

PUBLIC PERFORMANCE MEASURES REPORT 2015

NWT HEALTH AND SOCIAL SERVICES SYSTEM

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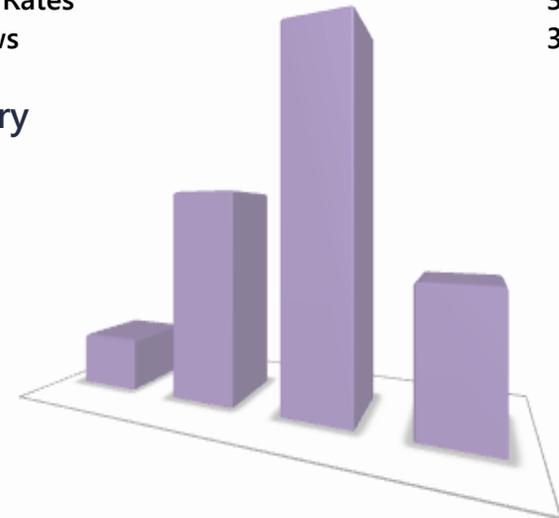
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Executive Summary

Background

In 2010/11 the Office of the Auditor General reviewed the programs and services of the NWT Health and Social Services (HSS) system, making a number of recommendations for system improvement. Two of these recommendations were for the Department of Health and Social Services (Department), in collaboration with the Health and Social Services Authorities (Authorities), to:

- develop a set of system-wide performance indicators for the health and social service system; and
- regularly inform the NWT Legislative Assembly, and the public, on system performance indicators.

Committed to fulfilling these recommendations, the Department:

- looked at what other jurisdictions (inside and outside of Canada) were doing in the area of performance measurement;
- worked with external consultants and HSS Authorities to develop a performance measurement framework; and,
- vetted dozens of indicators to come up with measures that would be reliable and reportable.

This is the first report based on that performance framework.¹

Scope of the Report

This is a summary report, intended to track and measure the overall performance of the NWT HSS system. 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 indicators may change over time but will be guided by the performance measurement framework for years to come.

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 also 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.

¹ For a description of the framework, please see the *NWT Health and Social Services Performance Measurement Framework*.



Statistical Summary

This summary provides a snapshot of the current status of NWT HSS system and overall population health and wellness, including trends. The trends reflect an interpretation of historical data and are explained more fully in the Notes section as well as in the detailed discussion of each indicator.

Arrow Colour (Trend)

Positive

Negative

Uncertain

Population Health and Wellness Outcomes and Determinants

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Change
Proportion of population self-reporting excellent or very good health status.	54%	52%	No	Stable
Colorectal cancer incidence rate (cases per 10,000).	8.7	9.8	No	Stable
Diabetes incidence rate (cases per 1,000).	6.6	6.6	No	Stable
Sexually transmitted infection rate (cases per 1,000).	23.7	24.4	No	
Immunization rates (proportion at full coverage by age 2).	63%	65%	No	n/a
Mental health hospitalization rate (cases per 1,000).	12.0	11.6	No	
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.	33.3%	35.0%	No	Stable
Proportion of population who self-report heavy drinking.	30.2%	29.7%	No	Stable
Proportion of population who self-report obesity.	24.4%	26.3%	No	Stable



Community, Individual and System Outcomes

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Change
Community Counselling Program - average number of clients per month.	1,689	n/a	n/a	n/a
Proportion of people who start and complete a full session of residential addictions treatment.	78%	n/a	n/a	n/a
Children in care - average number of total placements per year while in care.	2.4	2.3	No	Stable
Proportion of Aboriginal children in care placed in an Aboriginal home.	69%	68%	No	Stable
Proportion of children found to be maltreated (abuse/neglect) again within one year of having been maltreated.	29%	27%	No	Stable
Monthly average number of women residing in a shelter.	21.7	22.3	No	Stable
Monthly average number of children residing in a shelter.	18.9	18.9	No	Stable
Proportion of families readmitted to a shelter.	64%	58%	↑	Stable
Patient satisfaction (proportion satisfied with Hospital/Health Centre services)	92%	92%	No	n/a
Average number of days a patient waits to receive an offer of placement in a long term care facility.	59	112	↓	n/a
Proportion of telehealth sessions that were specifically for patient care activities.	67%	63%	↑	↑
Number of medical travel cases.	13,763	13,159	↑	↑
Proportion of medical travel cases with escorts.	36.0%	36.1%	No	↓



System Inputs

Indicator	Most Recent Time Period	Previous Time Period	Short Term Change	Long Term Change
Staff Safety (number of claims per 100 employees).	13.3	20.9		
Vacancy rate for Family Physicians.	34%	39%	No	Stable
Vacancy rate for Specialist Physicians.	15%	13%	No	Stable
Vacancy rate for Nurses.	26%	26%	No	Stable
Vacancy rate for Social Services Workers.	22%	24%	No	Stable
Proportion of patients not showing up for their family/nurse practitioner visit.	12.7%	10.8%		
Proportion of patients not showing up for their specialist practitioner visit.	11.4%	10.7%		Stable

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 2013/14 then the previous time period is usually 2012/13). 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 5 to 10 years.

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).

The directions of both 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 colorectal 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 long-term 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

In 2010/11 the Office of the Auditor General (OAG) reviewed the programs and services of the NWT Health and Social Services (HSS) system, making a number of recommendations for system improvement. Two of these recommendations were for the Department of Health and Social Services (Department), in collaboration with the Health and Social Services Authorities (Authorities), to:

- develop a set of system-wide performance indicators for the health and social service system; and
- regularly inform the NWT Legislative Assembly, and the public, on the system performance indicators.²

Committed to fulfilling the OAG's recommendations, the Department embarked on a process of developing a set of performance indicators as part of building a wider Accountability Framework.³ This process involved:

- looked at what other jurisdictions (inside and outside of Canada) were doing in the area of performance measurement;

² Office of Auditor General of Canada, *Northwest Territories Health Program and Services - Report of Auditor General of Canada to the Northwest Territories Legislative Assembly*, March 2011, p. 25.

³ GWNT, DHSS, *Performance Measurement Accountability Framework: Accountability Report* (Final – April 2014)
<http://www.hss.gov.nt.ca/sites/default/files/performance-measurement-accountability-framework.pdf>

- worked with external consultants and HSS Authorities to develop a performance measurement framework; and,
- vetted dozens of indicators to come up with measures that would be reliable and reportable.

The process resulted in a performance measurement framework, with an initial set of indicators to guide measurement. This is the first report based on that performance measurement framework.⁴

Scope of Report

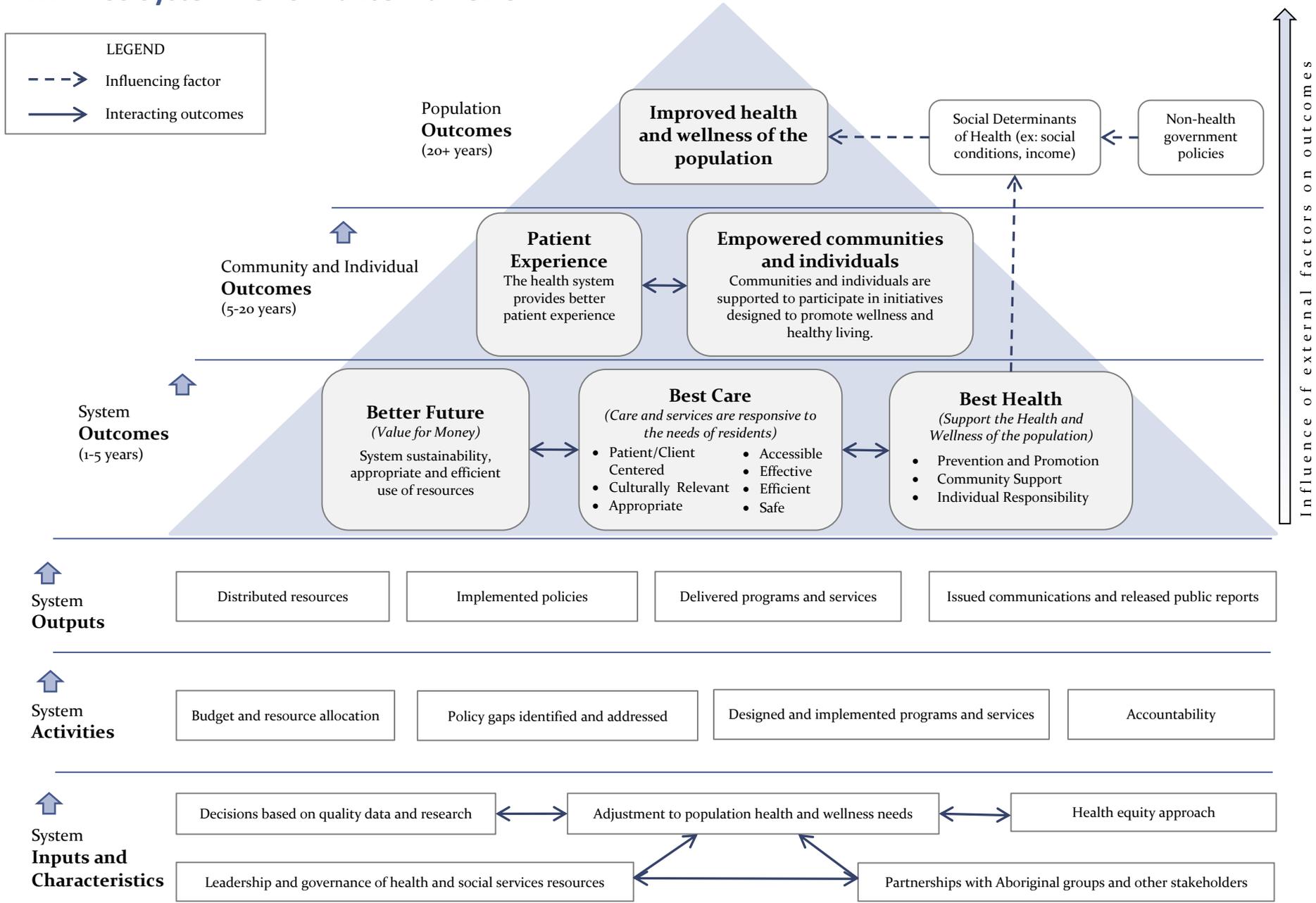
Ultimately, this is a summary report, intended to track and measure the performance of the NWT HSS system as it relates to improving the overall health status of the NWT. The indicators profiled in this report are by no means exhaustive of all the possible ways to measure performance. Rather, these indicators are meant to provide a general snapshot of important trends and issues facing the NWT HSS system.

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

⁴ For a description of the performance measurement framework, please see the *NWT Health and Social Services Performance Measurement Framework*.



NWT HSS System Performance Framework



*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 Environment

This report is not the only performance monitoring that is done by the NWT HSS system. The Authorities, 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 reports, annual reports, business plans, utilization reports, and special subject reports (e.g., cancer and addictions).

Data Sources and Limitations

The data for this report primarily came from the NWT HSS system (Department and Authorities), 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. When changes do occur, they 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 have a lot of detail that they collect and others do not.

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.

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

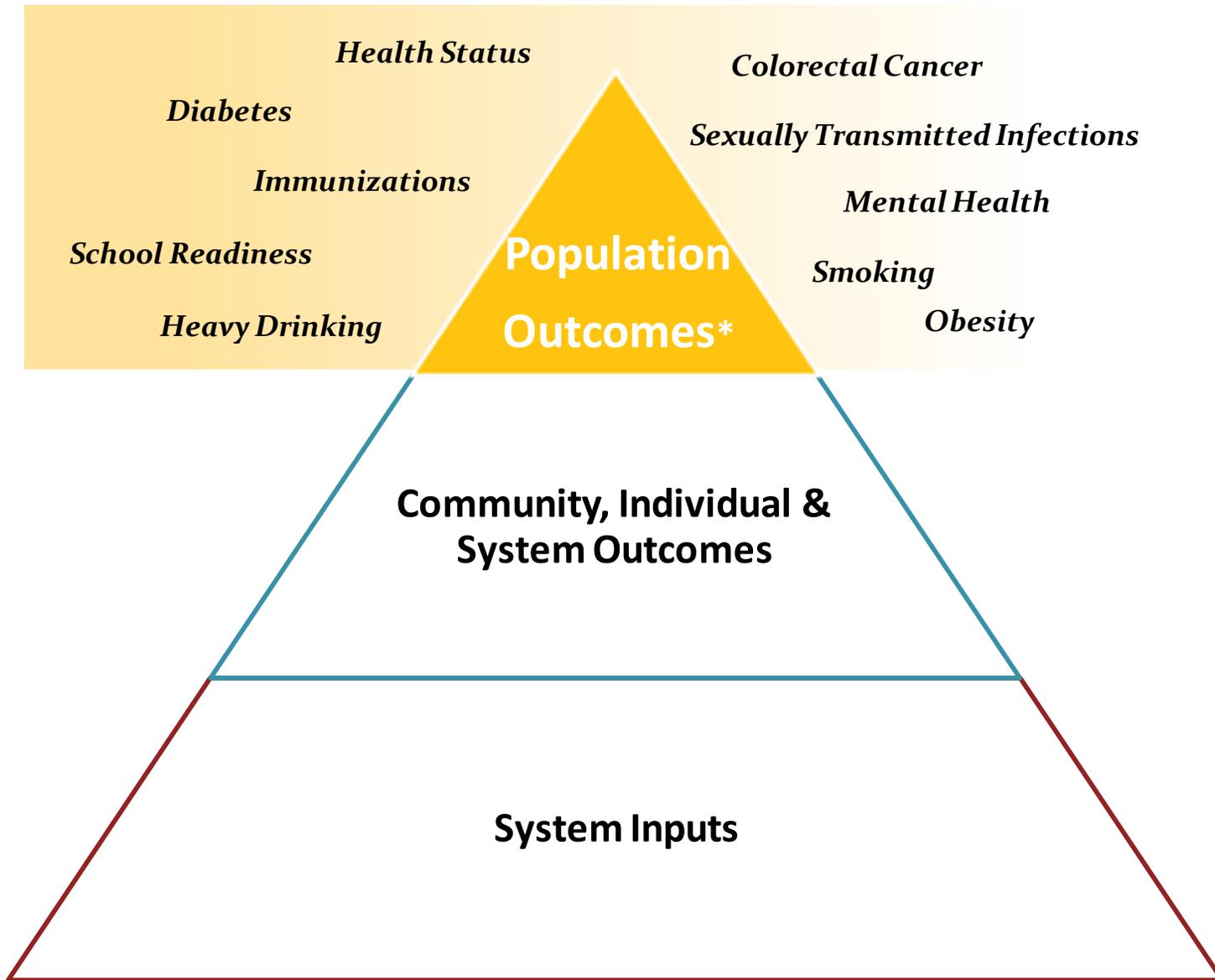
The source(s) of the data is presented.

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 will be set to provide a means of tracking how well we are doing as a system in achieving our goals.



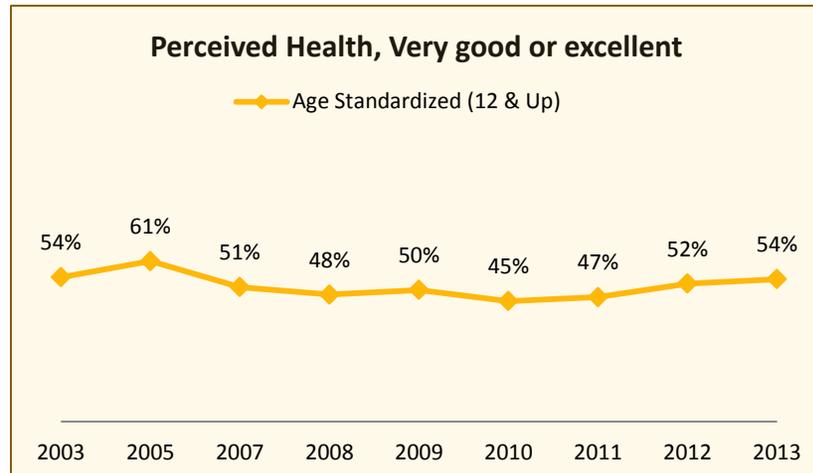
Section 1: Population Health and Wellness Outcomes and Determinants



*Population Health and Wellness Outcomes (includes determinants)



Health Status



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 54% 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

2013, whereas the national rate has increased slightly from 59.7% to 61.3% over the same time period.⁵

Other information

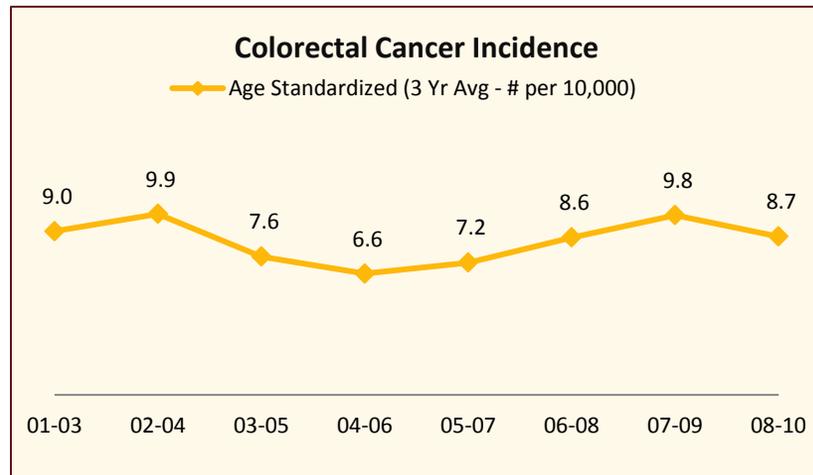
As seen in other parts of this report, and other reports (e.g. NWT health status reports), the NWT ranks poorly compared to the national average in a number of areas that have a major influence in overall well-being, including tobacco use, heavy drinking, and obesity.

Source

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

⁵The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Since 2007, the CCHS has been carried out annually.

Colorectal Cancer



What is being measured?

The age-standardized incidence of colorectal cancer in the NWT.

Why is this of interest?

Colorectal cancer is the second most frequently diagnosed cancer in the NWT for both men and women. As well, the incidence of colorectal cancer is significantly higher than the national rate. Colorectal cancer is to a large degree preventable, and treatable if caught early.

How are we doing?

Colorectal cancer has not increased over the last decade, ranging from 6.6 to 9.9 cases per 10,000 population (three-year averages). While there has been some fluctuation over the time period shown, the changes are not statistically significant. It is important to keep in mind that the average number of cases of colorectal cancer diagnosed each year are few – averaging 21.7

per year between 2001 and 2010. The NWT’s colorectal cancer rate for the latest period remains higher than the national rate.

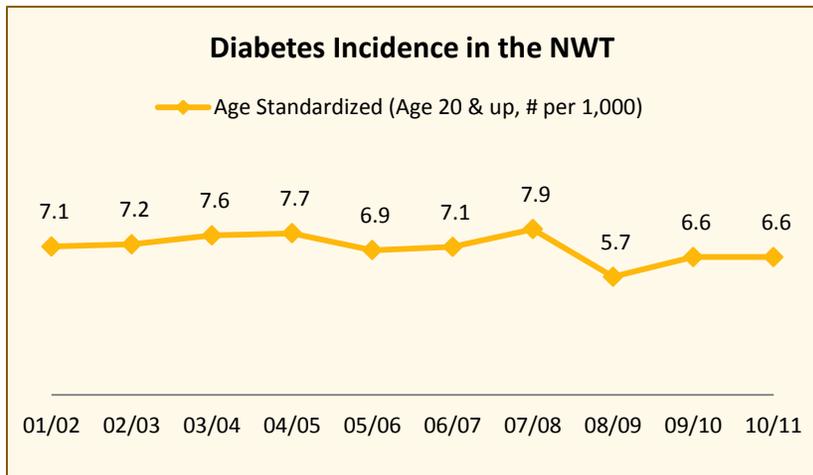
Fecal Immunochemical Test (FIT) detects blood in a person’s stool – an early indicator of potential colorectal cancer. Those testing positive are referred for a colonoscopy to help determine whether cancer exists. FIT rates have increased in recent years, from 12.8% in 2009-2010 to 24.6% in 2013-2014 (Age 50 to 74 years).

Sources

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



Diabetes



While the rate of new cases has remained stable, the prevalence of diabetes (cases overall) is on the rise in the NWT. Between 2001/02 and 2010/11, the prevalence of diabetes increased from 50.5 to 79.4 cases per 1,000 – an average annual increase of 5.2%. The prevalence of diabetes in the NWT is similar to the national average of 77.7 cases per 1,000 (2009).

Sources

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

What is being measured?

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

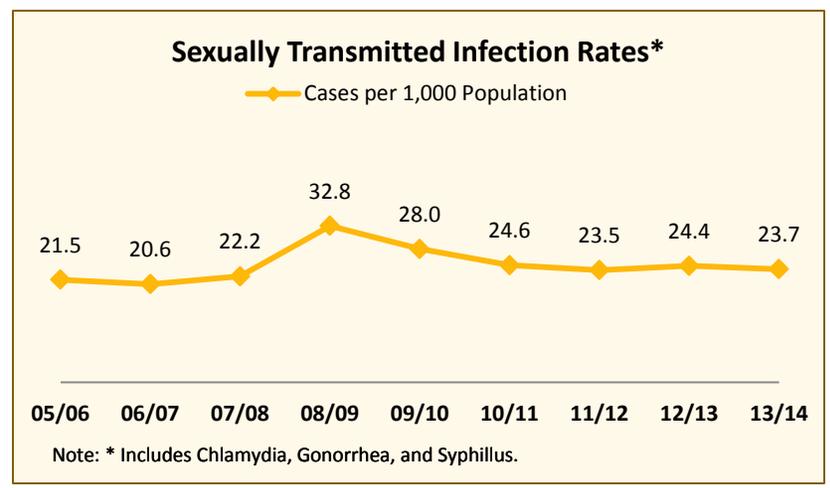
Why is this of interest?

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 2010/11, there were 216 new cases of diabetes diagnosed in the NWT (age 20 and up) – 6.6 cases per 1,000. The rate of new cases of diabetes has stayed about the same over the ten years between 2001/02 and 2010/11 – at around 7 per 1,000. The NWT's incidence rate is not significantly different than the national rate at 6.8 per 1,000 (2009/10).

Sexually Transmitted Infections



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 over seven times higher than the rest of Canada’s 3.2 cases per 1,000 (2010). 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 rate has evened off at an average of 24 cases per 1,000 over the last four years.



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.⁶

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, meningococemia, 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

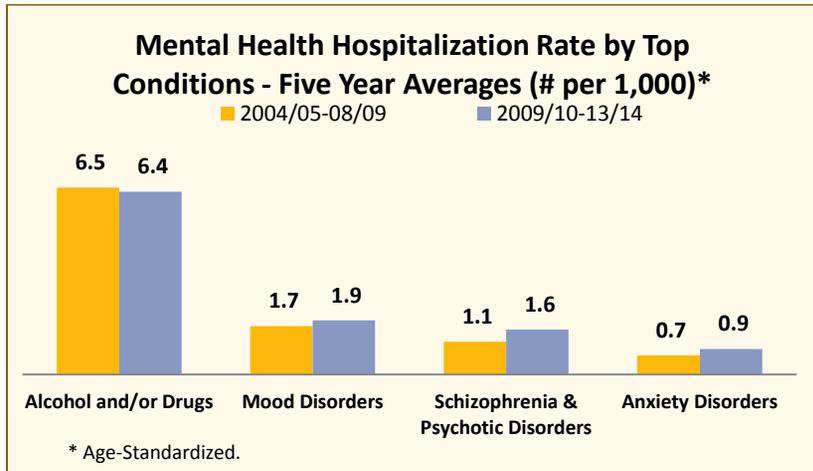
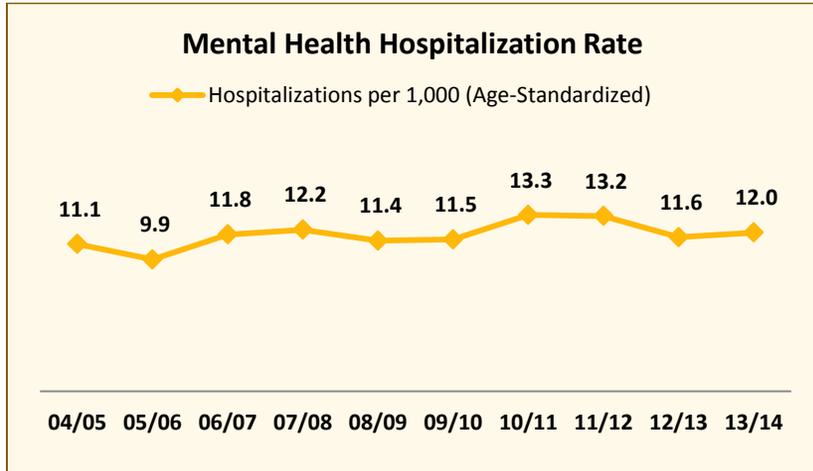
* Children born in 2011. n/a = Not applicable.
** National goal only includes pertussis and rubella, respectively.

Sources

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

⁶ Full coverage includes six vaccines (see Other information).

Mental Health Hospitalizations



What is being measured?

The annual rate of mental health hospitalizations, overall and by diagnostic category, for NWT residents.⁷

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 ten years, the rate of hospitalizations has been trending 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 2013/14.

The NWT’s mental health hospitalization rate is on average approximately over twice that of the national average (2012/13). 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 7 times) and anxiety disorder hospitalizations (over 3 times).

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

⁷ Only hospitalizations of NWT residents where the primary reason for the hospitalization was a mental health issue are included in the measure.



a hospital setting, preventing or reducing the frequency of hospitalization over the long run.

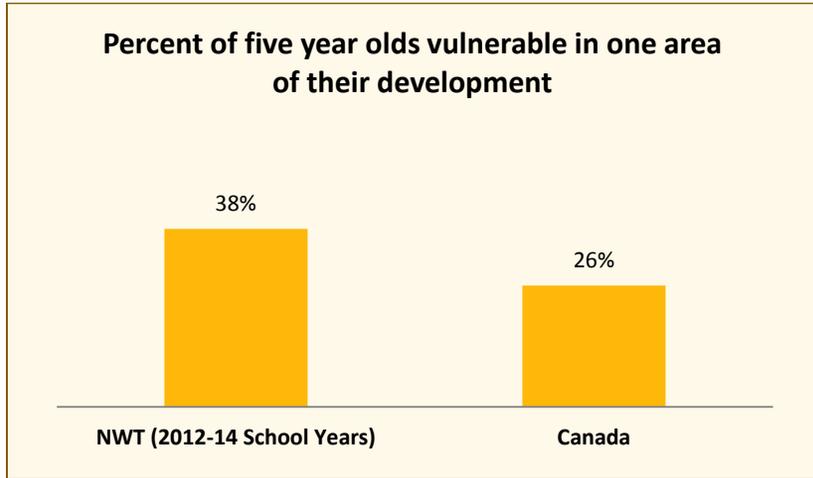
The 30-Day readmission rate for mental illness hospitalizations of NWT residents was 12.8 per 100 for 2012/13, not significantly different when compared to the national rate of 11.5.

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



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 47% higher in the NWT than the national average.⁸

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.

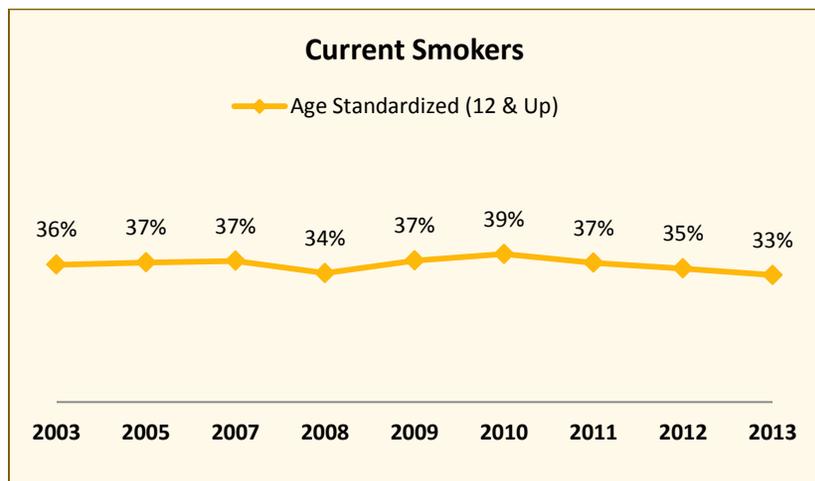
Sources

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).

⁸ Canadian results vary in year to year depending on provincial/territorial availability of results, covering a period of 2007/08 to 2011/12.



Smoking



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 33.3% of the NWT population, age 12 and over, report that they are daily or occasional smokers - which is higher than the national rate of 19.6%. Between 2003 and 2013 there have not been any significant changes in the NWT smoking rate,

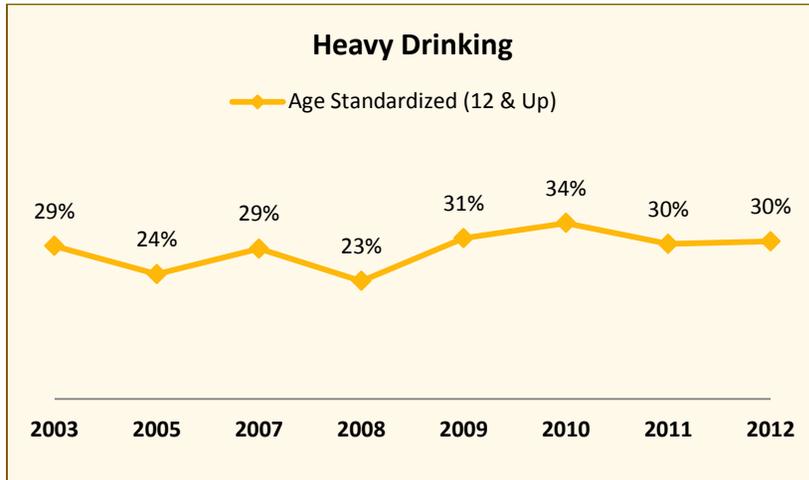
whereas the national rate has decreased from 23.4% to 19.6% over the same time period.⁹

Source

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

⁹ The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Since 2007, the CCHS has been carried out annually.

Heavy Drinking



What is being measured?

The proportion of the population who are considered to engage in heavy drinking (five or more drinks at a time, once or more a month, every month).

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 30% of the NWT population, age 12 and over, are considered to be heavy drinkers - higher than the national rate of 19%. 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.¹⁰

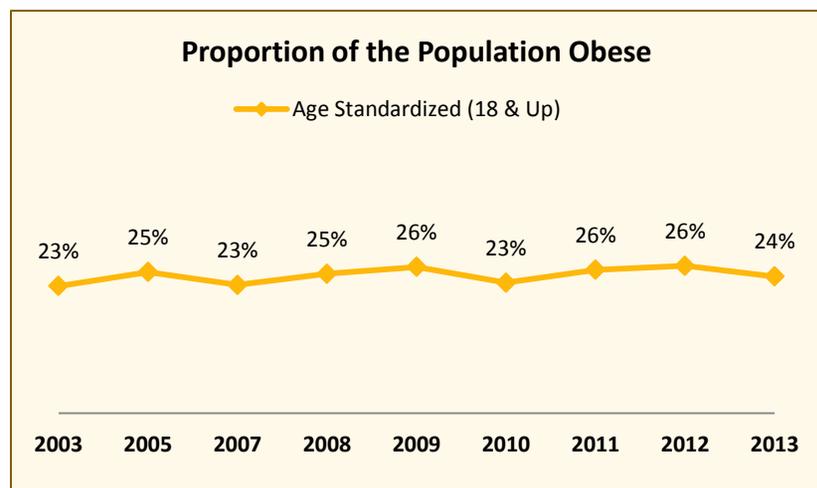
Source

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

¹⁰ The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Since 2007, the CCHS has been carried out annually. The definition of heavy drinking for women changed in 2013 from 5 to 4 drinks, making trending incomparable.



Obesity



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 24.4% of the NWT population, age 18 and over, are considered obese – significantly higher than the national rate of 18.2%. Between 2003 and 2013 there have not been any significant changes in the NWT obesity rate, whereas the

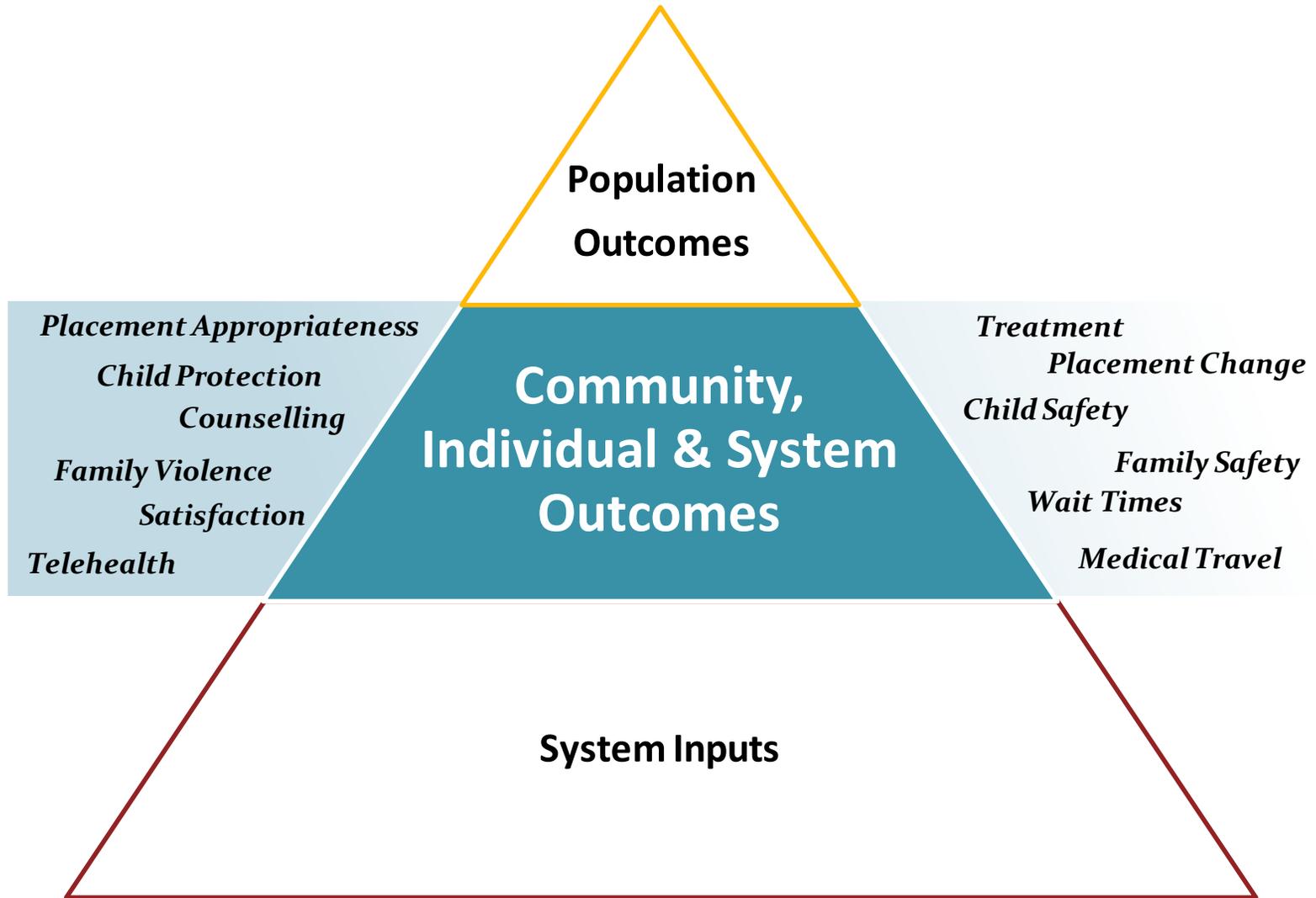
national rate has increased from 14.9% to 18.2% over the same time period.¹¹

Source

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

¹¹ The Canadian Community Health Survey had been carried out on a two-year cycle until 2005. Since 2007, the CCHS has been carried out annually.

Section 2: Community, Individual and System Outcomes



Community Counselling Program

What is being measured?

The average number of community counselling sessions 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. A more robust system of capturing information about the CCP is under development.

How are we doing?

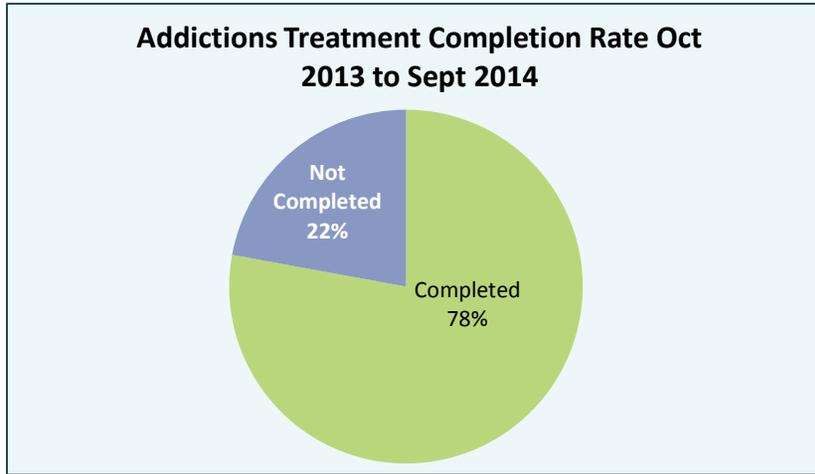
There is currently only one month of data. For the month of October in 2014, 1,689 client counselling sessions took place - 1,487 with adults and 202 with children/youth (under 19 years of age).¹²

Source

NWT Department of Health and Social Services.

¹² 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 a chart was not included.

Addictions Treatment



How are we doing?

There is currently only one complete year of data to assess how well we are doing but, for the twelve month period shown, over three-quarters of those who started a treatment session finished their session.

Source

NWT Department of Health and Social Services.

What is being measured?

The proportion of people who start and complete a full session of residential addictions treatment.¹³

Why is this of interest?

This is a measure of how well we are meeting client needs, by ensuring those clients that are ready for treatment have access. More importantly, it also measures the degree to which residential treatment programs meet the needs of clients.

¹³ Completion rates only include those applicants who actually begin treatment, and do not include those who are currently in treatment.



Child Protection Concerns

Apprehensions by Reason 2013/14	
Total Children Investigated	2,111
Total Children Apprehended	336
% Apprehensions w/ reason (s) stated	92.6%
% Apprehensions by reason	
Child suffered harm	
Physical harm	17.0%
Health/wellness harm due to substance abuse	7.1%
Physical/emotional harm due to neglect	4.2%
Due to exposure to domestic violence	4.2%
Sexual abuse	*
Malnutrition	0.0%
Child at risk for/due to	
Physical/emotional harm (substantial risk)	8.9%
Physical harm (substantial risk)	6.3%
Exposure to domestic violence	5.1%
Physical harm	2.1%
Emotional harm (Substantial Risk)	0.0%
Sexual abuse	0.0%
Parent/caregiver unwilling/unavailable	
To adequately care for child	40.2%
Child without functional legal guardian	5.1%
Deserted by caregiver	3.3%
Other Reasons	
Severe behaviour consistent with emotional harm	*
Medical authorization withheld by parent	*
Child less than 12 kills, injures or damages person or property	*
Impairment of the child's development	0.0%
No Reason Stated	7.4%

* 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 2013/14, 40% of all children apprehended were due to the parent or guardian being unavailable or unwilling to adequately care for the child, and 17% of children were found to have had suffered physical harm. There were a number of other reasons for apprehension, including 9% of cases where the child was found to be at a substantial risk of emotional or physical harm, 7% where they had suffered harm to their health or well-being, and 6% where they were found to be at a substantial risk of physical harm.

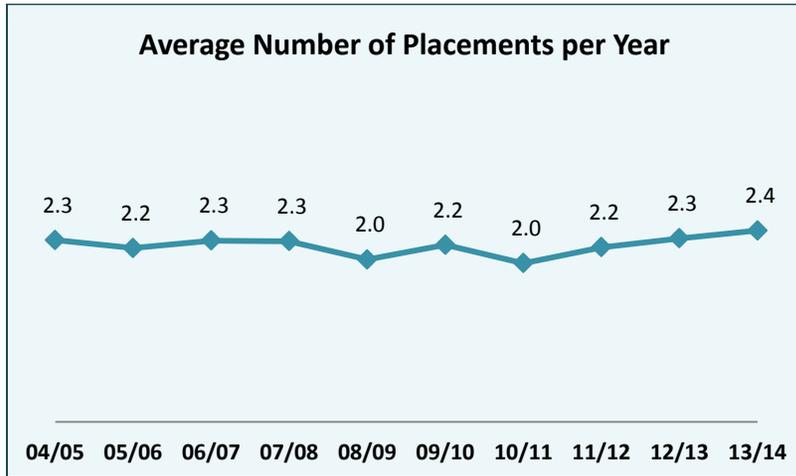
Source

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

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



Children in Care Average Number of Placements per Year			
Age	Average		Change
	04/05-08/09	09/10-13/14	
Total	2.2	2.2	0.4%
Under 3	2.2	2.6	18.6%
3 to 5	2.3	2.5	6.1%
6 to 11	2.1	2.1	-1.5%
12 to 15	2.3	2.2	-4.7%
16 & Up	2.0	1.8	-8.5%

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 ten years – ranging from 2.0 to 2.4 placements per year.

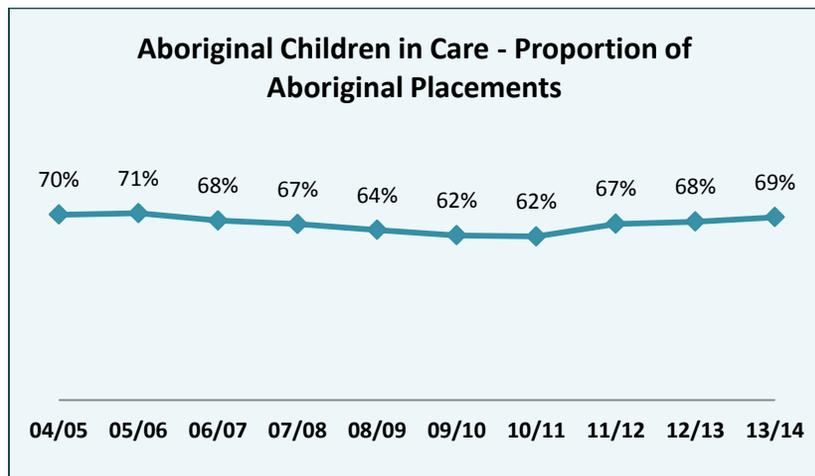
When examined by age group, the average number of placements per year varies insignificantly between age groups, and across time.

Source

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



Child Placement Appropriateness



How are we doing?

In last ten 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*.

What is being measured?

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

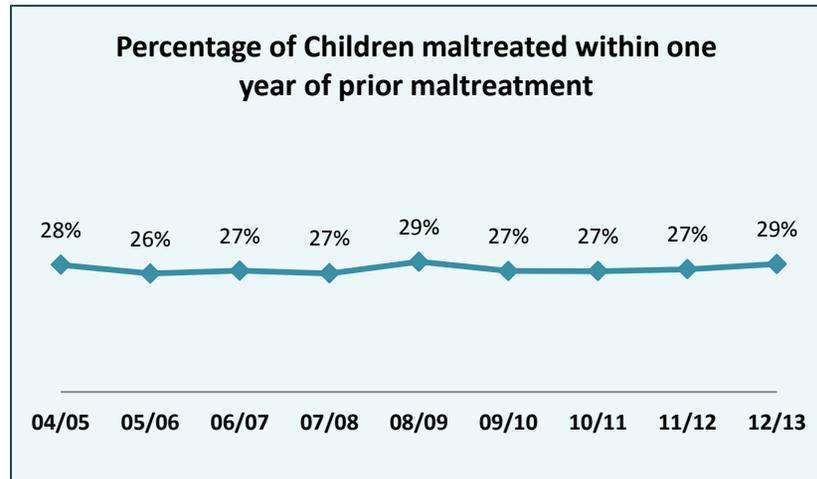
Why is this of interest?

In the last five years, Aboriginal children made up 97% of the children in care but only about 62% 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.

Child Safety



How are we doing?

In the last ten years, the proportion of children found to have been maltreated again (within one year) was relatively stable – averaging around 27% (high 29% and low 26%).

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

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



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 admitted to a shelter, having 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 five years, shelter usage has remained relatively consistent – averaging around 43 women and children admitted per month.

Over the last ten years, the proportion of readmissions to shelters has not changed significantly – ranging from 52% to 64% per year.

Source

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



Patient/Client Satisfaction

Patient/Client Satisfaction Various HSS 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%

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

Source

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

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.

Why is this of interest?

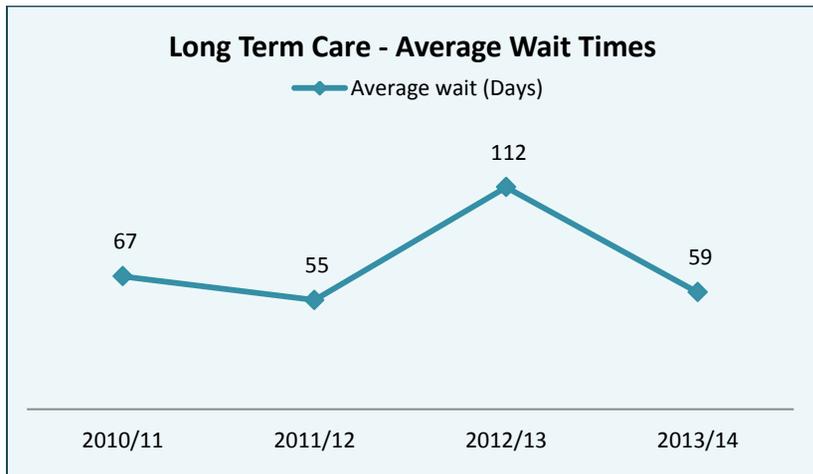
Assessing the level of satisfaction with the care patients/clients have received can provide a means for the NWT HSS system to improve the delivery of services.

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 95% of those filling out the questionnaires reporting that they were satisfied with the services they received.



Long Term Care Wait Times



What is being measured?

The average number of days a patient waits to receive an offer of a placement in a long term care facility.¹⁷

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 four years, the average wait time to be offered a placement in a long term care facility has ranged from 55 days to 112 days.

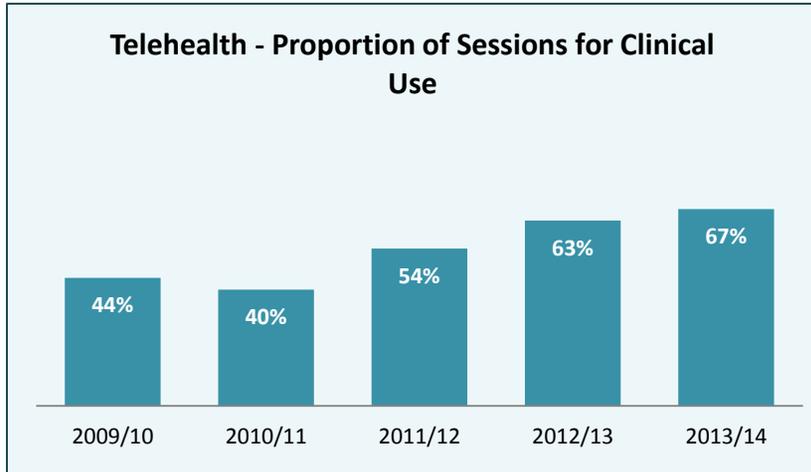
Long term care facilities have been running near full occupancy (96-97%) in the last three years.

Source

NWT Department of Health and Social Services.

¹⁷ 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 placement. When a client refuses a placement, they end up starting over in the wait list queue.

Telehealth – Clinical Usage



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 over 50% from 44% in 2009/10 to 67% in 2013/14.

Even though telehealth is being increasingly used for the prime purpose of its existence – 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

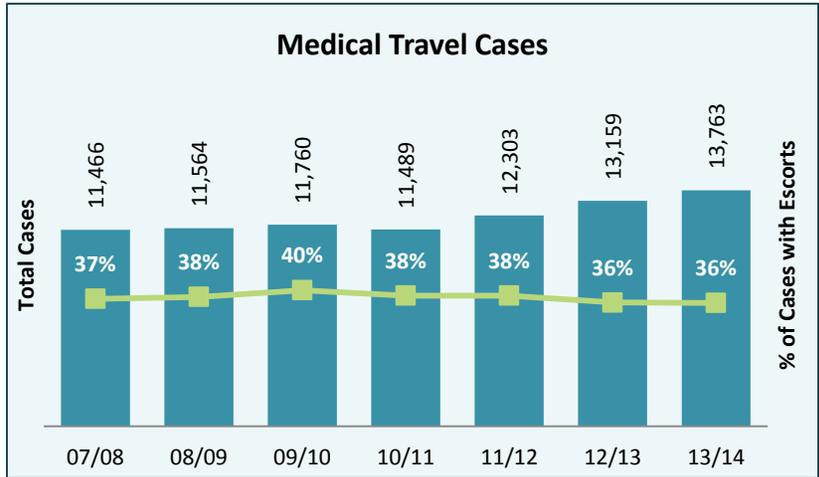
The overall number of telehealth sessions has nearly tripled from 1,356 to 3,912 between 2009/10 and 2013/14.

Source

Department of Health and Social Services.



Medical Travel



What is being measured?

The number of medical travel cases; and, the proportion of cases with an escort.¹⁸

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 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	302	4,748	36%
2013/14	13,763	316	4,950	36%

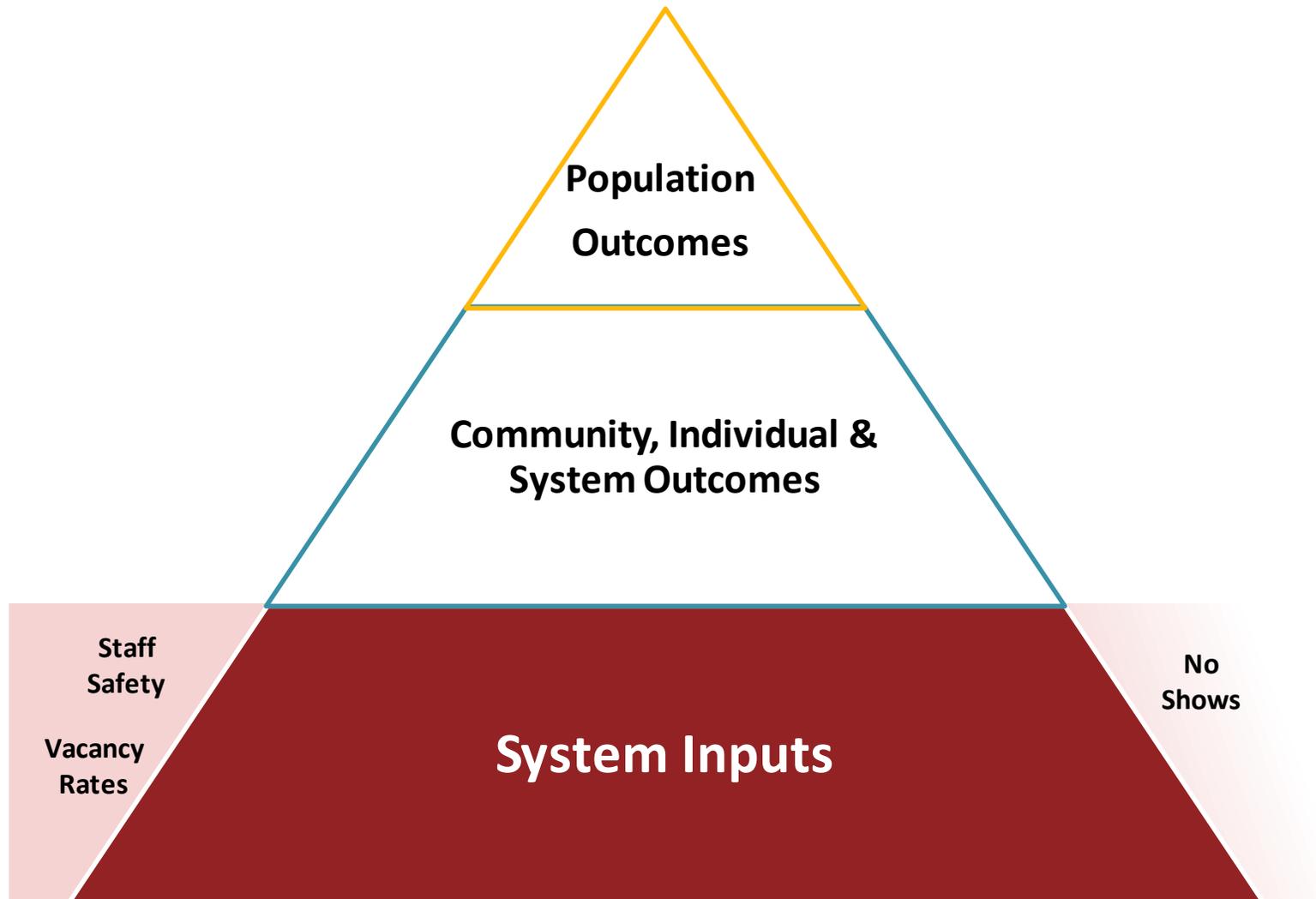
Rate = Number (#) of cases per 1,000 population

Sources

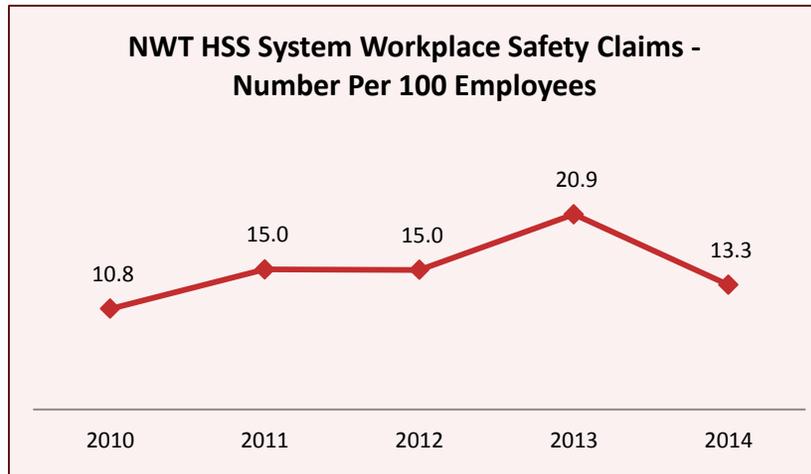
Stanton Territorial Health Authority, *Medical Travel Statistics*.
NWT Bureau of Statistics, *Population Estimates*.

¹⁸ 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).

Section 3: System Inputs



Staff Safety



Sources

Department of Human Resources and Workers Safety and Compensation Commission.

What is being measured?

The number of workplace safety claims per 100 employees.

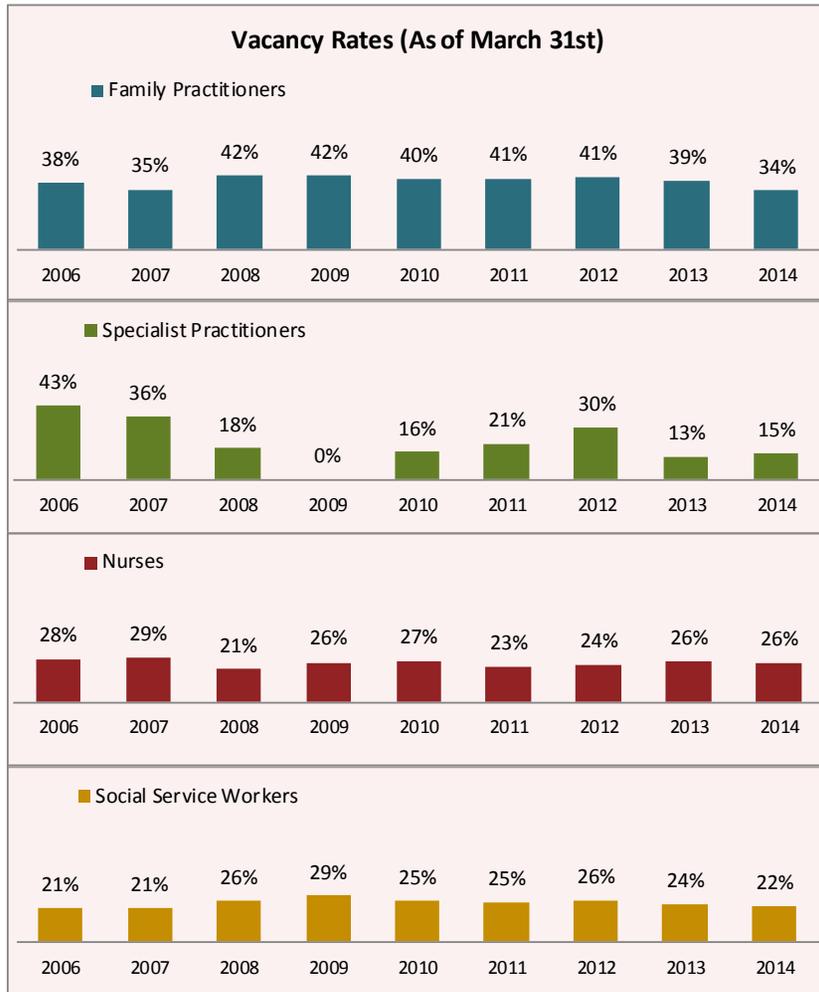
Why is this of interest?

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 13.3 per 100 in 2014. The 2014 rate is over twice that of the rate for the rest of the GNWT.

Vacancy Rates



What is being measured?

The vacancy rate for family practitioners, specialist practitioners, nurses, and social service workers.¹⁹

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, 2014, the NWT have had some relatively low vacancy rates – historically speaking – across some of these occupational categories. Family practitioner vacancy rate was 34%, the lowest it has been in nine years.²⁰ The specialist vacancy rate was at 15%, the third lowest rate in the time frame covered. For nurses, the rate was 26%; and for social service workers it was 22% - near the lowest in terms of the nine years examined.

Sources

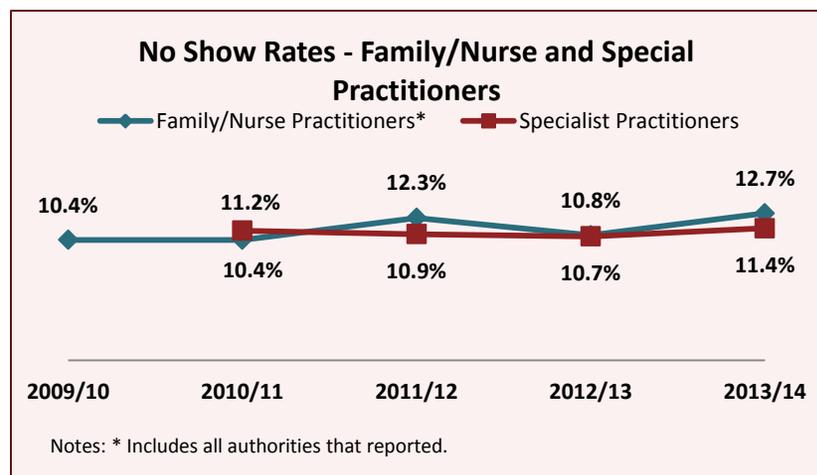
Department of Human Resources and Department of Health and Social Services.

¹⁹ These vacancy rates do not count vacant positions that are staffed by casuals or contracted labour, nor do these rates include those positions that have not been staffed due to operational reasons. Nurse vacancy rate includes relief nurse positions. Social service workers include social workers, counsellors and psychologists.

²⁰ Family practitioner rate for March 31, 2011 is an estimate.



No Shows



What is being measured?

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

Why is this of interest?

No shows to appointments with these professionals can represent a significant waste 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 five years, patients did not show up to approximately 10 to 13% of scheduled appointments to family and nurse practitioners.²¹ For specialists, the no show rate was approximately 10 to 11% over the last four years.

Source

NWT Health and Social Services Authorities.

²¹ No show rates for family and nurse practitioner appointments come from 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.

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.

