Government of Gouvernement des
Northwest Territories Territoires du Nord-Ouest
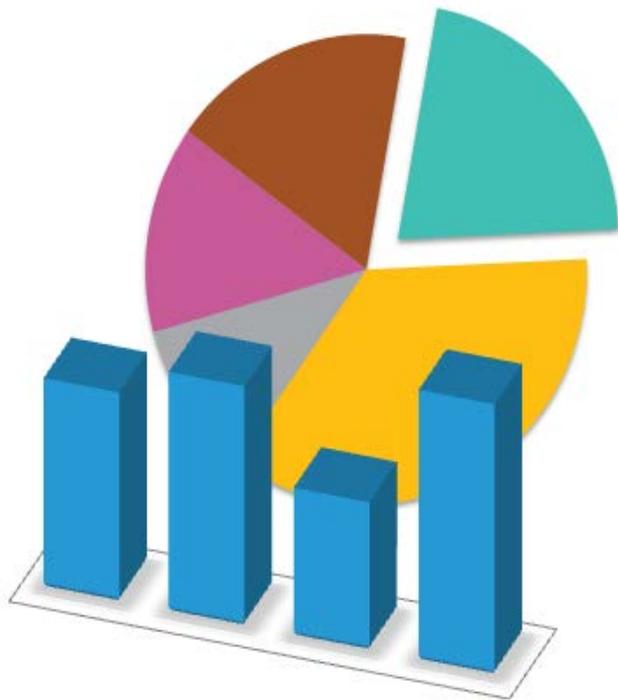
PUBLIC PERFORMANCE MEASURES
REPORT 2016

NWT HEALTH AND SOCIAL SERVICES SYSTEM

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Executive Summary

Background

Public reporting on the performance of the NWT Health and Social Services (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.

The purpose of this report is to inform the public and the Members of the 18th Legislative Assembly on the performance of the NWT HSS system. This is the second report of its kind with the first having been released in 2015. [1]

Scope of the Report

This is a summary report intended to track and measure the overall performance of the NWT HSS system. Rather, these indicators are meant to provide a general snapshot of important trends and issues facing the NWT HSS system.

The report is not intended to be a profile of the health status of NWT residents nor a report on the utilization of health services. Instead this report tracks and measures the performance of the NWT HSS system as it relates to improving the overall health status of the NWT.

A statistical summary of results, year over year and over the last few years (trends), is provided in the following pages.

Future Directions

Future reports will see new indicators added and may see some indicators dropped, and will eventually track system actions taken to improve health and wellness outcomes. Targets will be set to provide a means of measuring how effective the actions are in achieving our goals.

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[1] *Public Performance Measures Report 2015 – NWT Health and Social Services System* (May 2015).

Statistical Summary

This summary provides a snapshot of the current status of NWT HSS system and overall population health and wellness, including long-term trends and short term changes. 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).

Population Health and Wellness Outcomes and Determinants

Arrow Colour (Trend)		
Positive	Negative	Uncertain

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Proportion of population self-reporting excellent or very good health status.	50.9%	53.7%	No	Stable
Lung cancer incidence rate (cases per 10,000).	7.1	7.4	No	Stable
Diabetes incidence rate (cases per 1,000).	7.2	6.9	No	⬇ (green)
Sexually transmitted infection rate (cases per 1,000).	28.3	24.4	⬆ (red)	⬆ (red)
Immunization rates (proportion at full coverage by age 2).	63%	65%	No	n/a
Mental health hospitalization rate (cases per 1,000).	12.4	13.4	No	⬆ (red)
Proportion of children entering the K-12 school system identified vulnerable in one area.	38%	n/a	n/a	n/a
Proportion of population who self-report smoking.	32.5%	33.3%	No	Stable
Proportion of population who self-report heavy drinking.	32.5%	30.2%	No	Stable
Proportion of population who self-report obesity.	33.7%	24.4%	No	Stable

Statistical Summary

Community, Individual and System Outcomes

Arrow Colour (Trend)		
Positive	**Negative**	Uncertain

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Community Counselling Program - average number of clients per month.	1,012	n/a	n/a	n/a
Proportion of people who start and complete a full session of residential addictions treatment.	73%	78%	No	n/a
Children in care - average number of total placements per year while in care.	1.6	1.7	No	Stable
Proportion of Aboriginal children in care placed in an Aboriginal home.	69%	69%	No	Stable
Proportion of children found to be maltreated (abuse/neglect) again within one year of having been maltreated.	32%	29%	No	⬆ (red)
Monthly average number of women residing in a shelter.	28	24	No	Stable
Monthly average number of children residing in a shelter.	21	15	No	Stable
Proportion of families readmitted to a shelter.	65%	66%	No	⬆ (red)
Patient satisfaction (proportion finding counselling services of high quality)	99%	95%	No	n/a
Median number of days a patient waits to receive an offer of placement in a long term care facility.	33	46	No	n/a
Proportion of telehealth sessions that were specifically for patient care activities.	66%	58%	⬆ (teal)	⬆ (teal)
Number of medical travel cases.	14,331	13,248	⬆ (white)	⬆ (white)
Proportion of medical travel cases with escorts.	39%	39%	No	No

System Inputs

Arrow Colour (Trend)

| Positive | Negative | Uncertain |

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Trend
Staff Safety (number of claims per 100 employees).	14.1	13.3	No	n/a
Vacancy rate for Family Physicians.	41%	32%	No	Stable
Vacancy rate for Specialist Physicians.	25%	35%	No	Stable
Vacancy rate for Nurses.	19%	17%	No	⬇
Vacancy rate for Social Services Workers.	20%	19%	No	Stable
Proportion of patients not showing up for their family/nurse practitioner appt.	12%	11%	⬆	n/a
Proportion of patients not showing up for their specialist practitioner appt.	11%	13%	⬇	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 2015/16 then the previous time period is usually 2014/15). Short-term change is the difference between the two. The long term trend is the direction the numbers are heading over a time period of several years (seven or more). In some cases there are not enough years of comparable data to determine the direction of the trend.

A green arrow means the short or long term change is positive. A red arrow is a negative change. An arrow that is outlined in black means it is not clear if the change was positive or negative. For example, an increase in the number of medevacs may drive increased costs, but may also indicate a positive trend in diagnosing critical cases. "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 lung cancer), 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. medical travel cases), 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.

Introduction

Background

The Northwest Territories (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 Health and Social Services (HSS) budget makes up more than 25 per cent of the overall Government of the NWT's budget. The NWT has the second highest per capita costs in Canada. 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.

It is the purpose of this report to inform the public and the Members of the 18th Legislative Assembly on the performance of the NWT HSS system. This is the second report of its kind with the first having been released in 2015.[2]

Scope of Report

This is a summary report, covering over two dozen indicators. It is not intended to be an in-depth measure of any one area of system performance. The indicators profiled in this report are by no means exhaustive of all the possible ways to measure performance. Rather, these indicators are meant to provide a

general snapshot of important trends and issues facing the NWT HSS system.

The report is not intended to be a profile of the health status of NWT residents nor a report on the utilization of health services. Instead this report tracks and measures the performance of the NWT HSS system as it relates to improving the overall health status of the NWT.

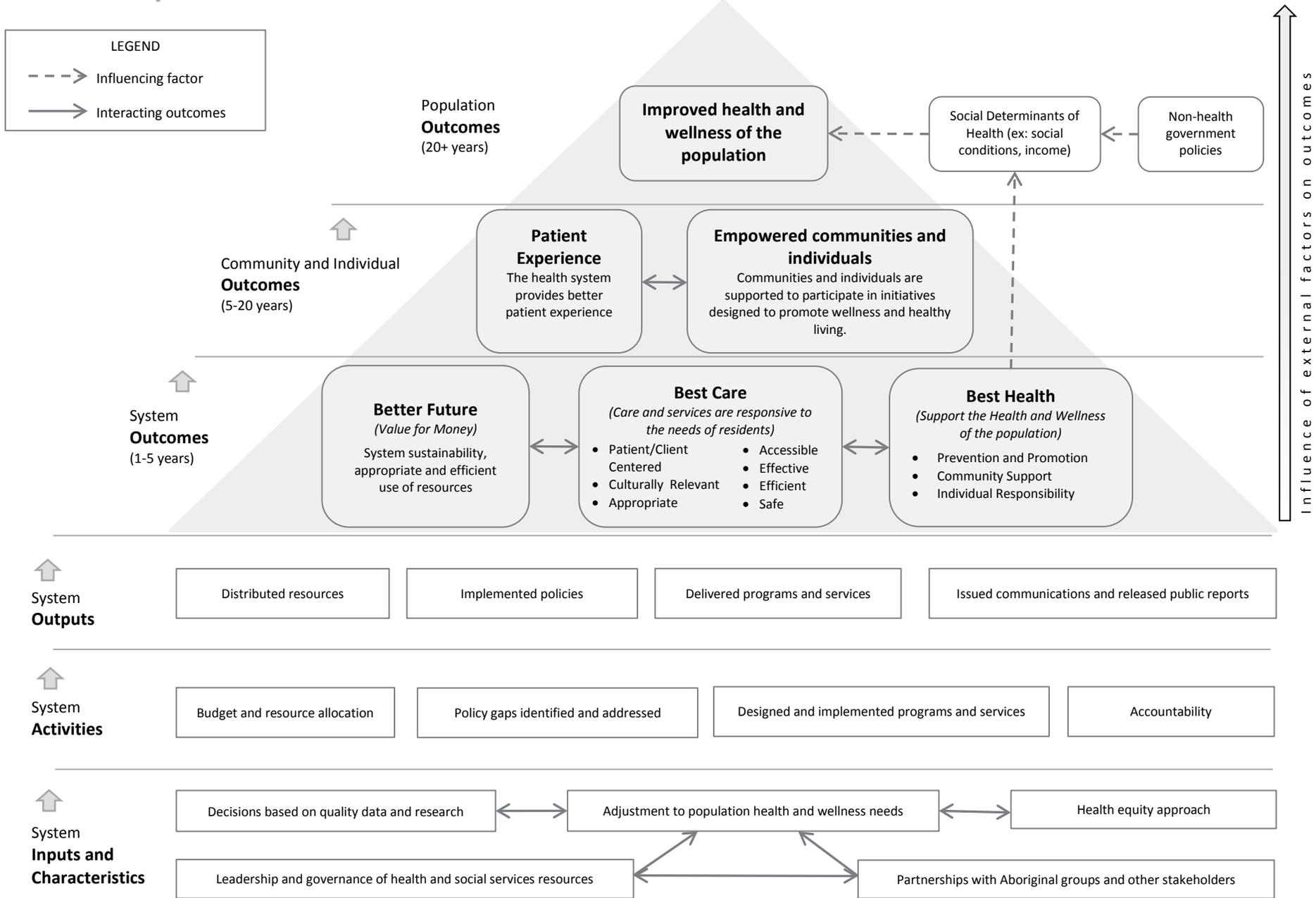The indicators reported on here may change over time; but such changes will be guided by the following performance measurement logic model (see next page).[3]

[2] *Public Performance Measures Report 2015 – NWT Health and Social Services System* (May 2015).

[3] For a description of the performance measurement framework, please see the *NWT Health and Social Services Performance Measurement Framework (*May 2015).

NWT HSS System Performance Framework

LEGEND
- - - → Influencing factor
——→ Interacting outcomes

Influence of external factors on outcomes

Population **Outcomes** (20+ years)

Improved health and wellness of the population

Social Determinants of Health (ex: social conditions, income)

Non-health government policies

Community and Individual **Outcomes** (5-20 years)

Patient Experience
The health system provides better patient experience

Empowered communities and individuals
Communities and individuals are supported to participate in initiatives designed to promote wellness and healthy living.

System **Outcomes** (1-5 years)

Better Future
(Value for Money)
System sustainability, appropriate and efficient use of resources

Best Care
(Care and services are responsive to the needs of residents)
- Patient/Client Centered
- Culturally Relevant
- Appropriate
- Accessible
- Effective
- Efficient
- Safe

Best Health
(Support the Health and Wellness of the population)
- Prevention and Promotion
- Community Support
- Individual Responsibility

System **Outputs**

| Distributed resources | Implemented policies | Delivered programs and services | Issued communications and released public reports |

System **Activities**

| Budget and resource allocation | Policy gaps identified and addressed | Designed and implemented programs and services | Accountability |

System **Inputs and Characteristics**

| Decisions based on quality data and research | Adjustment to population health and wellness needs | Health equity approach |

Leadership and governance of health and social services resources

Partnerships with Aboriginal groups and other stakeholders

Adapted from the Alberta's Health System Outcomes and Measurement Framework (2013); and CIHI's A Performance Measurement Framework for the Canadian Health System (2013)

Reporting and Analytics Environment

This report is not the only performance monitoring that is done by the NWT HSS system. The Northwest Territories Health and Social Services Authority, their program units and facilities, also conduct performance measurement internally and externally, for their own day to day management of the services they provide and to determine whether they are meeting their own particular goals and objectives.

This report is intended to be complementary to other reporting: health status info-graphics, annual reports, business plans, utilization reports, and special subject reports (e.g., cancer and addictions).

There is an expectation that the indicators reported on will evolve, over time, and future reports may revise how an indicator is reported as the system changes and information collection processes improve.

Reporting on the performance of the programs and services in any system is only as good as the analytical tools available to collect, disseminate, and analyze information about those programs and services. A strong analytics environment is central to tracking performance in a meaningful way.

Data Sources and Limitations

The data for this report primarily came from the NWT HSS system, as well as the Canadian Institute for Health Information, Statistics Canada, the NWT Department of Education, Culture and Employment, the NWT Department of Human Resources 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 in this report are subject to future revisions and are not necessarily comparable to numbers in other tabulations and reports. The numbers and rates in this report rely on information systems and population estimates that are continually updated and often revised. Any changes that do occur are usually small.

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

Report Structure

The report begins by exploring the population health and wellness outcome indicators, followed by a presentation of community, individual and system outcomes and, finally by examining system inputs.

Each indicator is explained as follows:

What is being measured?
This section provides a brief description of the indicator.

Why is it of interest?
This section explains why the indicator is relevant.

How are we doing?
This section provides a general discussion of either the most recent year of data available or any long term trend data (5 to 10

years) available. For a full list of short and long term changes, data availability permitting, see the Statistical Summary. Available national comparisons also may be presented here.

Other information

In some cases, there is additional detail provided that is useful to point out to the reader.
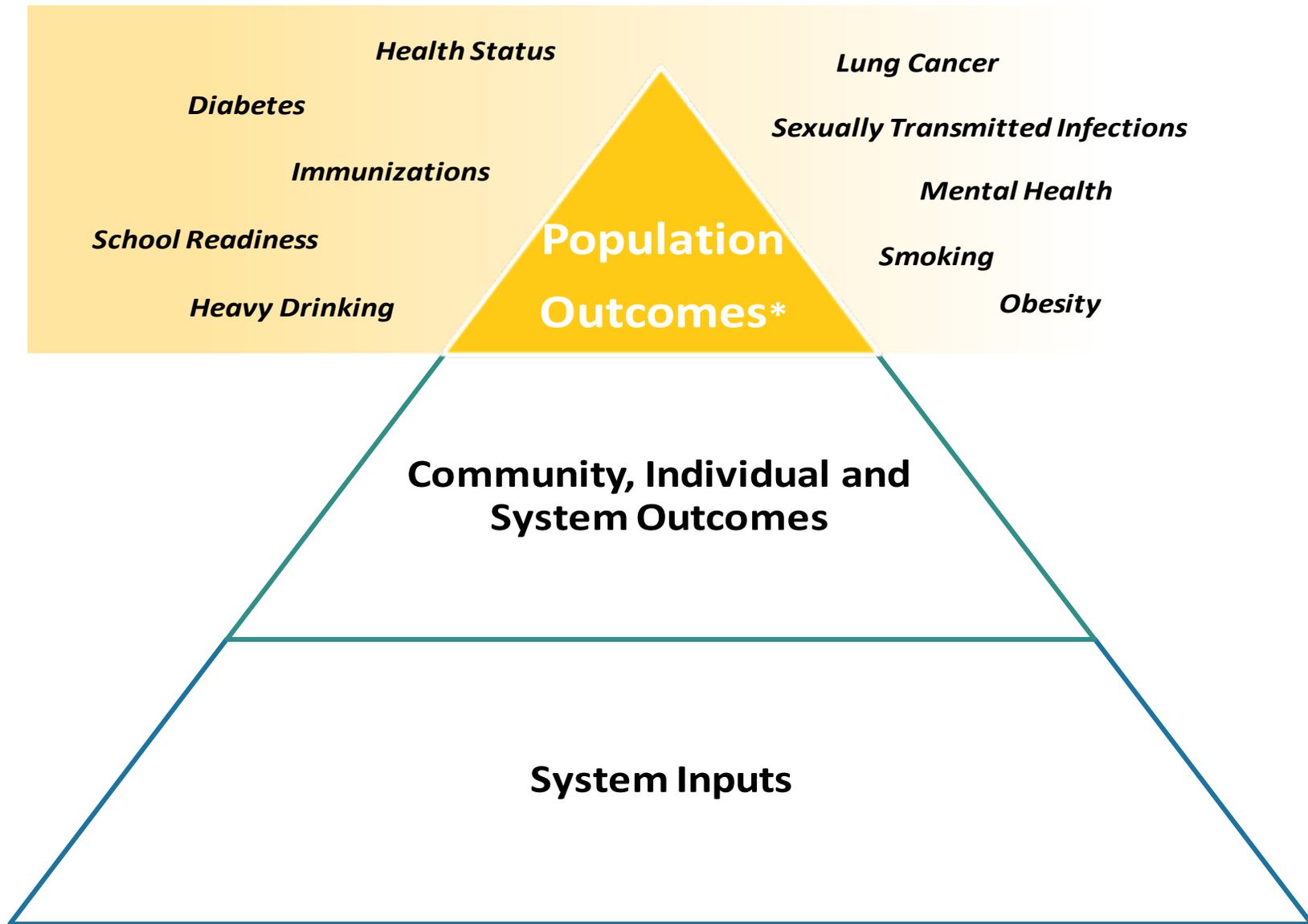
Source

The source(s) of the data is presented.

Future Directions

Future reports will not only see indicators added, revised and removed but will also eventually include summaries of actions taken to improve outcomes. Targets may be set to provide a means of tracking how well we are doing as a system in achieving our goals.

Section 1: Population Health and Wellness Outcomes and Determinants

Health Status

Lung Cancer

Diabetes

Sexually Transmitted Infections

Immunizations

Mental Health

School Readiness

Smoking

Population Outcomes*

Heavy Drinking

Obesity

Community, Individual and System Outcomes

System Inputs

*Population Health and Wellness Outcomes (includes determinants)

Health Status

Perceived Health, Very good or excellent

◆ Age Standardized (12 & Up)

2003	2005	2007	2008	2009	2010	2011	2012	2013	2014
54%	61%	51%	48%	50%	45%	47%	52%	54%	51%

What is being measured?

The proportion of the population who rate their overall health as being 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.

How are we doing?

Currently 51% of the NWT population (age 12 and over) rated their health as very good or excellent – significantly lower than the national rate of 61%. The NWT rating has been lower than the national rate in all survey years with the exception of 2005. The NWT rate has not changed significantly between 2003 and 2014, whereas the national rate has increased slightly from 59.7% to 60.9% over the same time period.[4]
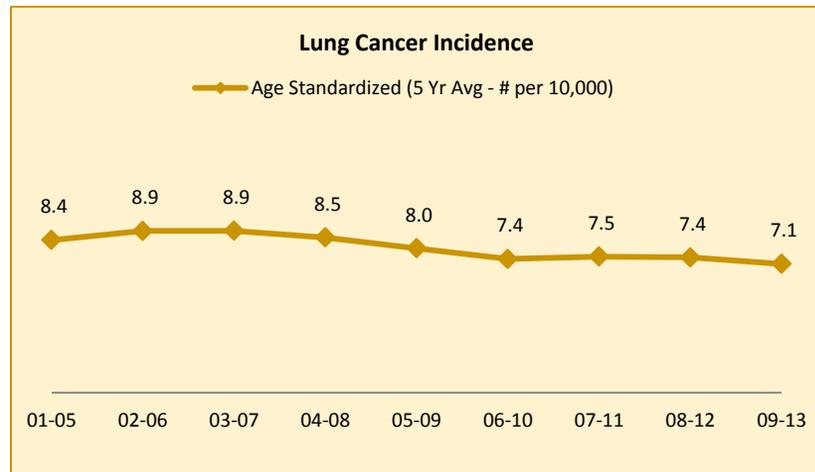
Other information

As seen in other parts of this report, and other reports (e.g. NWT health status reports), the NWT ranks poorly compared to the national average in a number of areas that have a major influence in overall well-being, including tobacco use, heavy drinking, and obesity.

Source

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

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[4] The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Between 2007 and 2014, the CCHS had been carried out annually. Since 2015, the CCHS returned to a two-year cycle in all three territories.

Colorectal Cancer

Lung Cancer Incidence

—◆— Age Standardized (5 Yr Avg - # per 10,000)

01-05	02-06	03-07	04-08	05-09	06-10	07-11	08-12	09-13
8.4	8.9	8.9	8.5	8.0	7.4	7.5	7.4	7.1

Nationally, lung cancer incidence is not significantly different than the NWT rate. The national incidence of lung cancer also decreased over the same time period.

Sources

NWT Department of Health and Social Services, *Cancer Registry* and *Cancer in the Northwest Territories, 2001-2010*; Statistics Canada.

What is being measured?

The age-standardized incidence (new cases) of lung cancer in the NWT.
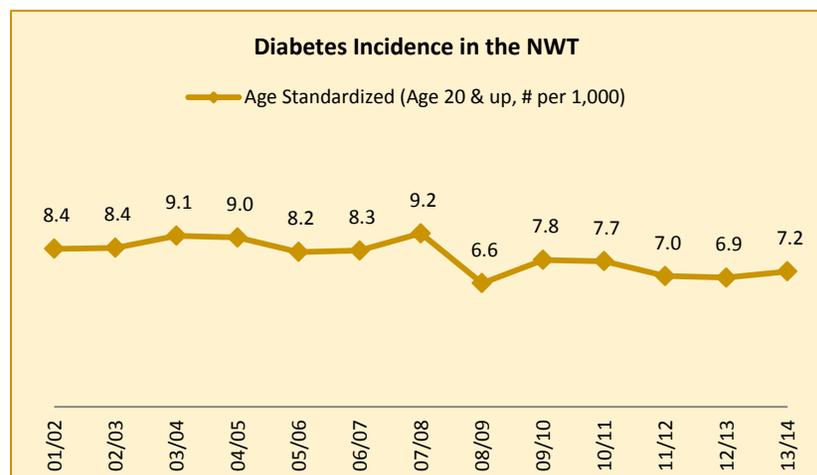
Why is this of interest?

Lung cancer is the third most frequently diagnosed cancer in the NWT for both men and women but is the number one cause of cancer death in both sexes. Lung cancer is primarily caused by tobacco use and is to a large degree preventable. It often does not present symptoms until it has progressed too far to respond well to treatment nor is there a simple routine way to screen for lung cancer.

How are we doing?

The incidence of lung cancer decreased between 2001-2005 and 2009-2013 by 16% from 8.4 to 7.1 cases per 10,000 population (five-year averages). It is important to keep in mind that the average number of cases of lung cancer diagnosed each year are few – averaging 16 per year.

Diabetes

Diabetes Incidence in the NWT

◆ Age Standardized (Age 20 & up, # per 1,000)

8.4 8.4 9.1 9.0 8.2 8.3 9.2 6.6 7.8 7.7 7.0 6.9 7.2

01/02 02/03 03/04 04/05 05/06 06/07 07/08 08/09 09/10 10/11 11/12 12/13 13/14

What is being measured?
The age-standardized incidence rate of diabetes in the NWT (new cases per 1,000 population age 20 and over).

Why is this of interest?
Most cases of diabetes are Type II. Type II diabetes is largely a preventable condition that can lead to serious health complications and, in some cases, death.

How are we doing?
In 2013/14, there were 205 new cases of diabetes diagnosed in the NWT (age 20 and up) – 7.2 cases per 1,000. The rate of new cases of diabetes has declined slightly – at a rate of 1.3% per year – between 2001/02 and 2013/14. The NWT's incidence rate is not significantly different than the national rate at 6.6 per 1,000 (2012/13).

While the rate of new cases has decreased slightly, the prevalence of diabetes (cases overall) is on the rise in the NWT.

Between 2001/02 and 2013/14, the prevalence of diabetes increased from 61.1 to 98.2 cases per 1,000 – an average annual increase of 4.0%. The prevalence of diabetes in the NWT is similar to the national average of 97.3 cases per 1,000 (2012/13).
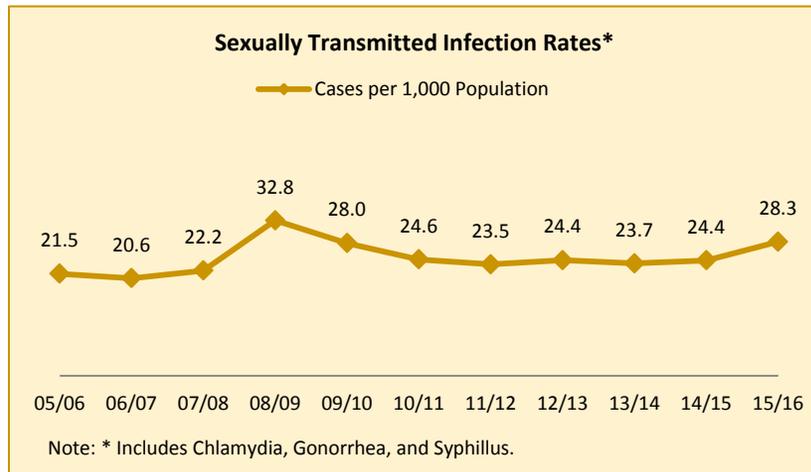
Notes
National numbers are preliminary.

Sources
NWT Department of Health and Social Services, *Chronic Disease Registry* and Public Health Agency of Canada, *National Diabetes Surveillance System*.

Sexually Transmitted Infections

Sexually Transmitted Infection Rates*

◆— Cases per 1,000 Population

| | | | 32.8 | | | | | | | |
| 21.5 | 20.6 | 22.2 | | 28.0 | 24.6 | 23.5 | 24.4 | 23.7 | 24.4 | 28.3 |

05/06 06/07 07/08 08/09 09/10 10/11 11/12 12/13 13/14 14/15 15/16

Note: * Includes Chlamydia, Gonorrhea, and Syphillus.

Sources

NWT Health and Social Services, *Communicable Diseases Registry*.
Public Health Agency of Canada, *Report on Sexually Transmitted Infections in Canada*.

What is being measured?

The incidence of Sexually Transmitted Infections (STIs): the number of STIs per 1,000 population per year.

Why is this of interest?

The incidence of STIs in the NWT is seven times higher than the rest of Canada's 3.4 cases per 1,000 (2012). 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?

After peaking in 2008/09, the STI rate evened off at an average of 24 cases per 1,000 between 2010/11 and 2014/15. In 2015/16, the rate increased by 16% from the year before to 28.3 cases per 1,000.

Immunization Rates

What is being measured?

The proportion of the population born in a given year (e.g. 2011) having received full immunization coverage by their second birthday.[5]

Why is this of interest?

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

How are we doing?

For children born in 2011, the latest immunization coverage study in 2014 revealed an immunization coverage rate of 63% by the child's second birthday for six vaccines in total. In comparison, the last study of children born in 2007, found that the coverage rate was 65%. The difference between the two is not statistically significant.

NWT coverage rates are much higher per single vaccine but generally are lower than national goals (see Other information).

Other information

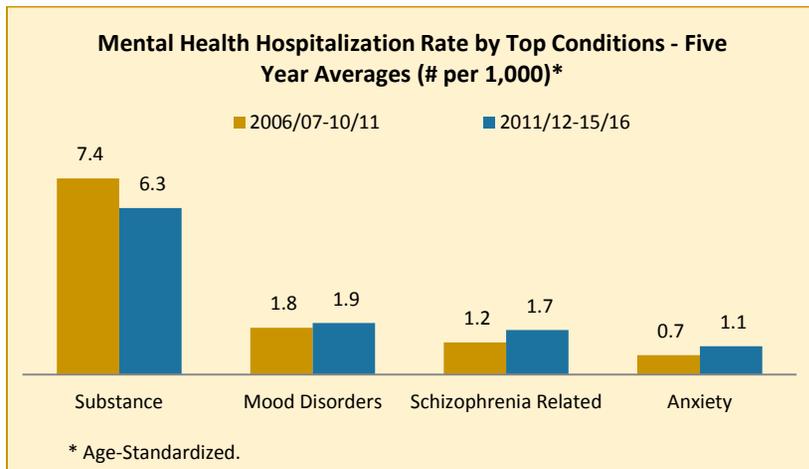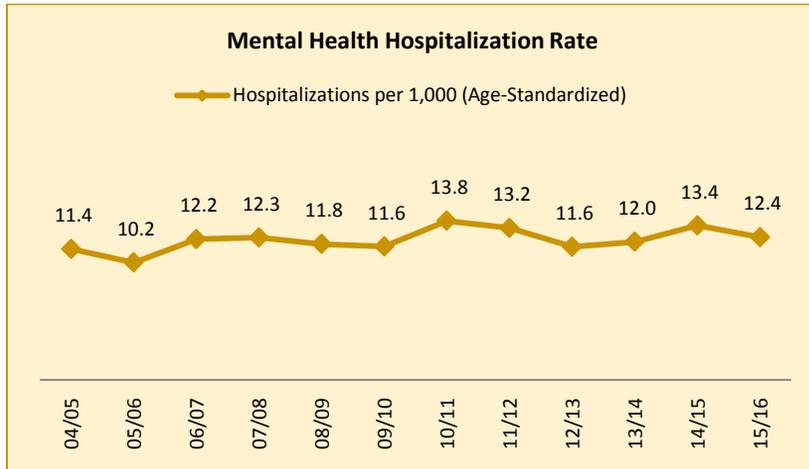| Vaccine by Diseases Protected Against and Coverage Rate (By 2nd Birth Day)	NWT 2014*	National Goal	Meet National Goal
DaPT Polio Act-HIB Diphtheria, pertussis, tetanus, polio and haemophilus influenza type b	75%	95%	No**
Hep B (TMF) Hepatitis B	87%	n/a	n/a
Men C Meningitis, meningococcemia, septicemia	85%	97%	No
MMR Measles, mumps and rubella	73%	97%	No**
Pneumococcal Conjugate (PCV - 13) Streptococcus pneumoniae	75%	90%	No
Varicella Varicella (Chickenpox)	88%	85%	Yes

* Children born in 2011. n/a = Not applicable.

** National goal only includes pertussis and rubella, respectively.

Sources

NWT Department of Health and Social Services, Immunization Records, Vital Statistics and Health Care Registry.

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[5] Full coverage includes six vaccines (see Other information).

Mental Health Hospitalizations

Mental Health Hospitalization Rate

◆ Hospitalizations per 1,000 (Age-Standardized)

	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Rate	11.4	10.2	12.2	12.3	11.8	11.6	13.8	13.2	11.6	12.0	13.4	12.4

Mental Health Hospitalization Rate by Top Conditions - Five Year Averages (# per 1,000)*

■ 2006/07-10/11   ■ 2011/12-15/16

	Substance	Mood Disorders	Schizophrenia Related	Anxiety
2006/07-10/11	7.4	1.8	1.2	0.7
2011/12-15/16	6.3	1.9	1.7	1.1

* Age-Standardized.

What is being measured?

The annual rate of mental health hospitalizations, overall and by diagnostic category, for NWT residents.[6]

Why is this of interest?

The NWT has a much higher rate of acute care hospitalizations for mental illnesses than the national rate. 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 2015/16.

The NWT's mental health hospitalization rate, between 2011/12 and 2015/16, is on average over two times higher than the national average (2013/14). The NWT has higher rates of hospitalizations for each of four main categories relative to national rates, with especially higher rates of alcohol/drug hospitalizations (over six times) and anxiety disorder hospitalizations (four times).

Almost half of all mental health hospitalizations were primarily to do with alcohol and drug abuse/dependency. While these patients often have other mental health conditions, in many cases their issues could possibly be treated or mitigated outside

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

of a hospital setting – which may prevent or reduce the frequency of hospitalization over the long run.

The 30-Day readmission rate for mental illness hospitalizations of NWT residents was 12 per 100 for 2014/15, not significantly different when compared to the national rate of 11.8.

Sources

NWT Department of Health and Social Services and CIHI, *Discharge Abstract Data;* CIHI, *Quick Facts*; NWT Bureau of Statistics, *Population Estimates*; and Statistics Canada.

School Readiness
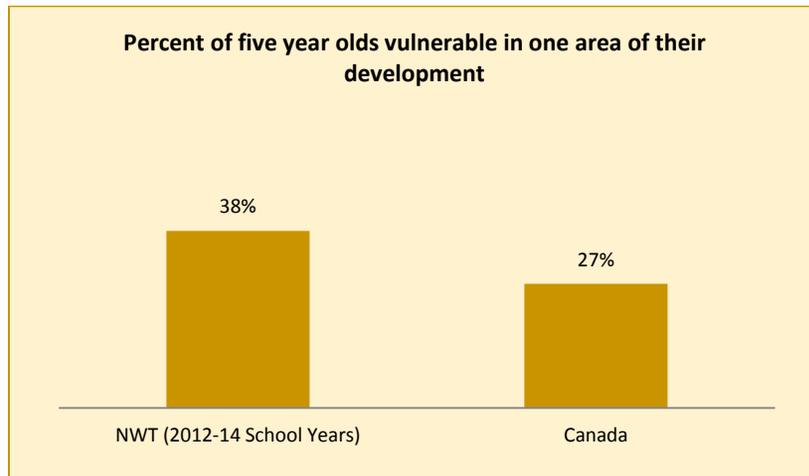
Percent of five year olds vulnerable in one area of their development

38%

27%

NWT (2012-14 School Years)   Canada

What is being measured?

The proportion of kindergarten students who are vulnerable in one area of their development as measured by the Early Development Instrument (EDI). The EDI is a kindergarten teacher-completed checklist that measures five areas of child development, including physical health, social competence, emotional maturity, language and cognitive development, and communication skills.

Why is this of interest?

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

How are we doing?

The proportion of kindergarten students who are vulnerable in one developmental area is approximately 43% higher in the NWT than the national average.[7]
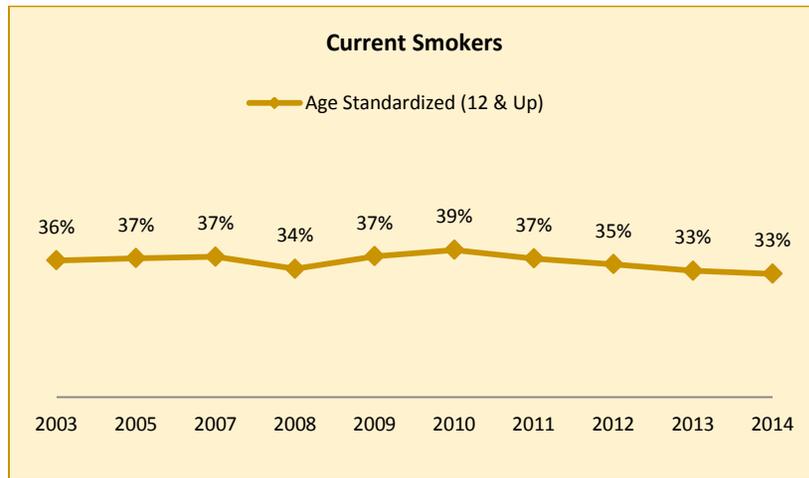
NWT children's scores varied across the five domains that make up the EDI. On physical health and well-being 22% were found to be vulnerable, 19% were vulnerable on communication skills and general knowledge, 17% were vulnerable on language and cognitive development, 17% were vulnerable on emotional maturity and 14% on social competence.

Sources

NWT Department of Education, Culture and Employment, *Early Development Instrument – Summary of NWT Baseline Results for the 2012, 2013 and 2014 School Years* (September 2014). Offord Centre for Child Studies, McMaster University and Canadian Institute for Health Information (yourhealthsystem.cihi.ca).

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[7] Canadian results vary in year to year depending on provincial/territorial availability of results, covering a period of 2007/08 to 2013/14.

Smoking

Current Smokers

— Age Standardized (12 & Up)

36% 37% 37% 34% 37% 39% 37% 35% 33% 33%

2003 2005 2007 2008 2009 2010 2011 2012 2013 2014

What is being measured?

The proportion of the population who are current daily or occasional smokers.

Why is this of interest?

Smoking is a largely preventable factor in a number of chronic diseases, including lung and other cancers, chronic lung problems, Type II diabetes, and cardiovascular diseases (heart attacks and strokes). Not only can smoking increase the risk of acquiring Type II diabetes, it can also increase the risk of severe complications of diabetes (such as lower limb amputations).

How are we doing?

Currently 32.5% of the NWT population, age 12 and over, report that they are daily or occasional smokers - which is higher than the national rate of 18.5%. Between 2003 and 2014 there have not been any significant changes in the NWT smoking rate,

whereas the national rate has decreased from 23.4% to 18.5% over the same time period.[8]

Source

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

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[8] The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Between 2007 and 2014, the CCHS had been carried out annually. Since 2015, the CCHS returned to a two-year cycle in all three territories.

Heavy Drinking

Heavy Drinking (Age-Standardized, Age 12 & Up)

32% 2013
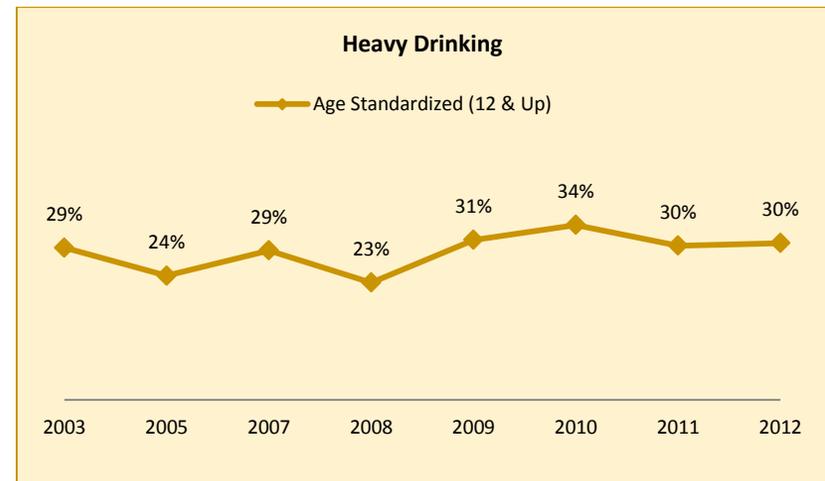
33% 2014
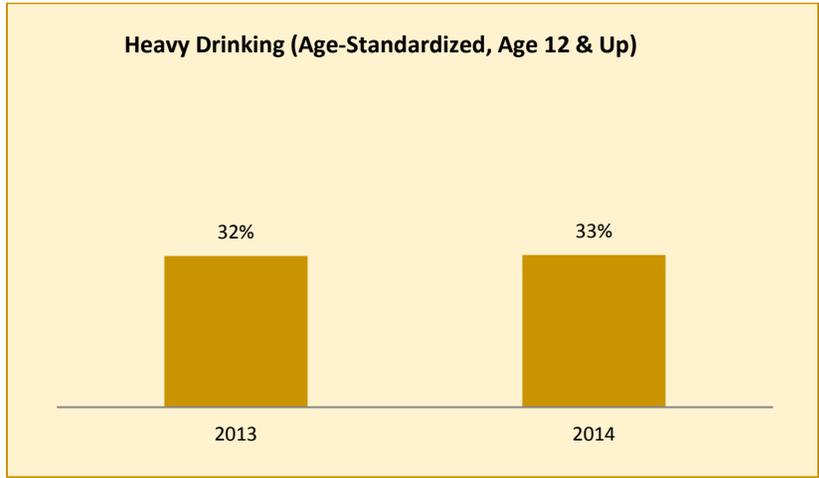
What is being measured?

The proportion of the population who are considered to have engaged in heavy drinking. Heavy drinking equals five or more drinks at a time, once or more a month, every month for males (four or more drinks for females).

Why is this of interest?

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.

How are we doing?

Currently 32.5% of the NWT population, age 12 and over, are considered to be heavy drinkers - higher than the national rate of 19.2%. Between 2003 and 2012 there have not been any significant changes in the NWT rate, whereas the national rate increased marginally from 17.5% to 18.8% over the same time period.[9]
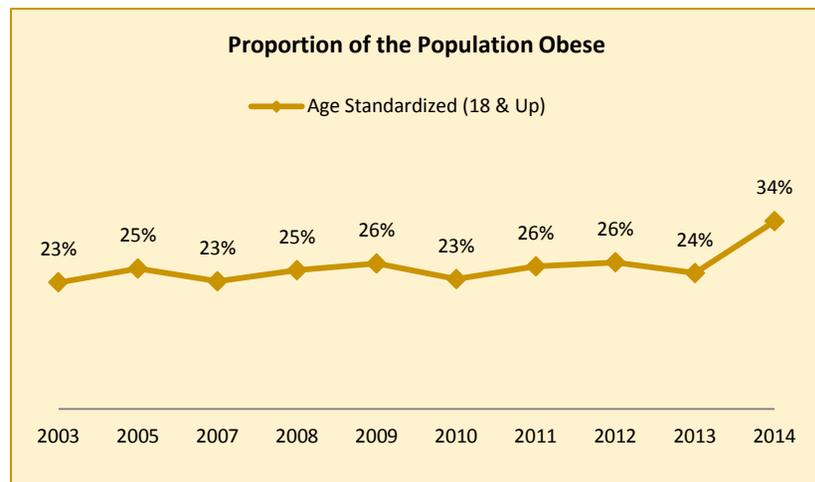
Heavy Drinking

Age Standardized (12 & Up)

2003	2005	2007	2008	2009	2010	2011	2012
29%	24%	29%	23%	31%	34%	30%	30%

Source

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

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[9] The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Between 2007 and 2014, the CCHS had been carried out annually. Since 2015, the CCHS returned to a two-year cycle in all three territories. The definition of heavy drinking for women changed in 2013 from 5 to 4 drinks, thus historical trends have been presented separately.

Obesity

Proportion of the Population Obese

Age Standardized (18 & Up)

| 2003 | 2005 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
| 23% | 25% | 23% | 25% | 26% | 23% | 26% | 26% | 24% | 34% |

What is being measured?

The proportion of the population considered obese (body mass index of 30 or more).

Why is this of interest?

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.

How are we doing?

Currently 33.7% of the NWT population, age 18 and over, are considered obese – significantly higher than the national rate of 19.5%. The obesity rate has increased by 48% in the NWT and 31% nationally between 2003 and 2014. For the NWT, most of the increase has occurred in 2014. Give the small sample of the population surveyed in the NWT, it is important to realize that the results for 2014 may be an anomaly. Future survey results will confirm whether the apparent increase is real.[10]

Source

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

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[10] The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Between 2007 and 2014, the CCHS had been carried out annually. Since 2015, the CCHS returned to a two-year cycle in all three territories.

Section 2: Community, Individual and System Outcomes

Population Outcomes

Placement Appropriateness

Child Protection

Counselling

Family Violence

Satisfaction

Telehealth

Community, Individual and System Outcomes

Treatment

Placement Change

Child Safety

Family Safety

Wait Times

Medical Travel

System Inputs
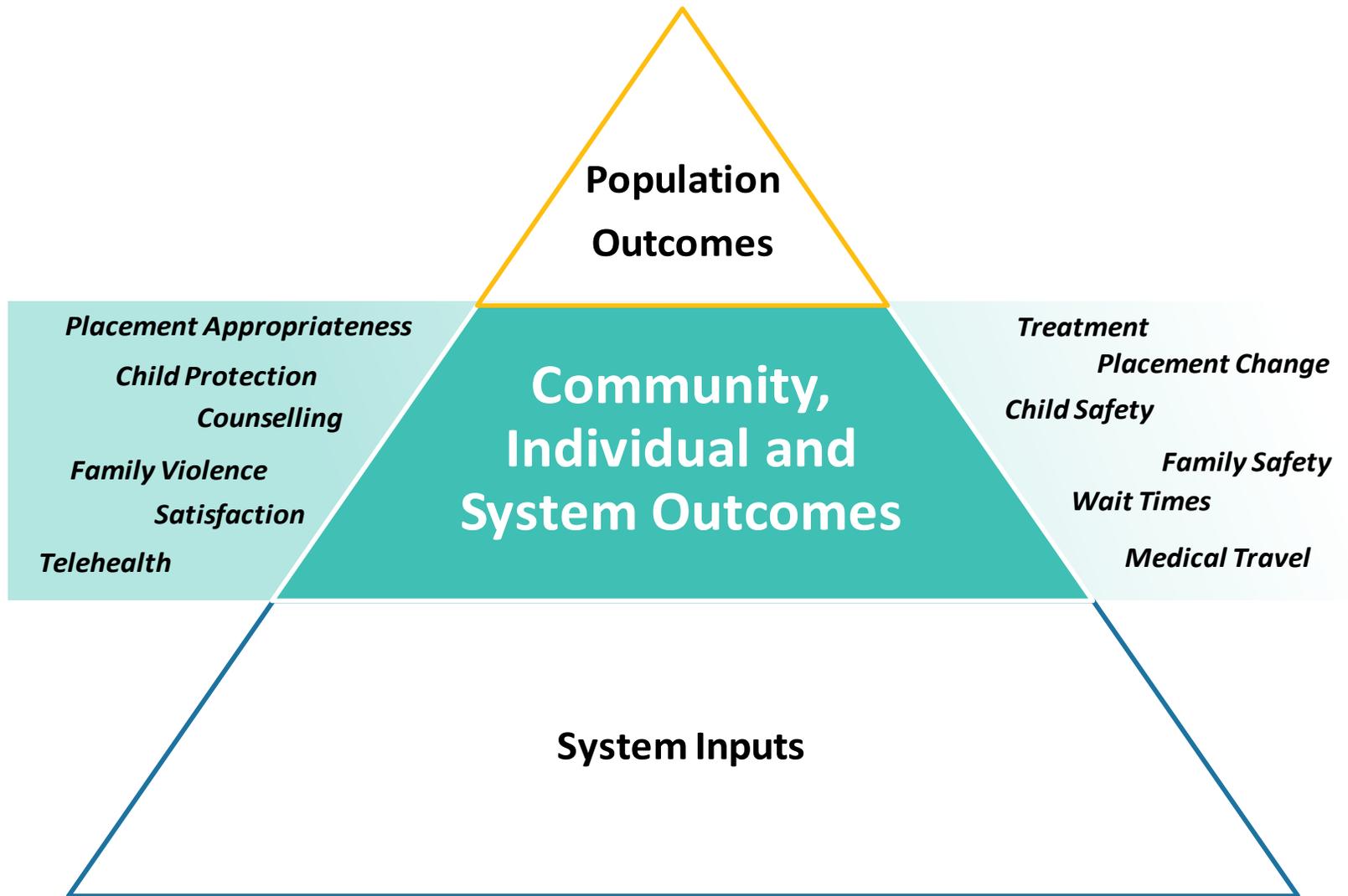
Community Counselling Program

What is being measured?

The average number of community counselling clients seen per month.

Why is this of interest?

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

How are we doing?

There is currently only one full year of data.[11] Between April 2015 and March 2016, an average 1,012 clients were seen per month.

Other information

The top five documented primary reasons (issues the client presented with) for counselling were addictions (24%), a diagnosed mental illness (11%), trauma (8%), relationship issues (7%) and undiagnosed mental illnesses (6%). The remaining reasons for presenting included such issues as difficulty managing stress, bereavement, suicide ideation, and family conflict.

Every effort is made to get a client into see a CCP counsellor in as short of time as possible. Residents in an immediate crisis, or at immediate risk, do not have to wait. For other clients, wait times vary from community to community. Some communities do not

have a wait list while others the wait can be up to two or more months – depending on the type of counselling in question.

Source

NWT Department of Health and Social Services.

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[11] As information collection improves, it is expected that indicators measuring the performance of the CCP will move beyond basic utilization statistics to those that measure outcomes. Because of a lack of available CCP data overtime a chart was not included.

Addictions Treatment

Addiction Treatment Completion Rate

■ % Who go for treatment who complete

78%	73%
2014/15	2015/16
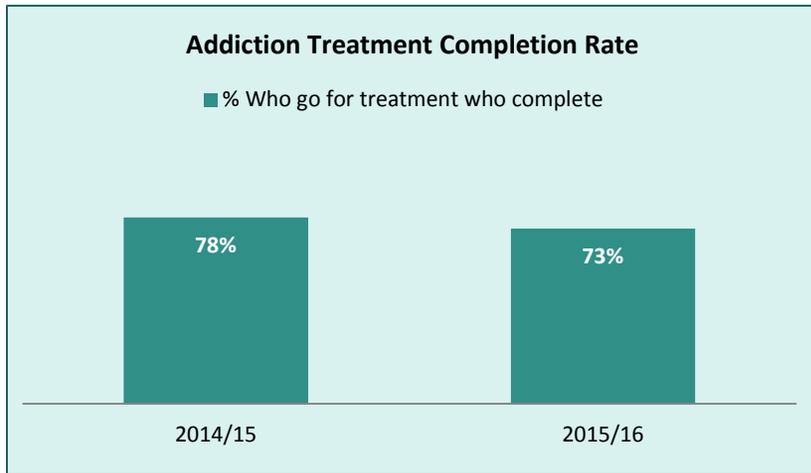
What is being measured?

The proportion of people who start and complete a full session of residential addictions treatment.[12]

Why is this of interest?

This is 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 only two complete years of data to assess how well we are doing but, 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 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.[13]

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.

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[12] Completion rates only include those applicants who actually begin treatment, and do not include those who are currently in treatment.

[13] Concurrent disorders are when the client suffers from an mental health issue (e.g., depression, bi-polar, schizophrenia) in addition to their addiction.

Child Protection Concerns

Apprehensions by Reason 2015/16

Total Children Investigated	1,913
Total Children Apprehended	200
% Apprehensions by reason	
Child suffered	
Health/Wellness harm due to substance abuse	8.0%
Physical Harm	4.5%
Physical/emotional harm due to neglect	3.5%
Harm due to exposure to domestic violence	*
Sexual Abuse	0.0%
Malnutrition	0.0%
Child at risk for/due to	
Physical harm (substantial risk)	30.0%
Exposure to domestic violence	18.5%
Emotional harm (substantial risk)	10.0%
Physical/emotional harm (substantial risk)	4.5%
Physical harm	*
Sexual Abuse	0.0%
Parent/caregiver unwilling/unavailable	
To adequately care for the child	67.5%
Deserted by caregiver	15.0%
Child without functional legal guardian	*
Other Reasons	
Impairment of the Child's Development	*
Severe Behaviour Consistent with Emotional Harm	0.0%
Medical Authorization Withheld by Parent	0.0%
Child less than 12 Kills, Injures or Damages Person or Property	0.0%

* Less than five cases have been suppressed.

What is being measured?

The proportion of children apprehended by the reason(s) for the apprehension.[14]

Why is this of interest?

The *Child and Family Services Act* (Section 7(3)) sets out 19 conditions under which a child may be in need of protection. This indicator enables a rank-ordering of those conditions from which prevention efforts and decision making can be guided.
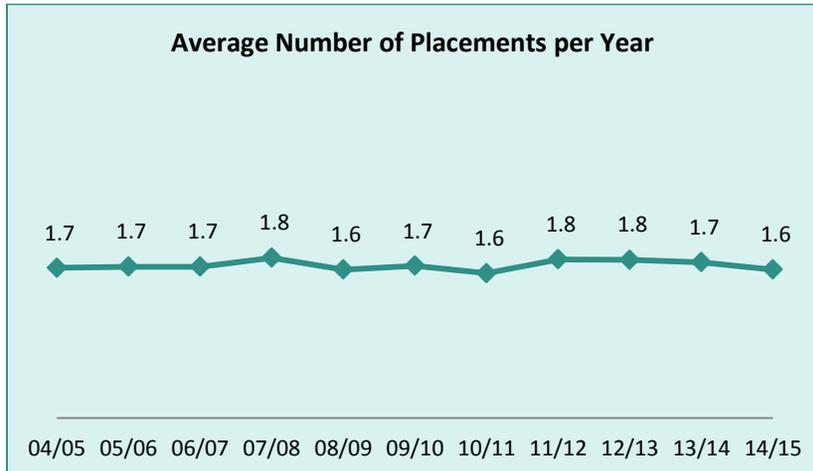
How are we doing?

In 2015/16, over two thirds (67.5%) of all children apprehended were due to the parent or guardian being unavailable or unwilling to adequately care for the child. Almost a third of children (30%) were found to be at a substantial risk of physical harm. Approximately 18.5% of children were apprehended because they were a risk due to exposure to domestic violence. There were a number of other reasons for apprehension, including 15% of cases where the child was deserted by their caregiver, 10% of cases where the child was found to be at a substantial risk of emotional harm, and 8% where they had suffered harm to their health or well-being.

Source

NWT Department of Health and Social Services, *Child and Family Services Information System* (CFIS).

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[14] There can be more than one reason for a child being apprehended. Also, the same child may have been apprehended more than once in the year. This indicator does not lend itself to be tracked over time and thus is not included in the statistical summary.

Children in Care – Placement Changes

Average Number of Placements per Year

| 1.7 | 1.7 | 1.7 | 1.8 | 1.6 | 1.7 | 1.6 | 1.8 | 1.8 | 1.7 | 1.6 |

04/05 05/06 06/07 07/08 08/09 09/10 10/11 11/12 12/13 13/14 14/15

Children in Care
Average Number of Placements per Year

Age	Average		Change
	05/06-09/10	10/11-14/15	
Total	1.7	1.7	0.3%
Under 3	1.8	1.9	10.2%
3 to 5	1.8	1.9	5.1%
6 to 11	1.6	1.6	-1.9%
12 to 15	1.8	1.8	0.4%
16 & Up	1.6	1.5	-6.2%

What is being measured?

The average number of placements per year, and by age group, for children in care.

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 average number of placements per child in care has changed little year over year in the last eleven years – ranging from 1.6 to 1.8 placements per year.
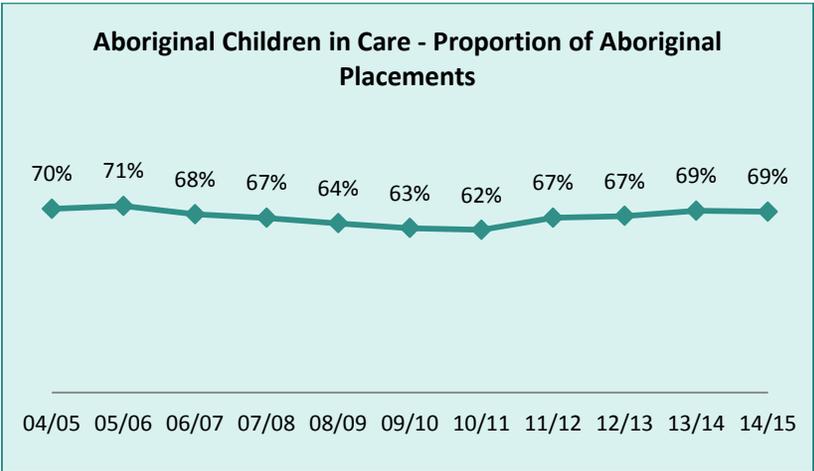
When examined by age group, the average number of placements per year varies insignificantly between age groups, and across time.

Source

NWT Department of Health and Social Services, *Child and Family Services Information System* (CFIS).

Child Placement Appropriateness

Aboriginal Children in Care - Proportion of Aboriginal Placements

70%	71%	68%	67%	64%	63%	62%	67%	67%	69%	69%

04/05 05/06 06/07 07/08 08/09 09/10 10/11 11/12 12/13 13/14 14/15

What is being measured?

The proportion of placements of Aboriginal children, placed out of their home, in an Aboriginal placement.[15]

Why is this of interest?

In the last three years, Aboriginal children have made up 98% of the children in care but only about 61% of the child population.

When an Aboriginal child must be placed outside of the parental home, and extended family is not an option, it is in the best interest of the child to be placed in an Aboriginal home.

[15] Children can have more than one placement in a given year. This measure counts all placements the child had in the year. It is possible for a child to have one placement with an Aboriginal foster family and one with a non-Aboriginal family in the same year.

How are we doing?

In the last 10 years, the proportion of Aboriginal children placed in Aboriginal homes has ranged from 62% to 71%.

Sources

NWT Department of Health and Social Services, *Child and Family Services Information System* (CFIS). NWT Bureau of Statistics, *Population Estimates*.

Child Safety

Child Safety - % of Children maltreated within one year of prior maltreatment

04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
28%	27%	27%	27%	29%	27%	27%	27%	29%	32%

How are we doing?

In the last 10 years, the proportion of children found to have been maltreated again (within one year) has ranged between 27 and 32%. In the last three years there has been a steady increase in the proportion of repeat cases, resulting in an increase of 11% between 2004/05 and 2013/14.

Source

NWT Department of Health and Social Services, *Child and Family Services Information System* (CFIS).

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."[16]

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

Family Violence and Safety

Average Monthly Shelter Admissions

■ # of Children　■ # of Women

Year	# of Women	# of Children
09/10	26	21
10/11	21	20
11/12	23	21
12/13	22	19
13/14	22	19
14/15	24	15
15/16	28	21

Shelter Re-Admission Rates

◆ % of Clients Previously Admitted

Year	%
04/05	58%
05/06	57%
06/07	52%
07/08	62%
08/09	55%
09/10	54%
10/11	53%
11/12	54%
12/13	58%
13/14	64%
14/15	66%
15/16	65%
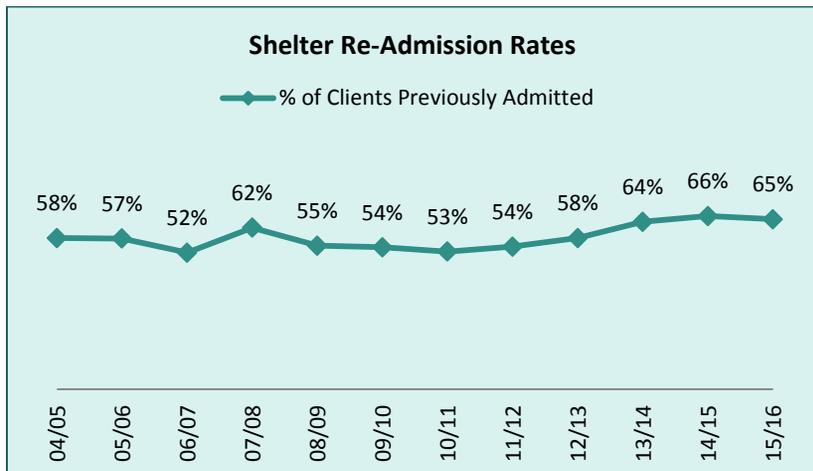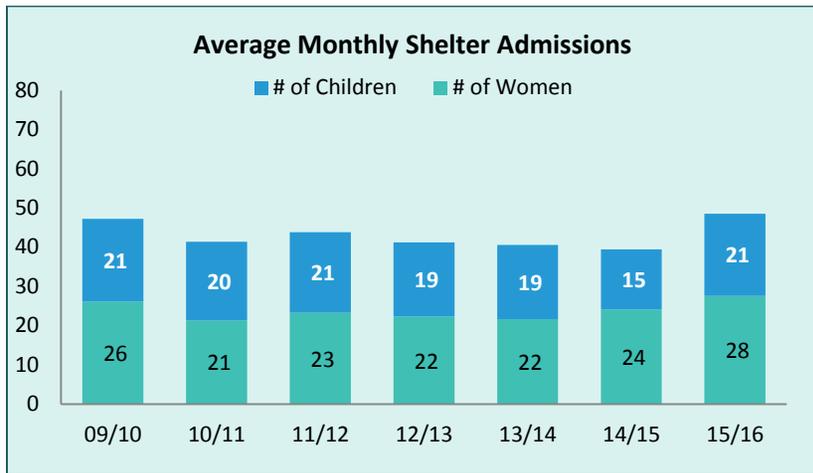
What is being measured?

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

Why is this of interest?

The average month 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 seven years, shelter usage has remained relatively consistent – averaging around 24 women and 19 children admitted per month.

Over the last 12 years, the proportion of readmissions to shelters has averaged 58% - ranging from a low of 52% (2006/07) to a high of 66% (2014/15).

Source

NWT Department of Health and Social Services, *Family Shelter Usage Statistics*.

Patient/Client Satisfaction

Patient/Client Satisfaction
Various H&SS System Services

Satisfaction Questionnaire	Year	% Satisfied
NWT Hospital	2008	86%
NWT Hospital	2010	92%
NWT Health Services	2012	92%
NWT Community Counselling Program	2013	95%
NWT Health Services	2014	92%
NWT Community Counselling Program	2016	99%

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 in the past year.[17]

Why is this of interest?

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

How are we doing?

Patient and client satisfaction questionnaires have been delivered across the NWT HSS system over the last few years. Results have been favourable – with 86% to 99% 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 six questionnaires have varied in terms of which service areas were surveyed.

Source

NWT Department of Health and Social Services, *Patient/Client Satisfaction/Experience Questionnaires.*

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[17] 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).

Long Term Care Wait Times

Long-Term Care - Median Wait Times

◆ Days

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	41	31	47	16	46	33
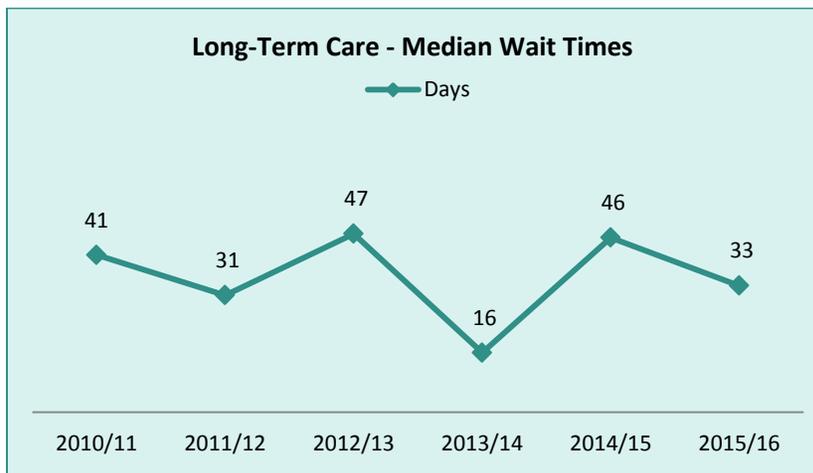
What is being measured?

The median number of days a patient waits to receive an offer of a placement in a long term care facility.[18] 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 six years, the median wait time to be offered a placement in a long term care facility was 33 days and has ranged from 16 days to 47 days.

While around 50% of clients have been offered a placement within a month, over two-thirds of clients have been offered a placement within three months.
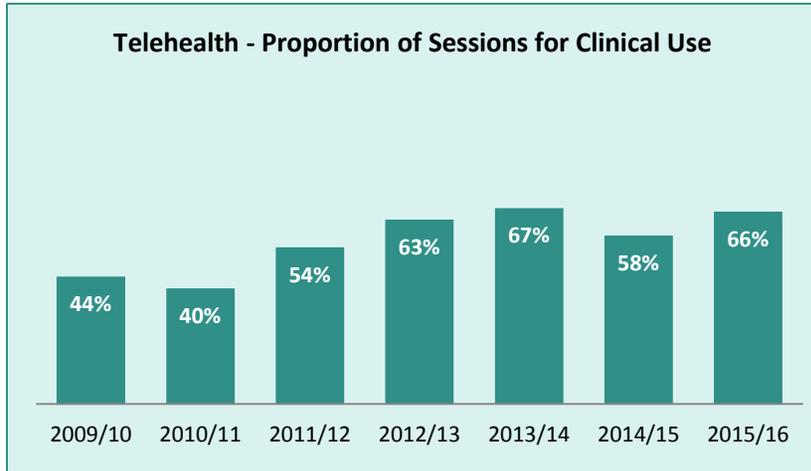
Long Term Care Wait Times

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	6 Years
Placements Offered	63	36	34	46	38	40	257
Average	67	55	112	59	98	82	77
Median	41	31	47	16	46	33	33
Proportion of Clients by # of Days before Placement Offer							
<8	13%	25%	18%	26%	8%	15%	17%
8 to 14	14%	22%	3%	20%	16%	18%	16%
15 to 21	8%	0%	12%	11%	8%	5%	7%
22 to 28	6%	3%	6%	9%	5%	8%	6%
29 to 92	25%	25%	24%	15%	29%	23%	23%
93 to 182	30%	19%	15%	9%	11%	18%	18%
183 & Up	3%	6%	24%	11%	24%	15%	12%

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

Source

NWT Department of Health and Social Services.

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[18] 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.

Telehealth – Clinical Usage

Telehealth - Proportion of Sessions for Clinical Use

2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
44%	40%	54%	63%	67%	58%	66%

Even though telehealth is being increasingly used to bring care to the patient/client in their community, it is important to realize that there is value in the other uses of telehealth technology. For example, using telehealth for education purposes and meetings facilitates staff learning and collaboration while minimizing the need for costly duty travel.

Other information

The overall number of telehealth sessions has nearly tripled from 1,356 to 3,989 between 2009/10 and 2015/16.

Source

Department of Health and Social Services.

What is being measured?

The proportion of telehealth sessions that are for clinical use (patient/client care).

Why is this of interest?

Telehealth technology presents a significant opportunity to improve access to services for all residents of NWT and allows for potential cost savings to be realized by using technology to minimize travel costs. Telehealth helps reduce medical and staff travel by providing remote access to clinical advice for patients and professionals.

How are we doing?

The proportion of telehealth sessions that were used for clinical reasons, as opposed to staff education sessions or meetings, has increased by nearly 50% from 44% in 2009/10 to 66% in 2015/16.

Medical Travel

Medical Travel Cases

What is being measured?

The number of medical travel cases; and, the proportion of cases with an escort.[19]

Why is this of interest?

Medical travel represents a significant percentage of the Department's budget every year (4 to 5%). Tracking medical travel utilization trends can help identify trends that may require further investigation (e.g. service provision in and out of the NWT, and within in the NWT).

How are we doing?

While the overall case load has been increasing, the proportion of cases with an escort has remained relatively stable, fluctuating between 36% and 40%. Between 2007/08 and 2010/11, the

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[19] Cases with escorts could involve more than one escort, and in some cases, the presence of an escort may not be flagged (where the escort paid for their flight first and later submitted a claim for reimbursement).

case numbers had been relatively steady but have increased in recent years, beginning in 2011/12.

Other information

Medical Travel Cases

Fiscal Year	Total Cases		Cases with Approved Escorts	
	#	Rate	#	%
2007/08	11,466	264	4,259	37%
2008/09	11,564	267	4,362	38%
2009/10	11,760	273	4,668	40%
2010/11	11,489	265	4,375	38%
2011/12	12,303	283	4,688	38%
2012/13	13,159	301	4,748	36%
2013/14	13,763	314	4,950	36%
2014/15	13,248	301	5,172	39%
2015/16	14,331	325	5,554	39%

Rate = Number (#) of cases per 1,000 population

Sources

Stanton Territorial Health Authority, *Medical Travel Statistics*. NWT Bureau of Statistics, *Population Estimates*.

Section 3: System Inputs

Population
Outcomes

Community, Individual and
System Outcomes

Staff
Safety

Vacancy
Rates

System Inputs

No
Shows
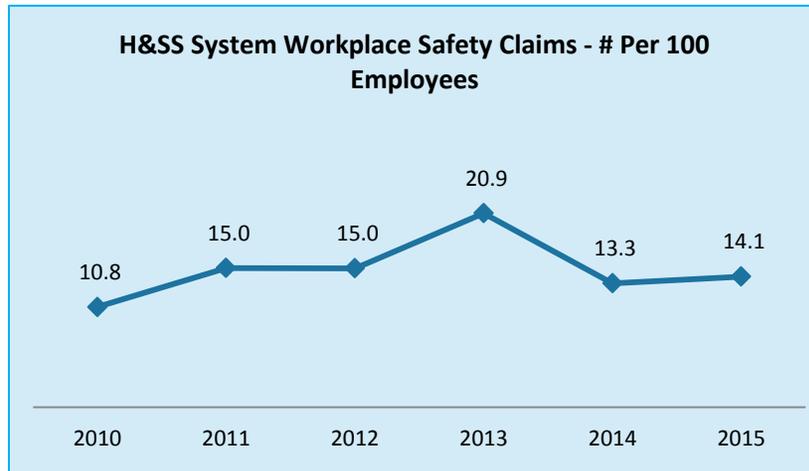
Staff Safety

H&SS System Workplace Safety Claims - # Per 100 Employees

2010	2011	2012	2013	2014	2015
10.8	15.0	15.0	20.9	13.3	14.1

Sources

Department of Human Resources and Workers Safety and Compensation Commission.
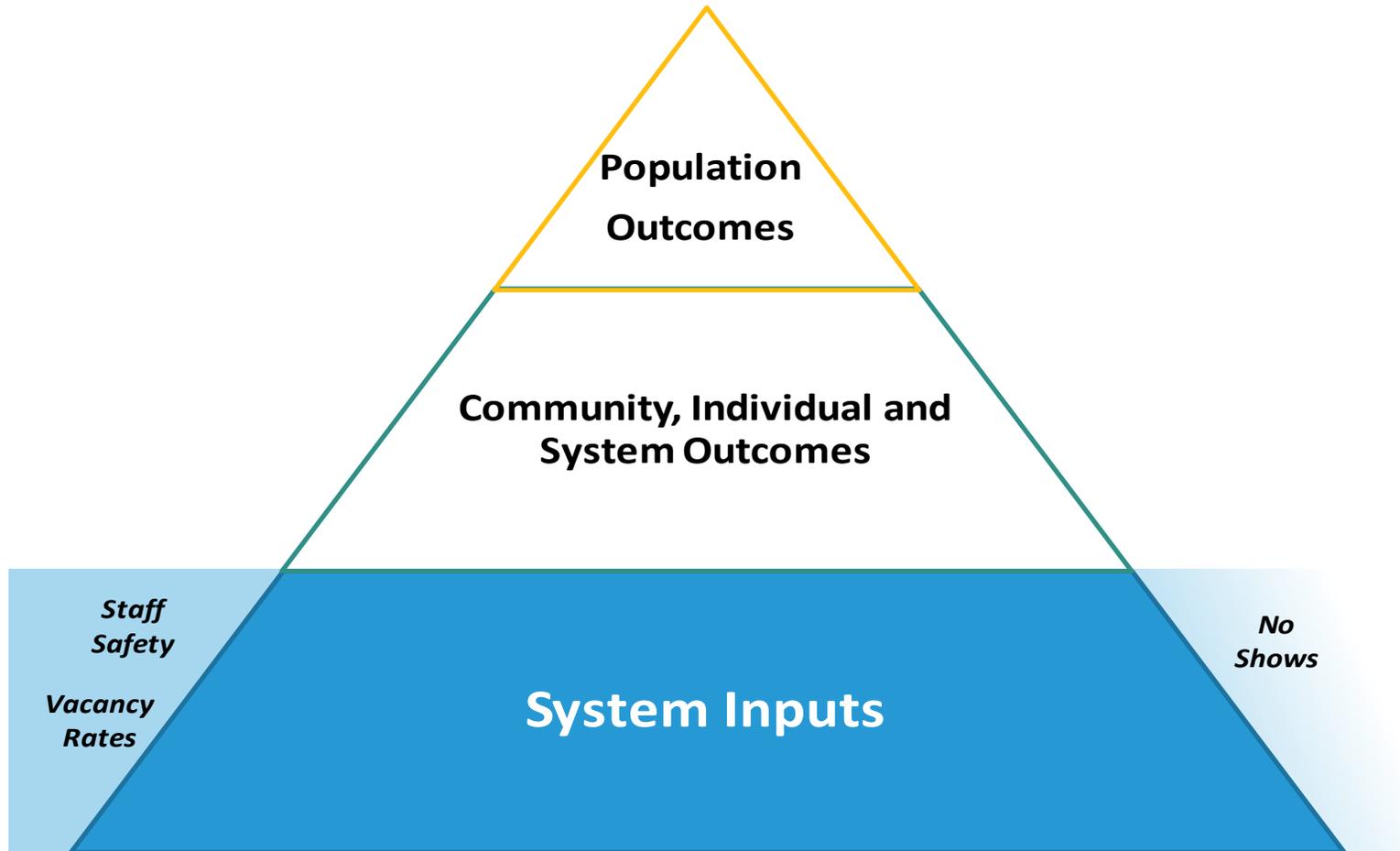
What is being measured?

The number of workplace safety claims per 100 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.
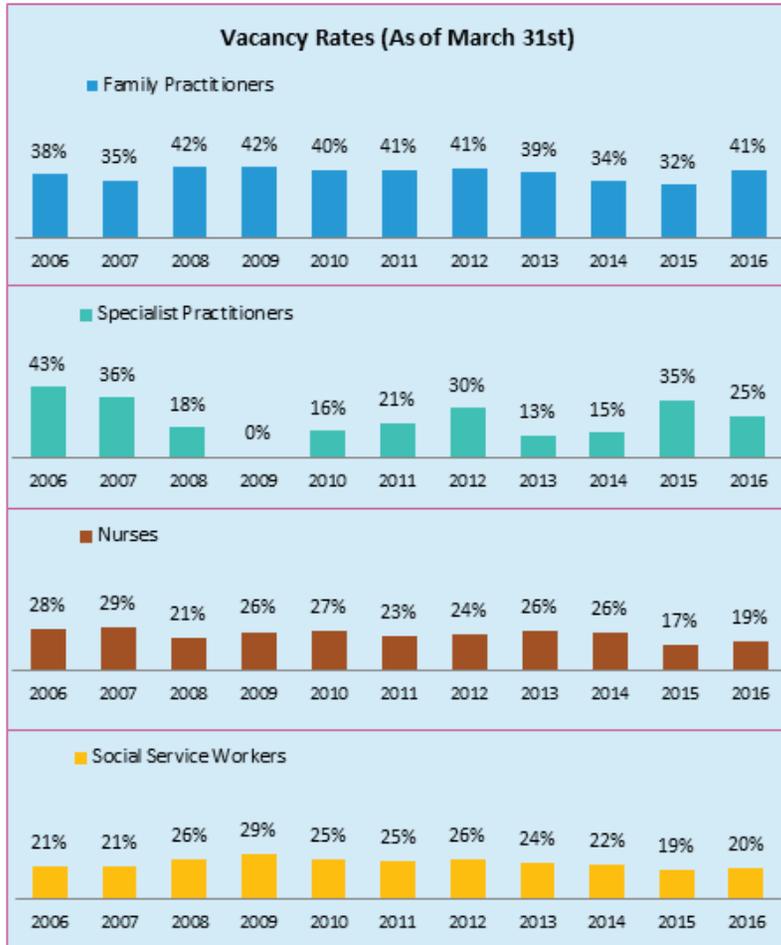
How are we doing?

Over the last five years the overall rate of safety claims have significantly increased from 10.8 per 100 employees in 2010 to 14.1 per 100 in 2015. The 2015 rate is over twice that of the rate for the rest of the GNWT.

System Inputs

Vacancy Rates

Vacancy Rates (As of March 31st)

Family Practitioners

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
38%	35%	42%	42%	40%	41%	41%	39%	34%	32%	41%

Specialist Practitioners

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
43%	36%	18%	0%	16%	21%	30%	13%	15%	35%	25%

Nurses

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
28%	29%	21%	26%	27%	23%	24%	26%	26%	17%	19%

Social Service Workers

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
21%	21%	26%	29%	25%	25%	26%	24%	22%	19%	20%

What is being measured?

The vacancy rate for family practitioners, specialist practitioners, nurses, and social service workers.[20]

Why is this of interest?

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

How are we doing?

As of March 31, 2016, the NWT have had some relatively low vacancy rates – historically speaking – across two of the four occupational categories examined. Nurse vacancy rate was 19% - the second lowest it has been in eleven years; and the social worker vacancy rate was 20% - also the second lowest in the same time period. Family practitioner vacancy rate was 41%, and the specialist vacancy rate was at 25%.[21]
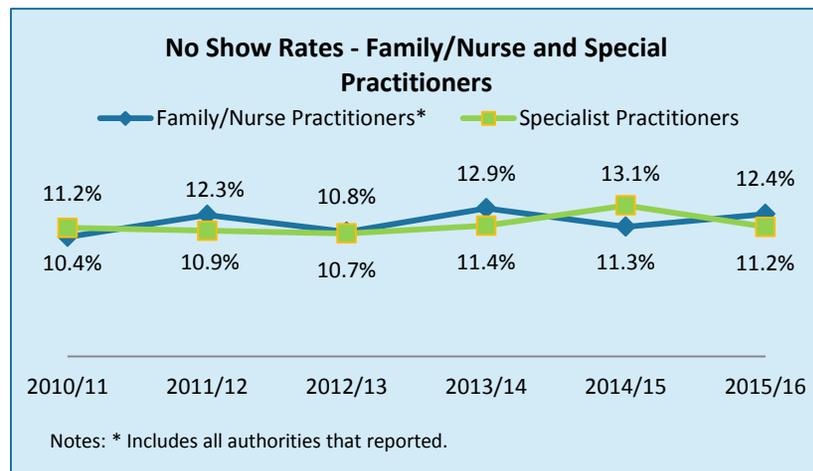
Sources

Department of Human Resources and Department of Health and Social Services.

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[20] Vacancy rates include vacant positions that are staffed by casuals or contracted labour, as well as positions that may have not been staffed due to operational reasons. Nurse vacancy rate includes relief nurse positions and midwives. Social service workers include social workers, counsellors and psychologists.

[21] Family practitioner rate for March 31, 2011 is an estimate. Family and specialist practitioner rates for 2015 are for May 5th.

No Shows

No Show Rates - Family/Nurse and Special Practitioners

—◆— Family/Nurse Practitioners* —■— Specialist Practitioners

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Specialist	11.2%	12.3%	10.8%	12.9%	13.1%	12.4%
Family/Nurse	10.4%	10.9%	10.7%	11.4%	11.3%	11.2%

Notes: * Includes all authorities that reported.

What is being measured?

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

Why is this of interest?

No shows to appointments with these professionals can represent a significant waste 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 six years, patients did not show up to approximately 10 to 13% of scheduled appointments to family and nurse practitioners.[22] For specialists, the no show rate was also ranged between approximately 11 to 13% over the last four years.

Source

NWT Health and Social Services Authorities (Pre-August 1, 2016).

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[22] No show rates for family and nurse practitioner appointments came from data provided by the seven HSSAs. 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.

Glossary: Definitions and Abbreviations

CCP: Community Counselling Program.

Department: Department of Health and Social Services.

GNWT: Government of the Northwest Territories.

HSS: Health and Social Services.

LTC: Long term care.

OAG: Office of the Auditor General of Canada.

STI: Sexually transmitted infections.

System: The Department of Health and Social Services and the Health and Social Services Authorities (NWT Health and Social Services Authority, Hay River Health and Social Services Authority and Tłįchǫ Community Services Agency).

NWT: Northwest Territories.