Northwest Territories Chronic Disease Prevention and Management Strategic Framework

March 2019

Government of Northwest Territories

Best health | Best care | Better future

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Message from the Minister of Health and Social Services

I am pleased to present the Department of Health and Social Services' (DHSS) *Northwest Territories Chronic Disease Prevention and Management Strategic Framework*. As the population around the world ages, there is a drastic increase in the risk and prevalence of chronic diseases. This issue has been recognized in the Northwest Territories (NWT) for quite some time.

The *Mandate of the Government of the Northwest Territories 2016-2019*, proposes to reduce the burden of chronic diseases by promoting healthy lifestyles and improving screening and management.

Chronic Diseases are one of six priorities outlined in *Caring for Our People: Strategic Plan for the NWT Health and Social Services System 2017-2020*. This key priority seeks to develop and implement a sustainable framework for chronic disease prevention and management that will positively impact the health of the people of the NWT who are at risk for and living with chronic disease.

The process of System Transformation has afforded the DHSS a number of opportunities for strengthening existing partnerships and establishing others. These partnerships are invaluable for setting the foundation for chronic disease prevention and management. The Regional Wellness Councils, especially, will be instrumental in bridging gaps between the DHSS and communities. In addition, the ensuing collaboration between the DHSS, the Northwest Territories Health and Social Services Authority (NTHSSA), the Hay River Health and Social Services Authority (HRHSSA) and the Tlicho Community Service Agency (TCSA) will result in robust Primary Care programs and services for all of the NWT.

The *Northwest Territories Chronic Disease Prevention and Management Strategic Framework* reflects the vision of DHSS to "Best Health, Best Care for a Better Future".

Glen Abernethy
Minister of Health and Social Services

Executive Summary

The *NWT Chronic Disease Prevention and Management Strategic Framework* outlines the commitment of the Department of Health and Social Service (DHSS) to reduce the burden of chronic disease in the territory. Chronic diseases are the most common cause of preventable death.

Chronic diseases are those diseases that typically last a long time and develop slowly. Chronic diseases include cancer, cardiovascular disease (heart disease, stroke), diabetes, and mental illness. The onset of chronic diseases is often linked to modifiable risk factors such as: smoking/snuff use, heavy alcohol consumption, physical inactivity, and a poor diet. Other risk factors that a person cannot modify such as age, gender, family history, unhealthy physical environments and poverty can make people more susceptible to developing a chronic disease. In addition, Indigenous peoples have a higher risk of experiencing chronic illness.

Chronic diseases can affect a person's quality of life, lead to hospitalization and premature death, result in higher rates of absenteeism and poor job performance, and contribute to escalating health care costs. The good news is, that prevention, early detection through screening, and effective medical and self-management can help to reduce the impacts of chronic disease on patients, families, communities and the health care system.

Building on existing DHSS strategies, and based on best practices research and input gathered from community members and health care providers across the NWT, the Framework outlines a patient and family-centred approach to the prevention and management of chronic disease within a primary healthcare context.

The **Vision** is patient and family-centred chronic disease services and initiatives that are:

- Coordinated
- Comprehensive
- Consistent
- Collaborative
- Culturally Safe

The system components of the Expanded Chronic Care Model[29], further described on page 11, focus on care and strongly support patients, families and care providers working together to prevent and manage chronic disease.

The following four **strategic priorities** set the direction for planning initiatives to help NWT residents prevent and better manage chronic diseases.

Introduction

Chronic diseases present a significant health challenge. In Canada, 1 out of every 5 people over the age of 20 has a chronic disease, or is at risk of developing a chronic condition.[1] In addition, Indigenous peoples experience higher rates of chronic disease than the general population.[2] While chronic diseases are the most common causes of death, it is possible to delay or prevent the onset of many chronic diseases through healthy lifestyle choices.

What are chronic diseases?

Chronic diseases are defined as diseases of long duration with a generally slow development. While chronic diseases can develop and progress differently, they have some common characteristics. Chronic diseases:

- have many causes but often share similar risk factors
- can occur at any age but become more common as people get older
- result in long-term illness, which often cannot be cured
- can negatively affect quality of life and limit daily activity
- require ongoing care to manage the disease or diseases

Examples of chronic diseases include[3]:

- Cancer
- Cardiovascular disease (e.g., heart disease, stroke)
- Diabetes
- Kidney disease
- Arthritis
- Respiratory illness (e.g., asthma, chronic obstructive pulmonary disease (COPD))
- Mental illness (e.g., depression, anxiety)

Many people suffer from more than one chronic disease. This may make managing their care much more complex and challenging.

What are risk factors?

Risk factors are those things that make us more susceptible to developing a disease. The onset and progression of chronic diseases are linked to modifiable, non-modifiable and other risk factors.

Modifiable risk factors are within a person's control and can be reduced through changes in behavior and lifestyle. Examples of modifiable risk factors linked to chronic diseases are:

- Unhealthy diet and excessive calorie intake
- Physical inactivity
- Smoking/smokeless tobacco (e.g. chewing tobacco/snuff)
- Heavy alcohol use.

Non-modifiable risk factors are not within a person's control and cannot be changed. Examples of non-modifiable risk factors linked to chronic diseases are:

- Age
- Gender
- Ethnicity
- Family history.

Other social and environmental factors are often not within a person's ability to control but rather, can be addressed through policy and larger structural changes. Examples of other factors linked to chronic diseases are:

- Poverty
- Unhealthy physical environments
- Poor housing conditions.

What are the impacts of chronic disease?

Chronic diseases can be very serious, affect a person's quality of life, lead to hospitalization and sometimes premature death. Chronic diseases not only represent a significant threat to the health of the population, but also to the sustainability of the health and social services system, and to the economic productivity of patients and families. Chronic diseases contribute to escalating health costs, higher rates of absenteeism, and poor job performance. Through prevention, early detection and effective management, the impacts of chronic diseases can be reduced.

Purpose

What is the framework?

The *NWT Chronic Disease Prevention and Management Strategic Framework* outlines the Government of the Northwest Territories (GNWT), Department of Health and Social Services' (DHSS) patient, family and community-centered approach to the prevention and management of chronic disease. The *Framework* is based on chronic disease research, promising practices in other Canadian jurisdictions, and information gathered from community members and health care providers across the NWT.

The *Framework* is one step in the journey to effectively prevent and manage chronic disease in the NWT, and identifies key priorities for future action necessary to strengthen the health and social services system, and support individuals and communities. The DHSS is fully committed to reducing the burden of chronic disease in the NWT. This is best accomplished using a team approach, with responsibility shared among NWT residents, communities, the health and social services system and the GNWT as a whole.

The *Framework* builds upon, and aligns with, existing DHSS strategies that aim to "achieve the best health, best care, for a better future": *Caring for Our People: Strategic Plan for the NWT Health and Social Services System 2017 to 2020*; C*harting Our Course: Northwest Territories Cancer Strategy 2015-2025*; *Mind and Spirit: Promoting Mental Health and Addictions Recovery in the Northwest Territories*; and *Building a Culturally Respectful Health and Social Services Framework*. The *Framework* lays the foundation for planning initiatives to help NWT residents prevent and manage chronic diseases.

Development of the Chronic Disease Prevention and Management Framework

The *NWT Chronic Disease Prevention and Management Strategic Framework* was developed by the Department of Health and Social Services based on best practices research and engagement with stakeholders from across the territory.

Best Practices Research

DHSS researched other health organizations and Canadian jurisdictions in order to identify and examine best and promising approaches to addressing chronic disease prevention and management. Conducting best practices research provided the Department with an opportunity to understand approaches used elsewhere, that are having a positive impact on chronic disease prevention and management and that may be worth exploring for the purposes of adoption by the GNWT.

Stakeholder and Community Engagement

Engagement helps us to strengthen relationships in communities, develop trust and ensure our approach is informed by patients and clients. Stakeholder and community engagements occurred in a variety of different ways:

Community Health Fairs

During interactive Health Fairs carried out across the NWT, community members had the opportunity to provide input into the development of the Framework. These Fairs focused on the smaller Indigenous communities, since they are disproportionately impacted by chronic disease. These events allowed for community concerns to be heard and important lessons to be learned. Engagement at Community Health Fairs included:

- Face-to-Face Survey
  Community members were asked questions about the care they received while managing their chronic disease(s).
- Open Discussions
  Community members were able to share concerns and ideas for improving chronic disease prevention and management with DHSS staff while at the health fairs.

Health Care Provider Survey

A cross-section of health care providers were asked to provide information on the health service design in order to identify gaps and inform system change. The survey was administered to targeted chronic disease leadership groups.

Figure 1: Stakeholder Engagement Locations

Chronic Disease in the NWT

In the NWT, the impact of chronic disease on the population is significant. In 2011, chronic diseases were responsible for 7 out of every 10 deaths in the territory, and 50% of all days spent in hospital were related to chronic conditions.[7] The chronic diseases that cause the highest number of deaths in the NWT are cancer and cardiovascular diseases (heart disease/stroke).[8] Since 2000, the rates of asthma, diabetes, chronic obstructive pulmonary disease (lung disease), and hypertension (high blood pressure) have all increased in the NWT.[9]

Chronic diseases are not evenly distributed in the territory. Certain segments of the population are at greater risk of developing one or more chronic diseases:

Elderly

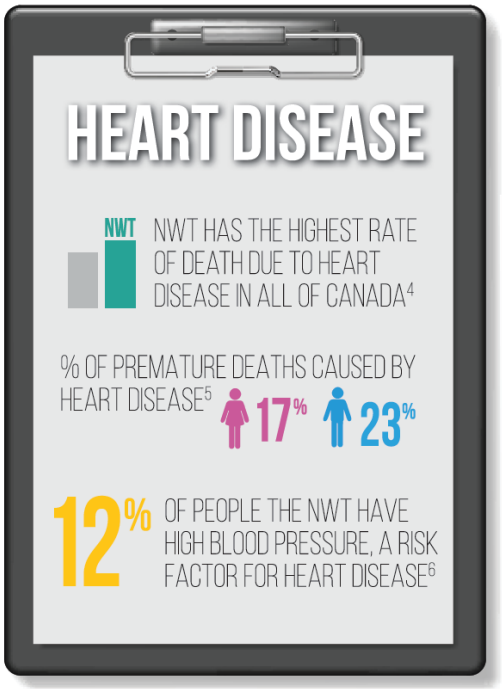
- The population is aging, which means we can expect an increase in the rates of chronic disease over time. As people grow older, it is also common for them to experience more than one chronic disease at the same time.

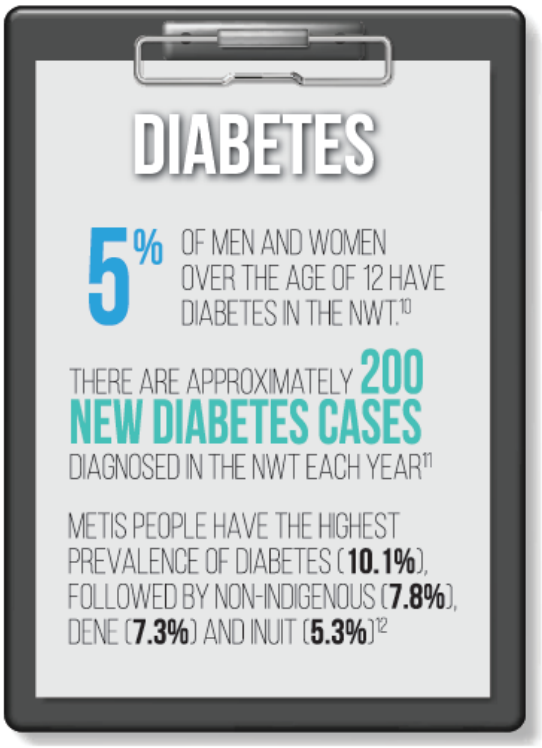
Indigenous

- Indigenous people face higher rates of chronic disease, in part, due to historic and ongoing policies that have altered the relationship between Indigenous populations and the land and traditional ways of living.[13]
- Over 50% of the NWT population is Indigenous; the Indigenous population in smaller NWT communities can be over 95%.

Those living in small, isolated communities

- People living in smaller, isolated NWT communities that are predominantly Indigenous, face additional challenges with high unemployment rates, high cost of living, high food costs and difficulties accessing fresh foods necessary for a healthy diet.
- Screening support and management of chronic diseases in smaller communities may be hindered by the requirement for referrals and transport to a larger centre.





Those experiencing mental illness

- People living with mental illness have a higher risk of experiencing other chronic conditions, and people with chronic disease are more likely to experience mental health challenges.[16] In the NWT, 18% of hospitalizations are due to mental illness, and this number is steadily rising.[17]

Those living in poverty

- Individuals with the lowest incomes are more likely to experience chronic diseases, and in the NWT the health and well-being of those with lower levels of education, income and employment would be similarly affected.[18,19,20]

Chronic Disease Prevention

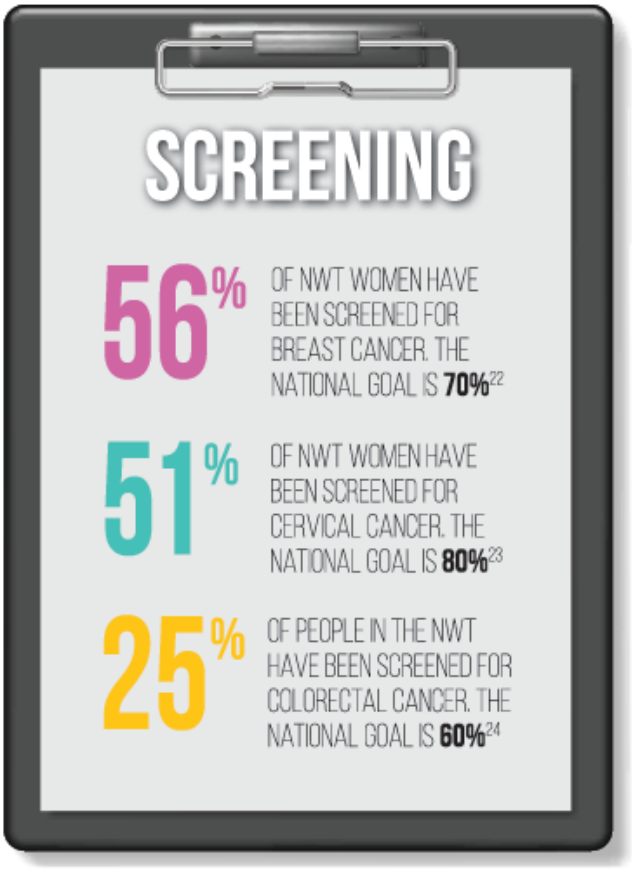
A healthy lifestyle, including participating in physical activity, eating a nutritious diet, limiting alcohol intake, living smoke free, managing stress and participating in protective factors (e.g. breastfeeding)[21], can reduce the risk of chronic disease by decreasing the chances of developing hypertension, high blood sugars, obesity and mental illness. Understanding one's medical history can also help to prevent chronic diseases.

By making healthier choices, not only can someone reduce their risk for chronic disease, but they will feel better and improve their overall quality of life. By visiting a health care provider in their community to discuss personal risk factors and be screened for chronic diseases, NWT residents can also learn about ways to prevent and manage risk factors that could lead to chronic disease and make informed decisions about their health.

Some examples of screening tests include:

- Mammograms for breast cancer
- Papanicolaou (pap) tests for cervical cancer
- Fecal testing for colorectal cancer
- Blood pressure screening for hypertension
- Blood sugar testing for diabetes

When chronic diseases are diagnosed early, they can be better monitored and treated to improve long-term health outcomes.



Chronic Disease Management

Chronic disease management refers to coordinated interventions that help monitor and control chronic diseases to improve health outcomes for the patient. Managing chronic diseases, especially if a patient has more than one at a time, can be complicated and require multiple approaches. Effective control of chronic diseases requires both medical management and self-management.

Care providers, patients, their families, and communities all have important roles to play in managing chronic diseases.

Medical Management

Chronic disease management often involves medical interventions, such as prescription medications and tests to monitor and evaluate management.

Self-management Support

The care and encouragement provided to patients and families with chronic conditions to help them understand their roles in managing their illness, make informed decisions about care, and engage in healthy behaviours.[25]

By taking a holistic, patient and family-centered approach to chronic disease care, care providers can assist patients with self-management support.

Self-management Skills

Patient skills such as problem solving, decision making and when/how to take action in order to help control the disease(s). [26]

Individuals with one or more chronic diseases can benefit from developing self-management skills.

NWT Chronic Disease Prevention and Management Strategic Framework

The *NWT Chronic Disease Prevention and Management Strategic Framework* will guide the HSS system's approach and direction to chronic disease prevention and management.

Vision

Chronic disease services and initiatives that are:

- **Coordinated**: well-planned and cohesive services that ensure a seamless navigation
- **Comprehensive**: holistic care that addresses the physical, emotional, social, and spiritual needs of the patient
- **Consistent**: care and services, and access to both, are as similar as possible for patients, regardless of where they live
- **Collaborative**: care providers, patients, families and other partners work together to make decisions
- **Culturally Safe**: is an outcome that is based on respectful engagement which recognizes and strives to address power imbalances inherent in the health and social services system. It results in an environment free of racism and discrimination where people feel safe receiving care.[27]

The *Framework* sets the context for improved patient quality of life and outcomes by:

- preventing the onset of chronic diseases,
- supporting people in managing their chronic diseases to reduce the number of highly complex patients that require significant medical attention and care, and
- reducing the economic burden placed on the health and social services system as a result of the prevalence of chronic diseases.

The *Framework* is based on a model of care that is patient and-family centred. It is respectful of culture, and delivered through partnership with individuals, families and communities.

The *Framework* takes into consideration that the overall health and well-being of the NWT population is determined by a variety of factors. There may be one factor that impacts a patient or a multitude of interrelated factors. Indigenous people are particularly impacted by these factors, referred to as the **key determinants of health**, including:

- Income and Social Status
- Social Support and Coping Skills
- Education and Literacy
- Employment/ WorkingConditions
- Physical Environments
- Healthy Behaviours
- Childhood Experiences
- Biology and Genetic Endowment
- Access to Health Services
- Gender
- Culture[28]

The NWT has focused on the health system components of the Expanded Chronic Care Model (Figure 2) as the foundation for the development and coordination of program and policy supports required for the effective prevention and management of chronic disease.

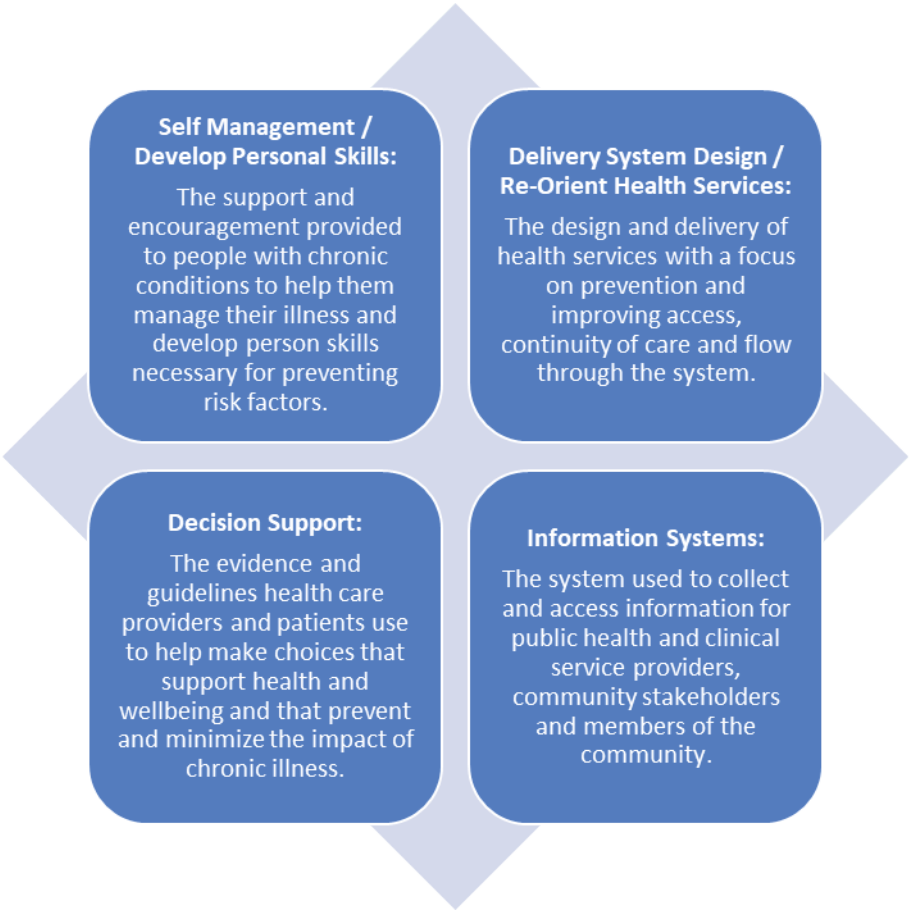


Figure 2: Health System Components of Expanded Chronic Care Model[29]

This systems approach to care, which strongly supports care providers, patients and families working together to prevent and manage chronic disease, forms the basis for the *Framework's* strategic priorities (Figure 3). The four priorities will set the direction for improving the outcomes of NWT residents at risk for, or experiencing, chronic diseases.

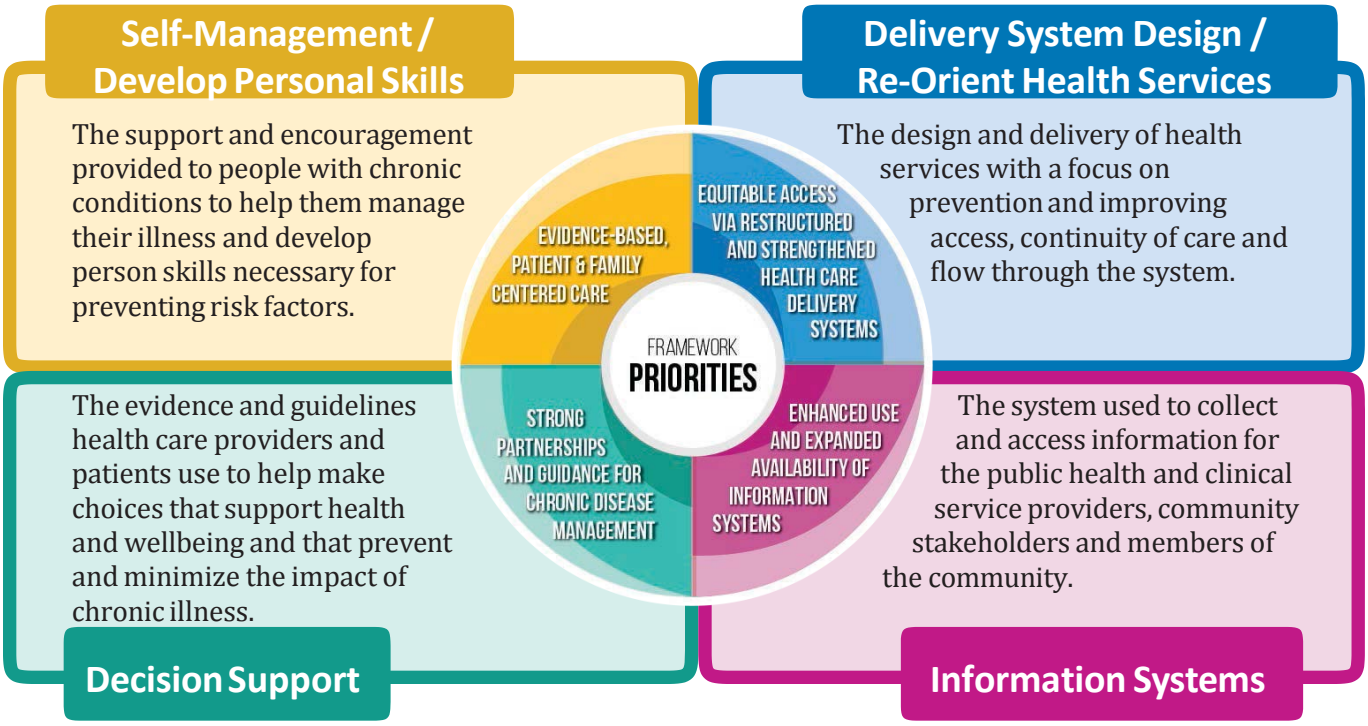


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Figure 3: NWT Framework for Chronic Disease Prevention and Management

Evidence-based, patient and family-centred care

To achieve the best possible outcomes for people living in the NWT, we need to both prevent and manage chronic diseases. Management of chronic condition(s) can be highly complex, and symptoms cannot be treated in isolation. A holistic approach must be adopted to effectively address the various physical, mental, social, cultural and historical factors that influence a person's health and well-being. Chronic disease care must be based upon the best available evidence and put the patient at the center of their care to address the physical, mental, social, cultural and historical factors that influence a person's health and well-being.

A holistic approach to chronic disease prevention and management places the patient and the family at the centre of the care. This approach is respectful of culture, creates a partnership and ensures patient and family involvement in their care and decision making.

Evidence-based standards, clinical practice guidelines and decision support tools are based on current research and best practice. They provide necessary instruments for consistent chronic disease prevention, screening and management. Ongoing professional development, along with continuous updating of standards and practices, ensures that NWT patients are provided with evidence-based care.

Evidence-based patient and family-centred care contributes to:

- increased patient and family involvement in chronic disease care and decision making
- increased knowledge, skills, and awareness among patients and families to prevent and self-manage chronic diseases
- targeted and meaningful professional development for care providers, as a result of identified gaps in knowledge or skill
- regular updating and further development of documents and tools for chronic disease prevention and management.

Equitable access through restructured and strengthened health care delivery systems

Many people in the NWT are at increased risk for developing one or more chronic diseases. However, delivering primary health care services to people in the NWT presents unique challenges, due to the territory's large geographic area and population that is dispersed among many small communities. A renewed focus on continuity of care and relationships between patients, communities and care providers is foundational to achieving culturally safe and effective care for all NWT residents. Enabling all care providers to work at their full scope of practice will enable to right care by the right provider in the right place at the right time, increasing access, patient health and system efficiency.

Equitable access to services means that patients and families with chronic diseases will be able to access care regardless of where they live. In smaller communities, this requires processes for referrals, travel, communication and support systems. The systems, processes and pathways, presently in place, need to be reviewed, restructured and strengthened. Equitable access will be achieved through coordinated, seamless, and timely approaches to chronic disease management.

Equitable access through restructured and strengthened primary health care delivery systems contributes to:

- increased patient satisfaction and decreased wait times for appointments and procedures
- increased efficiency and decreased redundancy
- decreased medical costs
- improved communication between care providers, patients and families.

Strong partnerships and guidance for chronic disease management

To effectively prevent and manage chronic diseases in the NWT, individuals, families, communities, employers, the health and social services system and providers need to take active roles in working together for better health. Partnerships will determine ways to provide safe places for being physically active, support the availability of traditional foods, support healthy workplace environments and provide opportunities at community events for community members to share information on healthy behaviours.

Collaboration between the health and social services system and community partners will strengthen the relationships and networks necessary to better serve communities through targeted programming derived from reporting of data and community-identified indicators. By promoting integrated data collection and distributing tools across stakeholder groups and organizations, we will be better able to understand our population's needs, and tailor chronic disease programs and services to effectively respond to those needs.

Strong partnerships will help to ensure that chronic disease prevention and management efforts are well-coordinated and draw upon the strengths of NWT residents, communities and the health and social services system.

Strong partnerships and guidance for chronic disease management will contribute to:

- increased community capacity
- improved communication between the health and social services system and communities
- improved programs and services for under-served populations
- community wellness.

Enhanced use and expanded availability of information systems

Our health information systems must be sustainable to meet the territory's long-term needs. Resources are limited and must be used effectively and efficiently to provide care for those in need, now and in the future.

Through continued investment in existing technologies such as telehealth and electronic medical records, e-consultation, and emerging innovations, we will be able to enhance efficiency within our system by ensuring that everyone, regardless of where they live, has access to chronic disease prevention and management supports.

Investing resources in the development and monitoring of chronic disease registries, databases and surveillance systems will provide care providers and policy makers with the information necessary to make informed decisions. Quality information supports the development and implementation of appropriate and effective chronic disease prevention and management programs and services.

Enhanced use and expanded availability of information systems will contribute to:

- improved care delivery without additional travel costs
- greater access to usable resources for care providers, patients and families
- current and NWT-specific chronic disease data
- continuous, targeted improvements in chronic disease prevention and management

Next Steps

The *Chronic Disease Prevention and Management Strategic Framework* provides the outline for a coordinated, comprehensive, consistent, collaborative and culturally safe approach to the prevention and management of chronic disease in the NWT. The four strategic priorities identified in the *Framework* set the direction for planning initiatives for the health and social services system.

Measuring progress will be essential to understanding the impact of the *Framework* and identifying future areas for focus. Indicators will be developed to track progress on each of the four priorities described in the *Framework*.

The *Chronic Disease Prevention and Management Strategic Framework* is one step in the journey to effectively preventing and managing chronic diseases in NWT.
Through integrated action, we can accomplish the priorities outlined in the *Framework* and promote a healthy and strong NWT.

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English

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

French

Kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.

Cree

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

Tłı̨chǫ

ʔerıhtł'ís Dëne Sųłıné yatı t'a huts'elkër xa beyáyatı theɂą ɂat'e, nuwe ts'ën yółtı.

Chipewyan

Edı gondı dehgáh got'ı̨e zhatıé k'ę́ę́ edatł'éh enahddhę nıde naxets'e edahłí.

South Slavey

K'áhshó got'ı̨ne xədə k'é hederı ɂedı̨htl'é yerınıwę nıdé dúle.

North Slavey

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

Gwich'in

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.

Inuvialuktun

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Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.

Inuinnaqtun

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