new graduate nurses or Registered Nurses to function in an extended practice in a remote community health centre. This training is offered through Aurora College and in 2016-2017, the Department supported fifteen individuals in this program.
- The Professional Development Initiative (PDI) provides HSS professionals with increased opportunities for professional development, education and training. In 2016-2017, PDI was offered to 418 staff.

CULTURALLY SENSITIVE PROGRAMS AND SERVICES

In 2015, the Truth and Reconciliation Commission Calls to Action called for all health systems to ensure cultural competency training. The NWT HSS system was already on this path, recognizing that cultural barriers and systematic racism are major concerns within the current healthcare system and that these barriers impede patient care and create disparities in the health outcomes between non-Indigenous and Indigenous patients. In 2016-2017, the Department continued planning and implementing activities to combat structural racism and develop cultural competency and safety.

In November 2016, the Department tabled Building a Culturally Respectful Health and Social Services System, a Commitment to Action document, to advance cultural safety across the system. The development of the document was informed by best practices, including departmental work over the past three years and lessons learned. The Commitment to Action document commits to developing an action plan that will be implemented jointly by Authorities and the Department and will outline the Department's direction in policies, standards, and training for the next five years.

ORGAN AND TISSUE DONATION

The Human Tissue Donation Act came into effect June 2015 establishing a legislative framework that allows NWT residents to consent to donate organs and tissues, streamlining the process and easing the burden of family decision making. Work is underway to finalize agreements with Alberta health to allow for the inclusion of NWT residents in the Alberta Organ and Tissue Donation Registry. This is expected to be implemented in the spring of 2018.

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 2016-2017.

Child and Family Services Act

An Act to Amend the Child and Family Services Act was passed June 4, 2015 and came into force April 1, 2016. The amendments address multiple areas to improve services for children, youth and families. Some highlights of the amendments include: re-defining youth and extending services to better serve youth and young adults, as well as allowing Indigenous organizations to participate in court hearings.

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. In February 2017, Bill 18, An Act to Amend the Health and Social Services Professional Act was introduced to address 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 out-dated professional legislation in a more efficient and consistent manner. The new Act is expected to come into force in 2017-18 with the introduction of the first set of profession specific regulations.

Hospital Insurance and Health and Social Services Administration Act (Bill 44)

An Act to Amend the Hospital Insurance and Health and Social Services Administration Act was passed in the Legislative Assembly on June 4, 2015 and came into force August 1, 2016, establishing the NTHSSA. The Act provided for the amalgamation of six Health and Social Services Authorities, improving care and services for NWT residents. The new Act also clarifies the Minister's authority and increases accountability and transparency of the health and social services system.

Marriage Act (Bill 13)

An Act to Amend the Marriage Act was introduced in the fall of 2016 and passed in the Legislative Assembly March 10, 2017. The Act provides for compliance with the federal Civil Marriage Act (2005), and aligns with other jurisdiction's marriage legislation while recognizing the unique challenges of the NWT by for example, making it easier for residents of smaller communities to obtain a marriage license. The Act came into force on June 1, 2017.

Vital Statistics Act (Bill 5)

An Act to Amend the Vital Statistics Act received assent on November 4, 2016, and 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.

REGULATIONS

Health and Social Services Professions Act (HSSPA)

Work on profession specific regulations under the Act continued throughout 2016-2017, 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 is a complete rewrite of the legislation, with 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 continued through 2016-2017, specifically:

- Assisted Community Treatment regulations
- Apprehension, Conveyance, and Transfer regulations
- Designation of Facilities regulations

- Forms regulations
- Review Board regulations
- General regulations

Vital Statistics Act and Change of Name Act Regulations
In order to bring Bill 5 into force, work on the Vital Statistics regulations and Change of Name regulations began in order to update the application process and forms.

Public Health Act Regulations
Work continued on the Health Hazard Regulations and Public Pool Regulations under the Public Health Act. The Health Hazard Regulations will update and replace the current General Sanitation Regulations and Tourist Accommodation Health Regulations. The amendments to the Public Pool Regulations will update the standards to be consistent with newer regulations in other jurisdictions.

STRATEGIC INVESTMENTS IN INFRASTRUCTURE

Significant work was completed on infrastructure projects throughout the NWT HSS system.

Project	Location	Work undertaken in 2016-2017
Avens Expansion *LTC Bed Development*	Yellowknife	Facility program development in progress
Behchoko Long-Term Care Facility *Replacement of 8 bed facility with 18 bed facility*	Behchoko	The project is currently in phase 2
Fort Providence Health Centre *Replacement – New Level B HSS center*	Fort Providence	Substantial completion on this project was issued
Fort Resolution Health and Social Services Centre *Replacement – New Level B HSS Centre*	Fort Resolution	Construction underway
Fort Simpson Health Centre *Replacement facility*	Fort Simpson	Planning in progress
Hay River Regional Health Centre *Replacement – New Level B/C HSS Facility*	Hay River	Substantial completion was issued in Spring 2016
Norman Wells Long-Term Care Facility *Replacement and new long term care facility*	Norman Wells	Construction in progress
Stanton Hospital Renewal *Renewal*	Yellowknife	Procurement process in progress
Territorial Extended Care Facility *Replace existing beds with new facility*	Yellowknife	Planning work for this project was completed
Trout Lake Health Cabin (Sambaa Ke) *Replacement of existing leased facility*	Sambaa Ke	This project was submitted for approval through the capital planning process
Tulita Health and Social Services Centre *Replacement facility*	Tulita	Planning in progress
Woodland Manor *Renovation/Expansion - 9 bed addition*	Hay River	Construction underway

INVESTMENTS IN E-HEALTH AND TECHNOLOGY

Matrix NT is the name given to the electronic Child and Family Services Information System replacement. This new data system is replacing an out-dated system and incorporates items such as the Structured Decision Making (SDM®) tools. The 2016-2017 fiscal year was the third year of this project and included activities such as proof-of-concept testing as well as the initiation of privacy and security activities in preparation for the training and system rollout that occurred in 2017 and any future training.

Electronic Medical Records (EMR) enables health care practitioners to better capture and share client medical information leading to better access and outcomes. The deployment of EMR in the NWT continued in 2016-2017 with the following communities integrating EMR into their facilities:

- Aklavik
- Colville Lake
- Fort Good Hope
- Fort McPherson
- Fort Providence
- Tsiigehtchic
- Tuktoyaktuk

Additionally, the Rehabilitation programs in Inuvik, Fort Smith, Stanton and Hay River. Public Health in Yellowknife and Audiology and Speech Language services were also incorporated into the EMR.

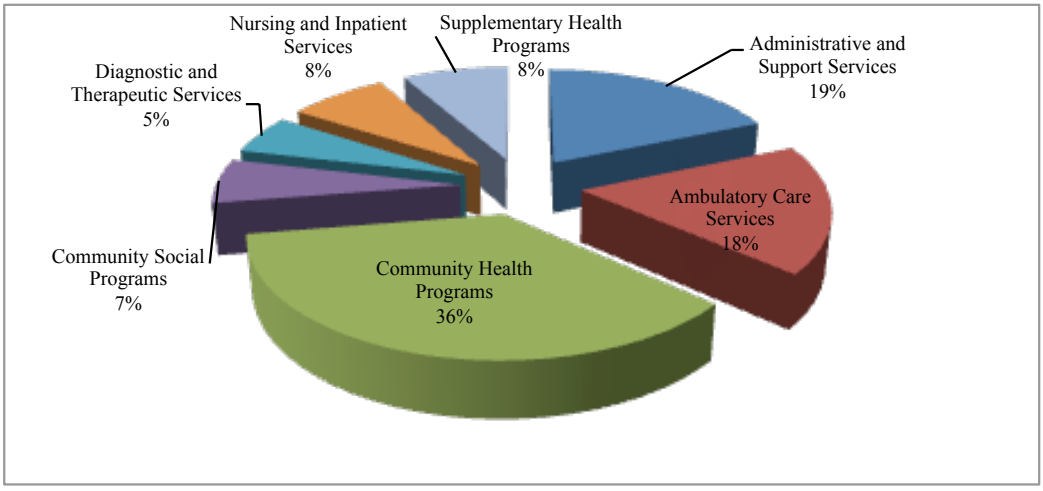
As a result of the latest implementations, the EMR now covers over 90% of the Territorial population and includes over 55,500 active patient charts. This means that more information is being shared with the health care and community care providers that require it, making a positive difference in the quality of care received.

Work continues through the remainder of 16/17 on the remaining communities of Fort Liard, Paulatuk, Sachs Harbour, Ulukhaktok and Lutselke.

Financial Highlights

In 2016-2017, the Department spent $441 million; $281.5 million went directly to the Health and Social Services Authorities to administer and deliver territorial and regional programs and services. The Department's total expenditures increased $16 million over the prior year. The increase was due mainly to higher volumes of residents accessing physician and hospital services outside the NWT; and increased prices and utilization of southern residential care facilities. In addition, the Department spent over $140 million on capital infrastructure projects and $37 million to perform work on behalf of others.

2016-2017 Department of Health and Social Services Actual Expenditures by Activity (in thousands)



2016-2017 Expenditures by Activity

	2016-17	2015-16
Activity	**Actual**	**Actual**
Administrative and Support Services	82,263	77,305
Ambulatory Care Services	78,222	70,667
Community Health Programs	159,285	154,558
Community Social Programs	27,108	27,867
Diagnostic and Therapeutic Services	23,989	23,928
Nursing and Inpatient Services	33,902	34,220
Supplementary Health Programs	36,359	36,341
Total	**$441,128**	**$424,886**

2016-2017 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	292,985	308,897	(15,913)	(58,146)
Hay River Health and Social Services Authority	32,175	29,458	2,718	(2,655)
Tlicho Community Services Agency	16,032	16,921	(889)	(1,901)
Total	**341,192**	**355,276**	**(14,084)**	**(62,703)**

In 2016-2017, the Authorities received approximately 83% of their revenues from the Department. Expenditures were $355 million and total revenue was $341 million, resulting in an operating deficit of $14 million. At March 31, 2017, the accumulated deficit was $62.7 million.

2016-2017 System Pressures

In 2016-2017, the Department spent $32.5 million for residents to access hospital services outside the NWT. This is $6 million more than the prior year. 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 $28.5 million in 2016-2017 for adult and youth residential care placements in southern facilities for NWT residents to access services not available within the NWT. This is $4.4 million more than the prior year. This includes services for residents with specialized cognitive or physical care needs. The number of residents requiring these services has increased, as have the complexity, and subsequent cost, of services accessed.

Human Resources continue to be the most significant cost pressure for the Authorities, with compensation accounting for up to 67% of total Authority expenditures. Authorities spent almost $240 million on staff in 2016-2017, significantly more than budgeted as there continued to be a number of unfunded costs that were one-time in nature or unpredictable, such as removal and relocation costs, overtime, and pension buybacks.

2016-2017 Compensation Expenditures by Authority (in thousands)

Authority	Total Expenses	Total Compensation	Compensation % of Total Expenses
Northwest Territories Health and Social Services Authority	308,897	201,401	65%
Hay River Health and Social Services Authority	29,458	25,543	87%
Tlicho Community Services Agency	16,921	12,771	75%
Total	**355,276**	**239,715**	**67%**

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*.[2] The indicators under best health are focused on the overall health and wellness of the population. Under best care, indicators examined look at access, quality and responsiveness of care and services provided to children, individuals, families and communities. For 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 is included under the Performance Measures section of this report.

The long-term trend is based on seven or more years of data, whereas the short-term change is the difference 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).

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 Overall Health As Very Good or Excellent	66.4%	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 (Cases per 10,000)	21.6	21.0	No	↓
Mental Health Hospitalization Rate (Cases per 1,000)	12.7	12.4	No	↑
Hospitalizations Entirely Caused by Alcohol (Cases per 1,000)	14.5	13.2	No	No
Opioid Related Hospitalizations (Cases per 10,000)	8.1	5.9	No	↑
Population Hospitalized for Self-Harm (Cases per 10,000)	19.3	14.0	No	↑
Sexually Transmitted Infections (Cases per 1,000)	31.1	29.5	No	↑
Early Development Instrument - Proportion of Children Vulnerable in One or More Domains	38.1%	n/a	n/a	n/a

[2]NWT Department of Health and Social Services, *NWT Health and Social Services Performance Measurement Framework, May 2015.* http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/performance-measurement-framework.pdf

Best Care Indicators	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Potentially Avoidable Mortality due to Treatable Causes (Cases per 10,000)	10.8	10.8	No	↓
Screening for Colorectal Cancer (% of Target Population)	24.8%	25.8%	No	n/a
Screening for Breast Cancer (% of Target Population)	53.6%	60.3%	↓	n/a
Screening for Cervical Cancer (% of Target Population)	51.0%	53.5%	↓	n/a
Childhood Immunization (% Fully Immunized by Second Birthday)	62.7%	63.4%	No	n/a
Seniors receiving the Flu Shot	57.3%	72.3%	No	Stable
Hospitalizations for Lower Limb Amputations (Per 1,000 Persons with Diabetes)	2.7	1.4	No	Stable
Long-Term Care Placement Wait Times (Days)	58	33	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)	6.5	1.4	No	Stable
Nursing-Sensitive Adverse Events - Medical (per 1,000 Discharges)	14.5	12.3	No	n/a
Nursing-Sensitive Adverse Events - Surgical (per 1,000 Discharges)	42.4	38.2	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)	14.0%	12.2%	No	Stable
Community Counselling Utilization (Monthly Average # of Clients)	871	1,020	⇩	n/a
Proportion Completing Residential Addictions Treatment	75.8%	72.2%	No	n/a
Family Violence Shelter Utilization - Women (Monthly Average)	25.8	27.6	No	Stable
Family Violence Shelter Utilization - Children (Monthly Average)	21.3	21.0	No	Stable
Family Violence Shelter Re-Admission Rates	68.3%	64.8%	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	6.7%	5.3%	↑	Stable
Median Length of an Alternative Level of Care Stay	28	27	No	Stable
Proportion of Mental Health Hospitalizations due to Alcohol or Drugs	46.1%	44.1%	No	↓
Emergency Department Visits that are Non-Urgent	12.1%	7.7%	↑	Stable
No Show Rates - Family/Nurse Practitioners	12.0%	12.3%	↓	↑
No Show Rates - Specialists	11.9%	13.1%	↓	n/a
Vacancy Rates - Family Practitioners	37.1%	40.6%	No	Stable
Vacancy Rates - Special Practitioners	30.0%	24.9%	No	Stable
Vacancy Rates - Nurses	5.4%	10.0%	↓	n/a
Vacancy Rates - Social Workers	6.4%	10.6%	No	n/a
Workplace Safety Claims - NWT HSS System (per 100 Employees)	15.8	14.6	No	n/a
Administrative Staffing - NWT HSS System (% of Positions)	27.9%	28.1%	No	n/a
Administrative Expense - NWT Hospitals (% of Expenditures)	6.3%	6.4%	No	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 2016/17 then the previous time period is usually 2015/16). Short-term change is the difference between the two. The long-term trend is the direction the numbers are heading towards 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.

Data Sources and Limitations

The data for this section 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.

The numbers and rates are subject to future revisions and are not necessarily comparable to numbers in other tabulations and reports. The numbers and rates 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.

Best *health*

Population Rating their Overall Health As Very Good or Excellent

Population Rating their Mental Health as Very Good or Excellent

Population that are Current Smokers

Population that are Heavy Drinkers

Population that are Overweight or Obese

Population that are Moderately Active or Active

Potentially Avoidable Mortality due to Preventable Causes (Cases per 10,000)

Mental Health Hospitalization Rate (Cases per 1,000)

Hospitalizations Entirely Caused by Alcohol (Cases per 1,000)

Opioid Related Hospitalizations (Cases per 10,000)

Population Hospitalized for Self-Harm (Cases per 10,000)

Sexually Transmitted Infections (Cases per 1,000)

Early Development Instrument - Proportion of Children Vulnerable in One or More Domains

Best Health – Health Status and Well-Being

What is being measured?

Two measures of health status and well-being: the proportion of the population, age 12 years & over, rating their overall health as very good or excellent and rating their mental health as very good or excellent.

Why is this of interest?

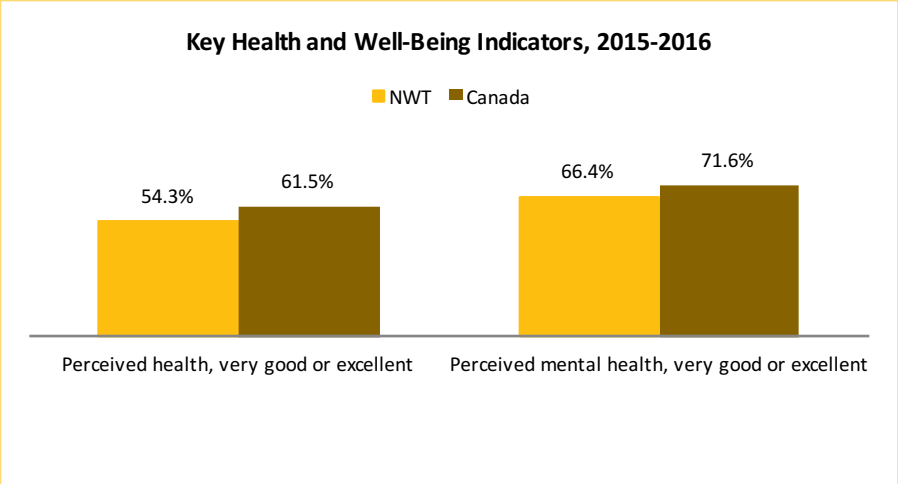
Self-reported health relates to how healthy a person feels, and is an important predictor of future health care use and mortality rates. Perceived mental health gives a general sense of the population afflicted from a mental or emotional disorder or issue.

How are we doing?

For 2015-2016, NWT residents were less likely to rate the overall health or mental health as being very good or excellent than was the case nationally.[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. As a result of these changes, comparisons to pre-2015 results have 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 years and over); the proportion who are heavy drinkers (age 12 years and over); the proportion that are obese (age 18 years and over); and the proportion who are physically active (age 18 years and over).

Why is this of interest?

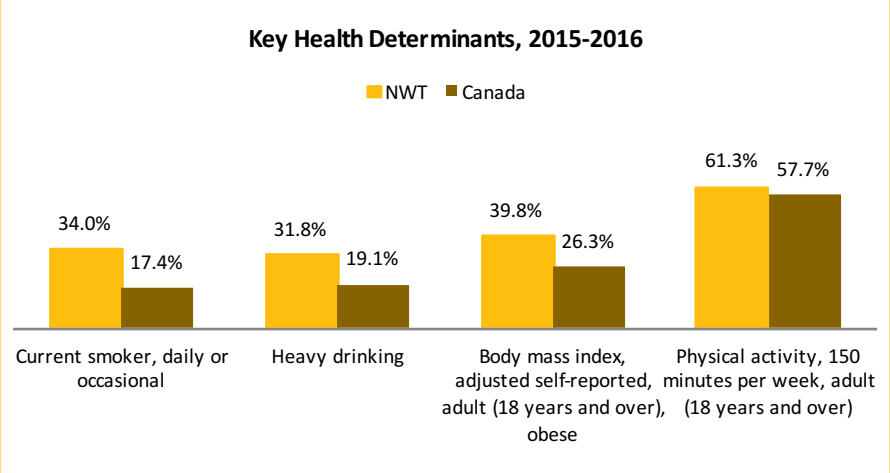
Smoking is a largely preventable factor in a number of chronic diseases, including lung and other cancers, chronic lung problems, type II diabetes, and cardiovascular diseases (heart attacks and strokes). Smoking can increase the risk of acquiring type II diabetes, as well as increasing the risk of diabetes complications (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 play 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.[4]

Source

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



[4]In 2015, Statistics Canada changed the content and the design of the Canadian Community Health Survey. As a result of these changes, comparisons to pre-2015 results have not been included in this report.

Best Health – Avoidable Death due to Preventable Conditions

What is being measured?

The age-standardized death rate 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 largely preventable (e.g. lung cancer and injuries). 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).

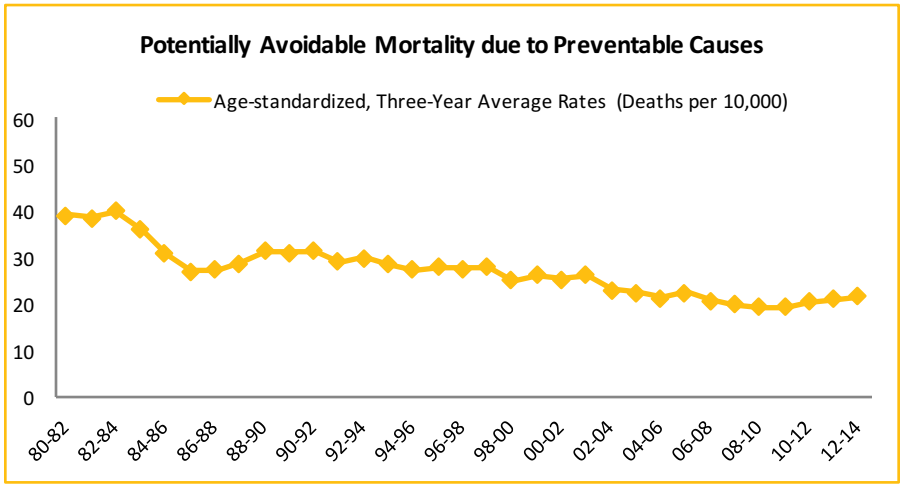
How are we doing?

The rate of avoidable mortality due to preventable deaths 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 – 21.6 versus 13.3 per 10,000 (2012–2014).

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.[5]

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?

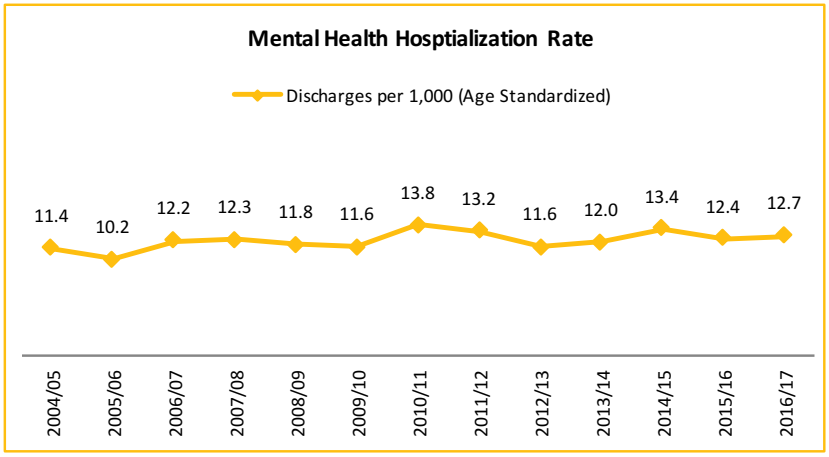
Over the last 12 years, the rate of hospitalizations has been trending slightly upwards. Alcohol and drug issues (dependency/abuse) represented just over half of all mental health hospitalizations.

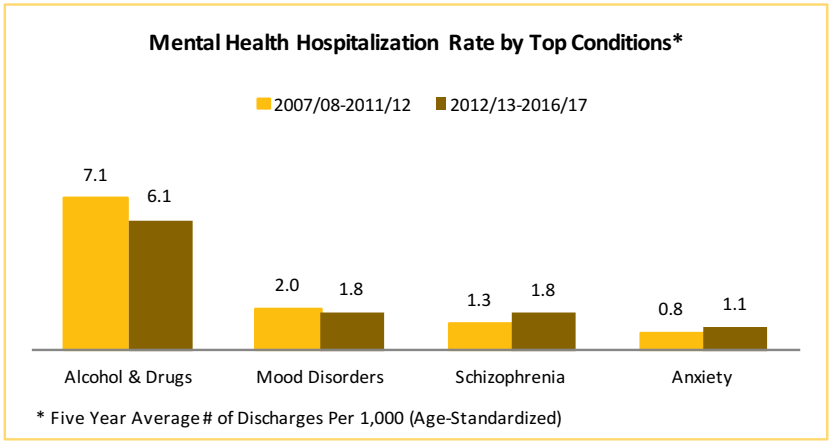
Together with the three next largest categories (mood disorders, schizophrenia/psychotic disorders, and anxiety disorders), they accounted for 9 out of 10 mental health hospitalizations between 2004/05 and 2016/17.

The NWT's overall mental health hospitalization rate, between 2012/13 and 2016/17, is on average over two times higher than the national average (2014/15). Compared to Canada, the NWT has especially higher rates of alcohol/drug hospitalizations (six times) and anxiety disorder hospitalizations (almost four times).

Sources

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





[5]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?

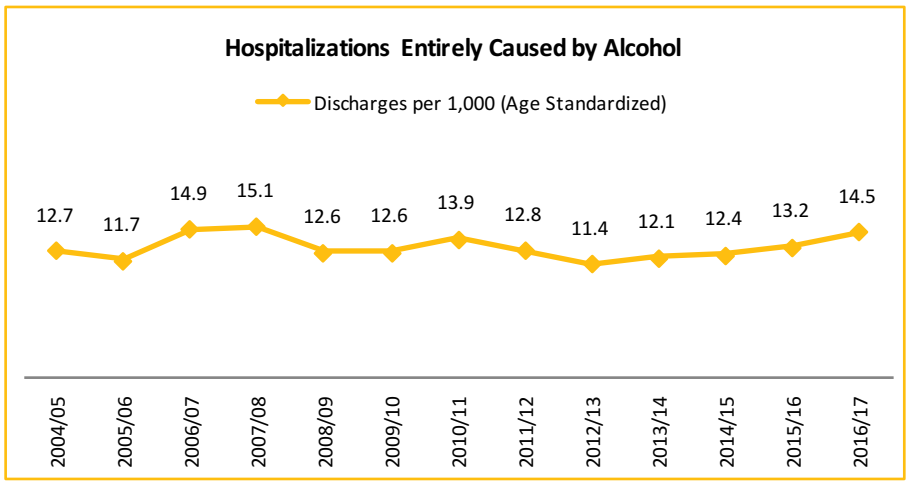
The abuse of alcohol is a cause or a contributing factor in a number of health conditions and is a leading factor in preventable death and disease. In addition, the harmful use of alcohol puts an unnecessary strain on the health, social services and justice systems.

How are we doing?

The rate of hospitalizations entirely caused by alcohol has fluctuated between 2004/05 and 2016/17 from a low of 11.7 to a high of 15.1. In 2015/16, the NWT rate of hospitalizations caused by alcohol was over five times the national average (13.2 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) of NWT residents.[6]

Why is this of interest?

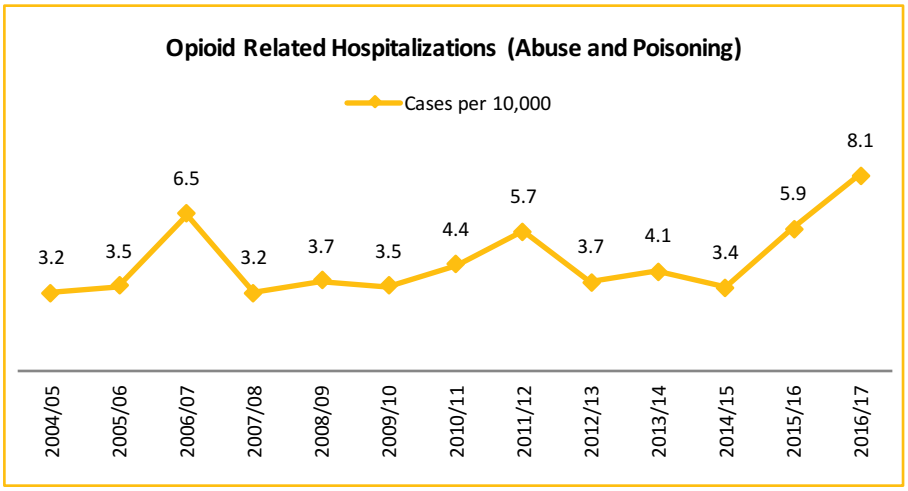
Across the country, opioid addiction is a public health crisis. Fentanyl overdoses have resulted in a record level of deaths due to opioids.

How are we doing?

The NWT rate of opioid abuse and poisoning hospitalizations has increased between 2004/05 and 2016/17 – with most of the increase occurring in the last two years.

Sources

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



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

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 (cases per 10,000).[7]

Why is it of interest?

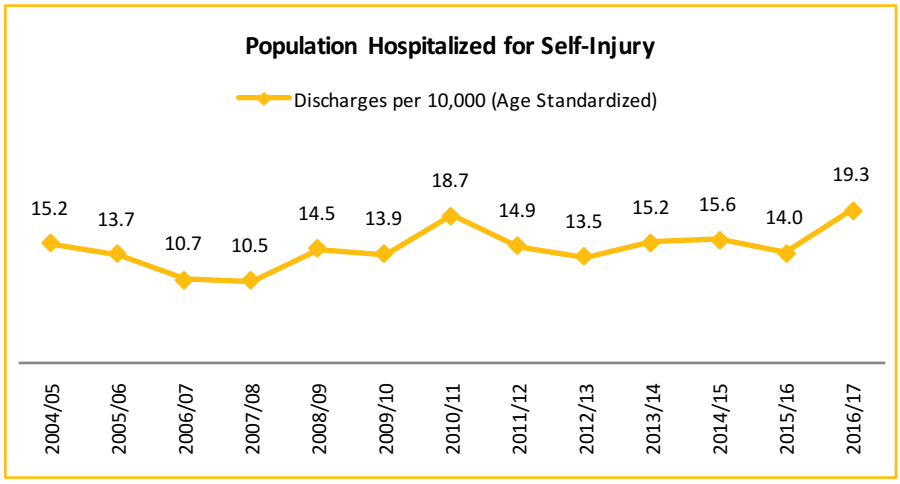
"Self-injury … is the result of either suicidal or self-harming behaviours, or both." "Self-injury can be prevented, in many cases, by early recognition, intervention and treatment of mental illnesses. While some risk factors for self-injury are beyond the control of the health system, high rates of self-injury hospitalization can be interpreted as the result of a failure of the system to prevent self-injuries that are severe enough to require hospitalization."[8]

How are we doing?

The rate of the population hospitalized for a self-injury has increased from 15.2 per 10,000 in 2004/05 to 19.3 in 2016/17. Most of this increase has occurred between 2015/16 and 2016/17. A direct comparison to a national average is not available but when examined by total hospitalizations, the NWT has a higher rate of self-injury hospitalizations than is the case nationally at 19.5 versus 6.6 per 10,000 (2015/16).

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?

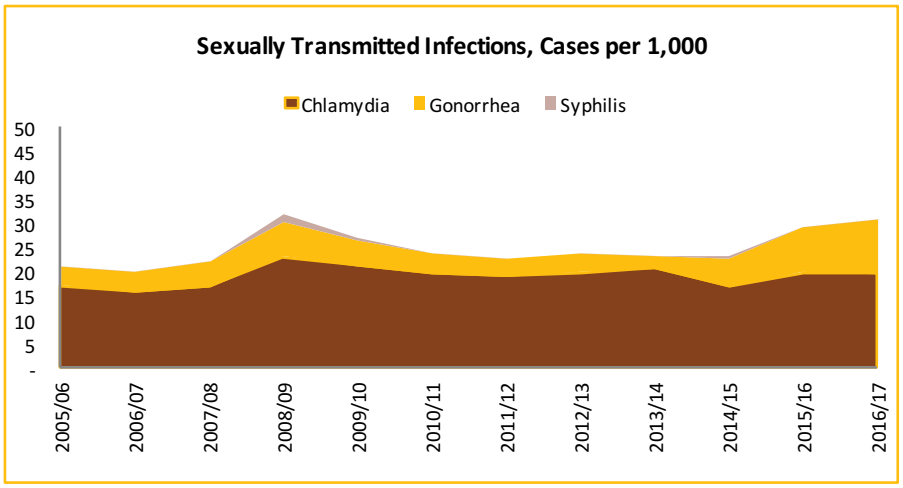
STIs are spread through practicing unsafe sex, and can cause infertility, ectopic pregnancies, premature births and damage to unborn children. The rate of STIs can provide a proxy of the degree to which unsafe sex is being practiced.

How are we doing?

The rate of STIs has increased in recent years growing by 35% from 23.1 to 31.1 cases per 1,000 between 2014/15 and 2016/17 – primarily due to an increase in the rate of gonorrhea. The incidence of STIs in the NWT is over seven times higher than the rest of Canada's 3.9 cases per 1,000 (2015).

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 as it is a determinant of how well a child will do in school, as well as health and well-being in later life. It is also a high level measure of the collective success of interventions aimed to improve the early development of children.

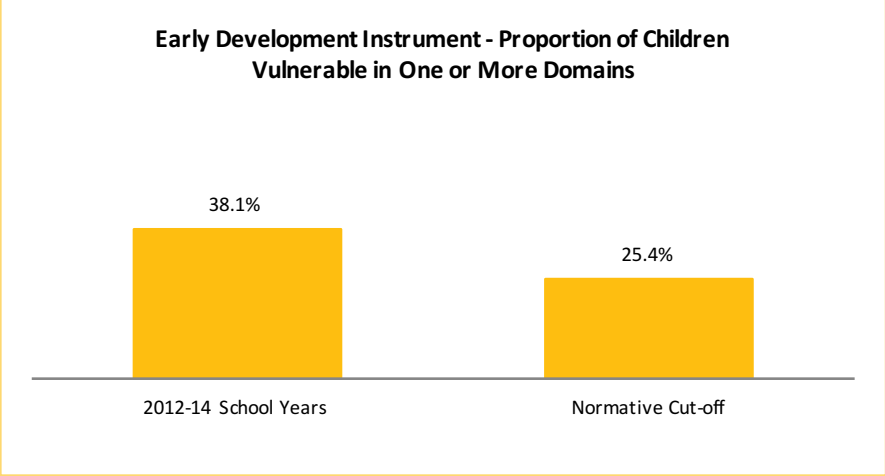
How are we doing?

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*

Screening for Colorectal Cancer (% of Target Population)

Screening for Breast Cancer (% of Target Population)

Screening for Cervical Cancer (% of Target Population)

Childhood Immunization (% Fully Immunized by Second Birthday)

Seniors receiving the Flu Shot

Hospitalizations for Lower Limb Amputations (Per 1,000 Persons with Diabetes)

Long-Term Care Placement Wait Times (Days)

Patient/Client Satisfaction - Satisfied or Very Satisfied

Hospital Deaths within 30 Days of Major Surgery

Inpatients Injured by Falling in NWT Hospitals (per 10,000 Discharges)

Nursing-Sensitive Adverse Events - Medical (per 1,000 Discharges)

Nursing-Sensitive Adverse Events - Surgical (per 1,000 Discharges)

In Hospital Sepsis (Cases per 1,000 Hospital Stays of 2 Days or More)

Repeat Mental Health Hospitalizations (% with 3 or More in a Year)

Community Counselling Utilization (Monthly Average # of Clients)

Proportion Completing Residential Addictions Treatment

Family Violence Shelter Utilization - Women (Monthly Average)

Family Violence Shelter Utilization - Children (Monthly Average)

Family Violence Shelter Re-Admission Rates

Child Welfare - % of Placements in Home Community

Child Welfare - % with One Placement per Year

Child Safety - % Repeatedly Maltreated within a Year

Best Care – Avoidable Mortality from 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]

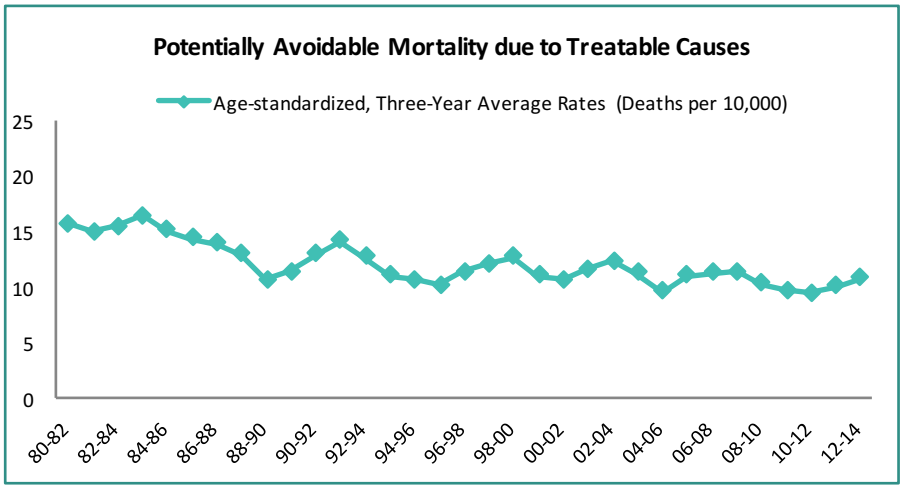
How are we doing?

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 less than 11 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 – 10.8 versus 7.0 per 10,000 (2012-2014).

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 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, screening is an effective strategy to identify and treat all pre-cancerous lesions and avoid further malignancy.

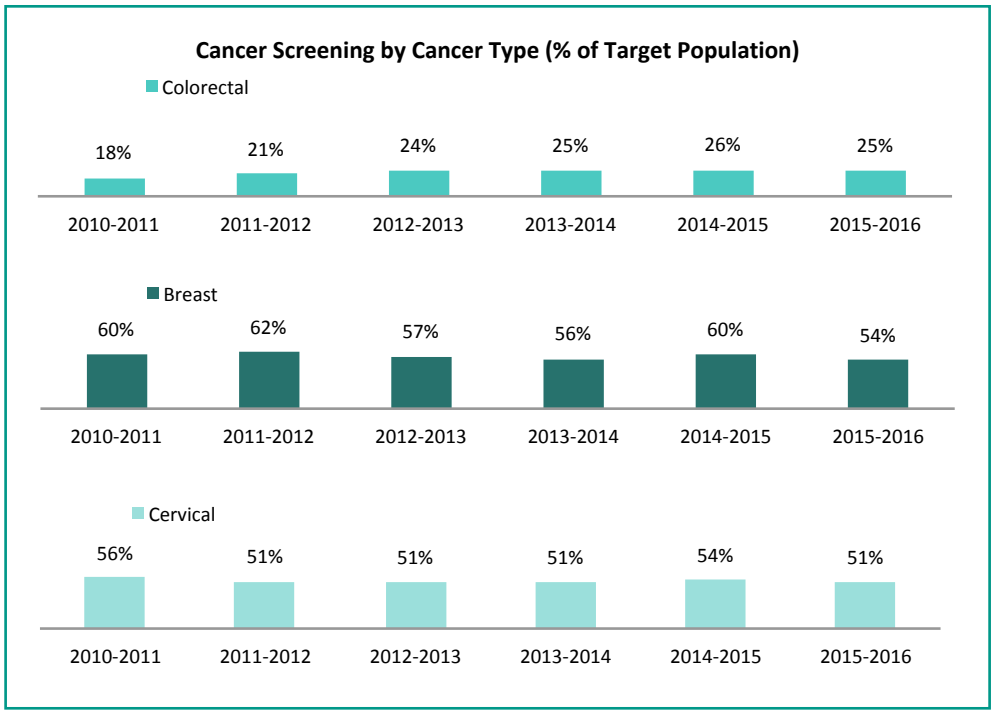
How are we doing?

Between the two-year periods 2010-2011 and 2015-2016 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, over the same six two-year time periods, the proportion of women receiving the Papanicolaou test (Pap test), has ranged from a low of 51% 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 is 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. This was similar to the coverage rate found for children born in 2011 (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 years and over surveyed who reported that they had a flu shot within the past year.

Why is it of interest?

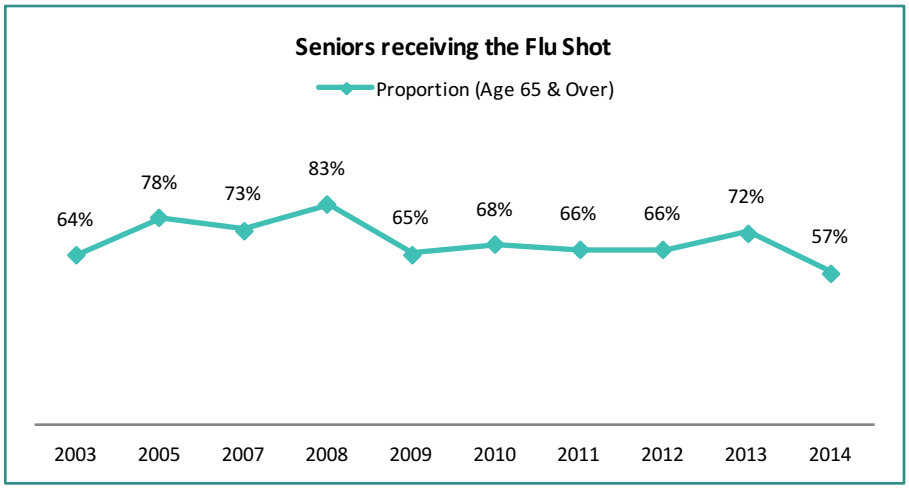
As immune defences become weaker with age, the senior population is of greater risk for serious complications from the flu, which can be effectively mitigated by annual influenza immunization.

How are we doing?

There has not been a statistically significant change in the proportion of the NWT senior reporting that they have had the flu shot. Historically, the NWT rate has also has not been different from the national average.

Source

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



Best Care – Lower Limb Amputations

What is being measured?

The three-year average number of hospitalizations for lower limb amputations amongst the population with diabetes (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 likely to suffer from foot ulcers and infections. Ulcers and infections if not successfully treated can lead to amputation.

How are we doing?

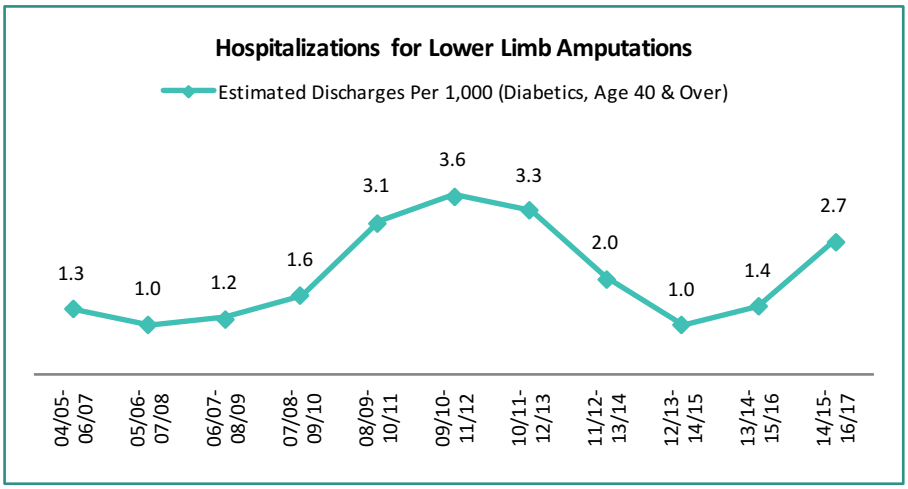
Since 2004/05 - 2006/07 the three-year average rate has fluctuated between 1.0 and 3.6 hospitalizations per 1,000. Compared to Canada, the NWT had a significant higher rate of hospitalizations in 2014/15 - 2016/17 (2.7 versus 1.1).[11] It is important to point out that the actual number of hospitalizations are small, ranging from 1 to 9 in any give single year.

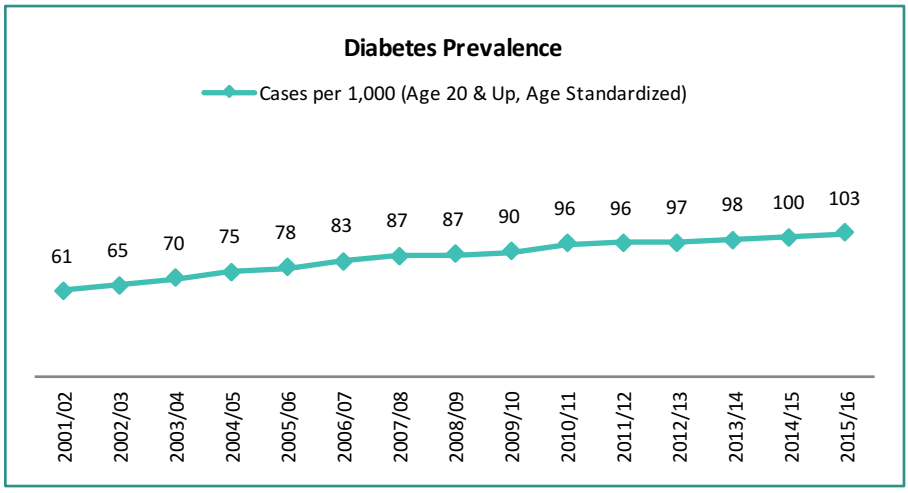
Other Information

The prevalence of diabetes, in general, has increased 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.





[11]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.[12] 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?

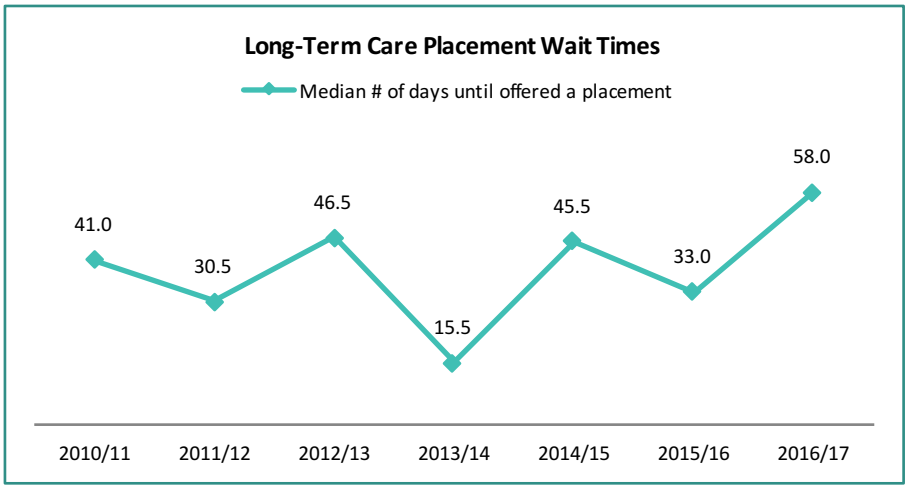
Over the last seven years, the median wait time to be offered a placement in a long term care facility was 35 days and has ranged from 16 days to 58 days.

While around 44% of clients have been offered a placement within 4 weeks, over two-thirds of clients have been offered a placement within three months.

Long term care facilities have been running near full occupancy (>90%) in the last three years.

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	7 Years
Placements offered	63	36	34	46	38	40	55	312
Average	66	55	112	59	98	82	120	84
Median	41	31	47	16	46	33	58	35
Proportion of Clients by Number of Days before Placement Offer								
<8	13%	25%	18%	26%	8%	15%	18%	17%
8 to 14	14%	22%	3%	20%	16%	18%	11%	15%
15 to 21	8%	0%	12%	11%	8%	5%	5%	7%
22 to 28	6%	3%	6%	9%	5%	8%	0%	5%
29 to 92	25%	25%	24%	15%	29%	23%	29%	24%
93 to 182	30%	19%	15%	9%	11%	18%	15%	17%
183 & Up	3%	6%	24%	11%	24%	15%	22%	14%

[12]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.[13]

Why is this of interest?

Assessing the level of satisfaction with the care patients/clients have received provides evidence to assist the NWT HSS system in making improvements to 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.

[13]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?

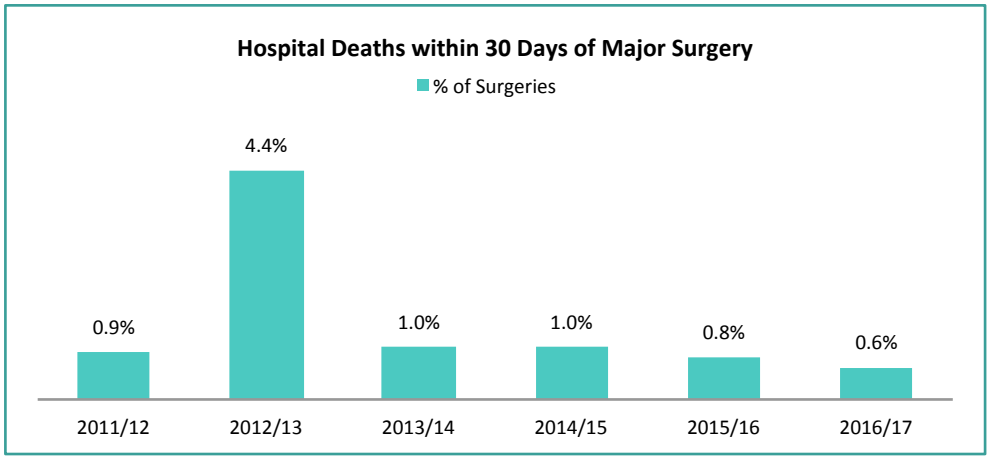
"Although not all deaths are preventable, reporting on and comparing mortality rates for major surgical procedures may increase awareness of surgical safety and act as a signal for hospitals to investigate their processes of care before, during or immediately after the surgical procedure for quality improvement opportunities."[14]

How are we doing?

With the exception of 2012/13, less than 1% 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.



[14]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 is an important part of patient-centered quality care.

How are we doing?

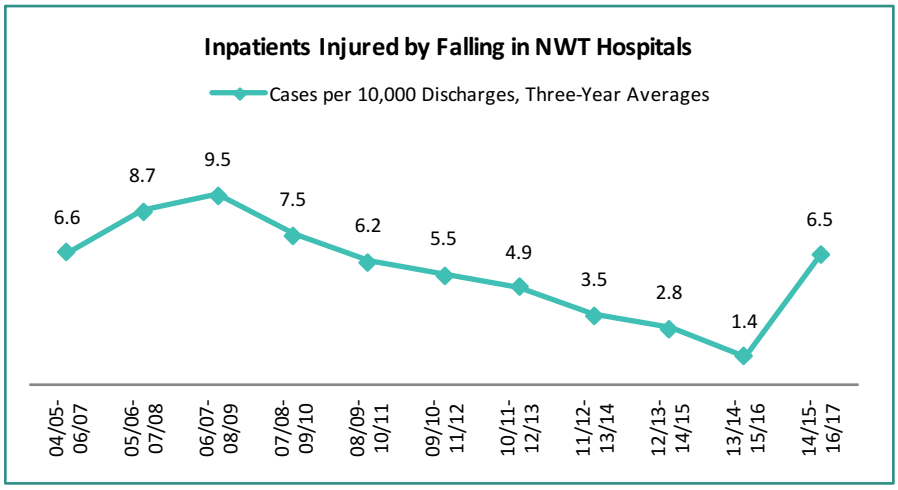
In time period shown, the annual number peaked at 9.5 injured per 10,000 discharges, on average, between 2006/07 and 2008/09, and then dropped down to an average of less than two per 10,000 between 2013/14 and 2015/16. The average rate has increased in the most recent three-year period to 6.5 per 10,000. Comparisons over time should be interpreted with caution as rates are based on a few cases in any given year (e.g., there were nine cases in total in the last three-year period).

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, in part by making sure patients avoid injury or infection during their 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. Further investigation and analysis based on the indicator results may possibly lead to quality improvement in nursing care."[15]

How are we doing?

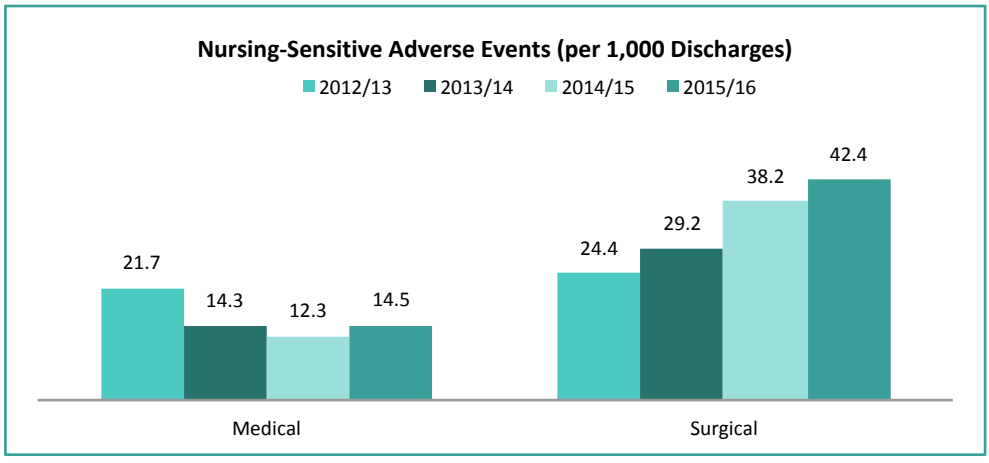
The annual number medical hospitalizations where the patient experienced a nursing-sensitive adverse event ranged from 12.3 to 21.7 per 1,000 discharges between 2012/13 and 2015/16. During the same four years, the annual number of surgical patients where a patient experienced an adverse event ranged 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 2015/16 compared to the national average (14.5 versus 27.3). The NWT's rate of nursing-sensitive adverse events for surgical patients in the same year was not statistically different from the national average (42.4 versus 33.5). It important to point out that the actual number of hospitalizations at NWT facilities, where an adverse event occurred, can be small (e.g., between 6 and 11 surgical cases per year), and thus changes in the rates should be interpreted with caution.

Notes

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.



[15]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?

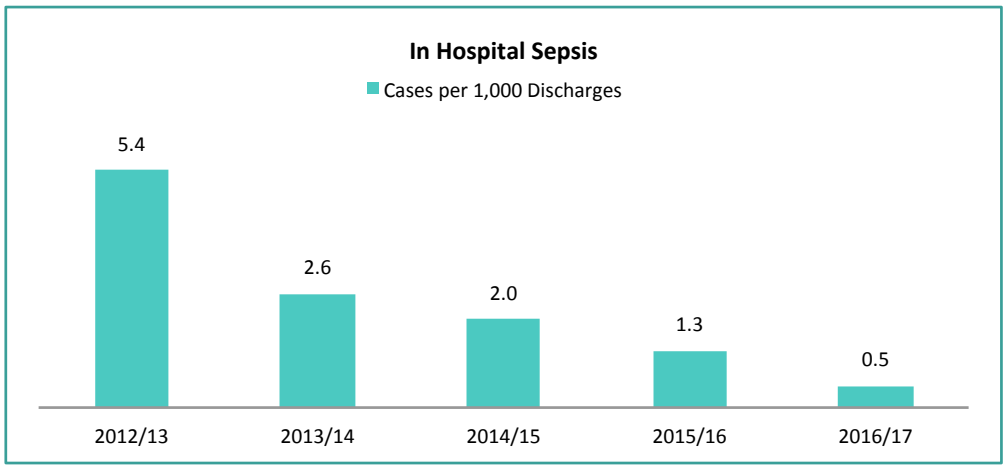
"Sepsis is a leading cause of mortality and is linked to increased hospital resource utilization and prolonged stays in intensive care units. Appropriate preventive and therapeutic measures during a hospital stay can reduce the rate of infections and/or progression of infection to sepsis. The indicator addresses the extent to which acute care hospitals are effective in preventing the development of sepsis."[16]

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.



[16]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, age 15 years and older, 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?

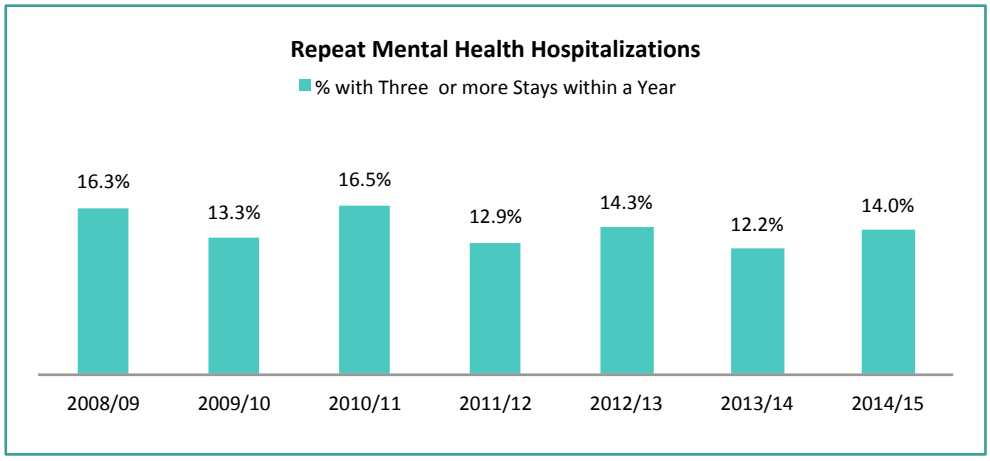
The rate of repeat hospitalizations has remained roughly steady, averaging 14% between 2008/09 and 2014/15. The NWT rate for 2014/15 is not significantly different from the national average (14% versus 11.5%).

Other Information

The NWT has a mental health hospitalization rate approximately twice the national rate. Approximately half of NWT hospitalizations for mental illness were primarily due to alcohol and drugs – six times the rate of hospitalizations nationally.

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) and provides an indication of the appropriateness of services being delivered.

How are we doing?

There is currently only two full years of data. In 2015/16, the average number of clients seen per month was 1,020. In 2016/17, the average had dropped to 871 clients per month.

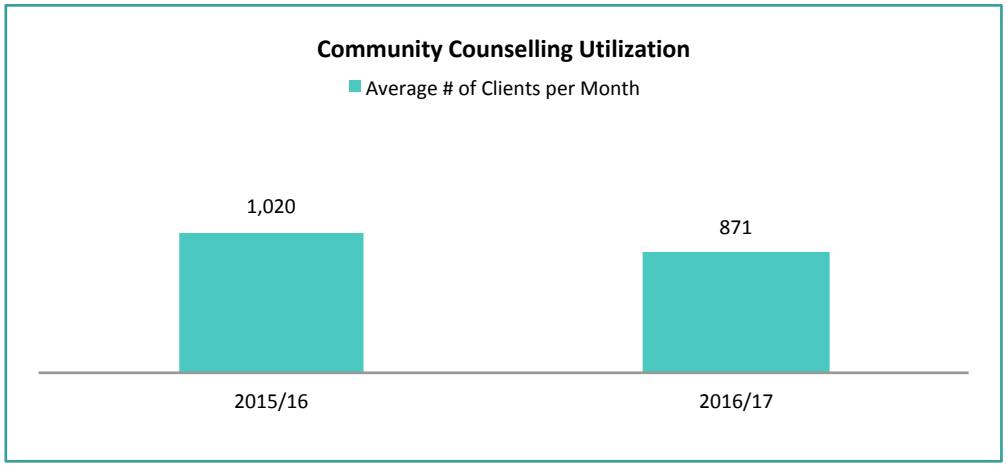
Other information

In 2016/17, the top five documented primary reasons (issues the client presented with) for counselling were addictions (26%), a diagnosed mental illness (11%), trauma (8%), undiagnosed mental health issues (6%) and relationship issues (6%). The remaining reasons for presenting included such issues as difficulty coping with bereavement, managing stress, family conflict and suicidal ideation.

Every effort is made to ensure clients are able to speak with a counsellor in a timely manner. 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?

There is currently three complete years of data. For the period shown, three-quarters of those who started a treatment session finished their session.

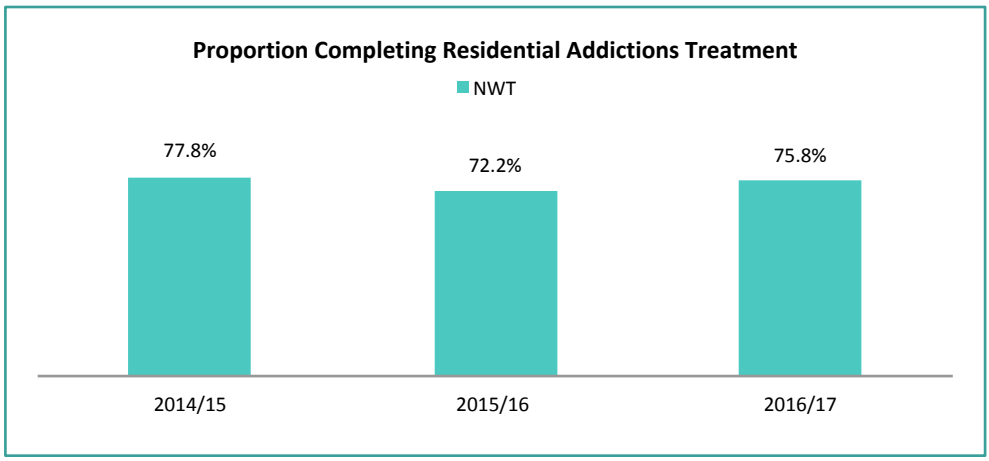
Other information

NWT residents have access to a variety of 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 readmission rates track the re-victimization of women.

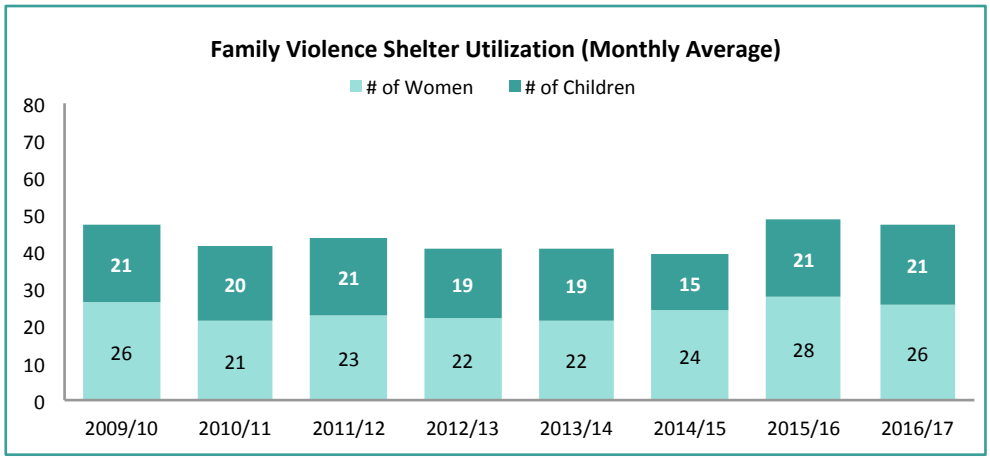
How are we doing?

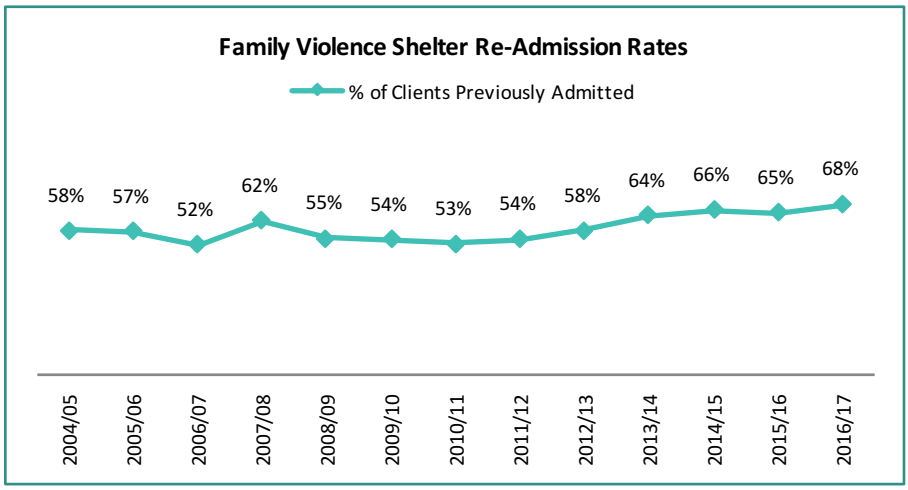
Over the last eight years, shelter usage has remained relatively consistent – averaging around 24 women and 20 children admitted per month.

Over the last 13 years, the proportion of readmissions to shelters has averaged 59% - ranging from a low of 52% (2006/07) to a high of 68% (2016/17).

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?

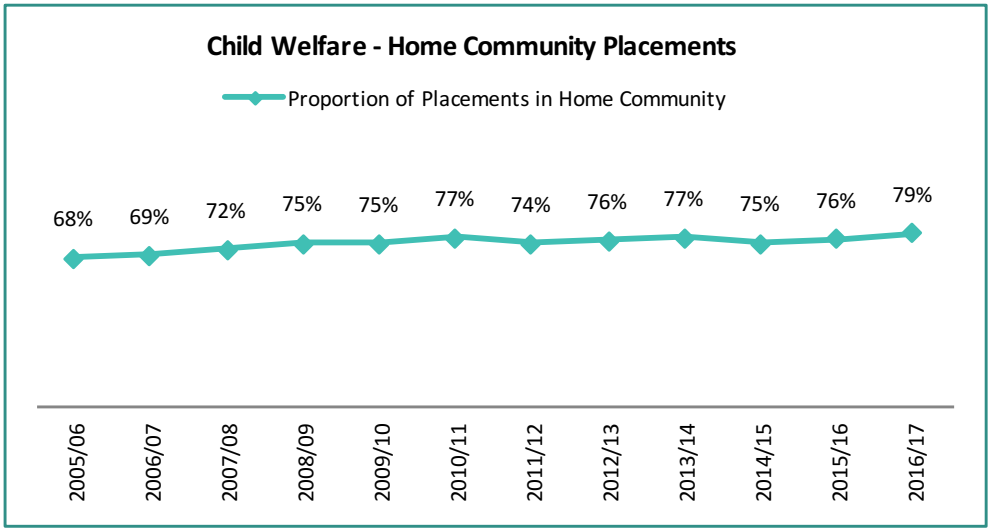
The proportion of placements in the home community has increased since the mid-2000s, going from 68% in 2005/06 to 79% in 2016/17.

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?

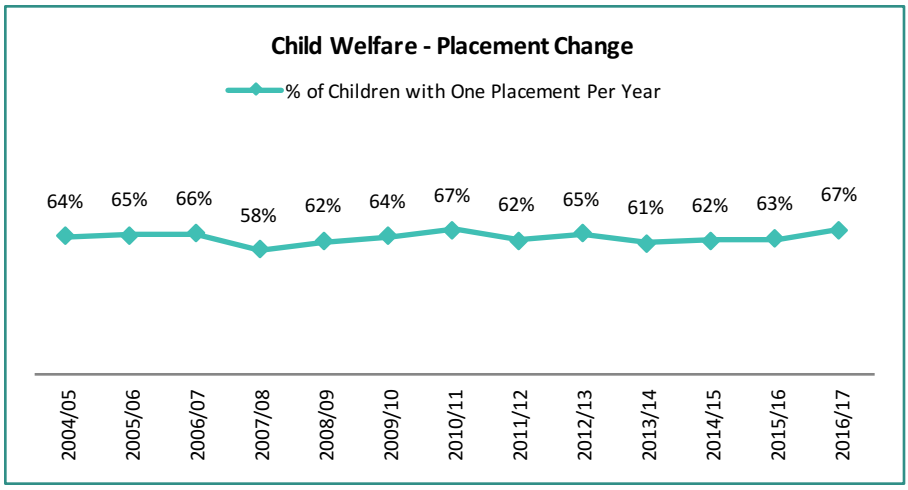
Multiple changes of placement are not in the best interests of children. For younger children multiple placements can lead to attachment disorders which may have life-long negative consequences.

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?

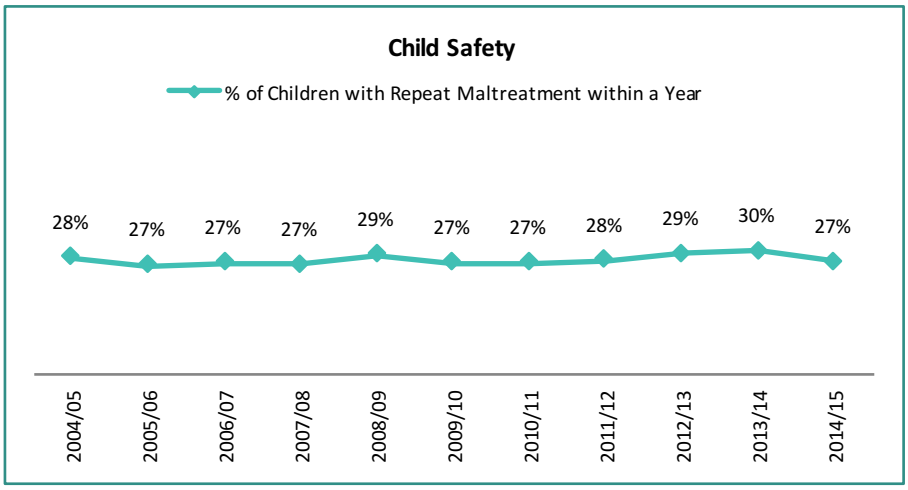
This measure focuses on the safety of children by tracking how well the child welfare system "… protect[s] children from further maltreatment."[17]

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.



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

Better *future*

Hospitalizations for Ambulatory Care Sensitive Conditions

Median Length of an Alternative Level of Care Stay

Proportion of Mental Health Hospitalizations due to Alcohol or Drugs

Emergency Department Visits that are Non-Urgent

No Show Rates - Family/Nurse Practitioners

No Show Rates - Specialists

Vacancy Rates - Family Practitioners

Vacancy Rates - Special Practitioners

Vacancy Rates - Nurses

Vacancy Rates - Social Workers

Workplace Safety Claims - NWT HSS System (per 100 Employees)

Administrative Staffing - NWT HSS System (% of Positions)

Administrative Expense - NWT Hospitals (% of Expenditures)

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."[18]

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 5.1% and 6.8% between 2007/08 and 2016/17.

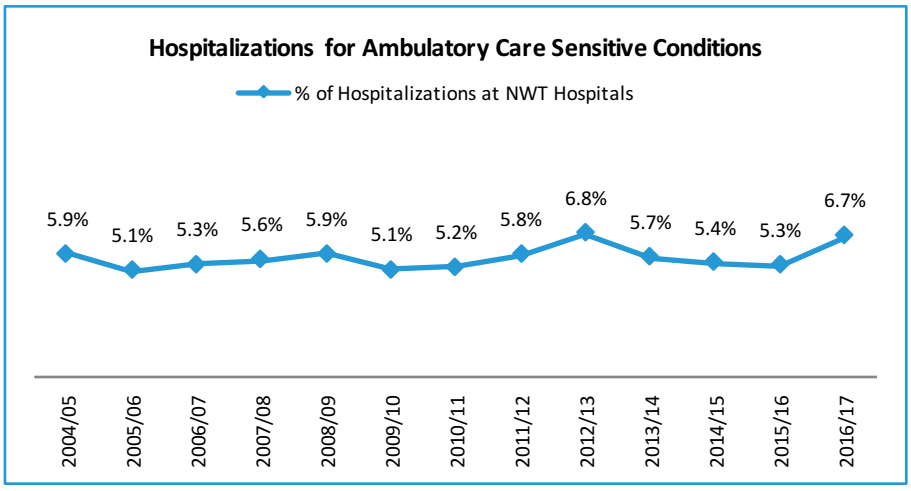
The NWT ACSC hospitalization rate (age-standardized) is almost twice the rate nationally at 65.2 per 10,000 (population) versus 32.6 per 10,000 (2015/16).

Notes

This indicator tracks NWT residents at NWT hospitals.

Sources

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



[18]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?

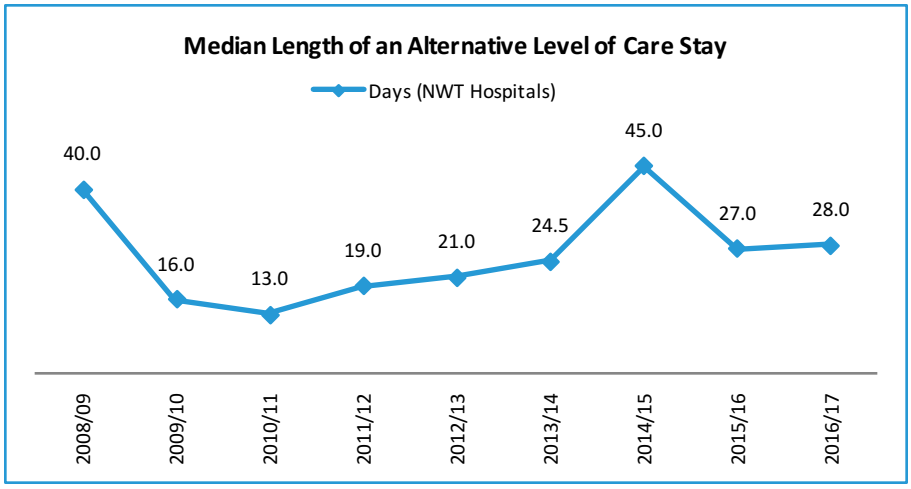
Acute care is the most expensive cost area in the health care system. ALC patients result in inappropriately used acute care beds, reducing the availability of space for patients who actually require acute care. The lower the proportion of ALC days to overall bed days, the better our response to patient needs and the greater the appropriateness of the use of health care resources.

How are we doing?

Between 2008/09 and 2016/17 the median length of stay has fluctuated between 13 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 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 hospitalization – at six times the national average.

How are we doing?

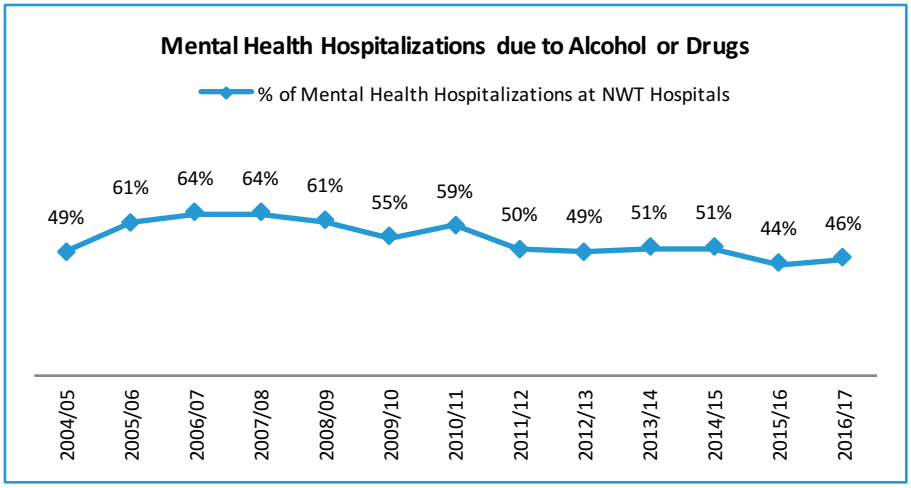
In the time period shown, the proportion of mental health hospitalizations due to A&D issues has decreased from a peak of 64% in the mid-2000s to a low of 44% to 46% in recent years.

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).[19]

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?

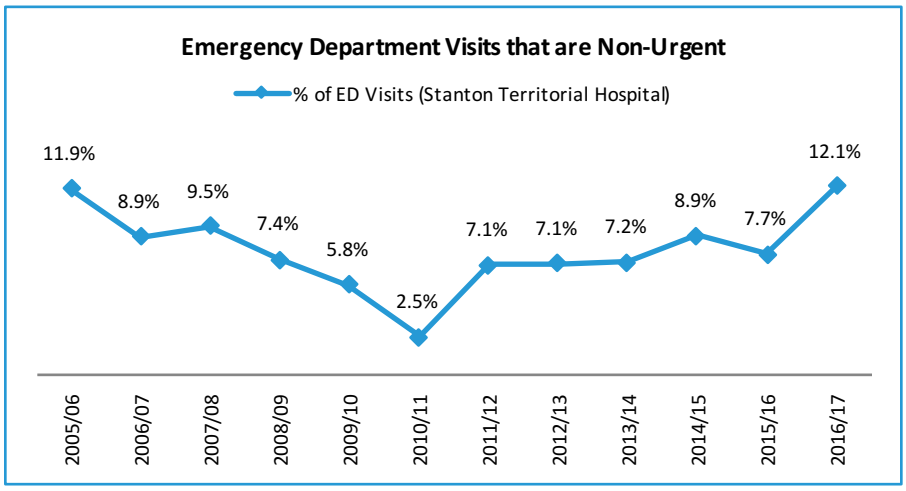
Patients who access emergency department services for health issues that could be seen at a primary care clinic (level 5 – non-urgent), that day or in the next day or two, are taking up limited resources that could be made available to higher priority patients.

How are we doing?

After decreasing to 2% in 2010/11, the proportion of emergency visits considered non-urgent has increased to 12.1% in 2016/17.

Source

Northwest Territories Health and Social Services Authority.



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

Better Future – No Shows

What is being measured?

The proportion of patients who did not show up for their scheduled appointment with a family physician, nurse practitioner or specialist.

Why is this of interest?

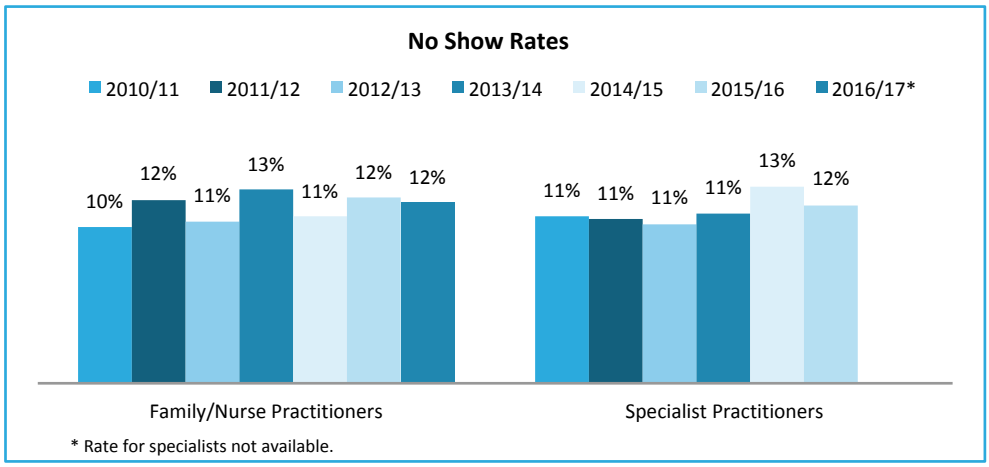
No shows to appointments with these professionals can represent a significant waste as well as needlessly delaying appointments. These no shows can result in lost appointment slots that cannot be readily filled. To maintain the sustainability of the NWT HSS system, while maximizing timely access, waste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

How are we doing?

In the last seven years, patients did not show up to approximately 10 to 13% of scheduled appointments with family and nurse practitioners.[20] For specialists, the no show rate also ranged from approximately 11% to 13% over the last six years.

Source

NWT Health and Social Services Authorities.



[20]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.

Better Future – Physician Vacancies

What is being measured?

The vacancy rate for family practitioners and specialist practitioners.[21]

Why is this of interest?

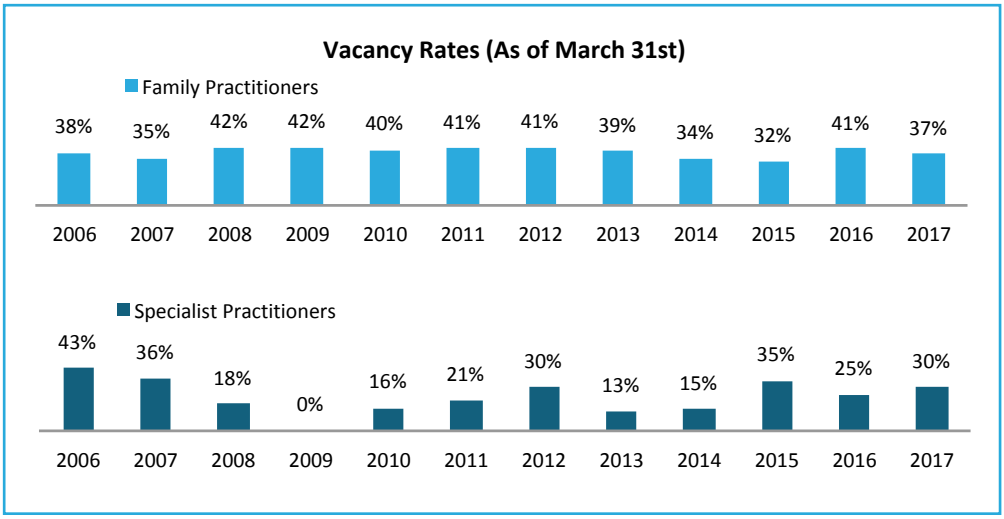
Physicians are key components of the NWT HSS system. Vacancies in these positions significantly impact the capacity of HSS system to deliver appropriate care.

How are we doing?

Since 2006, vacancy rates have fluctuated between 32% and 42% for family practitioners and between 0% and 43% for specialists. Recent vacancy rates for family practitioners and specialists are 37% and 30% respectively.

Source

Department of Health and Social Services.



[21]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?

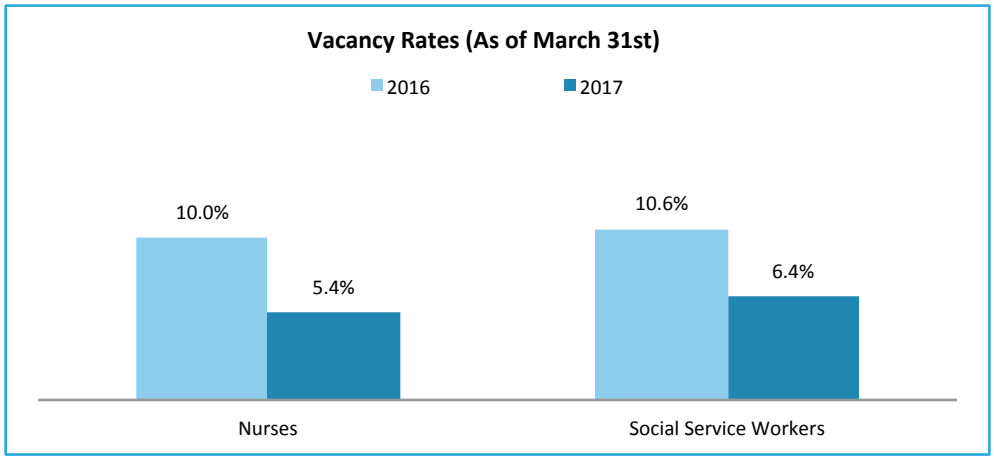
Nurses and social workers are key components of the NWT HSS system. Vacancies in these positions significantly impact the capacity of HSS system to meet the needs of the population.

How are we doing?

As of March 31, 2017, the vacancy rates for nurses and social service workers were 5.4% and 6.4%, respectively. Due to a change in methodology, historic vacancy rates for nurses and social service workers are not available.[22]

Sources

Department of Finance and Department of Health and Social Services.



[22]No Starting in 2016, vacancy rates for nurses and social service workers exclude positions not staffed due to operational reasons or occupied by casual/ contract staff. 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?

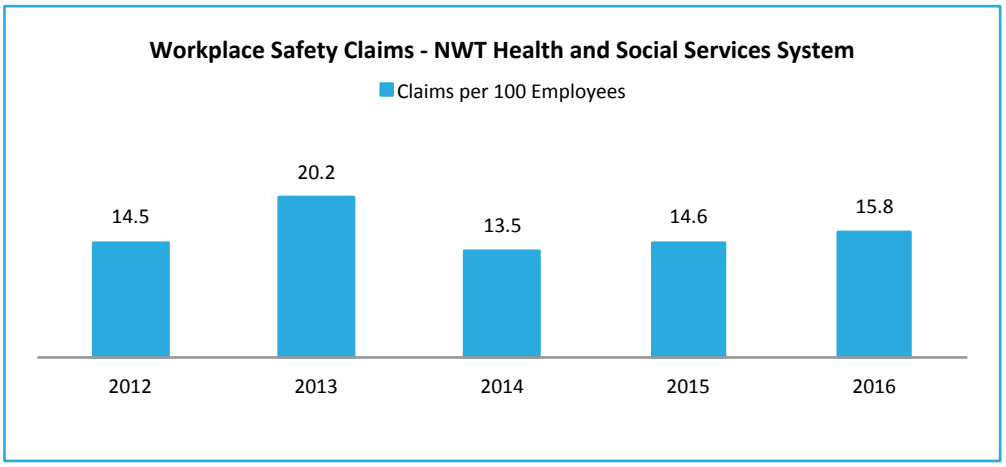
Excluding 2013, the overall rate of safety claims have remained relatively unchanged, fluctuating between 13.5 and 15.8 claims per 100 employees. In the last five years, the rate for the HSS system has been over twice that of the rate for the rest of the GNWT.

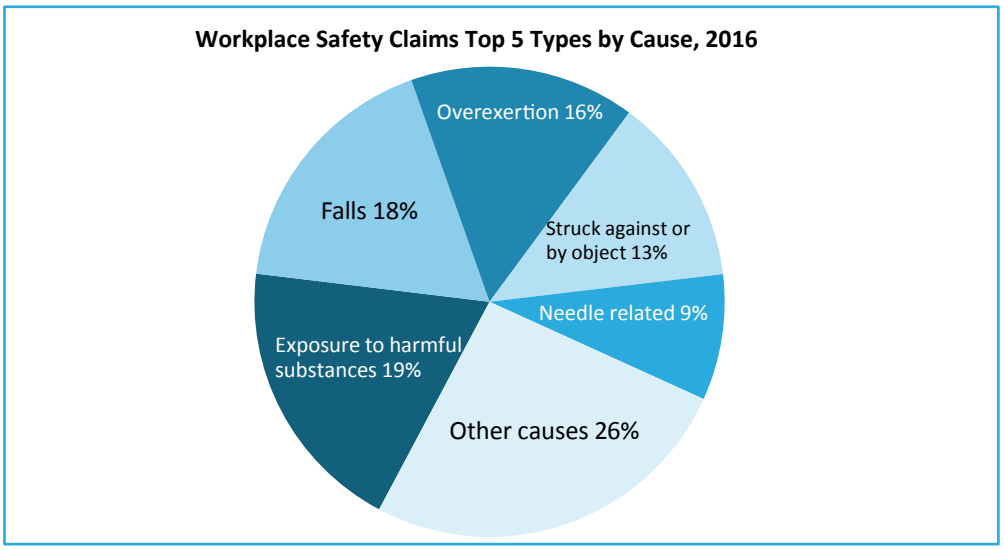
Other Information

In 2016, the top five causes for workplace safety claims were: the worker being exposed to harmful substances – primarily carriers of diseases (19%), falling (18%), overexertion (16%), worker was struck by or struck against an object (13%), and needle punctures and scratches (9%).

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 positions in the HSS system that is administrative.

Why is it of interest?

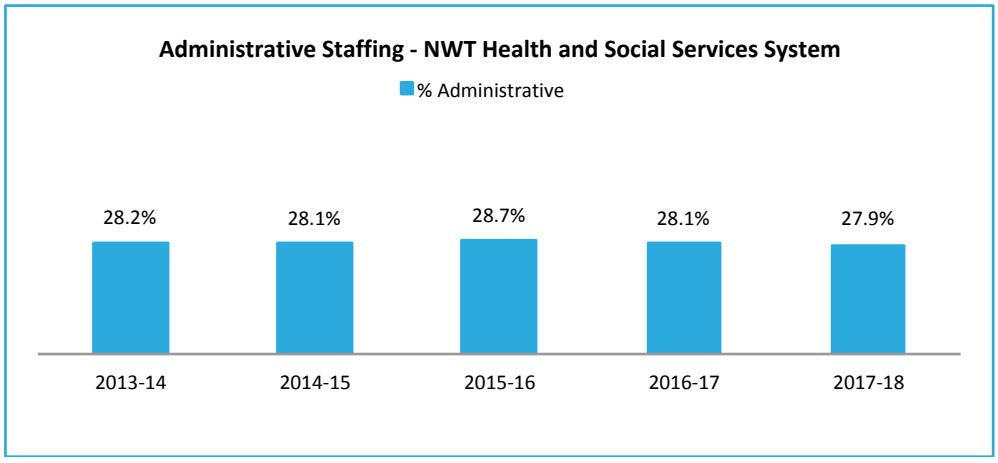
A goal of the health and social services system is to provide the best care as efficiently as possible in order for the system to be sustainable into the future. Increases in the proportion of administrative positions may reflect inefficiencies in the system that need to be investigated.

How are we doing?

The proportion of positions that is administrative has averaged around 28% over the last five 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?

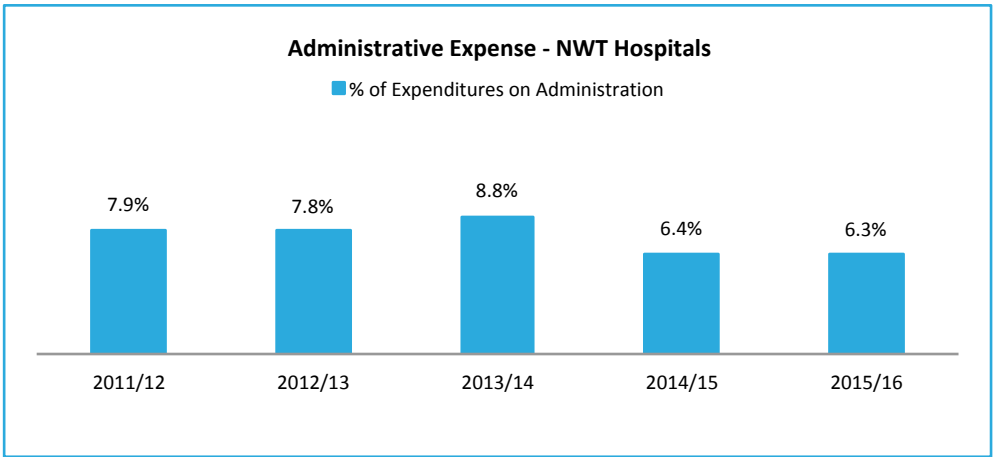
A goal of the health and social services system is to provide the best care as efficiently as possible in a sustainable manner. Increases in the proportion of funds spent on administration may reflect inefficiencies in the system that need to be investigated.

How are we doing?

While the NWT has historically had a higher proportion of hospital expenditures dedicated to administration than the national average (4.3% - 2015/16), the proportion has declined somewhat in recent years – from an average of 8.2% between 2011/12 and 2013/14 to an average of 6.4% between 2014/15 and 2015/16.

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, 2017 there were 42,780 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, 2017, there were 489 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 $55.5 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 Act'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, over $34.5 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

- Caring for Our People: Strategic Plan for the NWT Health and Social Services System (2017 to 2020)
- Report on Needs for Aboriginal Wellness at Stanton Territorial Hospital Authority
- Tobacco Control in the Northwest Territories Discussion Paper (FAQs)
- Tobacco Control in the Northwest Territories
- Proposed Key Elements – Licensed Practical Nurses Regulation (FAQs)
- Licensed Practical Nurses Regulation - Proposed Key Elements
- Mind and Spirit: Promoting Mental Health and Addictions Recovery in the Northwest Territories Strategic Framework
- Building a Culturally Respectful Health and Social Services System
- Annual Report of the Director of Child and Family Services, 2015-2016
- NWT Community Counselling Program Client Satisfaction Report 2016
- Public Performance Measures Report 2016: NWT Health and Social Services System
- Proposed Key Elements – Naturopathic Profession Regulation
- Naturopathic Profession Regulation - Proposed Key Elements (FAQ)
- Evaluation Report - TeleSpeech as a Delivery Tool for Speech Language Pathology Services for Children in the NWT
- NWT Community Wellness Initiatives Report 2014-2015
- Review of Non-intentional Poisonings by Narcotics

Brochures and Facts Sheets

- Quit Calendar
- NWT Tobacco Quit Guide
- NRTs can Double Your Chances of Quitting
- Mumps Information for Coaches, Recreation Coordinators, School Principals and Parents
- Healthy Eating and Weight Management Guide
- NWT Family Violence Shelters
- NWT Family Violence Shelters: You are not alone
- NWT Physical Activity Assessment
- Healthy Eating Assessment
- Backgrounder: Opioid Abuse and Naloxone Availability in the Northwest Territories
- You Can Quit Smoking - Your Path to a Smoke Free Life
- Opioid Overdose Signs And Symptoms
- Adoption in the NWT
- Older Child Adoption in the NWT
- Aboriginal Custom Adoption
- Environmental Contaminants Facts Sheets (33)
- General Fish Consumption Guidelines for the NWT
- Preventing Suicide - Where to get help in the NWT
- Mental Health - Where to get help in the NWT
- Addictions - Where to get help in the NWT
- How to use the FIT
- Electronic Medical Records
- Medical Assistance in Dying - Interim Guidelines for the Northwest Territories
- Tattooing and Your Health
- Smoke Exposure from Wildfire: Guidelines for Protecting Community Health and Wellbeing
- Wildfire Smoke and Your Health
- Health Effects of Smoke Exposure due to Forest Fires

Infographics and Posters

- Heavy Drinking in the NWT
- Harm From Someone Else's Drinking in the NWT
- Hallucinogen Use in the NWT
- Crack/Cocaine Use in the NWT
- Cannabis Use in the NWT
- Diabetes Rates in the NWT
- Colorectal Cancer Screening Rates in the NWT Cervical Cancer Screening Rates in the NWT
- Breast Cancer Screening Rates in the NWT
- Electronic Medical Records
- Early Childhood Intervention Pilots
- 7 of these pills contain enough fentanyl to kill you. How do you tell which ones?
- Are you concerned about drug use in your family or community? You are not alone.
- Naloxone can save your life from a fentanyl overdose
- Fentanyl May Be Hiding in the Drugs You're Using
- Cancer Screening Saves Lives

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

Si vous voulez ces informations dans une autre langue officielle, 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 theɔ́ą ɔat’e, nuwe ts’ën yółtı.
Chipewyan

Edı gondı dehgáh got’ı̨e zhatıé k’ę́ę́ edatł’éh enahddhę nıde naxets’ę́ 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 ᐱᓕᒍᐃᖅᑎᑦ ᐃᓄᒃᑎᑐᑦᓯᒪᓕᒐᑎᒃ, ᐅᕐᓂᑎᓐᓄᓂ ᐅᖅᑲᓕᓕᐅᓐᓇᖅᑐᑎᑦ.
Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.
Inuinnaqtun

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