Integrated Service Delivery Model

for the

NWT Health and Social Services System

A Detailed Description

March 2004

Northwest Territories Health and Social Services

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This document was created under the Joint Leadership Council's stewardship and the guidance of the Joint Senior Management Committee. After much debate, hard work and resolution, the current *Integrated Service Delivery Model* document defines the system we currently work in, and provides a clear path into our future.

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Executive Summary

The need for an integrated system of health and social services delivery in the north was identified in the Government of the Northwest Territories (GNWT) planning document, the *NWT Health and Social Services System Action Plan 2002-2005*. As a result of this commitment, the Task Team for the Service Delivery Model for Health and Social Services was established. The Task Team was to address the issues of core service delivery (Action 5.1.1), improving services to the people (Action 5.2), and formalizing an Integrated Service Delivery Model (Action 5.2.1). The work was to reflect the importance of building an Integrated Service Delivery Model (ISDM) based on a primary health care, or primary community care (PCC), approach[1].

The Task Team began to identify the work teams, or clusters, required to deliver services within an Integrated Service Delivery Model for the Northwest Territories (NWT) HSS System. These teams or clusters were identified as:

- Level One – PCC Teams
- Level Two – Regional Support Teams
- Level Three – Territorial Support Teams
- Corporate Support Teams.

The Department of Health and Social Services would provide some universal health and social services functions, play a key role on the Corporate Support Teams, set policies and standards, and monitor and evaluate the effectiveness of the system.

The Task Team also identified some of the important characteristics of an ISDM, including the use of a PCC philosophy. PCC incorporates a client-centered approach to the delivery of health and social services, utilizing a collaborative, integrated process of service delivery, and includes the following characteristics:

- the right services;
- the most appropriate provider;
- the best setting;
- the correct time;
- the most efficient and economical manner;
- public participation;
- shared accountability; and
- information gathering and sharing.

Over the past few years, there has been a wide assortment of health and social service pilot projects funded across Canada through the federal government's Health Transition Fund (HTF).

[1] In the NWT ISDM presented in this document, the term "primary community care" or "PCC" is used in place of the term "primary health care", which is more commonly used in other jurisdictions. PCC encompasses all of the primary health care principles and characteristics but is intended to reflect a broader, more comprehensive range of primary health, wellness, and social services established to meet northern client and community needs. However, where southern research or policy is being cited in this document, the term "primary health care" is used.

Based on the information generated through the HTF program, it has been determined that the transition to an ISDM with a primary health care foundation is sound, proven in a number of instances, but challenging to implement effectively in a short period of time. The literature states that implementation of an ISDM will take time and requires a developmental view, but will improve clinical and operational results.

The ISDM established for the NWT envisions a full range of service and systems integration in the NWT, from the level of PCC through to secondary and tertiary level services. The ISDM can best be defined as:

> *A primary, vertically integrated health and social services organization based on the Regional Health and Social Services Authority / Departmental structure; that has formal linkages with other health and social service providers in the NWT and elsewhere; and that has established delivery system processes, procedures, and tools that are rooted in a collaborative approach to client care in all core services areas, particularly at the primary community care level, but radiating outward to secondary and tertiary levels of care.*

The ISDM is driven by the vision established in the Department of Health and Social Services' Strategic Plan (1998) and reinforced in the *HSS System Action Plan* (2001):

> *Our children will be born healthy and raised in a safe family and community environment, which supports them in leading long, productive, and happy lives.*

The ISDM includes two sets of principles. The first set is the broad principles articulated in the GNWT document *Shaping our Future: A Strategic Plan for Health and Wellness* (1998). The second set is the specific ISDM principles recently developed by the ISDM Task Team for Health and Social Services and articulated in the Task Team's report:

- Patient and client focus
  - Continuity of care
  - Seamless transition of services
  - Comprehensiveness
- Ease and equitable access to services
  - Simplicity of design wherever possible
  - Clients understand system
- Competent care
  - Trained and healthy staff
  - Adequate support for staff
- Information driven
  - Quality assurance
  - On-going evaluation and feedback
- A sustainable and single system of services

- Personal responsibility
- Adaptability
- Accountability
- Transparency in communications.

Team Approach

The Task Team also began to identify the work teams, or clusters, involved in the delivery of services within a northern ISDM. These teams / clusters were identified as:

- Level One – PCC Teams
- Level Two – Regional Support Teams (regionally-based)
- Level Three – Territorial Support Teams (territorial-based and/or coordinated)
- Corporate Support Teams.

PCC Teams would operate at the community level to the greatest extent possible and would be structured according to guidelines and clear and concise role definitions established by Authorities and the Department. Members of the PCC teams would make referrals to regional support services, as required and according to proper referral protocols. These teams would likely include non-governmental organizations mandated to delivery health or social services programs and services. Members of this team could make referrals to regional support services as necessary.

Regional Support Teams would usually operate in centres that function as the base for the Regional Authorities and may include intra-disciplinary and multi-disciplinary teams of professionals. They would provide on-site services, along with some itinerant services to the communities of the regions. These teams would have some form of "surge" capacity to address extraordinary situations. Members of this team would make referrals to territorial support services and to services available outside of the NWT as necessary.

Territorial Support Teams would be made up of professionals located in the larger communities who have a mandate to serve the entire NWT. They would likely be members of the same profession but may also be inter-disciplinary. These teams would provide specialized on-site and itinerant support services to the regions and communities, through appropriate referral protocols and would also provide referrals to services available outside of the NWT.

Corporate Support Teams with regional / territorial linkages would develop and coordinate the management of major human resource functions (labour negotiations, recruitment, training, etc.); and the standardized development, management, and implementation of information technology, purchasing, board governance, and financial systems.

The Department of Health and Social Services would provide some universal health and social services functions, would play a key role on the Corporate Support Teams, would set health and social services standards (through legislation and policies), and would continue to monitor and evaluate the effectiveness of the system.

The core services being delivered at the community and regional levels may vary -- depending on demographics, population health indicators, or other information – but the protocols surrounding access, information sharing, case management, data collection, referrals, etc. would remain relatively constant.

The Task Team identified some important characteristics of an ISDM. These included:

- adapting and using a primary health care philosophy and approach as the foundation for service delivery;
- multi-tasking (professionals providing a wider range of services);
- co-location of services, so that clients can access a range of services at one facility;
- using a collaborative regional / departmental budgetary process;
- using a comprehensive information system, where each service site is electronically linked;
- establishing linkages with professional associations (collaborative networks);
- developing an implementation plan, possibly using pilot communities; and
- implementing the system gradually.

Adapting and Using a Primary Health Care Foundation

The ISDM Task Team for Health and Social Services identified the need to use a primary health care (PHC) philosophy and approach as the foundation for the ISDM, then adapted and expanded the PHC scope to encompass a wider range of health, wellness, and social services (now referred to as "primary community care"). Because of its PHC roots, an understanding of the concept of primary health care, and how PHC differs from integrated service delivery, is important to understanding the NWT's current ISDM.

Overview of Primary Health Care

Primary health care is the first point of entry for individuals to the health care system. This is where health services (including mental health services) are mobilized and coordinated to promote wellness, prevent trauma and illness, build capacity, provide support and care for common health issues, and manage ongoing problems to sustain functional independence at an optimal level (Adapted from the National Forum on Health 1997).

According to the literature, the essential elements of an effective primary health care approach normally include:

- citizen participation and choice;
- controlled access (gate keeping);
- clustering of services;
- use of multi-disciplinary and interdisciplinary teams;
- rostering and capitation funding;

- comprehensive core services;
- integrated information systems;
- an emphasis on quality; and
- access to secondary services and the potential for vertical (organizational) integration. (Mable and Marriott 2002, p.2-3).

In effect, primary health care implies that the first level of service delivery – the level that surrounds the client and responds to the immediate needs of the client – is integrated, at least at the community level. There are two types of integration that can occur: horizontal (or functional) and vertical. Horizontal integration means enhancing informal and formal linkages and working relationships among *different* agencies. "Vertical" integration means establishing a single, unified, and integrated organization with primary responsibility for providing a wide range of services. (Mabel and Marriott 2002, p. 15)

It must be noted that horizontal integration of primary health care services can be carried out whether vertical integration is in place or not. In other words, separate organizations can choose to work together to achieve common goals, informally, or through formal arrangements such as protocol agreements, shared services agreements, or contribution agreements. In some instances, horizontal integration provides more flexibility than vertical organizational integration because non-governmental organizations (NGOs) often can access separate sources of funding or have more flexibility in service delivery, such as utilizing special cultural practices.

In the NWT, a combination of vertical and horizontal integration and collaboration is essential if all available community resources are to be focused on the client in a coordinated and effective manner. Vertical integration is required in order to maximize resources and ensure overall coordination and consistency in service delivery, particularly with respect to core services.

From a practical perspective, in order to use the concept of primary health care as the foundation for a fully Integrated Service Delivery Model, the following issues must be taken into account:

- it is essential to develop a common electronic health record and provide staff with access to computers and other technology for services, information, and data gathering;
- it is essential to develop clear guidelines and protocols with respect to confidentiality of information that protect and safeguard this fundamental right of clients and their families;
- program administration requirements need to be simple and efficient;
- barriers to collaborative practice (such as jurisdictional and regulatory issues) must be overcome;
- the role of nurse practitioners, in particular, and other types of supportive health professionals (such as midwives, pharmacists, physiotherapist aids, etc.) needs to be expanded and defined;
- professional development opportunities, including skills and team-building training, need to be provided, with a focus on providing quality service;

- clinical guidelines and tools need to be developed – including assessment and referral guidelines and tools;
- "urgent" care services (i.e. quick responses to urgent client needs) need to be in place to reduce the need for subsequent "emergency" care services;
- the public needs to be fully informed about new systems or procedures; and
- coordinated "change management" must occur within existing systems to ensure proper buy-in and to overcome any fear or negativity regarding implementation of the public health care approach.

Primary Health Care vs. Integrated Service Delivery

It is useful to clarify the distinction between an Integrated Service Delivery Model and a primary health care approach, because there appears to be considerable overlap between these two concepts. In simplest terms, PHC refers to an integrated system of health care delivery, with a particular focus on medical health, at the community level – the immediate point of contact for the client. In the south, this model is put forward as an alternative to the more traditional practice of individual doctors (the family physician) having primary responsibility for patient care (diagnosis, therapy, and referrals). On a broader level, PHC "focuses on larger systemic issues of health care, such as population health and prevention programs, encouraging broad-based community health programs that feature the best use of all health care providers to maximize the health of the patient population and the best use of health resources in the system" (Lewis 2002).

Integrated Service Delivery can be viewed as the more comprehensive and global system of integration. Integrated Service Delivery incorporates a primary health care approach at the community level, but is also concerned with both vertical and horizontal integration at the global level, including the integration of secondary and tertiary levels of care. Integrated Service Delivery includes reorganizing core services, improving information access, standardizing processes, and improving consistency within the HSS system as a whole. It shares many of the same principles as PHC, but includes more comprehensive, system-wide changes.

Work of the Primary Community Care Task Team

The Primary Community Care Task Team (previously called the Primary Health Care Task Team) established by the Department prepared the document *The NWT Way: A Primary Health Care Framework* in the late spring of 2002. Although the term "primary health care" was used in the original documents, during subsequent meetings, the document was amended to provide a general definition and overview of PCC, from an NWT perspective. This document also outlines some of the special considerations and characteristics of an NWT PCC approach. These include the following:

The Right Services

- The first point of contact with the HSS delivery system will vary in the NWT depending on where a person lives and the core services available. However, clients will be able to access

advanced care and treatment services through a clear referral and transfer process accessed by the local health care provider.

The Most Appropriate Provider

- Care providers will have opportunities to work in multi-disciplinary settings and collaborate to ensure continuity of services and client care.
- The number and composition of the PCC Teams will vary depending on the target population, community, and available infrastructure.

The Best Setting

- Services are provided as close to the client as possible, in a culturally sensitive environment. Where services are not available locally, referral services and support are provided.

The Correct Time

- Emergency care will be accessible 24 hours per day, in some cases, using a 24/7-call centre for preliminary screening and referrals.
- Urgent care (early intervention and harm reduction) will be provided in order to reduce the need for referrals to secondary and tertiary care.

The Most Efficient and Economical Manner

- Clients receive comprehensive, culturally relevant care based on best practice standards, in a timely fashion, without waste or misuse, by competent providers, in a team environment.
- Investment in building a northern workforce, northern capacity, and establishing partnerships will support the provision of maximum services with finite resources.

Public Participation

- The public is a key stakeholder and should have input into the delivery of PCC.

Accountability

- Accountability is a shared responsibility among the public, care providers, health authorities, and the GNWT.

Information Gathering and Sharing.

Key Elements of the ISDM

The three key elements of the NWT Integrated Service Delivery Model include:

1. services integration and collaboration;
2. organizational integration and collaboration; and
3. a description of core services.

These three key elements can be summarized as follows:

1. Services Integration and Collaboration

In the ISDM, services integration and collaboration are rooted in a PCC approach to service delivery. PCC reinforces the need for services to be directed toward, and integrated at, the community level. It incorporates a client-centered approach to the delivery of health and social services, using a collaborative, integrated process of service delivery.

The PCC approach places the client/family at the centre, or heart, of the model, immediately surrounded by a set of integrated, collaborative processes and procedures that ensure all care providers work together to meet the client and family needs. These collaborative processes begin at the community level and radiate out to regional and territorial level services.

Two forms of collaboration must take place within this model. First, the different service providers at the community level making up a PCC Team must work together to meet client needs. This is referred to as "multi-disciplinary" collaboration. Second, care providers within each core service area must establish vertical, intra-disciplinary linkages to ensure a continuum of services from the community to regional to territorial levels.

2. Organizational Integration and Collaboration

The ISDM is strengthened through a system of organizational integration and collaboration, whereby service delivery agencies are structurally linked to maximize efficiencies and resources. The delivery system remains focused on the needs of the Client/Family and is structured to support the PCC Team's ability to respond to client needs in an efficient and economical manner.

Organizational integration must be both vertical and horizontal. Vertical integration involves establishing a single, unified, and coordinated organization that includes all of the groups and agencies responsible for health and social service delivery. These groups and agencies include the PCC Teams at the community level, the Regional Authorities, the Stanton Territorial Health Authority, and the Department.

Horizontal organizational integration refers to inter-agency integration and collaboration with respect to shared clientele. Inter-agency integration and collaboration can occur at the community, regional, and territorial levels, and can consist of partnership agreements, service agreements, and/or communication protocols.

It is important to note that, in order for all of the bodies and agencies involved in the HSS system to be "integrated", rather than merely "connected", a set of integrative and collaborative governance, management, administrative and service-delivery processes and procedures must be developed and maintained throughout the system, both vertically and horizontally.

3. Core Services

The third key element of the ISDM is a description of core services. Core services are those health and social programs and services eligible for public funding which are accessible to all residents of the NWT throughout their entire life cycle, and according to certain standards, policies and guidelines.

These services promote individual, family, and community wellness. The six categories of core services identified for the NWT are:

- Diagnostic and Curative Services;
- Rehabilitation Services;
- Protection Services;
- Continuing Care Services;
- Promotion and Prevention Services; and
- Mental Health and Addictions Services.

Current Directions

Service and organizational integration and collaboration do not happen naturally. For this reason, establishing and implementing the ISDM will require a comprehensive implementation plan that incorporates developmental and capacity building processes at the territorial, regional, and community levels.

Further, three directions regarding delivery of core services have been identified. These directions build on the current system but are incorporated within the overall goal of developing and implementing the ISDM.

Short Term Direction – Equitable Core Services Delivery would strive to maintain current service levels but would address inequities in community access to services. This would ensure that communities of similar size have similar base staffing allocations to deliver core services (there are currently inequities in the system).

Medium Term Direction – Advanced Core Services Delivery would ensure that service delivery and staffing allocations in all communities are advanced to meet base standards and would begin to move towards territorial benchmarks and standards (in many instances, existing services fall short of base standards).

Long Term Direction – Optimum Core Services Delivery would require a complete review of services required to bring the HSS system up to accepted territorial service delivery levels and standards.

Introduction

Definition and Principles

The Integrated Service Delivery Model (ISDM) for the NWT Health and Social Services (HSS) system envisions a full range of services and systems integration in the NWT, from the level of PCC through to secondary and tertiary level services. The ISDM can best be defined as:

> *a vertical and horizontal integrated health and social services organization based on the HSS Authority / Departmental structure that has formal linkages with other health and social service providers in the NWT and elsewhere, and that has established delivery system processes, procedures, and tools that are rooted in a collaborative approach to client care in all core services areas, particularly at the PCC level, but radiating outward to secondary and tertiary levels of care.*

The three key elements of the ISDM include:

- services integration and collaboration, based on a PCC philosophy;
- organizational integration and collaboration; and
- a description of core services.

The ISDM identifies a wide range of options in terms of the degree of integration desired and feasible at the present time, and also begins to identify a process for the equitable enhancement of core services.

Although the model requires the further development of an implementation plan if it is to be fully operationalized, the ISDM already incorporates many of the actions currently being undertaken through the *HSS System Action Plan*. These actions are already contributing to, and are consistent with, the development of a fully integrated services delivery model. The actions that are contributing to the ISDM have been noted in the description of the model below.

The ISDM is driven by the vision established in the *Shaping Our Future: A Strategic Plan for Health and Wellness* (1998) and reinforced in the *NWT Health and Social Services System Action Plan 2002-2005* (2001). This vision was developed based on the themes and principles of all previous health and social services reports and strategic planning documents. The NWT's vision for health and social services delivery is that:

Our children will be born healthy and raised in a safe family and community environment, which supports them in leading long, productive, and happy lives.

This vision expresses the long-term goal of the Model and any and all initiatives taken by NWT care providers to further develop and implement the Model.

The ISDM also inherently includes two sets of principles. The first set is the broad principles articulated in the Department's strategic plan, *Shaping Our Future* (1998):

- personal responsibility;
- basic needs;
- sustainability;
- continuum of care;
- universality;
- prevention-oriented system; and
- people-oriented system.

The second set of principles are the specific Integrated Service Delivery principles recently developed by the ISDM Task Team Health and Social Services and articulated in the Task Team's report:

- patient and client focus;
- ease and equitable access to services;
- competent care;
- information driven;
- a sustainable and single system of services;
- personal responsibility;
- adaptability;
- accountability; and
- transparency in communications.

As noted above, the ISDM actually consists of three main elements:

- services integration and collaboration;
- organizational integration and collaboration; and
- a description of core services.

All three of the elements must be established and maintained in order for the ISDM to be fully operational.

The vision, principles and the three key elements of the ISDM as described are the cornerstone for the development of integrated service delivery for NWT health and social services. These components provide the ability to create a system that allows for greater focus and support for the client and the client's family. Through this process, clear core services that individuals can expect to receive are identified.

Having the core services clearly defined allows the Authorities, in consort with the Department, to develop greater structural and functional integration and collaboration throughout the system, especially at the community level. The roles and responsibilities between the Department, Authorities and other service providers within the system can be clearly defined. Specific goals and objectives, outcomes and measures will be developed and consistently applied between each Authority. This allows for greater accountability, with increased consistency of service delivery, within the overall system.[2]

[2] A note on confidentiality: Throughout this document there are references to the importance of client confidentiality. Given the nature of the model promotes greater integration and collaboration throughout the system, the issue of confidentiality is important and needs to be addressed. It is a matter often cited as a barrier to communication as well as to integration and collaboration. The challenge will be to reassure the public that the efforts to integrate and collaborate to provide a better service will in no way jeopardize their confidentiality. Clear guidelines and protocols will need to be in place to protect and safeguard this fundamental right of our clients and their families.

Confidentiality policies to be used by the enhanced PCC team will be developed. They will deal with the exchange of information internally (between team members) as well as externally (outside the team). Moreover, the confidentiality model will take into account current legislation (duty to report) and professional standards.

Services Integration and Collaboration

In the ISDM, services integration and collaboration are rooted in a PCC approach to service delivery. The term "Primary Community Care" is similar to the term "Primary Health Care" but is being used in the NWT because it reinforces the need for services to be directed toward and integrated at the community level. PCC incorporates a client-centred approach to the delivery of health and social services, utilizing a collaborative, integrated process of service delivery, and includes the following characteristics:

- the right services;
- the most appropriate provider;
- the best setting;
- the correct time;
- the most efficient and economical manner;
- public participation;
- shared accountability; and
- information gathering and sharing.

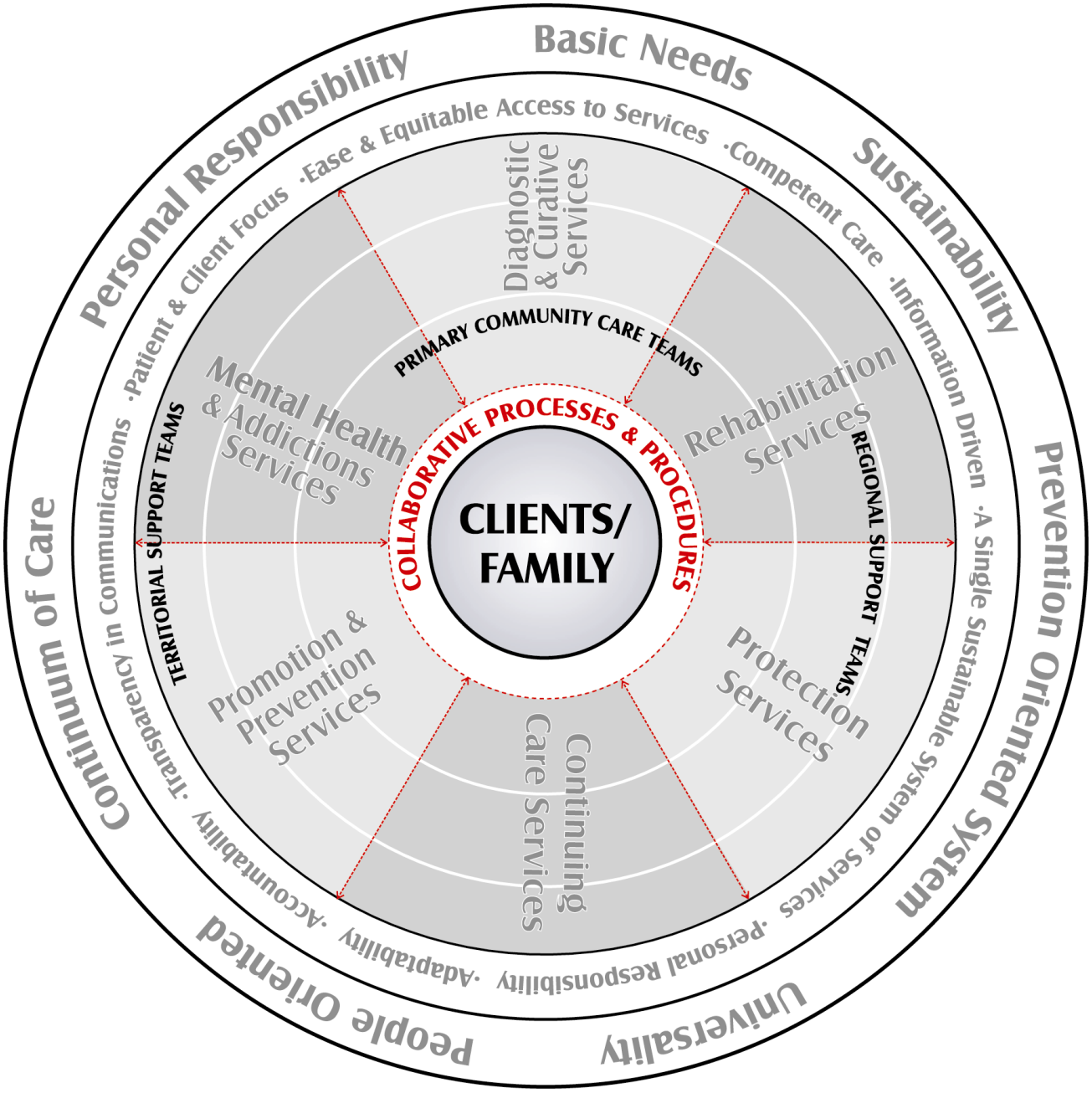
The PCC approach to services integration and collaboration is depicted in *Figure 1: Services Integration and Collaboration.*

Acknowledging the important link between individual and family care in the NWT, the Services Integration and Collaboration approach places the Client/Family at the centre, or heart, of the Model. Client/Family are immediately surrounded by a set of integrated, collaborative processes and procedures that ensure that all care providers work together to meet their needs. These collaborative processes begin at the community level (the primary point of contact) and radiate out to regional and territorial-level services.

Figure 1 illustrates how all of the core services available to health and social services clients in the NWT are coordinated around, and focused on, meeting client needs. These core services, which will be explained in more detail in a subsequent section of this Model description, fit into the following general categories:

- Diagnostic and Curative Services;
- Rehabilitation Services;
- Protection Services;
- Continuing Care Services;
- Promotion and Prevention Services; and
- Mental Health and Addictions Services.

Figure 1: Services Integration and Collaboration[3]



[3] Developed by Peter Redvers, Crosscurrent Associates 2002

In the NWT, the range and extent of core services provided at the community level varies, depending on the size of the community, population health indicators, facility development, and other factors. However, where particular services are not available at the community level, they will be made available to a client at either the regional or territorial level, and access to these services will be coordinated and managed, to the greatest extent possible, from the community level.

Within this Services Integration and Collaboration model, two forms of collaboration must take place. All of the different service providers at the community level make up a PCC Team and will establish collaborative processes for working together to meet client needs. This is referred to as "multi-disciplinary" or "horizontal collaboration". Where a particular service is not available in a community, a regional service provider may become a member of the PCC Team, including non-government organizations (NGO) partners.

Multi-disciplinary or horizontal collaboration will also occur at the regional and territorial service levels, again through a set of established processes and procedures. (However, a greater degree of multi-disciplinary collaboration will likely take place at the community and regional levels rather than at the territorial level, due to the fact that territorial and extra-territorial services tend to become more specialized and diffuse).

Aside from multi-disciplinary / horizontal collaboration, collaborative processes and procedures will also be established *vertically within each core service area*, ensuring a continuum of services from the community to territorial levels. For example, processes will be in place to ensure that mental health clients can be assessed, referred, and tracked efficiently from community to region to territorial level services, and back again, without undue stress or discontinuity of service.

In essence, collaboration will occur among service providers in each ring surrounding the client / family (horizontal collaboration) and will also radiate out from the client in each core service area (vertical collaboration). Binding this model together are the key principles of the Department of Health and Social Services strategic plan, *Shaping our Future,* (outer ring of Model) and the integrated service delivery principles recently developed by the Department in consultation with the Authorities (second ring).

Processes and Procedures

The PCC approach to service delivery does not happen naturally. As shown in Figure 1, it is the integrative and collaborative processes and procedures that surround the client and link together all core service providers that hold this PCC Foundations model together. It is essential, therefore, that these processes and procedures be defined, developed, and implemented. Those processes and procedures that are already being addressed through the *HSS System Action Plan* have been noted. The most important integrative and collaborative processes and procedures that must be developed and maintained presented below, while others have to be further elaborated.

The key process and procedures required to support an integrated, collaborative approach to services delivery include:

1. Co-location
2. Single Point Access / Flexible Access (see Action 5.1.3 of the *HSS System Action Plan*)
3. Standard Client Information Forms
4. Integrated Information Systems / Data Gathering
5. Case Management Protocols (see Action 5.2.4 of the *HSS System Action Plan*)
    - Definition of Client Rights
    - Inter-Disciplinary Collaboration Agreements
    - Roles and Responsibilities
    - Communication Processes
6. Standardized Assessment / Therapy Tools
7. Standardized Referral Procedures and Tools
8. Coordinated Discharge Planning (see Action 5.2.3 of the *HSS System Action Plan*)
9. Public Education (see Action 5.1.2 of the HSS System Action Plan)
10. Professional Development (see Actions 6.1.4 and 6.1.5 of the *HSS System Action Plan*)
    - Staff Orientation (see Action 6.1.3 of the *HSS System Action Plan*)
    - Mentoring (see Action 6.1.6 of the *HSS System Action Plan*)
    - Multi-tasking
    - Team Building
11. Change Management
12. Evaluation and Quality Control (see Action 5.1.4 of the *HSS System Action Plan*)

Organizational Integration and Collaboration

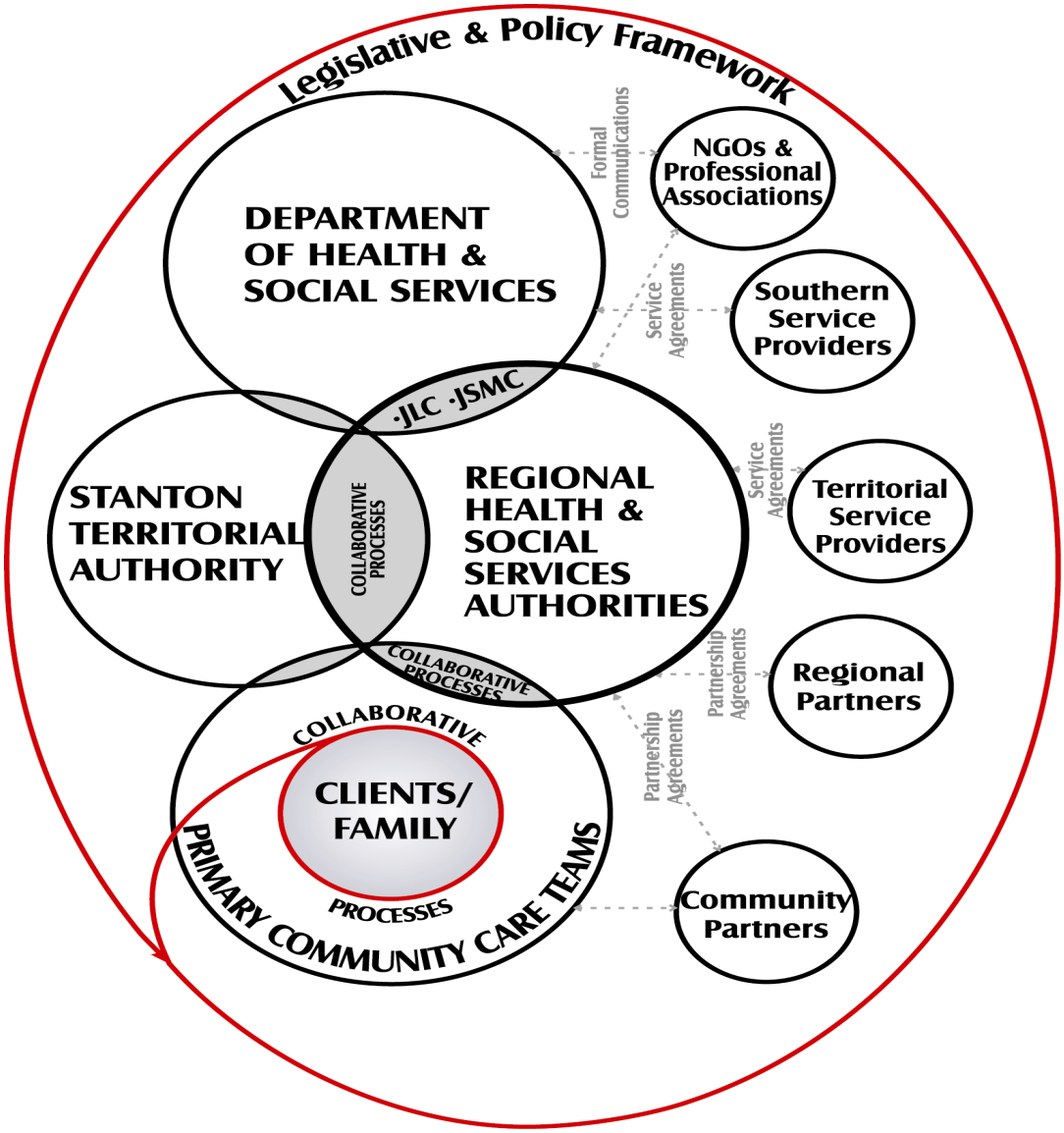
Along with services integration and collaboration, the ISDM requires systems or organizational integration and collaboration. Figure 2, Organization Integration and Collaboration, illustrates the type of organizational integration required for the ISDM to become fully operational. The overall integrated service delivery system remains focused on the needs of the Client/Family and is established and maintained to support the ability of the PCC Team to support and respond to client needs in an efficient and economical manner. The line that extends outward from the Client/Family core and encircles the entire Model is meant to convey the all-encompassing focus of the system on client and family needs, and on a PCC approach to service delivery.

Figure 2 illustrates the integrated, collaborative, organizational relationships that are currently being developed, and must be enhanced, in order for the ISDM to be fully operational. Overlapping circles illustrate "vertical" organizational integration – i.e. integration of those bodies that make up the primary, unified system. These primary bodies include the PCC Teams at the community level, the Regional Authorities, the Stanton Territorial Health Authority, and the Department. The inter-connection of these organizations is reflected in the shaded, overlap areas on the model. These bodies, which are governed by territorial legislation and policy, effectively constitute a single, vertically integrated health and social services delivery system.

Figure 2 uses dotted lines to illustrate "horizontal" organizational integration within the system – i.e. integration and/or collaboration established with independent agencies such as First Nations, NGOs, professional associations, private clinics, etc. in order to serve shared client needs. This type of inter-agency integration and collaboration occurs at the community, regional, and territorial levels, and can consist of partnership agreements, service agreements, and/or communication protocols. Service agreements are also established with agencies outside of the NWT. Overall authority for the ISDM rests with the Department, within a legislative and policy framework established by the federal and territorial governments.

It is important to note that, in order for all of the agencies depicted in this Model to be "integrated" rather then merely "connected", a set of integrative and collaborative governance, management, administrative, and service-delivery processes and procedures must be developed and maintained throughout the system. The key points where collaborative processes need to be established are highlighted through the shading in the Model. It is very important that consistent governance, management, and administrative structures, processes, and procedures are established between the regional authorities and the Department. It is particularly important that formal and consistent collaborative relationships are established between clients at the community level, Authorities (including Stanton), Department level, and other service providers.

Figure 2: Organizational Integration and Collaboration[4]



[4] Developed by Peter Redvers, Crosscurrent Associates 2002

Processes and Procedures

An integrated and collaborative approach to systems governance, management, and administration does not happen naturally. It is essential, therefore, that processes and procedures that support integration and collaboration at the systems level be developed and implemented, both vertically and horizontally. The most important integrative and collaborative processes and procedures that must be developed and maintained are explained below. Fortunately, the *HSS System Action Plan* already includes a considerable number of actions directed toward the establishment and maintenance of an integrated HSS system. Those processes and procedures that are already being addressed through the *HSS System Action Plan* have been noted.

Vertical Integration

1. The ISDM requires the development and maintenance of a clear and consistent legislative and policy framework that supports and empowers inter-disciplinary collaborative practice.

   This element has already been acknowledged and is being addressed in Action 7.3.1. Aside from those items listed in the *HSS System Action Plan*, other legislative initiatives that could be considered (because they are noted in literature relating to effective Integrated Service Delivery practice) include allowing pharmacists to issue medications under a nurse practitioner's prescription and legislating and regulating midwifery.

2. The ISDM requires a governance structure that establishes and maintains clear and consistent decision-making among organizational stakeholders:

   - The Department is currently clarifying the role and responsibilities of the Department and the Authorities (Action 7.1.3) and ensuring that the Memoranda of Understanding with the Authorities accurately and consistently reflect these roles and responsibilities.
   - A Joint Leadership Council (JLC) has been established (Action 7.1.1) to provide a forum for shared leadership and decision-making, and a Joint Senior Management Committee (JSMC) has been established (Action 7.1.2) to provide leadership and direction with respect to the operations of the overall system.
   - The organizational structure and business operations of the Authorities are currently being realigned on a system-wide basis to clarify roles and responsibilities and ensure greater consistency in operation among the Authorities. (Action 7.1.4)
   - The structure and operation of the Authority boards is being strengthened through the implementation of an NWT board leadership model, a standardized process for board appointments, and training for trustees. (Actions 8.1 through 8.4)

3. The ISDM requires sustainable systems management and accountability.

- A systems wide planning and reporting model is being developed to provide more overall coordination within the system and to ensure that all planning strategies and frameworks support the Department's overall strategic planning goals. (Actions 7.2.1 and 7.1.8)
- A standard funding model is being developed to ensure consistency and equity of resources among the regions. (Action 7.2.2)

  It must be noted that this funding model is most likely to incorporate a budgeting process based on partially 'capitated' core service delivery allocations, tied to territorial standards as described in Section IV on Cores Services. The funding model, which is dependent on the establishment of staffing and/or services standards, would likely include the following criteria:

  a. core service staffing allocations for PCC would be determined based on community populations (a form of capitation funding);
  b. regional service allocations would be determined based on regional per-capita staffing allocations for PCC and secondary care services provided from and at the regional level (taking into account regional overlap of some services);
  c. territorial service team allocations would be determined based on territorial per-capita staffing allocations for secondary and tertiary care services;
  d. costs for the infrastructure required to support staff and deliver these core services, including administrative costs, would be determined (recognizing that these costs may vary by region depending on road access, availability of facilities, # of communities etc.); and
  e. additional or special programming resources would be allocated to regions according to population health criteria determined by the Department.

- A standard financial accounting system and system of financial accountability is being put into place to assist in financial data gathering and ensure overall sustainability of the system. (Actions 7.2.3 and 7.2.4)
- An information management plan is being developed to ensure that all current databases are linked to allow the compilation of reliable and useful data. (Action 7.2.5)

  (Apparently, the cost and technical difficulties associated with converting all regions to the same information system is prohibitive at the present time, but the Department can utilize a program at the territorial level that can compile and analyze data from the different regional systems. This appears to be an effective mid-term solution and would allow more time for a phased in conversion of all systems.)

- A system wide accountability framework that allows for monitoring, reporting, performance-measurement, and program evaluation across all levels of the system is being developed. (see Actions 9.1 to 9.4)

4. The ISDM requires rationalization of human resources throughout the system. This includes clear and concise role definitions, consistent orientation, training and certification, human resource tracking, human resource planning, and surge capacity. Initiatives are currently being undertaken to address these HR issues. (Actions 6.1.1 through 6.2.1)

5. The ISDM assumes that there is equity in the delivery of, and access to, core services. A systems-wide definition of core services is required, along with standard guidelines and criteria for delivering (and accessing) these services. A more-detailed description of core services and core service options is presented in the final section of this report.

Horizontal Integration

From Figure 2, it is clear that inter-organizational linkages are critical to effective operation and sustainability of the NWT HSS system. Clear protocols for establishing working relationships with partner organizations and contracted service providers must therefore be established. These linkages can range in formality from simple protocol agreements, to partnership agreements, to legally binding contracts and contribution agreements.

Further work is required in this area and should include a review of existing partnership arrangements, contracts, and contribution agreements to ensure that service standards are being met, client information is being accurately documented and shared, and collaborative referral and client-management processes are being utilized. This is particularly important where the Department is funding the service.

Aside from formal integrative processes, informal integrative and collaborative processes can be established for information sharing, service delivery, and program planning purposes. These can include regular inter-agency meetings, where there is shared and overlapping interest in a client or client's needs, or personal contact and communication to better coordinate delivery of services and programs as the need arises.

As the lead agencies for health and social services in the NWT, the Department and Authorities must take the initiative to develop, enhance, and maintain these relationships at the community, regional, and territorial level.

Linkages with other GNWT Departments/Agencies

The essence of the ISDM is about how the Department and Authorities will work together to deliver of health and social services to the residents of the NWT. However, from the foregoing, it is clear that partnerships and collaborative relationships with other GNWT departments and agencies are critical for the successful delivery services to the public.

The model contemplates a team approach to the delivery of core health and social services. To be effective, these teams, located at the community, regional, territorial and corporate levels, will need to work collaboratively with a variety of other GNWT departments and agencies as well as NGO'S. It is critical that this concept of working in an integrated and collaborative manner is

promoted throughout the system. These partnerships will help ensure the success of the ISDM in making services to the public as accessible and seamless as possible.

There are many current examples of working together collaboratively in partnership. Some of these include:

- *Early Childhood Development Framework* (Health and Social Services; Education, Culture and Employment)

- *Seniors' Action Plan 2002-2003* (Health and Social Services; Executive; Education, Culture and Employment; Municipal and Community Affairs; Financial Management Board Secretariat, Bureau of Statistics, NWT Housing Corporation, NWT Seniors Society)

- *NWT Disabilities Action Plan* (Health and Social Services; Education, Culture and Employment; NWT Housing Corporation; Municipal and Community Affairs; Dene Nation; Inuvialuit Regional Corporation; Yellowknife YWCA; NWT Council of Persons with Disabilities; Yellowknife Association for Community Living)

- *Doing Our Part: The GNWT Response to the Social Agenda*, October 2002 (All GNWT departments have had some involvement); and

- The *Family Violence Action Plan* by the Coalition Against Family Violence (Health and Social Services; Justice; Education, Culture and Employment; Status of Women Council of the NWT; Salvation Army; Yellowknife YWCA; Yellowknife Victims Services; RCMP; Yellowknife Education District No. 1; Justice Canada; Yellowknife Health and Social Services Authority; Yellowknives Dene First Nation; NWT Legal Services; Women and Children's Healing and Recovery Program; NWT Seniors Society; Centre for Northern Families; Native Women's Association of the NWT; and Yellowknife Housing Authority).

Other opportunities will continue to present themselves and need to be pursued. Of particular note, are opportunities to partner with other departments and agencies in the delivery of rehabilitation and continuing care services. The sharing of infrastructure, information, expertise, human resources and equipment, where appropriate, among departments and agencies, will have great potential for creating better service. Such collaborative efforts will serve to enhance and strengthen service delivery to NWT residents and make for a truly integrated system.

Core Services

The strength of the NWT first and foremost resides with its people, its families and communities. The NWT's HSS system relies and builds on this strength to provide a complement of programs and services that aims to meet needs that extend beyond the inherent capacity of individuals and their natural support networks.

The Core Services element of the ISDM must describe, in broad terms, the range of services NWT residents can expect to have access to, either directly in their communities or elsewhere. These services are intended to assist them in achieving an optimal state of health and to lead long and productive lives in the context of healthy families and communities.

Although the ultimate accountability of this system resides with the Minister of Health and Social Services, programs and activities are delivered through a network of service providers, including the Department, Authorities, non-governmental organizations and other agents working under contract.

Guiding Principles

Core Services support the Department's mission statement *"to promote, protect, and provide for the health and well-being of the people of the NWT"*. They also support the five criteria of the *Canada Health Act,* namely that of universality, accessibility, comprehensiveness, portability and public administration. The following principles will underlie and guide the delivery of core services in the NWT:

- **Needs Based**
  Services can respond to a wide array of problems or situations that arise from basic and common needs of the population. These services can be preventative, diagnostic, curative, rehabilitative and palliative in nature.

- **Personal Responsibility**
  Individuals and families have personal responsibilities to address their health and social needs.

- **Common Orientation**
  Core health and social services are anchored at the community level and the system will establish effective linkages with groups, organization and other sectors that may impact on health status and behaviours.

- **Continuity**
  Services offer continuity of care to every individual, by coordinating referrals to more specialized (secondary or tertiary) levels of care and ensuring follow-up as required. This requires ongoing and strong communication links with other parts of the HSS system.

- **Multidisciplinary Teamwork**
  Core Services require both the input of the public and the integration of a multidisciplinary group of professionals working as a team. Each member of the team must be respected for the set of competencies and skills that he/she brings to the team.

- **Accessibility**
  Services are accessible to all age or population groups and as close as possible to where people live. At the primary care (front line) level, services must be available at all times to meet acute needs -- that is 7 days a week and 24 hours per day. Other services may require referral to a larger centre, but the costs of travel should not act as a barrier to such access.

- **Quality**
  Consistent quality is offered in all settings, irrespective of geographic location or time of day. The term "quality" is defined as the capacity of professional services or activities to improve or maintain the health and well-being of individuals and populations in a continuous way, taking into account their expressed desires and the evolution of knowledge on evidence-based clinical interventions and best practices.

Core Services are those health and social programs and services eligible for public funding which are available or accessible to all residents of the NWT throughout their entire life cycle, irrespective of gender, ethnicity, or location and according to certain standard policies guidelines and criteria.

Only the programs and services that are currently provided through public funding have been identified and described in this document. However, other types of treatment and support, such as traditional healing, cannot be overlooked and must be explored in more detail as an element of integrative services delivery. Further, individuals have the option of accessing other health and social supports if they so choose, such as chiropractic services or massage therapy. These may not be funded through the public system at this time and are therefore not discussed in this document. In the longer term, a greater use of private insurance and third party billing must be explored.

All core services cannot all be provided in each community. Some will be made available on a scheduled basis by visiting professionals. Others require a referral to another community or, occasionally, outside the NWT.

For the NWT HSS system, core services have been grouped into six broad categories:

- Diagnostic and Curative Services;
- Rehabilitation Services;
- Protection Services;
- Continuing Care Services;
- Promotion and Prevention Services; and
- Mental Health and Addiction Services.

Diagnostic and Curative Services

Defining Diagnostic and Curative Services

Diagnostic and Curative services are those that are required to diagnose and provide treatment. Diagnostic and Curative services have been categorized under three distinct areas:

1. Diagnostic Services;
2. Medical Travel Services; and
3. Treatment Services.

Diagnostic services include radiology, laboratory and pharmacy services. These services provide the means of providing the information to appropriately diagnose and treat residents. Medical travel services include ground ambulance, air ambulance, ambulance dispatch services, and taxi services, basically all modes of transportation a resident may utilize in order to access services, if not available in their own community. Treatment services provide active treatment and assessment to reduce the impact of medical conditions or disorders. Residents generally require acute-care services for short periods of time, in contrast to chronic or continuing care.

Examples of Diagnostic and Curative Services

The following list provides examples of the wide range of diagnostic and curative services available to NWT residents:

- first aid and CPR;
- community clinics – nurse and/or physician;
- hospital emergency department services
- general medical services – clinic visits, inpatient and day care;
- surgical services – inpatient and day care surgery;
- maternity services – prenatal, ante-natal and post-natal care;
- discharge planning;
- telehealth – consultations, referrals;
- radiology procedures – mammography, CT scanning;
- laboratory – chemistry, hematology, TB testing;
- chemotherapy, cardiac monitoring; and
- air ambulance services – scheduled charter.

Levels of Diagnostic and Curative Services

There are three levels of diagnostic and curative services: primary, secondary, and tertiary. The level of service provided is dependent on the service providers available and the identified needs for that particular community or region.

Primary Care

This is the level of care provided at the first point of contact with the HSS system. Every community will have access to, at least, a basic team of primary health and social services care providers and to some diagnostic services. All communities shall have access to clinical assessment and treatment, front line counselling, first aid, emergency care, after care, and monitoring of a plan of care. In very small communities, some of these services will have to be offered through visiting staff (a team of providers) with a system of referral / consultation for advanced assessment, care, and treatment.

In the NWT, primary care is most often provided through a combination of PCC teams and regional support teams. PCC teams operate at the community level and make referrals to regional support services, as required and according to proper referral protocols. Regional support teams normally operate in those centres that function as the base for Authorities and may include intra-disciplinary and multi-disciplinary teams of professionals that provide on-site services, along with some itinerant services to the communities in the regions. These teams have some form of "surge" capacity to address extraordinary situations. Members of these teams also make appropriate referrals to territorial support services and to services available outside the NWT.

Secondary Care

These are the referred services located within hospital or other facilities in the NWT that respond to advanced and/or specialized needs. Secondary care services includes internal medicine and surgery, alcohol and drug treatment (see also Addictions and Mental Health Services), psychiatry, pediatrics, obstetrics, and more advanced diagnostic services such as laboratory or more specialized radiology services.

Secondary care is most often provided by territorial support teams, comprised of professionals located in the larger communities who have a mandate to service the entire NWT. These teams can be multi-disciplinary or members of the same profession. These teams provide specialized on-site and itinerant support services to the regions and communities through appropriate referral protocols and also provide referrals to services available outside the NWT.

Tertiary Care

These are the more specialized diagnostic and treatment services that normally must be accessed outside the NWT, with some limited tertiary services being provided at Stanton Territorial Health Authority through visiting specialists.

Corporate Support and Linkages

The health professionals delivering these three levels of services are internally linked through referral and information sharing protocols. As well, corporate support teams throughout the system develop and coordinate the management of major human resource functions (labour negotiations, recruitment, training, etc.), along with the standardized development, management,

and implementation of information technology, purchasing, board governance, and financial systems.

The Vision for Diagnostic and Curative Services

Through proper and timely assessment, care, and treatment, the health and well-being of clients will be maintained and restored.

Preferred Future

The preferred future sees increased personal responsibility for health and well-being and less reliance on diagnostic and curative services for common health problems. All residents of the NWT will have access to basic or first responder level of diagnostic, medical travel, and treatment service in their community.

There will be a team approach to delivering services at all levels. There will be no sole providers, although in the smallest communities the team of community health workers may be part-time employees who cover off for one another and provide collegial support, whilst in larger communities PCC teams are characterized by a multi-disciplinary and full-time contingent of competent service providers. In-patient care is provided in communities with no hospital on a holding basis pending medevac or on a short term observation basis only.

Along with advanced diagnostic and curative service teams in Yellowknife, Stanton Territorial Hospital serves as a referral centre and hub for the following essential core physician specialist services: anaesthesia, general surgery, internal medicine, paediatics, obstetrics and gynecology, otolaryngology, ophthalmology, orthopaedics, psychiatry, and radiology. This clustering of specialists at the territorial level affords a service to the entire NWT population through a combination of on-site and visiting services. It remains necessary to refer out of territories for tertiary and highly specialized services that cannot be sustained within the NWT.

The current medical travel system generally provides timely access to diagnostic and curative services and will require continual monitoring and adjustment from time to time to sustain acceptable, appropriate, and efficient medical transportation at community, regional, and territorial levels.

Diagnostic and curative services provide residents with the basic treatment and assessment services. A level of service must be available in the home community of the resident, regardless of community size. If services are not available, then the system must be developed to transport the resident to where the services are available. As outlined above, changes to the system will allow better access to services. The new system will have flexibility, easier access to information, and appropriate referral to more specialized services.

Expected Outcomes

The future outcomes of this integrated and flexible system are as follows:

- A full compliment of health care providers, as defined in the service model, will provide residents with services as close to their home as possible.
- Residents will have seamless access to assessment and treatment services.
- Transportation services will be established to ensure the shortest wait time prior to transfer.
- Health care providers will be supported in their community and by regional providers.
- Health care providers will be trained to provide services required at each of the levels.
- Equipment and tools will be available to provide diagnostic assessments to residents presented with a disorder or problem.
- Regional centres will provide support and services to smaller communities.
- Discharge planning services will ensure that patients returning to their home community will continue to access services required.
- Quality and quantity of services will be monitored and evaluated on a regular basis.

Assessing the Current Diagnostic and Curative Services System

As noted earlier, the three main categories of diagnostic and curative services are diagnostic, medical travel, and treatment services. The current status of each of these services has been assessed below:

Diagnostic Services

Diagnostic services include laboratory, diagnostic imaging, and pharmacy services. Services are provided in varying levels throughout the NWT dependent on the equipment and trained personnel to provide the services. Most specialized services that are not available in the NWT are accessed through the Capital Health Authority in Edmonton.

Services provided at a community level:

- In communities with less than 500 persons, limited radiology and laboratory services are available. Residents in these communities must access the service at a regional level.
- In communities of over 500 persons, limited equipment is available to provide services and community workers have been minimally trained to perform these services. Very basic procedures in both laboratory and radiology are performed.
- In communities over 2500 persons, more specialized equipment is available for trained technicians and technologists.
- Basic first aid supplies that do not require a pharmacist to dispense or distribute are available in small communities. These supplies are similar to those one would purchase over-the-counter in a local drugstore.

- As community populations increase, the availability of pharmaceutical supplies is also increased with the availability of trained professionals for dispensing and distributing.
- In communities with populations over 2500 persons, there are local drugstores to provide basic and prescription service; therefore, only pharmaceutical services directly related to the assessment and treatment of patients are provided within health care facilities.

Services provided at a regional level:

- Regional centres are usually staffed with professionals who have received training in performing basic laboratory and radiology procedures and also in dispensing pharmaceutical supplies. Residents from smaller communities are usually referred to these centres for diagnostic services.
- In Hay River, Fort Smith, and Inuvik, trained technologists are available to perform specialized laboratory examinations in the community. These services are expanded basic services that include hematology and chemistry. Depending on the extent of treatment services, additional services such as a blood bank may be available.
- Radiology equipment at a regional level has been enhanced to support more specialized examinations. Trained technologists may be available to provide some specialized services with the availability of traveling radiologists. Films are sent to the territorial centre for interpretation.
- The nursing professionals in the centres usually provide pharmacy services. Regional pharmaceutical support is provided to some communities.
- In Hay River, Inuvik, and at Stanton, hospital pharmacists provide services to support assessment and treatment services provided at these regional levels.

Services provided at a territorial level:

- Full diagnostic imaging services are provided in general radiology, fluoroscopy, mammography, and ultrasound. A radiologist is available to provide the support to the technologists.
- Computerized Axial Tomography is provided at the territorial centre. All residents can access the service in the territories.
- All radiology films produced in the territories are interpreted at the territorial centre.
- Registered technologists provide full laboratory services. Specialized services such as blood bank, bacteriology, and TB testing are provided at the territorial level.
- Visiting pathologist services are available on a quarterly basis.
- Hospital pharmaceutical services are provided to support the services provided at the territorial level. Advanced practice pharmaceutical supplies such as services required for chemotherapy and intensive care services are also available.
- Limited professional pharmaceutical support is provided to regional centres.

Services provided out of territories:

- Laboratory specimens that require specialty testing are referred to southern jurisdictions. These services usually require the assistance of a pathologist.
- Some specialized diagnostic imaging procedures such as magnetic resonance imaging and nuclear medicine are referred to southern jurisdictions.

Medical Travel Services

Medical travel services provide residents with the mode of transportation to access all core services offered. Travel services include scheduled flight services, chartered flight services, air ambulance services, ground ambulance services, and ground transportation such as taxi services.

Services provided at a community level:

- In communities accessible by ground transportation, taxi services are available either in the community or from a community in close proximity. From communities that are only accessible by air, chartered scheduled services are available to provide residents with transportation to the centre where services are available.
- In the case of urgent and emergent care requirements, air ambulance services are available to most communities. Only communities without airport facilities are not accessible. In some cases, helicopter services will be utilized for medevac services.
- Residents may be transported to the regional centre to access services not available in the community.
- Most communities have designated a vehicle to provide ground ambulance services from the health centre to the airport facility.

Services provided at a regional level:

- Similar services are provided at the regional level as at the community level. Ground and scheduled air service is usually available to and from the regional centre.
- Air ambulance services are available within a specified time. All regional level communities are served by airport facilities.
- Inuvik serves as the northern site for contracted air medevac carrier services for the Beaufort-Delta area.

Services provided at a territorial level:

- Scheduled air service is available to transport residents from community and regional centres to the territorial centre.
- Ambulance services are available from within the centre and also from the airport facility.
- Contracted air medevac services with contracted professional nursing staff are available to provide services to all communities south of the Inuvik region. Back-up services are provided to the Inuvik area.

Services provided out-of-territories:

- Specialized neo-natal and pediatric air ambulance services are available from Edmonton. These services are usually directly linked to services at the territorial level.

Treatment Services

Treatment services are varied and include services required for assessment and treatment. Ambulatory services include clinic services in a community to outpatient procedures in a territorial facility. Emergency services include first responder services in a small community to intensive care services at the territorial level. Treatment services also include acute care assessment and treatment services in medical, obstetrical, pediatric, psychiatric, and surgical services. Dental and medical social worker services complete the treatment and assessment services available through diagnostic and curative core services.

Services provided at a community level:

- In all communities, regardless of population, a limited basic service is available where first aid and basic CPR will be available for emergency care. In the smaller communities, transfer to a regional or territorial centre will be required.
- In communities where professional nursing staff is available, clinical and emergency services are provided during regular work hours. After regular hours, emergency services are provided on an on-call basis and the nurse will respond to emergencies only.
- In larger communities, clinic and emergency services are provided during regular work hours. In some cases, the same professionals provide these services in a facility. In some communities, the clinic services are provided at one location and emergency services are provided in a hospital setting. In all cases, physician support is available.
- Fort Smith, Hay River, Inuvik, and Yellowknife all have facilities that provide inpatient and outpatient services. In Fort Smith and Inuvik, physician services are provided through the hospital only. In Hay River and Yellowknife, physician services are provided in a clinic setting and also in the hospital setting.
- Dental therapy services, based in the schools, are normally provided to pre-school and school-aged children, as well as emergency adult cases only. In most communities with a population of less than 500 persons, dental therapy services are provided from the region (see Promotion and Prevention Services for more details). Dentists provide visiting dental services to communities without a private dental clinic through a contractual arrangement with the respective HSS Authority. These contracts are covered by the First Nations and Inuit Health Branch, Health Canada, for services provided to Registered First Nations and Inuit people. Dental services are not a core service; however, they are available in the communities.
- Some telehealth services for assessment and treatment are available at the community level.

Services provided at a regional level:

- Regional centres provide services with professional nursing staff and usually physician support. In most cases, the physician support is on-site; in some cases, the physician support is intermittent.
- With the close proximity of the Dogrib region to Yellowknife, all inpatient services are accessed in Yellowknife.
- Fort Simpson has limited capacity to maintain emergency patients. Patients are usually transferred to Hay River or Yellowknife for services.
- Hay River, Fort Smith, Inuvik, and Stanton have clinics to provide services to residents along with inpatient services available in health care facilities.
- Inuvik and Stanton are the only two centres that provide obstetrical services. All residents access obstetrical services in these two centres.
- Stanton provides full surgical services. Limited surgical procedures are provided in Hay River. Inuvik has a general surgeon and general anesthetist to provide some surgical procedures.
- In some larger communities, dental services are available from private local dental clinics, with dentists and dental hygienists providing services to children and adults. As well, some larger communities have dental therapy services provided in the schools. Orthodontic services are available at the regional level, normally on a visiting basis. Dental and orthodontic services are not insured services.
- Some dental surgery is available in Hay River, Inuvik, and Yellowknife.
- Medical social workers (currently at Stanton and Inuvik) usually provide services within the hospital setting. Services may include discharge planning, case management, crisis intervention, psychosocial assessments, and group therapy.

Services provided at a territorial level:

- Specialists' services are provided through the territorial referral centre. Specialists travel to Fort Smith, Hay River, Fort Simpson, Inuvik (and the Kitikmeot region of Nunavut), to provide on-site travel clinics.
- Contracts have been established with various sub-specialists to provide travel services to Yellowknife. Residents from community and regional centres will access the service in Yellowknife.
- Professional nursing staff, family practice physicians, and various specialists provide assessment and treatment services in a facility. Specialized services include intensive care services, all phases of obstetrical care, psychiatrist services, and various specialized surgical procedures.

Services provided out-of-territories:

- Residents will be referred to southern jurisdictions for various sub-specialty services. These services include vascular surgery, neurosurgery, advanced cardiology, high-risk pregnancies, gastro-enterology, specialized psychiatry and intensive neo-natal care.
- Chemotherapy and dialysis protocols are established in southern jurisdictions, with some treatment provided at the territorial level.

Current Service Delivery Challenges

Some of the challenges listed below may be common to all the core service areas of this service delivery model. However, they are of particular concern in the move toward the vision and preferred future for diagnostic and curative services.

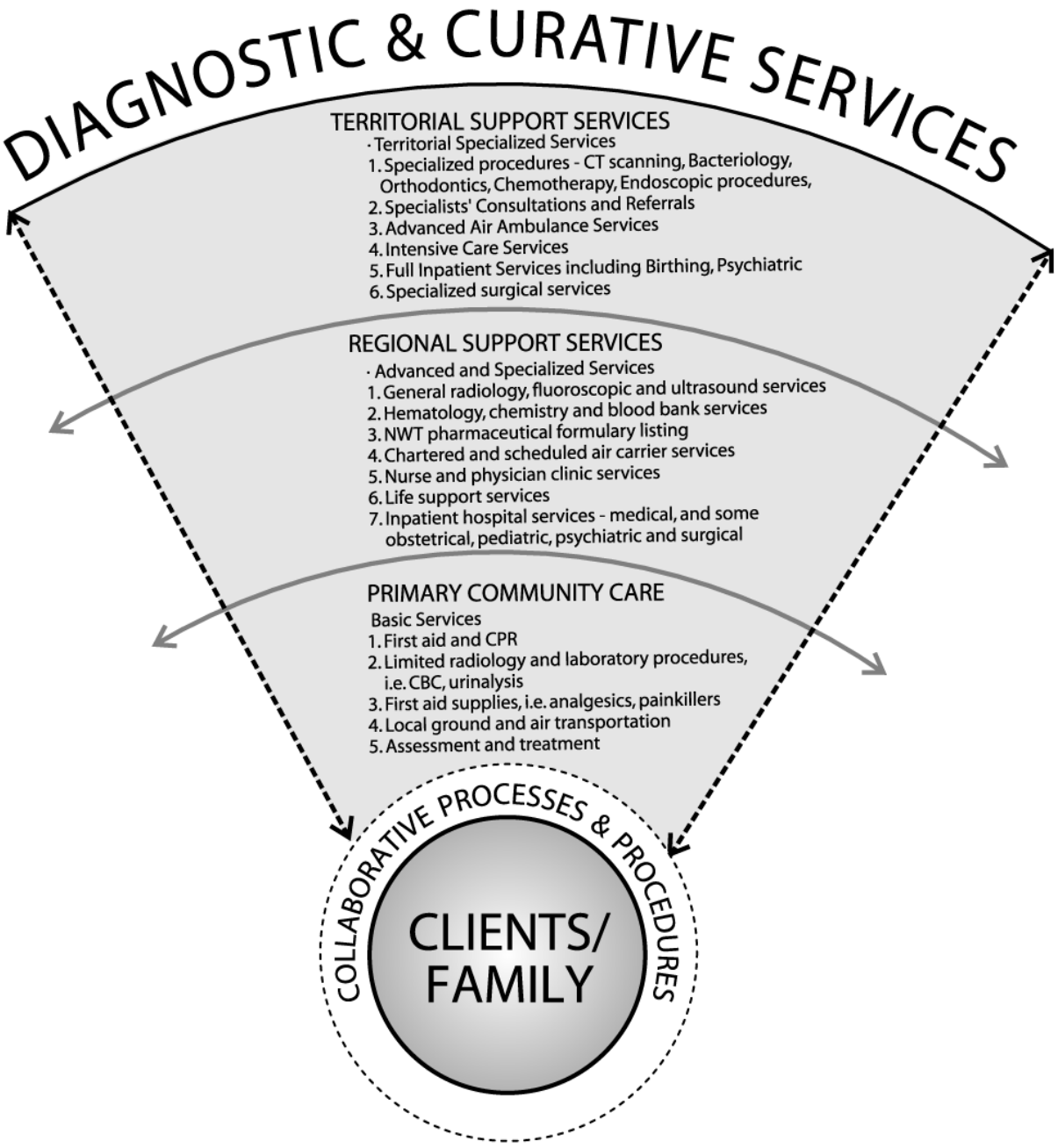
- It is difficult to recruit and retain key personnel for the system. This includes doctors, nurses, and a variety of allied health and social service professionals.
- It is important to ensure that PCC teams work in an integrated and collaborative manner with regional and territorial support teams. This will require a paradigm shift in philosophy and attitude to be successful. Indeed, without a significant measure of success in this area, there will be little progress toward making the integrated service delivery model a reality for clients and their families.
- The responsibility of the individual in maintaining health and well being is another critical challenge. Strategies will need to be deployed that move public thinking toward a wellness model and away from a largely illness-based model.
- Funding the system will continue as an enduring challenge well into the future. The existing system is already overwrought. The enhancements contemplated to move service delivery toward the preferred future will further tax an overburdened system.
- Supporting the service providers in their work to deliver quality and consistent services is another challenge. It will be essential to ensure that the necessary tools, equipment, infrastructure, training, maintenance, and repair is in place or accessible in a timely manner.
- Addressing public attitude and perception regarding services that are being pushed down to the community level and delivered by community- and/or regionally-based service providers will be an initial challenge at the very least. Will people see this move as an improvement in the level and quality of care or as an erosion of existing levels of quality care at the territorial and out-of-territorial levels?
- Additional pressures will be placed on the system as non-renewable resources and other economic development continues to grow at significant rates in the NWT. All this adds pressure to an already overstressed system.
- Self-government for Aboriginal peoples in the NWT will also bring challenges in the health and social sector.

Diagnostic and Curative Services within an Integrated Service Delivery System

Figure 3 illustrates the diagnostic and curative services that are provided at the community, regional, and territorial levels. In most cases, residents are able to access basic services in their home community. However, in communities with a small population, limited services may be provided and residents may have to travel to larger communities to access the services they require. As communities increase in population size, more basic services may be available and also more advanced and specialized services may be available. Regional centres provide a wide range of services to a defined area and provide the support structure for smaller communities. The territorial centre provides more specialized services to support the community health nurse, nurse practitioners and family practice physicians. The ISDM ensures that access to services within all communities is clearly defined.

Diagnostic and curative services form only one component of the ISDM. It is imperative to link diagnostic and curative services with the other core services to ensure residents have access to a complete range of health and social services.

Figure 3: Diagnostic and Curative Services within an Integrated Service Delivery System



Enhancing Diagnostic and Curative Services

The Department is committed to improving access to diagnostic and curative services:

- at the community level through enhancements to the primary community service team;
- at the regional level through collaborative practice networks;
- at the territorial level through enhancements to Stanton Territorial Hospital; and
- out of territories through contractual agreements with tertiary and specialized services.

At all levels, enhancements will be augmented through the use of telehealth and other technologies, such as a 1-800 call centre.

The following types of enhancements are being proposed.

General Enhancements

- establish staffing mix and staffing levels to meet client needs;
- provide for competency-based training and continuing education for all providers;
- establish health centre operations' managers separate from clinical supervisors;
- establish telehealth links in all community health centres;
- establish a 1-800 call centre;
- ensure adequate funding is on-going for the purchase and maintenance of up-to-date tools and equipment required to provide quality core services; and
- establish a financially-resourced inventory management process for maintaining tools and equipment.

Enhancing Diagnostic Services

- ensure appropriately trained personnel for diagnostic services at community, regional, and territorial levels (e.g., certified lay radiology workers, certified combined technicians, certified laboratory technologists, etc.);
- develop an NWT formulary for prescribers that is regularly updated (with separate schedules applicable for health centres, hospitals, and Supplementary Health Benefits);
- collaborative service networks for all diagnostic services; and
- increase Radiologist services at the territorial level to increase coverage and reduce on-call for the existing radiologist.

Enhancing Medical Travel

- Maintain an NWT-wide contract for medevac services
- Ensure scheduled airline service continues to smaller communities

- Increase staffing to improve communication between providers, for clients on medical travel. The client's PCC team will be advised on a daily basis of the client's status, including clinical updates, discharge, and follow-up (if required) for clients who have traveled:
  a) south to an Edmonton hospital, provided by Northern Health Services Network in Edmonton;
  b) south to a provider outside of an Edmonton hospital setting, provided by the NWT Medical Travel Unit;
  c) within the NWT to a provider outside of a hospital setting, provided by the NWT Medical Travel Unit; and
  d) to an NWT hospital - by the Hospital's Medical Social Worker.

Enhancing Treatment Services

Dental:

- locate dental therapist positions in all communities over 700 population where there is no dentist. These dental therapists will provide diagnosis and basic treatment for all preschool and school-aged children (see also the Promotion and Prevention Chapter); and
- encourage dentists to maintain service in larger communities. Although dentist services are not a core service, it is recognized that without the private sector service providers there would not be accessible dental treatment for all residents of the NWT.

Medical, Surgical, Paediatric, Obstetrical:

- enhance competencies of all providers at all levels through training programs (e.g. lay dispenser or community health workers, ICU nurses, obstetrics nurses, community health representatives, nurse practitioners, GP specialists, medical social workers, etc.);
- establish nurse practitioner positions in all communities and facilities where appropriate;
- ensure physician services are available to all communities by an on-site or visiting physician;
- ensure recruitment and succession planning for special skills family physicians to provide obstetrics and gynecology, anaesthesia, and general surgery in hospitals;
- ensure recruitment and succession planning for physician specialist at the territorial level to provide obstetrics and gynecology, anaesthesia, general surgery, internal medicine, paediatrics on a 24/7 basis;
- establish sustainable regional birthing services using multi-disciplinary staffing models including midwives; and
- expand telehealth for consultation and support at all levels.

Psychiatry (linked closely to Mental Health and Addictions):

- increase access to psychiatric services; and
- expand use of tele-psychiatric consultation and assessment to all community health centres.

Medical Social Work:

- establish medical social work positions in all communities with hospitals to enhance capacity for psycho-social assessments, individual and family psychotherapy, crisis intervention, and grief counselling; and
- coordinate discharge planning protocol at community, regional, and territorial levels.

Managing the Required Systems Change

As implementation of the ISDM occurs, community service providers will function as members of a PCC team. This will present certain challenges as many individuals currently providing services work in isolation of each other. While it is clearly recognized that integrated services delivery is beneficial, it has been the experience in other jurisdictions that it is not easy to achieve.

Knowing your colleagues is a fundamental precursor to being able to work together. The individuals making up the PCC team must have their roles and responsibilities clearly defined. Team building exercises will be vital. The team's physical space must be designed and adapted to fit the team, not the team to the physical space.

PCC teams provide an opportunity to better service clients through an integrated case management approach. Access and quality of services to clients will increase significantly with qualified providers, articulated roles and responsibilities, clinical supervision, and an integrated team of providers. These teams are able to refer to regional and territorial levels for expertise and specialized services.

Confidentiality policies to be used by the enhanced PCC team must be developed immediately. They must deal with the exchange of information internally (between team members) as well as externally (outside the team). Moreover, the confidentiality model must take into account current legislation (duty to report) and professional standards.

During the first years of implementation, each of the HSS Authorities will be facing several years of transition, as they must plan for the new positions and new funding coming into the system over the course of the next several years. HSS Authority transitional plans will be significant during these first years of implementation and will also be tailored to each region.

Current staff will have the opportunity to receive the certification and/or training required to develop their skills, to ensure all staff are incorporating best practices into the care provided. Job descriptions will be modified to address any new qualifications and responsibilities and will be salaried according to the job evaluation criteria.

Recruiting and retaining all service providers will be challenging. It will be necessary to partner with programs such as the GNWT's Maximizing Northern Employment initiative and Employee Education Assistance program and with agencies such as Aurora College. Salaries and benefits must be competitive with other jurisdictions.

Although there will no longer be sole providers, it is imperative that staffing vacancies are filled as soon as possible. To ensure staff are supported and do not burn out when a position is vacant, management must not delay filling the vacancy. Whenever possible, a "pool" of professionals that may be available on a temporary, as-needed basis, should fill vacancies until the competition process is completed.

Budgets for tools and equipment must be secured for that purpose only and not lost within the system. Authorities must develop short-term and long-term planning to ensure facilities have up-to-date, well-maintained equipment to provide quality services.

Establishing Immediate Priorities

Diagnostic and curative services provide a full range of primary, secondary and tertiary care services for all residents of the NWT through assessment and treatment. It is necessary to ensure that appropriate and capable caregivers are providing residents with the most suitable service either at the community level, or, where services cannot be provided locally, through timely referral to the right provider. It is imperative to provide services through a team-centered approach. Service caregivers must work together to provide holistic care to all residents in an integrated, collaborative manner.

The following priorities are aimed at enhancing, strengthening, and rationalizing diagnostic and curative service delivery throughout the territories and ensuring that this service is linked and coordinated with other core service delivery areas.

1. develop a long range equipment and tools plan, including a replacement (evergreening) schedule, standardization of equipment found in the various facilities and a schedule ensuring all equipment and tools are maintained to the industry standard;

2. increase telehealth usage and integration into the system which will expand the outreach support to communities; and

3. develop a rationalization plan for the number of hospitals found in the NWT, including location and total number of types of beds.

Rehabilitation Services

Defining Rehabilitation Services

Rehabilitation services help to improve and maintain the functional independence of clients with impairment from injury, chronic disorder, or disability. In addition to improving an individual's quality of life, rehabilitation services are an effective way of reducing the demands of family and publicly-funded support systems. Services are provided in a range of settings, including the home and health services agencies, and can be seen as including assessment, treatment, intervention, and education.

Treatment refers to direct hands-on treatment by a trained professional while intervention refers to patient care that is not directly with the client, such as program development or meeting with teachers or caregivers.

Examples of Rehabilitation Services

There are four main types of rehabilitation services.

- Physiotherapy – Provides assessment, maintenance, and restoration of the body's physical function and performance.
- Occupational Therapy – Provides service to clients with physical, cognitive, sensory, developmental and/or psychosocial disabilities to master the skills needed for optimum independence.
- Speech Language Pathology – Helps individuals to overcome and prevent communication problems in language, speech, voice, and fluency.
- Audiology – Provides early detection and evaluation of hearing loss and recommends appropriate treatment.

One individual may require a full spectrum of rehabilitation management while others may require treatment from one specific discipline.

Levels of Rehabilitation Services

Rehabilitation services are primarily coordinated through hospital-based professional teams. At the community level, hospital-based support teams will provide assessment, intervention, and education. Aftercare may be also available at the community level through paraprofessionals and linkages with continuing care personnel.

A full compliment of acute and non-acute rehabilitation treatment services can be accessed at regional or territorial hospitals or other designated centres. While some therapists may be dedicated to inpatient duties within the hospital, the majority of the service is non-acute, often in an outpatient setting. Where the needs of the client cannot be met in the NWT, services will be accessed out-of-territory.

The Vision for Rehabilitation Services

Clients will maximize their functional abilities, minimize the impact of their impairment, and maintain a healthy, independent lifestyle.

Preferred Future

From a broad perspective, rehabilitation program and resource decisions should be based on the concept of maximizing the return to independence across the system. The preferred future for rehabilitation services would include rationalizing and extending community coverage.

The preferred future would see teams of rehabilitation professionals clustered in three locations: Hay River, Inuvik, and Yellowknife. These teams would provide services to designated communities. Additionally, Stanton Territorial Hospital would provide some specialized rehabilitation services to clients from across the NWT and refer out-of-territory to a specialized rehabilitation centre for individuals that have experienced a severe stroke, brain injury, or other debilitating condition. Follow up in communities would be available through trained health care workers from the health centre. Some services would be provided through home care as well as in long-term care facilities as required.

Establishing linkages and collaborative practice with other GNWT departments in terms of service delivery in this area will be important to successful implementation. One example would be rehabilitation staff and schools working together in the area of special needs for children.

Expected Outcomes

The projected outcomes of the delivery approach noted above are as follows.

Community Coverage:

- everyone is entitled to rehabilitation services to address acute or severe conditions;
- everyone in a community with a hospital will have timely access to a full range of rehabilitation services;
- everyone within a three hour driving time to a hospital community has access to a full range of rehabilitation services by driving to a hospital community;
- communities without effective road access to a hospital community are serviced by a rehabilitation team based at a regional or territorial hospital;
- the use of telehealth is maximized and promoted; and
- the frequency of visits by rehabilitation teams is dependent on community size and other factors.

Integrating Travel and Telehealth:

- visits to outreach communities are provided by a therapist once every six months;

- the therapist uses telehealth halfway between visits to check in on progress.
- the rehabilitation aide meets with the client and connects with the rehabilitation specialist by telehealth each month. The rehabilitation specialist will assess and review progress and techniques used by the rehabilitation aide and provide guidance for further program enhancements or changes;
- the integration of travel and telehealth services is a routine operation;
- professionals have more frequent contact with clients and community support workers;
- there is closer supervision and support for community based service providers; and
- there is increased education and awareness of rehabilitation issues.

Integration with Other Programs and Initiatives:

- there is greater integration of rehabilitation programming within selected GNWT programs, such a long term care facilities;
- home care workers deliver a subset of occupational therapy and physiotherapy services;
- community rehabilitation aides address developmental and language delays in early childhood;
- therapists work directly with the school system;
- rehabilitation aides are funded from several sources, such as the school system and the *Early Childhood Development Initiative*;
- rehabilitation services maximize integration and collaboration with other related programs and initiatives, particularly:
    - continuing care services (homecare, supported living, long term care);
    - mental health and addictions services;
    - *Early Childhood Development Initiative*;
    - *Healthy Children's Initiative*;
    - *Senior's Action Plan*;
    - *NWT Disability Framework*; and
    - schools.

Staffing Clusters:

- staffing clusters are consolidated in Inuvik, Yellowknife, and south of the lake;
- there is a low turnover of sole-charge therapists, reducing disruptions of client services due to lack of coverage;
- coverage, cross consultations, and problem solving are all facilitated within the staffing clusters;
- few interruptions in service provision occur;
- support staff and equipment needs are met due to the critical mass of activity available to support these services and expenditures;
- therapists' time is utilized more efficiently through group programming; and

- effective working groups allow for rehabilitation employment opportunities for northerners.

Community Rehabilitation Services:

Support to community-based clients and support workers to ensure that:

- home support workers are trained in a subset of occupational therapy / physiotherapy to assist in meeting the physical needs of adults;
- 20 new community rehabilitation aide positions are created and these aides are trained in a subset of occupational therapy and speech language pathology to assist in meeting the cognitive and behavioural developmental needs of children; and
- regular contact with regional rehabilitation clusters is possible through integrated travel and telehealth programming.

Access, Funding, and Management:

- a private sector clinic in the NWT is established to allow timely client access to services;
- stakeholders participate in a coordinated and systematic use of third party funding -- such as the First Nations and Inuit Community and Home Care Program, *Early Childhood Development Initiative*, and school and education partnerships;
- someone is tasked with the ongoing development of the rehabilitation system in the NWT;
- a NWT rehabilitation steering committee is established;
- a project manager is tasked to implement improvements; and
- a new information management system is implemented.

Assessing the Current Rehabilitation Service Delivery System

Currently, seven health and social services (HSS) authorities have the responsibility of providing rehabilitation services to their constituent populations. Only four of these authorities actually provide rehabilitation services, and only one health authority (Stanton) provides all four primary rehabilitation services.

There are 33 funded positions devoted specifically to the NWT's rehabilitation needs. There are 20 therapists currently working at the NWT's three hospitals: Yellowknife (15), Inuvik (4), Hay River (1). The annual budget of $2.5 million is used primarily for staffing and all but $30,000 comes from GNWT core funding.

Staffing

Table 1 provides an overview of current staffing levels in the NWT (including funded positions if a vacancy exists).

Table 1: Staffed Rehabilitation Positions (as of June, 2002)[5]

Authority	PT	OT	SLP	AUD	PT Aid	OT Aid	SLP Aid	Clerical	Manager	Total
Inuvik										
Staffed	2.0	1.0	1.0		1.5		1.0	0.5		7.0
Funded	2.0	1.0	1.0		1.5		1.0	0.5		7.0
Stanton*										
Staffed	5.0	4.8	4.5	1.0		0.5		3.0	1.0	19.8
Funded	5.3	4.8	4.5	2.0		0.5		3.0	1.0	21.1
Hay River										
Staffed		1.0								1.0
Funded	1.0	1.0	1.0							3.0
Ft. Smith										
Staffed					1.0					1.0
Funded	1.0				1.0					2.0
Yellowknife										
Staffed		0.5								0.5
Funded	0.5	0.5								1.0
Total										
Staffed	7.0	7.3	5.5	1.0	2.5	0.5	1.0	3.5	1.0	29.3
Funded	9.8	7.3	6.5	2.0	2.5	0.5	1.0	3.5	1.0	34.1

* Stanton position information reflects service delivery for NWT residents. It does not include staffing resources to service the Kitikmeot region of Nunavut.

Facilities

All rehabilitation staff are located in the Yellowknife, Hay River, and Inuvik hospitals and the Ft. Smith Health Centre, except for the homecare rehabilitation staff attached to the Yellowknife HSS Authority. Space for rehabilitation services at Stanton is at capacity, with two disciplines operating off-site, which create management and logistical challenges. Inuvik will be well served for space once the new facility is completed in March 2003. Hay River and Fort Smith have an appropriate amount of space for current staffing levels.

Equipment

Current services are adequately equipped. Equipment tends to be beds, exercise equipment, treatment modalities and patient aids. In general, rehabilitation services are not capital intensive.

Access to Services

All NWT communities have access to the full range of acute (in-patient) rehabilitation services at a regional or territorial hospital, as outlined in Table 2. Generally, communities with a population of less than 125 receive services through referral to a regional or territorial hospital while communities with populations between 126 and 4000 access these services through visiting providers or at a regional or territorial hospital. Communities with hospitals have access to the full compliment of rehabilitation services. Clients within driving distance to a hospital

[5] PT=Physiotherapy; OT=Occupational Therapy; SLP=Speech Language Pathology; AUD=Audiology

may also access the full compliment of services. Access to rehabilitation services does vary among communities of similar size, however.

Small communities with the population under 250:

- receive no rehabilitation outreach services at the community level with the exception of Paulautuk, Tsiigehtchic, Sachs Harbour, and Colville Lake who are serviced by Inuvik physiotherapy, occupational therapy and speech language pathology.

Communities with the population between 251-1000:

- receive physiotherapy services except, Lutselk'e, Ft. Liard, Ft. Providence, Ft. Resolution and Wha Ti.
- receive occupational therapy services except Lutselk'e, Ft. Liard, Ft. Providence and Ft. Resolution.
- receive speech language pathology services except Lutselk'e and Ft. Liard.
- audiology travels to Holman from Stanton.

Communities with the population greater than 1001:

- receive occupational therapy, physiotherapy and speech language pathology on a full time basis with the exception of Ft. Smith, Ft. Simpson and Rae Edzo;
- Ft. Smith receives outreach services from all four rehabilitation disciplines except Physiotherapy;
- Ft. Simpson receives outreach services from all four rehabilitation disciplines;
- Rae Edzo receives outreach services from all rehabilitation disciplines except Audiology; and
- audiologist travels to Hay River and Inuvik from Stanton.

Outreach services primarily consist of assessment and recommendations for intervention. There is little to no opportunity for direct treatment. A physician's referral is required for occupational therapy or physiotherapy outpatient treatment. Other clients may access services directly or through parents, teachers, or community health staff.

Services available outside of the NWT through the Capital Health Authority include:

- intensive neurological rehabilitation for stroke, spinal cord and head injury clients;
- neurological developmental diagnostics for preschool and school age children;
- specialized seating clinics;
- swallowing assessments; and
- driver evaluation and training.

Table 2: Community Coverage (as of June 30, 2002)

	PT	OT	SLP	AUD	Population	%
Stanton						
Yellowknife					18,231	43.3%
Rae Edzo					1,864	4.4%
Wha Ti					476	1.1%
Rae Lakes					278	0.7%
Wekweti					154	0.4%
Other					153	0.4%
					21,156	**50.3%**
Inuvik						
Inuvik					3,451	8.2%
Tuktoyaktuk					979	2.3%
Ft McPherson					910	2.2%
Aklavik					748	1.8%
Holman					470	1.1%
Paulatuk					323	0.8%
Tsiigehtchic					195	0.5%
Sachs Harbour					153	0.4%
					7,229	**17.2%**
YKHSS						
Yellowknife						
Ft Resolution					562	1.3%
Lutsel K'e					377	0.9%
					939	**2.2%**
Sahtu						
Norman Wells					882	2.1%
Ft Good Hope					747	1.8%
Deline					645	1.5%
Tulita					506	1.2%
Colville Lake					96	0.2%
					2,876	**6.8%**
Hay River						
Hay River					3,835	9.1%
Enterprise					88	0.2%
					3,923	**9.3%**
Ft Smith						
Ft Smith					**2,625**	**6.2%**
Deh Cho						
Ft Simpson					1,273	3.0%
Ft Providence					837	2.0%
Ft Liard					524	1.2%
Hay River Res.					268	0.6%
Wrigley					183	0.4%
Nahannie Butte					82	0.2%
Trout Lake					68	0.2%
Kakisa					50	0.1%
Jean Marie					50	0.1%
					3,335	**7.9%**
Total NWT					**42,083**	**100.0%**

Key
Fort Smith
Hay River
Inuvik
Stanton
YKHSS

Scope of Practice

Table 3 illustrates the range of rehabilitation services available to NWT residents.

Table 3: Scope of Practice

Discipline	Offered as of June 30, 2002	Offered in NWT on limited basis	Not Currently Offered in NWT
PT	- Adult in-patient: post stroke, orthopedics (fractures, post surgical), cardio-respiratory, general medicine (elderly). - Adult outpatient: orthopedics, pain management, custom knee braces, home care, managing other chronic conditions.	- Pediatrics - Cardiac rehabilitation (inpatient only) - Long term care (mobilization, exercise) - Neuro rehabilitation (head, spinal injuries) - Acupuncture - Home visits	- Cardiac rehabilitation* (out-patient) - Work conditioning and/or hardening* (preparing to return to work) - Intensive rehabilitation (post stroke, injury) are sent to Edmonton
OT	- Adult in-patient: ADL assessments, general medicine, acute neuro and LTC. - Adult outpatient: rheumatology, splinting, orthotics, pressure garments, vascular assessments, custom neck collars, other chronic conditions, home care. - Paediatrics: sensory-motor, development, school-related function, self-care.	- Ergonomic assessments - Seating assessments (e.g. wheelchairs) - Neuro rehabilitation (head, spinal injuries) - Cardiac rehabilitation (inpt. Only) - Home visits	- Mental health assistance * - Cognitive rehabilitation, acute neuro - Work conditioning and/or hardening* - Functional capacity evaluations - Swallowing assessment
SLP	Articulation (sounds); Language (receptive and expressive); Voice, pragmatics; Apraxia (motor programming); Dysarthria (motor speech); Listening attention (w/OT and psych)	- Stuttering (child only) - Swallowing (Inuvik only) - Neuro rehabilitation (head, spinal injuries) - Prevention and promotion - Augmentative communication	- Fluency treatment - Aural rehabilitation (use of residual hearing) - Intensive stuttering program (adult) - Intensive resonance (cleft palate) - Swallowing assessment (outside of Inuvik)
AUD	Audiological assessments (tone conduction); Speech audiometry; Tympanometry; Visual Reinforcement Audiometry (VRA); Distortion Product Otoacoustic Emissions; Auditory Brainstem Response (ABR); Central Auditory Processing (CAP); Electronystagmography (ENG); hearing aid prescription; dispensing counselling; education; school support; Aural rehabilitation (use of residual hearing).	- Education re: hearing conservation (group) - Fitting/adjustment of hearing aids for community clients	- Aural rehabilitation (speech reading) - Cochlear implant mapping - Inter-operative monitoring

*May be able to offer a limited service in NWT with additional resources.

Current Service Delivery Challenges

Rehabilitation challenges are primarily associated with demand, coverage, communications, child development, and referral, although a few other types and challenges also exist.

Latent Demand, Waiting Lists, and Caseloads

- unmet needs for paediatric services;
- latent demand for physiotherapy in Yellowknife (physician estimates indicate potentially 3,000 un-referred cases annually) and speech language pathology services in all regions;
- excessive waiting lists in all disciplines in Yellowknife; speech language pathology in Hay River (as of June 2002, waiting times range from 18 – 30 weeks depending on service); and non-urgent referrals from outlying communities (may have to wait 6 – 12 months to be assessed by outreach therapist);
- huge caseloads for therapists in all disciplines and all regions (the speech language pathology in Inuvik deals with 171 cases); and
- increased complexity of pediatric clients requires greater service coordination and integration.

Community Coverage

- inequity of outreach services available to communities, especially those with populations less than 350 – many communities do not receive any outreach services;
- most communities have no community support personnel to help clients follow through with program plans;
- therapists may see clients once or twice a year for assessment and design/modification of treatment plans, but very little active treatment provided;
- in some regions, outreach paediatric services may not be available depending on the skills/experience of the individual therapists; and
- in many cases, therapists are not able to appropriately monitor client progress.

Communications

- education of public and health professionals needed regarding availability, type, and benefit of rehabilitation services;
- information management, specifically the charting system, does not make it easy to share information, either between disciplines or between facilities;
- perception of occupational therapy / speech language pathology being under-referred (in some regions) due to lack of knowledge regarding the services they can provide;
- education of public regarding responsibility of the individual and family in their own treatment program and general health; and

- discharge/transfer process between facilities is too dependent on the individual therapist – we need to have a more consistent system in place to facilitate a smooth transfer of client and appropriate information.

Children with Developmental and Language Delays

- no trained support personnel in the communities to assist clients/families to follow through with treatment programs;
- speech language pathology services universally identified as a gap by stakeholders in all regions; and
- Student Support Needs Assessment (2000) – identified 900+ school age students requiring speech language pathology services (potentially an additional 400 – 500 preschool age children); 250+ students requiring occupational therapy; 50+ requiring physiotherapy; and only 50% of students receiving the treatment they require.

Referral Process

- inequalities with referral process, which is done differently for each discipline:
  - physiotherapy needs physician referral;
  - occupational therapy in hospital need physician referral;
  - occupational therapy (in Inuvik region) needs physician referral;
  - occupational therapy (in YK region) outside of the hospital accepts referrals from health centre staff, schools, parents, and/or families;
  - speech language pathology accepts referrals from anyone;
  - Audiology accepts referrals from anyone; and
  - Disciplines can cross-refer to another discipline, sometimes bypassing the physician referral.

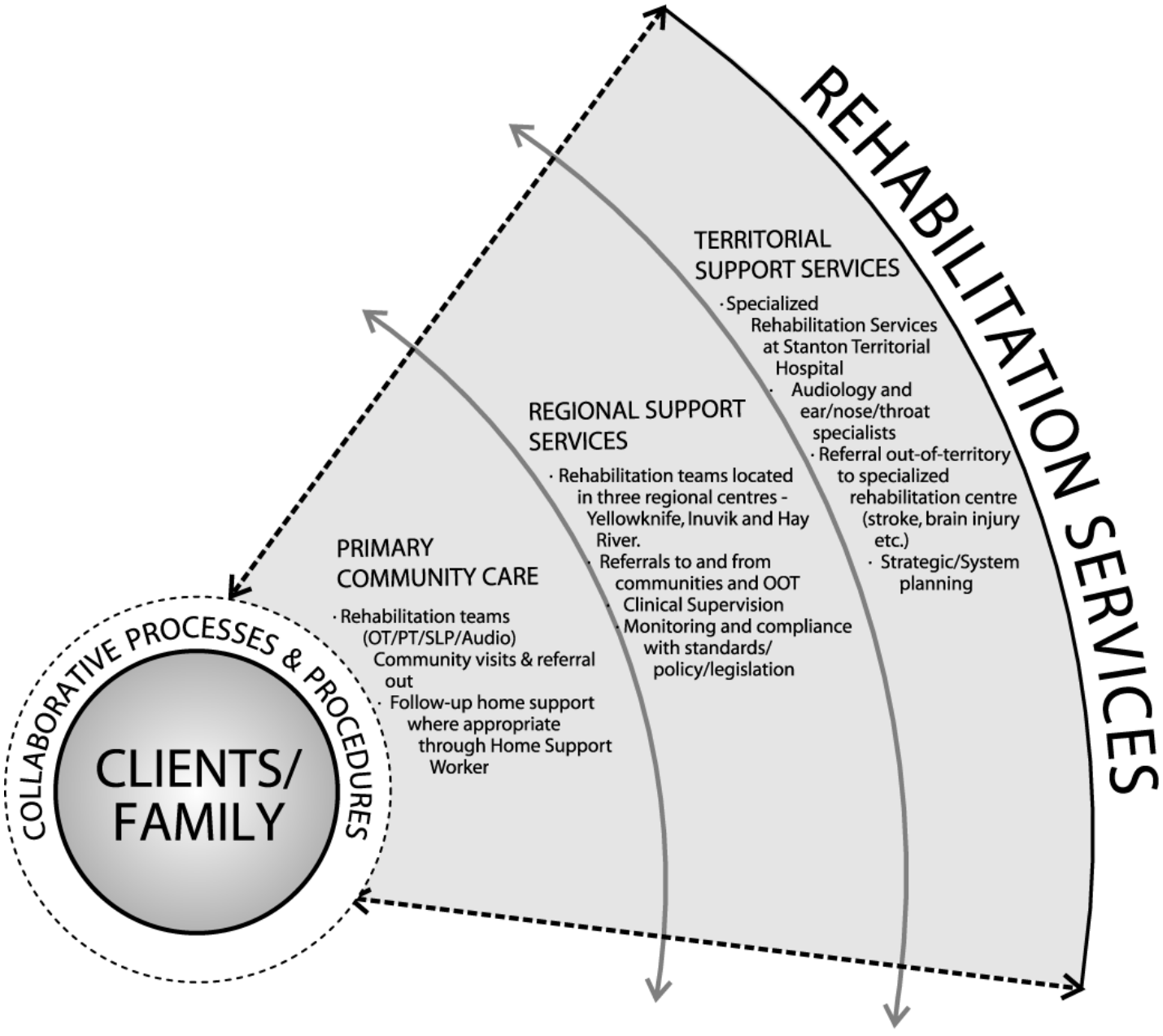
Miscellaneous

- information management system is not compatible across the HSS authorities and across disciplines;
- in hospital and community settings, there is an inconsistent use and availability of support staff (clerical, aids and assistants); and
- statistical collection system needs to be updated on a Territorial basis for the information to be more useful.

Rehabilitation Services within an Integrated Service Delivery System

Rehabilitation Services is one of six core service areas identified in the NWT ISDM. It is important that all of these services are incorporated into a system-wide service integration and collaboration system. Figure 4 presents a visual overview of the rehabilitation services that one might expect to find at the community, regional, and territorial levels within the overall ISDM system.

Figure 4: Rehabilitation Services within an Integrated Services Delivery System



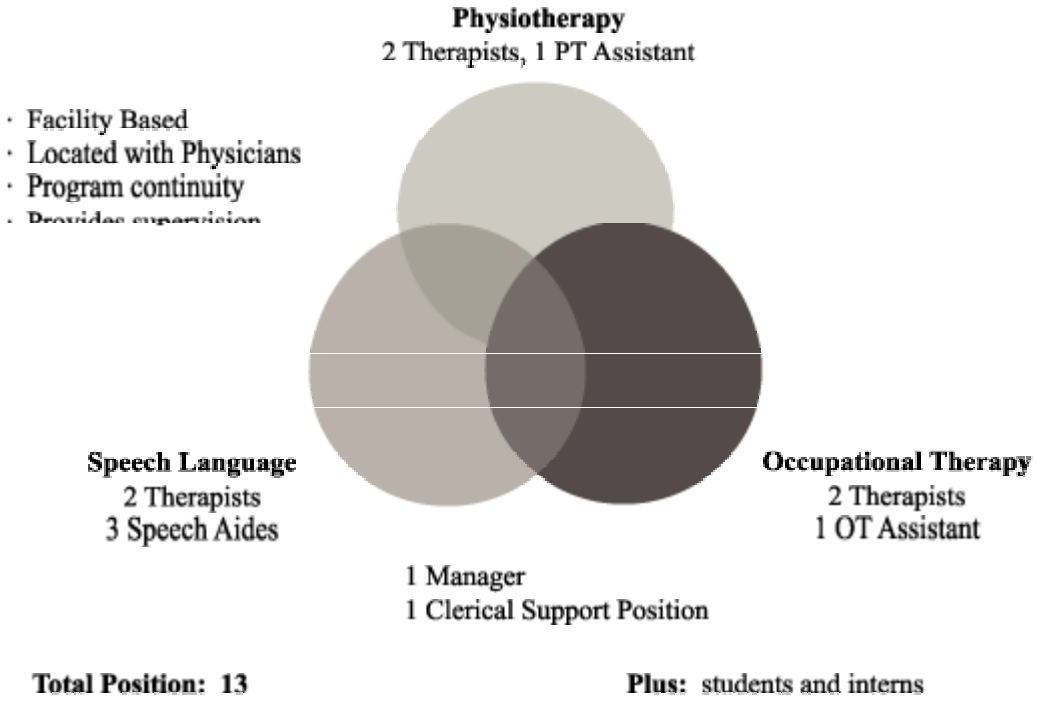
Enhancing Rehabilitation Services

The *Review of NWT Rehabilitation Services* (July 2002) provided clear direction regarding the enhancement of existing rehabilitation services. The report stresses the need to establish at least three rehabilitation staff clusters in the NWT and strengthen community-based rehabilitation support services.

Rehabilitation Staff Clusters

Figure 5 illustrates the proposed regional rehabilitation staff clusters or teams at Inuvik, Hay River, and Yellowknife:

Figure 5: Rehabilitation Staff Cluster



Four such clusters would be needed to support:

- more effective group treatment programs;
- the concepts of the *Early Childhood Development Initiative* and other departmental initiatives; and
- the integrated travel/telehealth programming described earlier.

The configuration shown in Figure 6 would be used as a minimum configuration in Inuvik and Hay River. In Yellowknife there is justification for two staff clusters. The Yellowknife, Inuvik

and Hay River clusters should be built up to the level described above first, prior to considering smaller clusters in other communities.

There is an assumption that the staff clusters, particularly the aide positions may not be wholly situated in the centre but may eventually be situated in smaller communities. In order to implement program delivery through aides situated in smaller centres, clear guidelines, program delivery restrictions and supervision are essential components of this outreach. Integrating assistants and aides into the program design enhances the working groups and creates entry points and advancement opportunities for northerners.

Along with the four rehabilitation staff clusters identified above, there is a need to include two audiologists and one audiology technician. The audiologists would be based in Yellowknife with one dedicated to provide service at Stanton Territorial Hospital and one dedicated to travelling throughout the north. The audiologist technician would work with the audiologist based at Stanton.

Community-Based Rehabilitation Services

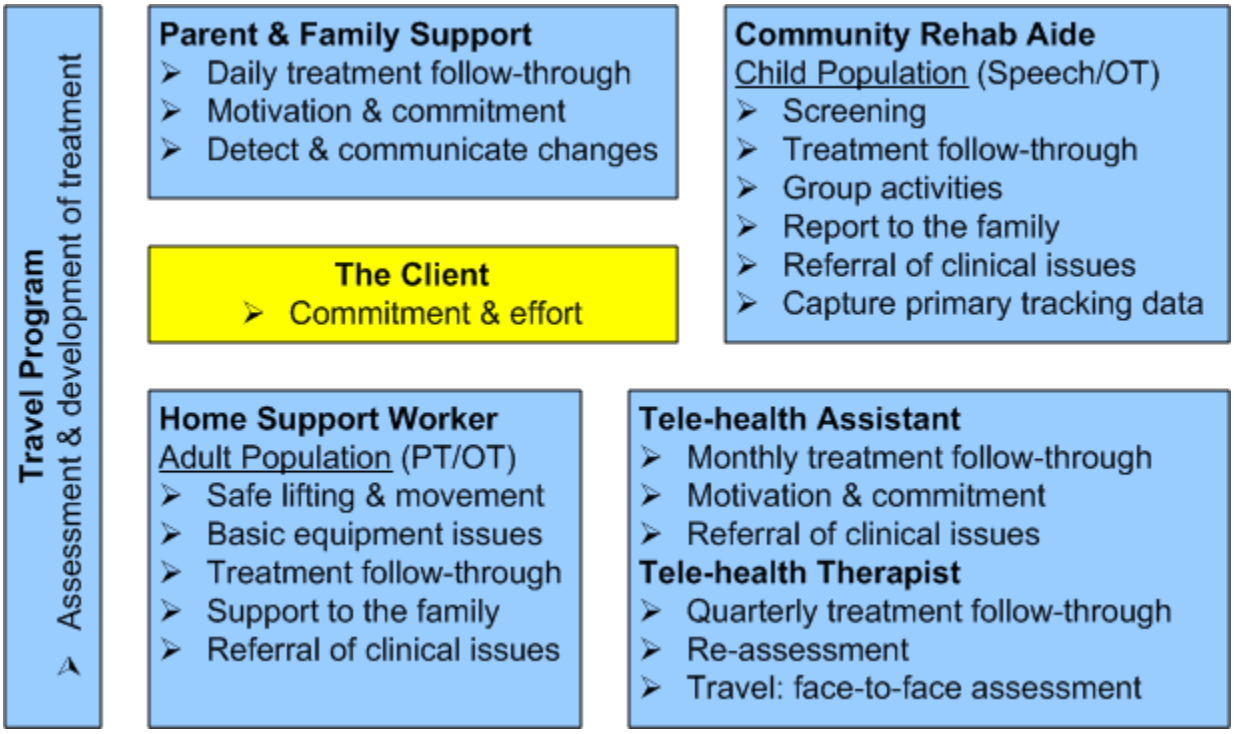
Figure 6 (next page) shows the various rehabilitation service components that can be brought to bear on the needs of community clients.

Early childhood workers and Aboriginal early childhood programs can participate in screening. They can also assist in supporting and motivating families in the treatment follow-through process, and by conducting the group interaction portions of the treatment programs. Tracking of child needs can be conducted regionally to ensure that no child with developmental delays slips through the cracks.

Figure 7 (following page) takes a more detailed look at how each rehabilitation service provider could interact with the client.

Figure 6: Community Rehabilitation Service Model

Figure 7: The Community Rehabilitation Team



Integrating Homecare Workers

The existing home support workers could be tasked with a subset of physiotherapy and occupational therapy responsibilities focused on adult and elderly clients, assisting them to be as independent as possible. Training for these responsibilities would be part of the standard homecare curriculum. Homecare workers would be instructed when to involve a physiotherapy or occupational therapy, and how to interact with regional rehabilitation staff (e.g. by mailing digital images and video clips). As needed, the homecare worker would work jointly with therapists to resolve problems such as the fit of a hearing aid or the installation of grab bars.

Homecare workers would receive problem-solving support, supervision on rehabilitation responsibilities, and education on current issues from the therapists. There would be little or no incremental cost for this integration of homecare and rehabilitation.

Utilizing Community Rehabilitation Aides

Community rehabilitation aides could be trained in a sub-set of speech and occupational therapy activities centred on cognitive, development, and behavioural issues. The focus would be on child therapy and development needs with a goal of creating more independent, higher functioning adults. An important secondary goal would be to create adults that will make fewer demands on future public services. Community aides would focus on speech and developmental therapies, and would be supervised at a regional level by the speech language pathologist. This approach will help preserve the intent of the positions in the face of a multitude of local

demands. Such an aide could be employed as a half-time position and combined with another half-time position such as teaching aide or early childhood worker. Larger communities (e.g. 1,000 people) could utilize full-time or multiple positions.

Recruiting capable individuals to fill such positions will experience the same challenges as the homecare program and some of the Aboriginal early childhood programs. It will take several attempts to hire each position and several years of persistence to build a network of competent community rehabilitation aides. Program design considerations that will help in recruiting include:

- utilizing on-the-job training, with limited time away from home, to expand the pool of interested individuals;
- providing a strong regional management function; and
- ensuring close supports and linkages to the expertise of fully-trained therapists.

There would be a substantial additional cost for community rehabilitation aides; however, some initial costs could be shared with the *Early Childhood Development Initiative*. The predominance of Aboriginal people, rural communities, and early childhood needs makes a community rehabilitation aides service an attractive partnership candidate for external funds.

Recommendations Regarding Community-Based Service Enhancement

The *Review of NWT Rehabilitation Services* offers the following key recommendations to improve support to community-based clients and support workers:

- train home support workers in a sub-set of occupational therapy and physiotherapy practices to assist in meeting the physical rehabilitation needs of adults;
- create 20 new community rehabilitation aide positions that will be trained in a sub-set of speech language pathology and occupational therapy practices to assist in meeting the cognitive and behavioural development needs of children; and
- provide regular contact with the regional rehabilitation clusters through integrated travel and telehealth programming.

To the extent that the home support workers and community rehabilitation aides utilize rehabilitation practices, they should be supervised by therapists working in the health system. The overall community rehabilitation effort should be managed through one of the few rehabilitation clusters to ensure that the desired results are being achieved.

Managing the Required Systems Change

The current service delivery model for rehabilitation services does not meet a minimum or equitable standard for the service. However, the comprehensive changes required cannot be practically implemented over a short period of time. Effective change management likely requires the following eight-year timeframe:

- changes could be implemented in the near future to rationalize community service assignments, and programming could be reorganized to better use therapist time and focus on delivering more effective rehabilitation services.
- over the next three years, increased emphasis could be put on community rehabilitation needs in order to reach a greater number of people – with the goal of providing minimum effective rehabilitation services to 95% of the population.
- in the five years following, the system would be enhanced to identify and treat all functional limitations. Community rehabilitation aides would be utilized and therapists would work directly with homecare, *Early Childhood Development Initiative*, and school programs. Therapists would work in effective clusters, with the critical mass required to obtain full value for rehabilitation expenditures.

Establishing Immediate Priorities

To enhance current rehabilitation services and ensure that these services are effectively integrated and coordinated within the HSS system, the following priority actions have been identified:

- implement and coordinate rehabilitation services from staffing clusters in Inuvik, south of the lake and Yellowknife and establish a rehabilitation steering committee to coordinate efforts between the Department and the Authorities; and
- design consistent access policies for rehabilitation services.

Protection Services

Defining Protection Services

Protection services aim to safeguard the health and well being of individuals and families.

Protection services are usually provided in the context of a legislative and/or policy framework that empower designated persons or institutions to take specific actions that are deemed necessary to protect the integrity of the person within the social context of family, culture and community. Such is the case with the Offices of the Chief Medical Health Officer, Public Guardian, Mental Health Director, Director of Child and Family Services, and the Director of Adoptions.

There are many pieces of legislation that define the parameters of the various areas within protection services. The Acts provide a framework for services in general but also have provisions that are used during critical instances. The following are the four main Acts that affect this service area.

The *Public Health Act* provides for the appointment of a Chief Medical Health Officer and the establishment of a system of public health in the NWT. This Act includes the surveillance and control of communicable diseases.

Child and Family Services Act provides the legislative framework for child protection service activities under the direction of the Director of Child and Family Services. The predominant objective of this Act is to promote the best interests, protection, and well being of children. The Act also identifies the family as the basic unit of society and its well-being should be supported and promoted.

Adoption Act: Adoption is the social, emotional, and legal process through which children who will not be raised by their birth parents become full and permanent legal members of another family. Decisions concerning the adoption of children should be made in accordance with the best interests of children, recognizing that differing cultural values and practices must be respected in those decisions.

Guardianship and Trusteeship Act: Administered jointly by the Department of Health and Social Services and the Department of Justice, this Act, in terms of guardianship, allows the court to appoint a guardian for people who can no longer care for themselves or understand the consequences of their decisions. It is designed to allow people to live as independently as possible by restricting the guardian's decision making to those areas in which the person is unable to make his/her own decisions.

Further to these Acts, the Department of Health and Social Services has developed *Family Violence Shelter Minimum Standards.* The standards contained in this document outline the expectations for what is to be delivered in shelters, not how it is to be delivered. The Department

is responsible for monitoring the Authorities to ensure that contribution agreements contain these standards and that the Authorities monitor the shelters according to these standards.

Protection services normally represent one component of a spectrum of activities within a particular program area of health or social services, and are therefore seldom, if ever, established as a stand-alone activity.

For example, public health services include five "core" areas of activity[6] that support and reinforce one another. These include:

- Health Surveillance;
- Health Promotion;
- Disease and Injury Prevention;
- Health Protection; and
- Population Health Assessment.

The *Disease Registries Act* and the *Public Health Act* provides legislative framework to carry out critical disease surveillance and health protection activities under the authority of the Disease Registrar/Chief Medical Health Officer. Those statutory roles represent the "safety net" component of a more comprehensive set of public health services that are provided as a means to improve the health status of the population as a whole.

Social Services are a continuum of services that support children, families and individuals. The *Guardianship Act* and *Child and Family Services Act* provide the legislative framework to carry out critical protection and support services to promote the best interests of the client. These include but are not limited to:

- promotion of healthy children, families and communities;
- child protection;
- voluntary services to support children, youth and families;
- crisis intervention;
- prevention;
- early intervention;
- community development; and
- education.

Authorities have strong linkages with non-government organizations (NGOs) to provide services in the area of family violence, addictions, and mental health. The social services system also has strong linkages to territorial and federal departments – such as Education, Culture and Employment; Justice; Housing; and the RCMP – to provide integrated client services across the system.

[6] *Survey of Public Health Capacity in Canada*, Report to Federal/Provincial/Territorial Deputy Ministers of Health from the Advisory Committee on Population Health, March 2001.

Examples of Protection Services

- The Public Guardian intervenes on behalf of those adults who are unable to understand the information required to make personal and health decisions or the consequences of these decisions.
- Child Protection Workers provide services to ensure the safety and protection of children and youth.
- Family violence shelters are established in communities to provide access to safe emergency placement for families.
- Environmental Health Officers monitor the quality and safety of man-made and natural environments (i.e. our drinking water or food supplies).
- Individuals appointed under the *Mental Health Act* are empowered to take action to protect and support persons who are experiencing serious mental health difficulties.

Levels of Service

As noted, Protection Services normally represent one component of a spectrum of activities within a particular program area of health or social services. The four main program areas include:

1. Public Health Protection, including Environmental Health, Communicable Disease Control, and Emergency Planning / Preparedness;
2. Child and Family Services including child protection and adoption;
3. Family Violence; and
4. Public Guardianship.

The majority of core protection services are made available in every community, large or small. Some of these will require the support of visiting professionals coming in on a scheduled or as needed basis to complement what can be done by local providers. This applies to support activities related to the control of an infectious disease outbreak, monitoring of drinking water quality, issuing health advisories through the Office of the Chief Medical Health Officer, conducting investigations under the authority of the Director of Child and Family Services, etc.

Occasionally, protection services may require a referral to a larger community if local resources are not available. Family members may be temporarily sent to another community to access a safe shelter. A person newly diagnosed with TB may be required to go to a hospital with an appropriate isolation room for initial assessment and treatment.

Commonalties within the Protection Services Delivery System

Protection services safeguard the public. Although these services are provided through a variety of specific service areas, it is important to identify the common areas within this system. These include:

- emergency preparedness;
- support areas - working together such as the Public Guardian working with the Mental Health Director;
- protection areas - child and family services staff working with other service areas to ensure the safety of the children and their families;
- links with other core services such as promotion and prevention (e.g. immunizations);
- orientation tools for primary care providers; and
- cluster of professionals who support front-line workers (regional and territorial support teams).

The Vision for Protective Services

Families, children, and individuals live in a safe and nurturing environment.

Preferred Future

Protective services should use the least intrusive measures to ensure the safety and well being of children, families and individuals. Integrated procedures will have an emphasis on family support that takes into account a system that ensures its' providers have knowledge and understanding of core services. This will enhance the ability to provide a more coordinated approach.

In the ISDM, which is based on the PCC philosophy, service providers understand their roles and responsibilities and respect that of others. This is accomplished through collaborative practice protocols and service networks. These protocols and collaborative service networks encourage communication between the various service providers to better meet the needs of the client. Protocols and collaborative service networks are established at the community, regional, territorial, and corporate service levels as well as across the continuum of providers – including other territorial and federal government departments, NGOs, and professional organizations. This provides seamless, cross-disciplinary, service delivery throughout the system with the end result being integrated service delivery.

Expected Outcomes

Public Health:

- there will be decreased incidence of preventable illness;
- the health care system will be more sustainable;
- greater capacity to deal with emerging public health threats will exist; and
- increased job satisfaction and stability will enhance the ability to recruit public health personnel.

Child and Family Services:

- the working partnership between clients, their families, service providers, and government to plan, develop and deliver services will be enhanced resulting in increased stability for children and their families;
- greater capacity to deal with emerging child protection issues will exist;
- a more integrated, coordinated system between service delivery providers will allow for prevention and intervention case plans prior to the emergence of child protection concerns;
- communities will be supported in their efforts to develop community based programs that address the needs of vulnerable children and their families; and
- there will be an increased focus on the needs and best interests of children when developing an integrated case plan.

Family Violence:

- changes to the system will provide more appropriate access for clients;
- the system will be better coordinated amongst and between the shelters and Authorities;
- the working partnership between clients, their families, service providers, and government to plan, develop and deliver services will be enhanced; and
- communities and families will be supported in their efforts to maintain balance in their lives while providing care for vulnerable community and family members.

Guardianship:

- a more integrated, coordinated service between Long Term Care and the Public Guardian will allow for guardianship care plans for represented persons to be in place prior to the Guardianship Order being granted.

Assessing the Current Protection Service Delivery System

As noted, the protection system includes four main areas. There is some degree of overlap between the areas noted (Public Health, Child and Family Services, Family Violence, and Guardianship), as well as across the five other core service areas that have been defined by the Department. The current services available for each of the four protection areas are noted separately for ease of presentation.

Health Protection

In this document, the term "health protection" refers to programs and activities that aim to protect NWT residents against health risks and hazards. Research (providing evidence), surveillance (monitoring and forecasting health trends, particularly preventable disease conditions), risk management (assessing and responding to health risks), and program development (taking action) form the basis of health protection activities. As mentioned earlier,

these form part of a greater "public health" continuum that also includes health promotion and disease or injury prevention activities.

Health protection programs and services are often associated with a core group of specialized health professionals such as medical health officers, environmental health officers, public health nurses, and disease control specialists, with the support of epidemiologists and other officers. However, particularly in the context of the NWT, it should be noted that many health protection activities must be done through community health nurses, community health representatives and other members of PCC teams, under the guidance of those more specialized resources located at the regional or territorial levels.

Medical Health Officers

Medical Health Officers are physicians who have obtained additional training in the field of public health and have been appointed to this function under the *Public Health Act*. This additional training can be obtained through a variety of Diploma or Masters level programs. However, in Canada, a majority of Medical Health Officers have completed a 4-year specialty program in community medicine. Community medicine is that branch of medicine concerned with the health of populations. The community medicine specialist uses population health knowledge and skills to play leading and collaborative roles in the maintenance and improvement of the health and well-being of the community. Through inter-disciplinary and inter-sectoral partnerships, the community medicine specialist measures the health needs of populations and develops strategies for improving health and well-being, through health promotion, disease prevention and health protection. The community medicine specialist demonstrates skills in public health leadership, development of public policy, and the design, implementation and evaluation of health programs, which are applied to a broad range of community health issues.

The community medicine specialist can engage in a number of activities, such as:

- the planning and administration of health services, whether in institutions or in government;
- community-oriented clinical practice, with particular emphasis on health promotion, disease prevention and health protection;
- the assessment and control of occupational and environmental health problems; and
- teaching and research.

There are currently three established Medical Health Officer positions in the NWT, including that of the Chief Medical Health Officer with the Department of Health and Social Services and two regional Medical Health Officers, one with the Inuvik Regional Health and Social Services Authority, which has been vacant since August 2001, and the other with Stanton Territorial Health Authority, which was staffed in the fall of 2003.

Environmental Health Services

Environmental Health Services is a vital component of the public health system. The role of the Environmental Health Officers within this service includes preventing disease and injury,

promoting health, and improving the environment through the use of education, consultation, inspection, monitoring and if necessary, by the enforcement of public health legislation. Environmental Health Officers have a statutory obligation to enforce public health legislation dealing with environmental health issues such as safe water, safe food, safe waste disposal, air quality, safe housing, and communicable disease control including enteric disease investigation and outbreak control and vector related diseases such as rabies or West Nile Virus. They are also involved in recreational water safety (e.g. safe swimming pools or public beaches), tobacco enforcement such as tax collection, and contaminants review. Injury prevention, disaster preparedness, personal services, community and environmental sanitation, and education and promotion also fall under the services provided through the Environmental Health area.

These activities are carried out through federal and/or territorial working groups that establish standards, policies and procedures that are to be adhered to. Environmental Health Officers are directly involved in testing, monitoring, public education, and awareness.

Currently, there are seven Environmental Health Officer positions in the NWT. These positions are found in Yellowknife, Inuvik, and Hay River. The Chief Environmental Health Officer, a position located within the Office of the Chief Medical Health Officer in the Department of Health and Social Services, provides territorial support and backup services. One Senior Environmental Health Officer and two Environmental Health Officers are assigned to Stanton Territorial Health Authority to provide environmental health services to 14 communities including the Yellowknife, Dogrib, and Deh Cho regions. The Inuvik Regional Health and Social Services Authority has a Chief Environmental Health Officer and one Environmental Health Officer who provide services to the communities found within this region. Hay River has one Environmental Health Officer who provides services to eight communities, including Hay River, Fort Smith and to some communities within the Deh Cho region.

This staffing complement has remained unchanged for a couple of decades now, despite significant increases in population size and economic activities. Besides direct services to communities, Environmental Health Officers must also monitor aspects of the *Public Health Act and Regulations* that apply to work sites such as exploration camps, fishing / hunting lodges, mining communities, etc. With the increased economic activities related to resource development, the capacity of Environmental Health Officers to carry the extra workload is severely strained, limiting the ability to be proactive.

Public Health Nurses

Public health nurses are trained in a specialized field of nursing focusing on prenatal health, maternal health, infant services, preschool health, school health, adult health, communicable disease prevention, chronic care services, and health promotion activities. In the NWT, Public health nurses are currently working in public health units located in Inuvik, Hay River, Fort Smith, and Yellowknife. In other towns and hamlets, community health nurses incorporate the role of Public health nurses within their scope of practice.

Both the Medical Health Officers and the Public health nurses play key roles within the Public Health component of Protective Services.

Communicable Disease Control Services

Communicable Disease Control (CDC) services are coordinated at the territorial level through the Office of the Chief Medical Health Officer. Under the guidance of the Chief Medical Health Officer and with technical support from Disease Registries staff, two CDC specialists, the Chief Environmental Health Officer, and one project officer provide leadership for disease control and public health in the NWT by setting guidelines, standards, and protocols.

There is a need for ongoing review of NWT practices and protocols to ensure current scientific knowledge is reviewed and considered for incorporation into revised protocols that meet the needs of the north. Various support advisory committees are also mandated to provide timely advice to the Department and to the Authorities on various CDC-related issues to ensure an optimal level of service. Some of these advisory committees established include the Arctic Nurse Leadership Network, the Laboratory Advisory Committee, the NWT - Advisory Committee for Immunization, the Anti-microbial Steering Committee, and Hospital Infection Control Committees.

CDC staff is responsible for TB programming, including case finding, surveillance and monitoring, and training and awareness. Responsibilities for various components of this program are found at the community, regional, and territorial levels.

For TB case finding, the clinical practice committee develops clinical practice standards that are sent to the regions and from there to each community. All practitioners are to use the clinical practice standards and TB protocol for early case finding. Participation in the Canadian TB National Committee is also part of the departmental staff responsibilities. They will bring back information concerning national TB issues and make recommendations specific to this area.

All suspected and confirmed TB cases are reported to the Chief Medical Health Officer. Summaries are reported to Health Canada on a monthly basis and compiled in a centralized TB Registry that contains all reported TB surveillance in the NWT. The Chief Medical Health Officer continuously reviews reported cases to determine if there are any trends that need to be addressed. The Manager of Community Health Services (or equivalent) within each Authority coordinates surveillance activities in all communities and evaluates the completeness of this surveillance. All surveillance is completed in each community following the established protocols and standards.

TB program training is an important component of this area. Department staff provides training sessions during site visits and some central meetings for the Authority plus participates in conferences for health care professionals. The Nurse Educator / Mentors train new nurses in each region. Physicians who have advanced training in TB take the lead in TB case management for their Authority.

TB program awareness ensures the public has the information they require. Education sessions at schools, health fairs, and public gatherings are continuously done to increase awareness and prevention education.

The Sexually Transmitted Disease (STD) program includes program planning to meet the needs of escalating STD rates in the north. The Department sets out guidelines for screening, treatment, and contact investigation. The Department completes audits to ensure all community health centres are meeting program standards. The Authorities are responsible for orientation and assisting with the audits. Case management, contact investigation, client teaching and counselling, and community awareness and education are conducted at the community level.

HIV/AIDS screening, monitoring, education, and awareness is another component of the communicable diseases section. Programs and supports are similar to the STD program with prenatal, blood donor, and high-risk activity screening as an added community service. Other areas of focus include hepatitis C, B, and meningitis surveillance and control.

Ensuring childhood and adult immunizations are administered according to standards set out by the NWT Immunization Advisory Committee is also included in the communicable diseases section. Each Authority ensures through audits that the NWT immunization schedule is being done according to these standards and assists with nurse orientation and certification to this program. Childhood and adult immunizations are administered by community health nurses in all 21 small communities as well as to the satellite communities and by the public health nurses in the four larger communities of Yellowknife, Hay River, Fort Smith, and Inuvik. This includes promotion, early childhood immunization, and wellness clinics for adults, school immunization, travel clinics, managing outbreaks of a vaccine preventable disease, and occupational health.

CDC specialists in the department direct health care professionals with respect to case-by-case disease management, such as diagnosing, treating, managing, and controlling measures for all reportable diseases.

Community staff is responsible for reporting all reportable communicable diseases and unusual diseases to the Authority. They ensure case management and preventative measures are undertaken. This also includes public education and awareness. The Authorities are responsible for reporting reportable and unusual presentations to the Health Protection Branch at the Department. The Department provides support, coordination of outbreak management, and assists with awareness and education for front-line workers and the public. All services within this area are inter-connected between the community, region, and Department.

Community Emergency Preparedness

Community emergency preparedness provides emergency services to communities experiencing disasters. Various government departments collaborate through the Emergency Preparedness Committee where protocols and procedures are established and available in cases of disaster. Health and Social Services employees are frequently called upon to assist with the design and operation of reception centres in order to provide short-term assistance to disaster victims. Reception centre responsibilities include emergency food assistance, emergency clothing, emergency lodging, and registration and inquiry services. Specialized services such as personal services, counselling, first aid, communications, volunteer services, pet care, and transportation services may also be provided through the Reception Centre.

Child and Family Services

Protection services include child protection and adoption. Services for children, youth and families include services to increase the family's ability to care for and nurture their children.

Community Level Services

Child Protection:

Child protection provides an initial response and investigation to community members' concerns regarding the well being and safety of children. Child protection social workers, using the guidelines of the *Child and Family Services Act* assess the risk of harm to children. Dependent upon their conclusions they will determine whether voluntary or court ordered services would be in the best interest of the child and family. As part of the services to the child and family, referrals to community, regional, and/or territorial resources may be required. These may include treatment centres, family violence shelters, counselling programs, psychological assessments, or other resources.

Child protection also provides emergency after-hours services. On-call social workers are designated within each Regional Authority to assess and respond to call from the community regarding child protection concerns.

Permanency Planning:

Permanency planning refers to the appropriate long-term placements for children in the care of the Director of Child and Family Services. Possible placements include:

- reunification with the family;
- foster care;
- group home or residential treatment facility;
- adoption; and
- independent living services.

Adoption:

The adoption program consists of five types of adoptions: custom, private, step-parent, departmental, and inter-country adoption.

Regional Level Services:

Regional level social services include:

- supported living facilities for youth who cannot remain with their families for various reasons;
- addiction treatment referrals;

- assessments of parental and child functioning;
- psychological assessments as identified;
- family support;
- referral to territorial and/or out of territory facilities; and
- regional supervisors provide supervision and support to Community Social Services Workers.

Territorial Level Services:

Territorial level services under Child and Family Services include:

- Child Protection and Adoption Worker trainings – if successful in this training, they will then be appointed as Child Protection Workers or Adoption Workers to act on behalf of the Director of Child and Family Services or Adoptions;
- all adoptions are regulated by the *Adoptions Act* are under the authority of the Director of Adoptions;
- treatment centres (Trailcross in Fort Smith and Territorial Treatment Centre (TTC) in Yellowknife);
- psychiatric assessments through Stanton Territorial Hospital;
- coordination of southern placements;
- policy and planning;
- monitoring and evaluation;
- Child and Family Information System – a computerized data collection and monitoring tool that tracks services provided and legal status of children who are served through the *Child and Family Services Act*;
- special projects e.g. Looking After Children training; and
- Inter-provincial Desk – movement of children to and from provinces and territories.

Family Violence Programs

Community / Regional Level Services:

Shelter services are NWT programs that ensure women and children have the opportunity to seek shelter in a safe place. Many women must leave their community to be safe, as the closest shelter may not be safe for them. As well, if the closest shelter is full or the woman is not safe in the closest shelter, there is a responsibility to move the woman to another shelter in the NWT.

All of the family violence programs are third party programs – the Department funds the Authorities and the Authorities in turn fund non-government organizations to run the programs. Although the Authorities provide funding to the shelters through core funding from the Department, the understanding is that the Authorities have a responsibility to provide this service to any woman in the NWT, no matter where she resides, on an equal basis.

The family violence program currently has five shelters:

- Inuvik Transition House;
- Sutherland House – Fort Smith Tawow Society;
- Allison McAteer House – Yellowknife;
- Hay River Family Resource Centre; and
- Tuk Women and Children's Shelter – Tuktoyaktuk.

As well there are two family violence prevention programs:

- Fort Good Hope Victims of Violence Advocacy Program; and
- Fort Providence Family Life Program.

In addition:

- Inuvik Health and Social Services Authority provides some family violence counselling and advocacy through their Social Services office in Aklavik; and
- social workers in the communities also provide services.

Shelter services include:

- emergency shelter for women and children who are victims of family violence;
- some counselling – in-house and drop-in;
- referral services – women are referred to shelters from a number of different organizations. Social workers within the system provide these referrals on a regular basis as do the RCMP, alcohol and drug treatment programs, hospitals etc. However, referrals can come from any organization, counselling, churches etc. Women are also referred for a number of reasons: physical abuse, emotional/mental abuse, financial abuse, sexual abuse, and sexual assault that occurs within a family structure including common-law family situations;
- shelter workers refer women to other services – alcohol and drug treatment, income assistance, mental health counselling, RCMP, legal aid, housing, and any other service that will help the woman gain independence and control of her situation;
- children are also admitted to the shelter with their mothers. Shelter workers also provide referral services to these children. Services can be far reaching, but must have the permission of the mother, with the exception of a referral made to social services, under the *Child and Family Services Act,* where there is suspected abuse;
- advocacy for support from various agencies; and
- community awareness including: school visits, community workshops, radio interviews, professional workshops, community events, and a crisis line.

Family violence prevention services may include (not all programs are the same):

- life skills counselling;
- referral services;
- advocacy; and
- community awareness.

Territorial Level Services:

The Department employs one Family Violence Prevention Specialist, based in Yellowknife, who supports the Authorities in the development, implementation and monitoring of family violence prevention programs. As well, this person is involved in planning of prevention and promotion activities with all sectors involved in the prevention of family violence.

In some cases, women from within the NWT may need to be moved out-of-territory. This involves finding a shelter in Canada where she would be safe, and paying moving expenses for her and her children to that shelter. As well, women from other provinces or territories who cannot find a safe place choose to come to the NWT are accepted. In this situation, the client would live at an NWT shelter at no cost to her or to the originating province or territory, but the originating province / territory would pay the removal costs.

Part of the program includes the ability, in the most severe cases, to work with national bodies to change the identity of women and to move them to a safe place within or outside the NWT.

Guardianship

Guardianship services are currently provided at the territorial level through the Office of the Public Guardian and with the assistance of regional public guardian representatives appointed by the Authorities. The accountability in relation to guardianship orders is largely to the Supreme Court of the NWT, where all the guardianship applications are heard and orders granted. Guardianship services are available to all community residents who meet the assessment criteria and are deemed by the court to benefit substantially from the program.

The regional public guardian representatives provide an essential service to the administration of the program. They assist in the application process by contacting family members to determine the nearest relatives to the proposed represented person. They complete forms, determine with the Public Guardian the most appropriate person to complete the Assessment Report, recommend family members as guardians, and serve documents. They can also be delegated decision-making responsibility for Represented Persons.

Guardianship services are tied in closely with long-term care services, available at the community, regional or territorial level.

Current Service Delivery Challenges

Public Health Protection

Public health protection services currently benefit from the experience and dedication of a stable core group of professionals who have held problems in check and provided continuity of purpose. However, this has not been uniformly true across all regions and communities, due to staff turnover and reorganization. In many ways, this system remains extremely fragile and overly dependent on a few individuals.

The main challenges currently include:

- The need for a new *Public Health Act*:

  The current NWT *Public Health Act* was established in 1957. Since that time, there have been few changes, except an increase in the number of regulations. Today's *Public Health Act* is fragmented and not adequate to deal with emerging public health issues and models in the current environment. Aside from being outdated, the Act is not consistent with the current administrative arrangements for delivering public health services and does not comply with the principles of administrative law, the *Access to Information and the Protection of Privacy Act*, or the *Charter of Rights and Freedoms*. A discussion paper has been prepared for public consultation purposes, but the legislative agenda has not allowed the 14th Assembly of the territorial legislature to deal with this issue, which means another two years will be required at a minimum before a new Act can be put into force.

- The need to improve public health information systems to avoid duplication of data entry operations, but, more importantly, to assist in decision making through timelier access to critical information on the emergence of disease.

  The practice of public health protection requires timely ("real time") access to information related to new cases of suspected or confirmed illness, as well as the ability to cross-reference information; for example, an individual's immunization status or previous test results. Current public health databases are for the most part relying on older versions of software that are now unable to generate needed reports in an efficient manner. Furthermore, existing databases have little ability to share information electronically. Although the Department is in the process of implementing a new public health information system, developed through a collaborative F/P/T effort, Authorities are moving in different directions (e.g.: MediSolution for some, or HealthSuite for others) that will not necessarily communicate efficiently with each other. The integration or at least the ability to exchange information between various systems is critical to ensure optimal performance of public health protection services.

- The need to build surge capacity and to redeploy resources according to emerging issues to respond more effectively to disease outbreaks and other public health threats.

The practice of public health protection is based on a specialized body of knowledge and abilities. These human resources are few in numbers and are further fragmented throughout the system. Positions in one region may remain vacant for long periods, critical programs may falter, yet the ability to monitor and redeploy efforts according to current priorities is limited. This problem was highlighted in the 2001 report assessing the status of TB control in the NWT, *Action Plan to Strengthen Tuberculosis Management and Control - An Initial Response to the Report on Tuberculosis Control in the Northwest Territories* (Fanning Report). The development of surge capacity at the territorial level was one of the critical recommendations of this report.

- Organizational structures are not always aligned with public health imperatives.

  At the levels of the Authorities, public health staff currently works under varying reporting structures and may not always be receiving effective guidance and support. This is particularly true of Environmental Health Officers who, in accordance with legislation, should be working in close collaboration with if not the direct direction of a Medical Health Officer. Similarly, there are important linkages and synergies between public health protection, disease prevention and health promotion activities that can be facilitated when professionals work within the same unit and coordinate their work plans accordingly.

Child and Family Services

The following are the challenges within the current system that need to be addressed.

- standards and policies need to be developed and/or enhanced to be reflective of evidence based best practice;
- provision of a continuum of quality services, taking into account recruiting, retaining and maintaining professional expertise;
- ensuring the existence of a system of care that facilitates, in the shortest possible time, permanent, stable care relations for children; and
- long term planning and development to respond to the needs of children and families

Family Violence

Generally speaking, the Family Violence program has been under-serviced for a number of years. Women do receive support as required, but improvements can and should be made. Programs for those who abuse are limited and should be implemented. Support for the children needs to be increased. The following identifies the more specific areas of concern within the family violence area[7].

[7] Because this area overlaps with the core services of Mental Health and Addiction and Promotion and Prevention, references to these service areas are shown, where appropriate.

Increased funding and support for family violence programs is required in the following areas:

- programs for abusers and trauma recovery programs need to be available (see Mental Health and Addiction),
- counselling for women who have been abused is limited (see Mental Health and Addiction),
- funding for shelters in operations, maintenance, capital, training and salaries;
- second stage housing or transition housing;
- training for shelter workers and social workers needs to be implemented. (see Mental Health and Addiction);
- programs for men who are abused;
- supports for children who witness abuse (3 out of 5 shelters have no programming);
- safe houses need to be identified;
- clinical supervision of shelter staff is required; and
- increased funding for family violence awareness programs including elder abuse prevention/education (see Promotion and Prevention).

Protocols, policy and collaborative service networks across the government system to address the following issues need to be established.

- Shelters are isolated, as they are not part of the "system". Currently there is no team approach to case management or delivery of services.
- Women who choose to leave their relationship, but require additional supports after they have finished their stay in the shelter require help to re-establish themselves and their children. They need such things as affordable housing, household items, career counselling, and support to live independently. Protocols, memorandums of agreements, and policies need to be established across the GNWT that support women in making these life changing choices.

Family violence legislation (including elder abuse) should be enacted. This would minimize the impact the changes to the *Child and Family Services Act* have on victims of family violence by allowing the victim to stay in the home and removing the abuser.

Evidence based decision making is required to develop appropriate family violence prevention and crisis intervention programs that meet the needs of the clients. To do this effectively, better data collection is needed to truly identify the type and extent of programs that are required. It is suggested that family violence information be added to the CFIS and Health Suite system. This would address family violence situations that do not result in shelter usage.

Guardianship

Some of the challenges noted in providing guardianship support include:

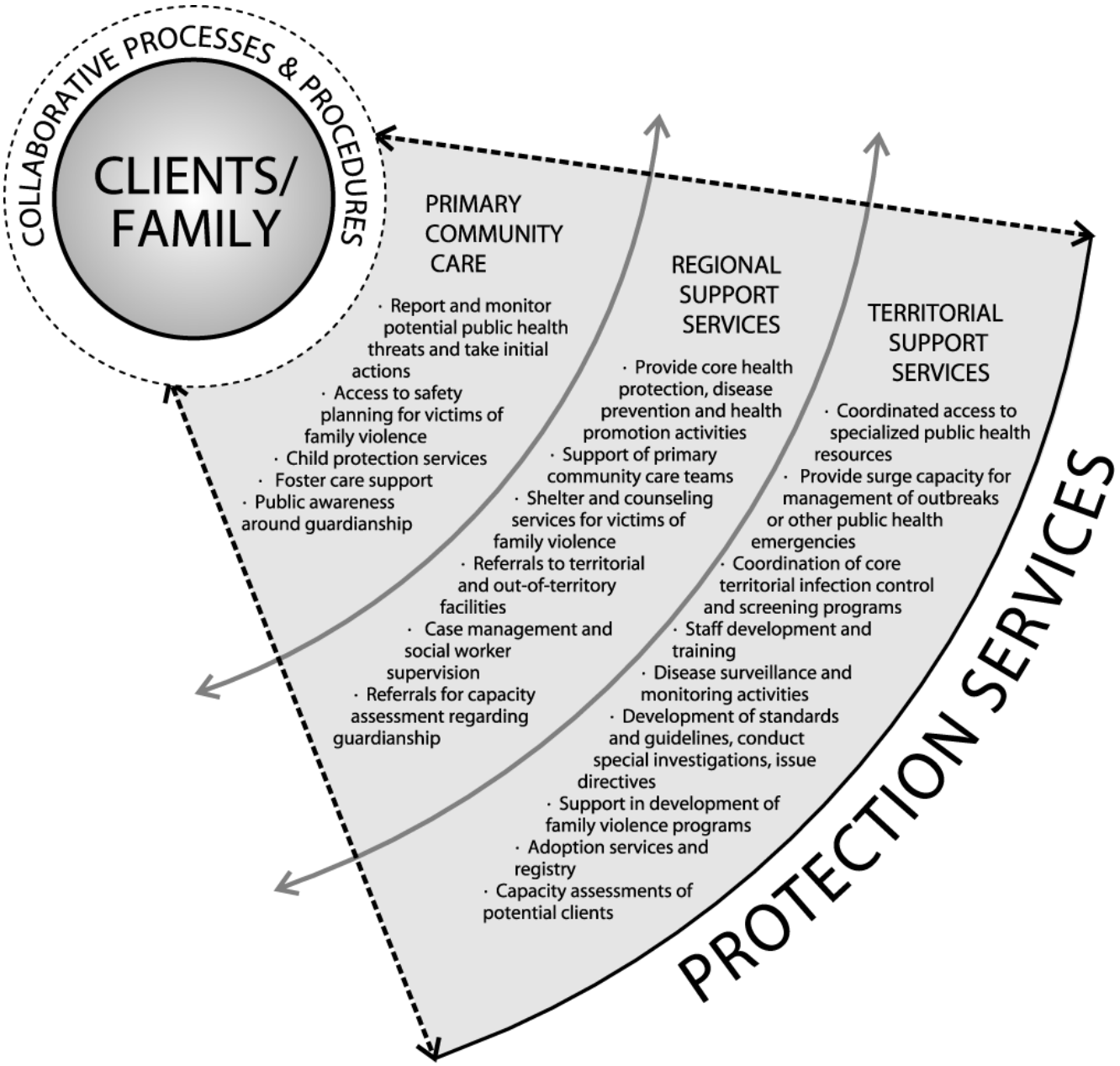
- promoting public awareness of private guardianship and the responsibility of the family and community in taking care of persons who have lost or reduced capacity to take care of themselves;
- building depth at the regional level to carry out capacity assessments on potential guardianship clients;
- developing guardianship care plans in collaboration with Departmental and Authority staff; and
- developing services in the North for represented persons including services to address complex needs as well as adult foster care.

Protection Services within an Integrated Service Delivery System

Protection Services is one of the six core services identified within the ISDM. Delivery of these services is based on the PCC philosophy.

Figure 8 illustrates the continuum of protection services from the community, region to the territorial level. Direct program delivery is found at the community level with various other services being delivered at the regional, territorial and outside the territory.

Figure 8: Protection Services within an Integrated Service Delivery System



Enhancing Protection Services

To enhance a system that responds to clients needs in an integrated way, case management roles within protective services will be established. This role is assigned to a care provider for every individual that becomes a client. The case manager works with the client and other professions from intake to the end of aftercare to meet the needs of that client. To ensure that the client's needs are met, any number of care providers could provide this case management role, depending on the unique needs of the clients. Some examples of professions that may take on this role are family support workers, home support workers, community health representatives, social workers, mental health workers, addictions workers, shelter workers, nurses, etc. In order to ensure accountability for this role there would be reporting responsibilities with other caseworkers on the client's case as well as supervision from the regional and territorial levels.

Public Health

Health protection services need to remain integrated within the broader public health realm that incorporates the four other core areas including disease surveillance, health promotion, disease and injury prevention, and population health assessment.

The Office of the Chief Medical Health Officer position situated within the Department of Health and Social Services will be responsible for:

- public health policy development;
- standard setting and monitoring;
- the oversight and enforcement on the application of the *Public Health Act and Regulations*;
- the production of manuals and clinical practice guidelines relating to public health programs and activities; and
- the disease registry.

The Office of the Chief Medical Health Officer would be responsible for the Environmental Health Officers and the Medical Health Officers working at the regional level, including monitoring, hiring, and reporting relationships either directly to the Chief Medical Health Officer or a delegate.

The main advantage for grouping the Environmental Health Officers under the Department of Health and Social Services include:

- establishment of clear reporting lines as well as using a trained Environmental Health Officer as the supervisor / manager;
- increased uniformity and consistency of the Environmental Health Program;
- improved co-ordination and standardization;
- allowance for surge capacity;
- provision for effective coverage for vacant positions;

- allowance for specialization of roles;
- provision for increased flexibility and freedom to locate positions in appropriate communities based on need, availability of housing, etc.;
- building a team approach, rather than dividing up limited resources; and
- simplifying and allowing for more effective recruitment and retention.

An alternative to this would be to have a Public Health Operational Support Unit established with the Stanton Territorial Health Authority. This unit would be responsible for:

- direct delivery of environmental health programs;
- coordination of territorial level health promotion activities and cancer screening programs;
- support to regional / local disease prevention and control as well as emergency preparedness activities;
- orientation and training of new health care providers;
- travel medicine; and
- communicable disease outbreak management.

Regional Medical Health Officers need to be re-established within the Inuvik Health and Social Services Authority and the Hay River Health and Social Services Authority. A full time Medical Health Officer position should remain at Stanton to head the territorial unit, or be brought into the Department. This position would also service as Deputy Chief Medical Health Officer. The Chief Medical Health Officer and the Deputy Chief Medical Health Officer should be community medicine specialists, or have equivalent qualifications. Regional Medical Health Officers could be general practitioners with a combination of additional training and experience dealing with public health programs.

Environmental Health Officers would work with the Medical Health Officers. It is recommended that three Environmental Health Officer positions be located in Yellowknife, two positions be located in Hay River and two in Inuvik. The addition of an extra position in Hay River can be justified by the impact of resource development in the Deh Cho. A Senior Environmental Health Officer position would remain at the Department.

Each Authority would have a dedicated public health team that services not only the home community but has a regional support role and can provide surge capacity. The teams would include community health representatives, Public health nurses, Dental Therapists and/or Dental Health Promotion Officer, and a Health Promotion Specialist. Larger Public Health Units in Hay River, Inuvik and Yellowknife would also incorporate a regional nutritionist, Environmental Health Officers, and a Medical Health Officer (full-time in Yellowknife, part time in Inuvik and Hay River), who would provide services to the greater region. The Yellowknife Public Health Unit would be assigned territorial mandates with regard to travel medicine and the management and/or coordination of screening programs, including training and quality assurance. Dedicated public health teams and supports at the community, regional, and territorial levels will ensure a sound level of skilled professionals with the knowledge to deliver public health programs.

Research capacity needs to be enhanced to ensure people are receiving the best care possible, based on the latest information.

Public health education and awareness, linking with promotion services, including appropriate resources and materials need to be developed.

Child and Family Services

The clients of child and family services will benefit from the integration into the HSS system as contemplated in the ISDM. System integration will ensure that enhancements are realized and seamless service delivery is provided across the system with the end result being more consistent services to clients and their families. The following are the enhancements suggested.

- Additional protocols and collaborative service networks will be established at the community, regional, territorial, and corporate levels as well as across the continuum of providers, including other territorial and federal departments, NGOs and professional organizations.
- Standards and policies will be reviewed to ensure the encouragement of collaborative practice as supported by the ISDM.

Family Violence

In order to ensure that integration and enhanced services take place in the family violence area, the following needs to occur.

At the community level:

- social workers, mental health counsellors, community wellness workers, and addictions workers need education and training in order to have the best knowledge to provide support and counselling for victims and abusers;
- a common referral process for all workers to access the aid of shelters, counselling services, psychiatric services needs to be established; and
- safe housing and transitional support for women who want to re-establish their lives away from the abusive relationship are needed.

At the regional level there is a need to:

- increase funding to shelters;
- have clinical supervision available to shelter workers; and
- work with Authorities to set up supports for abusers who are not incarcerated.

At the territorial level there is a need to:

- increase funding to shelters; and

- establish a residential program for men who abuse so that they can deal with their issues and work on root causes is needed.

Public Guardian

Enhancements to this area include the following:

- assessment services should be reviewed in conjunction with other assessment services required by the Department, (i.e. long term care assessments);
- the Regional Public Guardian duties need to be added to the job descriptions for those who are providing this service;
- more coordination and planning between long term care and public guardian services is required;
- new services need to be developed in the NWT to provide for high needs Represented Persons, who pose a security risk to themselves or others; and
- further enhancement may be obtained from conducting a formal, objective evaluation of the guardianship program.

Managing the Required Systems Change

The ISDM as well as the proposed changes to core services of Promotion and Prevention and Mental Health and Addiction provides a unique opportunity to enhance Protection Services.

Funding resources are required to ensure adequate levels of service can be provided. This will include resources for new personnel in all areas (e.g. additional Environmental Health Officers, Social Workers, etc.), training development and delivery and material resource and development for public awareness and promotion.

Recruiting and retaining people with expertise may be difficult, given the salaries for some areas such as Medical Health Officers are not competitive and there is a national shortage of trained physicians. Individuals must have the skills to do their job but must also work with the PCC teams, using multiple strategies to deliver their programs. Job descriptions and training need to be standardized and reporting relationships need to be clearly identified.

PCC teams provide an opportunity to enhance services to men, women and children who are dealing with family violence, both from the abused and abuser point of view. It will be important to fund shelters on a need basis and provide training opportunities for shelter workers. Training in the area of family violence should also be offered to the prevention workers, and mental health workers identified in the Mental Health and Addictions core service area.

Establishing Immediate Priorities

In terms of moving towards the vision and preferred future for protection services, the following are considered to be priority areas for action.

Public Health

- Establish public health units in every Authority / region.
- Revise the current *Public Health Act.*

Child and Family Services

- Review and revision of standards and policies to reflect best practice and address integration issues.
- Amend the *Child and Family Services Act* to reflect current Canadian law.
- Development and implementation of a integrated permanency planning system to ensure a continuum of services that address children's needs through the period that they are involved with the child and family services program.

Family Violence

- Define the roles of shelters and subsequent funding requirements.

Public Guardian

- Ensure that a Deputy Public Guardian is appointed in each Authority.

Continuing Care Services

Defining Continuing Care Services

Continuing care refers to those services that maintain or improve the physical, social, and psychological health of individuals who, for a variety of reasons, may not be able to fully care for themselves. The goal of continuing care is to improve independence and quality of life for these individuals and their families.

Continuing care reflects the need for a progressive and flexible system of care that allows individuals to access all of the services they might need.

Examples of Continuing Care Services

In the NWT, there are three main levels (or streams) of continuing care services, incorporating a wide range of care services.

- home and community care services include respite care, chronic care, foot care, medication management, palliative care, ambulating, social support, Meals-on-Wheels and equipment loans;
- supported living services include seniors independent living with supports to more encompassing supportive living services with increased levels of support and day programming options, including employment and education support and/or 24 hour custodial care in a group home; and
- facility living services include long-term care and extended care support, providing care for individuals whose needs cannot be met at home.

Levels of Continuing Care Service

Three levels of continuing care services provide for a continuum of services based on client need.

Home and Community Care

The home and community care stream consists of a variety of services delivered at the community level that enable clients to remain at home, often reducing the need for long-term or acute care alternatives. This stream is consistent with an emerging national and international trend to support people in their own homes and communities for as long as possible to prevent or delay institutional care. This approach is particularly useful in the NWT, because institutional care is often only available in a distant community.

Supported Living

The supported living stream provides increased care services and a degree of supervision when needs exceed home care services. Supported living allows clients to receive services in a home-like environment – usually in apartments, seniors' facilities, or group homes – while maintaining as much independence as possible. Clients are grouped according to their needs. Supported living services can be delivered at the community, regional, or territorial levels, depending on the availability of appropriate facilities and professional support services.

Facility Living

The facility living stream provides 24-hour care for clients who can no longer live independently, even with assistance, and require moderate to high levels of care. Long-term care is for clients with severe chronic disabilities, resulting in physical fragility and/or mental impairment. Extended care and long-term care refer to forms of facility living in the NWT, which may be in a hospital and or long-term care facility. Long-term care facility living is normally accessible at the regional and territorial levels. However, where the needs of the client cannot be met in the NWT, placements are accessed out-of-territory.

The Vision for Continuing Care Services

Individual needs are being met in the least intrusive manner, promoting the greatest opportunity for lasting wellness and functional independence.

Preferred Future

With this vision at the forefront, continuing care services will build towards the preferred future based on the following goals:

- Individuals will receive supportive services in their homes or as close to home as possible.
- Individuals with special needs will live as independently and as close to home as possible.
- Individuals, who cannot live independently, even with assistance, will receive the service they need in a facility setting that is as home-like as possible.
- The continuing care system will be consistent, coordinated, and integrated throughout the NWT.

Home and Community Care Stream

Every resident in the NWT will have access to an increased number and quality of services that are provided by highly skilled and certified employees. These services will include:

- Case management
    - assessment, placement, and care planning;
    - nursing care;
    - dressing changes;

- medication management;
- home support services;
- personal care;
- homemaking; and
- home visitation program.

- Nutritional services
  - support from other professional services such as physicians, gerontologists, pharmacists;
  - rehabilitation services such as occupational therapy, physiotherapy, speech-language therapy;
  - home management including problem solving, counselling, assistance with daily living tasks;
  - respite care;
  - provide relief for family caregivers;
  - equipment loans; and
  - regional equipment depot for client loans when necessary.
- Placement services
  - Continuing Care Assessment Package ensures that clients receive the right service, in the right place, at the right time.

Every home support worker will be trained and certified by 2005.

Home and community care programs will be accessible to as many residents of the NWT as possible. The location of service delivery will be within the client's home or another place of residence within his/her community. When the client requires more services than home and community care programs can provide, he/she will move along the continuum to a supported living or facility living level of service.

Supported Living Stream

Clients whose needs are no longer met through the home and community care stream will be able to access a range of supportive living options. Clients will reside in either an independent environment (independent or apartment living) or cluster living. Independent and apartment living will be available in communities as needed across the NWT. Cluster living accommodation is envisioned to include grouping of three to six individuals who require varying levels of supportive services. The physical environment will normally include some common space and shared services. These services may include 24 hour emergency call but do not include 24 hour supervision. The security and safety of clients will continue to be a prime concern.

Increased opportunity for employment and socialization will also be a focus. There will be the opportunity for clients to reside in the type of supported living best suited to individual abilities and needs.

An array of service and living options for seniors will be developed based on the following two principles:

- maintenance of independence and self-sufficiency for as long as possible; and
- residence options as close to home, family and cultural group as possible.

It is likely that cluster living would only be available in regional centres because of the increased need of supportive services such as day programming.

Facility Living Stream

Future planning for long-term care facilities will be focused on meeting the needs of individuals requiring the highest level of care. Individuals in specialized long-term care facilities will be admitted based on their assessed functional ability. Individuals with fewer complex needs will receive care in the community in their own homes or in supported living arrangements. The need for specialized facilities to meet the needs of specific groups, such as the cognitively impaired or the adult diagnosed with Fetal Alcohol Spectrum Disorder who exhibits aggressive behaviours, will be addressed.

The preferred model anticipates a reduced use of residential care by individuals whose functional impairment can be accommodated by alternative community services. The proposed NWT shift from current practice in use of residential care is quite modest compared to changes proposed and being implemented in other jurisdictions, due to the specific challenges of service delivery in the NWT.

The actual number of clients in facility living is not expected to decrease over the next few years due to the increase in the seniors' population. However, with expanded supportive living arrangements and home and community care programming, it is anticipated that there will be a decline in the percentage of the population that requires long term care in a facility. Clients will have more options available to them, specifically from the home and community care stream and the supported living stream.

Systems Changes

Each of the regional Authorities will:

- implement a family support component;
- expand respite care to include family caregivers of children with disabilities;
- expand palliative care services;
- ensure compliance with standards and directives;
- deliver and coordinate the program based on the ISDM, standards, and directives;
- ensure Home Care staff are certified;
- allow clients to be part of the decision-making process for care; and
- encourage and train families to care for their loved ones.

Overall territorial coordination of the continuing care system will be provided by:

- monitoring home care programs to ensure that staffing levels and services meet standards set in the ISDM;
- ensuring territorial standards regarding the number of hours and types of services that are available to each client is based on need and availability of resources;
- ensuring quality of services and programs through monitoring and evaluating core services and priority areas that are implemented;
- addressing the data collection needs of the home care program, based on outcomes identified at the territorial level;
- implementing quality assurance procedures; and
- defining the roles and responsibilities of each member of the home care team.

Assessing the Current Continuing Care Services Delivery System

The current delivery system for each of the three Continuing Care streams is as follows.

Home and Community Care Stream

Home and community care services are provided at the community level through programs offered by the regional Authorities. The GNWT provides funding of approximately $2.8 million to the authorities along with an additional $3.2 million from the Federal First Nations / Inuit Home and Community Care Initiative. The First Nations / Inuit funding agreement currently in place[8] was negotiated with Health Canada to enhance existing home care programs in the NWT.

Currently there are approximately 680 clients receiving home care services through the NWT's home and community care program. Services accessed at the community level include[9]:

- home management;
- personal care (e.g. foot care, bathing);
- nursing services (e.g. wound care, medication management, blood pressure monitoring);
- respite care (e.g. support services provided at scheduled times to assist family caregivers);
- nutrition programs (e.g. Meals-on-Wheels);
- general home upkeep/handyperson work;
- palliative care; and
- scheduled extended hours of care are available in some larger communities.

[8] Although Health Canada has committed to these resources for a three-year period, they are subject to federal government priority and Treasury Board approval.
[9] Consistency of delivery of these services varies by community.

Regional support services are also provided to home and community care clients. The services at the regional level consist of:

- assessment;
- case management;
- placement services;
- training to families and workers;
- equipment loans;
- rehabilitation services; and
- other professional services as available and as required.

Territorial support services for home and community care clients include:

- public awareness;
- program coordination; and
- accountability and data collection.

Current staffing levels for home and community care vary according to availability and the health needs of specific communities. Generally, staffing at the community level consists of:

- home support workers and/or
- registered nurses specializing in home care and/or the community health nurse providing home nursing support

Staffing at the regional level also varies from one region to another and may consist of:

- a regional program coordinator
- specialized and support staff such as:
    - registered nurses;
    - social workers;
    - nutritionists;
    - rehabilitation specialists (e.g. Occupational Therapist, Physiotherapist, Recreational Therapist);
    - clerk/interpreters; and
    - other professional services.

Staffing at the territorial level consists of a senior nursing consultant for homecare.

The current staffing levels for home and community care are presented in Table 4.

Table 4: Current Home and Community Care Staffing Levels[10]

Health Authority/ Community	Deh Cho	Dogrib	Ft. Smith	Hay River	Inuvik	Yellowknife	**Total**
# Regional Home Care Coordinators	1.0	1.0	1.0	1.0	2.0	1.0	**7.0**
# Home Support Workers	6.5	5.0	4.25	3.0	10	15.5	**44.0**
# Nutritionist	0	0	0	0.5	0	0	**0.5**
# Occupational/ Physical Therapists/ Rehabilitation Assistant	0	0.5	0	0	1.0	1.0	**2.5**
# Social Workers	1.0	0	0	0	0	1.0	**2.0**
# Registered Nurses*	0	0	1.0	4.0	1.0	6.2	**12.0**
# Licensed Practical Nurses	0	0	0	0	0	1.0	**1.0**
# Activity Coordinators	1.5	0	0	0	0	0	**1.5**
Total Staff	10.0	6.5	6.25	8.5	14	25.7	**70.5**

* Community Health Nurses provide home nursing support in many communities throughout the north.

Supported Living Stream

Clients in the supported living stream of the Department's *Continuing Care Framework* are grouped together according to their needs and can include clients with multiple or complex disabilities and those with mental illness. Supported Living options include cluster apartments,

[10] Source: Department of Health and Social Services September 2002

seniors' independent living units, and group homes. Funding for Supported Living arrangements is provided by the GNWT to the regional Authorities. Regional Authorities either provide services directly or contract non-government organizations (NGOs) or other agencies to provide these services. Clients from other regions are often accommodated.

The current Supported Living options (including group homes) available to NWT residents are illustrated in Table 5 and 6 below.

Table 5: Supported Living Options (as of September 2002)

Service Provider	Residence Type	# of Beds	Client Type	# of Clients
YACL	Independent Living	5	Intellectual disability, FASD, mental health issues	5
YWCA	Apartments	16	Intellectual disability, FASD, mental health	16
Chartrand Homes	2 apartments 1 independent	8 1	Mental health issues Mental health issues	8 1
Stanley Isaiah	Supported living	10	Multiple disabilities, intellectual disabilities	3
TOTAL		40		33

Table 6: Group Homes (as of September 2002)

Service Provider	Residence Type	# of Beds	Client Type	# of Clients
Chartrand Homes	4 group homes	20	Foster family for mental health issues	20
Inuvik	Group home	5	Multiple disabilities	5
TOTAL		25		25

Supported living services include:

- one to three meals daily;
- housekeeping, laundry;
- medication monitoring;
- counselling;
- emergency call system;
- supervision, security;
- education, life skills development/management, employment programming; and

- personal attendant services.

The NWT Housing Corporation maintains 94 seniors' independent housing units in 22 communities, which share common security and dining/recreation space and allow for the efficient delivery of continuing care services.

Territorial service standards for group homes have been implemented by the Department of Health and Social Services and standards for supported living services are in draft.

Currently, the majority of supported living facilities are located in Yellowknife. The Stanley Isaiah facility in Fort Simpson opened during the 2002/2003 fiscal year. Program and staffing were phased in during that time.

As a component of the supported living stream, the *NWT Disabilities Framework* was completed in June 2002. This framework provides direction for the development and implementation of programs and services for persons with disabilities. The framework builds on work done at the territorial, provincial, and federal levels and includes five priority areas for action: education, employment, income, disability support, and housing.

An action plan will be completed by January 2004 and will identify new and/or enhanced programs and services under each of the priority areas identified in the framework.

Facility Living Stream

The facility living stream provides 24-hour care for clients who can no longer live independently, even with assistance, and require moderate to high levels of care. The Facility Living Stream of the Continuing Care Framework (Table 7) includes the following facilities.

Table 7: NWT Care Facilities (as of September 2002)

Community	Facility Name	# of Beds
Fort Smith	Fort Smith Health Centre – Extended Care Northern Lights Special Care Home	12 21
Hay River	H.H. Williams Memorial Hospital – Extended Care Woodland Manor	8 16
Fort Simpson	Deh Cho Long Term Care Facility	20
Rae/Edzo	Jimmy Erasmus Seniors Home	8
Inuvik	Inuvik Regional Hospital – Extended Care Charlotte Vehus Home	16 8
Aklavik	Joe Greenland Seniors Home	8
Yellowknife	Stanton Territorial Hospital – Extended Care Aven Manor	10 29
TOTAL		156

Current Service Delivery Challenges

Current continuing care services have been reviewed in order to identify areas in which service delivery could be improved. The following challenges have been identified under each of the three streams of continuing care.

Home and Community Care

There is a need for each Authority to deliver services based on a consistently accepted vision. The Authorities currently deliver home care services based on their own vision of continuing care services and on identified needs at the regional and community level. In some instances, services vary among Authorities and communities. Some communities have excellent access to home care services, including clinical support for clients and home support workers, while others have home support services delivered from the band office, with limited clinical support and nursing services from the health centre.

More home support workers with appropriate training are required. In order to address this situation:

- 26.5 new home support worker positions have been created;
- home support workers will be hired over the 2003/2004 fiscal year;
- 50% of home support workers have been trained and certified;
- 20% are currently completing the second of three modules of the home support worker certification program; however,
- 30% of the home support workers remain uncertified.

"Care for the Caregiver" support services need to be enhanced. This is a significant challenge. The success of the home and community care stream depends on the other supports that are in place for the client, including caregiver and family support. These informal caregivers play a significant role in supporting individuals with long-term health conditions, allowing them to continue living in the community. Many caregivers are willing to sustain immense loads, adjust their lives considerably, and incur significant costs in order to support a family member in need of care. However, this adjustment does take its toll – mentally, physically and socially. "Care for the Caregiver" is an essential component of the home and community care stream, and takes the form of respite care and education for family members.

Supported Living

Attempts have been made in the past to repatriate clients who are currently placed in southern facilities. The policy of repatriation has had limited success due to the lack of suitable placements and critical back up services and supports in the NWT.

The commitment to provide placements for individuals with more complex behavioural, mental, and physical disabilities will challenge the system to develop new programs over the long term,

particularly because the majority of these clients are children or young adults. Providing territorial services for these clients must be a priority.

Facility Living

The current utilization of long term care facility beds in the NWT includes a high proportion of residents that could be supported in the community if appropriate community supports such as supported living options and home care services were available in all communities. The acuity testing carried out during 2002, indicated that some of the residents could have been cared for in their own homes. Most of the existing facilities do not meet national standards for multi-level care facilities.

The acuity levels of clients, assessed in 2002, revealed a high percentage of clients had very complex care needs. This indicated that existing facilities have a mix of clients that should be housed in a multi-level care facility. Most of the current facilities were not designed for this complex need.

Staff will have to develop increased skill levels to care for clients with greater and more complex needs.

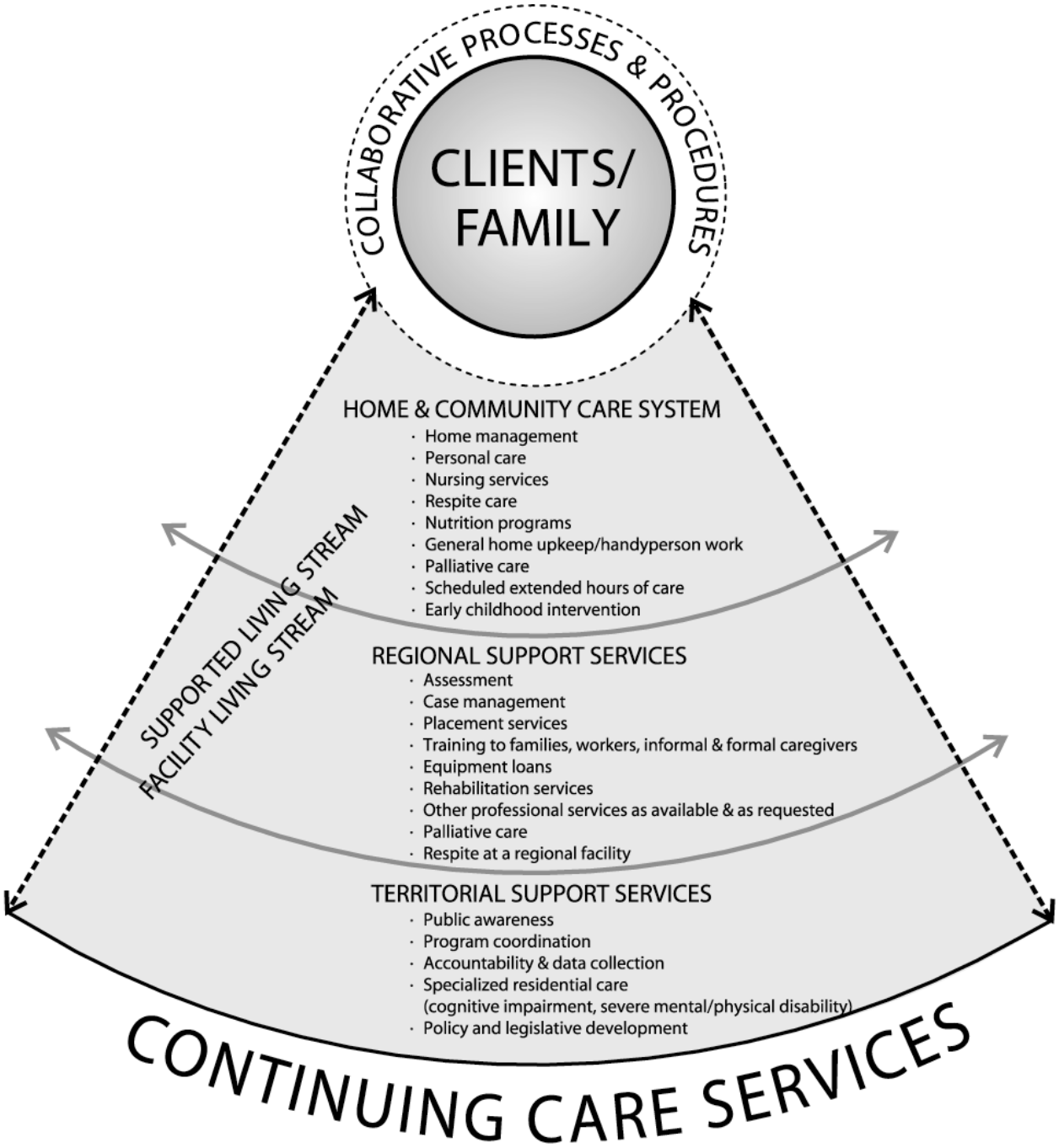
A changing resident profile will impact on physical design requirements and will require attention to programming and staffing needs.

Continuing Care Services within an Integrated Service Delivery System

Figure 9 details the continuum of continuing care services within the ISDM. Home and community care is delivered to clients and their families and also has the largest client base, due to the importance of allowing clients to remain at home as long as possible. The delivery of this service is primarily at the community level but supported at the regional and territorial levels.

Supported living is the second stream of care and is often provided at the regional level, with some services being offered in Yellowknife. Facility living, which has the smallest client base, is usually provided in regional centres or, in exceptional cases, in territorial or southern facilities. All of the essential elements of a collaborative and integrated approach to service delivery – such as case management techniques, standardized assessment and referral protocols, a single point of access, and linkages with other core service areas – are incorporated into the delivery of continuing care services.

Figure 9: Continuing Care Services within an Integrated Service Delivery System



Enhancing Continuing Care Services

The Department is committed to an ongoing process of enhancing continuing care service delivery in the NWT, based on the PCC approach. The *Continuing Care Framework* developed by the Department has identified the following actions that can be taken to improve service delivery in all three continuing care streams.

General Enhancement of the System

- implement a single point of entry process ensuring that clients are placed at the appropriate service level or facilities, utilizing a continuing care referral system;
- implement a data collection and monitoring system based on desired outcomes (quality assurance);
- implement a system-wide capital plan based on future needs;
- ensure quality of care for continuing care decision-making; and
- link day programming across the streams.

Enhancing the Home and Community Care Stream

- incorporate all home care staff into the PCC Team at the community level;
- ensure that staffing levels are adequate and consistent throughout the system; adjust staffing requirements as needed;
- work with Aurora College to provide home support worker training and certification on campus and through distance education;
- certify all home support workers by 2005;
- ensure that all home care staff receive training in priority areas such as foot care, diabetes, palliative, respite, rehabilitation, and early intervention for children of families at risk;
- ensure that all home care programs include a family support component. Workers with this kind of additional training will concentrate on early childhood development and assist children and their families to obtain the support they need to ensure the positive development of their children. There will be pilot programs initiated in four communities in 2002/2003, with incremental programs in place by 2004/2005;
- deliver support and training to family caregivers to assist them to care for their loved ones at home for as long as possible; and
- implement a public awareness campaign that will educate the public about the available home care services in each region and about a career path in this field, using posters, videos, public service announcements, and highs school career fairs, etc. This would increase the number of Aboriginal people and high school students choosing this career path.

Enhancing the Supported Living Stream

- Supported living options will be available to clients through:
  - individual supported living, including supervision and home support;
  - cluster living (4 to 6 clients), including supervision, custodial care and medication management; and
  - group home living (6-9 clients), including 24-hour supervision, custodial care, and medication administration.
- Enhancement of the supported living stream in the NWT will be supported through the expansion of independent living facilities and group homes. An allocation of $1.3 million has been identified in the *2003 – 2004 Business Plan*.
- Develop and cost the *Disability Framework Action Plan* by June 2003.
- Implement standards for the supported living program.
- Monitor and evaluate programs and program standards on a regular basis to ensure compliance.
- Develop a single point of entry for all facility placements, including group homes and southern placements.

Enhancing the Facility Living Stream

- Ensure that the HSS System's planning principles, goals, and strategies are aligned with national and international trends to increase the capacity to support clients in their own homes (utilizing emerging models of supported living arrangements) and focusing residential facility care on the higher need clients only.
- Develop a strategy to plan and operate a residential care program that reflects the identified needs of the NWT population with respect to size, facility design, location, and programming, including:
  - targeting residential care to higher care need clients, including clients with cognitive impairment;
  - establishing equitable access to residential care for the appropriate populations, with admission to territorial facilities made at the territorial level;
  - standardizing admission criteria;
  - reviewing and confirming the future role of each facility, outlining appropriate renovations, and new requirements (building on previous findings and recommendations);
  - optimizing the way the existing facilities are used through minor renovations, specialized programming, and grouping of clients where appropriate;
  - strengthening NWT capacity to provide specific assessment, treatment, and residential services for the cognitively impaired population;
  - increasing the education and skill levels of staff, families, and communities; and

    - renovating and expanding residential capacity with the needs of the cognitively impaired in mind.
- License all facilities.
- Shift the role of residential care to respond to the higher proportion of clients with cognitive impairment or have behavioural problems, without adding new beds.
- Apply staffing standards for long-term care facilities resulting in an increase of 26 positions, with $1.5 million allocated to long term care facilities in the *2003-2004 Business Plan* and ongoing.
- Implement standardized reporting for all facilities.
- Lead the interdepartmental working group in the implementation of the *Seniors' Action Plan*.
- Fund non-government organizations to research and propose options necessary to better care for cognitively impaired residents in facilities.

Managing the Required Systems Changes

The identification and development of three streams of continuing care, with a focus on community-based care, is the first step towards ensuring quality, ongoing continuing care services in the NWT. Partnerships with other departments, communities, and non-government organizations will ensure that the system provides services for all residents with special care needs.

Implementation of the ISDM will ensure that continuing care service providers will function as members of the PCC teams in all regions of the NWT. Implementation of the ISDM will present some challenges as care providers develop the procedures and protocols essential for working together. The benefit will be a cooperative working environment for all stakeholders. A system that provides a single point of entry must be developed, using a continuing care referral system.

Current staff will have the opportunity to receive the training required to develop their skills. This will ensure all staff incorporates best practices into the care provided. Job descriptions will be reviewed to ensure there is consistency within the system.

Establishing Immediate Priorities

In terms of moving towards the vision and preferred future for continuing care core services, the following are considered to be priority areas for action.

Supported Living Stream

- Implement the Persons with Disabilities Framework Action Plan by:
    - designing support services for persons with mental and/or physical disabilities through supported living options;
    - developing placement capacity for persons with mental and/or physical disabilities in the NWT; and
    - developing appropriate respite care.

Home and Community Care Stream

- Increase the numbers of appropriately trained home support workers.
- Ensure there is consistency of service and equity of access across the NWT.

Facility Living Stream

- Ensure there are adequate specialized facilities and services for persons with cognitive impairment.
- Ensure all facilities are licensed.

Promotion and Prevention

Defining Promotion and Prevention Services

Promotion and Prevention programs and services aim to enhance a process whereby people are provided with ways and means of taking greater control over factors that impact their health and well-being. In this sense, they are key contributors to the overall strategic goal of improving NWT residents' optimal physical, emotional, mental, and social well-being within healthy and supportive environments.

Health promotion focuses on achieving equity in health by providing equal opportunities and resources to enable people to achieve their optimum health potential. This includes improving life skills, encouraging healthy choices, acquiring skills and education, and increasing the opportunities for individuals to grow and make healthy choices. The entire range of factors and conditions that influence health are considered.

Primary prevention refers to the prevention of illness or injury. Secondary prevention is the early detection of problems before further illness or disability results. It is the anticipatory action taken to reduce the likelihood of an undesirable health condition. Prevention services take into account individual, environmental, and societal factors that contribute to problem development. In a recent report of the Auditor General, it was noted that "preventative health activities are estimated to be six to forty-five times more effective than dealing with health problems after the fact".

Examples of Promotion and Prevention Services

Promotion

- territorial-wide promotion strategies and initiatives;
- reducing the impact of second-hand smoke[11]. Results from the 1999 Labour Force Survey indicated that the community of Holman, despite high smoking rates among adults, had one of the highest proportions of smoke-free homes in the NWT (64%) compared with other small communities (39% on average). This occurred in large part as the outcome of a sustained effort by the local Community Health Representative with active support from regional and Departmental resources;
- Fetal Alcohol Spectrum Disorder information and training provided to workers such as nurses, adult educators, social workers, shelter workers, RCMP, recreation workers, etc.;
- de-normalization of alcohol consumption during pregnancy via training of bar staff to promote serving non-alcoholic beverages to pregnant patrons;
- promotion of priority admission to addiction treatment facilities for pregnant clients;

[11] A good example of the impact of health promotion efforts was reported in *Smoke Alarm*, May 2001.

- initiatives that aim to de-normalize tobacco use so that it is no longer the norm to smoke; workshops and activities that increase the awareness of the dangers of smoking and increase changes in attitude;
- policies and standards that support healthy environments such as baby-friendly workplaces, smoke free workplaces, etc.;
- regional training for local coordinators in nutrition and health promotion;
- nutrition programs at schools, day care centres and seniors' facilities offered at the community and regional level; and
- supporting communities to develop their own programs for the promotion of active living, such as an active living and nutrition education program for children, in combination with regional and territorial strategies.

Prevention

- immunization Programs: scheduled immunization (e.g. chicken pox, etc); and special immunizations such as meningitis, flu clinics, travel clinics, etc.;
- reproductive health, pregnancy/childbirth, and parenting programs;
- community-based and regionally-supported Fetal Alcohol Spectrum Disorder (FASD) prevention and awareness projects, including screening for early childhood developmental delays which may be the result from prenatal alcohol exposure;
- comprehensive tobacco strategies such as the creation of healthy public policy through non-smoking municipal by-laws that decrease the exposure to environmental tobacco smoke are being initiating in many communities;
- home care programs that provide preventive teaching so people remain safe and are less likely to require further hospitalization;
- the prevention of injury, chronic diseases such as diabetes and obesity and substance abuse / addictions (including tobacco), through educational, walking clubs to promote active living, etc.
- family health programs such as maternal, infant, child and school age health programs, well-baby, well-child and postnatal "clinics", and home visits by health and social services workers to prevent infant or child illness;
- promoting awareness of root causes for substance abuse during pregnancy, which may result in Fetal Alcohol Spectrum Disorder;
- cancer screening programs to aid in early detection of cancer; and
- screening for speech / language / vision / hearing / dental / nutrition problems that can be corrected through early detection.

Levels of Service

Health promotion and prevention is provided in the context of a population health model, with the goal of improving the health of the population and decreasing health inequities. The population health approach builds on a long tradition of public health, community health, and

health promotion and recognizes that many interrelated factors and conditions contribute to health. Programs and services are evidence-based and best-practice based. The resulting knowledge is used to develop and implement territorial, regional, and community policies and actions that will achieve a healthier population.

Primary prevention is the sum of efforts that aim to ensure people will remain free of disease. Health promotion, immunization programs, and the enforcement of public health legislation and regulations are all activities that contribute to primary prevention efforts.

Secondary prevention interventions are those activities that seek to uncover diseases at the earliest possible stage before they have caused illness or expensive treatment and at a time when there is a greater probability of cure or stability in instances of chronic illness. Screening programs are one of the main tools of secondary prevention. By definition, screening activities or tests are offered to people who are still apparently in good health. Screening interventions must therefore meet specific criteria in terms of acceptability, safety, reliability, and cost-effectiveness. Well recognized screening programs include breast mammography (breast cancer screening), PAP tests (cervical cancer screening), vision / hearing screening, Nipissing developmental screening, screening questionnaires about alcohol / drug use in pregnancy, etc.

Tertiary prevention activities aim to intervene early enough in the disease process to prevent death or limit long-term disabilities. Some screening programs, such as Fetal Alcohol Spectrum Disorder, diabetes, or HIV screening, are forms of tertiary prevention and allow for early intervention to mitigate the impact on the disease.

Community

Programs and services are provided at the community level through various individuals and agencies. Clients and population groups have access to services through the health and social services care system, as well as independent agencies that work in conjunction with the system. For example, Community Health Representatives plan and coordinate health promotion activities in the community, based on the overall needs and priorities for the community. This can include activities such as promotion of nutrition in the schools through classroom visits or grocery store tours. Dental therapists provide programs in the schools related to the prevention of dental caries. Public health or community health nurses provide classroom teaching to students on various topics as requested by the school. Other allied health and social services workers provide assistance to residents in a variety of ways that best suit the individual or community needs.

Screening programs include screening for TB, well-man, well-woman clinics and prenatal and postnatal assessments. One community may elect to promote bike safety while another community or region may feel that snowmobile safety or addictions are larger priorities.

Regional

At the regional level, some Authorities have dedicated health promotion staff that coordinate health promotion activities and set the direction of focus for their respective region. Regional programs are linked to community and territorial identified needs for both promotion and prevention type activities.

Territorial

Programs and services at the territorial level include the development of programming frameworks and long-term plans, healthy public policy development, and broad program activity development for initiatives that have territorial-wide applications, such as the *Action on Tobacco* or *Active Living Strategy*. Departmental staff assists in priority and goal setting that support the departmental strategic action and business plans. The Department provides support and creates partnerships with others to carry out the direction identified in these various approved health and social services plans.

Territorial goals are to improve quality of life, improve health status, and decrease the need for expensive treatment. Those tasked with health promotion and prevention maintain working relationships with all levels of government, other service providers, non-government organizations, communities, the private sector, families, and individuals in the development of long-term strategies that support promotion and prevention.

The Vision for Promotion and Prevention Services

Our children will be born healthy and raised in a safe family and community environment, which supports them in leading long, productive, and happy lives.

Preferred Future

In accordance with the *Ottawa Charter of Health Promotion* (1986), promotion and prevention will work towards the betterment of all people and communities by promoting wellness and health, and supporting and encouraging residents to make healthy choices for themselves, their families, and their environments.

Health is understood to be a capacity or resource for everyday living that enables one to pursue goals, acquire skills and education, grow, and satisfy aspirations. In order to achieve the vision as identified, the preferred future will need certain long-term criteria in place to be achievable. These criteria include:

- political will on a territorial, regional, and community level for a long-term health promotion strategy;
- adequate and protected resources;
- adequate levels of skilled staff; and
- on-going monitoring and evaluation[12].

[12] Example of Effective Health Promotion (from *The Shift, 2002, Volume 5)*:
A dramatic example of effective health promotion comes from North Karelia, Finland.
Thirty years ago, North Karelia had the highest death rates in the world. What was unique in N. Karelia was the political will to change. In 1972, the North Karelia project, a comprehensive community based health promotion program for the prevention of heart disease, began. They invested in prevention programs to reduce tobacco use and

In essence, promotion and prevention requires protected resources for a population health approach, where a continuum of activities, programs, and services are systematic and sustainable within an identified funding model. Demonstrated effectiveness will result from ongoing monitoring.

Expected Outcomes

The outcomes or benefits of promotion and prevention using the population health approach extend beyond improved health status outcomes. A healthier population makes more productive contributions to overall societal development, requires less support in the form of health care and social benefits, and is better able to support and sustain itself over the long term. Actions that result in good health also bring wider social, economic, and environmental benefits for the population at large. These benefits include a sustainable and equitable health care system, strengthened social cohesion and citizen engagement, increased national growth and productivity, and improved quality of life.

Changes to the system will allow more increased upstream investments in order to improve wellness and increase the number of productive communities, reduce health care spending, and improve the quality of life for northerners. A population health approach will address health determinants in a comprehensive, well thought out way, based on a long-term vision.

Effective promotion and prevention is the common sense approach to wellness. Much work is required if this is to be done in a logical manner, to establish the right programs for the right people at the right time and to decrease the dependence on the system.

A system that creates a spirit of collaboration and willingness to work together to achieve happy productive communities is achievable; however, it will take money and time. In the long-term, it is well worth the investment and is worth repeating that an *ounce of prevention is worth a pound of cure.*

Assessing the Current Promotion and Prevention System

Promotion and prevention is addressed through a wide variety of people, agencies and organizations at the community, regional, territorial, and departmental levels.

Services provided at the community level:

- Health promotion and nutrition programs and services generally are not distinct at the community level and are often included as part of other services such as well-woman clinics

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to promote healthy eating and active living. These were developed and delivered through partnerships with industry, media, and local communities. Healthy public policies were introduced, including tobacco legislation and policies to reduce the fat and salt content of foods. The net effect was an environment in which the healthy choice became the easy choice. After 25 years, the results show major population-wide lifestyle change in smoking and diet, reduced blood cholesterol and blood pressure, a 71% decrease in lung cancer, and a 49% decrease in all-cause mortality.

and day cares. The level of attention to prevention and promotion varies from community to community and is dependent on the priority and value given to these programs and services, time, and the existence of such programs.

- 33 communities receive services from Authorities. Depending on community size, programs and services may be provided through hospitals, public health units, health centres, or community health workers. Many health centres have a community health representative on staff, either through a full time or part time position. Some Community health representatives are employed through the Band and others are employed through the Authority.
- Community health representatives, nurses, and dental therapists provide programs and services in the schools to promote active living, healthy eating, good oral hygiene, self-care, and healthy lifestyle choices. Because of short staffing, this is not always a regularly scheduled activity.
- The Stanton Territorial Health Authority covers all communities, primarily in the area of care and treatment, with health teaching as part of discharge planning.
- Four communities (Fort Smith, Hay River, Yellowknife, and Inuvik) have separate public health units that focus on prevention, health promotion and screening services. Yellowknife and Hay River offers health information about travel issues and required immunizations for other countries.
- Small communities that do not have community nurses on site may have services provided by a community health worker with other care and treatment services provided on a rotational basis by visiting physicians and nurses from larger centres.
- The *Health Promotion Strategy* through the Department offers one-year funding to community-based programs. Guidelines define that proposed programs support the health and well being of prenatal women, infants, children and youth, particularly in the areas of tobacco harm reduction and cessation, healthy pregnancies, active living, and injury prevention.
- Except where there is an elder's facility, there is limited opportunity at the community level to address the unique promotion and prevention needs of seniors.
- Monthly newsletters to communicate and provide information are distributed in some regions either by the community health representative or from the Authority. Communication within and between communities in the same Authority region is a challenge.
- Some community health and social service centres offer a public health component in their programs. These are NWT mandated programs aimed at people at risk for a communicable disease.
- Prenatal, postnatal, well-child, well-woman clinics and services are offered at the health centres.
- The Yellowknife Public Health Unit has developed a number of information pamphlets covering various health issues. These are posted on the Authority's web site so that other regions can have direct access to this information.
- Childhood and adult immunizations are administered according to standards established by the NWT Immunization Advisory Committee. This has also been noted in the communicable

diseases section. Each Authority assists with nurse orientation and certification to this program and ensures, through audits, that the NWT immunization schedule is being done according to the standards. Childhood and adult immunizations are administered by Community Health Nurses in all 21 small communities as well as to the satellite communities and by the public health nurses in the four larger communities or Yellowknife, Hay River, Fort Smith and Inuvik. This includes promotion, early childhood immunization, and well clinics for adults, school immunization, travel clinics, managing outbreaks of a vaccine preventable disease and occupational health.

- Screening for communicable diseases in the general population may be done at the community level. Screening provides the opportunity for early detection and early intervention, thus decreasing morbidity, mortality, and the spread of a communicable disease. Screening programs that pertain to communicable diseases are addressed under the *Public Health Act* and the *NWT Community Health Nursing Standards*. Currently, there are no health promotion standards in place, as there are in other jurisdictions.

Screening services include:

- screening for TB and testing for sexually transmitted diseases (STDs), and HIV; and
- vision, hearing, and speech screening (offered at the schools).

Screening services for STD or cervical cancer (Pap test) are done either through specific programs or as part of a regular assessment performed by a doctor or nurse at a health centre, Public Health Unit or doctor's office.

There are currently eleven dental therapist positions: six in the Inuvik region, two in the Dogrib region, one in Lutselk'e, one in the Deh Cho region, and one in Ft. Smith. Dental therapists are generally located in the schools and spend most of their time with pre-school and school aged children. Dental therapists provide services in consultation with a Dentist.

Dental therapists provide oral health promotion and dental disease prevention activities at the community level such as:

- fluoride treatments: fluoride varnish to infants and pre-school children who are at-risk for early childhood caries (cavities), and a fluoride rinse and brushing program in the schools;
- sealant: (plastic coatings on the chewing surfaces of back teeth) to prevent caries;
- oral health presentations to teachers, caregivers, special needs groups, health professionals, and colleagues;
- consultative and technical/professional guidance to the public, health professionals, education personnel, and caregivers;
- participating in oral health surveys, collecting baseline information to substantiate and direct program development; and
- traveling (in some cases) to satellite communities to provide basic preventive services and oral health promotion.

Services provided at the regional level:

- There are a number of regional services provided to the 33 communities of the NWT. Nutrition and health promotion programs are distinct programs that operate at the regional level, across many regions, while other promotion and prevention programs and services are based at the regional authority level and operate solely within their area.
- A regional health promotion program is based at Yellowknife Health and Social Services Authority. This program provides services to the five southern Boards and Authorities in 18 communities. Regional services provide print and video resources from the lending library. There is limited support offered at the "regional" level in the area of promotion and prevention (e.g. limited support for community health representatives, dental therapists, etc). At present there is no such program in the Inuvik region.
- Two regional nutrition programs, one based in Inuvik and one in Yellowknife, provide a range of programs and services to the 13 and 18 communities within their respective jurisdictions. The regional nutrition program based in Yellowknife provides services for five Authorities and is mandated to work within the early childhood and seniors health area.
- Local health professionals from Stanton Territorial Health Authority offer diabetes prevention and treatment services in some communities through a traveling team. In other communities, local health providers provide this service.
- Community wellness, home care, and dental programs exist regionally in the Deh Cho, provided by the Deh Cho Health and Social Services Authority.
- An Early Childhood Program operates in the Dogrib Region under the Regional Health and Social Services Program, Dogrib Community Services Board.
- A Community Health Services Program operates in Hay River and includes public health, diabetes, and home care services. Some services are extended to the Hay River Reserve, which is under the Deh Cho Authority.
- Inuvik regional services include dental, diabetes, and nutrition and home care programs.
- Yellowknife Health and Social Services Authority, under the Community Health Program, operate a Home Care Program and Public Health Unit, providing service to Yellowknife, Dettah and N'dilo.

Support provided by the Department of Health and Social Services:

The Department has a health promotion team comprised of one team leader and two health promotion specialists.

The Department developed a health promotion strategy, entitled *New Directions: Healthy Choices* (1998), which is ongoing and evolving. Through this strategy, a number of priority areas for the GNWT were established. Currently, the three major areas being addressed are:

- *Action on Tobacco Strategy*;
- Healthy Pregnancies; and
- Active Living.

A fourth area that is being developed will focus on injury prevention.

In addition, a number of initiatives link with activities that have territorial wide applicability, such as the health promotion fund, community health representatives training, and setting up an evaluation framework for health promotion and prevention.

The Department's health promotion team works in cooperation with a wide variety of partners and organizations. Examples of this type of cooperation include:

- development of a CHR training strategy in consultation with key stakeholders and community health representatives;
- development of strategic direction and plans that are applicable to a territorial population base;
- planning comprehensive health promotion strategies based on a Population Health approach. These strategies focus on the health of populations, address key determinants and their interactions, base decisions on evidence, and recommend increases to upstream interventions. (Upstream interventions are intended to help people maintain or improve their health before it is compromised). The strategies also apply multiple strategies, collaborate across sectors and levels, employ mechanisms for public involvement, and demonstrate accountability for health outcomes;
- working with regions, communities, and organizations on various components of each strategy and each strategic direction;
- working with partners at the and provincial levels, as well as providing direction, and taking direction from the JLC and JSMC; and
- funding certain non-government organizations, such as the Northern Nutrition Association for a School Tobacco and Healthy Eating survey, and the Canadian Public Health Association, NWT/Nunavut Branch for assistance with the Quit and Win Contest, etc.

Support provided by territorial agencies:

- At the territorial level, separate from Departmental activities, Stanton Territorial Hospital provides activities in prevention through the Diabetes Education Program, primarily by working with the Diabetes Care Network. There are a number of prevention programs that occur through traveling diabetes teams and screening clinics. These programs aim to prevent further complications of diabetes.
- Territorial organizations may provide components of promotion and prevention activities through such efforts as breast health awareness (NWT Breast Cancer Action Group), NWT Baby-Friendly Breastfeeding Initiative Committee, Canadian Diabetes Association, Canadian Public Health Association, and the NWT Parks and Recreation Association, etc.
- Some prevention and promotion activities are also being conducted by Aboriginal organizations, such as the Dene Nation and Inuvialuit Regional Corporation. These, and other organizations, receive some funding from the GNWT or the federal government for health or health-related promotion and prevention programming.

Federal Wellness Funding Linkages:

- Federal funding is available on a proposal basis for programs such as Aboriginal Head Start, and the Aboriginal Diabetes Initiative, Brighter Futures, Canada Prenatal Nutrition Program, Community Action Program for Children, etc.
- Some of the federal programs are supported through the Northern Secretariat situated in Ottawa which consults with the GNWT and local providers. Other programs, such as *Brighter Futures* and the *First Nations and Inuit Canada Prenatal Nutrition Program* are administered by the GNWT Department of Health and Social Services. Funding is accessed on a proposal basis and is allotted depending on community size. Funding is channelled to the communities via the Bands. In some cases programs and services are offered at the health centres (i.e. Canada Prenatal Nutrition Program) in which case the nurse and community health representative are involved with the delivery of the program.
- Community based Canada Prenatal Nutrition Programs receive program support, assistance in proposal development and reporting requirements, program planning and delivery, and training, including skill and knowledge development through regional nutritionists for the program. There is one position in the "south" and one in the "north".

Service Delivery Challenges

Promotion and Prevention activities significantly cut across the entire spectrum of core service areas. The service provided is often to service providers, community governments, and other organizations rather than health and social services clients and their families. This is particularly true for health and wellness promotion. The challenges are therefore varied and significant. The following looks at the challenges from a number of perspectives: working together, training and skill development, research and knowledge, communication services, healthy public policy, and community development.

1. Working Together:

Ensuring that those involved in health promotion and prevention activities (e.g. dental therapists, community health representatives, community wellness workers, etc.) are part of an integrated collaborative team at the community, regional, and territorial level will be an ongoing challenge. This is particularly true of those who work at different sites within a community (e.g. dental therapist at the school).

Regional support to community health promotion and prevention activities will be critical to working together effectively. The challenge will be to establish the need for health promotion and other specialists/supervisors at the regional level across the HSS system.

Another challenge is ensuring sufficient funding for health promotion and prevention activities is consistently and evenly distributed throughout the system.

2. Training and Skill Development:

Providing appropriate training and skill development opportunities for community staff is a significant challenge.

Appropriate, consistent, and ongoing cross-cultural awareness training opportunities are vital for health and wellness professionals who come to work in the NWT. It has always been a challenge to offer this kind of awareness and evaluation on a regular and consistent basis.

3. Research and Knowledge:

A major challenge is knowing whether health promotion and prevention and the related programs and activities are having a positive impact on the health and well being of the population in the NWT. Without being able to demonstrate in concrete terms the efficacy of health promotion and prevention activities, it is difficult to maintain or increase funding levels. It is therefore critical that solid indicators and measures, together with regular and consistent data collection across the system, be put in place to help substantiate expanding this vital area. The challenge will be to show clearly that an investment in health promotion and prevention is a wise and effective choice in the work towards the Department's vision of having children born healthy and raised in a safe family and community environment.

4. Communication:

A critical ingredient of the ISDM is clear communication. Moreover, as highlighted in the principles underpinning the model, there must be transparency in communication at all levels throughout the system. If integration and collaboration are to work, especially in the health promotion and prevention area, clear communication between and amongst service providers at all levels is critical.

One cautionary note is in regard to confidentiality. It is a matter often cited as a barrier to communication as well as to integration and collaboration. The challenge will be to reassure the public that our efforts to integrate and collaborate to provide a better service will in no way jeopardize their confidentiality. Clear guidelines and protocols will need to be in place to safeguard this fundamental right of our clients and their families.

5. Reorienting Services:

It is estimated that most jurisdictions across Canada spend about five percent of the health and social ISDM shows that about forty-nine percent of the health and social services budget is spent on treatment and an average of three percent is spent on prevention and promotion. New ways of providing programs and services with adequate funding are required.

The challenge will be to ensure health promotion and prevention becomes a long-term priority at all levels (community, regional, and territorial). Many other community and regional priorities overshadow this area, such as self-government and economic development, which do not tend to consider promotion and prevention as a key component of the system.

6. Healthy Public Policy:

Standardized health promotion and prevention policy needs to be created in a number of areas (e.g. dental health, infant feeding / breast feeding, active living) as well as the development and implementation of specialized programs (e.g. prevention of infant anemia or childhood obesity). The commitment to work on these activities will depend largely on being able to demonstrate concretely that such efforts make a significant impact on the health and well being of NWT residents.

7. Community Development:

Community development is a concept that is largely misunderstood. It is really about communities developing the capacity to find community solutions to community problems or issues. The role of health promotion and prevention is to equip communities through awareness, information, education, and training. Individuals and communities as a whole need to be encouraged to explore the range of possibilities open to them. This is an ongoing challenge and there is a need to create community development opportunities in a structured, consistent manner.

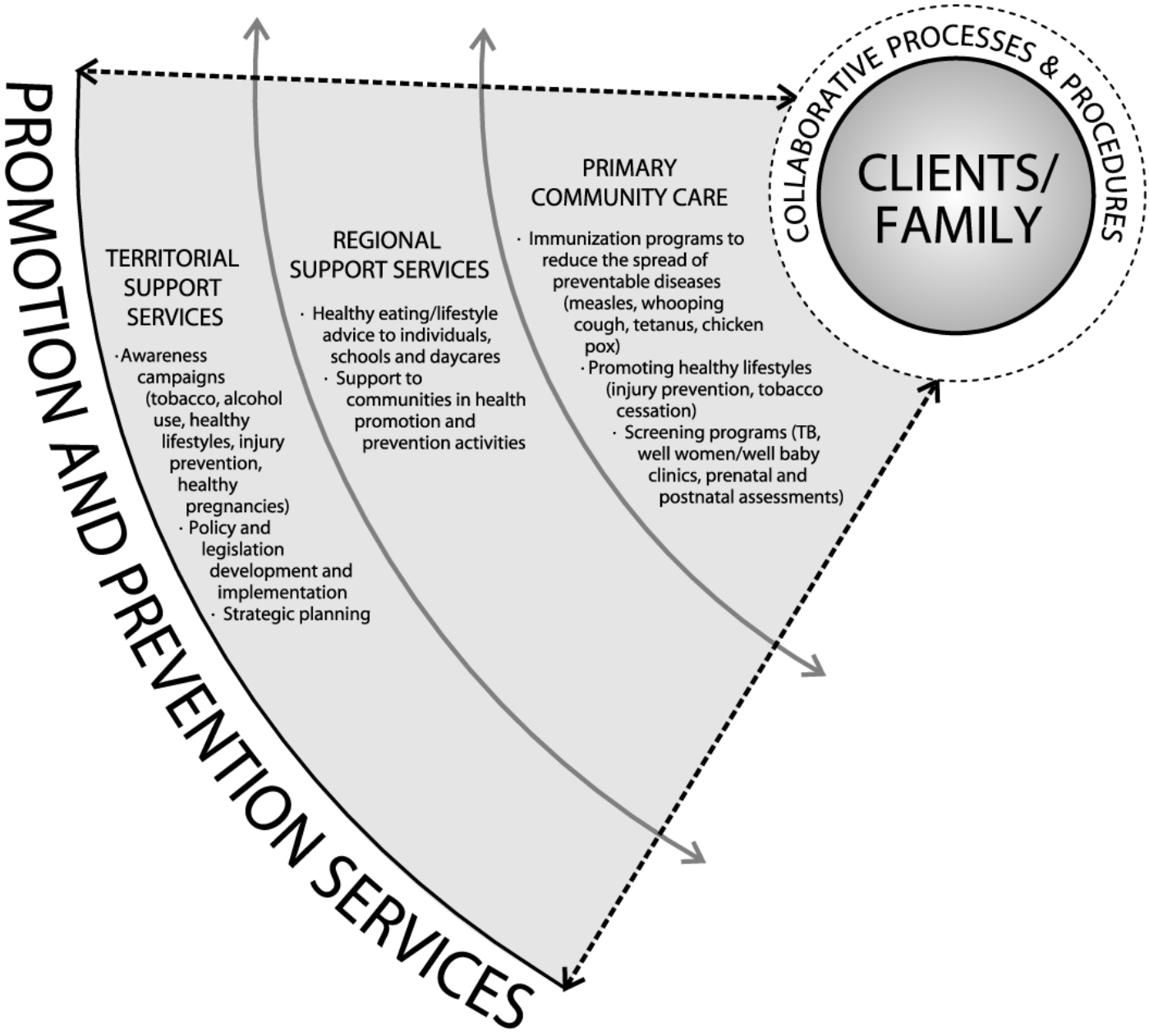
Health Promotion and Prevention within an Integrated System

Health promotion and prevention services are one of the six core services identified within the ISDM. Delivery of these services is founded on a PCC approach.

Figure 10 illustrates the continuum of promotion and prevention services available in the NWT. Direct program delivery is found at the community level, using a community development approach. It is essential that the communities identify the priorities and needs for their community and plan their programs accordingly. At the regional level, there is some direct promotion and prevention type activities but the majority of the support is provided in the form of training and skill development type activities, along with regional awareness and promotion campaigns. The territorial level is more focussed on providing direction through various strategic plans that address the identified needs of the north.

Partnerships are developed to create environments that support personal responsibility for health gains and healthy lifestyle choices. This is often referred to as an *upstream approach* to creating wellness and improving health status. It is imperative that all staff understand their role within the promotion and prevention field. They need to take opportunities to provide information and create awareness whenever they can. This individual approach along with group support and awareness are essential elements in the effective delivery of promotion and prevention programs.

Figure 10: Promotion and Prevention within an Integrated Services Delivery System



Enhancing Promotion and Prevention Services

An integrated and well-funded system for prevention and promotion, not overshadowed by treatment, is being proposed using a Population Health approach that supports the PCC model of delivery. Developing a strong promotion and prevention approach requires territorial, regional, and community support and public involvement. Under the direction of the JLC / JSMC, a core group of promotion and prevention team members would create a virtual "Centre of Excellence for Health Promotion" in the NWT. Groups involved would play the lead role in creating environments so people in the NWT are able to make healthy choices that enable them to lead productive and happy lives. Consolidating, enhancing, and re-profiling health promotion and prevention funding will achieve more successful outcomes.

There are eight key elements in Health Canada's *Population Health Template Working Tool* (2001) that is proposed for the NWT. All eight elements are necessary to fully implement a population health approach. Table 8 explains the steps to implementing a population health approach based on the Health Canada template. Communities, regional, and territorial organizations, including the Department, must carry out these actions to ensure that health promotion is effective.

The Department's health promotion strategy, *New Directions: Healthy Choices* (1998) would form part of element #5 of this proposed model. It would be one of the many strategies to be employed to enhance existing services.

Table 8: Population Health Template Working Tool

Elements	Definition	Steps	Examples
1. Focus on the health of the population.	Assess health status and health status inequities over the life span at the population health level.	1.1. Determine indicators for measuring health status 1.2. Measure and analyze health status to identify health issues a. Assess conditions characteristics and trends	This element introduces the issue or concern and explains its connection to health and the populations affected by it.
2. Address the determinants and their interactions.	Measure and analyze the full spectrum of factors, and their interactions, known to influence and contribute to health determinants.	2.1 Determine indictors for measuring the health determinants. 2.2. Measure and analyze the determinants of health and their interactions to link the health issues identified in element 1 to the determinants.	This element "frames" the health issue in terms of how it came about, e.g. what factors or determinants contributed to it, and how far upstream these factors located. This forms the basis for population health interventions.
3. Base decisions on evidence.	Population health uses "evidence-based" decision making". Evidence of health status,	3.1 Uses best-evidence available at all stages of policy and program development.	This element defines evidence-based decision making and the need to support findings and recommendations. It includes

Elements	Definition	Steps	Examples
	the determinants of health and the effectiveness of interventions is used to assess health, identify priorities and develop strategies to improve health.	3.2 Explain criteria for including or excluding evidence. 3.3 Use a variety of data. 3.4 Generate data through many measures. 3.5 Identify and assess interventions for effectiveness Disseminate research findings and facilitate policy uptake.	info about what evidence is available, strengths and weaknesses.
4. Increase upstream investments.	The potential for improved population health is maximized by directing increased efforts and investments "upstream" to maintain health and address root causes of health and illness. This creates a more balanced and sustainable health system.	4.1 Apply criteria to select priorities for investment, such as: - magnitude of the health issue(s); - status of current response; - ability to effect change; - readiness of key players; - appropriateness for involvement; and - cost effectiveness. 4.2 Balance short and long-term investments. 4.3. Influence investments in other sectors.	This element explains the options for intervention considered and how choices are made in terms of addressing immediate causes, and at deeper levels (broad determinants) over the long-term – for example, in upstream investments (protection, prevention, health promotion and action on determinants) and downstream investments (treatment or rehabilitation).
5. Apply multiple strategies.	Population health integrates activities across a wide range of interventions that make up the health continuum, from health care to prevention, health promotion, and action on health determinants	5.1 Identify scope of action for interventions. 5.2. Take action on the determinants of health and their interactions 5.3. Implement strategies to reduce inequities in health status between population groups. 5.4 Apply a comprehensive mix of interventions and strategies. 5.5. Apply interventions that address issues in an integrated way. 5.6. Apply methods to improve health over the life span. 5.7. Act in multiple settings. 5.8 Establish a coordinating mechanism to guide interventions.	This element answers the question "how much should we take on". It frames the actions or strategies and describes combinations, levels, and at what sites, over what time frame and who will implement them. An example of one strategy that would continue to be applied is the Department's Health Promotion Strategy, *New Directions: Healthy Choices* (1998).

Elements	Definition	Steps	Examples
6. Collaborate Across all Sectors and Levels.	Population health calls for shared responsibility and accountability for health outcomes with multiple sectors and levels whose activities directly or indirectly impact on health or the factors known to influence it.	6.1 Engage partners early on to establish shared values and alignment of purpose. 6.2 Establish concrete objectives and focus on visible results. 6.3 Identify and support a champion. 6.4 Invest in alliance building. 6.5 Generate political support and build on positive factors in the policy environment. 6.6 Share leadership, accountability, and rewards among partners.	This element describes the partnership-building process and what it takes to make it work. It includes who is represented at the table and how they are contributing. It also explains how the group is structured and organized, people's roles, responsibilities and relationships. This includes leadership, management, coordination, processes, mechanisms and communication modes.
7. Employ Mechanisms for Public involvement.	Population health promotes citizen participation in health improvement. Citizens are provided opportunities to contribute meaningfully to the development of healthy priorities and strategies and the review of health-related outcomes.	7.1 Capture the public's interest. 7.2 Contribute to health literacy. 7.3 Apply public involvement strategies that link to overarching purpose.	This element outlines how the public is involved at different stages of the initiative (e.g. needs identification, planning, delivery, evaluation), including their roles (advisory committee members), peer helpers and the process by which they are engaged (e.g. surveys, focus groups, community forums).
8. Demonstrate accountability for health outcomes.	Population health focuses on health outcomes and determining the degree of change that can actually be attributed to interventions.	8.1 Construct a results-based accountability framework. 8.2 Develop baseline measures and set targets for health improvement. 8.3 Institutionalize effective evaluation systems. 8.4 Promote the use of health impact assessment tools. 8.5 Publicly report results to facilitate knowledge uptake.	This element identifies the accountability tools needed to capture and report on changes in the health status of populations and determinants of health.

In order to enhance promotion and prevention services in the north, these eight key elements need to become the cornerstone for all future work. Some of the types of activities that will occur to implement these key steps are as follows:

- long-term goals will be developed at the territorial level, with input from the regions and communities, to ensure the goals truly reflect the overall needs of the population;
- health promotion and prevention tools will be developed, adapted, or adopted from other jurisdictions to meet a range of learning styles and literacy levels. These tools will be used

consistently throughout each region. Use of these tools will assist in creating an integrated, collaborative approach to programs and services;

- work plans for staff at all levels will clearly indicate the areas of health promotion and prevention that will be addressed. This will be in keeping with community, regional, and territorial priorities. This will also include record keeping, data collection, and analysis to ensure that future planning is firmly established on evidence-based information;
- the Department will ensure that integrated approaches to population health are utilized and that the programs are community-based, flexible, and comprehensive. Ongoing data analysis will determine program effectiveness and outcomes and changes to health status;
- standardized policy and procedure manuals will be developed in areas such as nutrition and/or dental health;
- a territorial *Oral Health Strategy* developed by a Dental Steering Committee will provide a framework for providing prevention and oral health services, based on community size. Monitoring and evaluation will be a strong component of this work (see also Diagnostic and Curative Services);
- module-based and mentorship training will be developed and implemented;
- training of local coordinators (such as community health representatives) will be provided in order to strengthen community-based promotion and prevention programs;
- regional staff will be hired to provide support to the community level providers;
- minimum qualifications identified in approved job descriptions for the hiring of community health representatives will be standardized;
- telehealth will be used as a means of communicating – creating linkages and supporting training;
- a Community Health Team model will be developed. This team will interact with a Regional Support Team in training, planning, delivering. and evaluating health promotion and prevention programs and services. Services will be offered in a meaningful way that is cooperative and collaborative;
- PCC teams, who will deliver programs and services, will be multi-disciplinary (e.g. will include health promotion specialists). An adequate mix of appropriately trained personnel will be integrated into the teams at all levels;
- linkages with non-government organizations, other government departments, band councils, schools, etc. will be made as appropriate. This will ensure stronger programs and services and increased cooperation, leading to consistency within programs and less duplication;
- public consultation and review will be requested as each new strategy is developed;
- communities will be asked to identify their priorities and needs through surveys, consultation and feedback;
- young mothers and adults will be supported to return to school;
- diabetes education programs will be enhanced; and
- a system of tracking changes will be developed and reviewed in order to determine changes to health status.

Further work must be carried out to ensure that the template (Table 8) is being applied in a systematic way to the overall planning, implementation, and evaluation process for health promotion and prevention. Through this work, the Department, working with Authorities and other partners, will ensure a full range of programs and services is available, accessible, and appropriate for all those in the NWT.

These tasks will require budget allocations specifically dedicated to this area. Budget allocations will be dedicated specifically to promotion and prevention programs. The long-term goal is to have 20% of budgets allocated to health promotion and prevention activities. Changes will not be seen immediately but will take place over the long-term. Patience and long-term support is essential for this system to be effective.

Managing the Required System Changes

As implementation of the ISDM unfolds, each element outlined in the population health template working tool needs to be addressed. There will be challenges, since health promotion is often only considered when there is extra time to do work in this area. Priorities are often not well defined. As well, health and social services workers often work in isolation of each other and also in isolation of other service providers within their communities and regions. Barriers include a lack of time to devote to establishing priorities and committing to a process of evidence-based decision-making. Many at the community level, such as community health representatives, are involved in activities that are more treatment or administrative, and it will be necessary to reorient the way work is done. Health promotion and prevention work-plans must be completed, activities monitored, and outcomes measured. The determinants of health must be addressed in a coordinated fashion.

Recruiting and retaining people with health promotion expertise may be difficult, as a certain skill set is needed to undertake effective health promotion strategies at all levels. Individuals who work in PCC must work in multi-disciplinary settings and use multiple strategies, where the wellness of individuals, families, and communities are seen in a holistic way. Job descriptions and training will need to be developed to reflect this need for special expertise.

Community, regional and territorial teams can join together to use a population health approach that provides opportunities to better serve the population as a whole. Access to programs and services that improve the environment of the individual, family, and community must all be taken into consideration. Teams must work together with a wide variety of partners, organizations, and the private sector to achieve the aims that are set out for populations as a whole.

Establishing Immediate Priorities

Recognizing that the population health template working tool can be utilized within the framework established by the ISDM, the following priority has been identified.

- Develop healthy living / healthy choices programs in the areas of:
  - tobacco;
  - diabetes;
  - injury prevention;
  - healthy pregnancies; and
  - addictions.

Mental Health and Addiction Services

Defining Mental Health and Addiction Services

Mental health and addiction services encompass the areas of mental health, addictions and family violence through prevention, treatment and aftercare and are delivered as an integrated program. These services assist those with a mental illness, mental health issues, addiction, or concurrent disorders to receive the care and support they need to live in optimal health.

Examples of Mental Health and Addiction Services

- community based mental health and addiction counselling services;
- prevention, promotion, education, and awareness services;
- assessment and referral to psychiatric and psychological services;
- crisis stabilization and group home services for those with a mental illness;
- medical detoxification;
- residential treatment for persons with addictions, mental health, and concurrent disorders; and
- family violence prevention and shelter programs (see also Protection Chapter).

Levels of Service

Prevention, treatment, and aftercare services are available with coordination and clinical supervision at a regional level. The PCC team makes referrals to secondary and tertiary level services. Some facility based / specialized mental health and addictions services are available at the territorial level. Out-of-territory care is available when the NWT capacity is exceeded or unable to provide the most appropriate care required. These services assist those who have an addiction or those who suffer from mental health issues to receive the care and support they need to live with optimal independence and health status.

The Vision for Mental Health and Addiction Services

People will be supported to live balanced lives by promoting, protecting, and restoring their mental well being.

Preferred Future

The staff and other service providers for Mental Health and Addiction Services will be integrated into the PCC team of the HSS system.

Best practices and research indicate strongly that in order to assist and support an individual dealing with an addiction or family violence issue, it is critical to address the underling mental health issues that contribute to the addition or violence / abuse experienced by an individual or

family must be addressed. One cannot separate the two when counselling and treating the individual and/or family.

The philosophy of this core service area is best illustrated using the analogy of the ***umbrella of mental health***, where it is understood that mental health encompasses such issues as mental illness, addiction, trauma, family violence/abuse, residential school abuse, etc.

These services will undergo a paradigm shift in its clinical structure and definition. The current and very separate addiction and mental health programs will be integrated into one ISDM, where the provision of services are delivered through a multidisciplinary team who will provide prevention, treatment, and aftercare services at multiple levels (community, regional and territorial).

The multidisciplinary team will be translated primarily through the following positions:

- Community Wellness Workers;
- Community Mental Health Workers; and
- Clinical Supervisors.

In staffing these positions, the Authorities will be able to tailor their Mental Health and Addictions team to offer therapeutic and clinical counselling in the areas of addiction, mental health and family violence. A variety of practitioners will be recruited from such professions as social work, nursing, mental health workers, addiction counsellors, etc. all having a wealth of experience in front line work. These teams will be operating at the community and regional levels.

Mental health and addictions services will provide residents with a continuum of services that will allow clients to continue living in their community or region with supports that can be accessed through the HSS care provider. The client will be able to access primary services such as assessment, counselling, and referral services as well as a variety of psychiatric crisis services that will support them through a personal or family crisis or a more organic psychiatric crisis (Assertive Community Treatment Team or Crisis Stabilization Units). A level of care at the regional level will be provided to assist clients and their families in maintaining a certain degree of independence, as they are able to access such placements through group homes services or through supported independent living units. These services will be accessible through the PCC team.

Mental health and addictions services will also provide residents with access to residential treatment programs for addictions, mental health, or concurrent disorders for the adult and youth populations. These services will be accessible through the PCC team.

Specific Future Outcomes

Mental health, addictions, and violence are complex inter-connected issues with deep, root causes that can stem from systemic or biological problems. Changes to the system will allow better access to services for clients. Any member of the PCC team can act as the point of entry

into the system. The new system will have flexibility, easier access to information, and appropriate referral to more specialized services. Accessibility, accountability, coordination, and evaluation will be emphasized, using a multidisciplinary service delivery approach to providing care.

The client has the right to make choices about the support and care they require. Services will be provided in the least restrictive environment as close to the person's home as possible. Communities and families will be supported in their efforts to maintain balance in their lives while providing care for vulnerable community and family members.

Prevention

Effective prevention services for mental health, addictions, and violence require trained staff working in a team environment. Members of the PCC team act as a resource for referral and provide supervision and direction. Prevention messages and support come from each member of the team in a variety of settings. Specially trained Community Wellness Workers will take the lead in prevention outreach, community wellness, and group events. The expected outcome would be that:

- people have knowledge, support and skills to make healthy lifestyle choices with respect to healthier relationships, positive parenting, reduction in risky behaviours, reduction in the consumption of alcohol and other drugs/substances, etc.

Treatment

Effective treatment programs rely on trained staff working in a team environment. Skilled, community-based providers are the key to supporting and delivering integrated services. They understand the community needs and have the capacity to deliver services in the community where they live and work. The expected outcome would be that:

- people have access to qualified therapeutic staff and/or programs to resolve their mental health, addiction and/or Family Violence problems, which in turn, would result in reduced symptoms, decreased medications, increased personal stability and wellness, etc.

Aftercare

Enhanced working partnership between clients, their families, service providers, communities, and government to plan, develop, and deliver services will be developed. Expected outcomes would include:

- people will maintain the gains made in treatment; and
- people will have fewer re-admissions to addiction and/or psychiatric treatment services.

Assessing the Current Mental Health and Addiction Services Delivery System

Mental health and addiction services are offered through a wide variety of agencies at the community, regional, and territorial level.

Services provided at the community level:

- A total of 27 community addiction programs are funded through six Authorities. Some of these programs offer blended mental health and addictions services.
- Counselling, support, education and prevention strategies and programs on addiction issues are provided by the community Addiction Counsellors, in partnership with non-government organizations and other GNWT Departments such as Education, Culture and Employment and Justice.
- Current addiction and mental health services include basic assessment, preliminary counselling, some specialized counselling, referrals to treatment and treatment follow-up/aftercare on an individual and/or group basis. The level of service provided varies among communities.
- In the absence of mental health and addiction counsellors, nurses and social workers provide ad hoc mental health and addiction services to residents especially in the small communities in the NWT.
- Mental health programs and on-the-land programs for youth are offered by some Aboriginal band councils who use federal community wellness program funding, such as the *Brighter Futures Program* (approximately $4 million per year).
- Friendship Centres offer support and referral programs utilizing a variety of funding sources.
- Healing activities in response to residential school abuse are offered by Aboriginal organizations through funding accessed from the Aboriginal Healing Foundation. This funding has been available since 1999.
- Committees responding to the specific needs of their community have been developed in some communities. For example, Suicide Prevention and Response Teams, Residential School Healing Circles, and/or Wellness Committees.
- Assessment and referral services to residential addiction treatment programs are provided when required.
- Community-based family violence prevention programs providing counselling, referral, and advocacy services are found in Fort Good Hope (Victims of Violence Advocacy Program) and Fort Providence (Family Life Program).

Services provided at the regional level:

- Mental health services provided by social workers, nurses, and/or physicians are funded through the Authorities. Services are either delivered directly through authority staff or through non-government organizations.

- Authorities fund residential treatment services for children in care and southern treatment services.
- Community-based Mental Health Workers and/or Regional Mental Health Specialists are found in some Authorities.
- Counselling centres offering services region-wide are found in Inuvik, Yellowknife, and Hay River.
- Regional psychiatric support in Yellowknife includes: psychiatric group homes and supported independent living units (available to territorial residents) and one mental health drop-in centre (The Independent Clubhouse). The Yellowknife Authority administers these contracts.
- Safe Shelter programs, funded through the Authorities, that are delivered by non-government organizations include:
    - Inuvik Transition House;
    - Sutherland House – Fort Smith Tawow Society;
    - Allison McAteer House – Yellowknife;
    - Hay River Family Resource Centre; and
    - Tuktoyaktuk Women and Children's Shelter.

Services provided at the territorial level:

- Stanton Territorial Hospital Psychiatry Unit provides observation, assessment, diagnosis, and treatment of acute adult psychiatric inpatients. There is a resident psychiatrist and a visiting psychiatrist who provide care as part of the overall team. Children receive limited assessment, diagnosis, and treatment from a visiting child psychiatrist.
- The Stanton Territorial Hospital Psychiatry Unit provides an unofficial, 24/7-crisis line that clients or caregivers can access.
- A Critical Incident Stress Management team is accessible by contacting the Yellowknife Program Coordinator.
- The Stanton Mental Health Clinic provides counselling services in Yellowknife and also provides visiting services in some NWT communities on a regularly scheduled basis.
- Residential addictions treatment services are offered through the Nats'éjée K'éh Treatment Centre (Hay River Reserve) with territorial funding routed through the Deh Cho Health and Social Services Authority. Nats'éjée K'éh provides a 30-bed adult (co-ed) program for substance abuse.
- A Help Line/HIV/AIDS Information Line operates every evening from 7 to 11 p.m. and is administrated by the Canadian Mental Health Association – NWT Division.

Services provided by the Department of Health and Social Services:

- Program Consultant positions in Mental Health, Addictions, and Family Violence.
- Contribution agreements with territorial non-government organizations (i.e. Canadian Mental Health Association - NWT Division).

- Psychiatric treatment services contract with Alberta Hospital Edmonton.
- NWT Suicide Prevention Training Program.
- Authorities access funding to refer youth to southern residential addictions treatment programs. This funding is also used for adults whose treatment needs are beyond the scope of services delivered at Nats'éjée K'éh Treatment Centre.
- Mobile Treatment Pilot Programs for Women and Youth were delivered in response to community requests to have addiction treatment provided closer to home. These programs incorporated traditional healing and the knowledge of elders and utilized community addiction counsellors.

Services provided by non-government organizations:

- The Aboriginal Healing Foundation funds many community based education and healing projects related to residential school issues.
- The Salvation Army Withdrawal Management Program is located in Yellowknife and funded by the Yellowknife Authority. The program targets adults who are experiencing initial stages of withdrawal from alcohol and/or other drugs and offers them a safe environment to begin the early stages of recovery from addiction.
- The Women and Children's Healing and Recovery Program is operated by a coalition of Yellowknife non-government organizations, with funding from the Yellowknife Authority. The program targets women dealing with trauma (e.g., sexual abuse and domestic violence) and addiction related issues. This program is accessible to women from outside Yellowknife although housing and travel are not funded.
- The Centre for Northern Families (formerly the Yellowknife Women's Centre) provides emergency, drop-in, outreach, and support services to women and their families. Services include emergency housing, advocacy, prenatal and postnatal programs, family support program, clothing depot, a lunch program, and supportive counselling.

Current Service Delivery Challenges[13]

At present, providers are often delivering services to the same client but are not aware of what services their fellow practitioners are providing. This can create a significant duplication of services. Another concern is that the client often does not know where to go or which service provider to see. Consequently, the client does not always obtain the services they require from the most appropriate provider, at the best time, in the right setting, in the most economical manner. These represent the key challenges in the delivery of mental health and addictions services. The following challenges also need to be addressed in the development of a more fully integrated and comprehensive service delivery system for mental health and addictions:

[13] Numerous reports have identified gaps in the system including *"A STATE OF EMERGENCY..." - A Report on the Delivery of Addictions Services in the NWT*, May 2002; *Minister's Forum on Health and Social Services*, January 2000; *Mental Health Needs Assessment*; and *Social Agenda - A Draft for People of the NWT*, April 2002.

- increasing the flexibility and coordination of community-based services;
- enhancing case management -- i.e. linkages with other service providers such as schools, justice, and/or recreational programs;
- emphasizing prevention and promotion programs at the community level;
- increasing accessibility to community mental health and addiction services and specialized mental health and addictions treatment for adults and youth;
- increasing clinical support/supervision for front-line workers;
- increasing training for front line staff;
- enhancing current residential addictions treatment services to include treatment for concurrent disorders and mental health treatment programs; and
- increasing access to mental health and addiction services after hours.

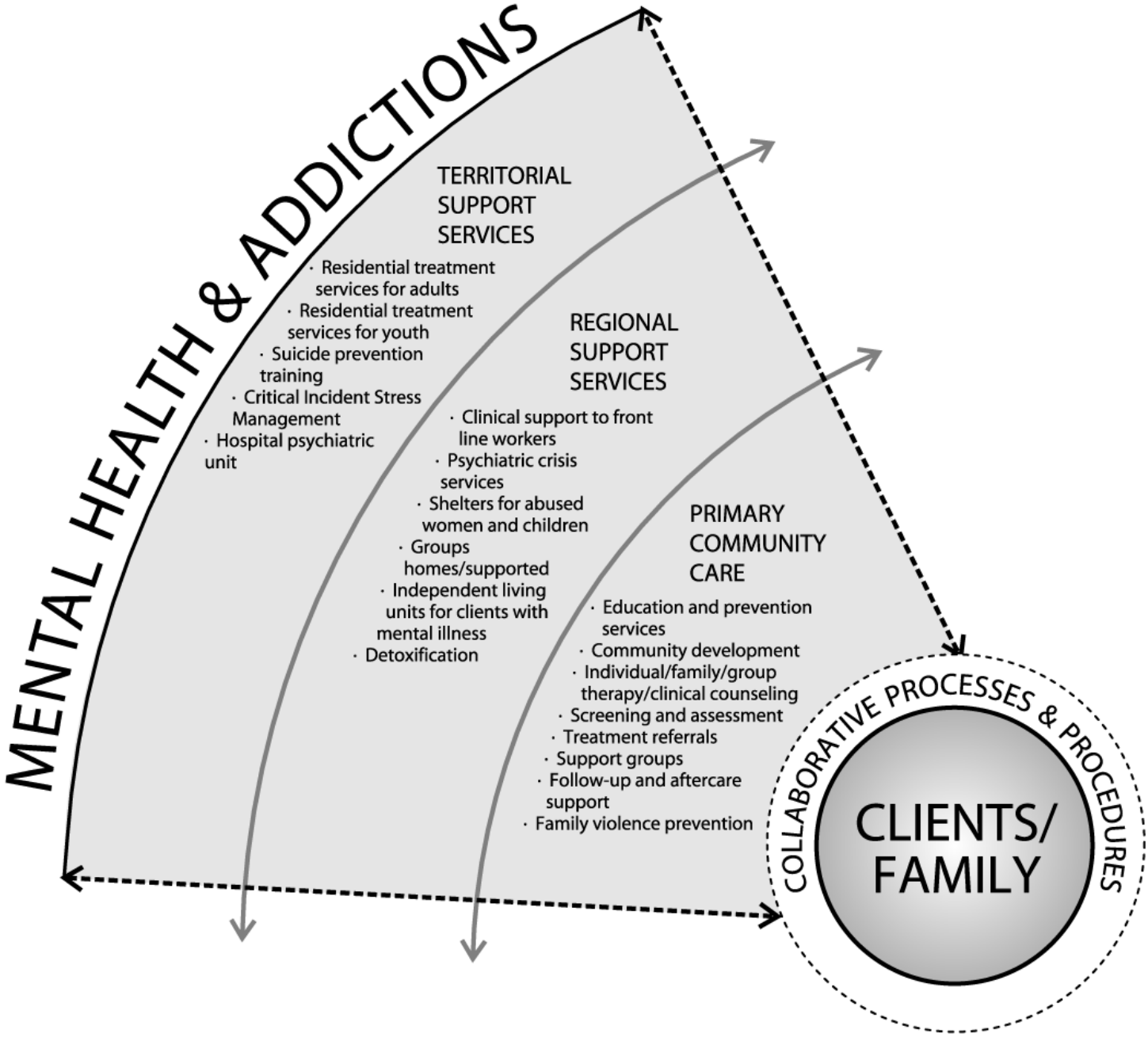
Mental Health and Addiction Services within an Integrated Service Delivery System

Mental health and addiction services is one of six core services identified within the ISDM.

Figure 11 illustrates the continuum of mental health and addiction services available in the NWT. Prevention, awareness, and early intervention services are provided at the community level to the greatest extent possible, with a focus on addiction, mental health, and family violence. Aftercare programming and services are also offered, wherever possible, within communities. Professional mental health counselling and support services are provided at the regional level with residential treatment, tertiary care, and psychiatric services offered at the territorial level. In some situations, referrals outside of the NWT are required.

Although the focus for community, regional, and territorial level services is somewhat different, all three levels share responsibility for addressing basic prevention, treatment, and aftercare issues. As well, due to the complex nature of mental health and addictions problems, it is imperative that mental health and addictions staff forge linkages with other care providers within the HSS system, including NGO providers. Case management techniques, standardized assessment and referral procedures, single point access, and other collaborative processes and procedures are essential elements in the effective delivery of mental health and addiction services.

Figure 11: Mental Health and Addiction Services within an Integrated Service Delivery System



Enhancing Mental Health and Addiction Services

The following section describes the various levels of service for mental health and addiction in terms of enhancements in prevention, treatment, and aftercare. PCC teams, with strong regional and territorial support, will play a lead role in ensuring that all people of the NWT are able to live productive and balanced lives. This will be achieved by consolidating and re-profiling community, regional, and territorial funding and providing the required supports as identified by the communities and regions. These enhancements will be part of an overall action plan to guide implementation over the short, medium and longer term.

Enhancing Prevention Services

1. **Community wellness workers** will provide communities with prevention and promotion activities regarding healthy lifestyle choices. The community wellness workers will work within the PCC team, focussing on education, prevention, and after care. They will provide information about the negative impacts of substance abuse, unresolved mental health problems, and untreated mental illness. The community wellness workers will also provide support to self-help groups and will assist with the development of recovery and aftercare groups. The community wellness worker will play an important role in community development and support of interagency activities.

   Training of personnel is recognized as fundamental for strengthening and developing community-based services. Community wellness workers require a level of education and training in order to meet the demands of the job. Training will be module-based with current workers having access to training for several years to meet new responsibilities and qualifications.

   Current mental health / addiction staff could provide this level of service. Their level of training and skills will be assessed (using Prior Learning Assessment tools and other methods) and further training will be offered if necessary, in partnership with Aurora College and other partners to ensure community wellness workers receive the education required to meet the expectations of this role.

   Community wellness workers will be able to refer clients to a Community Mental Health Worker or other members of the PCC team, either in their community or in a larger community. Clinical supervisors (who may be located in another community) will provide supervision.

2. **Mental health, addictions, and violence prevention educational tools** will be developed, adapted, or adopted from other jurisdictions and used consistently throughout each region. This will assist in creating an integrated, collaborative approach to service delivery.

3. **Suicide prevention training** must have strong Departmental and Authority support to ensure continued success.

Enhancing Treatment Services

1. **Community mental health workers** will provide integrated community mental health counselling services.

   The community mental health worker is a member of the PCC team, providing care to people living with mental illness and those who require specialized mental health and addiction services. The community mental health worker will:

   - provide therapeutic individual, group, and family counselling in the areas of mental health, addictions, trauma, marital, sexual abuse, etc.;
   - provide comprehensive mental health and addiction screening / assessments;
   - monitor and manage psychiatric medication regimens;
   - utilize case management techniques;
   - organize referrals to specialized addictions and psychiatric services at the regional and territorial levels as required; and
   - assist with crisis intervention.

   The community mental health worker position stresses a community development approach to services using the context of the client's family and home environment.

   Community mental health worker positions will be staffed in medium and large communities. Their duties may include travel to the smaller communities in their respective regions. The community mental health worker positions will be staffed with professionals who have clinical qualifications in psychology, addictions, social work and/or mental health appropriate to the position. They will refer to other members of the PCC team as needed and will be clinically supervised.

2. **Clinical supervision** of community wellness workers and community mental health workers is imperative to the success of the mental health and addiction programs and services being delivered. The Clinical Supervisors are members of the PCC team. Their main responsibility is to provide clinical and managerial supervision for the community wellness workers and the community mental health workers. They will act as a resource specialist in mental health and addictions to the PCC team, such as providing consultation and assessments for clients at risk or clients who are challenging the PCC team. It is expected that Clinical Psychologists, Social Workers with Masters Degrees, or Degree Nurses who specialized in Psychiatry who have several years of front line / direct clinical experience will staff these positions.

3. **Specialized mental health services for youth** will be established at the territorial level. These services will be provided in the areas of mental health, addictions, and concurrent disorders in a residential treatment centre. Specialized treatment is often needed for youth who develop mental illness, have an addiction, and/or who have experienced trauma. Where local or regional specialists cannot meet youth needs in the community, they will be referred to territorial residential treatment services. Youth and their families will undergo a

comprehensive assessment and a multidisciplinary team will offer treatment services. Services will include crisis stabilization beds (for youth who are not served by the adult psychiatry unit), educational day programming, and group therapy. Links with the family and community will be strengthened by including families in all aspects of assessment, treatment and after-care, providing family residential units at the treatment centre, and offering initial assessment and after-care programs in the home community.

Needs assessments will be done to determine the most appropriate type of residential treatment services for youth. There will be one location for specialized assessment and treatment services for youth that will include or have access to pediatric and rehabilitation services.

4. **Nats'éjée K'éh** will be enhanced to provide treatment services to adults in the areas of mental health, addictions, and concurrent disorders treatment. Nats'éjée K'éh will be re-profiled to offer a more comprehensive range of services that address the interface between addictions, mental illness, concurrent disorders, and trauma. A multi-disciplinary team will deliver holistic programming. The current staff will receive further training so they can deliver such treatment programming and possibly mobile treatment programs. Mobile intervention services will provide screening, crisis intervention, and short-term follow-up services in collaboration with other community resources. Once the re-profiling has occurred, improved links will be built between residential services and community mental health work, through the enhancement of after-care and mobile treatment.

5. **Detoxification** protocols will be adopted. Hospital staff will receive training to deliver this service. These services provide medical detoxification to clients who are experiencing withdrawal symptoms from a substance. Members of the PCC team will make referrals to this service. Services will be provided in the hospitals at Yellowknife, Hay River, and Inuvik.

6. The use of **telehealth** (tele-counselling, support and case management) technology will be expanded. This level of service will be provided in communities where telehealth services are currently available or projected (10 sites). This will provide the client, community wellness worker, community mental health worker, clinical supervisor, and the PCC team access to specialized psychiatric assessment and treatment services at the community level using telehealth technology. These services would otherwise be accessed at a territorial level or tertiary level, depending on the service required.

7. **Women recovering from trauma** will be referred to the most appropriate treatment and recovery programs available. Services might include assessment, FOCUS program (group therapy, living skills, literacy, and job readiness), trauma therapy, family support, child-care, and children's therapeutic programs. Supportive housing is a key component to the program, but is limited to two units. The Department will support the program in their application for additional housing support.

8. **Shelter services** provide emergency shelter for women who have been abused (and their children). The services will be provided in Inuvik, Tuktoyaktuk, Yellowknife, Fort Smith,

and Hay River. These services are custodial in nature. An increase in operation and maintenance funding is necessary for these facilities. Shelter staff may refer clients to any member of the PCC team for advocacy, counselling, and follow-up support as identified.

Current Family Violence counselling and prevention staff will have their level of training and skills assessed through a Prior Learning Assessment tool and other methods. Further training will be offered when applicable.

9. Funding for southern residential addictions referrals will be enhanced on an interim basis, until the services are further developed in the north.

10. Registered Psychiatric Nurses will be eligible to practice in the NWT through accepted registration procedures.

Enhancing Aftercare Services

1. **Psychiatric group homes** and services will be expanded. The group home functions as part of the continuum of supported housing services available to people with mental illness. Clients may move between hospital, residential group home, and independent living units with continuing access to services.

   Psychiatric group homes with 4-6 beds provide residential care to those with a psychiatric illness who need significant assistance with living skills and support to remain in the community. Clients will have access to services including 24-hour supervision, living skills, counselling, crisis intervention and behaviour support, literacy and vocational training, medication education, sheltered workshop/supported job placements, social and recreational opportunities. Unfilled group home beds can be used for short-term crisis or respite placement.

   This level of service will be developed beyond Yellowknife to include Inuvik where there is a demonstrated psychiatric need to support the facility. The PCC teams, as well as the Assertive Community Treatment and Crisis Stabilization Unit, will provide support for the group homes as required. A needs assessment will be done to determine further psychiatric group home needs in Yellowknife once the Inuvik home is operational.

2. **Supported Independent Living Units** will be enhanced. Supported independent living units function as part of the continuum of supported housing services available to people with mental illness. Clients may move between the various services, with continuing access as required.

   Supported Independent Living Units are apartment units reserved for compliant individuals with a psychiatric diagnosis who have sufficient skills and abilities to live independent lives, but who still require some monitoring and/or support in order to manage their illness and maintain balance in the community. With support, the client can achieve a level of independent living and can often manage some form of employment. They will have access to services that include life skills training, vocational support, medication monitoring and

education, counselling, self-help groups, etc. Hours and level of support will form part of a care plan based on the clients' needs. The case management team will review the care plans.

Supported Independent Living Units will be provided in Inuvik and Yellowknife where there is a sufficient psychiatric need to support such a facility. The PCC teams, as well as the assertive community treatment and crisis stabilization unit services, will provide support as required.

3. **Psychosocial day programming** for group homes and supported independent living units will be created. These will be adapted from existing programs and services offered in other jurisdictions.

4. Adults who require more **specialized support for psychiatric disorders** will be able to access the following services. They range from the least intrusive to the most intrusive level of care:

    - psycho/social day programming;
    - supported independent living;
    - group homes;
    - assertive community treatment services;
    - crisis stabilization units; and
    - in-patient psychiatric treatment at Stanton Territorial Hospital.

Assertive Community Treatment teams and **services** will be established.

Assertive community treatment provides intensive mental health and support services in the community for individuals who have severe mental health illness (functional disabilities), high hospital admission rates, substance abuse problems, and tend to be frequent users of social support services. This treatment is intended for the approximately two per cent of the population who have severe and/or persistent mental illness. It is expected that such treatment will decrease hospitalization rates, improve level of functioning and decrease caregiver burden.

Assertive community treatment services are designed for person's who have:

- severe or persistent mental illness that seriously impair their ability to function in the community. Priority is given to persons with schizophrenia or other psychotic disorders or bipolar disorders with significant impairments. Often there is a significant concurrent substance abuse disorder;
- significant functional impairments as demonstrated by the inability to perform the range of practical daily living tasks required to live in the community such as obtaining food, shelter, safety, employment, or housing;
- continuous mental health and service needs that exceed a minimum of eight hours per month;
- inappropriate social behaviour that increases the demand for police or community agency interventions
- an intensive use of mental health hospital beds with two or more admissions per year; and

- non-compliance to traditional treatment and refusal of traditional community mental health follow-up services.

Assertive community treatment training will be provided for current members of the PCC teams. Assertive community treatment teams will be accessible from a number of regional centres and will be implemented over a period of time based on need.

Crisis Stabilization Units provide short-term residential care to voluntary adult clients, who need specialized services for psychiatric conditions, such as assessment, treatment, and stabilization services. These unites provide stabilization of psychiatric symptoms in a safe environment with short- term admission (minimum of 24 hrs to a maximum of 72 hrs). This program provides a continuum of community, day program and inpatient care.

Such services are designed for persons who have:

- severe or persistent mental illness that seriously impair their ability to function in the community;
- severe stress related to a psychosocial crisis that is chronic or acute and that seriously impairs their ability to function in the community;
- non-compliance with pharmaceutical treatment and refusal of community mental health follow-up services;
- significant functional impairments as demonstrated by the inability to perform the range of practical daily living tasks required to live in the community such as obtaining food, shelter, safety, employment, or housing;
- continuous mental health needs that exceed a minimum of eight hours per month; and
- two or more hospital admissions per year for mental health issues.

A needs assessment will be done to determine the most appropriate crisis stabilization services required in the NWT.

Adult psychiatric beds at Stanton Territorial Hospital will be used in situations where the presentation of the client surpasses the program mandate of the crisis stabilization unit or assertive community treatment teams. This would be in instances where the client had carried through on a suicide attempt, was suicidal and unable to contract for safety on a crisis stabilization unit, was homicidal, psychotic, or required intervention and support to deal with a psychiatric illness. In-patient psychiatric treatment would be provided for both voluntary and in-voluntary clients.

Managing the Required Systems Changes

As implementation of the ISDM occurs, community service providers will function as members of a PCC team. This will present certain challenges as many individuals currently providing services work in isolation of each other. While it is clearly recognized that integrated services delivery is beneficial, it has been the experience in other jurisdictions that it is not easy to achieve.

A “triage” system that directs the client to the right service provider at the right time must be constructed and put in place prior to adding new service components.

Confidentiality policies to be used by the enhanced PCC team must be developed immediately. They must deal with the exchange of information internally (between team members) as well as externally (outside the team). Moreover, the confidentiality model must take into account current legislation (duty to report) and professional standards.

Currently, many of the community addiction workers and community mental health workers are outside of the traditional HSS system. As we enter the first years of implementation of this core service each of the Authorities will be facing several years of transition, as they must plan for the new positions (community wellness workers, community mental health workers, and clinical supervisors) and new funding coming into the system over the course of the next several years. Authority transitional plans will be significant during these first years of implementation and will also be tailored to each region as the Authorities are presently delivering addiction and mental health service very differently.

Current mental health, addictions, and violence prevention workers will have the opportunity to receive the training required for the prevention positions. Training will be designed using a module approach and a variety of distance education methods. Job descriptions will be modified to address the new responsibilities and will be salaried according to the job evaluation criteria.

Recruiting and retaining community mental health workers and clinical supervisors will be challenging. It will be necessary to include Registered Psychiatric Nurses into the range of providers in the NWT. It will be necessary to partner with programs such as the GNWT’s Maximizing Northern Employment initiative and Employee Education Assistance program and with agencies such as Aurora College.

For current practitioners in the HSS system, the addition of new types of workers into the system will also be a challenge. Knowing your colleagues is a fundamental precursor to being able to work together. The individuals making up the PCC team must have their roles and responsibilities clearly defined. Team building exercises will be vital. The team’s physical space must be designed and adapted to fit the team, not the team to the physical space.

PCC teams provide an opportunity to better service clients through an integrated case management approach. Access to and quality of services to clients will increase significantly with prepared providers, articulated roles and responsibilities, clinical supervision, and an integrated team of providers. These teams are able to refer to regional and territorial levels for expertise and specialized services when local capacity has been exceeded.

Establishing Immediate Priorities

The immediate broad priority for mental health and addiction services is to invest at the community level. This is where most prevention, outpatient treatment, and aftercare should take place.

The following actions were identified as first year priorities within the system, with other specific actions to be identified in a more-detailed work plan:

- continue to implement the Mental Health and Addictions Strategy;
- develop a plan to ensure that Community Wellness Workers, Community Mental Health Workers and Clinical Supervisors are hired as identified in the Mental Health and Addictions Strategy and the proposed staffing levels / staffing mix for each authority / region; and
- implement the Family Violence Strategy.

Supporting Service Integration and Collaboration

The ISDM indicates some of the most important processes and procedures supporting effective integration and collaboration are as follows (not necessarily in order of importance):

- co-location of services;
- single point access/flexible access;
- standard client information forms and integrated information systems/data gathering;
- case management protocols;
- standardized assessment, referral and therapy tools;
- coordinated discharge planning;
- public education;
- change management; and
- quality control and evaluation.

This list is not exhaustive but does reflect current theory and approaches to integrative, collaborative practice. Before examining each of these items in more detail, it is important to understand the terms "integration" and "collaboration" in a PCC context.

Collaboration in a PCC context refers to processes by which health care providers work together to provide a range of primary health services, while still maintaining distinct and independent practices. For example, a physician might refer a patient, using a standardized referral form, to a mental health specialist who works in the "mental health" division of the same health Authority. The patient would perceive that he/she is receiving a separate service from an independent specialist who has some form of working relationship with the primary health care provider. (Strosahl, 1998, p. 163)

Integration in a PCC context refers to processes by which a wide range of health care services is provided as a single, seamless service, with less obvious distinctions between the service providers. As an example, instead of a physician referring a patient to a mental health provider, the physician might call on the provider (located in the same office) to assist with a preliminary diagnosis, or arrange for the patient to return (through the same appointment procedure) for a follow-up visit involving the other provider. From the patient's perspective, he/she is not utilizing different health care services, but is getting one service to address his/her presenting problem from a closely integrated team of providers. (Strosahl, 1998, p. 163)

The terms are used together because most PCC situations will involve both integration and collaboration in varying degrees, depending on factors such as the ability to co-locate, the degree of systems integration possible (whether providers can be employed by the same agency), regulatory issues (regarding confidentiality and information sharing), and attitudes (between different care providers). However, each of the processes and procedures discussed in this section contribute, in their own way, to more integrative and collaborative practice. The degree

to which a system is integrated and collaborative is dependent on the degree to which all of these processes and procedures are being implemented.

Co-location of Services

Co-location of services, sometimes referred to as clustering of services, has been identified as a necessary (but not sufficient) condition for an effective integrated care system (Strosahl, 1998, p. 159), and appears to be particularly useful with respect to medical (often referred to as primary) and mental (behavioural) health services. The need for a close working relationship between these two disciplines is based on research that strongly suggest that the majority of health problems are "not either biological or psychological; they are both, presented in undifferentiated form" (Blount, 1998, p.6). According to research done in the United States:

> *"...less than 20% of patients' visits to primary care physicians are for symptoms with discoverable organic causes and 10% are clearly psychological in nature. That leaves the vast majority with no discoverable organic etiology in which organic factors and psychological distresses are seen as mutually necessary from the physicians point of view to understanding the purpose of the visit ...Many people present the distress in their lives in the form of physical symptoms, but most primary medical settings are designed to treat people with biologically based problems."*
>
> (ibid, p. 6-7)

Research also indicates that, where co-location does not occur, between 50 to 90% of patients referred by physicians to mental health care providers do not receive treatment (ibid, p.8). Co-location of primary care and mental health care services, where the mental health provider is incorporated, on site, into the PCC Team, allows mental health issues to be more readily addressed as a fundamental component of the primary health care system. It also acknowledges the proven link between physical and emotional health and can help to reduce the stigma attached to mental health problems.

One of the Health Transition Fund projects deployed mental health workers in capitation-funded primary care settings in Nova Scotia and then evaluated patient satisfaction with this service compared with service from more traditional physicians' clinics.

> *"The evaluation found that patients at the intervention site received improved access to appropriate mental health services [including] decreased waiting times, reduced visits to emergency, more referrals for mental health consultations at their own site, and high rates of patient satisfaction. The patients' mental health outcomes improved, and there was improved collaboration and communication between health care providers."*
>
> (Mable and Marriott, 2002, p. 41)

Based on recent primary health care projects that involved the co-location of medical and mental health care providers in the Calgary school system; the locating of a outreach clinic at a inner-

city shelter; and the provision of nursing, physician, dietician, social work, and mental health services (through a mental health nurse) at a Community Health Centre, Alberta Health and Wellness concluded that:

> *"Having services located in one place (co-location) does not necessarily guarantee integration or collaboration, but can facilitate its development. Co-location was seen to be a key factor in fostering understanding of the roles of other team members, improved communication and*
>
> (*Integration: Lessons Learned*, Alberta Health and Wellness, 2001, p. 9)

In the NWT, a significant number of health problems that present physically (involving a wide range of illnesses and injuries) are being addressed through primary (medical) care but are clearly and unequivocally linked to addictions and other mental health care issues. Co-location of services in the NWT, therefore, means ensuring that PCC teams involving primary and mental health care providers are, to the greatest extent possible, located in a single facility or co-joining facilities, so that clients have ready access to, and ease of referral between, these overlapping health disciplines, In the smaller communities, co-location would reasonably involve nursing and addictions/mental health staff, while in the larger communities it might involve physicians and psychologists or other front-lone mental health specialists. Secondary and tertiary care services are already co-located to a certain extent at Stanton Territorial Hospital (and integrated by the fact that they work for a single agency) and are collaborative to the extent that processes of communication and case management are utilized between disciplines.

Significantly, the current *Addictions, Mental Health and Family Violence Framework for Action* highlights the importance of co-locating addictions, mental health and family violence services, but does not mention the co-location of primary and mental health services. In the literature, co-location of *intra*-disciplinary services is assumed and has clear benefits in terms of communication, cooperation, and cost (for example, shared administrative functions). But integrated service delivery implies the integration of *inter*-disciplinary services where there is clear evidence of links between these sectors, such as the case with primary and mental health care.

Co-location is already taking place in the smaller communities in the NWT, particularly in the primary care area where most health centres are set up to accommodate visiting teams of specialists, including dental teams. In the larger communities, many primary care services are often already located at the health centres or hospital, along with other core services such as rehabilitation, protection services, public health, and secondary/tertiary levels of continuing care. Of all of the core services, mental health services are most often off-site.

Co-location of primary and mental health services in the NWT is complicated by the fact that some addictions/mental health services are provided by non-government organizations (that may not support this approach) and many health centres – the prime facility in many communities for primary health services – are not large enough to accommodate additional services or staff. As well, prior to co-locating staff, other elements of integration/collaboration need to be in place. These other key elements include case management protocols, public education, and professional

development, to ensure that differing providers are able and prepared to work together more closely and the public is aware of and supportive of this type of change.

However, with the relatively high rate of mental health problems in the NWT and the clear acknowledgement that these problems put considerable pressure on primary care services, better integration and collaboration between mental health/addictions and primary care services may be considered a priority.

Single Point Access / Flexible Access

Within a PCC system, the term "access", in its narrowest sense, refers to physical access to services and therefore overlaps with the concept of co-location of services. Clients can come to one facility and receive a wide range of health care and social services on site. This situation is more efficient for the client, particularly those who have difficulty moving around easily, and allows for streamlined administrative, communications, and public relations procedures (and staffing) for the health and social services provider.

At a somewhat broader level, physical access also encompasses the ability to easily enter the facility (disabled parking, wheelchair ramps, handrails, etc.) along with other physical access issues such as site location with respect to the target population, hours of operation, and geographic location (clients having to travel outside of the community for services rather than services being provided on a regular basis in the community).

Integrative and collaborative "access" also refers to the process by which a client can enter the HSS system through one "provider" (every provider becomes an entry point) and then be referred for other services within the system without having to "re-enter" the system through another access point, particularly where services are located at different sites or are even provided by independent agencies. Once "in the door" so to speak, the client is directed and tracked through a variety of services, as needed, until the particular issue being addressed is resolved. Responsibility for directing and tracking the client within the system is maintained by the original provider as long as the presenting health or social service issue is within the domain of that provider, so that the client sees the original care provider as their primary advocate and can always return to that entry point for further support and guidance. Where the presenting client issue is clearly in the domain of another care provider, the entry provider holds responsibility for the client until it is formally shifted to the new provider who then becomes the primary "access" point and client guide and advocate within the system. The focus of this exercise is to ensure that clients, once they have entered the system, do not at any point feel disconnected, abandoned, or isolated within the system.

At a deeper level, "access" implies a level of comfort and trust that the system is sensitive to client needs. This element of access is critical in a cross-cultural environment, where attitudes, communication protocols, and language can present significant barriers to access, particularly for northern Aboriginal peoples. From this perspective, access implies cultural awareness and sensitivity on the part of care providers, use of interpreters as needed, and the acknowledgement and use of culturally appropriate health and wellness treatment modalities. As well, in some instances, such as with health promotion, it may be better, to provide services at a site that is

already attracting the client groups being targeted, such as an Aboriginal cultural centre, rather than trying to draw these clients to a site or facility that does not have the same level of comfort.

Another key element of "access" is the cost of services – including such things as travel, ambulatory aid, and pharmaceutical costs. In the north, where access to special nutritional supplements or food products can be limited, special diets can also be prohibitively expensive. Access from a financial perspective, therefore, implies that a client's essential, prescribed needs are met without undue burden on the client or family.

A final key element of access is knowledge of available services. Clients must know what services are available and how and where to access these services.

Within an integrated and collaborative system, it is assumed that there is some inherent flexibility with respect to access, but specific measures that can be taken to ensure "flexible access" include evening and weekend service hours, toll-free service centres operating 24 hours a day, seven days a week, and mobile clinics.

Within the NWT, a number of steps have occurred, and planned or underway to enhance an integrated and collaborative approach:

- publishing and distributing a core service pamphlet so that citizens of the NWT have a better understanding of what services are available and how to access them (Action Plan 5.1.1.);
- a certain degree of co-location is in place and other options are being reviewed by Authorities;
- most (if not all) health and social services facilities have disabled access;
- some specialty services are provided through mobile clinics at the community and/or regional level – enhancement of mobile services is being considered;
- community health representatives and/or clerk/interpreters are available in most communities to provide interpretation services;
- all essential services are provided off-hours (either through off-hours clinics or on-call services) along with some specialty clinic services; and
- essential services are generally provided at no cost to the client, or (in some instances for some clients) are at least subsidized.

However, there are number of significant access problems in the NWT that will have to be addressed from both short-term and long-term perspectives.

- Residents of the NWT who live in small to medium sized communities do not have regular, local access to primary services normally provided by physicians and mental health care professionals. In fact, a few communities do not have local nursing services but rely on Lay Dispensers/Community Health Workers and many communities have addictions counsellors who lack comprehensive training or certification. Where demographics do not support on-site practitioners, mental health workers, with broader counselling and referral skills and

higher certification, can be utilized in place of addictions counsellors. Both of these options are being considered at the present time.

- Outside of Yellowknife, access to specialty services (and more common services such as birthing) is limited and sporadic at the community level, and often requires travel, including travel for extended periods. In the fall of 2003, the Legislative Assembly enacted the Midwifery Profession Act. As this legislation is implemented, it is expected to support the greater use of midwives across the NWT.
- There is a minimal cross-cultural training provided for health and social services staff and communications and client/provider relationships can be negatively affected. As well, the use of locums, short-term contract nurses, and the high turnover in staff can make the delivery of this type of programming difficult and costly. In regional centres, interpretation services are not always readily available. The Department is currently assessing options relating to cross-cultural training.
- Equity of services among communities in the NWT is not always apparent. The Department is currently working with Authorities to consolidate and re-profile core service delivery funding and resources to ensure equity among communities and regions.
- Significantly, the process by which a client enters the HSS system through one "provider" and is then referred for other services within the system without having to "re-enter" the system, is not fully understood, promoted, or articulated, and therefore varies widely. For an integrated and collaborative access system to work effectively, considerable work is required in the areas of:
  - client information systems;
  - case management protocols; and
  - referral and tracking procedures.

- Professional development for care providers (team building, client services, and communications)

Standard Client Information Forms and Integrated Systems / Data Gathering

> *A single entry point and a computerized information system were found to be invaluable in facilitating service delivery integration.*
>
> (Leatt, 2002, p. 18)

> *Many of the projects identified the lack of common health record or information database as a barrier to integration.*
>
> (*Integration: Lessons Learned*, Alberta Health and Wellness, 2001, p. 13)

> *All of the 301 projects commented on the difficulties of selecting, implementing, and using new technology.*
>
> (Mable and Marriot, 2002, p.10)

One of the primary barriers to services integration across Canada identified through federal Health Transition Fund projects was the lack of effective, consistent, and compatible information gathering systems, from both client-service and population health planning perspectives. However, it does not appear that any one solution was found to resolve this problem. In fact, in Alberta, some of the approaches used to document and share client information were not highly technical. The Lakeland Regional Health Authority utilized a "Communications Passport" for clients in a palliative care project. Clients carried this "passport" to all appointments and multi-disciplinary team members were encouraged to document appointments, medications, and pain and symptom management (*Integration: Lessons Learned*, 2001, p. 13). The Northwest Community Health Centre in Edmonton continued to use a paper record but established better procedures for sharing this information with other care providers.

Regardless of whether an electronic or paper-centred client information system is used, or even whether the information is initially shared, the first step in developing an integrated approach to information gathering is to develop and implement a standardized information gathering form (or set of forms). The second step is to develop a corresponding database(s). It is possible that electronic information gathering systems have already been developed, for similar purposes. For example, a pilot project in Nova Scotia developed an advanced information system that includes an electronic patient record and a practice management system that track all the providers/ methodologies. Modification of existing forms and/or databases would be much more cost-effective than creating a new system from scratch, and a search for existing forms could be carried out.

Standardized gathering systems could be used by a variety of care providers for case management purposes (in paper or electronic form); and the same systems, stripped of personal indicators, could also be used to generate community, regional, and territorial population health information (through higher level database applications).

Considerable forethought would have to be given to the design/adaptation of these systems, to ensure that they are easy to use and capture as much relevant information as possible. For example, a universal client registration/referral form could be used for all clients, regardless of the core services utilized by the client. But separate, more specific information-gathering forms would then be developed and used within each core services area – all of which would be linked electronically. For example, the Child Welfare League recommended the development of a Child and Family Information System for use by social workers, which was implemented in January 2003. Other information systems being proposed include a:

- Public Health Information System;
- Community Health Information System;
- Vital Statistics System;
- Medical Travel System;
- Northern Health Information Management System; and
- Patient and Hospital Scheduling System.

Care must be taken to ensure that each of these systems have some degree of compatibility to accommodate linkages with other systems and data collection instruments, as needed.

Once these systems are developed, the Department would have to mandate their use throughout the HSS system to ensure information gathered prior to the use of these systems could be integrated, so current records would also have to be maintained for a considerable period of time.

The issue of client confidentiality has been identified as a barrier to information sharing within a multi-disciplinary community care team, but this can best be addressed at the point of entry into the system through client information release forms that allow for both specific and broad consent to be given. The Department already utilizes these types of forms and it would not be difficult to develop a standard consent form for use by all delivery agents within the HSS system. Controlled access to shared information would be critical and systems and protocols would have to be established to guide implementation. Again, even if a client does not consent to have information shared, the information being gathered for all clients would be standardized and can be collated, stripped of personal indicators, for broad planning purposes. As well, if a client subsequently agreed to have personal information shared for case management purposes, it would already be in a form amenable to that purpose.

Although the cost of networking communities on a regional/territorial level may prohibit full data integration, other means can be used to share information on an as-needed basis. What is most important is that the information being gathered can be easily shared and analyzed when required. The current vertically-integrated organizational structure of the NWT HSS system lends itself well to the use of standardized information gathering tools and systems. Information compatibility with other provinces and federal agencies may be less realistic at this time because the negotiations required to achieve consistency may be years in making. However, the Canadian Institute on Health Information is working on standardized, Canada-wide measurement tools and their work should be reviewed prior to the development of NWT instruments.

Case Management

> *Integrated case management refers to team approach taken to co-ordinate various services for a specific [client] through a cohesive and sensible plan. All team members work together to provide assessment, planning, monitoring and evaluation. The team should include all service providers who have a role in implementing the plan, and wherever possible, the [client and client's family].*
>
> (Rutman, 1998, Appendix A)

Integrated case management refers to a structured process whereby clients are assisted in negotiating a complex system, and where a variety of assessment and therapeutic services are coordinated by the care providers to maximize their effectiveness to the client. Case management is a simpler and more focused version of services integration and collaboration, based around the specific needs of individual clients. As such, case management can and does include a fairly wide range of options, and therefore, there is a continuum of case management protocols we can choose from, ranging from informal to formal. In order of least to most formal, these include:

1. courtesy calls or memos between care providers;
2. exchanging client information, as needed;
3. establishing a formal referral relationship, through protocols;
4. case management meetings between care providers; and
5. joint sessions/meetings with the client. (Blount, 1998, p.2).

According to a recent British Columbia study, the development of a formal case management system must address the following issues:

- client involvement;
- relationship building among providers;
- definition of roles and responsibilities;
- shared responsibility, accountability, decision-making, and conflict resolution mechanisms;
- data gathering and information sharing;
- case conferencing; and
- pro-active assessment, planning, review, and follow-up. (Rutman, 1998, Appendix A)

These matters might be addressed in some form of service provider case management Agreement or protocol, based on a standard format but adapted to suit the needs of specific situations.

Effective case management is rooted in and requires, to some degree, all of the other key elements of a collaborative system, and is at the heart of collaborative service delivery. It encompasses all of the collaborative processes and procedures that surround the client/family in the Services Integration and Collaboration model presented in Figure 1. From a client's perspective, integrated case management is the "face" of an integrated service delivery system – the primary element of system that clients see and deal with directly on a daily basis.

Although case management approaches within core service sectors has been discussed for some time in the NWT (Coyne, 1994; Health and Social Services, 1998; Lutra Associates, 2000), it appears to have been implemented to a limited degree, likely due to the challenges associated with its implementation.

> *A standardized case management model was absent. While there was excellent work in some communities, it seemed more often to be a function of the particular skills and attitudes of the individual worker than as a consequence of a system capacity.*
>
> (Child Welfare League, 2000)

The British Columbia study noted earlier identified a number of barriers associated with integrated service management implementation. The main barriers included:

- the different language, perspectives, and philosophies of different service providers;
- issues of turf, power, and control;
- differing belief and comfort with client involvement;
- lack of agreement on information sharing policy and protocols;
- concern over the extent and rate of change required;
- staff workload issues; and
- existing systems of documentation.

The evaluation report on the Alberta Primary Health Care Project noted that the changes required in order to fully implement a case management (or interdisciplinary) approach to health care included "becoming more inter-disciplinary (blurring of professional boundaries) versus multidisciplinary (involving different professionals who maintain their professional boundaries)" [Howard Research, 2000, p.4]. However, the report also concluded that "one of the primary challenges to successful integration expressed by projects is that of turf protection – most commonly among key providers" (ibid, p. 45).

In order to overcome the challenges associated with implementing a broad-based case management system, the British Columbia study recommended that "within each region, someone is assigned responsibility to oversee and act as a consultant to the implementation and ongoing practice of integrated service management" (Rutman, 1998, p. 4). Without this ongoing development and nurturing approach, the barriers to integrated service management may prove difficult to overcome.

Pilot projects can also be used to test new case management systems. In fact, Action 5.2.2 of the *NWT Health and Social Services System Action Plan 2002-2005* (2001) provides the opportunity to "establish integration demonstration projects based on the Primary Health Care model" and pilot projects are being established by the Dogrib, Inuvik, and Yellowknife Authorities. These demonstration projects could be viewed, in effect, as pilot case-management projects; could build on the research done in other jurisdictions; and could provide valuable information with respect to case management (and, effectively, integrated service delivery) at the PCC level. The development, implementation, and monitoring of these types of projects could be seen as an essential first step toward establishing comprehensive case management approaches throughout the NWT HSS system.

According to the literature, "a pilot project should be designed to work clinically, operationally, and financially…The very first pilot is to show that [a proposed system] can work well in at least one spot" (Peek and Heinrich, 1998, pp. 173, 174). Pilot projects "also open up alternatives to prevailing mental health models and stimulate organizational change" (ibid, p. 174). From this perspective they can play a key role in change management.

Standardized Assessment, Referral and Therapy Tools

The use of standardized assessment, referral, and therapy procedures and tools has become more common in the NWT over the past few years and is consistent with effective services integration

and collaboration. Examples of the types of tools and/or procedures currently being used include:

- a universal neo-natal hearing screening;
- a Nipissing Development Screen to evaluate the physical, social, and intellectual development of children;
- a Continuing Care Assessment Package to assess clients' service needs;
- an application for Treatment Form for entry into residential addictions programming;
- implementation of diabetes, wound care management, foot care, palliative care, and home intravenous programs, with appropriate caregiver training; and
- an assessment and referral process regarding medical travel, including the authorization of emergency services.

Screening and referral processes have been recommended for rehabilitation services and for children at risk. Other instruments and processes have likely been developed within and among the Authorities but are not fully documented or shared within the system.

Standardization of assessment, referral, and therapy tools and procedures becomes increasingly important where locums and contract nurses are being utilized or in other situations where there is a relatively high turnover in staff. Without these tools and procedures, quality assurance and consistency in service delivery becomes problematic.

Although, the Health Transitions Fund appears to have generated a number of different assessment tools, these instruments appear to be very specific to the project at hand and were not designed to be integrated into a more global system, and have limited application in the NWT. A process should be put in place for identifying existing tools and procedures throughout the NWT HSS system. This process would identify existing tools and procedures that have been developed and validated through provincial health authorities or professional bodies. The process would include the piloting and evaluation of appropriate tools and procedures for common assessment, referral, and therapy applications in the NWT – ensuring that these tools and procedures are currently valid.

Coordinated Discharge Planning

Action 5.2.3 of the *NWT Health and Social Services System Action Plan 2002-2005* (2001) identifies the need to "implement coordinated discharge planning throughout the system". It calls for a "coordinated discharge planning protocol" to be implemented throughout the system. A Discharge Planning Task Force was subsequently struck in the early spring of 2002 "to develop a coordinated discharge planning model for the NWT" (Terms of Reference for the Discharge Planning Group). A draft model was developed and a presentation was provided to the Joint Leadership Council for review. The Council has requested that the working group look at the problems with discharge right now and to see what can be fixed right now to make the discharge process better.

Coordinated Discharge Planning is defined as follows:

> *The Discharge Planning Process coordinates the client's discharge through collaboration between members of the interdisciplinary health care team, patients, and families. The Discharge Planning Process assists in early identification and assessment of the client's needs, and implements timely discharge plans along with an integrated continuum care. The process ensures efficient utilization of hospital and community resources.*
>
> (Discharge Planning Standards and Guidelines; p. 3)

Further, Discharge Planners are defined as:

> *...qualified health care professionals who ensure that the discharge planning process includes identification, assessment, goal setting, planning, implementation, coordination, and evaluation.*
>
> (Ibid. p. 3)

According to existing research, an effective coordinated discharge planning process:

- begins on admission to a hospital or other residential care facility;
- is well coordinated;
- relies to a great extent on nurses and social workers;
- offers a designated, one-stop contact point for physicians and other care workers;
- it is integrated in the continuum of care;
- is based on timely and effective communication;
- incorporates the use of discharge planning meetings;
- utilizes formal and consistent documentation and standard coordinated discharge planning tools; and
- respects the right of individual choice.

From an individual and family caregiver perspective, an effective and coordinated discharge planning process also:

- recognizes and engages family caregivers;
- explorers collaborative care options;
- provides post discharge follow-up;
- uses plain language;
- clarifies roles and responsibilities; and
- establishes guidelines to address sensitive issues and ensure shared decision-making.

Through the use of questionnaires and planning team working sessions, the Discharge Planning Task Force identified issues of specific concern to the NWT. These included:

- inconsistencies in the NWT HSS system with respect to coordinated discharge planning policies, procedures, systems, communications, and forms – including inconsistencies within individual hospitals and Authorities;
- minimal attention paid to coordinated discharge planning with respect to mental health issues;
- a lack of understanding within northern and southern hospitals of the capacity of smaller communities to respond to discharge issues;
- slow and cumbersome decision-making processes where immediate funding is required to meet client needs; and
- limited data available to analyze and make informed coordinated discharge planning decisions.

The Task Force made the following conclusions:

- the NWT should adopt the Discharge Planning (Standards and Guidelines of the Canadian Association of Discharge Planning and Continuing of Care;
- a dedicated Discharge Planning coordinator, with clerical support, should be funded for the NWT;
- Authorities should designate Discharge Planning coordinators;
- the Department should implement a standard data collection system, focusing on outcomes; and
- the Department should implement and communicate coordinated discharge planning guidelines and provide coordinated discharge planning information to all stakeholders

The Task Force also developed a basic Discharge Planning model, but as noted below, this model may be redundant given the option of the ISDM.

Having reviewed the Task Force's report, it can be reasonably concluded that the coordinated discharge planning is one element of an overall case management process, and fits in well with the PCC approach identified within the ISDM. In fact, it could be considered as one element of the Service Provider Case Management Agreement suggested in the Case Management section above. Where an integrated case management system has been established, the protocols and staff identified for case management coordination might logically address coordinated discharge planning issues.

Given the need to begin to address discharge issues at the time of referral and admission, it also makes sense to include coordinated discharge planning information on the standardized information gathering systems suggested in the Standard Client Information Forms and Integrated Systems/Data Gathering section above. The use of standardized coordinated discharge planning tools is quite consistent with another key Services Integration element: Standardized Assessment, Referral, and Therapy Tools. Coordinated discharge planning could

also be included as a component of the public education and consumer evaluation processes and documents discussed in the following sections.

Although coordinated discharge planning appears to have an institutional life of its own in many jurisdictions, separating it from an overall case management process may not be practical in the NWT. Ensuring that coordinated discharge planning is incorporated into broader Integrated Service Delivery discussions from this point forward is therefore imperative.

Public Education

> *As nurses, physicians, and other health care providers and planners consider how best to meet the health care needs of communities now and in the future, research-based data and renewed attention to the perspectives of the consumer are essential. The examination of receptivity of health care consumers to proposed alternatives is a crucial step in planning and implementing a program of health care reform that will meet current and future health needs of citizens…*
>
> (Armer, 1998, p. 529)

> *To advance primary health care, change must not only take place at the point of service delivery, it needs to be understood and appreciated at the client level. Patients must recognize the merits of continuity of care over the "quick fix" provided by episodic care. For example, prevention and promotion require extensive public awareness building, before they impact significant portions of the population.*
>
> (Howard Research, 2000, p. 113)

> *The public must be better prepared for transitions in primary health care. Changes should be articulated clearly and with confidence in their benefits. There is a need for better understanding of existing resources and options. Public education must include a better understanding of new models and settings, so both the public and decision-makers are confident in the quality of services regardless of where they are accessed. The public and other stakeholders also need to have reasonable expectations of the kinds of services possible in communities, and need the support to overcome any conflicts associated with "community empowerment", which some may consider the "dumping" of responsibility onto communities. At the same time, communities, once committed, can be powerful lobbyists, a fact that should be recognized by those implementing policy changes. Governments should participate in public education programs – and encourage [other stakeholders] to do so as well – to present the new directions and models, the lessons learned, the benefits of change, and examples of success within Canada and other jurisdictions.*
>
> (Mable and Marriott, 2002, p.26)

The last quote could have been written specifically for the NWT, although it is a summary of public education needs based on all of the Primary Health Care projects funded across Canada

through the Health Transitions Fund program over a three-year period. It is particularly appropriate for the NWT given the current, seemingly rapid restructuring of the HSS system.

Significantly, the *HSS System Action Plan* includes at least six actions that deal directly with public awareness and involvement:

- Action 5.1.1 calls for the publication and distribution of a core services document that lists available core services (completed);
- Action 5.1.2 calls for publication and distribution of a handbook that encourages and supports client self-care practices (completed);
- Action 5.1.3 provides a toll-free line for general health and self-care information;
- Action 5.1.4 calls for an annual consumer satisfaction evaluation system and report;
- Action 5.2.1 calls for the development of an ISDM that can be used to depict and explain the PCC approach that is being established and how this approach will be operationalized (current document); and
- Action 5.2.5 calls for the establishment of ongoing working relationships with communities to "define and respond to the health and social impacts of development."

Action 5.1.2 and 5.1.3 are particularly important within the HSS system due to the fact that lifestyles of diseases such as alcoholism, tobacco use, and obesity are common in the north and add significant, and, one might argue, unnecessary costs to the HSS system. Capacity building in the area of self-care must be an essential component of the system. Although, it is not an action as such, more self-care information must be provided at the specific, individual-patient level, because "historically, patients have not had access to their own medical records and, consequently, may have little understanding of the nature of their own health problems" (Leatt, 2002, p. 10).

Along with these actions, the organizational system currently being developed is based on the direct involvement of Chairs and CEOs from each of the Authorities. One of the key roles of these stakeholders is to bring forward the concerns and needs of the public consumers of the HSS system, so that these concerns and needs are addressed at the highest planning and accountability levels of the system. Further, the NWT has made extensive use of public forums, broad consultation processes, and HSS public planning workshops to gauge public sentiment and identify health and social services priorities. The most recent of these was the Social Agenda Conference, which tended to support an integrated, holistic, and culture-based approach to addressing social issues throughout the NWT (*Social Agenda Conference Report*, 2002). This finding was mirrored in Alberta where it was determined that "primary health care includes the mobilization of community resources, and increased community responsibility for the provision of holistic, quality care, that addresses the physical, mental, and spiritual needs of the patient" (Howard Research, 2000, p. 108).

The value of ongoing public education and involvement in planning and evaluation of the HSS system should not be underestimated, particularly where special interest groups tend to promote their particular interests within the system rather than promoting and supporting overall system's interest. Public involvement requires a frank and honest sharing of information and ideas.

Importantly, public confidence requires that the Department and its agencies are able to demonstrate that they are proceeding in a well-planned, well-paced, and orderly fashion, with clear strategies and reasonably predictable and positive outcomes.

Change Management

> *Change management is about actively managing change rather then reacting to circumstances that cause change. Strategies for change management include opportunities to learn, to celebrate success, build awareness, and engage [service providers].*
>
> (Howard Research, 2000, p. 120)

> *Working together in an interdependent system requires effective interpersonal and professional relationships. Connections between working professionals and their knowledge, skills, and talents must be made and sustained.*
>
> (Sullivan, 1998, p. 467)

Moving from a "traditional" model of health and social services delivery to a more fully integrated system requires a significant number of organizational and procedural changes, particularly for service providers, including both health care professionals and administrators, particularly where professionals have tended to work in isolation of one another in the past. For example, the earlier section on case management identified a number of barriers and challenges that arose in British Columbia when implementing a basic case management system within one health care sector. Implementing the ISDM will be much more complex because it encompasses a broad range of cross-disciplinary systems and service delivery changes.

For this reason, change management must be a fundamental element of the Integrated Service Delivery process. From this literature, it appears that effective change management incorporates the following key qualities, characteristics, and/or components.

Successful change management requires "**transformational leadership**":

> *Vision, participation, value-laden, freedom to act responsibly and creatively, trust openness, and learning are the attributes of the transformational leader and the transformed organization. The organization is compromised as a community of varied people with various positions but with common cause. They engage in teamwork to do their work, recognizing working together as the only way to accomplish their mutually agreed upon goals. Decision-making in the transformational organization is by consensus, with the group working through issues and reaching a decision.*
>
> (Sullivan 1998, p. 470)

This description applies equally to the mega-organization (the Department as a whole) and to the PCC Teams proposed in the ISDM. Transformational leadership can be developed to a certain degree through recruitment of individuals open to change; by providing team-building, problem-solving, conflict-resolution, and communication training; and by providing comprehensive

orientation for new members (ibid, p. 479). Transformational leadership must address the documented tendency for different service providers to resist a collaborative service delivery approach.

From a community development perspective, the degree of transformation that is proposed within the HSS system and the complexity of the socio-political environment in which these changes must be made dictates that, at least, one territorial position and one position per region must be established to guide any coordinate the implementation of the PCC model of service delivery proposed.

Successful change management requires **evidence-based planning and decision-making**, which means that systems must be in place to gather information that can be used to evaluate the impact and effectiveness of changes as they are made. In effect, the planning phases of change must include planning for evaluation, based on the measurable outcomes that are desired. Measurable outcomes can include objective information such as reduced costs, lower rates of emergency care and other health population data, reduced staff turnover, etc. and can also include subjective information such as client and service provider satisfaction (Lewis, 2002). Change indicators must be established before substantive change is introduced into the system.

Change management requires **policy and structure**, so that when changes are made they are perceived to be well planned and long-term rather than reactive, chaotic, and ephemeral. Individuals within an organization must feel that there is long-term value to investing time and energy into certain types of changes; change upon change can create frustration and stress and can significantly decrease motivation. In the NWT, there is the appearance of constant change within the HSS system, which tends to undermine client confidence in the system. The introduction of the ISDM must therefore be seen as a logical extension and continuation of the move toward a more integrated and responsive system that has been taking place for the past 15 years. It must proceed at a pace that is comfortable for the public and the primary stakeholders. Expectations must remain reasonable. The model establishes the vision and direction, but requires controlled and structured implementation.

Change management must ensure that **service providers have the skills necessary** to accommodate a new way of doing business. Because of collaborative, integrated approach to service delivery calls upon service providers to provide cross-disciplinary services in some instances (the blending of professional boundaries), staff must broaden their professional skills and all providers in the system must respect and accommodate this cross-disciplinary approach (within the context of clinical protocols that set obvious and reasonable limits). Some professional development training may have to be provided, particularly with respect to mental health and addictions issues, due to the fact that these behavioural problems underlie many of the presenting medical and social problems evident throughout the NWT system. Within the NWT, resistance or reluctance to utilize paraprofessionals such as nurse practitioners, mid-wives, and traditional healers must also be addressed, along with expanding the role of professionals such as pharmacists and occupational therapists.

Change management must respect the fact that the **HSS system is already understaffed**, which causes large workloads and stress, and also **faces high turnover rates**. Trying to impose change

too quickly in this environment will likely result in resistance at all staffing levels. Based on the information generated through the Health Transition Fund program, it is safe to say that the transition to an ISDM with a primary health care foundation is theoretically sound, proven in a number of instances, but challenging to implement effectively in a short period of time. This perspective is echoed throughout the literature, and best summed up as follows:

> *"Remember that successful implementation is not just a one-time technical installation to a clinic or care system. Take a developmental view of it. New principles and practices of collaboration are gradually mastered by people working in clinics and new operational and financial systems gradually drawn to match. Expect things to grow rather than to appear fully mature. Expect to have them grow. Expect growing pains. Expect different growth patterns from clinic to clinic. Expect improved clinical, operational, and financial results, but don't expect them full-blown from day one."*
>
> (Peek and Heinrich, 1992, p. 200)

Quality Control and Evaluation

> *While client satisfaction is a good measure of quality in primary health care, it doesn't replace the need to ensure clinical quality. A full assessment of quality has to happen over the long term and include evaluation of outcomes.*

(Marion Relf, from Quality, Lessons Learned; Alberta Health and Wellness, 2000, p. 4)

Quality care requires assessment from three different perspectives:

- the patient/client perception of quality;
- the provider perception of quality; and
- an outcome-based measure of quality.

Patient/Client Perceptions

According to the literature, the patient/client perspective of quality appears to be shaped by a number of key factors, the most important of which is access:

> *Client perceptions of health service quality are closely related to perceptions of access to health services. (Howard Research, 2000, p. 61) Patients' or clients' perception of quality is often affected by their access to services.*
>
> (Mable and Marriott, 2002, p. 15)

However, from a client perspective, "access" includes the following elements:

- proximity to home;
- prompt service;
- provider availability;

- immediate referrals; and
- good rapport with the health care providers, including the ability to build a trusting relationship. (Quality, Lessons Learned; p. 6)

It must be noted that, in the NWT, this type of trusting relationship can be deeply affected by cross-cultural considerations.

Other factors that appear to affect a client's perception of quality include such things as:

- range of services available;
- competency of the care providers; and
- continuity of care. (Ibid)

By effectively addressing these service delivery issues, patient / client satisfaction will likely rise.

Before these issues can be addressed, however, client information has to be gathered and evaluated. In the NWT Action 5.1.4 of the *NWT Health and Social Services Action Plan 2002-2005* addresses the need to evaluate consumer satisfaction within the HSS system. Some information is already being gathered through the Canadian Community Health Survey, which is conducted every two years at no cost to the GNWT. However, this survey is based on a poll of only 1,000 residents and may not be effective at gathering information from Aboriginal populations or marginalized populations, who are major clients within the HSS system.

The Department is assessing the possibility of using the Labour Force Survey to gather health and wellness information every five years, and is also assessing the cost of developing a custom survey that could be done annually. In this case, a standard client survey form would have to be developed, implemented, and analyzed throughout the NWT, with regional and territorial level data gathering systems in place to review and analyze the results. At a more basic level, standardization forms could be located at all HSS sites and clients could be encouraged to fill these out on a regular basis. The most common instrument for measuring quality from a client perspective is a client survey form that uses a closed-ended, rated, question format. The types of questions asked would focus on the issue of access and the other key client factors noted above.

Provider Perceptions

> *Quality was also a significant theme among providers. While provider and client perspectives of quality are similar in some respects, providers' view of quality seemed dominated by "quality control". Common indicators of quality care appear to be adherence to clinical practice guidelines and scopes of practice identified for health professionals, as well as quality improvement processes.*
>
> (Howard Research, 2000, p. 52)

Pilot projects associated with the Health Transition Fund have led to the conclusion that, from a provider's perspective, the quality of service increases most rapidly with the collaborative development of clinical standards and practice guidelines. This research has provided clear

direction to the NWT and other jurisdictions: developing and/or adopting a comprehensive set of clinical standards and guidelines for all professions will contribute greatly to an overall improvement in service quality. This approach might be taken immediately with respect to addictions and mental health services, given recent criticisms of these services and ongoing questions regarding professional standards and quality.

According to providers, another major influence on service quality is an increased understanding of other's practices and the opportunity to work in a team environment.

For example, a "shared care model" in Alberta involving physicians and mental health clinicians resulted in physicians reporting "greater effectiveness and confidence in dealing with mental health issues, fewer and more appropriate referrals to external agencies, improved diagnostic capabilities, more time spent counselling patients, and greater attention and time dedicated to studying mental health issues" (ibid, p. 55). This type of information has value for the NWT as we consider strategies arising from the Social Agenda initiative. The PCC approach within the ISDM is an effort to create the type of multi-disciplinary, team environment stressed in the literature.

A third major influence on provider perceptions of quality is the gathering and sharing of "timely, relevant, and accurate information" concerning a client's condition. In pilot projects, the use of a standardized consultation template for sharing information among providers proved very successful. These templates also became valuable as a tool for general assessment of clinical practices.

Aside from implementing clinical standards and guidelines, team approaches, and structured information sharing practices, providers identified the need for a structured process to continually assess service quality. Clearly, evaluation instruments must gather information relating to these three key quality indicators. There appears to be a number of evaluation instruments available:

> *Provider-based assessment frameworks to assess quality are popular and take many forms (e.g. outcomes management, physicians profiling, continuous quality improvement, benchmarking, indicators, severity measurements, appropriateness, total quality improvement).*
>
> (Howard Research, p. 53)

Whatever quality assessment process is adopted, the ISDM calls for consistency in evaluation processes among all health authorities.

Outcome-based Assessment

It appears that quality care assessment generally tends to rely on client and/or provider perceptions; in effect, subjective rather than objective information. Objective measures of quality would relate less to the "process" of service delivery and more to the "outcome" of service delivery: i.e. health indicators. But many of the pilot projects funded through the Health Transition Funds were too short to objectively measure health outcomes (Quality – Lesson Learned, p. 8). In the NWT, broad health indicators are difficult to use in many instances

because of the low population levels – the reliability and validity of the generally accepted indicators is questionable over short periods of time. It might be appropriate to develop shorter-term, community-based health indicators, by bringing together health professionals and identifying those types of indicators that consistently and reasonably reflect changing health and social services trends within a community. This would be consistent with recent research findings that suggest "facilitating stakeholder participation if the selection of indicators helps to ensure a successful evaluation process" and "local factors necessitate adaptation of existing tools" (Howard Research, p. 61). Even with these indicators, correlating health changes to specific initiatives may not always be possible due to the complex dynamics of northern communities.

Cost-effectiveness is also an element of quality. However, it appears that the cost-effectiveness of specific initiatives is also difficult to assess objectively, "particularly if more than one organization or agency [is] involved" (Quality – Lessons Learned, p. 11). It makes sense, therefore, to first implement proper quality control measures, assess client/provider satisfaction before and after implementation, and, if these measures raise client/provider perceptions of quality, work to maintain those measures while reducing the cost of implementing them.

Summary of Quality Control

In summary:

- clients perceptions of quality relate closely to access, including the client/provider relationship, which can be affected by cultural considerations;
- providers primarily relate quality to standards and guidelines, team involvement, information sharing, and structured evaluation processes;
- the subjective nature of quality makes it difficult to measure, but qualitative measures are still valuable for planning and programming purposes;
- appropriate, valid, short-term health indicators (which indirectly measure the overall quality of service delivery) must be developed in consultation with community-based health providers; and
- it may be difficult to directly correlate client/provider satisfaction and cost-effectiveness, but is worthwhile and prudent to implement key quality control measures in a cost-efficient manner.

Summary Observations and Conclusions

1. Services integration and collaboration, as defined in the PCC component of the ISDM, involves the implementation of a number of key processes and procedures. A service delivery system is successfully "integrated" and "collaborative" only to the extent that it incorporates these processes and procedures.
2. The "co-location" of primary and mental health services, and the need for close working relationships between these disciplines, is considered to be an essential foundation for integrated HSS delivery and must be reviewed in the NWT context.

3. "Single point access" for a wide range of health and social services generally increases client satisfaction. "Access" refers to physical access (which encompasses everything from ramps, to hours of operation, to the location of a facility or service); the entry points and processes into the system (with each provider an entry point efficiently linked to other providers); levels of trust and comfort with care providers (with significant cultural implications for the north); and cost (of travel, medications, diets, prosthetics, etc.). Due to the high importance of access to client perceptions of quality, access issues must continue to be addressed as a priority in the NWT, through the definition and rationalization of core services delivery systems.
4. The effective and efficient "gathering of data and information" is both an essential foundation for HSS service delivery and the most complex element to implement. The key elements of an efficient information gathering system are the development of standardized instruments; the mandated use of these instruments, while respecting client confidentiality; and the continual gathering, analyzing, and sharing of the information being gathered.
5. "Case management" is the "face" of an integrated service delivery model – the primary element of the ISDM that clients see and deal with on a daily basis. It is a structured process to assist clients to negotiate a complex system, by coordinating a wide range of assessment and therapeutic services. The main barriers to effective case management are differing provider perspectives; control issues; lack of agreed upon policies and protocols; ineffective systems of communication and information sharing; and staff workloads. The introduction of case management systems has generally been more successful when first piloted and where someone is assigned to coordinate implementation.
6. "Standardized assessment, referral, and therapy" procedures and tools are essential to effective ISDM implementation. A number of these types of procedures and tools are already in place in parts of the NWT system, but appropriate procedures and tools need to be identified and used throughout the system.
7. "Coordinated discharge planning", although a discrete component of a number of provincial health jurisdictions, must be addressed as a key component of case management within the NWT and must be incorporated into standard client forms developed for information gathering and sharing purposes.
8. "Pubic education" must provide clients with the information they need to practice self-care and to efficiently access services where required. It must also allow for public input into important decision-making processes. The Department is already implementing a few positive actions towards these ends. Public education must also increase client confidence in the Department's ability to proceed in a well-planned well-paced, and orderly fashion, with clear strategies and predictable and positive outcomes. From this perspective, public education is inherently linked to change management.
9. Effective "change management" requires transformational leadership skills; evidence based planning; a sound policy and organizational framework; the development of new Integrated Service Delivery skills and attitudes among professionals; and the recognition of real barriers such as workloads and high turnover rates. Change management allows for the establishment of a reasonable and practical pace for ISDM implementation, particularly in an environment of stakeholders in the change process.

"Quality control" is often based on subjective client and provider perceptions involving access, standards, teamwork, and information sharing. It requires structured, ongoing "evaluation" of these perceptions. Where more objective information is required, the development of indicators and instruments for assessing service outcomes is required. Cost-effectiveness is difficult to measure, but can be achieved indirectly.

Next Steps

The ISDM, the principles that underpin it and the three key elements of service integration and collaboration, organizational integration and collaboration and core services have been described. Each of the six core service areas have included a definition and examples of the core service, the vision, preferred future and expected outcomes of each one, an assessment of the current situation and the challenges, an overview of proposed enhancements, a note on managing the required change and a list of immediate priorities. Activities that will support service integration and collaboration are also outlined.

This significant body of work has involved extensive consultation and discussion with Authority and Department staff and senior management. The necessary next steps are every bit as critical and work has already begun. The following is a brief overview of the remaining work to be done.

1. Determining the preferred staffing level/mix for the delivery of core services.

- There are two aspects to this work: requirements for PCC at the community and regional levels; and secondary and tertiary care including hospitals and other facilities.
- Work on this task as it relates to PCC is well under way. Several workshops involving Authority CEO'S and Departmental senior staff have been held over the past several months. It has involved mapping what is currently in place, identifying the gaps and what is needed at the community and regional level.
- Costing of the PCC staffing levels/mix in terms of the short, medium and long term.
- Initial work on secondary and tertiary care has begun but is in the early stages of development. There is a need to gather appropriate information and data for this aspect of the exercise to enable informed decision-making including the need to make decisions around the scope of service to be delivered at hospitals. Another sub-group has been established to carry out this task.

2. Determining the staffing level/mix for the management and administration of core service delivery.

- This is a necessary step in the process to ensure that appropriate organizational structures and levels of human resources are in place to support PCC and other service delivery staff within the system.
- This work too is currently under way. A subgroup has been established to prepare this plan, which will be integrated into the work being done in item one noted above.

3. Development of an Implementation / Transition Plan.

- This is a major initiative that will require considerable time and effort on the part of Authority and Departmental staff. Based on the work already done or in process, this plan will be presented as Part II of the ISDM in a companion document.

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