Integrated Service Delivery Model

for the

NWT Health and Social Services System

A Plain Language Summary

March 2004

Northwest Territories Health and Social Services

Introduction

This summary is a basic outline of the Integrated Service Delivery Model (ISDM).[1] The Department of Health and Social Services and all the Health and Social Services Authorities worked hard to develop this model. We are committed to using the ISDM as the basis of our health and social services system.

Why should you read this summary?

We encourage you to read this document to:

- ✓ Understand the primary community care approach and how all the parts of the system work together.
- ✓ Help you do your job well and work together for positive change.
- ✓ Help evaluate change over time.
- ✓ Share this information so everyone, over time, can be more aware of the ISDM and understand its benefits.

Who should read this summary?

- ✓ Employees of the Department of Health and Social Services.
- ✓ Employees of all the Health and Social Services Authorities.
- ✓ Non-government organizations and their employees who have a health and social services mandate.
- ✓ Private businesses and their employees who deliver health and social programs and services.
- ✓ Residents of the NWT.

[1] Printing of this document has been made possible by a financial contribution from the Primary Health Care Transition Fund, Health Canada. The views expressed herein do not necessarily represent the official policies of Health Canada.

What information is in this summary?

Part A of this summary gives you the philosophy and vision of the ISDM. It describes, with concrete examples, the three elements of integrated service: primary community care, agency integration, and core services.

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Part A: Integrated Service Delivery Model – Philosophy and Vision

What is the Integrated Service Delivery Model?

The Integrated Service Delivery Model (ISDM) is a team based, client-focused approach to provide health and social services. With this model, we'll increase our focus on health prevention and health promotion. Over time, we'll increase our use of nurse practitioners, midwives, and mental health workers. We'll enhance services, such as public health, rehabilitation services, and family counseling.

Integration and collaboration are the heart of ISDM. To integrate means to bring parts together into a whole. Health and social service care becomes a single, seamless service. To collaborate means caregivers work together, but maintain their distinct, independent practices.

The ISDM combines 3 key elements:

1) Use a primary community care approach.
2) Ensure all caregivers and their organizations are connected and work together.
3) Describe and strengthen core services.

Why do we need the Integrated Service Delivery Model?

For years we've been working to better integrate our health and social programs and services. The ISDM provides a clear framework to accomplish this task.

We believe this approach will reduce some of the challenges we now experience in our health and social services system:

- ✓ People across the NWT will have better services and more equal access to services.
- ✓ All Health and Social Services Authorities will have more consistent policies and procedures, and meet standards for core services.

- ✓ The Department and other agencies will be more consistent, fair, and transparent when they distribute and account for funding and other resources.

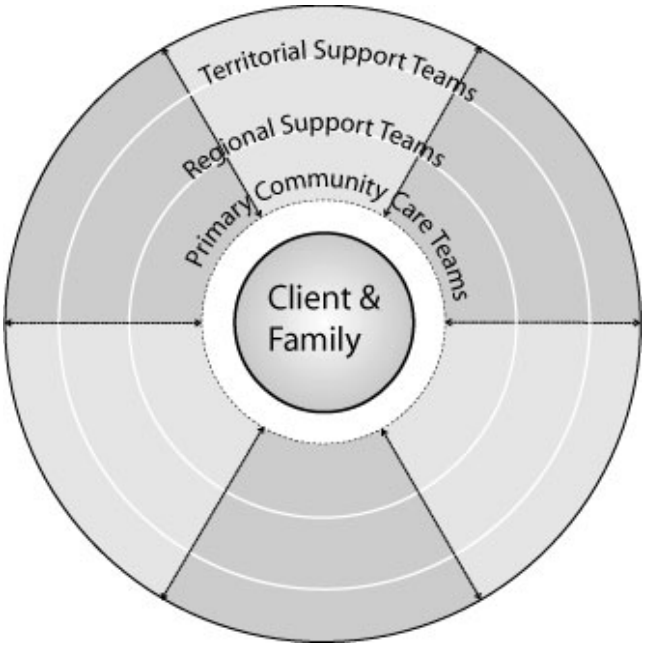
What is the primary community care approach?

Primary community care brings together people who **need** help with people who **provide** help. Services are as close to the client as possible. The client is the focus.

Characteristics of the primary community care approach	
✓ **Provide the right services.**	Caregivers collaborate with different disciplines so people get the care and support they need.
✓ **Use the most appropriate caregiver.**	Caregivers use a clear referral and transfer process so people see the right caregiver – whether in their own community or elsewhere.
✓ **Provide the best setting.**	People access services as close to home a possible, in a culturally sensitive environment.
✓ **Give service when people need it.**	People have access to emergency care all day every day, directly or through the NWT call centre. The call centre screens and refers calls to a caregiver.
✓ **Be efficient & economical.**	Over time, early intervention and harm reduction programs affect the kind of care people need. Professional caregivers use best practices. We invest in our caregivers and build capacity.
✓ **Encourage public participation.**	The public has a unique perspective of the health and social services system. We listen to what the public says and keep them informed.
✓ **Be accountable.**	We all help monitor and evaluate the system.
✓ **Gather & share information.**	Caregivers share information to help people get the care they need. Caregivers totally respect their client's confidential information.

'Primary community care' is similar to 'primary health care'. We use the term 'primary community care' to emphasize the need to direct services toward the community level.

A person's first contact with the health and social services system is usually a member of the primary community care team. This team includes community-based health and social services caregivers. The number and variety of caregivers varies from community to community.



Primary community care teams work closely with regional and territorial health and social services caregivers. The objective is to have the most positive impact on their client's health and well-being.

Regional teams provide services on-site in regional centers and travel to communities. The number and variety of health and social services caregivers varies from region to region.

Territorial health and social services caregivers have a mandate to serve the whole NWT. They usually provide specialized services in a central location. They may refer people to services outside the NWT.

Caregivers work in many different disciplines. They have cooperative working agreements and follow accepted procedures to work together effectively and efficiently. They share information as needed, with the client's permission. They respect the absolute need to keep client information confidential.

Who are the main agencies?

Various agencies administer and deliver our health and social programs and services. This table briefly outlines the key responsibilities of each type of agency under the ISDM.

Agency	Main responsibilities under the ISDM
Department of Health & Social Services	• Develops and implements legislation, standards, and policies. • Works with all Health and Social Services Authorities, other territorial departments, and the federal government. • Plans for and funds the health and social services system. • Monitors and evaluates.
Regional Authorities	• Provide health and social services through the primary community care teams and regional support services. • Plan, monitor, and evaluate regional and community services. • May provide a specific territorial service. • Work with other health and social services agencies.
Stanton Territorial Authority	• Provides specialized, territorial services. • Provides community support services for Yellowknife and some regional support to the rest of the NWT. • Refers people to out-of-territory specialized services. • Works with other health and social services agencies.
Non-government organizations	• Provide community, regional, or territorial services, usually through a contribution agreement. Two examples are programs for people who experience family violence and programs for people with disabilities. • Work with other health and social services agencies.
Private businesses	• May provide community, regional, or territorial services, usually through a contract. Two examples are treatment facilities and research projects.

What structures or processes encourage health and social service agencies to integrate and collaborate?

The Integrated Service Delivery Model works best when the main agencies integrate and collaborate.

This section discusses some structures and processes that encourage the main agencies to integrate and collaborate.

Main Agencies	Structures and processes that support integration and collaboration.
Department of Health and Social Services.	Legislation and policies.
Stanton Territorial Authority.	Governance.
Regional Health and Social Services Authorities.	Human resources.
Non-government organizations.	Funding & accountability.
Private business.	Information management.
	Formal & informal agreements.

To integrate means to bring parts together into a whole. Health and social service care becomes a single, seamless service. To collaborate means caregivers work together but maintain their distinct, independent practices.

Legislation and policies support integration and collaboration.

- Legislation is the framework for health and social services. The Department develops legislation that supports collaboration and integration of different disciplines.

  For example: The new *Midwifery Profession Act* brings midwives into the system.

- The Department uses policies to establish the standards, guidelines, and criteria that agencies should meet when they deliver core services.

Governance supports integration and collaboration.

- The Joint Leadership Council (JLC) and the Joint Senior Management Committee (JSMC) each provide a forum for cooperative, informed decision-making. The Department and all Health and Social Services Authorities are represented on both.

  The JLC reviews major health and social services policy issues and advises the Minister. The JSMC reviews shared program and service delivery issues.

- Each Health and Social Services Authority will sign a Performance Agreement with the Department. The Agreement identifies clear, consistent roles and responsibilities for each Health and Social Services Authority.

- Each Health and Social Services Authority is developing the same organizational structure and business operations. They will use a common NWT board leadership model and a standard process to appoint and train their board members.

Human resources support integration and collaboration.

- Most caregivers who work for the primary community care team and regional support services work for a Regional Authority. For example, all mental health workers will become employees of a Regional Authority.

- Regional Authorities and the Department are developing guidelines to structure primary community care teams and to clearly define their roles. These teams may include caregivers who work for non-government organizations.

- All employees must have clear, consistent job descriptions. All agencies must orient their employees consistently, and train and certify them where appropriate. All agencies should track their employees and plan for human resource needs, including how to recruit and retain staff.

Funding and accountability support integration and collaboration.

- Health and Social Services Authorities and the Department use a system wide, common model to plan for and report on programs and services. They help develop and coordinate territorial action plans, such as the *Seniors Action Plan* and the *Health Promotion Strategy*.

- The Department is developing a standard funding and budget process for Health and Social Services Authorities. The process may include one or more of the following criteria:
  - ✓ Funding for primary community care teams is partly based on community population – a form of per-capita funding.
  - ✓ Funding for regional support services is partly based on per-capita staffing formulas for primary community care and regional support.

- ✓ Funding for territorial support services is partly based on per-capita staffing formulas for regional and territorial support services.
- ✓ Funding for special territorial programs, such as *Action on Tobacco*, is based on population health criteria.
- ✓ Community and regional factors such as road access, infrastructure needs, impacts of resource development activity, and caseloads may affect funding.

- All agencies use a common model to monitor, report on, measure, and evaluate their programs – for example, the *Results-based Management and Accountability Framework*.

- All agencies must report to the Department and the Minister to account for their funding and to evaluate their programs.

- All Health and Social Services Authorities are setting up the same system to account for and report on their finances.

- Health and Social Services Authorities will develop and use a consistent method to regularly report on each core service area. The reporting method includes predetermined indicators and measures.

Information management supports integration and collaboration.

- The Department compiles and analyzes data from all regions. It continually updates the data system to meet ongoing needs.

- All Health and Social Services Authorities are converting to the same tracking system. They need to link their databases so they can compile reliable, useful data.

Formal and informal agreements support integration and collaboration.

- Health and social services agencies and individual caregivers develop and use formal and informal agreements. Informal and formal agreements are equally important.

- Formal agreements are official or legal agreements. They include protocol agreements, partnership agreements, contribution agreements, and contracts. The objectives of these agreements are to:
  - ✓ Meet proper standards for different services.
  - ✓ Record and share information accurately and consistently.
  - ✓ Cooperate among caregivers to refer and manage clients.

- Informal agreements are unofficial. They include things such as regular interagency meetings or personal contact. The objectives of these agreements are to:
  - ✓ Share information about services.
  - ✓ Plan for and coordinate programs.

- Health and Social Services Authorities and the Department work closely with other government departments and agencies, as well as non-government organizations.

  Legislation, policies, strategic plans, and other activities overlap specific mandates and include a variety of agencies. Examples of these activities include the *Early Childhood Development Framework for Action*, *NWT Action Plan for Persons with Disabilities*, and the *Family Violence Action Plan*.

What are Core Services?

Core services are health and social programs and services available to all NWT residents. The Department and Health and Social Services Authorities are responsible to provide core services to NWT residents.

People receive some core services from the health and social services caregivers who make up the primary community care team. The number and variety of caregivers is different in each community.

People receive some services from caregivers who serve a region. People might travel to a regional center or other community for help. Or the caregivers might visit their community. The number and variety of caregivers varies from region to region.

People receive some core services from caregivers who serve the whole territory or from caregivers outside the NWT. People usually travel to where the service exists.

There are 6 core service areas.

In the following subsections, we briefly describe each core service area.

We describe what services people can expect to receive from community, regional, and territorial caregivers **after we fully implement the ISDM**.

What are Diagnostic and Curative Services?

Core diagnostic and curative services primarily help us identify physical symptoms or conditions and treat them. These services may also help identify symptoms or conditions of mental illness.

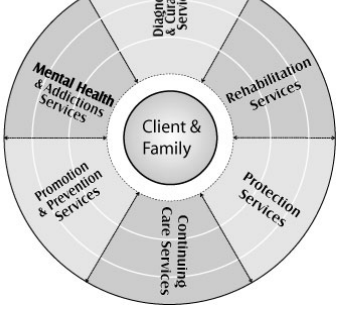
Core Diagnostic and Curative Services	
Primary Community Care Teams	✓ Provide first aid and CPR. ✓ Do limited radiology and lab procedures such as blood and urine analysis. ✓ Assess and treat common illnesses. ✓ Work with regional support services to coordinate referrals to services outside the community.
Regional Support Services	✓ Do radiology, fluoroscopy, and ultrasound. ✓ Do hematology, chemistry, and blood bank. ✓ Coordinate emergency and scheduled air travel. ✓ Offer some inpatient hospital services.
Territorial Support Services	✓ Do specialized procedures such as CT scan, bacteriology, orthodontics, chemotherapy, ophthalmology and endoscopic procedures. ✓ Offer intensive care and psychiatric care. ✓ Provide some specialized surgeries. ✓ Coordinate out-of-territory services.

What are Rehabilitation Services?

Core rehabilitation services help people improve and maintain their independence if they have an injury, disability, or chronic disease. There are four main types of rehabilitation services:

1) Physiotherapy – to assess, restore, and maintain physical function.
2) Occupational therapy – to develop physical, cognitive, sensory, developmental, and/or psychological skills for independence.
3) Speech language pathology – to overcome and prevent communication problems in language, speech, voice, and fluency.
4) Audiology – to detect and evaluate hearing loss as soon as possible, and recommend treatment.

Core Rehabilitation Services	
Primary Community Care Teams	✓ Refer people to regional support services. ✓ Give follow-up home support and motivation. ✓ Use community rehabilitation aides. ✓ Work with rehabilitation teams who visit communities.
Regional Support Services	✓ Provide rehabilitation services. People access rehabilitation teams with referrals to and from communities. ✓ Supervise, monitor, and comply with standards, policies, and legislation.
Territorial Support Services	✓ Deliver specialized rehabilitation services at Stanton Territorial Hospital such as audiology and ear/nose/throat specialists. ✓ Do referrals out-of-territory for things such as stroke or brain injury. ✓ Develop and implement strategic and system plans. ✓ Coordinate out-of-territory services.



What are Protection Services?

Core protection services help us protect and take care of vulnerable people. They help us manage and control public health issues such as clean air and water, safe food handling practices, and the outbreak of diseases.

Part of the work of core protection services is to follow and enforce legislation.

- ✓ *Public Health Act*.
- ✓ *Child and Family Services Act*.
- ✓ *Adoption Act*.
- ✓ *Guardianship and Trusteeship Act*.
- ✓ *Disease Registries Act*.
- ✓ *Mental Health Act*.

Core Protection Services	
Primary Community Care Teams	✓ Report, monitor, and take action for public health. ✓ Provide safety planning for victims of family violence. ✓ Offer child and family services to support the well-being of children. ✓ Increase public awareness about guardianship.
Regional Support Services	✓ Coordinate activities to protect and promote health, and to prevent disease. ✓ Provide shelter and counseling for victims of family violence. ✓ Do referrals to territorial and out-of-territory facilities. ✓ Coordinate case management and supervise social workers. ✓ Do referrals to assess capacity for guardianship.
Territorial Support Services	✓ Coordinate specialized public health resources. ✓ Provide extra staff for public health emergencies. ✓ Coordinate programs to screen and control infections. ✓ Monitor diseases. ✓ Develop and enforce standards and guidelines, do research. ✓ Help develop family violence programs. ✓ Oversee adoption services and keep an adoption registry. ✓ Assess capacity of people for potential guardianship. ✓ Coordinate and provide specialized treatment and facilities.

What are Continuing Care Services?

Core continuing care services support us, and our family caregivers, when we can't fully take care of ourselves. There are three main types of services:

1) Home and Community Care – includes respite care, chronic care, foot care, palliative care, social support, equipment loans, and Meals-on-Wheels.
2) Supported Living – includes seniors' independent living with supports, supportive living with day programs, and 24-hour care in a group home.
3) Facility Living – includes long-term care and extended care support for people who can't live at home.

Core Continuing Care Services	
Primary Community Care Teams	✓ Provide home management and personal care. ✓ Coordinate respite care. ✓ Offer nutrition programs. ✓ Coordinate general home upkeep and handyperson work. ✓ Offer palliative care. ✓ Schedule extended hours of care. ✓ Do early childhood intervention.
Regional Support Services	✓ Coordinate case management and placement. ✓ Train families, staff, and community helpers. ✓ Coordinate equipment loans. ✓ Offer rehabilitation services. ✓ Provide palliative care. ✓ Offer respite at a regional facility.
Territorial Support Services	✓ Increase public awareness. ✓ Coordinate programs. ✓ Collect data and be accountable. ✓ Provide specialized residential care.

What are Promotion and Prevention Services?

Core promotion and prevention services help us improve our health status and overall quality of life.

Health promotion includes things such as life skills, healthy choices, education, or any other factors that influence your health and well-being.

Health prevention looks to human, environmental, social, cultural, and other factors to prevent illness or injury, or to detect and stop problems early.

Promotion and Prevention Core Services	
Primary Community Care Teams	✓ Immunize children to reduce the spread of diseases such as measles, whooping cough, tetanus, and chicken pox. ✓ Immunize adults - for example against the flu virus. ✓ Promote healthy lifestyles. For example, to get more exercise, to stop smoking, or to prevent fetal alcohol spectrum disorder. ✓ Do screening programs, such as TB screening. ✓ Hold well-adult and well-child clinics. ✓ Do prenatal and postnatal assessments. ✓ Help with school health programs. ✓ Provide parenting classes.
Regional Support Services	✓ Develop public education materials about healthy lifestyles for a variety of audiences. ✓ Support communities in health promotion and prevention activities.
Territorial Support Services	✓ Coordinate awareness campaigns. For example to promote safety and prevent injuries or to encourage healthy pregnancies. ✓ Coordinate territorial immunizations. ✓ Develop standards and monitor impacts.

What are Mental Health and Addictions Services?

Core mental health and addictions services provide care and support to people who have a mental illness or an addiction. These services work to promote, protect, and restore mental well-being and help people to live balanced lives.

Mental Health and Addictions Core Services	
Primary Community Care Teams	✓ Do public education, especially about prevention, including how to prevent family violence. ✓ Provide individual, family, and group counseling and therapy. ✓ Screen and assess people, and refer them for treatment. ✓ Offer support groups. ✓ Provide follow-up and aftercare support.
Regional Support Services	✓ Offer clinical support to front line workers. ✓ Provide psychiatric crisis services. ✓ Shelter people who experience violence. ✓ Provide group homes, supported living, and independent living units for people with mental illness. ✓ Provide for and support detoxification. ✓ Refer people to the hospital psychiatric unit.
Territorial Support Services	✓ Offer residential treatment services to adults and youth with addictions. ✓ Train staff about suicide prevention. ✓ Offer Critical Incident Stress Management. ✓ Coordinate out-of-territory services.

How do caregivers and the public benefit from the Integrated Service Delivery Model?

When we fully implement the ISDM, **NWT residents will**:

- ✓ Get help from the most appropriate caregiver, at the right time, in the most supportive way possible.
- ✓ Better understand what services are available, the level of service they can expect, and how to access those services.
- ✓ Have more consistent access to services in all regions.
- ✓ Have better quality services and more services - especially in areas such as mental health and addictions, home care, and rehabilitation.
- ✓ Look to an integrated team of caregivers; receive coordinated, seamless service including referrals and follow-up; and be certain caregivers protect confidential information.
- ✓ Call the 1-800 phone line for information and assistance.
- ✓ Benefit from increased health promotion and prevention and be more responsible for their own care.

When we fully implement the ISDM, **caregivers will**:

- ✓ Develop strong, supportive working relationships among different disciplines and communicate well.
- ✓ Use the primary care approach and coordinate client care effectively and efficiently.
- ✓ Have clear procedures and guidelines to refer clients, manage cases, and record and manage data.
- ✓ Look to the team environment and the integrated system to enhance professional development.
- ✓ Increase their overall job satisfaction.

Part C: Priority actions to implement the Integrated Service Delivery Model

The Integrated Service Delivery Model (ISDM) will take time to fully evolve. Some aspects of this system are already in place, some are in process, and others may take several years.

This section outlines some priority actions we've identified in each core service area. It also outlines some actions to improve integration and collaboration between and among caregivers and their agencies.

Over a period of time we will work on these actions to better integrate our health and social services system.

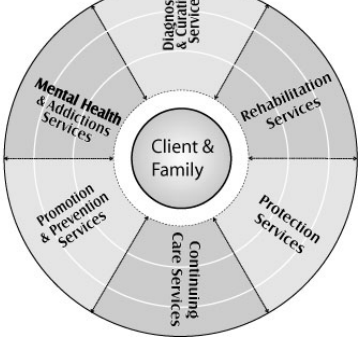
What are the priority actions in each co

Diagnostic and Curative Services Priority Actions:

- ✓ Develop a long-range plan for diagnostic equipment, including a replacement schedule. Standardize equipment in various facilities. Develop a schedule to maintain equipment to industry standards.

- ✓ Increase our ability to use tele-health. Expand tele-health outreach support to all communities.

- ✓ Develop a plan for NWT hospitals, including where they're located and what services each hospital will provide.



Rehabilitation Services Priority Actions:

- ✓ Set up one rehabilitation team in Inuvik, two teams in Yellowknife, and one team split between Hay River and Fort Smith.
- ✓ Establish a steering committee to coordinate services between the Department and Health and Social Services .
- ✓ Design and use consistent access policies.

Protection Services Priority Actions:

- ✓ Establish public health units within every Regional Authority.
- ✓ Revise the *Public Health Act* to reflect current public health practices.
- ✓ Review and revise standards and policies for child and family services. Standards and policies should reflect best practices to support children and families. They should clearly indicate how child and family services integrate with other services.
- ✓ Amend the *Child and Family Services Act* to comply with current Canadian laws.
- ✓ Develop and implement a planning system to meet each child's need with a continuum of services while they're involved with child and family services.
- ✓ Define more clearly the role of family violence shelters and their funding needs.
- ✓ Appoint a Deputy Public Guardian for each Regional Authority.

Continuing Care Services Priority Actions:

- ✓ Implement the *NWT Action Plan for Persons with Disabilities*. Develop more living options for persons with mental and/or physical disabilities, including supported living options. Develop respite care.

- ✓ Properly train and increase the number of home support workers.

- ✓ Offer consistent home and community care, and equal access to this service across the NWT.

- ✓ Make sure people with cognitive impairment specialized, licensed facilities and services.

Mental Health and Addictions Services Priority Actions:

- ✓ Invest in mental health and addictions services at the community level – where most prevention, outpatient treatment, and aftercare should take place.

- ✓ Continue to implement the *Mental Health and Addictions Strategy*. For example, hire community wellness workers, community mental health workers, and clinical supervisors to the proposed numbers and mix of staff for each Regional Authority.

- ✓ Implement the *Family Violence Action Plan*.

Promotion and Prevention Services Priority Acti

- ✓ Develop healthy living/healthy choices programs for tobacco, diabetes, injury prevention, healthy pregnancies, and addictions.

What actions support agency integration and collaboration?

This section briefly outlines the various actions that support agency integration and collaboration.

Main Agencies	Actions that support integration & collaboration.
	Co-location of services.
	Single point access / flexible access.
Department of Health and Social Services.	Change management.
Stanton Territorial Authority.	Case management.
Regional Health and Social Services Authorities.	Public education.
	Standard forms and systems.
Non-government organizations.	Standard assessment, referral, and therapeutic tools.
Private business.	Coordinated discharge planning.
	Quality control and evaluation.

Co-location of services to support integration and collaboration:

Co-location means services are physically located in the same place, or close by. Co-location is particularly useful for medical and mental health services. For example, the mental health worker might work in the same clinic as a nurse practitioner or doctor.

Co-location supports the proven link between physical and emotional health, and can help reduce the stigma of mental health.

In smaller communities, co-location might involve nursing staff, social workers, and addictions and mental health workers. In larger communities co-location might involve doctors, psychologists, nurse practitioners, nutritionists, rehabilitation staff, or other caregivers.

Single point access / flexible access to support integration and collaboration:

We can look at access in many ways. Access can refer to:

- ✓ How easily people can get into a building.
- ✓ Whether or not the amount and type of space in a building meets peoples' needs.
- ✓ The hours during the day or night people can receive services.
- ✓ Where a service is located compared to the people who need the service – within or outside a community.
- ✓ The ways people enter and move through the system.
- ✓ The comfort people feel. Do people trust the system to meet their language, cultural, and other needs? Do people trust the system to keep their information confidential?
- ✓ If and how the system does meet peoples' language, cultural, and other needs.
- ✓ The cost of services including travel, walking aids, special diets, and drugs.
- ✓ The knowledge people have about what services they can get and how and where to get them.

- ✓ Community gossip and lack of anonymity. People may hesitate to seek help if they think or know others will see them and talk about it.

Flexible access may include evening and weekend service hours; toll-free services that operate every day, all day; and mobile clinics.

Single point access allows a person to enter the system through one caregiver and be referred for other services, without re-entering the system. The first caregiver directs and tracks the person, until another formally takes over. The person never feels disconnected, abandoned, or isolated within the system.

Change management to support integration and collaboration:

Change management means to actively manage change rather than react to things that cause change. With change management, we regularly gather and analyze information about what impact our decisions have and how effective they are.

Our health and social service delivery system has changed a lot over the past 15 years. The ISDM is a logical extension of that change. As we fully implement the ISDM, people will experience more change. We'll plan and manage these changes so caregivers and other staff will experience minimal stress and the system will be disrupted as little as possible.

People involved with change management will need team-building, problem-solving, conflict resolution, and communications training. Staff will receive orientation about the ISDM. Caregivers will develop new and broader professional skills to do their jobs in new ways. Everyone will respect and accommodate the cross-disciplinary approach.

Change management recognizes the context. Right now caregivers have large workloads and a lot of stress. The system is understaffed and we have a high turnover rate. Change will take time and patience.

Case management to support integration and collaboration:

Case management means caregivers use a defined process to help people through the system. Caregivers coordinate assessment and therapies so people get the most effective care. Effective case management is at the heart of collaboration. Case management processes will fully respect client confidentiality.

Case management includes formal and informal protocols. Formal protocols are official agreements to do things a certain way in a given situation. One example is child sexual abuse protocols. Informal protocols are unofficial things such as interagency meetings to share program information.

Three Regional Authorities have initiated case management pilot projects. This is a first step to establish comprehensive health and social services case management in the NWT.

Public education to support integration and collaboration:

Public education means we effectively communicate with people. Here are 6 examples of public education the Department and Health and Social Services Authorities have completed or that are ongoing:

- ✓ Publish and distribute a core services document.
- ✓ Publish and distribute a handbook to encourage and support self-care practices.
- ✓ Provide a toll-free line for general health and self-care information.
- ✓ Develop a system for the public to evaluate services. Produce and distribute an annual report of this evaluation.

- ✓ Use the ISDM to explain the primary community care approach and how we'll implement it.
- ✓ Work with communities to define and respond to the health and social impacts of resource development.

Standard forms and systems to support integration and collaboration:

Standard forms mean that each profession or discipline uses the same form to gather the same information. Some standard forms will be common among and between disciplines. Some standard forms will be particular to one or more disciplines.

Standard systems mean that a common database records information from the standard forms.

The forms and the systems need to be easy to use. They need to capture the relevant information. We need to be able to easily analyze and share the information. We also need to protect client confidentiality.

Standard assessment, referral, and therapeutic tools to support integration and collaboration:

Standard tools means that all caregivers use the same and the most appropriate procedures for tests, referrals, and therapies.

In the NWT, standard tools have become more common in the past few years. For example, we use:

- ✓ The Nipissing Development Screen to evaluate a child's physical, social, and intellectual development.
- ✓ The Application for Treatment Form to enter a residential addictions program.
- ✓ The Continuing Care Assessment Package.

We need to identify existing tools and procedures, and to pilot and evaluate appropriate tools and procedures to commonly apply across the NWT.

Coordinated discharge planning to support integration and collaboration:

Coordinated discharge planning guides a person's care when they leave a hospital or residential care facility.

The primary community care team, the client, and their family work together to create the plan. Planning starts when a person enters a facility. The key elements are timing and follow-up care. Coordinated discharge is one element of the whole case management process.

The Joint Leadership Council is reviewing a model for a 'coordinated discharge planning protocol'.

Quality control and evaluation to support integration and collaboration:

We use quality control and evaluation to find out if we deliver the services we want, to the people who need them, in the best way we can. We assess the quality of services from three perspectives:

1) The public or the client.
2) The caregiver.
3) Outcome-based measures.

Clients and caregivers often evaluate health and social services based on similar factors such as access, standards, teamwork, and sharing information.

Outcome-based measures use indicators such as number of health centre visits and population health data. We need structured, ongoing evaluation from all three perspectives.

Part C: Do you need more information?

You might want to know more about:

- ✓ The details of primary community care, integration and collaboration, or core services.
- ✓ The process we used to develop the ISDM.
- ✓ The people we consulted to develop the ISDM.
- ✓ The services available in your community or region.

Get a copy of the full report about the ISDM from the Department of Health and Social Services.

Phone: 867-920-6173

Website: www.hlthss.gov.nt.ca (see publications section)

Get more information about services in your community or region from your Health and Social Services Authority.

Health and Social Services Authorities	Phone
Deh Cho Health and Social Services Authority	867-695-3815
Dogrib Community Services Board	867-392-3000
Fort Smith Health and Social Services Authority	867-872-6200
Hay River Health and Social Services Authority	867-874-7100
Inuvik Regional Health and Social Services Authority	867-777-8000
Sahtu Health and Social Services Authority	867-587-3438
Stanton Territorial Health Authority	867-669-4111
Yellowknife Health and Social Services Authority	867-873-7276