VOICES ON
SENIORS CARE

New Brunswick Medical Society
Société Médicale du Nouveau-Brunswick
NB
Dedicated to your health • Dévouée à votre santé

Association médicale canadienne
Canadian Medical Association

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INTRODUCTION

What answers do you get when you ask 15 eminent leaders and influential organisations, all working in seniors care in New Brunswick, the same question?

That's the premise behind "Voices on Seniors Care in New Brunswick."

All of the following ideas were graciously submitted by their authors to the New Brunswick Medical Society and the Canadian Medical Association. We wanted to know their answer to just one question:

"What should we do differently to most benefit seniors in New Brunswick?"

We had the simple idea of compiling their suggestions and comments into a single document, to be read by the public, health leaders, and each other.

What you will find in the following pages is a gold mine of ideas on how we can improve what we are doing to benefit seniors. We can say that with humility because respectfully, the ideas are not ours – they are the collective wisdom of dozens of patients, providers, and the public, all working with our seniors in mind.

The New Brunswick Medical Society and the Canadian Medical Association have our own views on what we should do to improve seniors care, too. In fact, we've written dozens of pages of commentaries and suggestions. Many have to do with our mismatch of supply to demand in terms of what our health system does (and doesn't do) and what our seniors really need. Some of our ideas are about process, and what we call "patient flow" – or how people move in the health

"THE RULES"

The following was the entire direction given to our selected contributors in July 2015.

"To ensure everyone is organising their work along similar lines, some rules are necessary. These will also be articulated at the beginning of the final document for the reader to understand. Submissions shall be:

- No longer than 750 words (in English).
- Action-oriented and related to specific and tangible projects, initiatives or programs, not general philosophies or principles.
- In keeping with the theme of the event, should not place blame or assign responsibility, but should add to a constructive dialogue about what should be done.
- Offered in English and in French. All organisations should use a translator of their personal preference. We serve members and the public in both official languages. If you are an individual needing assistance to translate your work, please contact us to make arrangements.
- Should refrain from including diagrams, visuals, or references. You are welcome to use your text to point to these supports on a website for the reader to find.
- Contain an additional 100-word explanation on the writer's qualifications, interest, or experience on the issue at hand.
- The deadline for your submission, in both official languages, is 4.30 p.m., September 14, 2015."

system. A lot have to do with our views on care based in institutions, like hospitals and nursing homes, and care based in the community, like homecare workers and informal caregivers.

Our views can be found on our respective websites, **www.cma.ca** and **www.nbms.nb.ca**. And while seniors care is tremendously important in New Brunswick because of our aging population and strained resources, we also support Demand a Plan, an initiative to ensure seniors care is on the national radar, too. Ultimately, every province in the country will face New Brunswick's demographic challenge. If we change the way we provide care to seniors and help them thrive, we have a lot to teach our nation.

We encourage you to read what commentators have proposed. Some things you may have heard before, and some are likely new. Some may not be able to be done, and some may be well on the way to completion. But all of them deserve a read and your critique, because together, they show the alignment and discord among influential and intelligent groups all working on the same goal: improving seniors care in New Brunswick.

In standard medical literature format, we hereby inform you that no one was paid, or paid us, to have their submission included. We sought no funding from any third party to create this guide. All contributions are available in both official languages of New Brunswick and where they were not originally, we paid to have them translated. We did not seek any public submissions, and carefully curated who we asked to write a piece for this collection. No contributor saw the work of any other before the final document was published.

We would like to thank the New Brunswick Health Council for generously sharing their time and data to help create the visual graphs and charts you see at the beginning of this document.

Finally, we leave you with the rules we designed to ensure this process was fair. Most contributors would have preferred more space to expand upon their answers, and most probably would have preferred a more specific question! But the goal of this work is to show our similarities and our differences as we examine seniors care and the playing field was level for all.

We hope you enjoy reading "Voices on Seniors Care". And we hope the change sought in these pages is reflected in the care we provide for seniors now and into the future.

Dr Camille Haddad and
Dr Chris Simpson
Honourary Co-Chairs
2015 Roundtable on Seniors Care,
Fredericton, New Brunswick

SENIORS POPULATION HEALTH SNAPSHOT 2015

New Brunswick		Seniors Male	Seniors Female	Seniors Average	Overall NB Average	Canadian Seniors Average		Rank (NB Seniors to Canadian Seniors)
Population Health Outcomes								
See their health as being very good or excellent	(%, 2014)	35.7	40.6	38.4	54.0	45.0	●	10/10
See their mental health as being very good or excellent	(%, 2014)	57.0	62.1	59.9	66.7	69.0	●	10/10
Pain or soreness that prevents activities (physical or emotional)	(%, 2014)	14.7E	21.7	18.5	16.3	21.3	●	3/10
Life satisfaction, satisfied or very satisfied	(%, 2014)	87.0	89.8	88.6	92.0	89.3	▲	7/10
Life expectancy at 65	(years, 2007-2009)	17.7	21.1	19.5	19.5	20.2	▲	7/10
Confident at managing chronic health condition, very confident	(%, 2014)	48.2	42.1	44.1	42.2	--		--
Health Determinants								
Health Services - account for 10% of the health determinants								
Has used Tele-Care or other telephone information lines in the last 12 months	(%, 2014)	3.4	5.3	4.5	7.4	--		--
Has a regular medical doctor	(%, 2014)	95.9	97.5	96.7	92.1	94.8	●	2/10
Medical doctor visit within the last year	(%, 2014)	88.6	89.9	89.3	79.6	90.8	●	8/10
Adults 65 years and up who have received the flu shot in the last year	(%, 2014)	58.1	63.6	61.1	61.1	63.1	▲	5/10
Family doctor coordinating care with other health care providers	(%, 2014)	77.2	71.0	72.7	70.7	--		--
Access to a family doctor within 5 days	(%, 2014)	67.3	63.9	65.4	60.3	--		--
Has access to a primary health team	(%, 2014)	--	--	31.7	28.5	--		--
Alternative level of care (ALC) days to total inpatient days	(%, 2013-2014)	--	--	24.3	24.3	13.5	●	10/10
Wait time for hip replacement surgery (within 26 weeks)	(%, 2014)	--	--	--	74.0	83.0	▲	7/10
Average number of days to complete long term care generic assessment	(days, 2013-2014)	--	--	59.0	59.0	--		--
Wait time for nursing home placement	(days, 2014)	--	--	92.5	92.5	--		--
Nursing home beds	(rate per 1,000 population aged 75 or older, 2014)	--	--	81	81	--		--
Special care home beds	(rate per 1,000 population aged 75 or older, 2014)	--	--	117.2	117.2	--		--
Clients served by Extra-Mural Program	(rate per 1,000 population, 2013-2014)	--	--	48.7	48.7	--		--
Evaluation of care received for mental or emotional health, very helpful	(%, 2014)	54.7	64.7	61.7	55.7	--		--
Rating satisfaction/experience of overall health care services, 8, 9 or 10 out of scale of 10	(%, 2014)	80.5	78.5	79.4	67.9	--		--

New Brunswick		Seniors Male	Seniors Female	Seniors Average	Overall NB Average	Canadian Seniors Average		Rank (NB Seniors to Canadian Seniors)
Health Behaviours – account for 40% of the health determinants								
Physical activity during free-time, moderately active or active	(%, 2014)	47.3	34.5	40.2	49.6	47.7	▲	7/10
Eat 5 or more fruit or vegetables a day	(%, 2014)	29.1	40.9	35.5	35.9	42.9	▲	5/10
Adults with unhealthy weight (obese)	(%, 2014)	23.9	21.6	22.6	26.4	20.0	▲	4/10
Seeing your stress as being a lot	(%, 2014)	7.0E	8.9	8.0	20.1	11.2	●	2/10
Current smoker, daily or occasional	(%, 2014)	11.2	9.7	10.3	19.2	9.4	▲	7/10
Always wears a bicycle helmet while on a bike	(%, 2014)	69.4	65.6E	68.6	53.2	48.3	●	3/10
Social and Economic Factors – account for 40% of the health determinants								
High school diploma or less	(% aged 65 and older, 2014)	47.3	53.6	51.0	38.7	--		--
Living in low income ($25,000 or less household income)	(%, 2014)	20.8	38.4	30.4	17.2	19.9	▲	6/10
No insurance coverage for prescription medications	(%, 2014)	15.2	19.0	17.3	17.4	--		--
Sense of belonging to your community, somewhat strong or very strong	(%, 2014)	71.4	79.5	75.9	71.3	73.9	●	8/10
Unable to leave the house because of health problems	(%, 2014)	7.8	14.1	11.4	11.3	--		--
Have trouble finding their way around the health care system	(%, 2014)	4.6	6.7	5.8	9.3	--		--
Physical Environment – accounts for 10% of the health determinants								
Exposure to radon at home	(% above 200 Bq/m3, 2012)	--	--	--	20.6	--	●	10/10
Transportation problems	(%, 2014)	4.4	6.4	5.5	7.1	--		--

Provincial rank in Canada

- ● Doing well (ranked 1, 2, 3)
- ▲ Caution (ranked 4, 5, 6, 7)
- ● Lagging (ranked 8, 9, 10)

Note: seniors defined as 65 years old and older
Rating by best (1) to worst (10); includes all provinces (10).
E = Use data with caution, sample size too small
-- = data unavailable

New Brunswick Health Council
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Sources:
New Brunswick Health Council (NBHC) Primary Health Survey 2014 (seniors n = 4,281, total population n = 13,614)
Statistics Canada
Government of New Brunswick administrative data sources

SENIORS POPULATION
HEALTH MAPS

These maps show information related to seniors in New Brunswick.

Figure 1
Seniors living in low income (Statistics Canada, 2011)

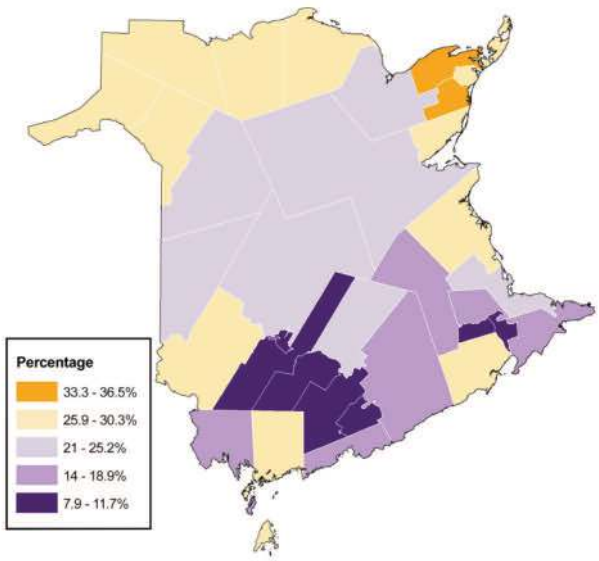

Figure 2
Personal family doctor who helps coordinate the care from other healthcare providers when needed for seniors (2014)

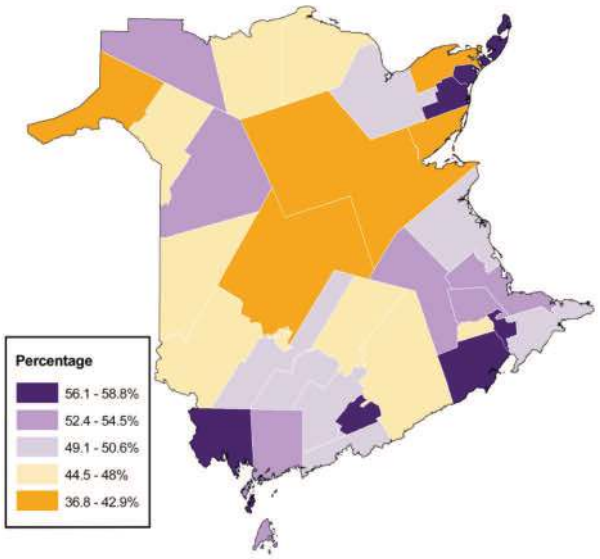

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Figure 3
Seniors who found the cost of medication too high (2014)

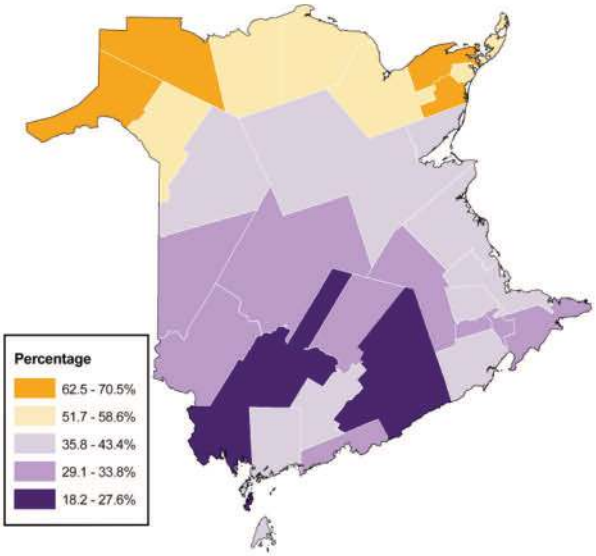


Figure 4
Seniors who are very confident at managing their chronic health condition (2014)

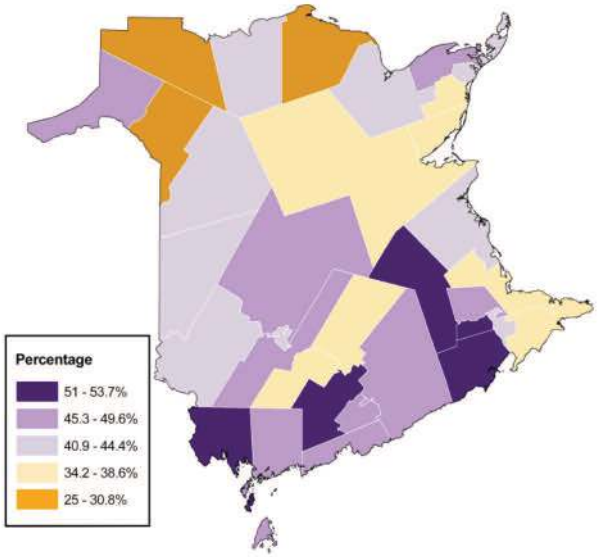


Figure 5
Seniors with transportation problems to get health services (2014)

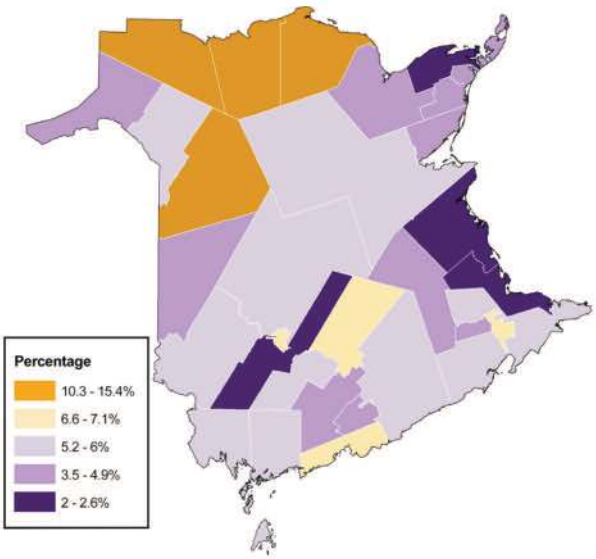


Figure 6
Seniors who responded having someone in the household with memory loss (2014)

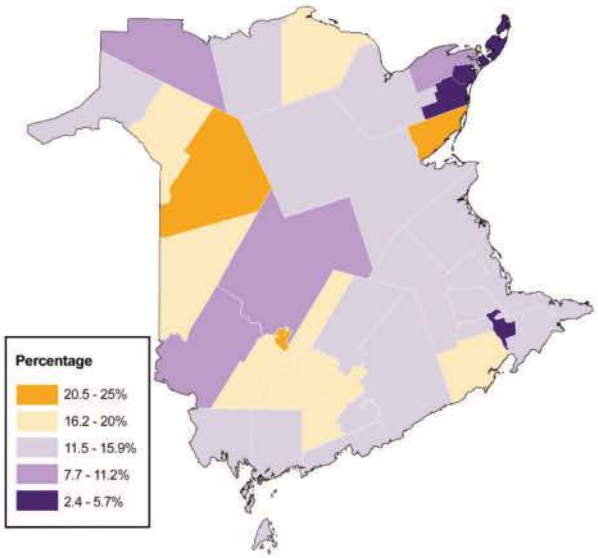


Figure 7
Seniors who see their mental or emotional health as very good or excellent (2014)

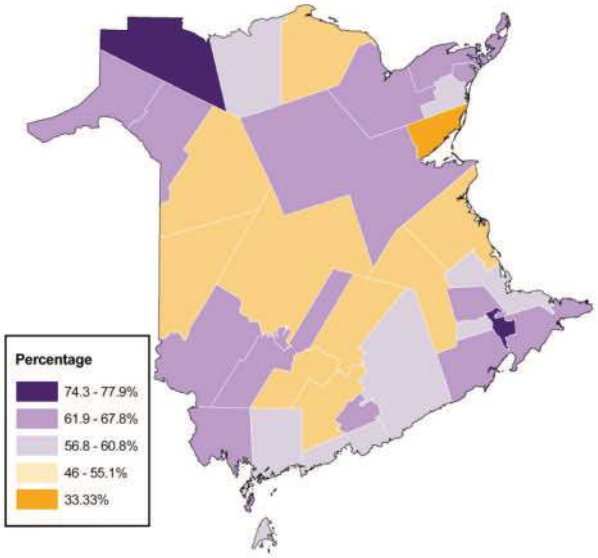


Figure 8
Seniors who are unable to leave the house because of a health problem (2014)

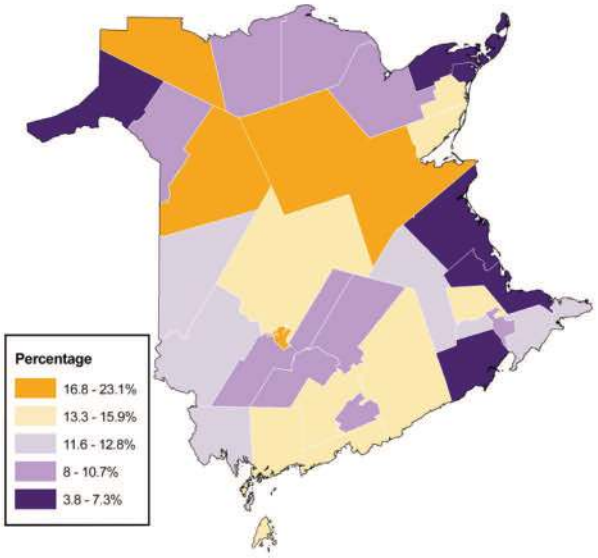


Figure 9
Alternative level of care (ALC) days to total inpatient days (2013-2014)

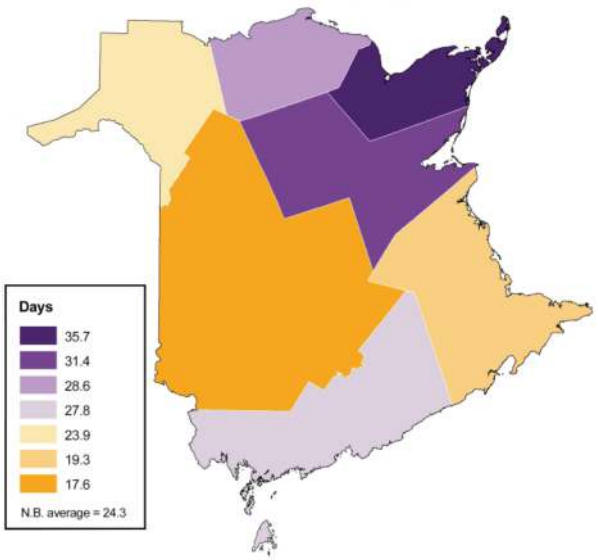


Figure 10
Nursing home beds per 1,000 population aged 75 or older (2014)

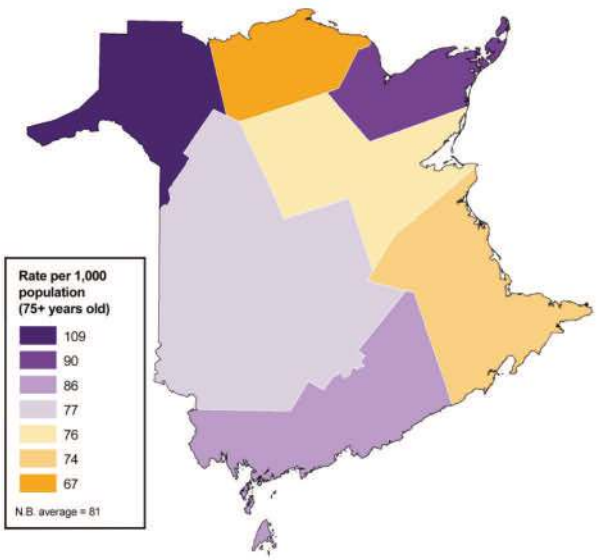


Figure 11
Special care home beds per 1,000 population aged 75 or older (2014)

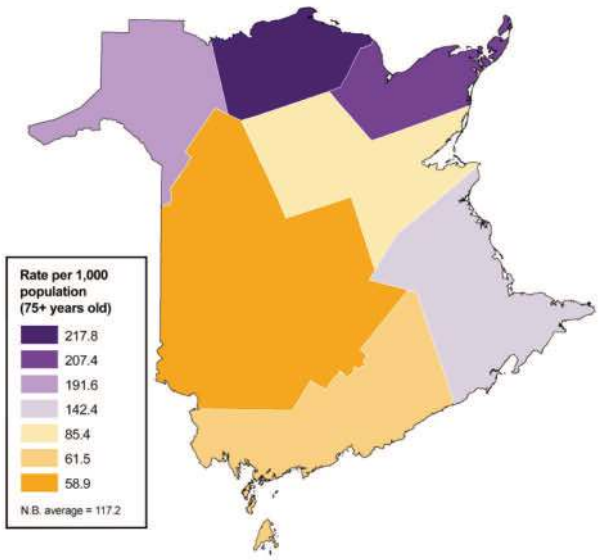
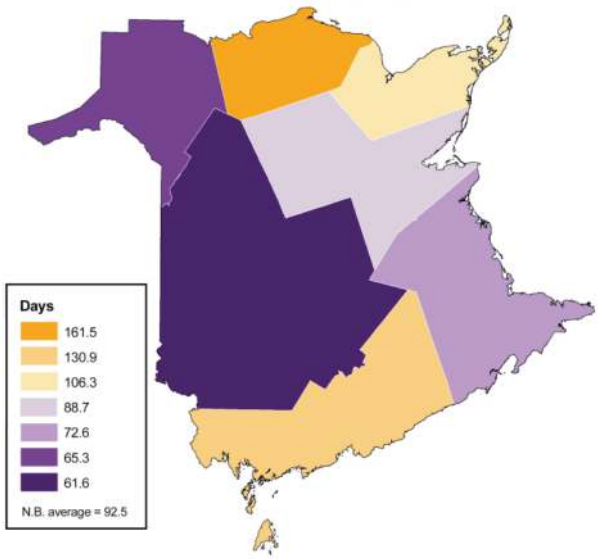


Figure 12
Average number of days for placement in long-term care home (2014)



Sources: New Brunswick Health Council, Primary Health Survey and Government of New-Brunswick

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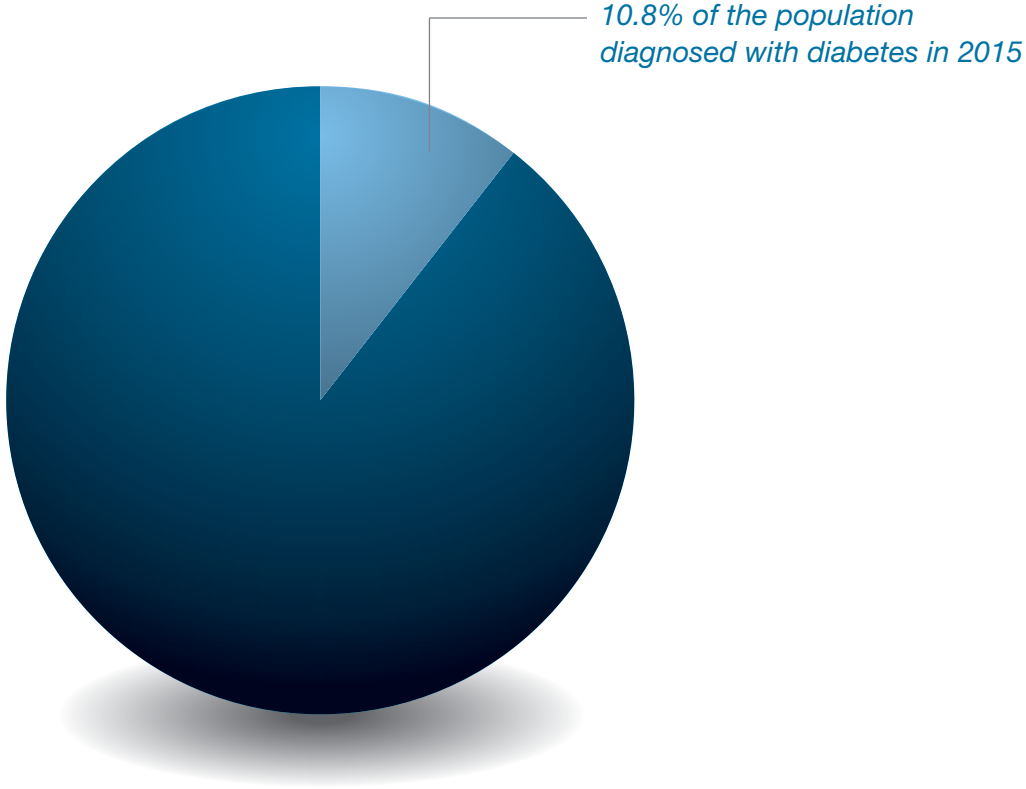
CANADIAN DIABETES **ASSOCIATION**

Improving Care for Seniors with Diabetes in New Brunswick

In New Brunswick, diabetes has reached epidemic levels. The New Brunswick Diabetes Registry identified 74,987 people with diabetes in 2013-2014.[1] The Canadian Diabetes Association (CDA) estimates that in 2015, an estimated 83,600 people (10.8% of population) will be diagnosed with diabetes. When combined with the estimated 135,180 people with prediabetes, diabetes affects nearly one in three New Brunswickers. Of the population living with diabetes in this province, over 80% are aged 50 years and older.[2] Given diabetes affects primarily older age groups and seniors it is indeed high time to focus the provincial government's attention on senior care.

Seniors with diabetes in New Brunswick require financial support to help them self-manage their disease more effectively, so as to avoid or delay serious and potentially life-threatening complications that can develop from poorly managed diabetes, such as heart attack, stroke, kidney failure, blindness and amputation. Seniors with diabetes are likely managing their diabetes with multiple daily medications. They also need diabetes supplies, such as blood glucose test strips, to

[1] *New Brunswick Department of Health. Diabetes in New Brunswick 2014*
[2] *Canadian Diabetes Association. Canadian Diabetes Cost Model, 2015.*



ensure their diabetes is well-managed. The majority of seniors would not have employers' insurance coverage that helps to pay their high costs for drugs and supplies after retirement. The CDA's own research estimates that, in general, New Brunswickers with type 2 diabetes have to pay $3,400 annually out of their own pocket to pay for medications, supplies and devices to manage their diabetes, which is the highest among all jurisdictions in Canada. For seniors with diabetes in New Brunswick, who have no income or low income and therefore face high costs, their only option is the public drug program.

The New Brunswick Prescription Drug Program covers drugs costs for seniors with diabetes, at no cost (i.e. no premium) and some co-payment. However, diabetes supplies (such as blood glucose test strips), which are essential for self-management, are not covered under the basic plan. To obtain coverage for diabetes supplies, seniors with diabetes would need to purchase extended health benefits from the Medavie Blue Cross Seniors' Health Program which covers diabetes supplies. Delays in purchasing the additional plan (due to diabetes diagnosis later in life, for example) can result in a one-year waiting period before these benefits would kick in, which would severely compromise their diabetes management. The additional cost to obtain coverage for test strips and the delays in receiving benefits are serious challenges raised by many seniors with diabetes. The high cost of test strips may cause people to skip testing to save cost, resulting in poor glucose control, failure to detect or prevent hypoglycemia, and increase the risk of diabetes-related complications and costly acute care interventions. Hence, the CDA strongly recommends diabetes supplies, such as test strips, be covered under the basic plan of the public drug program for seniors with diabetes.

New Brunswickers with type 2 diabetes have to pay $3,400 annually out of their own pocket to pay for medications.

About the Canadian Diabetes Association

The Canadian Diabetes Association (CDA) is a leading authority on diabetes in Canada and around the world. It has a heritage of excellence and leadership, and its co-founder, Dr. Charles Best, along with Dr. Frederick Banting, is credited with the co-discovery of insulin. Across the country, the CDA leads the fight against diabetes by helping those affected by diabetes live healthy lives, preventing the onset and consequences of diabetes, and discovering a cure. The CDA is supported in its efforts by a community-based network of volunteers, employees, health care professionals, researchers, and partners. By providing education and services, advocating on behalf of people with diabetes, supporting research, and translating research into practical applications, the CDA is delivering on its mission.

CAPITAL REGION SENIOR AND RETIRED PHYSICIANS GROUP

The Assessment Process for Long Term Care

This essay is based on the experience of a senior New Brunswick physician whose wife required nursing home placement. This left him with several questions about the nursing home application process. He has shared his concerns with us:

"Firstly, why was the assessment of the person's disability considered to be secondary to the assessment of who would be responsible for costs involved in whatever care she might require? Should the assessment of the need for care not be the primary issue, or at least of equal importance to the question of payment liability?

Secondly, why was there such a lack of transparency in the assessment process, with regard to the criteria for disability as well as the income cut-off level for financial liability? Knowing the family income level which would trigger full financial responsibility would help the responsible party begin planning immediately.

Thirdly, why is the assessment by the health care team in a clinic or a hospital where an individual has been receiving care, considered irrelevant in determining the future needs of the person under consideration? Also, can a person's need for care be adequately assessed from a cursory evaluation in an hour or less, which appears to be the current process? Specialized health care staff could be helpful in the training of assessment staff, in areas such as the Mini-Mental examination, for example."

Our colleague's recent experience with the issues mentioned above illustrates the opacity, complexity, and inefficiency of the current assessment process for Long Term Care. Based on this experience we have the following comments and recommendations:

The reasons for home care assistance and placement in Special Care and Nursing Home institutions are primarily due to the person's medical conditions and functional disabilities. These issues should be assessed first. There would appear to be no valid reason to delay physical, mental or social assessments while awaiting a financial assessment. The financial assessments can follow, or be done concurrently.

The current assessment process is often triggered by a crisis. The family or caregivers should be encouraged to start the long-term care assessment in advance of a crisis. The assessment process should be done in a timely manner, as determined by the needs of the patient and the family, and then be adjusted accordingly should the person's needs change suddenly during the assessment period or during the waiting period for placement.

Capital Region Senior and Retired Physicians Group

The Capital Region Senior and Retired Physicians Group consists of approximately fifty physicians in the Capital Region who are either fully or semi-retired. Most members worked for decades in Fredericton and were heavily involved in the community and notably, the Dr. Everett Chalmers Regional Hospital and its Foundation. Now, members continue to contribute to their community through some patient care, a great deal of fundraising, and continued advocacy. The Executive Committee of the Group authored this report on behalf of its members.

All stakeholders, including the patient, the family and physicians, should be aware of the assessment process for long-term care. They need to know the goals and the mechanics of this process. This would include details of the medical and functional assessments, the financial assessment, and the evaluation criteria for cognition and mental capacity. The application and assessment process needs to be more transparent to families and to health professionals. Understanding this process would greatly reduce family stress and increase their ability to fully assist in the assessment process, thereby accelerating the whole evaluation.

The long-term care assessment should be a team effort, as is the Comprehensive Geriatric Assessment of the elderly. Assessments already performed by family physicians, geriatricians, occupational therapists, physiotherapists, social workers, EMP staff and other health professionals should be included in this long-term care assessment. When there have been detailed geriatric and functional evaluations done in hospital, then the hospital assessment team could be empowered to complete the evaluation for long term care based on their professional assessments. Duplication of assessments by the Department of Social Development staff may be unnecessary and time-consuming. The assessment process should not be the sole responsibility of a dedicated group, as it is at present.

Our comments are based on this personal experience, and on the professional experiences of a group of physicians who have been involved in seniors' care for many years. We would appreciate the opportunity to have input into the long-term care assessment process.

ALZHEIMER SOCIETY OF NEW BRUNSWICK

Defeating the Dark Shadow of Dementia in New Brunswick

Introduction:

The diagnosis of Dementia, for thousands of New Brunswickers, is as serious and probably more disruptive to families than most other diagnoses. While there is no cure for the various forms of dementia, much of the suffering experienced by families, caregivers, and Persons with Dementia can be reduced by wiser, more appropriate deployment of resources.

It is important to emphasize this: we are talking about a Disease Process, not simply a matter of aging!

The Dark Shadow of Dementia:

When diagnosed with Dementia, the family unit is forever changed. The dreams of pursuing goals in later life are snuffed out; the dreams of travel, relaxation, leisure time with grandkids, etc., are now gone.

The elements of the Dark Shadow:

1. Stigma and social pressure: Dementia has been lumped together with mental illness. Mental health has been enjoying a correction of the stigma associated with it as the mental health societies across the continent have waged war against the stigma. Similarly with Dementia, we need an all-out attack on the stigma and perceptions associated with it. This is not about "dad's just getting old and forgetful"; it is a real, discernable, definable disease of the brain which can be shown on scans.

2. Family and caregiver distress: Distress commences when it takes a long and unnecessarily protracted period to get a diagnosis. Often families struggle to get the attention of the family physician; then there is the long queue at the Geriatrician's office. It should not, generally, require 18 months to two years to get a diagnosis. Once the diagnosis is made and communicated to the care giver, the failure to provide hope, prognosis, a plan for the future, etc., is tragic.

3. Acceptance of Dementia as a major chronic disease: Our health and social care systems are familiar with Diabetes, MS, Cardiac Disease, and a number of other diseases well recognized with treatment protocols, drug therapies and such. Dementia, in New Brunswick, is the least understood and most under-rated of all. As such, treatment practices are all over the map, confusion abounds, approaches to care and support differ depending on which community you reside in or which physician is attending you. The truth is there are far more people impacted by this disease in NB than any other single disease grouping; and the total cost to society is far greater than heart disease or cancer. Family doctors and others practicing at the Primary Care Level need more training and there needs to be an entirely new way of dealing, at the primary care level, with elders who perceive symptoms either in themselves or their loved one.

4. Lack of information in navigating the system: The consistent message from all who believe they are beginning the Dementia journey with a loved one to those who are well along the journey the message is one of desperation: I need help! Where is the help? Unlike other diseases, help is not a pill away! Or a series of treatments away! Help takes the form of periodic respite; help in coordinating care; education for caregiver, family, and health care professionals. Then there is the question of how to pay for help and where to find information about available support.

5. Inappropriate treatment practices: Living at home surrounded by family is the optimum way to care for one with Dementia. But as the disease progresses, various interventions are required and more assistance needed to the point that at some time, depending on the socio-economic situation, care in a facility may be required. Dementia is not like other diseases in terms of care requirements so placement in an acute care facility is totally inappropriate; in those environments, staff have not had adequate training to care for persons with Dementia appropriately. Consequently, these people decline and deteriorate while occupying a highly expensive acute care hospital bed.

6. Loss of hope: This is, of all the issues, the least discussed and the least appreciated by those who provide service to persons with Dementia. Having lived a good life, one decides it is time to retire and enjoy life on their schedule. With a diagnosis, all the dreams of enjoying these latter years of life are shattered.

The Dark Shadow can be eliminated but not without major attitude changes. More funding is not the primary issue - inspired leadership is!

Alzheimer Society of New Brunswick

This submission was written by Ken McGeorge, Acting Executive Director, Alzheimer Society of New Brunswick. The Alzheimer Society of New Brunswick is a not-for-profit health organization whose mission is to alleviate the personal and social consequences of Alzheimer and related diseases, through information, education and support, and to promote public awareness and the search for a cause and cure for the disease.

The diagnosis of Dementia, for thousands of New Brunswickers, is as serious and probably more disruptive to families than most other diagnoses.

HORIZON HEALTH NETWORK
A STRATEGIC FOCUS ON SENIORS

As the largest provider of health care services in New Brunswick, Horizon has a clear view of the impact of our changing population demographics. Seniors represent the largest proportion of our patient population. These changes have come as no surprise. Our staff and physicians have introduced many initiatives to improve the care of seniors. From the recruitment of specialist geriatricians, to the professional development of front line clinical staff in the latest clinical practice guidelines and the establishment of specialized geriatric programs, we have attempted to provide a range of services to meet the specific needs of this population.

However, the waves of change continue to grow. Earlier this year, we released a bold new strategic plan which makes clear our position on this very important issue. This plan outlines the importance we have placed on working with our partners to rebuild healthcare together. This theme permeates our plan as we recognize that required change must occur in collaboration with patients and families, communities, providers and other stakeholders. Our challenge is to ensure that the priorities and plans for our system are aligned with those of our provincial government.

Horizon Health Network

Focused on patient and family-centred care, Horizon Health Network operates 12 hospitals and more than 100 medical facilities, clinics and offices, and provides services ranging from acute care to community-based health services.

With a collaborative, team approach to offering services in English and French, Horizon leads the way in delivering sustainable, safe and quality health care services to residents of New Brunswick, as well as northern Nova Scotia and Prince Edward Island.

Horizon has an annual budget of approximately $1 billion and has more than 12,400 employees, 1,000 physicians and 4,600 volunteers, auxiliary and alumnae members, as well as 20 foundations and 21 Auxiliary and Alumnae organizations.

Our Board and our staff have committed to four key priorities.

Strategic Priority 1: Above all, we will work with our patients and families to create and sustain an exceptional patient and family centred care environment.

Our goal is to ensure that patients and their families have the information, knowledge and support they need to make informed choices about their care. We also want to ensure that care and treatment decisions respect patients' needs, values and preferences. We are making significant progress by introducing patient experience advisors who are helping us to see the care experience from their perspective so that we can improve how we deliver care. This is particularly important and relevant for seniors who many times present complex needs.

Strategic Priority 2: We will establish centres of expertise that foster and communicate strong clinical leadership, improve patient outcomes and drive research as a core activity.

Within five years, care for seniors will be a strategic pillar of our services, with strong and clear leadership and profile. Management of elderly patients will benefit from a new centre of expertise in aging and eldercare.

Strategic Priority 3: We will significantly increase the relative share of resources to improve community-based primary care, and support expensive tertiary services that our aging population will require.

Horizon routinely has 25 per cent of its acute care beds occupied by citizens – Alternate Level of Care patients – who ideally, would be better served in their homes, or in long term care facilities. Hospitals designed for acute care are ineffective and inefficient in caring for people who required long term residential care. With the lack of appropriate programming, facilities and skill-sets, providing care in hospitals to seniors and others who should be in the community, frankly, is harmful to the well-being of these citizens. A well-designed health system should feature both strong centres of hospital-based care and appropriate community-based care "close to home" for New Brunswick residents. These two elements must work hand in glove in order to ensure that New Brunswickers receive the services that they need to be as healthy as they can be. With increasing levels of chronic illness, our citizens need access to the right health professional at the right time, preferably as close to home as possible. Increasingly urgent is the need to provide appropriate care options that enable elderly residents to remain in their homes or, at least, near their home communities.

Strategic Priority 4: Through collaboration with government, other agencies and organizations, we will advocate for major organizational change and secure partnership opportunities to enhance the care provided to New Brunswickers.

Dramatic changes will take place in the near future in federal/provincial funding support. These changes have provided us with an opportunity to create a new approach for New Brunswick. Our new model must be practical and fit our circumstances within a broad framework that provides guidance. But we must be frank: significant new investment will be required if we are to develop a new model of care for our aging population. We will advocate for improved collaboration with the long-term care sector by encouraging amalgamation of organizations that currently share responsibility for long-term care to our elderly population.

We recognize that these changes represent major shifts in how care is designed and delivered. System leadership, a shared vision, consensus and collaboration are essential precursors to effective change.

GERIATRICIANS OF NEW BRUNSWICK

What should we do differently to most benefit seniors in New Brunswick?

The senior population can be divided into the well (70%), the frail (20%) and the institutionalized (10%). For the purposes of these discussions, the focus will be on the frail and institutionalized seniors.

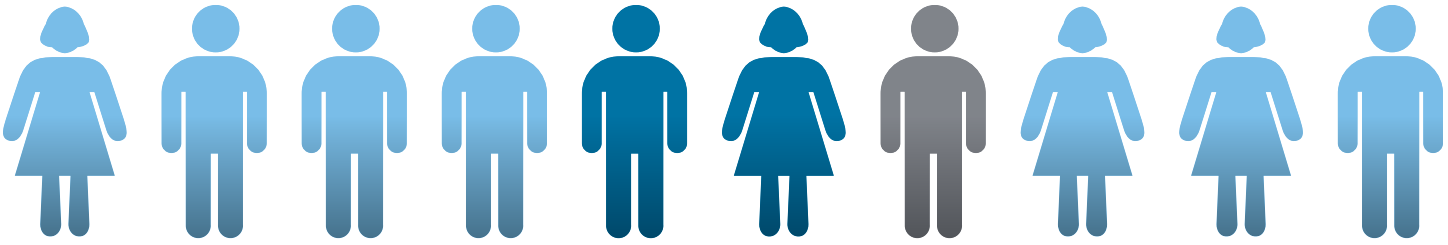
The frail senior lives in a precarious balance of medical, cognitive, functional, psychological and social problems. When this balance is upset, they often enter the acute care health system in crisis.

The institutionalized senior has multiple severe medical comorbidities (including dementia). They require 24 hour supervision, nursing and medical care.

We all want seniors to be able safely manage in their own homes as long as possible. However, when care needs exceed what is safe at home, there must be timely access to higher levels of care such as assisted living, special care homes and nursing homes.

This spectrum of care options from home to nursing home is necessary for a successful system. A critical factor for a successful plan for NB is to accurately identify how much of each needs to be available and at what cost. Below, we consider the major components.

Home Care – For the frail older adults at home, the services needed must be available to all. The care can be supported by the Extra Mural Program, in collaboration with the primary care physician. If homemakers are needed, they need to be affordable for all seniors, regardless of income. Currently, homemakers are subsidized if the senior meets the financial requirements. While this assists those in most need, it does not help the middle income seniors who still cannot afford to pay for services. This needs to be re-evaluated.



The well *The Frail* *The institutionalized*

Assisted living facilities/special care homes – Assisted living facilities and special care homes are part of the care options in New Brunswick. The number and types of facilities, the services they offer, and their cost, vary greatly across the province. Some are subsidized and some are private pay. In areas with improper balance of availability, some facilities struggle to fill their beds alongside others that are always at capacity with waiting lists.

Adequate number of nursing home beds – There will always be a percentage of seniors that require 24 hour nursing and regular medical care in a nursing home (NH). The right number of NH beds for a given population 75 years of age and older is unclear. However, if you look to other provinces for a benchmark, the number most commonly seen is around 100 NH beds/1000 people over the age of 75. The current plan in New Brunswick is for 75 beds per 1000 people over 75. This is too low and the shortfall has led to the large number of seniors waiting in our hospitals and their homes for this level of care. Approximately 25% of all hospital beds are filled with such people, designated as Alternate Level of Care. The majority wait for a NH bed. Until an accurate per capita NH bed target is identified and implemented, seniors will continue to wait in the hospital.

Attention must be turned to what is the "fair "cost to the individual for those needing a NH level of care. The cost of this care needs to be equitable, affordable and similar across Canada.

Types of Care in Special Care Homes (SCH) and Nursing Homes

The nursing/medical care available in these facilities differs. Thus, the type of person who will benefit from each is different. It is not reasonable to expect a SCH to be able to meet the needs of someone whose care requires a nursing home. When a senior's care needs are not able to be met in a SCH, their utilization of emergency departments and acute care hospitals increases. This is neither good for the senior, nor the system.

Ease of Access to Care

Currently, the only access point for home care, special care homes and nursing homes is through the Department of Social Development. The wait times for these assessments can be long and the case management of these clients is challenging. Allowing other partners in the system to do the assessments and manage these cases would help improve the ease and timeliness of care.

What is important is that seniors receive the right care, in the right place, at the right time, at the right cost. Change is needed to achieve this.

About the writers

This is a joint submission representing the views of the majority of the physicians in New Brunswick who deliver specialized geriatric care. This is based on clinical experience caring for thousands of patients and their families in this province, as well as research in this area. Geriatrician contributors are: Pamela Jarrett, MD FRCPC FACP, Associate Professor of Medicine Dalhousie University, in Saint John with Horizon Health Network; Patrick Feltmate MD FRCPC, Assistant Professor of Medicine Dalhousie University, in Fredericton with Horizon Health Network; and Michele Conrod MD CCFP DGM, Associate Professor of Medicine Dalhousie University, in Moncton with Horizon Health Network.

ABILITY
NEW BRUNSWICK

New Brunswick seniors are telling us that we must prioritize person-centred planning services to help seniors live as independently as possible, be active in their communities, and reduce pressure on our health and long-term care systems.

According to Statistics Canada (2012), 35% of New Brunswickers over 65 live with a disability, and 66.5% of these – approximately 25,000 seniors – live with a mobility disability. A significant population of New Brunswickers will develop a disability after age 65 often as a result of falls/injuries, medical complications or the onset of other conditions. At the same time, an increasing number of people with a long term disability live longer due to improvements in the detection and treatment of disease and advances in rehabilitation. However, the increase in longevity does not necessarily mean these seniors are maintaining an adequate quality of life. Baby boomers have had fewer children than previous generations, and the support they can anticipate from adult children is less than the previous generation. Other concerning issues experienced by seniors are social isolation, inactivity, access to transportation, access to safe, affordable accessible housing and funding for home modifications, access to primary health care, poverty and access to income supports, food security and nutrition, and management of chronic health conditions.

35% of New Brunswickers over 65 live with a disability, and 66.5% of these live with a mobility disability.

In a time of significant provincial fiscal challenges, ensuring the health and quality of life of an increasing population of seniors, while maintaining sustainable long-term care and health costs is of increasing concern. Services for seniors are provided with a complex and often confusing network of government, private and community service providers which span both social services and health care. Programs provided by hospital and government programs are, of necessity, limited in the planning and coordination time they can provide to help seniors explore their needs and goals, seek out and identify supports and navigate programs and services. Government systems are overtaxed and staff are forced to prioritize the most difficult and critical cases. This reality makes it nearly impossible to focus on planning, diversion or system avoidance.

Ability NB uses a person-centred planning model (Navigator Framework) which focuses on the achievement of quality of life goals identified by the service participant in their individual action plan. As part of a recent pilot, we worked one-on-one with 276 seniors with a mobility disability who were referred to our services due to barriers in independent living and a risk of nursing home placement. Less than 2% of these seniors were placed in a nursing home.

Through our navigator service delivery we meet with seniors with a mobility disability in hospital, rehabilitation centres and/or in their homes. We convene solutions teams with the individual, family, other members of their support network and service providers. The Rehabilitation Counsellor (navigator) is an allied health and human service provider who:

1. Works one-on-one with the senior to empower, plan, resolve priority unmet needs and identify goals;
2. Has, or can learn and build, the information and resources needed to allow a senior to make informed choices and decisions, and to achieve goals;
3. Identifies possible routes and options for, and may facilitate access to, services and supports.

Our research and evaluation demonstrates that good planning takes dedicated time. The average amount of time a Rehabilitation Counsellor spends to help each senior reach goals in their plan is 36 hours. Ability NB provides this service at a considerably lower cost than can be provided by government.

It is time to look to our community organizations for expertise in service delivery. Community organizations are often leaders in innovation and have greater flexibility to explore creative, community solutions that will help individuals reduce their reliance on government programs. We leverage in-kind resources and engage in continuous learning to ensure our staff are knowledgeable in the over 3,000 resources available to seniors.

The importance of planning is getting lost in the dialogue on aging. Strong, creative, person-centred planning is demonstrated to avoid unnecessary institutionalization, avoid unnecessary use of government programs, return our nursing home stays to shorter duration and ensure our hospital beds are used for acute care. New Brunswick needs to answer the following questions now: where are planning services for seniors best delivered in our province and how can we build better planning services?

About the writer

Haley Flaro (BA – Sociology, UNB) has served as the Executive Director of Ability New Brunswick for nine years and has an extensive background in working with vulnerable populations, including seniors, to develop community-based programs and public policy. Formed in 1956, Ability NB is a provincial community-based non-profit organization. Its mission is to empower the independence and full community participation of persons who have a spinal cord injury or mobility disability by providing innovative services and developing progressive public policy. They deliver bilingual community-based Rehabilitation Counselling services everywhere in New Brunswick.

NEW BRUNSWICK
HUMAN SERVICES COALITION

Crisis to Conquest – The Community Holds The Key

The New Brunswick Human Services Coalition was born five years ago to bring together representatives from the community to collectively try and improve the overall situation in New Brunswick for our clients, their families, and our workers and agencies. We are members of Home Care, Special Care Homes, Community Residences, Vocational and Day programs, and Community-Based Family Support. We are the "Community Based Social Services Sector" which includes nearly 10,000 care providers and agencies delivering services to thousands of our vulnerable New Brunswick citizens. Our services have long been recognized and referred to as "essential for the delivery of social services in New Brunswick".

Our mandate encompasses three main areas that are directly related to the delivery and sustainability of quality care for our clients:

1) The need for upgraded and standardized training.
2) Fair service rates and wage levels reflecting experience, training, and responsibility.
3) Appropriate regulation for the sake of quality and competence.

Indirectly and directly the Community-Based Social Services Sector is a crucial part of service delivery that is in need of attention. The sector has been woefully under-resourced for years in comparison with hospitals and nursing homes. This has resulted in mass difficulty and strain; the largest challenge being the recruitment and retention of qualified workers. Work has been done to try and improve working conditions, yet workers still receive little better than minimum wage and are considered the "working poor". Young people look at these positions as a second job, a way to gain valuable experience, but recognize no real career is possible. We have nothing to offer workers with post-secondary training. In the end, our seniors suffer through unfair changes and anxiety from high staff turnover, and agencies continue to struggle.

Indirectly and directly, the Community-Based Social Services Sector is a crucial part of service delivery that is in need of attention.

Where could the money come from? Rough estimates show we need 40 - 50 million dollars annually to bring wages up $4 to $6 dollars per hour. Plenty of provincial money comes and goes and often we question the choices made. Would this be considered a good choice? Is investing in the caring, generous workers of New Brunswick a good idea? Would this improve the quality of care for our seniors? One suggestion has been to restore the taxes to the 2009/10 levels with a significant portion of the additional revenue

strategically earmarked for this community-based sector; hinting we could have a revenue problem rather than a spending problem.

New Brunswick has always been proud of its community spirit and sense of good will for your fellow neighbor, and for good reason. Community is where the heart is. We are caring, generous people. Our valued traditions and simple pleasures like beautiful waterways, vast forests and covered bridges are the envy of many around the world. We "go with the flow"; take things as they come and learn to adapt when things happen. That attitude is great when things are going well and all is calm. However, that's not where we find ourselves today!

All over the news, there's a new phrase coined each week. "Silver Tsunami", "Bed Blockers", and on it goes. Studies, steering committees, policies, round tables and strategies, have become the new lingo. A lot of money has been spent, promises have been broken, elections have been lost, and where are we today? Smack dab in the middle of a huge problem with lots of "ideas" but no real action plan.

About the writer

Jan Seely has been a Special Care Home owner in the small communities of Martinon and Grand Bay-Westfield near Saint John for over 20 years. She holds the position of Chairman of the NB Human Services Coalition and is also Executive Director of the NB Special Care Home Association. Jan continues to work hard to bring positive change to the sector by working collaboratively with all stakeholders.

Was it our "go with the flow" attitude? Did the government cause it? Is it because our youth have all migrated west? Who knows who or what caused it, none of that matters now. What matters is getting back to the thing we are most proud of, our communities! The solution lies with it, but it doesn't come without investment. As the present government stated so well in their platform promise "we need to look at long-term care through the lens of quality of care and sustainability, not simply dollars and cents". The time has come to do just that.

We can make all the plans in the world and create plenty of new initiatives, but none of it can happen without a strong community of workers and agencies well equipped to deliver. As important as doctors, hospitals, and nursing homes are, the solution does not lie solely or mostly with them. Nor does it lie with cutting public services. Instead it lies with strategic investment in community-based services and in making the existing public services, especially in health and social services, work more effectively.

THE COLLEGE AND UNIVERSITY RETIREE ASSOCIATIONS OF CANADA

In light of the often-cited concern about population aging and its effects on Canadian society, it is important to examine home care as one key alternative to hospital or nursing home care.

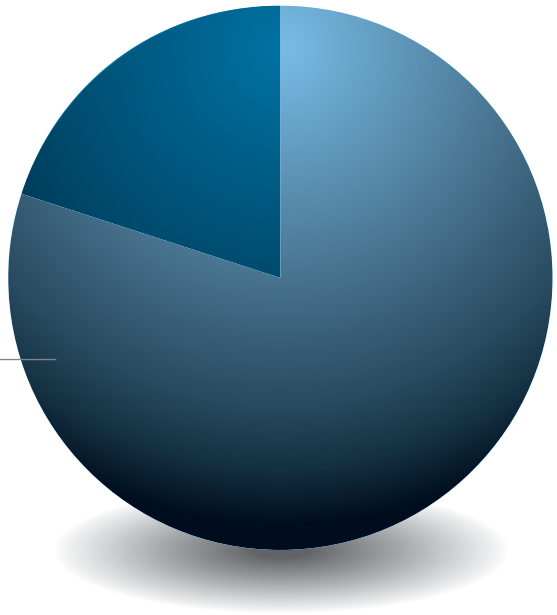
Home care is defined as services for "recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social or therapeutic treatments and/or assistance with the essential activities of daily living." However, home care is also necessary for generally healthy, able, aging persons who may need assistance with bathing, house cleaning or repairs, cooking, shopping and transportation.

As the Canadian Medical Association has noted, "the aging of Canada's population is the most pressing policy imperative of our time." Its President has pointed out that around 3 million health care beds a year at a cost of $1,000 per day are taken up by seniors because long term or home care is not available.

Given the high cost of warehousing seniors in hospitals while awaiting a place in another facility, how feasible is home care as an alternative? Depending on the level of care and hours required, home care may be more suitable and affordable. Not all seniors need to go to a long term care facility after a hospital stay, and most would prefer to remain at home as long as possible.

At the present, the Canada Health Act does not consider home care as an insured service, and each province provides a different level of support for home care and has different regulations. What is common to all provinces, however, is that 80% of home care providers for individuals with long-term care needs are unpaid, informal caregivers. In 2012, 28% of Canadians aged 15 and older cared for a family member or friend with a long term health condition, disability or aging needs. Various estimates exist for how much money unpaid caregivers save the public purse, but a Statistics Canada study estimates the savings at $24-31 billion.

80% of home care providers for individuals with long-term care needs are unpaid, informal caregivers.



According to 2012 Statistics Canada data, 9 of 10 unpaid caregivers provide care for a year or more and 1 of 5 say caregiving has negative physical and emotional health effects, as well as economic repercussions such as out of pocket costs and days of lost work. Even those who can hire some additional help report problems finding appropriate and consistent care with the turnover in home care workers. Since not everyone has a network of family and friends available to provide help and since only limited and inconsistent financial supports and in-kind services exist, the need for sustainable and regulated home care is crucial. What is more, in the absence of a legislated national framework, the various levels of government need "a set of harmonized principles for home care that would guide policy and program development to achieve a level of consistency across the country while respecting important jurisdictional differences," according to the Canadian Home Care Association.

These principles include client and family-centered care that is integrated and focused on continuity and quality of care. Care should be accessible—seniors need to have information on the options available. It should be sustainable and integrated with the health system to deliver cost effective care derived from evidence-based research and practice. Finally, such home care should be held to accountability standards.

A real shift away from acute care, to support home care and long term care in the community, will require more than the adoption of these principles: it will also require fiscal policies and planning at all government levels to ensure there are sufficient resources. Data must also be available to determine accountability and evidence-based decision making. Given the extensive role played by family caregivers, we need strategies and programs that support them, such as meaningful financial and tax incentives as well as respite care. Home support workers who are employed to provide care need to be trained and certified; their work also should be adequately remunerated and valued.

In short, seniors need the federal government to work with the provinces and territories to put in place policies and programs that ensure access to high quality, affordable, long term care for seniors across Canada. Home care and long term care should be part of our insured health system supported by meaningful financial and tax incentives for individuals and families. This is an opportune time to put seniors on the political agenda and commit to finding solutions for the long term.

Sources available upon request.

About the writer

Dr. Linda Kealey is Chair of the Health Policy Committee of CURAC. She holds her doctorate from the University of Toronto and was a Professor at UNB in History for thirteen years, with a considerable academic career in research and teaching prior to her arrival. She has published over two dozen refereed articles and chapters, edited four volumes of essays, and has been co-editor of Atlantic and Canadian Historical Review. For her service, including as a key figure in bringing the Congress of the Humanities and Social Sciences to UNB, she was awarded a UNB President's Medal in 2012.

THE NEW BRUNSWICK ASSOCIATION OF NURSING HOMES

NBANH has created an innovation agenda specific to the nursing home sector that embraces a strong community role for nursing homes to benefit NB seniors.

About the writer

Jodi Hall possesses a degree in Adult Education from the University of New Brunswick and holds a Masters Degree in Health Studies with a major in leadership from Athabasca University. In her capacity as the Director of Operations for the New Brunswick Association of Nursing Homes, she has acted as a researcher for the Premier's panel on Healthy Aging chaired by Dr. John McLaughlin and has been the author of numerous reports and submissions on the need for social change in the long term care sector. She also acts as the lead co-ordinator for the Collaborative for Healthy Aging and Care.

Part One - Redesign of Nursing Home Role within Continuum of Care:

Introduction of specialized care options in nursing homes in four categories:

1. Respite: adult day programs; nursing home wait list support; family caregiver support and education; renewed role for respite beds.
2. Social: transportation; neighbor to neighbor programs targeted to prevent social isolation.
3. Service Centre: wellness clinics and primary healthcare functions delivered through the nursing home.
4. Specialized Care Services: responsive behavior care teams; hospice beds; complex-short stay convalescent care.

Community-based services to area seniors: 96% of nursing homes are already supporting community services for seniors, but with expansion, these operations could also serve a valuable risk assessment function. Observations could be shared with all stakeholders for common information that supports coordination efforts.

Joint approach to senior care placements and admissions: Modeled after a best-practice in Norway, a team of various long term care providers determines how and where the persons' needs can be met. The Long Term Care Community team reviews the needs of an individual and uses a flexible approach to ensure the appropriate resource is provided regardless of the setting.

Part Two - Investment in Capacity with a Return on Investment

Support for social financing: Social finance consists of a public-private partnership with social outcomes as the return. Social impact bonds, where the government pays the service provider only on previously agreed upon outcomes, could be a win-win for all stakeholders.

Care team development: An anticipated result of government efforts to support seniors to remain at home is that nursing home resident complexity will go up. Having a workforce in nursing homes who can respond to future resident needs has to be considered now. Specifically:

1. Leadership education for Registered Nurses
2. Establishing educational standards and training opportunities for Resident Attendants
3. Full scope of practice for Licensed Practical Nurses are essential considerations
4. A study of the potential for use of care team ancillary staffing, such as the role of an Extended Care Paramedic and an enhanced role for Nurse Practitioners in all nursing homes.

Enhanced use of technology: The modernization of nursing homes through technology is an important initiative to better understand resident care needs; become positioned for more efficient administration of the homes through technology; and support community based senior care.

Support the Collaborative for Healthy Aging and Care and community prototypes: The Collaborative for Healthy Aging and Care emerged from the Summit for Healthy Aging and Care held in November of 2012. The operational framework is structured on the concept of social prototyping, which starts with a community dialogue to determine what the needs of a local community are. Members of the Collaborative share available knowledge, resources, experiences, etc... to assist in developing new capacity. Nursing homes can work with their communities to lead in prototype development.

Learning and research priorities: A post-secondary focus on long term care is needed to raise the profile of geriatrics and attract new graduates. Investing in opportunities for research through availability of fiscal dollars, but also providing resources for nursing homes to serve as "living labs" working in partnership with the research community.

Part Three - Long Term Care Sector Alignment

Long Term Care Act: The development of a Long Term Care Act has the potential to restructure the sector to eliminate silos that support efficiency within the continuum of care, and allow for recognition of the unpaid caregiver in a meaningful way. A new Long Term Care Act could ensure nursing homes can more easily initiate senior care innovation, for residents and seniors in the community.

Long term care workforce strategy: A workforce strategy that includes Home Care, Special Care, Nursing homes and Regional Health Authorities is needed. Specially to address standardized education, regulation, recruitment, retention and other common human resource matters, such as wages.

Common "tools" and "language": Having a common tool and a shared vocabulary across the continuum of care would support efficient communication. Social Development has announced the introduction of MDS, which is a resident acuity measurement system. This tool could be used in special care home settings, home care and with Alternative Level of Care patients.

THE NEW BRUNSWICK NURSES UNION

Nurses know discussions about the difficulties of providing care to aging New Brunswickers are not new; seniors who are not, or no longer, acutely ill occupy hospital beds while waiting for alternative levels of care. When seniors are in hospital longer than they need to be, not only is that bed unavailable to others and the cost of keeping them there high, but they are not receiving care that aligns with their needs. A reduction in hospitalization rates and lengths of stay can only be achieved through appropriate alternative services for seniors.

About NBNU

NBNU represents approximately 7000 registered nurses employed across the province in acute care, community health care and long-term care. Our members provide invaluable service to New Brunswickers every day in our health networks and understand health issues.

Canada's frontline nurses, as represented by the Canadian Federation of Nurses Unions, offer the following recommendations:

1. That the federal government develop a national plan for safe seniors care, with long-term, dedicated funding and effective enforcement mechanisms. This plan should include the following elements:

- Equity and inclusivity across Canada with access based on need;
- National standards for safe, quality patient care, especially with respect to staffing and the enforcement of minimum staffing;
- The creation of a human resources strategy for the long-term care and home care sectors, which addresses working conditions, training and discrepancies in compensation;
- Increased training and education in seniors care across the health care sector;
- Recognition of the primacy of public or non-profit ownership;
- Strategies to ensure continuity of care and care providers between services;
- Increased support for unpaid caregivers through the funding of more paid caregiver positions.

2. That provincial governments build on the national plan by ensuring the provision of:

i. A stable workforce

- *Establish a goal of 70% full-time nurses (and other health care workers) in all sectors. This measure is in recognition of the fact that care is a relationship requiring continuity among care providers. Ideally, the 30% part-time complement would be filled by regular part time staff to ensure effective teamwork and staff familiarity with residents'/patients' care needs;*
- *Discontinue competitive bidding which encourages discontinuity of care and tends to favor lowest cost over quality care.*

ii. Adequate staffing levels and appropriate staff mix

- *Uphold, and enforce, existing staffing and other regulations for all sectors in which seniors receive care;*
- *Introduce new regulated minimum standards to increase the quality of care and reduce absenteeism and overtime costs;*
- *Mandate a minimum standard of 4.5 hours of direct care per resident each day to improve residents' quality of life (worked hours);*
- *Mandate a minimum of one RN per shift (worked hours) with an increase in RN numbers as required by the acuity level of residents.*

iii. Training and education

- *Develop standards promoting ongoing, consistent in-house education and training for nurses and other providers in all sectors where seniors seek care;*
- *Encourage employers to promote teamwork among providers and implement team building strategies such as organizing joint education/in-service opportunities;*
- *Increase education on seniors care in all health care provider programs.*

iv. An integrated system

- *Ensure better coordination, communication, and collaboration between sectors and settings to avoid costly (in human, as well as financial, terms) complications, including the provision of adequate care/beds/providers in all sectors, with special attention paid to times of transition (e.g., transfers, discharge, admission). Team practices are particularly useful for chronic conditions and seniors.*

3. That the federal and provincial governments join together in funding home care to ensure the provision of adequate and appropriate short-term and extended home care services available for seniors who need them in order to reduce avoidable complications and adverse outcomes, and decrease the care burden on family members, which, in turn, negatively impacts caregivers' work lives and health.

4. That the federal government introduce and enforce new seniors care standards that go beyond traditional clinical standards, to promote a person-centered culture that takes a holistic approach to seniors care, considering the whole person, their diverse background and history, with the objective of improving the overall quality of seniors' lives.

As stated, the recommendations above are supported by registered nurses nation-wide and include leadership roles for the federal and provincial governments as well as all agents within the healthcare system. NBNU knows that our current provincial government is facing difficult fiscal realities and support their continued pressure on federal candidates as well the federal government formed following the election for increased health transfers. We would like to see ongoing, increased funding of the Home First program that was introduced under the previous provincial government and other measures to further integrate various supports for seniors in their communities. The system can be streamlined for improved coordination of services by removing seniors care from the Department of Social Development and bringing those services into the Department of Health. NBNU also supports the provincial government's recent move to build new nursing homes, but we do not support the privatization of nursing home care.

A PATIENT'S PERSPECTIVE
PENNY ERICSON

I believe we should establish Community Health Centres (CHC) throughout the province that utilize both health care professionals and community-based support programmes.

The CHC should be designed to provide seniors with easy access to professionals who can assist them with positive decision-making in the areas of exercise, nutrition, non-medical symptom management, and daily management of health challenges. A physician will be part of the CHC team. Family physicians will be encouraged to support the activities of the Centre.

There are Non-Governmental Organizations (NGOs) in the province that have excellent programmes to assist seniors in better management of health challenges. It would assist seniors in our diverse communities if there was a Health Centre Board that included NGO representatives. They could work with clinic staff to develop educational programmes in clinics based on best practice guidelines and programme suggestions developed at the national level. It is rare that a senior has only one health challenge; consequently, it would be a better system if the NGOs involved could tailor programmes that would include more than just one disease. Nutrition education is a good example, as seniors managing diabetes or cardiac disease have similar challenges that could be managed in one education session. Healthy eating for seniors is a generic topic that could cover all participants who come to a clinic. Exercise is very important for seniors, especially now that the baby boomers are arriving. Many of them have had sedentary jobs that have left them with less core strength and resilience than their parents who fished, worked in the woods, or farmed.

We don't need expensive technology to improve our communication and assessment skills. We need to focus on listening to what the seniors and their families need and help them to address these issues within a CHC setting.

Parish Nursing is a growing, community-based program that assists seniors who are at home, in the hospital, and transitioning back to home or to long term care. They are similar to a Hospice in that they provide services from volunteers who have received empathy and confidentiality training from professionals. Their impact is growing in NB. They are re-creating the concept of community support and demonstrating how beneficial this can be. It is a positive beacon of change for a province that has been lured into believing that our governments will take care of us.

Another benefit of a CHC is socialization. Seniors who become isolated are at increased risk of poor health. Having a local centre that encourages seniors to attend for group meetings on nutrition, exercise, medication safety, etc. will provide social support as well as needed health information. Members in the groups will know friends and neighbours who probably should be there, and they are in a better position to help them attend than a one-line recommendation from a health professional.

Clinics and individual practitioners will assist seniors more effectively if they listen carefully to both the text and context of the seniors' issues. We live in a province with issues of deplorable health literacy as well as an unfortunate level of illiteracy. Taking time to learn what the senior understands/sees/reads/and hears is crucial to "compliance". The term "non-compliant" tells me more about the communication skills of the health care professional than it does the senior!

There are many barriers to good communication that we need to remember. For example, the senior may have a hearing deficit that has not been diagnosed, or a hearing aid isn't working properly. Vision is a safety challenge that we should help the seniors identify. Are their glasses greasy or smudged because they don't see the difference? When was their last visit to an eye doctor? Are they using glasses that a deceased family member used? Not seeing well can break a hip as easily as ice! For individuals who rely on Social Development cheques for subsistence living, correcting the aforementioned issues may be financially difficult. It is also difficult for them to cope with dental hygiene. The government will pay for having all of their teeth extracted, but it will not pay for dentures. Nutrition becomes a real challenge for individuals without teeth.

These are significant issues hiding in simple assessments. We don't need expensive technology to improve our communication and assessment skills. We need to focus on listening to what the seniors and their families need and help them to address these issues within a CHC setting.

About the writer

Penny Ericson is a lifelong Registered Nurse, now retired, and a long-time advocate for better patient care. She maintained an active professional and academic career which culminated as the Dean and Professor Emeritus at the Faculty of Nursing at UNB. She is a Past President and Lifetime Member of the Canadian Gerontological Nursing Association and the New Brunswick Gerontological Nursing Association, the current Co-Chair of the Patient/Family Advisory Committee for Horizon Health Network and a Board Member of Hospice Fredericton, the NB Lung Association, and Patients for Patient Safety Canada. She is devoted to her community work, church, and family.

THE DEPARTMENTS OF HEALTH AND SOCIAL DEVELOPMENT

Seniors desire to live in their own homes for as long as they possibly can. Statistics reflect this as 92% of seniors in Canada live in private dwellings.[1] Aging in place means having the health and social supports that allow for seniors to remain safely and independently in their own home and community. Most jurisdictions show movement towards investing in more community-based supports and independent living strategies.

Current spending reveals that funding for residential care facilities accounts for more than half of Social Development's budget and outpaces spending on home support services by 5.5 times. In the coming years, the population of seniors in New Brunswick will continue to increase. Because of this and factoring in inflation (assumed annual rate of 2%), if nothing is done, the cost of services provided to seniors will increase by almost $300M dollars over 15 years.

Home First is a strategy to improve outcomes for seniors across the continuum of care spectrum that will reduce the need for services by promoting wellness and healthy aging and incorporating preventative services; by providing more care at home and supports for caregivers, and; by integrating services to allow for seamless navigation.

The *Home First* strategy is based on the accumulation of results from various stakeholder engagements over the last few years including the Summit for Healthy Aging and Care, Living Healthy, Aging Well and other consultations. Consistent messages were heard from citizens, caregivers, and service providers about how to improve senior care in NB.

Home First is an evidence-informed strategy that reviewed over 10 existing provincial plans and leading practices from Canada and other countries along with an extensive analysis of current state data for New Brunswick health and social services.

A number of *Home First* initiatives will be designed and implemented through a collaborative partnership with the Departments of Social Development and Health and the Horizon and Vitalité Health Networks that will :

- Promote healthy living and wellness;
- Promote safe, age-friendly communities that support seniors to age in place, in their homes and communities;
- Increase the quality of life for seniors by supporting them to stay at home and successfully manage their functional limitations and health challenges;
- Reduce unnecessary hospital admissions and lengthy hospital stays; and
- Reduce or prevent premature admission to residential care.

[1] *Statistics Canada, Living arrangements of seniors, 2011 Census of Population.*

The vision of Home First, **"Healthy aging enabled by appropriate supports and care within a responsive, integrated and sustainable system"**, is supported by three pillars for success:

1) Healthy Aging;
2) Appropriate Supports and Care and
3) Responsive, Integrated and Sustainable System.

Initiatives that are actively being addressed are :

- **Better Integration/coordination of health and social services**
  - *Improving the Integration of Health and Social Services*
  - *Improvement of the Long-Term Care Assessment Process*
  - *Paramedic Referral to Extra Mural Program*
- **More community-based services and home health care visits**
  - *Seniors Resource Centres*
  - *Wellness Clinics for Seniors*
  - *Community-based dementia care such as the First Link® referral program*
  - *Rapid Rehabilitation and Reablement Services*
  - *Expanded Extra Mural Program Tele-homecare*
- **Coordinated case management and care navigation**
  - *Senior's Navigator*
  - *Collaborative Care Pilots*
  - *Collaboration on the Toll-Free Senior's Information Line*
- **Prevention initiatives that promote wellness, healthy aging and home safety; thereby preventing falls, injuries and general ill health**
  - *Senior's Health, Well-Being and Home Safety Review*
  - *Minor Home Repairs Grant*
- **Supports for Caregivers (Formal and Informal)**
  - *Increased adult day centre respite spaces*
  - *Expanded use of remote monitoring technologies such as Carelink*
  - *Enhancing supports for informal caregivers*
  - *Training for senior care workers.*

As these plans become reality and services are deployed within the province, we will be closely monitoring not only the performance of the services but the outcomes that we hope to achieve. Key to the success of Home First is the realization of fewer residential facility placements for seniors and shorter stays, fewer preventable hospitalizations and emergency room visits, fewer Alternate Level of Care (ALC) bed days attributed to seniors awaiting placement and increases in the proportion of seniors supported at home and being case managed in the community by team(s) of health and social services professionals.

This kind of transformative change will require a shift – by individuals, families, care providers and professionals – in the way that home and community-based care is understood, valued and integrated into the broader health and social care system.

For more information on the Home First strategy, please refer to the document online at: http://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/HomeFirst.pdf

THE NEW BRUNSWICK PHARMACISTS' ASSOCIATION

Views on Seniors Care in New Brunswick

Sometimes a small action can yield an incredible result.

I see this in my pharmacy practice almost daily. Sometimes all it takes is a dosage adjustment to alleviate a patient's dizziness and prevent a dangerous fall. Educating a patient to avoid eating grapefruit with certain medications, for example, may prevent significant drug interactions and hospitalization. Even simply helping a patient organize his/her medications may keep that patient out of the hospital and healthier, longer.

In answer to the question "What should we do differently to most benefit seniors in New Brunswick?" I'm not offering a "big plan". Rather, I will offer specific actions that would significantly improve the lives of our seniors.

Let's start with some quick facts:

- Almost two thirds of seniors (aged 65 and over) take five or more prescription drugs.
- More than 40 per cent of seniors age 85 and over take more than 10 drugs.
- Adverse drug reactions are the number one reason for the hospitalization of seniors in New Brunswick.

Taking smaller steps to help seniors better manage their medications and even perhaps take fewer medications would yield significant positive results. Some suggestions:

Expansion of the NB PharmaCheck™ Program – Seniors covered under the New Brunswick Prescription Drug Program who are taking three or more prescriptions for chronic conditions are eligible to have a publicly-funded medication review annually with their pharmacist as part of the NB PharmaCheck™ program. New Brunswickers who hold a valid health card from the Department of Social Development are also eligible. Expand this program to cover all seniors 55 years and over, people who have been discharged from hospital and people with chronic conditions. Medication reviews help improve

More than 40 per cent of seniors age 85 and over take more than 10 drugs.

patients' knowledge of and adherence to their medications, enhance the potential benefits associated with their medications and reduce the potential risks and adverse reactions. I've seen how valuable these reviews are.

Deprescribing – Consider the development of evidence-based clinical deprescribing guidelines. Our health care system focuses on diagnosing patients and prescribing medications, but attention also needs to be paid to reducing unnecessary medications and discontinuing inappropriate therapies, especially in the case of seniors. These guidelines would complement medication reviews and provide pharmacists with the necessary protocols to deprescribe treatments that are contributing to side effects or are no longer needed.

Electronic Drug Information System – Roll out an electronic Drug Information System that collects information about all medications dispensed to patients, including seniors. Often, seniors use several pharmacies to fill prescriptions. A DIS will allow pharmacists to see all the medications a senior is taking, thus helping to prevent any potential drug interactions and to help manage side effects. The system will also be an important tool in the prevention of drug abuse. The development of this system is underway by the Province of New Brunswick, but it needs to be finalized and implemented as soon as possible.

Publicly-funded compliance packaging – Seniors who take several medications would benefit greatly by having the pharmacy package their pills in an organized way. These "blister packs" make it easy to keep track of multiple doses and help patients take their medications correctly, which ensures they get the full benefits and avoid adverse reactions. PEI recently made this a publicly-funded service for eligible seniors. New Brunswick should do the same.

Trial prescription program – The creation of a 14-30 day trial prescription program for new prescriptions with known high incidences of side effects will reduce drug wastage and reap significant savings. Too often, patients will fill their prescriptions for 90 days only to discover after 10 days or so, that they are having unmanageable side effects. When a physician or pharmacist switches the patient to a different medication, the patient is still left with hundreds of unused pills. This program would reduce that drug wastage by dispensing smaller amounts of first-time prescriptions with high incidences of side effects. British Columbia, Saskatchewan and Quebec have reaped significant savings by implementing trial prescription programs.

Expand publicly-funded immunizations – This suggestion does not involve medications but would benefit seniors greatly. Allowing pharmacists to deliver all publicly funded vaccines such as those for whooping cough and pneumococcal infection would increase patient access to these important injections and free up doctors to handle other patient concerns. Seniors are especially vulnerable to pneumonia as well as to shingles. The shingles vaccine should also be publicly-funded and administered by pharmacists.

New Brunswick pharmacists are medication experts and vital front-line health care professionals. Every single day, pharmacists use their training and knowledge to help keep seniors healthy. But more can and should be done, and we are eager to work collaboratively with other health care professionals to do just that – even if it is only one small action at a time.

About the writer

Daniel Pike (BSc., Pharm) is the President of the New Brunswick Pharmacists' Association as well as a pharmacist at the Medicine Shoppe in Fredericton and Guardian Pharmacy in Nackawic.

VITALITÉ HEALTH NETWORK

Respect, Independence, Protection, Safety

Like other Canadian provinces and most industrialized countries, New Brunswick faces significant demographic challenges. The province therefore has to transform and modernise a healthcare system that is not well adapted to an aging population.

According to the statistics, seniors want to remain in their environment, however numerous barriers stand in their way. However, data shows that institutionalization and prolonged stays in care facilities meant for short-term acute care episodes negatively impact autonomy and recovery, in addition to resulting in much higher costs compared to care and services provided at home.

The answer to the question « What could we do differently to improve the wellbeing of seniors in New Brunswick? » raised a number of suggestions from stakeholders, managerial staff and doctors responsible for services to seniors in the Vitalité Health Network. This submission aims at improving current practices and to integrate teachings acquired over the years. It is also presented with a profound knowledge of the needs of these clients. Furthermore, it follows our observations of the current traditional model of service delivery that needs to be reviewed in depth in order for stakeholders to be better prepared to handle the challenges that lie ahead.

1. Implementation of a true policy on integrated services to seniors, based on accessibility, fairness, quality, efficiency, respect and freedom of choice while taking into account linguistic diversity of communities, urban areas and rural areas. The fiscal situation of the province also needs to be considered.

- This mostly includes health services, community services, lodging and transportation. With this vision, the assessment services of the Department of Health and the Department of Social Development should be better integrated in order to ensure better coordination; ease transitions across care settings; increase efficiency and effectiveness; and accelerate the decision making process. Nursing homes' ability to receive clients that have complex needs should also be reviewed.

About Vitalité Health Network

Vitalité Health Network is a Regional Health Authority providing and managing health care and services in an area covering northern and southeastern New Brunswick. The Network is the only Francophone managed organization of its kind in the country and has nearly 70 points of service providing a range of health care and services to members of the public in the official language of their choice. The Network has approximately 7,390 part-time and full-time employees, over 550 physicians, including 250 specialists, and nearly 930 volunteers. The Network's 2014-2015 budget was $618,4 million.

2. Implementation of an approach focused on seniors, including better adapted and organized hospitals to respond to the needs of these clients.

- Introduction of geriatric-based approach: ensure that human resources are qualified, avoid extended stays in emergency and no longer keep patients on stretchers in the hallways. In order to reduce the total number and duration of hospitalisations, we should have in place the following services: geriatric evaluations in the emergency department, early dementia screening, day hospital, recovery beds, respite care and rehabilitation services.
- Improve liaison and communication between nursing homes and hospitals to ensure appropriate services delivered and proper transfers of patients into the emergency room. Better medical care can reduce hospitalization rates, especially for patients who have lost their independence, and those nearing the end of their lives.
- Development and implementation of wound prevention and treatment programs.
- Implementation of a mobile team of experts in geriatrics including nurses from the Extra-Mural Program that can provide residential and nursing home care.
- Increased use of residential telehealth: this technology is already used by patients suffering from COPD and heart failure, however it could also be used for palliative care and other services.
- The staff from the Extra-Mural Program developed a screening tool to determine risk factors for falls, including a related form, but this is not sufficient. We need to encourage physical, intellectual and social activities by putting in place classes on fall prevention.
- Screening and early identification of patients at risk of physical, psychological, verbal or financial abuse.

3. Implementation of an integrated approach and philosophy aimed at keeping seniors in their homes while recognizing that they can choose their services and lifestyle, including the possibility of taking risks.

- Offer staff working with seniors and the medical community a training program that ensures the involvement of seniors in the decisions made in relation to their different options of services. These decisions relate to social or medical interventions (returning home after hospitalisation, place of residence, end of life care, declining surgery, ceasing treatment, etc.) There should be an awareness campaign on the importance of seniors sharing their advanced medical care wishes with their family well before the end of their lives.

4. Ensure that seniors have access to a family physician and to primary health care.

- Simple and efficient support systems should be put in place to help people find a family physician quickly. Due to the increase in need, a higher number of doctors and of staff trained in geriatrics is needed.

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