



The New Brunswick
Association of
**NURSING
HOMES**

L'Association des
**FOYERS
DE SOINS**
du Nouveau-Brunswick

Surviving ➡ Sustaining ➡ Thriving:

Mapping an Innovative Path for Long Term Care

New Brunswick Association of Nursing Homes Inc.

November 2014

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Executive Summary

The New Brunswick Association of Nursing Homes has served as the sector's official voice for the last forty two years. In addition to providing a wide range of membership services, we also work closely with our partners, which includes government. Our sector has experienced many challenges since our inception, but in the last four years our accomplishments as an association, working with nursing homes and government, have created a number of efficiencies and have set a path for future innovations in long term care.

As part of our journey over the last four years, we have worked to generate new information that enhances the understanding of the business, along with the social impact and care contributions of nursing homes. We have considered data from each of these lenses and can confidently share our findings which demonstrate the significant role of nursing homes in the province. Here are a few examples that demonstrate that nursing homes are a viable and essential resource in each community they serve:

- Nursing Homes contribute more than \$171,000,000+ to the economy above what is spent by the province on operations and resident support.
- NB volunteers give 285,192 hours a year to nursing homes, which is the equivalent of 146 full time nursing home jobs.
- The social network of people directly or indirectly affiliated with nursing homes in NB is 95,000.

Our vision for the future

Leading excellence in long term care, is multi-faceted but is anchored in our belief in community-based non-profit nursing homes which are a home first, before a medical facility. We believe nursing homes are a key part of a community's services for seniors into the future. In working towards this vision, we will remain committed to partnership development and collaboration, system efficiency and best business practices, resident safety, care excellence, quality of life, and social responsibility.

We have identified key operational initiatives for the short term to further generate efficiencies, which include:

- Absenteeism management
- Facility maintenance program
- Backend office systems, including generic accounting software to increase accountability
- Occupational Health and Safety education and software
- Nursing Home Boards of Directors governance education
- Recruitment and retention of Nursing Home Administration

Each of these initiatives will address outstanding issues and support the introduction of an innovation agenda.

The innovation agenda is comprised of three parts and builds on the *Home First* strategy to support aging in place.

1) Redesign the role of the nursing home within the continuum of care

- This redesign can be organized around four categories; respite services, social care, service center, and specialized care services. Each area would build on the existing expertise within nursing homes.

2) Investing in capacity with a return on this investment

- Significant returns can be achieved with targeted investment in the nursing home sector. The investment opportunities include: social financing in nursing homes; care team development and augmentation; enhanced use of technology through cloud-based computing; Collaborative for Healthy Aging and Care prototype development opportunities; learning and research priorities, including a youth recruitment strategy to work in nursing homes, post-secondary engagement and support for research in nursing homes through academic partnerships.

3) Long term care sector alignment

- The elimination of silos within the continuum of long term care is another key aspect to support innovation. A *Long Term Care Act* that recognizes both paid and unpaid caregivers is necessary to recognize all streams of support for senior care in NB. A Long Term Care Workforce Strategy which is developed collectively with the long term care sector is necessary to address known recruitment and retention issues that will be faced in the near future. Shared tools and nomenclature are needed to standardize communication.

We are feeling positive as we view the opportunities ahead and we look forward to the contribution that the nursing home sector can make through community-based leadership. Preparing for the increased need for senior services must be addressed in the near future and from the lens that aging is not a disease.

Introduction to NBANH

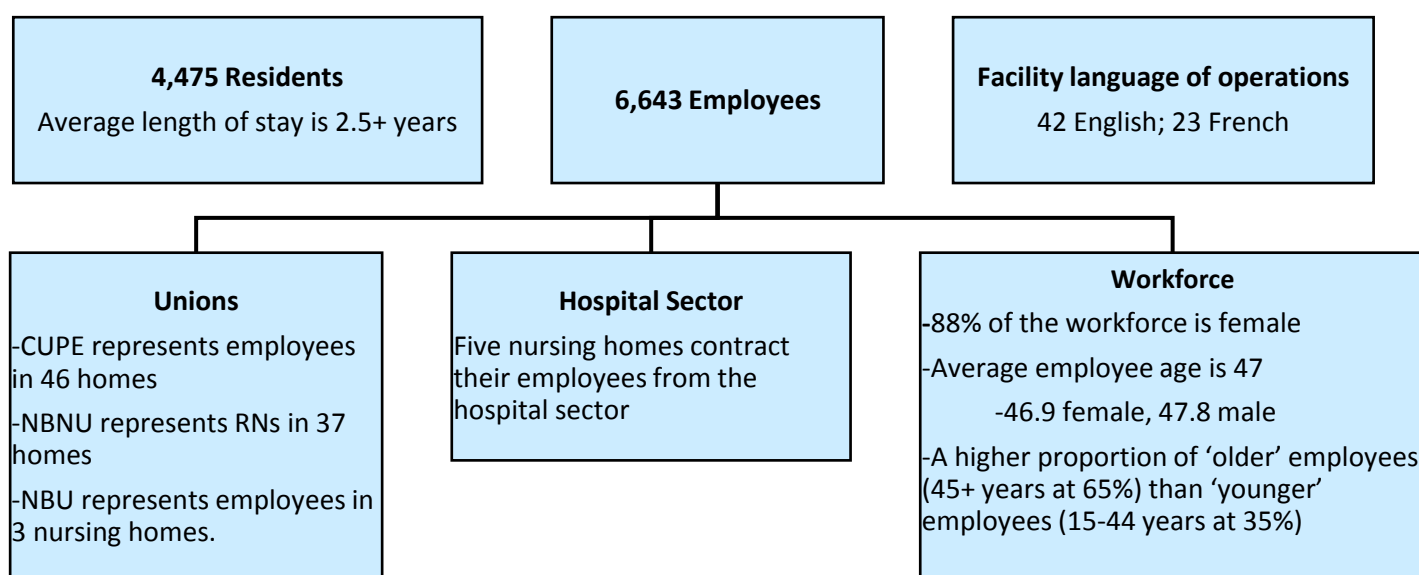
Who we are and what we do

The New Brunswick Association of Nursing Homes (NBANH) became an incorporated association under the *Companies Act* in 1972 as a not for profit organization and has worked for the betterment of nursing homes since that time. Over the last forty-two years, our association has become the unified voice of all nursing homes and has an unparalleled depth of knowledge about the governance and operations of nursing homes. Although we do not have direct authority to implement change within the nursing homes, we work closely with nursing homes and government to support and facilitate change while acting as a sector advocate. Over time, our knowledge of the entire long term care sector has grown as the complexities of the system fueled by demographic change, policies and economics has demanded that we understand the interdependence of nursing homes. This includes the perspective of nursing homes as a standalone sector with matters unique to nursing homes, within the larger continuum of long term care and our shared points of interest, and within the bigger social context for New Brunswick. This document is an overview of who we are, what we do and what we have embraced as an organization looking to the future. This includes our operational accomplishments, as well as our operational and strategic ambitions. Finally, we have briefly outlined a three part innovation strategy that will lead to an environment where we can stop questioning whether we can survive; stop solely focusing on how we can sustain, but plan for an environment where seniors in NB can thrive.

Who Are Our Members, Residents and Workforce

NBANH represents all sixty-five licensed nursing homes in New Brunswick. Sixty-two of the facilities are operated by their own non-profit community board and are independent corporations with each having their own management structure, which is regulated through the *NB Nursing Home Act*. The remaining three private facilities are owned by Shannex and operated under a contract with the province.

Summary of Sector (see appendix 1 for data by facility):



What are our sector challenges and how are we moving forward?

We are pleased that although there are long standing operating challenges for nursing homes, the Department of Social Development has worked closely with our sector over the last four years to find solutions to these issues. The challenges can be summarized as chronic underfunding for supplies and wages; no funding for information technology and lack of sector support in the form of human resources or resident acuity measurement tools. As a result, nursing homes have not been able to keep pace with modern approaches to long term care. New initiatives from the Department of Social Development are being rolled out to nursing homes and the NBANH is pleased to support the rollout of resident acuity measurement software (MDS), an electronic human resources program (itacit), and a province wide facility insurance program.

Historically, nursing home business opportunities and workforce management strategies that would result in operating efficiencies had not been developed. As a result of the most recent economic downturn, the NBANH was forced to look within and find efficiencies in order to ease pressure on the public purse. From this perspective, the NBANH decided to play a lead role over the last four years through many accomplishments:

- Represented nursing homes in the Essential Services Legislation hearing process.
- Negotiated collective agreements with various sector unions on behalf of the sector. See appendix 2 for a description of this function.
- NBANH staff member served as a contributor to the Premier's Panel Report *Living Healthy; Aging Well*.
- Developed a proposal "*Innovation through Integration: Blending Primary Healthcare and Long Term Care Together*". See appendix 3 to review.
- Implemented a provincial Employee and Family Assistance Program and an award winning wellness program for all employees in nursing homes. See appendix 4 for a description.
- Chaired an Operations Committee that identified opportunities for efficiencies and savings in nursing home operations and worked with nursing homes and Social Development to implement strategies.
- Established a Continuing Care Safety Association. See appendix 5 for a description of this organization's function.
- Worked with FacilicorpNB to introduce a new group purchasing opportunity for nursing homes by providing nursing homes with access to Medbuy, a national buying group;
- Received a \$350,000.00 Federal grant to implement a provincial elder abuse prevention program. See appendix 6 for a description of this initiative.
- Rolled out a Workplace Claims Management program managed by Morneau Shepell and funded by Social Development. Since its introduction two years ago, a 66% reduction in overall claims has been achieved resulting in a \$4.7 million annual recurring reduction. More savings are anticipated over the next three years.
- Worked with sector stakeholders to initiate a provincial dialogue on healthy aging and care, and the establishment of a provincial Collaborative for Healthy Aging and Care. See appendix 7 to review *We are all Neighbors in Aging* and the Collaborative framework.

Understanding our Impact - Communities, Economics and Budgets

The demographics of New Brunswick and its future projections are well known. NBANH has carefully considered key facts for anticipating the impact on nursing homes if the system stays in its current model.

- Adults over the age of sixty-five currently makeup 16% of our population, and this number is projected to reach 25% in twenty years - a 9% increase. This means 122,000 65+ will swell to 188,750 65+ by 2039.
- We have the second oldest population in Canada.
- Rural communities in NB have the highest rate of aging and have the highest percentage of 65+ individuals on a per capita basis. This is further fuelled by the in-migration of youth to cities in NB and the out-migration of youth to western destinations.
- Nursing Homes traditionally service 3-4% of the 65+ population in NB.
- The NB population experiences a high rate of chronic disease that could be positively impacted by health promoting behaviors.

Budget:

Using this information, conservative projections can be made to understand future budget needs:

- A 25% increase in the 65+ population means that New Brunswick will see this demographic balloon to 188,750 seniors citizens without a corresponding increase in youth. That is 65,120 more individuals who are 65+ than today.
- If Nursing homes continue to service 3.75% of this population group, it would require 7,078 beds; an increase of 2,570.
- Social Development spends \$305,800,000 net annual budget to fund nursing homes. Client revenues add another \$79,200,000, for a total budget of \$385,100,000 on nursing homes annually; approximately \$85,426 per bed.
- The addition of 2,570 beds would require an annual budget increase of \$219,544,820.

The NBANH Board of Directors is aware and understands the serious sustainability challenge this projection raises for nursing homes which would likely be unachievable with present provincial financial resources.

Economics:

The cost of operating nursing homes and supporting individual residents is understood to be expensive, but what is not well understood is the impact nursing homes have on the economies of the communities in which they are situated, and how that translates into the New Brunswick economy. In a highly conservative exercise, the NBANH analyzed the economic and socio-economic factors of nursing homes. The amount of money put into a nursing home on an annual basis was considered. This included the government cost for both nursing home operations and government employees who work on behalf of nursing homes, donations made to NH foundations and revenue from cafeteria sales. The total direct cost determined was \$386,597,060. This was compared to the economic contribution of nursing homes through business activity, tax contributions, NH employee and other related workforce consumer activity. The analysis also included the value of resources where money is not exchanged, such as

volunteer contributions and community services offered by nursing homes. The calculated total economic value is \$557,949,986.

This represents **\$171,352,926** of annual economic contribution over and above the cost of nursing homes in NB. This is a significant consideration from a financial point of view, in particular for rural communities where the nursing home is the primary economic driver. However it is also an important indicator of their socio-economic impact in communities. See appendix 8 to review the summary data for this report.

Community Services Role:

Nursing homes have a close relationship with the communities in which they are located. This goes beyond the economic view and becomes one of social responsibility, which has been embraced by nursing homes and is evidenced through the volume of affiliated services they offer. A 2014 scientifically designed survey commissioned by the NBANH (See appendix 9 to view survey report) determined that 96% of nursing homes offer affiliated services to their local community. These services are broad and include activities such as meals on wheels, non-profit housing, senior's day care, respite care, transportation, community space for events, and various supports for charitable activities. 61% of the nursing homes indicated that these services are offered on a breakeven basis, 10% subsidized community programming and only 15% gained revenue from the activity. 69% of these nursing homes also reported that it would be highly unlikely these community services would continue to be offered were the nursing home unable to provide support.

Nursing homes also enjoy tremendous volunteer support which has a direct impact on the quality of life for residents. Volunteers contribute 23,766 hours per month or **285,192 hours annually**, which is the equivalent of 146 full time jobs.

Community support for nursing homes is also expressed through fundraising activities. 2% of homes reported receiving more than \$100,000 annually; 6% of homes reported receiving between \$50,000-100,000 and 88% reported receiving \$50,000 or less. 90% of nursing home Administrators noted that the community financial support makes a significant contribution to their operations.

The relationship between nursing homes and their local community is greatly important to both entities. Any restructuring of the community-based nature of nursing homes would most likely have a significant negative impact on a broader scale, but would ultimately be difficult to fully anticipate. A great number of people are directly or indirectly connected in a social network linked to NB's nursing homes. In an analysis of the human factor impact of nursing homes, it is estimated that close to 95,000 people are in the social network of nursing homes. We do not know how nursing homes fully influence this social network at this time, however the concept of the aging experience theoretically is impacted at a societal level by nursing homes.

With a clear understanding of the impact of nursing homes within New Brunswick, the NBANH recognizes its influence and with that its responsibility as an organization for the future.

A Vision for New Brunswick Nursing Homes

The NBANH Board of Directors established a vision statement to *“Lead Excellence in Long Term Care”* and established the necessary strategies to seek and develop solutions that will lead change within the sector, while working collaboratively with other long term care partners. We began to research whether

there were global best practices on how excellence could be achieved. We were inspired by the nursing home model in Australia where nursing homes are structured as a hub and spoke model in the communities with a host of services being offered to community seniors. We were also inspired by the work in Denmark where a nursing home has not been built since 1986 as they have heavily invested in other support models for seniors. There is certainly much we can learn from their long term care systems, which may not necessarily be a fit in every aspect for NB, but we can learn a tremendous amount about the journey they took as a nation to establish the system they use today. The journey began as a national conversation about how citizens wanted to experience aging, and from there they established a national philosophy that would shape future expectations.

For the NBANH Board, this required changing traditional views and considering new approaches in some instances while holding on to others. The views of the board can be summarized in these three key points:

The NBANH believes in the community-based non-profit model for nursing homes governed by a community volunteer Board of Directors. The rationale for this is based on the significant community relationship that exists between nursing homes and their communities as described in the previous section.

The NBANH has embraced a philosophical position that nursing homes are more social in nature than medical, serving as a home first for the residents who live there. This is a shift from the institutional and medical lens through which nursing homes have been traditionally viewed. Medical and nursing care are an important aspect of a nursing home's services, but providing an environment where quality of life can still be enjoyed and individuals are not defined by a disease is essential to ensuring that people can "live".

This position reflects our global best practice findings on the long term care services structure and illustrates the importance of remaining aligned with the Department of Social Development. This request is not a disregard for the work of other departments, but simply a reflection of our eye to the future and where we envision 'the best fit' for nursing homes. We recognize that this departmental alignment continues to make us unique in Canada, but in our opinion, this positions the province to be a national leader of social innovation in aging.

In considering the ongoing demographic change in NB, our fiscal realities, and geographic and cultural considerations in delivery of services, NBANH sees an opportunity to realign senior services through NB's nursing homes. There are many examples to draw from to demonstrate potential opportunities a model adjustment could offer, such as the "hub and spoke" approach used in Australia. This also can serve to support social prototyping which is a concept put forth by the Collaborative for Healthy Aging and Care. The community placement of nursing homes throughout the province are positioned to assume a significant role in the coming years to support seniors in the community

What we have committed to:

1) Partnership Development and Collaborative Working Relationships

The NBANH has made a commitment to work with all stakeholders involved in any aspect of a senior's agenda. This step began when the NBANH established its vision to lead excellence in long term care. As our engagement with key partners began to grow and our circle of discussion became larger over the last few years, our organization accepted the responsibility we saw emerging and used NBANH resources to fuel an open discussion. With partners, the first attempt to facilitate a public conversation on what we want our aging experience to look like in NB, was the "*Summit for Healthy Aging and Care*" in November of 2012. With 325 participants ranging in age from 17 to 93, the event was unique and informative. Based on the key learnings at the summit, the Collaborative for Healthy Aging and Care emerged. In addition, the findings from this event were freely shared with government and were influential in the strategies of the *Home First* initiative.

Since the Summit, the Collaborative has continued to grow and expand in the number of partners. Today, there are 28 organizations that have made a formal commitment to support the Collaborative for Healthy Aging and Care with several others involved in our dialogue. We continue to lead this group, serving as the back bone organization to this effort. In our 2014 document, *We are all Neighbors in Aging*, this journey is documented. See appendix 7.

Our commitment to working with partners includes working with government. NBANH sees many opportunities for collaboration with government in the *Home First* Strategy, specifically in the operationalization of the various outlined approaches. In considering NBANH's vision for the future potential model for nursing homes, community-based initiatives would be of mutual interest. There is potential that joint initiatives could be beneficial to all stakeholders through strategic alignment of efforts. NBANH is open to explore these potential opportunities.

NBANH has also worked to develop a dialogue with our "sister" organizations who fulfill an association function by representing those who deliver long term care services at other points in the continuum of care. This specifically includes home care and special care, and also the newly formed Continuing Care Safety Association. To date, we have embarked on joint efforts through the Collaborative work, but remain open to future points of alignment as we see benefit in creating unity in the long term care sector. We are committed to explore options and mutual benefits of bringing greater unity to long term care through collective association efforts.

2) System Efficiency and best business practices

Four years ago, the NBANH made a commitment to nursing home system efficiency and began to examine in depth the operating cost of nursing homes with the ambition of finding savings. Through the work of an Operations Committee, whose membership included nursing home Administrators, FacilicorpNB and an Assistant Deputy Minister from Social Development, seven areas were identified for potential efficiencies. Several of these initiatives have been implemented or are in the process of being implemented, the last of which is the provincial nursing homes insurance initiative.

With approximately 80% of the nursing home budget going to salaries, the largest area for potential savings is with human resource management. Two significant areas for potential savings identified were in the Worksafe compensation rates charged to nursing homes and in the area of absenteeism management. In considering occupational health and safety matters in nursing homes, a three part strategy was identified:

1) prevention- education	2) management support and tools	3) claims management
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In partnership with government, the third part of the strategy was addressed first due the financial impact on the sector. NBANH worked with an expert claims management firm, and within two years reduced Worksafe claims and the sector base rate. This has resulted in a 5-6 million dollar savings. The NBANH addressed the first strategy by completing the process with WorksafeNB to launch a Continuing Care Safety Association, which will manage occupational health and safety education for the continuum of care with a key focus on front line worker education. This safety association is now operating and preparing its education plan for roll out. The second strategy, which is the third to be addressed, is being implemented with the introduction of an occupational health and safety software management tool. This is now managed by the Safety Association and will be rolled out to nursing home management teams this fall. See appendix 5 to learn more about the NBCCSA.

With the success of the claims management program, NBANH is advocating to launch an absenteeism support program with the same company. See their proposal attached in appendix 10. This will once again require a partnership between NBANH and government, which has proven to be a successful model.

Standardization of administrative backend office systems would offer the opportunity to align internal processes amongst nursing homes and generate data that could be benchmarked. This is valuable in determining best practices, offers ease in providing operational support to all homes, and has the potential to create system efficiencies. This could apply to a shared accounting software, psychometric programs, and staff scheduling software.

3) Resident Safety, Care Excellence and Quality of Life

The mandatory skill mix in nursing homes (20% Registered Nurse, 40% Licensed Practical Nurse and 40% Resident Attendant) is understood to be an attractive aspect to consider in times of economic limitations. The NBANH is committed to resident safety and views skill mix through this particular lens. NBANH is open to a discussion on skill mix in nursing homes in consideration of all the following items:

- Skill mix in nursing homes can't be operationally designed until it has been strategically considered in light of the *Home First* initiative. Due to the ripple effect of policy changes as a result of *Home First*, we anticipate that individuals seeking admission to nursing homes will require more complex care in the future. Ensuring skill mix can be adjusted quickly based on the needs of residents is a critical consideration in guaranteeing resident needs can be met at all times by the appropriate care provider.
- Adjustments to skill mix must be evidence-based and driven by the needs of residents. The knowledge, skill and judgement of licensed care staff are the "invisible" services that are

necessary to care for nursing home residents and what sets the nursing home environment apart from other points along the continuum of care.

- Nursing home skill mix comparisons with other provinces can't be made directly without considering the differences in the workforce. The most significant note for New Brunswick is that there are no educational standards or regulatory oversight for Resident Attendants. This has been compensated for with the mandatory skill mix for RNs and LPNs, but becomes a further point of consideration in anticipating the care needs of nursing home residents in the future. Many Resident Attendants have been trained on the job and are not prepared to provide care to residents who have higher acuity care needs. An education strategy for Resident Attendants will need to be considered as well as the potential for ancillary staff to support care delivery, such as the role of an Extended Care Paramedic and the enhanced use of Nurse Practitioners.

The Clinical Care Committee is an NBANH board appointed committee whose members are Nursing Home Directors of Care representing each region of the province. This committee is responsible to interpret research findings and produce sample policies and/or guideline documents to support clinical services to residents. The committee's recent work on bed entrapment prevention has educated the sector on these risks. NBANH has been pleased to work with Social Development on this issue and is committed to develop a procurement strategy in partnership with nursing homes and Social Development.

As part of the NBANH strategic plan, a commitment was made to support resident quality of life. As such, the Clinical Care Committee is currently working on a quality of life study with nursing homes to produce resident quality of life guidelines in the coming year.

4) Social Responsibility

In consideration of the province's changing demographics, the development of the Collaborative for Healthy Aging and Care and the relationship that nursing homes have with local communities, NBANH has embraced a social responsibility philosophy. This philosophy has committed the NBANH to consider its strategic and operational planning through this lens. This motivated the NBANH to include programming for seniors in the community. This is evidenced by:

- 1) Our work with the PEACE program which is funded through a Federal grant.
- 2) Serving as the backbone organization for the development of the Collaborative for Healthy Aging and Care which is working to positively impact communities.
- 3) Recognition of the work of volunteers around the province through the hosting of our annual Nursing Home Volunteer Awards Gala Dinner.

In considering the future through this lens, the potential of social financing is being closely studied by the NBANH. This concept is based on social finance models found in the United Kingdom, Australia and the United States and would provide a financial model that has shown to be beneficial in addressing their demographic challenges. The potential of this finance model would not be restricted to nursing homes, but to the entire sector of healthy aging and care. The NBANH looks forward to working with a variety of partners when this model can be fully developed.

What's next?: Opportunities for Short Term Operational Partnerships and the Introduction of an Innovation Agenda

Proposed Operational Initiatives for Nursing Homes:

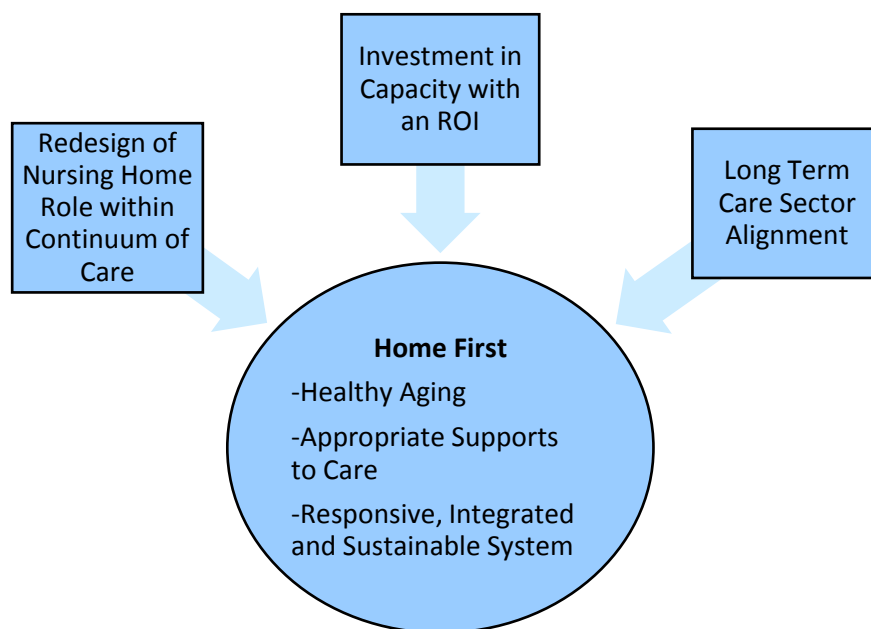
Operational Initiative	Rationale	Lead
Absenteeism Management	Nursing Homes in NB currently have a need for absenteeism support. Average sick time for employees has reached approximately 14-16 days and costs 11,000,000+ annually. NBANH has developed a legally vetted process for nursing homes through Attendance Support Guidelines and has a Provincial Wellness and Employee and Family Assistance Program which are pillars in any attendance support program. In spite of these efforts, improvements in attendance have not been achieved consistently. Absenteeism Management and support is complex, both from a legal and human perspective, and in many instances expert support is required. Also, the nursing home sector does not have Human Resource employees, and this function falls to Directors of Care and Administrators who have little time to dedicate to the time consuming management of absenteeism. For this reason, NBANH is supporting the Absenteeism Support Proposal from Morneau Shepell. Morneau Shepell has a proven track record in assisting national organizations (Canada Post, Air Canada) in the management of absenteeism and has been an excellent partner to the NBANH and the Government of NB in the Disability Claims Management program currently in operation.	Morneau Shepell See appendix 10 to review proposal.
Facility Maintenance Program	The NBANH Operations committee began to meet in the fall of 2011 to identify potential efficiencies and cost avoidance opportunities within nursing homes. The committee, made up of NH Administrators from around the province, generated a report that identified seven items that warranted further investigation and business analysis. Six of the seven recommendations have been addressed. Nursing Homes annually spend significant funds on electricians, plumbers or other tradespeople to maintain their facilities. A nursing home facility maintenance program could be introduced that would reflect the best and most cost efficient approach to facility maintenance and repair. The Operations Committee did not complete work on this item as it was communicated that would part of the study Social	NBANH, with the Department of Social Development will initiate a Facility Maintenance program Committee with sector stakeholders to understand the need, what resources are required to service it, and

	Development is engaged in with an external consultant. To our knowledge, work on this opportunity has not yet been initiated. To assist in moving this project forward in the short term, NBANH is proposing to lead this review with key stakeholders.	how that can be most efficiently achieved.
Backend Office System (accounting /payroll) and HR Operational Support (scheduling / psychometrics / skill Mix-innovation opportunity)	Nursing homes in NB are all individual corporations that have Administrative structures and organizational cultures which have independently evolved over time. Although all adhere to the <i>Nursing Home Act</i> , Regulations and policies, how the operationalization of these functions are achieved can be done quite differently. When it comes to functions that are dependent on IT systems, the operationalization options becomes even broader. Nursing homes do not have a line item in their budget for Information Technology and over time that has resulted in a variety of processes, software and has generated multiple data sets that are incompatible for analysis. In addition, the cost for individual purchase of IT software is significantly higher than through group purchasing. With the use of cloud based technology, the opportunity to support a consistent use of software in nursing homes can be achieved. This would allow nursing homes to benefit from economies of scale as well as create the opportunity for collective nursing home data. NBANH has reviewed opportunities to host cloud based software such as accounting software, psychometrics (could have a variety of applications) and scheduling software. NBANH is proposing to launch a formal study with the Department of Social Development on the use of cloud computing and collective software procurement as a membership service.	NBANH working with a nursing home committee and with Social Development.
Occupational Health and Safety Education: BIF / U-First / Occupational Health and Safety software tools	NBANH completed the process in 2013 to initiate a sector safety association under the <i>Occupational Health and Safety Act</i> . It was structured as a continuing care safety association so its services could move beyond nursing homes and also include Special Care and Home Care. NBANH, with the Continuing Care Safety Association, proposes the development of an Occupational Health and Safety Education Plan to be delivered across the continuum of care. Such an initiative would require the support of WorksafeNB and the Department of Social Development.	Continuing Care Safety Association

<p>Nursing Home Board of Directors Governance education</p>	<p>The nursing home environment has experienced and will continue to experience significant changes that not only impact operations but also the strategic considerations that must be made. Nursing homes need to have strong boards who are equipped to govern for the future. Nursing Home board members are highly dedicated volunteers who bring a wide range of skills to the table, which may or may not include governance expertise. To support their role, NBANH proposes to contract LearnSphere (a New Brunswick Non-Profit Organization specializing in Governance education) to deliver governance education to board leaders. Synchronous and a-synchronous educational options will be designed to maximize program delivery in the most cost efficient format. This initiative will require the support of the Department of Social Development.</p>	<p>NBANH and Learn Sphere</p>
<p>Recruitment and Retention - Nursing Home Administration</p>	<p>Recruitment and retention in nursing home administrative leadership has become a more challenging issue in recent years. A salary inversion has occurred with the wage scale for Directors of Nursing and Registered Nurses as a result of the most recent signing of the collective agreement with NBNU. The same situation exists with the Dietary Manager and cooks with CUPE. There are multiple examples where the supervisor is being compensated less than the employees they supervise. Nursing homes needing to recruit a Director of Nursing or a Dietary Manager face a tough challenge.</p> <ul style="list-style-type: none"> • Accountants and Administrator wages are below the professional norm; • Administrators in facilities with 50 beds or less are only funded at a half time position, • The recent end to retirement benefits for managers and the continuation of this benefit for front line employees has created further frustration. <p>It is understood that funds are limited and everyone must be a part of the solution in New Brunswick, but the ongoing imbalance has made administrative leadership in nursing homes unattractive. Many nursing homes have had to top-up salaries to simply be competitive. NBANH believes nursing homes deserve the best management talent for the sake of residents and to ensure nursing homes are positioned to have the leadership that is essential to moving the sector from “surviving” to “thriving”. As such, the NBANH proposes</p>	<p>NBANH and Social Development</p>

	<p>a sector compensation study be commissioned that not only considers wages, but other attractive compensation options. Such a study could also seek to understand the psychometrics and/or qualifications needed for nursing home leadership. Once completed, the findings can serve as a map to correct the inversion situation and support the development of nursing home leadership for the future.</p>	
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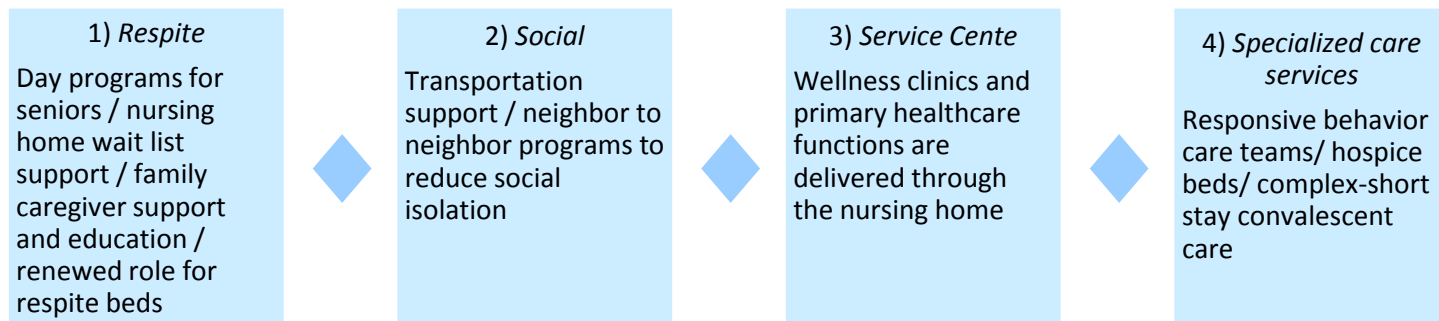
Three Part Innovation Agenda Building on the *Home First* Strategy



The elements in this innovation agenda are specific to the nursing home sector consistent with the mandate of the NBANH. However, the potential exists for these elements to be considered from the perspective of the full continuum of care, and would be an appropriate activity for a long term care task force to consider. We recognise that some of these elements are consistent with the *Home First* initiative but they are considered from the perspective of the NBANH as described in this document. Other initiatives are consistent with the vision of *Home First* while introducing new concepts for consideration.

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

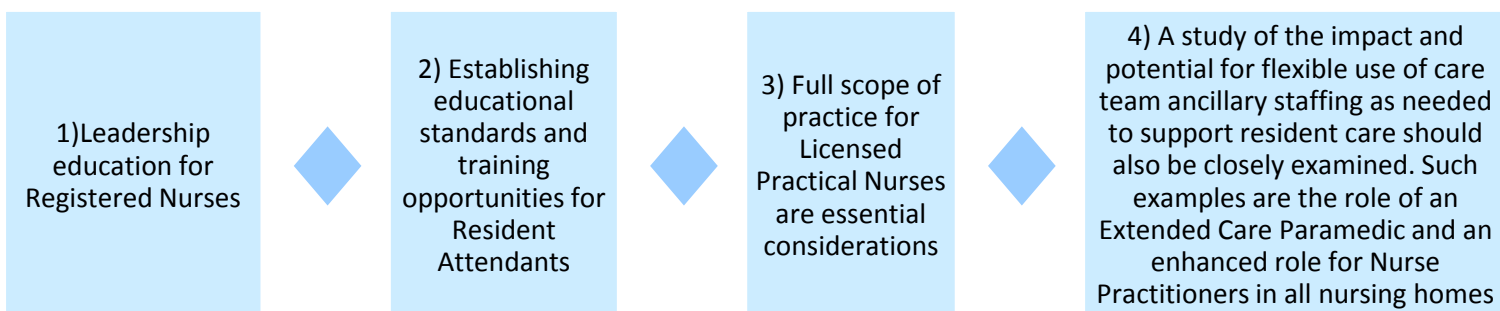
- a) ***Introduction of specialized care options in nursing homes:*** Special Care Home potential to deliver rehab care is being studied within the *Home First* Strategy. However there is also potential for nursing homes to engage in non-residential care services and specialized care services that require a skilled nursing environment. These potential options can be organized in four service categories:



- b) **Community-based services to area seniors:** The majority of nursing homes are already supporting community services for seniors as noted in the economic impact section of this document. With support, community services that are already operating in nursing homes could also serve a valuable risk assessment function. Observations could be shared with social workers, extra-mural, non-profit organizations or even groups such as churches that have a volunteer base to maintain contact and support with community seniors on a regular basis.
- c) **Regional Health Authority / Nursing Home / Social Development - Joint Regional Admission Committees:** The function of such a committee is to have all nursing homes in a region, the Regional Health Authorities and representatives from Social Development meet on a monthly conference call to discuss any individual waiting more than six months in hospital for admission to a nursing home. Specifically, this committee will seek creative options for admission to nursing homes. Committee representatives should have the authority to authorise unique supports/ programming/ funding/ and develop processes where expertise and care being offered to an individual while in the hospital can continue to be offered with the care/ service following the individual to the nursing home. This in turn provides the nursing homes with the necessary service capacity to meet specific individual needs and admit them as a resident. Examples exist where this activity occurs, but not in a consistent mandated approach throughout the province that has the capability to extend services and resources outside of the traditional program structure.

Part Two - Investment in Capacity with a Return on Investment

- a) **Support for social financing:** Social finance is a relatively new concept in Canada, and has largely been pioneered in the United Kingdom. It consists of a public-private partnership with social outcomes as the return. This philosophy is used as an innovative strategy to tackle chronic social issues in our society. The return on investment is evaluated based on a financial and social goods criterion. Social impact bonds (SIB) are the most known and ambitious initiative in this new financial tool box where the government pays the service provider only on previously agreed upon outcomes. For nursing homes who wish to offer further community based programming, social financing options could be a win-win for all stakeholders.
- b) **Care team development:** As noted earlier in this document, the successful implementation of *Home First* will lead to individuals being admitted to nursing homes with more complex care needs. Having a workforce in nursing homes who can respond to future resident needs has to be considered now. Specifically:



An equipped care team with professional care services has been shown to improve resident outcomes which can be associated with cost reductions in care expenditures.

- c) **Enhanced use of technology:** NBANH is pleased with the *Home First* strategy to invest in the modernization of nursing homes through technology. This includes a resident acuity assessment tool (MDS) and an electronic personal file (itacit). These are extremely important initiatives for nursing homes, and are the start for other future opportunities related to enhanced use of technology. Cloud based software can provide an opportunity to streamline functions, such as accounting. Several nursing homes have made investments in technology on their own, in spite of not having information technology as part of their nursing home budget. Both care and administrative technology investments can assist in detecting and troubleshooting issues earlier and give Administrators the opportunity to determine trends and impact outcomes leading to greater system efficiency. For seniors in the community, the opportunities for enhanced use of technology are significant and could potentially play a role in how nursing homes may support seniors in the community in the future.
- d) **Support the Collaborative for Healthy Aging and Care and community prototypes:** The Collaborative for Healthy Aging and Care emerged from the work that was the result of the Summit for Healthy Aging and Care held in November of 2012. The key learnings from the Summit served to create a strategic and operational framework for the Collaborative. The operational framework is structured on the concept of social prototyping. A community dialogue is initiated to determine what the needs of a local community are. Members of the Collaborative are expected to share available knowledge, available resources, experiences, *etc...* to assist the community in addressing its needs. It is about creating system capacity through the sharing of “partial” resources from many to create what is needed. One current example is the collaboration between the nursing home in the Village of Gagetown (Orchard View), the NBANH, Université de Moncton, Mount Allison University, and the Atlantic Institute on Aging to run a bus service for community seniors. Through the use of the nursing home’s bus and bus drivers, this service supports isolated seniors in the community to get to doctor appointments, go to the grocery store or just to get out. There are other multiple opportunities for nursing homes to work with local communities as members of the Collaborative for Healthy Aging and Care. This innovation offers an approach that gives great value for social impact. As prototype opportunities further emerge, we anticipate that any investment from government will offer a return.
- e) **Learning and research priorities:** A post-secondary focus on long term care is needed to raise the profile of geriatrics and attract new graduates. In addition, long term care is in need of knowledge that can only be obtained through academic research. 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 will support knowledge translation and quickly move best practices to the bedside. These types of investments are difficult to quantify and express as a return on investment, however a skilled and efficient workforce delivering the best of care to residents are associated with stronger financial outcomes.

Part Three - Long Term Care Sector Alignment

- a) **Long Term Care Act:** As noted in the *Home First* strategy, the development of a *Long Term Care Act* for New Brunswick would be well received. It has the potential to restructure the sector, so silos can be eliminated to support efficiency within the continuum of care. The *Act* also presents the opportunity to recognize the role of the unpaid caregiver as having a position of great significance in the overall continuum, and recognizing this contribution in a meaningful way. The development of legislation that allows opportunities for nursing homes to be part of an innovation agenda is important. Operational regulations and policies that impact on nursing home operations must be considered simultaneously with the development of a *Long Term Care Act* to ensure consistency and any adjustments are appropriately supported.
- b) **Long term care workforce strategy:** We anticipate that the nursing home workforce of the future will need to look different than today, which will be influenced by resident care needs, funding, and unions. We also understand that nursing homes are part of a dynamic that impacts on the workforce across the continuum of care and look forward to participating in the Joint Human Services Review for senior care workers as a *Home First* initiative. There are however, key nursing home workforce challenges that will require investment and innovative approaches to address them. The largest group of employees in nursing homes are Resident Attendants. Resident Attendants are a non-regulated group without required educational credentials. Individuals with credentials are sought by nursing homes, but are not always available. In these instances, nursing homes provide on the job training and seek individuals who present with an appropriate aptitude for senior care work. Innovative training approaches can be created for current Resident Attendant employees who have not completed formal education. On the job on-line module based education that employees pay to complete through pay-roll deduction can be used to support employees to obtain standardized education for resident care. With the completion of each module the employee is prepared to provide more skilled care. This also allows individuals without educational credentials to still be hired with responsibilities that reflect their level of module completion.

With the average age of nursing home employees being in their late forties, the need for a youth recruitment strategy is necessary. A strategy currently in use in Ontario and Alberta is the Health Care Aide High School Career Program. This program allows high school students to earn Health Care Aide credits during the school year and internships at long term care facilities during the summer. Students can graduate with a high school diploma and the Health Care Aide Certificate. Vocational training in high school is not a new model and could once again be a viable and important aspect of a Senior Care Workforce Strategy.

The use of psychometrics has grown in recent years and has become a valuable tool in recruiting individuals to a workplace with the appropriate aptitude for the required work. There are many examples of psychometric tools which, in addition to using them for front line staff recruitment, could also be used by Boards of Directors in evaluating candidates for Administrative positions or in the recruitment of board members themselves.

Exploring new approaches to integrate ancillary staffing can also be considered. “Sitters” have been commonly used as needed to support a specific resident’s needs, but expanded nursing home access to Nurse Practitioners and exploring new concepts with the introduction of an Extended Care Paramedic could have multiple benefits to both staff and residents.

- c) ***Common “tools” and “language”:*** Having a common process tool and a shared vocabulary across the continuum of care used by all providers would offer efficient communication through clear messaging. For example, the admission process can result in several misunderstandings between the discharge of an individual from the hospital and admission to a nursing home, causing frustration among all involved. Social Development has announced an investment in nursing homes to introduce MDS, which is a resident acuity measurement system. This is a common tool used in nursing homes globally, but can also be used in special care and home care. As the roll out of MDS is just getting underway in nursing homes, there are MDS innovation opportunities to consider in NB in all LTC settings, including the extended care units in the Regional Health Authorities.

Conclusion

There is much to be considered, planned for and implemented within a few short years, but there are real opportunities that will continue to enhance and refine operational processes while shifting to a long term care system that strategically embraces innovation. All stakeholders must work together to find collective solutions that equip and empower local communities while government policies are put in place to support creative innovative solutions. Nursing homes are positioned to lead this innovative future because of their geographic locations, infrastructure, professional staff, existing community leadership and an existing commitment for the care and concern of NB seniors.

Appendix 1

NBANH- Membership Facility Profile

Region One: South East – Moncton Area									
#	NURSING HOMES	RESIDENTS	EMPLOYEES	LANGUAGE	CUPE	NBNU	NBPEA	HOSPITAL	SHANNEX
1	DREW NURSING HOME	118	179	E	1				
2	FOREST DALE HOME INC.	50	75	E	1	1			
3	FOYER SAINT-ANTOINE	30	54	F					
4	FOYER ST-THOMAS	30	44	F	1				
5	JORDAN LIFECARE CENTRE	50	70	E	1	1			
6	KENNETH SPENCER MEMORIAL HOME	200	198	E	1	1			
7	LA VILLA MARIA INC.	73	99	F	1	1			
8	MANOIR ST-JEAN-BAPTISTE INC.	50	81	F					
9	MONARCH HALL	72	60	E					1
10	RE1TON LIONS NURSING HOME INC.	30	50	E					
11	SALVATION ARMY LAKEVIEW MANOR	50	78	E	1				
12	VILLA DU REPOS INC.	126	200	F	1	1			
13	VILLA PROVIDENCE SHEDIAC INC.	190	250	F	1	1			
14	WESTFORD NURSING HOME	30	52	E		1			
14	REGION 1 TOTALS	1099	1490	8-E 6-F	9	7	0	0	1
Region Two: South - Saint John Area									
1	CAMPOBELLO LODGE INC.	30	52	E	1	1			
2	CARLETON KIRK LODGE	70	105	E			1		
3	CHURCH OF ST. JOHN & ST. STEPHEN	80	130	E	1	1			
4	DR. V.A. SNOW CENTRE INC.	50	100	E	1				
5	EMBASSY HALL	72	100	E					1
6	FUNDY NURSING HOME	27	55	E				1	
7	GRAND MANAN NURSING HOME INC.	30	55	E	1	1			
8	KENNEBEC MANOR INC.	70	130	E	1	1			
9	KINGWAYCARE CENTER	75	110	E	1	1			
10	KIWANIS NURSING HOME INC.	70	105	E	1	1			
11	LINCOURT MANOR INC.	60	100	E	1	1			
12	LOCH LOMOND VILLA INC.	196	330	E		1	1		
13	PASSAMAQUODDY LODGE INC.	60	92	E	1	1			
14	ROCMAURA INC.	150	240	E	1	1			
15	TURNBULL NURSING HOME INC.	50	75	E	1				
15	REGION 2 TOTALS	1090	1779	15-E	11	10	2	1	1
Region Three: Central-West - Fredericton-Woodstock Area									
1	CARLETON MANOR INC.	80	115	E	1				
2	CENTRAL CARLETON NURSING HOME	30	51	E					
3	CENTRAL NB NURSING HOME INC.	30	45	E	1	1			
4	MILL COVE NURSING HOME INC.	71	110	E	1	1			
5	NASHWAAK VILLA	30	54	E				1	
6	ORCHARD VIEW	40	62	E					
7	PINE GROVE	70	100	E		1			
8	RIVER VIEW MANOR INC.	40	59	E	1				
9	THOMAS HALL	72	89	E					1

#	NURSING HOMES	RESIDENTS	EMPLOYEES	LANGUAGE	CUPE	NBNU	NBPEA	HOSPITAL	SHANNEX
10	TOBIQUE VALLEY MANOR INC.	30	55	E	1				
11	VICTORIA GLEN MANOR INC.	65	92	E	1				
12	W.G. BISHOP NURSING HOME	30	46	E				1	
13	WAUKLEHEGAN MANOR	36	63	E				1	
14	WHITE RAPIDS MANOR INC.	40	60	E				1	
15	YORK MANOR INC.	214	310	E	1	1			
15	REGION 3 TOTALS	878	1311	15-E	7	4	0	4	1
Region Four: North-West – Madawaska Area									
1	FOYER NOTRE-DAME DE ST-LEONARD	45	70	F	1	1			
2	FOYER STE-ELIZABETH INC.	50	68	F	1	1			
3	FOYER ST-JOSEPH DE SAINT-BASILE	126	180	F	1	1			
4	RESIDENCE MGR. MELANSON INC.	42	58	F	1				
5	VILLA DES CHUTES	69	99	F	1	1			
6	VILLA DES JARDINS INC.	30	59	F	1	1			
6	REGION 4 TOTALS	362	534	6-F	6	5	0	0	0
Region Five: North – Campbellton-Dalhousie									
1	CAMPBELLTON NURSING HOME INC.	100	120	E	1	1			
2	DALHOUSIE NURSING HOME	105	150	F	1	1			
2	REGION 5 TOTALS	205	270	1-E 1-F	2	2	0	0	0
Region Six: North-East – Peninsula Area									
1	FOYER N.-D. DE LOURDES	130	189	F	1	1			
2	LES RESIDENCES INKERMANN INC.	30	55	F	1	1			
3	MANOIR EDITH B. PINET INC.	30	59	F					
4	RESIDENCES LUCIEN SAINDON	54	70	F	1	1			
5	RESIDENCES MGR. CHIASSEON INC.	85	133	F	1	1			
6	VILLA BEAUSEJOUR INC.	80	122	F	1	1			
7	VILLA CHALEUR INC.	13	26	E			1		
8	VILLA SORMANY INC.	61	94	F	1	1			
9	VILLA ST-JOSEPH INC.	64	93	F	1	1			
9	REGION 6 TOTALS	547	841	9-F	7	7	1	0	0
Region Seven: East – Miramichi Area									
1	FOYER ASSOMPTION ENRG.	50	74	F	1				
2	MIRAMICHI SENIOR CITIZENS HOME	81	124	E	1	1			
3	MOUNT ST. JOSEPH NURSING HOME	133	165	E	1	1			
4	TABUSINTAC NURSING HOME INC.	30	55	E	1				
4	REGION 7 TOTALS	294	418	1-F 3-E	4	2	0	0	0
65	NURSING HOME SECTOR	4475	6643	42-E 23-F	46	37	3	5	3

Appendix 2

NBANH Labour Relation Role with Sector Unions

Of the sixty-two community owned nursing homes governed by volunteer boards in the province, general and service employees are represented by Locals of the Canadian Union of Public Employees (CUPE) in forty six facilities. In order to efficiently negotiate Collective Agreements and manage labour relations, NBANH maintains a relationship with the New Brunswick Council of Nursing Home Unions (NBCNHU) who oversee the CUPE locals throughout the province. Although neither the NBANH nor the NBCNHU can legally bind the parties they represent, the structure allows for consistent recommendations and interpretations of the Collective Agreement. This structure also allows government to communicate with CUPE through the NBANH on funding matters.

The general and service employees at three homes (Loch Lomond Villa, and Carleton Kirk Lodge in Saint John; and the Villa Chaleur facility in Bathurst) are represented by the New Brunswick Union of Public and Private Employees (NBPEA). Historically, the Local Unions in these homes have followed the lead of the provincially negotiated CUPE contract.

The New Brunswick Nurses Union represents Registered Nurses in 37 homes. The representation structure is similar to that of CUPE described above. The remaining nursing homes that do not have unionized general and service employees or unionized nurses follow the corresponding provincial Collective Agreement in all applicable respects including salary, seniority, job descriptions, etc.

Five of the sixty two nursing homes use the labour relation services provided by the Horizon Health Network. These employees are a part of the Part 3 Collective Agreement. Labour relations services and negotiations are managed through the Horizon Health Network.

The Association employs two lawyers who provide an array of legal services that also include labour relations.

Appendix 3

The New Brunswick
Association of
**NURSING
HOMES**



L'Association des
**FOYERS
DE SOINS**
du Nouveau-Brunswick

Innovation Through Integration:

"Bringing Primary Healthcare and Long Term Care Together"

Proposal

*Prepared by: The New Brunswick Association of Nursing Homes
For the Primary Health-Care Consultation*

August 2011

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PROPOSAL SUMMARY

What:

Utilizing mobilized multidisciplinary teams to deliver wellness and supportive programming to seniors in rural communities through local area nursing homes.

Purpose:

The purpose of this model is to keep at-risk rural community dwelling seniors in a maximum state of wellness so that they may continue to live independently. The goal is to provide the supports necessary to maintain the individual's maximum state of wellness, thereby reducing costly service utilization.

Key Features:

- Focuses on seniors who are well, or functioning in the community with supports, but are at risk for health decline/ loss of independence and acute service utilization.
- Uses existing infrastructure and expertise of local nursing homes in rural NB.
- Uses the unique program name of "Senior Care Community" of which community seniors can become members to receive wellness support.
- Utilizes a Mobile Multidisciplinary Team in conjunction with the local area nursing home to deliver the services.
- Uses an open referral feature to identify at-risk seniors.
- Utilizes an in-home geriatric assessment to identify risk.

Projected Outcomes:

Short Term:

- Reduced acute services use by seniors
- Maximized infrastructure capacity
- Better continuity of care for seniors
- Improved healthcare access for rural seniors
- Expanded social network for community and resident seniors
- Expanded role of the nursing home in the community

Long Term:

- Cost savings due to reduction in acute service use
- Reduction in wait time and ER overcrowding
- Reduced ALC bed use

- System reform for primary healthcare
- Improved primary care for general population
- Improved health outcomes for rural seniors
- Prolonged independence for seniors
- Relief of social isolation for rural seniors
- De-institutionalizing the nursing home

Added Value:

- The Senior Care Community Model creates an opportunity to increase access for nursing home residents to primary care with members of the multidisciplinary team being brought to the nursing homes. It also allows for “ease of access” for the frail elderly.
- The model brings the “walls of the nursing home” down by integrating with the community for service delivery.
- Nursing home residents can benefit from increased community interaction, rather than often being isolated from it, or having very limited engagement.
- Decreases social isolation of community seniors.

Why this Model is Innovative:

- Blends resources from long term care and acute care.
- Utilizes existing resources and expertise in a new way.
- Brings services to the rural population, which has the highest per capita population of seniors in NB and is historically the most underserved.
- Focuses on maintaining wellness and needed supports to prolong independence for seniors, with the goal of preventing the “crisis point” that leads to the ER visit.
- Expands the role of nursing homes in their communities.
- Incorporates research-supported best practices into model.

Request:

The intent of this proposal is to seek the support of stakeholders in order to develop the “Senior Care Community” model into a pilot project. The background section of this document provides significant support for the conceptual basis and operational features of the model, as well as a preliminary description of the implementation process, and anticipated outcomes.

BACKGROUND:**INTRODUCTION**

New Brunswick (NB) has a high proportion of seniors, particularly in rural regions. As a historically underserved population, rural residents experience poorer health. The process of aging, combined with the vulnerability of living in a rural area, makes rural seniors a high risk population for adverse health outcomes. Seniors are also heavy users of healthcare services (Aminzadeh & Dalziel, 2002). As the cost of acute care, such as hospital services is extremely high, the growing number of seniors will continue to drive health care costs.

Based on the traditional medical model of healthcare, our current system of service provision is reactive, treating the ill and injured with acute services. The heavy reliance on costly services, to the neglect of lower cost preventive measures, is an unsustainable practice in the face of a population with declining health and growing needs.

Approximately 25-30% of hospital beds are occupied by 'Alternate Level of Care (ALC)' patients (Horizon Health Network, 2011). These individuals no longer require acute care services, but remain in hospital. The vast majority are seniors who are awaiting placement in a long term care facility. This contributes to increased wait times and emergency room (ER) overcrowding, and affects the quality of care provided to all patients.

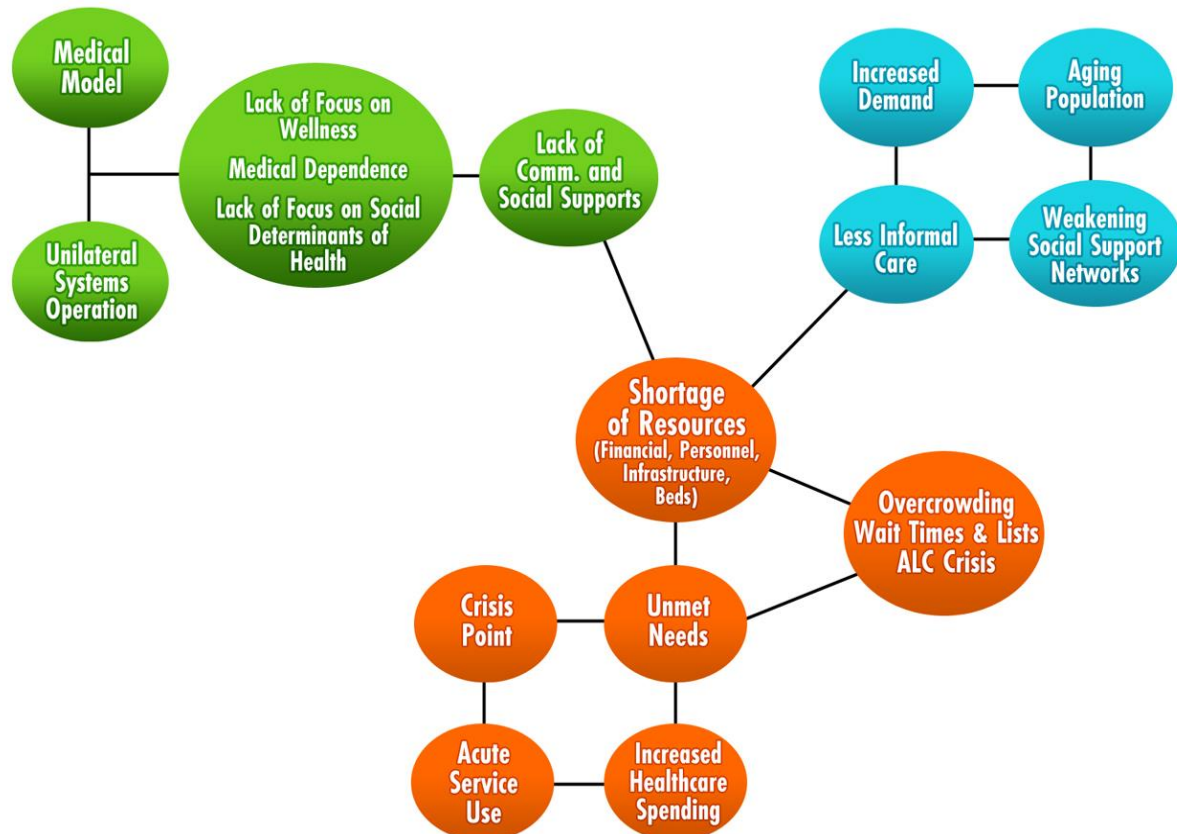
Most ALC patients are admitted through the ER, and the majority with general illnesses such as pneumonia, general weakness, and urinary track infections (R. McCloskey, personal communication, July 12, 2011). Thus, many of the health concerns for which seniors seek medical attention could have been prevented or could be managed effectively at home provided the appropriate services are available. Furthermore, the vast majority of ALC patients are admitted or subsequently diagnosed with dementia (CIHI, 2009; R. McCloskey, personal communication, July 12, 2011). Considering the burden of dementia on the caregiver, this is a strong indication that there are insufficient supports for informal caregivers. This lack of social and preventative services for seniors and their caregivers, leads to unmet needs that ultimately compile to a point of crisis resulting in the need for medical attention or the misuse of acute care as a last resort.

As the risk for disability and loss of independence due to illness increases with age, once seniors are in need of acute care, their rate of service utilization increases and they often become medically dependent. However, due to a lack of resources within the long term care sector, such as a shortage of nursing home beds and home care services, seniors in need are forced to remain in hospital until the appropriate care becomes available. These patients, termed ALC, though medically discharged, are unable to return home.

Seniors' heavy use of acute services and the worsening ALC crisis are symptomatic of inadequacies within the long term care and healthcare systems. As resources are scarce, there is a dire need to find efficiencies within the systems. A highly underused approach is to address the needs of seniors before they reach a point of crisis resulting in acute service utilization and institutionalization. Although we recognize that ultimately more capacity will be needed in the long term care sector simply in consideration of population numbers, we do not feel this is a complete answer as it is not addressing the root of the problem which requires a systems-level solution. Our current model is an unsustainable and expensive approach to long term care. However, as the immediacy of need and scarcity of resources has prevented a fundamental shift toward a preventative model of healthcare, we must use innovative strategies to identify efficiency and capacity within the system.

THE PROBLEM

The driving force of the proposed model is multifaceted, stemming from a complex network of problems as introduced above. Barriers arising from systematic and social processes have collided to produce a web of interconnected problems manifest in the current healthcare crisis and the health of the population. The following diagram depicts the network of problems flowing from foundational properties to symptomatic effects:



These factors have collided, resulting in a system that is not meeting all the needs of the population, specifically in that both the acute care and long term care systems are limited by fiscal realities and increasing demand in providing the continuity of care required to support healthy aging. The concern is that with insufficient resources comes inequity; as such, those who are most at risk tend to be underserved and have poorer health outcomes. In a public healthcare system, this means the entire population is affected by the consequences of this.

TARGET POPULATION

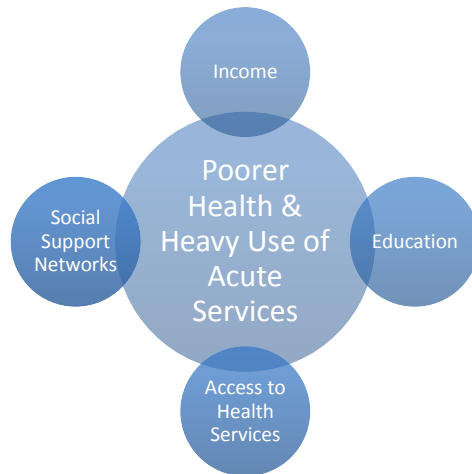
As the number of seniors in need of health and long term care services grow, there is a great need to identify those who are most at risk for health decline, loss of independence, and acute service utilization. This high risk group is a target population for service intervention. Based on key social determinants of health, a risk profile can be developed to identify vulnerable groups. The following table lists these key risk factors, including demographic, socioeconomic, and social variables:

Demographic	Socioeconomic	Social
<ul style="list-style-type: none">• Age• Sex• Geography	<ul style="list-style-type: none">• Income• Education	<ul style="list-style-type: none">• Social Support• Access to Services

Considering these determinants of health, rural seniors are identified as a high risk population. Rural residents are more likely to have unmet needs (Ham et al, 2003) and those with unmet needs are more likely to visit the ER (Levesque et al, 2004).

RURAL SENIORS

Rural areas have a higher proportion of seniors than do urban areas (Dandy & Bollman, 2008). This means that the impact of an aging population will be magnified in rural regions. The problem is only intensified by the pre-existing risk factors associated with rural living:



Rural populations are generally in poorer health than their urban counterparts (Hay et al, 2006). They have lower incomes and education levels (Hay et al, 2006), socioeconomic factors that are known determinants of health (PHAC, 2010); and, the shortage of health professionals and facilities limits access to health services (Hay et al, 2006). The issue of access is magnified by geographical barriers, including transportation, road, and weather conditions (Hay et al 2006; Clark & Leipert, 2007). The process of aging, combined with the vulnerability of living in a rural area, makes rural seniors a high risk population.

INFORMAL CAREGIVERS

In addition to these risk factors, one of the most powerful influences on rural seniors' health is the lack of a strong social support network. Families are smaller, and workforce participation is increasing, especially for women. In fact, in Atlantic Canada the fertility rate is the lowest in the country, a near reversal from past trends (Statistics Canada, 2009). And, as people wait longer to have children they are simultaneously raising children and needing to care for their elderly loved ones. This phenomenon, known as the 'sandwich generation', creates added stress for caregivers (Williams, 2005). Not only do families have less time to act as caregivers and with fewer family members to divide the task between, but many seniors no longer have family living nearby (Clark & Leipert, 2007). The outmigration of youth in search of employment, education, and life experiences is particularly prevalent in Atlantic Canada. The isolation experienced by many rural seniors is a significant contributing factor to their health.

Whether families are nearby or not, the role of the family in caregiving is changing. As most seniors living in the community prefer to and do receive the majority of care informally, with the primary caregivers being family (Clark & Leipert, 2007; Shiner, 2007), this has a significant impact on the population's capacity to age in place. As the number of seniors grows, and the availability of informal care declines, fewer seniors will be cared for in the community. In fact, the literature has shown that caregivers are a strong predictor of service use and institutionalization, perhaps even more so than is health status (Penhall & Whitehead, 2000; Shur & Whitlatch 2003). This means we need to ease the burden on caregivers by providing seniors and their caregivers

with the supports necessary to maximize wellness and prolong independence. As such, the inclusion of caregivers, and the consideration of their needs, is integral to the success of any model of care targeting seniors.

KEY HEALTH RISKS

Based on key health risks for seniors identified in the literature, practices aimed at the prevention and management of these health concerns is key for any geriatric model of preventative care:

Key Health Risks for Seniors*			
Dementia	Falls	Chronic Illness	Circulatory, Respiratory, & Digestive Conditions

*CIHI, 2009; CIHI, 2009b; NBHC, 2011; Nova Scotia Department of Seniors, 2009; R. McCloskey, personal communication, July 12, 2011; SmartRisk, 2009.

SNAPSHOT OF NEW BRUNSWICK

The profile of rural seniors identified in the literature, identifies (in the table above) the key health risks for seniors.

According to survey results published in the New Brunswick Health Council's 2011 report on primary health care, rural communities experience:

- Higher proportion of seniors
- Lower education levels
- Lower incomes
- Higher use of ER as primary source of care
- Higher number who have visited ER in the last 12 months
- High rate of chronic illness
- Lowest health score
- Lowest access score

Snapshot of New Brunswick

Chronic Illness	ER Use	Knowledge
<ul style="list-style-type: none"> •86% of NB population aged 65+ have one or more chronic conditions •22% of this group take 6+ medications •Top chronic conditions : high blood pressure or hypertension, arthritis, and chronic pain (*conditions commonly associated with aging) 	<ul style="list-style-type: none"> •42% of NB population visited ER in past year (*nearly double the national average) •Rural population more likely to have a family doctor, but also more likely use ER •After the family doctor, the ER is the second most frequented source of care for seniors 	<ul style="list-style-type: none"> •By age 65 only 29% of those with chronic illnesses stated they knew how to prevent further problems •Of those 65+ who take 6+ medications, only 34% of them know what their medications do •Lower level of education is associated with lesser understanding of prevention and medications

SOLUTION

The needs of an aging population overlap the boundaries of the long term care and healthcare systems. This unique feature actually lends the opportunity to create capacity through the integration of the two systems. The blending of resources maximizes infrastructure and streamlines services for a high risk population. The current fiscal climate prohibits substantial investment in preventative initiatives that yield cost-savings through improved health outcomes. However, by uncovering efficiency through integration, this unprecedented approach to service delivery will provide a low-cost and timely solution to the health system impact of an aging population, while ultimately delivering the long-term benefits of preventative action.

The following will introduce a new, truly innovative, model of service delivery that will assist in addressing the needs of New Brunswick's rural seniors through the integration of long term care and healthcare services.

THE SENIOR CARE COMMUNITY MODEL

The NBANH calls for the development of a "Senior Care Community" to serve seniors living in rural areas. The proposed model is based on an extensive search of the literature, including review of best practice. This model addresses current gaps in service delivery, including the unique needs of a rural senior population.

PURPOSE

The purpose of this model is to keep high risk seniors in a maximum state of wellness. Our primary goal is to provide the supports necessary to maintain wellness, thereby reducing costly service utilization.

DESCRIPTION OF MODEL

The essence of the Senior Care Community model is the delivery of multidisciplinary care to community-dwelling seniors. Members of the Senior Care Community will have access to a multidisciplinary care team made up of professionals already working in the health and long term care sectors. Service provision will concentrate on social and preventative health services, rather than medical care, and will be available to those seniors identified as high risk for health decline, loss of independence, and acute service utilization.

The standout feature of the Senior Care Community model is the centralization of services and the care team within the local nursing home. By expanding the role of the nursing home to include community care, the province will capitalize on geriatric-specific amenities and expertise. This unique utilization and reallocation of existent local resources maximizes infrastructural capacity, leading to high efficiency and cost-savings for the province while actually improving access and quality of care for an underserved population.

PROCESS

The referral process for the Senior Care Community will be open, including referrals from the community, physicians, and self-referrals. Upon referral, the individual and their caregiver, family, or other support will be welcomed into the nursing home for a preliminary consultation, which will include completing a risk profile. Once a potential member is identified as high risk for health decline, loss of independence and/or acute service utilization, an in-home geriatric assessment will be scheduled. This key function of the care team will be performed by specified members of the team, likely a nurse or nurse practitioner with experience in geriatric care and a social worker.

Following the in-home assessment, the full team will meet to discuss results and develop an individualized care plan based on the member's specific needs. As the care plan will be specific to each individual, the services provided will vary from member to member. Each member will have access to regular care services provided through the nursing home, and will be scheduled for services according to their needs. Services will include, but are not limited to: participation in activation and recreation programs in the nursing home, dietary counseling, mental health counseling, medication management, basic physical check-up, occupational therapy, personal care, and member navigation and referral. Member navigation will include educating the member and their caregiver or

family members about available health and social services, as well as long term care options. If necessary, arrangements may be made for extended healthcare needs including referrals to necessary medical services or professionals.

The listed services are health promoting strategies intended to keep at-risk community-dwelling seniors in a maximum state of wellness so that they may continue to live independently. Many of the services provided are known to assist in mitigating the risks associated with key health concerns for an older population.

THE MODEL'S INNOVATION

What separates this model from other outreach or community-based services targeted at seniors can be seen at both the conceptual and operational level.

How is this model different?			
CONCEPTUAL		OPERATIONAL	
INTEGRATION	PREVENTION	SUSTAINABILITY	BEST PRACTICE
Blending Long Term Care & Healthcare	Maintaining Wellness	Utilizing Existing Resources	Multidisciplinary Team Approach
Pooling Resources	Prolonging Independence	Expanding Role of Nursing Home	In-Home Preventative Geriatric Assessment
Delivering Health Services to Community in Long Term Care Facility	Social Supports		
	Preventative Health Services		

PREVENTION THROUGH INTEGRATION

The point and type of care provided by the multidisciplinary team reflects a wellness approach that differs from health and long term care services currently available. As a health promotion initiative, the model focuses on prevention by targeting those at risk of becoming, rather than those who are already medically dependent. Like the healthcare system, the long term care system in New Brunswick is based in a medical model of service provision. Rather than reactively providing care to those who are ill or injured, this program seeks to keep individuals in a maximum state of wellness by preventing needs from compiling to the point of crisis whereby utilization of costly medical services or institutional care are required.

By blending services and resources, an unprecedented integration of the health and long term care sectors marks innovation in *primary health care reform*.

Rather than providing medical or acute care, the mandate of the model is to provide the supports necessary for maintaining members in a maximum state of wellness. As a proactive approach, this prevention-focused outreach service seeks out individuals in need as opposed to the passivity of the typical care process of waiting until a patient seeks help. As both the healthcare and long term care systems are inundated by the immediacy of acute needs and a lack of sufficient resources, the capacity for either sector on its own to effectively provide and manage health promotion initiatives is limited. Innovation through integration strengthens the capacity of each partner by finding efficiencies *between* rather than solely *within* each sector. Likewise, system benefits are dually realized. Furthermore, by blending services and resources, an unprecedented integration of the health and long term care sectors marks innovation in primary health care reform.

Innovation through integration strengthens the capacity of each partner by finding efficiencies *between* rather than solely *within* each sector.

SUSTAINABILITY

Though urban populations have a greater overall number of seniors, rural populations have a higher share of seniors (Dandy & Bollman, 2008). This disproportionate number of elderly residents means the impact of an aging population is greater in rural areas, especially when combined with the fact that resources are already insufficient. When considering available resources along with the differing age structures of rural versus urban populations, it becomes clear that each population will also require different solutions to an aging population (Dandy & Bollman, 2008). What works in one location will not be the most effective or cost-efficient in the other. For example, even though a particular program or service may be utilized by a higher proportion of seniors in a rural setting, the overall use would still not compare to the number of seniors utilizing the service in an urban setting, even if it is a significantly smaller proportion of the population. Thus, as the return-on-investment of adding infrastructure in a rural area is very low, capitalizing on existing resources is the most cost-effective means of delivering service to a rural population.

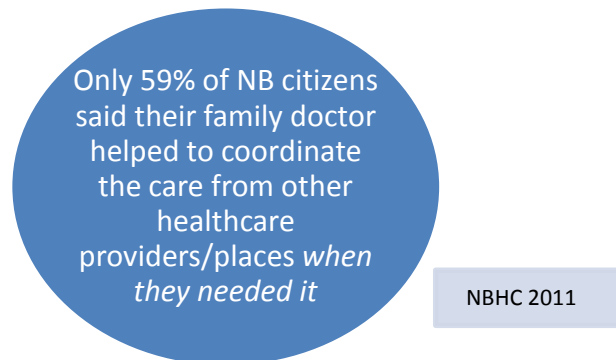
The distinguishing feature of this model is sustainability. The innovation in using the nursing home as the site of service eliminates the need for adding costly infrastructure. Furthermore, the need for new hires is reduced by reallocating required health professionals and nursing home staff. As a cost-efficient strategy, this model effectively addresses the needs of seniors, while reducing the impact of an aging population. And, perhaps more importantly, it fills a historical gap in service delivery to rural populations by providing the care they need, where they need it, and at minimal cost to providers.

Finally, establishing multi-use sites in rural areas is a noted strategy to increase access to services for rural seniors. As a recognized community fixture, the nursing home and its staff have earned the trust of local residents, thus enhancing participation in programs and services (Clark & Leipert, 2007).

BEST PRACTICE

MULTIDISCIPLINARY TEAM

One of the key features of this model is the multidisciplinary team (MDT) approach. Multidisciplinary care teams provide coordinated, comprehensive care to patients. This client-centered approach meets the needs of the patient by implementing an individualized care plan, designed by a collaborative effort among the expert team members, and based on consultation with the patient.



As seniors have complex care needs (Hallberg& Kristensson, 2004; Johansson et al, 2010), the primary care physician (PCP) alone cannot afford the time, nor possesses the full array of expertise necessary to address the spectrum of care. Thus in order to maintain health, seniors need access to various health professionals and services, and an integrated care plan (Aminzadeh & Dalziel, 2002; MacAdam 2008). Within our current health care and social service systems, each of these service models operates unilaterally (Johansson et al, 2010). The result is a fragmented care plan that is difficult to navigate, especially for seniors who may already face multiple barriers to accessing appropriate care. The multidisciplinary care team thus establishes a site of care management, facilitating access and simplifying care.

Due to the impact of the various determinants of health on the health status of seniors, it is essential that medical personnel integrate their practice with the efforts of other professionals from different sectors in order to produce the desired health outcomes (Muckle & Turnbull, 2011). As the PCP is the primary source of care for most seniors living in the community (NBHC, 2011), a crucial component of the model is to continually and consistently involve the PCP in the care plan developed by the MDT.

Based on other models of successful multidisciplinary teams working with geriatric clients, team members may include: a nurse practitioner, a pharmacist, an occupational therapist, a social worker, nursing staff, administrative personnel, and those with geriatric expertise (Johansson et al, 2010; Neill & Powell, 2009).

By reducing unmet needs through the improved coordination of care, multidisciplinary teams have been demonstrated to reduce the use of the ER and the risk of hospitalization (Khan et al, 2008; Scott et al, 2004). There is also strong evidence that multidisciplinary care teams lead to improved quality of life and increased patient satisfaction, including consistent reports of better self-reported health among patients (Lemieux-Charles & McGuire, 2006; Johansson et al, 2010; Scott et al, 2004).

IN-HOME PREVENTATIVE GERIATRIC ASSESSMENT

Another distinguishing element of the model is the mobile geriatric assessment service, a key function of the MDT. Geriatric assessment is an important means of early detection and identification of risk factors, but too often is completed in hospital after an individual has already presented with an acute care need. Programs such as the Quick Response Team in NB act to redirect the care of seniors in the ER through the use of timely assessment and follow-up action. Though this assists in reducing lengthy hospital stays and readmission, it does little to mitigate initial acute service utilization such as visiting the ER. Considering that nearly without exception, all ALC patients are admitted to the hospital through the ER, addressing needs before they require acute care is paramount.

There is consistent evidence in the literature demonstrating that community-based geriatric outreach programs, including geriatric assessment, reduces the need for ER visits, hospital admission, and institutionalization (Hallberg & Kristensson, 2004; Stuck, 2002; Duke, 2005; Penhall & Whitehead, 2000; Aminzadeh & Dalziel, 2002). Thus preventative geriatric assessment, by addressing unmet needs before they compile to the point of crisis, is an effective mechanism for mitigating costly service use. As an element of best practice, geriatric assessment carried out in the home is most effective as it expands the scope of information gathered (Penhall & Whitehead, 2000). Thus, the significance of the geriatric assessment function is that it is mobile, allowing for a comprehensive analysis of risk that outside the home could not be captured.

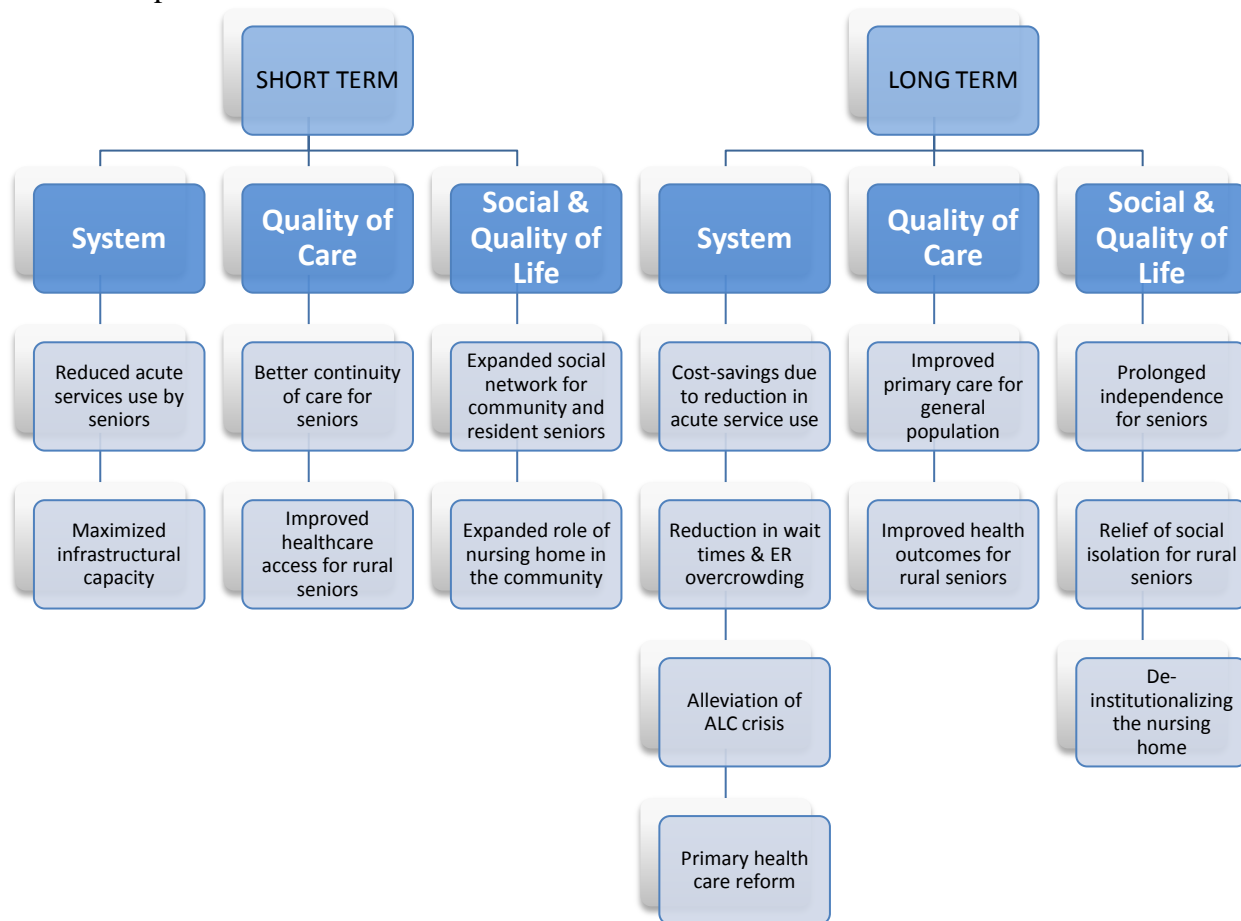
Finally, without appropriate follow-up and intervention, the value of geriatric assessment is lost (Stuck, 2002). Thus, the dual function of the MDT in performing comprehensive geriatric assessment and providing necessary services through the nursing home, addresses the need for follow-up action.

ANTICIPATED OUTCOMES

By taking the same diagram that depicts the network of problems driving this model, adjustments have been made to demonstrate the target area and resultant outcomes.

SHORT AND LONG TERM OUTCOMES

The anticipated outcomes of this model are far-reaching and will be realized through both short and long-term benefits. The following table provides a detailed layout of the anticipated outcomes of the model, divided by timeframe, as well as by target areas for improvement.



ADDED VALUE FOR NURSING HOME RESIDENTS

As an added feature, by bringing additional health professionals into the nursing homes, nursing home residents have the potential to benefit from this expertise. And, in addition to the planned services provided within the center, members will benefit from the social interaction with other community members, staff, and the nursing home residents. This is dually beneficial for the nursing home residents who will regain a much needed connection with peers and members of the community. This ‘breaking down the walls’ effect for the nursing home will promote community engagement; a longstanding gap within the long term care sector.

REQUEST FOR PILOT PROJECT

While the conceptual basis for the “Senior Care Community” model has been developed by the NBANH, the implementation design will require the collaboration and support of several organizations due to the complexity of integrating the long term care and primary health care systems. The required organizations are identified as:

- Selected nursing homes as pilot sites
- Regional Health Authorities
- Department of Social Development
- Department of Health

A pilot design is currently under development, and the concept has been shared with the Atlantic Institute on Aging. The institute has expressed that they are very interested in exploring the opportunity to initiate a pilot study. In addition, many nursing homes have had a long standing interest to support seniors in the community and have done so through senior housing, fitness programs, etc... This concept has been discussed with some nursing homes who could be potential pilot sites and would be supported by Administration in these facilities.

CHALLENGES

It is recognized that with innovation, there are complex challenges that inevitably present. This model identifies an opportunity for innovation from a systems perspective that may cause more investment to be made by one department in order for significant returns to be realized in another, but ultimately serving the province better. As such, we anticipate there will need to be negotiations between the identified organizations prior to a pilot implementation. This is also why the preparation of a pilot project budget cannot be prepared by the NBANH as part of this proposal without each of these organizations participating.

Finally, it is also noted that although there are both short and long term outcomes with this model, it is recognized that the most impacting outcomes would require a longer period of time to measure, for example the impact this model would have in reducing the number of ALC patients would take time to determine as this model focuses on preventing/ delaying/ reducing seniors needing to seek healthcare services. As such, the NBANH is designing a program evaluation strategy which we understand is essential to determining program success. The evaluation methodology would be completely developed as part of the pilot design process with stakeholder organizations and would be integrated in to the overall pilot implementation.

CONCLUSION

In spite of the noted challenges, this model offers a strategy to service the growing needs of seniors in New Brunswick by utilizing resources we already have. We feel that the potential role of the “Senior Care Community” model can be expanded beyond what has been identified in this proposal as other exciting concepts exist when integration of community services, long term care and primary healthcare services are allowed to work outside of traditional silos, becoming something greater than programming and processes, but a community, that seniors want to be a member of.

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Appendix 4

Employee and Family Assistance Program (EFAP)

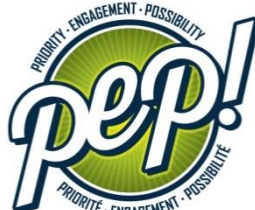
In 2010, the Association embarked upon the implementation of a province wide employee and family assistance program (EFAP). The program was established as a joint venture with the unions, administration and governance members.

From 2010 to 2014, EFAP services were provided by Ceridian. Following the end of the contract with Ceridian, the joint committee suggested a call for proposals from other suppliers. After the evaluation of the proposals, the committee recommended retaining the services of Shepell-FGI as the EFAP provider for a three year contract. The contract will cost approximately \$ 500,000 and the program is offered to all nursing homes in the province, with the exception of the five that hold contracts with the hospitals and the three Shannex homes. These eight homes offer their own EFAP.

The EFA Program is considered to be the anchor of any wellness program and for that reason we believe it is essential to ensure that the foundation of our program is solid. Shepell-FGI is an international company that offers EFAP services to many organizations worldwide and provides a 24/7 service in both official languages.

The main function of this program is to provide counseling services to employees and their immediate family members. However, the counseling component of the program only addresses the problems after they arise. It is important to note that the program also has a prevention and education component called *WorkHealthLife*. The prevention side of the program helps employees in their journey to achieve their personal and/or professional goals before a problem occurs. This component is very important since it is an immediate extension of our workplace wellness program.

NBANH'S Provincial Workplace Wellness Program: PEP!



In addition to the Employee and Family Assistance Program (EFAP), the Association, in collaboration with its Benefits Advisory Committee decided in 2010 to contract Morneau Shepell to generate a study to assess the health needs of the workforce. This was the next logical step in our plan to decrease the level of absenteeism in our sector and to take the next step of focusing on a wellness culture. The literature is clear on this, and several studies over the past decade have shown significant return on investment (ROI) when a well managed wellness program, amalgamated with an EFA Program, are implemented in an organization.

Over 52% of all provincial Nursing Home employees participated in the Morneau Shepell study and the company was able to provide us with a comprehensive report on our state of health. The study also clarified our key wellness needs. Morneau Shepell conducted their research using the following planning steps:

1. Conduct Environmental Scan and Best Practices Research
2. Conduct Integrated Data Analysis
3. Conduct an Employee Health Needs Assessment
4. Develop a Workplace Health and Wellness Strategy
5. Develop the Program Operational Plan

Following the recommendations of Morneau Shepell's report, the Association took the necessary measures to achieve the 5 steps that emerged from their evaluation. To date, we are proud to say that the five steps have been completed successfully and that a full-time employee manages the PEP! Wellness Program. Our wellness coordinator joined the Association in 2012 and the program was launched in January 2013. The PEP! program was developed based on the results of Morneau Shepell's evaluation and covers the main topics related to work absences in our sector. These are: *Mental health, Musculoskeletal Injuries, Chronic Diseases such as diabetes and cancer and Cardiovascular Diseases.*

An operational plan is developed each year and is presented to our Board of Directors by the Wellness Coordinator. She works in collaboration with the homes' wellness champions and wellness committees in implementing the initiatives each quarter, and provides the necessary support to make sure each home achieves their goals. The wellness coordinator will also work closely with the NB Continuing Care Safety Association (NBCCSA) over the next years as both initiatives provide education to the nursing home sector. Moreover, NBANH's wellness program recently received, after just one year of implementation, the Award of Distinction from the Heart and Stroke Foundation. The award recognizes the best Workplace Wellness Programs offered by New Brunswick companies or organizations.

The PEP! Wellness Program is offered on a voluntary basis to the same homes that participate in the EFA Program. To date, 85% of NB's nursing homes are participating in the wellness initiative. The program is funded by a surplus from the Health and Benefits Plan and the total costs are approximately \$ 275,000 per year. We will do a follow-up employee health needs assessment with a Return on Investment (ROI) study. We are committed to keeping the government informed on the progress of this initiative. We believe that this initiative is a key element in the strategy to improve the health of nursing home workers and in turn will lower rates of absenteeism.

The various initiatives and programs implemented over the past five years by the Association have helped to create a culture of wellness and health & safety among the workers and managers. We also trust that the synergy between programs will reduce costs related to absenteeism and will help in reducing costs associated with short and long term disability. We believe that programs and initiatives such as the *Employee and Family Assistance Program (EFAP), the PEP! Wellness Program, the Continuing Care Safety Association (CCSA) and the WorkSafe Claims Management Program* are among the initiatives that will help us educate nursing homes employees, and better equip our managers. We plan to continue to integrate the umbrella of initiatives in order to effectively manage our human resources and increase cost savings for our sector in the future.

New Brunswick Continuing Care Safety Association

**New Brunswick
Continuing Care Safety
Association Inc.**



**Association de sécurité
des soins continus
du Nouveau-Brunswick Inc.**

Launched in January 2014, the creation of the New Brunswick Continuing Care Safety Association (NBCCSA) was designed to place more focus on preventing injuries and illness rather than adjudication and payment of claims. A quality approach is to eliminate deficits by concentrating on improving the system and addressing illnesses and injuries before they occur in a prevention focused approach.

The Safety Association is designed to:

- Educate organizations to address and improve employee health & safety which can lead to improved operations and better bottom-line results.
- Help organizations establish benchmarks and identify the return on investment by improving their management of health & safety.
- Provide guidance and tools with which continuing care operators can conduct self-assessments that identify strengths and weaknesses.
- Assist organizations in developing action plans that improve health & safety in a way that contributes to improved delivery of care.

Most exciting is the leading edge technology analytical tools being developed by the NBCCSA which can be easily adapted to care service delivery models; not only in New Brunswick but across Canada. These tools will help predict and prevent workplace injuries in a care setting. This software forces organizations into a proactive, real-world application of a safety management process using leading indicators, predictive analytics and everything in between to optimize each establishment's chances of reducing and eliminating many of their hazards leading to current injuries. This software will be rolled out to NB nursing homes by early 2015.

The Safety Association will continue to innovate through its health and safety approach, making it an invaluable asset to the sector well into the future.

PEACE - An Elder Abuse Prevention Program



Seniors are known to be very vulnerable members of our society who consequently become targets by individuals they know and trust to take advantage of them. In light of the expected growth in senior population, it is reasonable to assume that NB Seniors will only grow more vulnerable to potential abuse and mistreatment, which presents an urgent need for our communities and governments to take action.

Elder abuse is a complex social issue comprised of many contributing factors. We understand through literature that elder abuse is highly underreported, thus not only allowing perpetrators to continue their misbehaviour, but also compounding the lack of awareness and resulting absence of reporting future cases. Fear of retribution, lack of general knowledge on abuse, negative perspectives on aging, and the lack of awareness of available resources are often contributors to underreporting. Additionally, care-related stress and negative perspectives on aging on the part of perpetrators often play a role in abuse situations. The growing complexity of seniors' healthcare needs creates an added level of dependence on other individuals, and often further isolates them socially and physically from their families and communities.

When looking at the issue within the geographical, social, and economical context of the province of NB, it is easy to understand how NB's seniors are especially vulnerable to abuse and mistreatment. In addition to being amongst some of Canada's most aged population, the majority of New Brunswickers reside in rural communities where social and physical isolation becomes even more prevalent. Coupled with the rampant migration of younger families leaving for other parts of the country, NB seniors are often left with a much smaller, and sometimes non-existent, support system to protect them from the vulnerabilities that come with the inevitable process of aging.

As part of its vision to lead excellence in Long Term Care, the NBANH has taken responsibility to shed the spotlight on elder abuse not only amongst nursing home staff, but also within community-dwelling seniors, other LTC member and partners, and members of the general public. The program developed for this purpose, PEACE (Prevention of Elder Abuse Centers of Excellence), is facilitated through an open and honest dialogue which will reduce abuse by increasing awareness and addressing contributing factors such as caregiver stress, workplace violence, ageism, and abuse intervention strategies.

By engaging other participants of the LTC sector in the PEACE program, the NBANH is facilitating the exchange and distribution of resources that will strengthen the fabric of our communities and provide the support for seniors to be protected and to protect themselves. Moreover, these exchanges further strengthen the partnerships needed in creating a more comprehensive and responsive network of health and social services that will inherently serve to provide our seniors with the dignified and respectful aging experience they deserve.

WE ARE ALL Neighbours IN Aging

A New Conversation • A New Culture • A New Collaborative • A New Brunswick Story

In these days of profound financial challenges in the province, New Brunswick has the fastest growing seniors population in Canada. This cohort will double in the next twenty years. During that time, seniors will outgrow the language commonly used to define them as well as the system designed to support them. As we know, this is already happening.

What many of us don't know is that seniors could become one of the province's greatest assets. The majority of seniors—with children and grandchildren living in Alberta and elsewhere—will have two choices: leave the province to join their families or stay “at home.” If they stay, this new generation of seniors will bring their talents, experience, and discretionary income to bear in reinventing the province. But what support and lifestyle would they be staying for? Does a siloed system focused on institutional care fit the needs of today's and tomorrow's seniors? Is it financially sustainable? Is it even working? In many cases, the answer is no.

These are rare and challenging circumstances, and government cannot—and should not—lead the way alone.

As Maritimers, we are envied for our neighbourly values—for our history of arriving full spirit to the collective effort. We know what it means to be part of a community, and now, through that lens, many are coming together to give rise to a new culture of aging in New Brunswick.

This is the story of how one conversation grew to include citizens in the hundreds, of all ages. Let us tell you what we have learned—because the next steps will require everyone.

PRESENTED BY

New Brunswick Association of Nursing Homes
New Brunswick Home Support Association
New Brunswick Special Care Home Association
Association Francophone des Etablissements de Soins Spéciaux du N-B
Association francophone des aînés du Nouveau- Brunswick
New Brunswick Senior Citizens Federation
Research Center on Aging, Université de Moncton
New Brunswick Health Council
Réseau de Santé Horizon Health Network
Réseau de Santé Vitalité Health Network
University of New Brunswick; Saint John
Canadian National Institute for the Blind
Lifetime 360 Home Accessibility Solutions
Kings Way Care Centre
Orchard View Long Term Care
Mount Saint Joseph Nursing Home
Forest Dale Home
Pine Grove Nursing Home
Ability New Brunswick
Government of New Brunswick
John McLaughlin, President Emeritus
University of New Brunswick
Eileen Malone, senior's advocate
Complete Purchasing Services Inc.
Lawtons Drugs
Jean Coutu Pharmacy Fredericton
New Brunswick Real Estate Association
Continuing Care Safety Association of New Brunswick
Atlantic Institute on Aging



HOW IT BEGAN

2011

It began with just a few of us—leaders from the province’s largest long-term care providers meeting together like never before. The invitation came from the New Brunswick Association of Nursing Homes (NBANH). Tasked by government to find efficiencies within an already stretched budget, NBANH realized that too many factors were beyond their control. The only way forward was in collaboration.

For years, we had all worked in silos, often as rivals for available funding. We were disparate groups, in a small province, serving a common audience, and rarely talking—but at that first meeting, everything changed. The New Brunswick context had pushed us to an edge. In that room, we spoke candidly. We exposed our vulnerabilities. We acknowledged that the situation was bigger than all of us. Then it started. Our conversation evolved from an operational perspective to a systemic one, revealing how one resource here, could fill another gap there, if we saw everything and everyone as part of the solution.

In search of more voices, we engaged academics and seniors’ advocates. But it still wasn’t enough. Despite being pushed into this discussion by economics and demographics, we now felt pulled by an emerging vision that spoke to our hearts and minds. No one was suggesting 50 more nursing homes—despite the impossibility. The conversation was pointing toward a shift seen in other countries—replacing the primacy of institutional care with the power of grassroots collaboration, enabling seniors to stay at home as long as they desired as active contributors to age-friendly communities.

This would be a shift in New Brunswick culture itself, which, as we soon realized, meant the conversation belonged to everyone. Thus, over one year, our group of then eleven members collaborated in preparing a two-day summit that would swing its doors open to the public.

“It was intriguing to be engaged by the Association of *Nursing Homes* to discuss, in large part, *aging in place*. I was immediately interested in the out-of-the-box thinking—because that’s exactly what we needed.”

—Jean-Luc Bélanger, General Director, Association francophone des aînés du Nouveau-Brunswick

“It’s time to change the conversation. If we see seniors as a burden, we only see part of the solution. It’s about the creative energy that new people and fresh thinking can bring when we see everyone, including seniors, as contributing to the way forward.”

—John McLaughlin, President Emeritus, University of New Brunswick



Summit for
Healthy Aging and Care;
Innovating Together

Sommet sur le
vieillissement en santé et les soins;
Innovons ensemble

November 6th & 7th
Fredericton Inn, Fredericton

Les 6 et 7 novembre
Fredericton, au Fredericton Inn

The time has come to think about change...

Le temps est venu de penser au changement...



THE GATHERING

2012

On November 6, 2012, over 300 participants streamed through the doors of the Fredericton Inn to attend the Summit for Healthy Aging and Care. They included 18- to 94-year-olds, anglophones and francophones, curious citizens to government ministers, all coming to re-envision aging in New Brunswick—with the media close behind.

The sheer number of participants spoke volumes, and the stories people told spoke even louder. The entire conference was designed on one premise above all others: to capture everyone's voice in creating a shared vision and mandate for action. The experts were the participants; the solutions were within them.

Achieving such a feat with over 300 participants called for a nontraditional approach—one that would elicit an alternative mindset and make a large group feel like one. There was a computer at each table feeding the highlights of small-group discussions into a word cloud that was evolving on a screen at the front of the room. A graphic artist with eight-foot poster boards captured key ideas and themes in a way that retained the spirit usually lost in the fray. A Juno award-winning pianist put music to every mood, carrying the group through otherwise awkward transitions and deepening every moment of reflection. The facilitators magically softened the crowd and then energized it anew—weaving everyone's contributions into a single tapestry to behold, while inviting participants to bring their whole selves to the room. Without these specialists, and the collective effect of how they engage large groups, the event would never have become the start of what now feels like a provincial movement.

Through ideas, stories, laughter, and tears, participants expressed their hunger to have a voice, their readiness to be part of the solution, and their desire to support, first and foremost, aging at home—whatever and wherever someone feels that is. In the end, all of us who had poured sweat and soul into organizing the summit felt we had received a grassroots mandate to define “what happens next.” We are forever grateful to the corporate sponsors who helped make this possible.

THREE QUESTIONS WE ASKED & what over 300 people told us

What is the future we wish to create?

A place where seniors are respected, valued for their wisdom, and connected with an intergenerational mix of young and old.

What are the barriers and enablers to creating that future? Enablers: willingness to change, malfunctioning system, population growth, existing resources. Barriers: cultural resistance, poor coordination and communication, institutional focus.

How do we bridge the gap between present and future?

The power of people. Neighbourly support. A focus on aging at home.

“There was an openness for people to truly share their ideas and feelings. This gave me hope. The system is broken, and we have to think even bigger than we are thinking now. To find solutions, we need to listen to and stand behind people daring to say and do something different.”

—Eileen Malone, advocate and 80-year-old citizen

“The conferences and other networking events provided an excellent platform to exchange ideas and share experiences. Through such events, we can ensure we plan for the future based on best-practices and innovative models that will enhance the quality of life for our seniors and their families.”

—Madeleine Dubé, Minister of Social Development, New Brunswick



—Charles Holmes, facilitator and session designer



WHAT CAME NEXT

2013

Ultimately, the summit inspired the concept of a provincial collaborative—for developing innovative and synergistic connections across the province. From sharing underutilized resources to harnessing human capital, members of the collaborative would achieve more by thinking as a whole, while remaining their own individual entities.

Using the outcomes of the summit, we created a framework for moving forward—including a shared philosophy and vision, success indicators and outcomes, an operational framework for prototypes, and more. Upon sharing these ideas with a spectrum of stakeholders, our group instantly expanded, with more organizations and individuals requesting formal inclusion.

We started working on a proposal for our first prototype of collaborative action. Meanwhile, government surrounded themselves with graphic art from the summit as they crafted the Home First strategy.

As the year unfolded, many of us received phone calls from citizens up to 92 years of age—sharing ideas, checking progress, relieved that momentum had not been lost. However, we knew that this spontaneous engagement would one day stop if we did not formally sustain the conversation.

On the one-year anniversary of the summit, we gathered another 212 people using the same facilitators and the teleconferencing technology Maestroconference—which allows for plenary and small group discussion and removes the restrictions of mobility and distance. At that gathering, the message was clear: we were on the right track, the need was growing by the minute, and people were eager to see ideas in action.

A COLLABORATIVE TAKES SHAPE

Shared Philosophy

Seniors in New Brunswick experience improved quality of life.

Shared Vision

Linking stakeholders of healthy aging and care for sustainable collaboration.

Strategic Priorities

Caring Communities
Continuing Care
Consultation and Contribution

“We were already getting calls: ‘Is someone out there who could help us with this or that?’ And we were able to connect the dots on a few situations fairly easily—such as matching one seniors group that could no longer afford space with an organization that offered space in return for education. Once we can formalize how to do this more effectively, we can work neighbour-to-neighbour in making every resource go further.”

—Jodi Hall, Director of Operations, NBANH

“In the Maestro call, I began to see the shift—people realizing they could no longer blame or ask the government for everything, and that they, their families, and their communities had an important part to play. I remember one woman putting it so simply: ‘All I need to know is that you need me.’”

—Suzanne Dupuis-Blanchard, Associate Professor of the School of Nursing and Director of the Center for Aging Research, Université de Moncton



THE WAY FORWARD

2014 - ONWARD

In the late winter of 2014, we celebrated. Members of the collaborative had received grant funding for the first 12-month prototype. Inspired by a successful US model, the initiative enables a local community to address their own transportation challenges for seniors. Specifically, it supports a local nursing home in putting its vehicles to greater use through the creation of a community volunteer drive service. We hope that this initiative will become a model and inspiration, enabling other communities to identify their own transportation solutions.

This is an exciting start, but barely enough to keep our momentum. Now is when the greatest push is needed—in effort and ideas. To make progress, we must answer some key questions:

- How do we sustain the public conversation?
- How do we keep a diverse collaborative anchored by a shared philosophy?
- What structure will allow the collaborative to do its best work?
- How do we become a voice of authority for government, working on complementary sides of the same issue for a 360-degree approach?

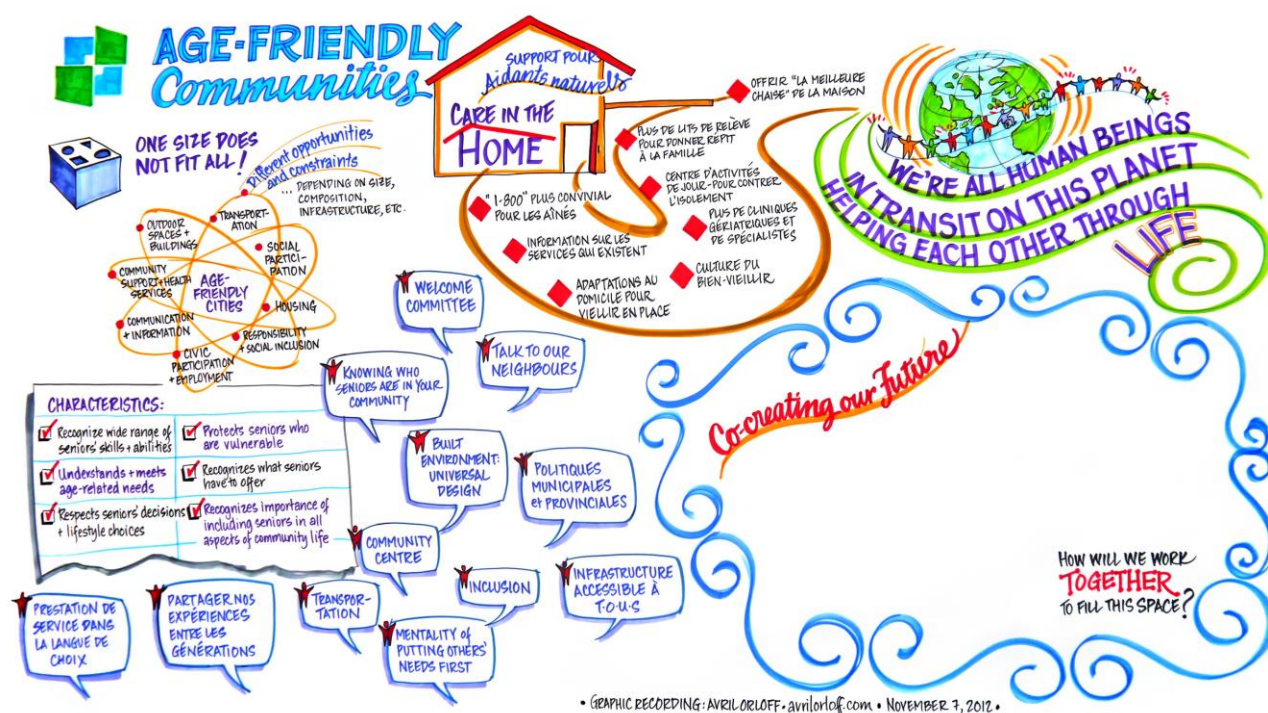
This story belongs to everyone! Please send your ideas to Jodi Hall, Director of Operations at the NB Association of Nursing Homes at jhall@nbanh.com.

“I have great admiration for the people in this collaborative. After years of protecting their own interests, they’ve said, ‘we’re not just going to swim in our own little pool—we’re going to jump in the ocean together.’”

—Michael Keating, Executive Director, NBNH

“We anticipated this day, and we are here now. It’s time to do things better and together.”

—Janet Thomas, Director, Nursing Home Services, Department of Social Development





Economic Impact of Nursing Homes in New Brunswick in 2014 A Brief Overview

Table 1: Economic and Socio-Economic Factors

Generator/Indicator	Assumption	\$\$\$
DIRECT IMPACT (Money Initially Spent)		
Operations in NHs/ Government funding	Salaries and all other expenses combined	385 100 000
Operations in NHs/ Other sources of revenues	100 000\$ x 5 NHs Foundations + 10 000\$ x 30 NHs Found. 400\$/month/62 NHs cafeteria sales	1 097 600
Employment/ Gov. Workforce related	Salaries Only 10 employees x 20.71\$/hour x 37hrs/week x 52 weeks	398 460
Total Direct Impact		386 597 060
INDIRECT IMPACT (Increase in Business to Business Activity)		
Employment/ Suppliers	(Food, Medical supplies, Others supplies and services in NB) Manufacturing/processing: 5, Distribution 10, Service 62 77 x 20.71\$/h x 37hrs/week x 52 weeks	3 068 145
Employment Local Businesses	5 people x 10\$/h x 37 hrs./week x 52 weeks x 62 NHs	5 964 400
Income Tax NHs Employees	39 846 \$ x 9.68% (NB) x 6567 employees	25 120 193
Income Tax Gov. Employees	39 846 \$ x 9.68% x 10	38 253
Income Tax Suppl. Employees	39 846 \$ x 9.68% x 77	294 541
Income tax Local Businesses	19 240\$ X 9.68% x 310	108 326
Corporate Tax	4.5% x 100 000\$ x 20 companies	90 000
Total Indirect Impact		34 693 858
INDUCE IMPACT (Money spent by people employed)		
NHs employees\ Personal Consumption	6567 people in NHs x 20 000	131 340 000
Other workforce related\ Personal consumption	10 people(GNB) x 20 000 = 200 000 77 people (suppliers) x 20 000 = 1 540 000	1 740 000
Total Induce Impact		133 080 000

NON-ECONOMIC FACTORS (Value of resources without money exchange)		
Volunteers in NHs	Board members and other volunteers. No visit from family members counted) Total for 632 NHs 24,166 hours/month x 12 months x 10.50\$/hour (min. wage)	3 044 916
Delivery of Program to Community	-62 nursing homes offer at least one (1) program on a regular basis. -The delivery of the program involve at least 2 employees at 4 hours per week per NH Value per NH per year : \$20.71/h x 2 employees x 4 hours/week x 52 weeks \$8 615 Total value for 62 NHs total for a year \$ 534 152	534 152
Total Non-economic Factors		3 579 068
GRAND TOTALS:		
Total -Non-Econ. Factors		554 370 918
Total +Non-Econ. Factors		557 949 986

Notes Table 1:

- It is understood that Table 1 represent an incomplete reading of the situation as very conservative assumptions
- Operations in NHs: GOV: Including Resident contribution. OTHER: fundraising campaign + cafeteria, etc.: Assumption; 35 Foundations: 5 raise 100 000 annually and other raise: 10 000. Cafeteria: av. of 400/month. X 62
- No. of employees in Nhs (NBANH Ma4rch 2013)
- No. of employees Related/ Social Development + Facilicorp
- $20.71 \times 37 \text{ h3week} \times 52 = 39\,846$
(<http://www2.gnb.ca/content/gnb/en/departments/finance/taxes/personal.html>)
- Corporate Tax in NB (<http://www.cra-arc.gc.ca/tx/bsnss/tpcs/crprtns/prv/nb/menu-eng.html>)
- Injection in local economy by Nh's employees
Pessimist Assumption based on full time and part time position, unionized and non-unionized employees:
<http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/famil108a-eng.htm>
<http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/famil130e-eng.htm>)
- Injection in local economy by other workforce
- Volunteers contribution (ref. Volunteer Canada, TD Economic- April 2012 and Statistic Canada-March 2014)
- Cents not counted.

Table2: The Human Factor

The number of people directly/indirectly connected in a social network linked to a nursing home in NB.

Work		Families and Friends		Total
NURSING HOMES				
		Family	Friends	
Employees	6567	9850	6895	23 312
Residents	4508	9016	7012	18 536
Volunteers	1178	589	589	2 356
Total				44 204
OTHER IN THE SECTOR AND LOCAL ECONOMY				
		Family	Friends	
Gov. Employees	10	10	10	60
Venders/Supplier Employees	77	77	77	231
Other-Population of NB	50 000	-	-	50 000
Total				50 291
Grand Total				94 495

Notes Table 2:

- By people factor we refer to the number of people directly involved in the sector and their communication of values and experiences to others. It is understood that the total social impact as the number of people reached are much greater than what described above.
- Employees
 Family: .5 Spouse, .5 Children + .5 Brother/sister = 1.5/ empl. X 100% of employees
 Friends In NB = 1 for 80% of employees + 1 for 25% of families
- Residents
 Family: 2 for each resident
 Friends: 50% of residents will share with at least 1 friend + 50% of families with 1 friend
- Volunteers
 Family: 50% will share with at least one member of their family
 Friends: 50% will share with one friend
- Other –Population of NB: 751 170 (adult pop.) - 44 495 (NHs + Gov. + Suppl. X 7% = 50 000
 (<http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=Eng&GK=PR&GC=13>)

April 2014

Nursing Homes and their Communities

New Brunswick Association of Nursing Homes
June 12, 2014

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Introduction

Nursing Homes play an important role in the communities they serve. In addition to providing care, dignity and quality of life to their residents, Nursing Homes provide or support other needed services. As well, Nursing Homes receive significant support from their communities, either as volunteer hours or financial support.

The nature of Nursing Homes, as community-based, locally administered not-for-profit organizations, facilitates this beneficial reciprocal relationship. Just as Nursing Home benefit from the help and support of the broader community, Nursing Homes provide critical support to services delivered beyond their facility walls.

While this mutually beneficial relationship has existed for many decades, this is the first time that the New Brunswick Association of Nursing Homes (NBANH) has undertaken a survey of Nursing Homes to get a clearer understanding of the relationship between Nursing Homes and their communities.

From May 23 to June 9, 2014, Nursing Home Administrators were asked to respond to an on-line survey. The questionnaire was relatively brief and Administrators could respond to the survey in the official language of choice (copies of this questionnaire can be found in the Appendix).

The on-line methodology is a very appropriate way to survey Nursing Home Administrators. Not only are their emails known, ensuring that every Administrator has an equal opportunity to participate, this approach accommodates individuals with a busy daily schedule. There was a 74 percent response rate from Administrators (48 of 65).

This survey also benefits from a finite sample factor. These results are accurate to within +/- 3.8 percent at a 95 percent level of confidence. This means that the results in the report would not vary by more than +/- 3.8 percent than if all Administrators had participated in this study.

This survey was conducted in accordance with the standards and guidelines of good practice established by the Marketing Research and Intelligence Association (MRIA), the professional association of the market research community in Canada.

Executive Summary

These results are based on an on-line survey of Nursing Home Administrators conducted between May 23 and June 9, 2014. These results are accurate to within 3.8 percent at a 95 percent level of confidence.

Affiliated Services

Almost one-half of Nursing Homes (48%) provide senior's day care or respite care to support caregivers in the community. Two-in-five Nursing Homes support the Meals on Wheels service (42%), provide support for families providing care (40%), or provide assisted living apartments or affordable housing (38%) in their communities.

One-quarter of Nursing Homes provide activities (25%) and transportation services (23%) and one-fifth support access to nurses and medical advice (21%). Ten percent of Nursing Homes provide space for community events. One-third of Nursing Homes (35%) support a diverse range of services, such as child day care, support for charitable activities, and health promotion.

Only four percent of Nursing Homes do not provide any services, beyond residential care, to their communities.

Three-in-five Nursing Homes (61%) provide these affiliated services on a "break-even" basis. Only 15 percent of Nursing Homes say that they gain revenue from providing these affiliated services and a further 10 percent say that their Nursing Home subsidizes these services.

Nursing Homes are critical to the sustainability of these affiliated services in their communities. Over two-thirds of Administrators (69%) say that that is unlikely that these services would continue in the community if the Nursing Home were unable to provide support.

Volunteer Hours

On average, a Nursing Home receives approximately 365 hours of volunteer time per month. Overall, New Brunswickers volunteer over 23,766 hours each month to support the care, dignity and quality of life of Nursing Home residents.

Given the magnitude of this contribution, it is not surprising that 96 percent of Nursing Home Administrators say that this volunteer effort is "very important" to proving care, dignity and quality of life to Nursing Home residents.

Community Support

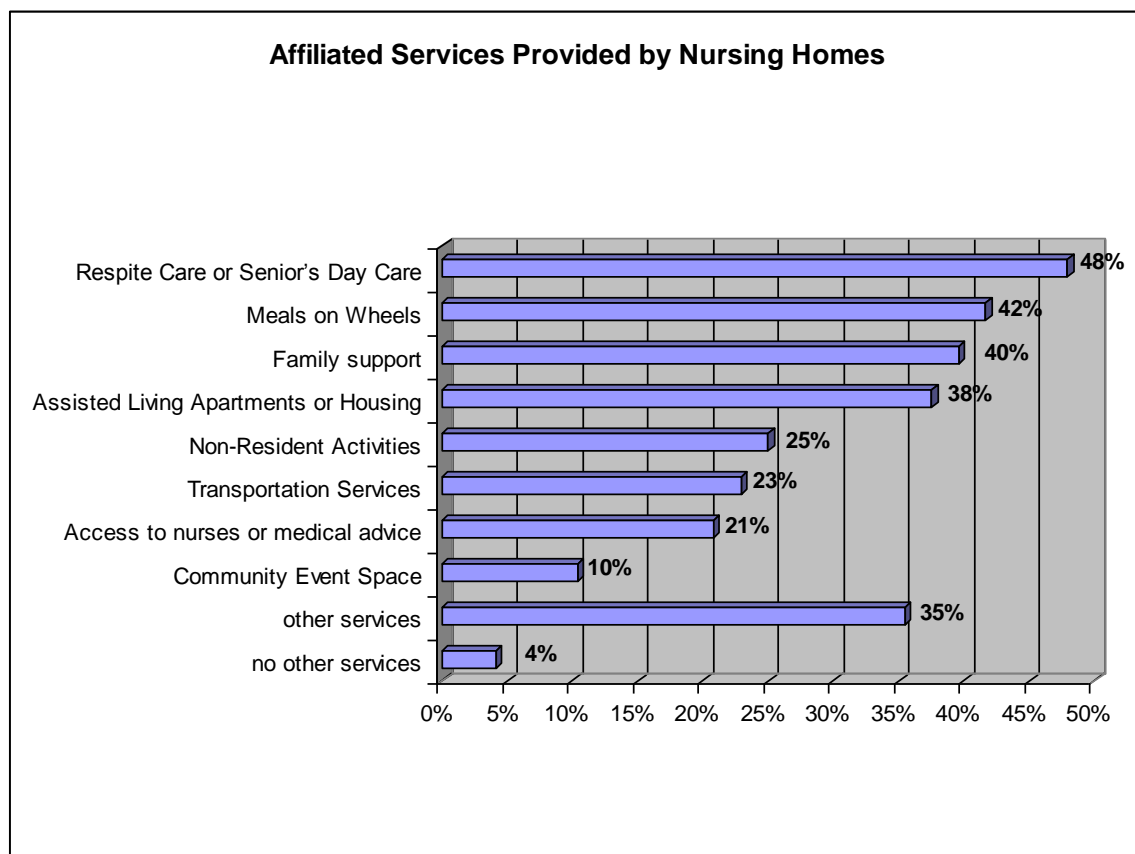
Nine-in-ten Administrators (88%) say that their home receives less than \$50,000 per year through community fund-raising activities. Six percent say that they receive between \$50,000 and \$100,000 and two percent say they receive over \$100,000 in community support per year.

Nine-in-ten Nursing Home Administrators (90%) say that this community financial support makes a significant contribution to their operations, with two-thirds (67%) stating that this contribution is “very significant.”

Affiliated Services

To start the survey, Nursing Home Administrators were asked about the services that are supported or provided by their Nursing Home in addition to the care they provide to residents.

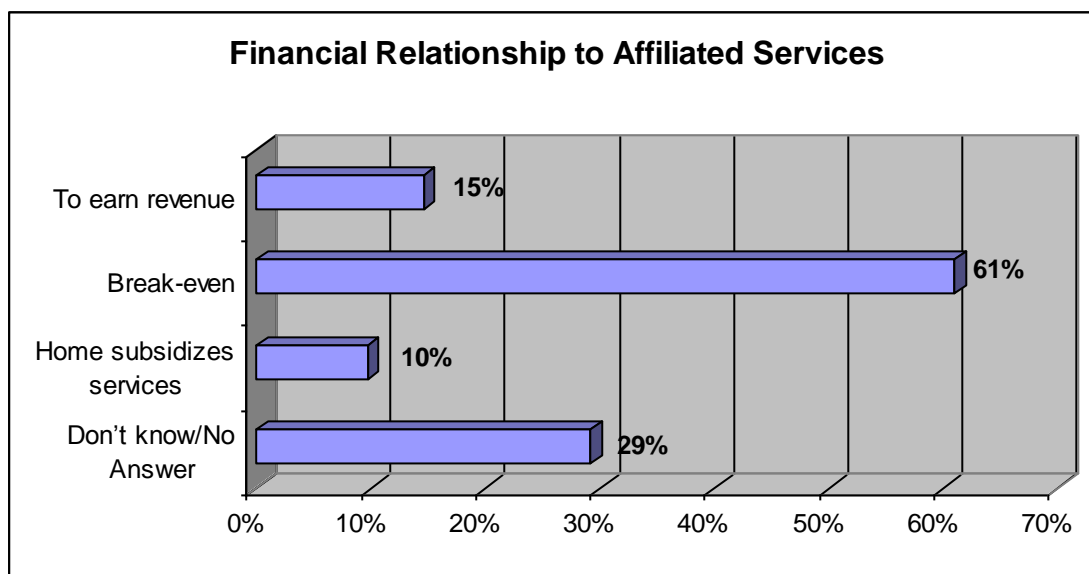
Almost one-half of Nursing Homes (48%) provide senior's day care or respite care to support caregivers in the community. Two-in-five Nursing Homes support the Meals on Wheels service (42%), provide support for families providing care (40%), or provide assisted living apartments or affordable housing (38%) in their communities.



One-quarter of Nursing Homes provide activities and social interaction for non-resident seniors (25%) and transportation services (23%). One-fifth of Nursing Homes support access to nurses and medical advice (21%) in their communities. One-in-ten Nursing Homes (10%) open their doors for community events, religious services or public education activities.

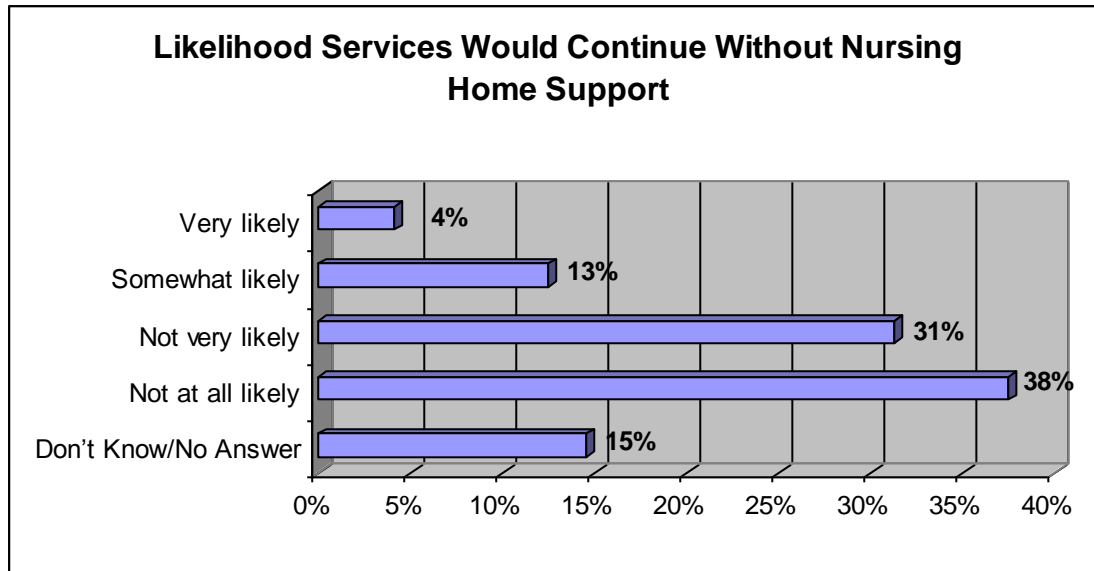
One-third of Nursing Homes (35%) support a diverse range of services, such as child day care, support for charitable activities, and health promotion, to their communities. Only four percent of Nursing Homes do not provide any services, beyond residential care, to their communities.

Since an overwhelming majority of Nursing Homes provide additional services to their communities, it is important to understand the financial relationship between the Homes and these affiliated services. Three-in-five Nursing Homes (61%) provide these affiliated services on a “break-even” basis. Only 15 percent of Nursing Homes say that they gain revenue from providing these affiliated services and a further 10 percent say that their Nursing Home subsidizes these services.



Almost one-third of Nursing Homes (29%) were unable or unwilling to provide an answer to this question.

Although these affiliated services are most likely to have a neutral impact on the revenue position of the Nursing Home, Nursing Homes are critical to the sustainability of these affiliated services in their communities. Over two-thirds of Nursing Home Administrators (69% not likely overall, 38% not at all likely) say that that is not likely that these services would continue in the community if the nursing home were unable to provide support. One-in-six Administrators (17% likely overall, 4% very likely) believes that these services would continue to be delivered without support from their Nursing Home.

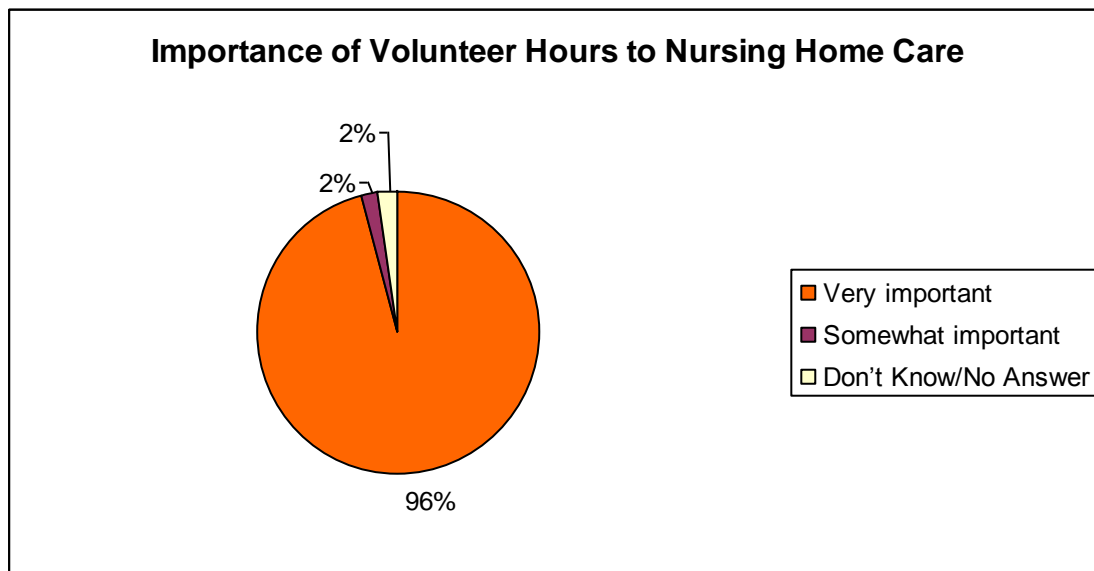


Fifteen percent of Administrators were unable or unwilling to respond to this question.

Volunteer Hours

In addition to the professional care provided by staff, Nursing Homes rely on a significant amount of volunteer time to provide activities and other forms of care that contribute to the quality of life of residents. On average, a nursing home receives approximately 365 hours of volunteer time per month. Overall, New Brunswickers volunteer over 23,766 hours each month to support the care, dignity and quality of life of Nursing Home residents.

Given the magnitude of this contribution, it is not surprising that 96 percent of Nursing Home Administrators say that this volunteer effort is “very important” to proving care, dignity and quality of life to Nursing Home residents.

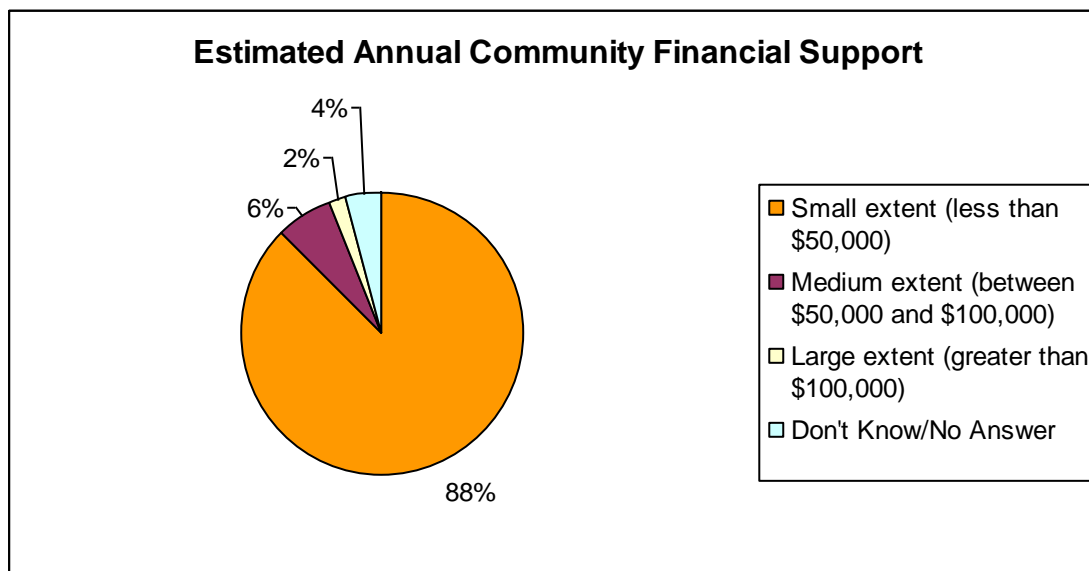


A further two percent said that this contribution was “somewhat important” and another two percent were unable or unwilling to provide a response to this question.

Community Support

Nursing Homes also rely on community fund-raising activities to support the purchase of equipment or otherwise subsidize the activities and services they provide. Administrators were asked to estimate the annual value of this community support to their Homes.¹

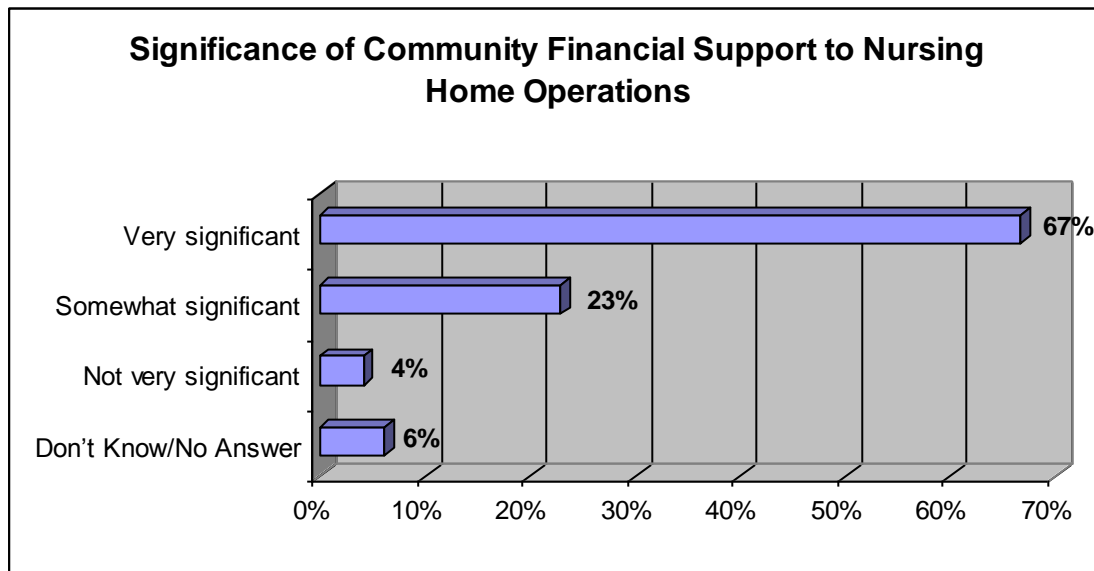
Nine-in-ten Administrators (88%) say that their home receives less than \$50,000 per year through community fund-raising activities. Six percent say that they receive between \$50,000 and \$100,000 and two percent say they receive over \$100,000 in community support per year.



Four percent of respondents were unable or unwilling to respond to this question.

Nine-in-ten Nursing Home Administrators (90%) say that this community financial support makes a significant contribution to their operations, with two-thirds (67%) stating that this contribution is “very significant.” Four percent of Administrators say that this financial support from the community is “not very significant” to their operations and six percent were unable or unwilling to respond to this question.

¹ It should be noted that these figures do not include the monies raised by foundations or charitable organizations affiliated with the Nursing Homes. Instead, this estimate refers only to the funds received by the Homes themselves.





Attendance & Disability Solutions

Progressive Strategies to Impact Better Attendance and Return to Work Outcomes

October 3, 2013

Key Market Trends

- Public Sector Transformation of Absence Management
- Increased Cost of Absence
- Increase in Mental Health Claims
- Aging Workforce and Chronic Disease
- Legislative Requirements (e.g. Accommodation)
- Engagement / Productivity
- Administrative Integration / Complexity

Key Challenges in Public Sector

- Need to transition sick leave and disability plans **from** being viewed as “an earned entitlement” **to** a “safety net” that helps employees get back to health and back to work.
- Need to shift focus **from** proving illness **to** support for medical and non-medical issues
- Engaging all stakeholders (employees, people leaders, labour groups, leadership) through change and ongoing participation

GNB Objectives

We understand that GNB is committed to finding opportunities to reduce cost of public service and that of publically funded corporations / agencies.

Attendance and Disability represents significant opportunity to reduce costs by 10-25% within a one year timeline.

\$1M - \$4M of net cost reduction potential at NBANH.

NBANH Current State

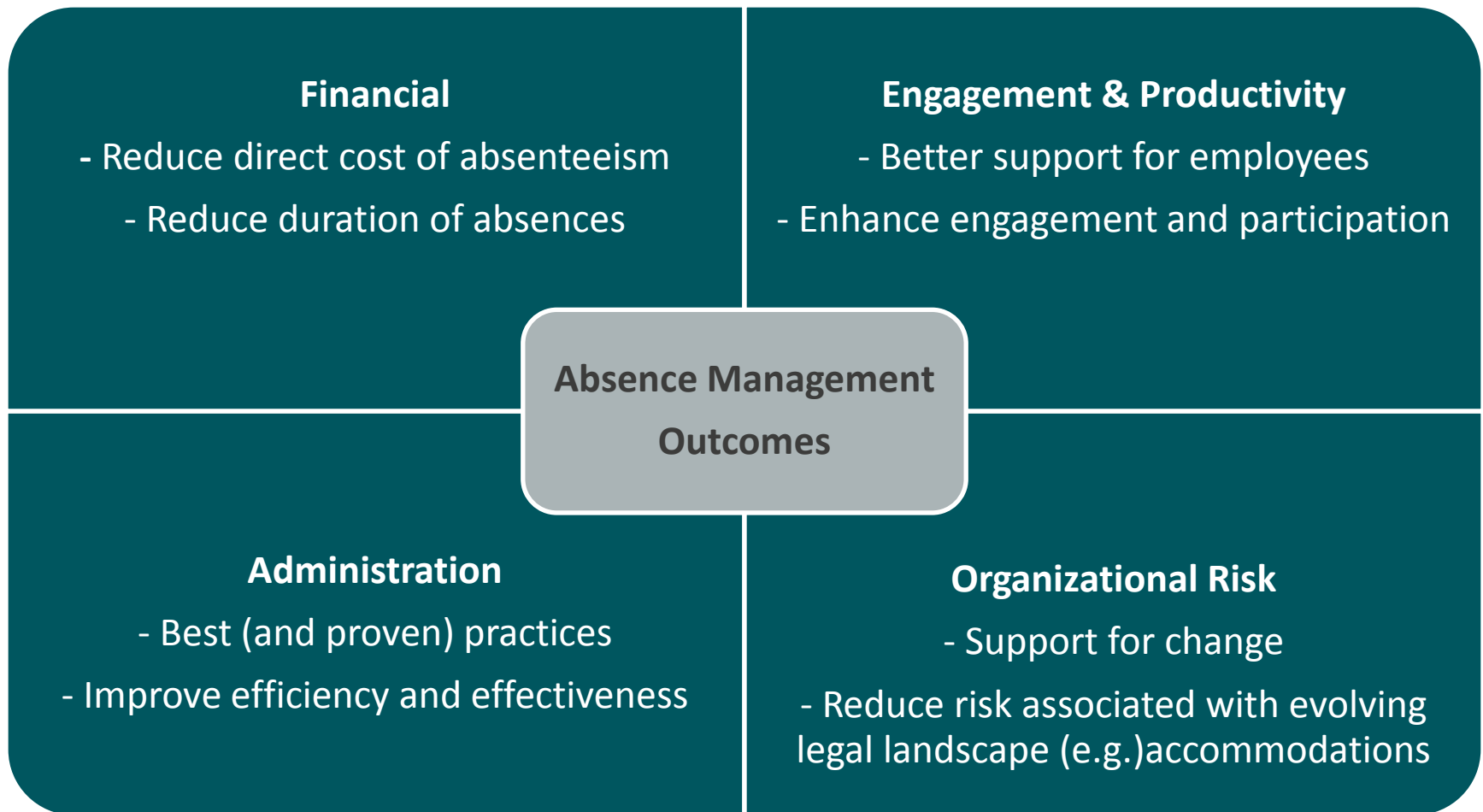
Number of employees	6,000
Number of paid days lost / year	15
% salary for reduced pay	100.0%
Benefit load (% of salary)	15%
Direct salary per diem - reduced for STD	\$150
Total sal. per diem - reduced for STD with benefits	\$173
Total days lost to disability	90,000
Cost of sick leave per employee	\$2,250
Cost of disability per claim (with benefits)	\$2,588
Total cost of disability (salary costs only)	\$15,525,000
Total cost of current disability program	\$0
Total direct cost of disability	\$15,525,000

Potential Savings

Target Reduction in Incidence	10%	25%
Average # of days lost	14	11
Reduction in Total Days Lost	2	4
Savings Due to Reduced Incidence	\$1,552,500	\$3,881,250

Approximate Program Management Costs	\$500,000	\$500,000
Net Increase in Program Costs	\$500,000	\$500,000
Net Savings	\$1,052,500	\$3,381,250
Direct cost ROI Ratio (to 1)	3.11	7.76

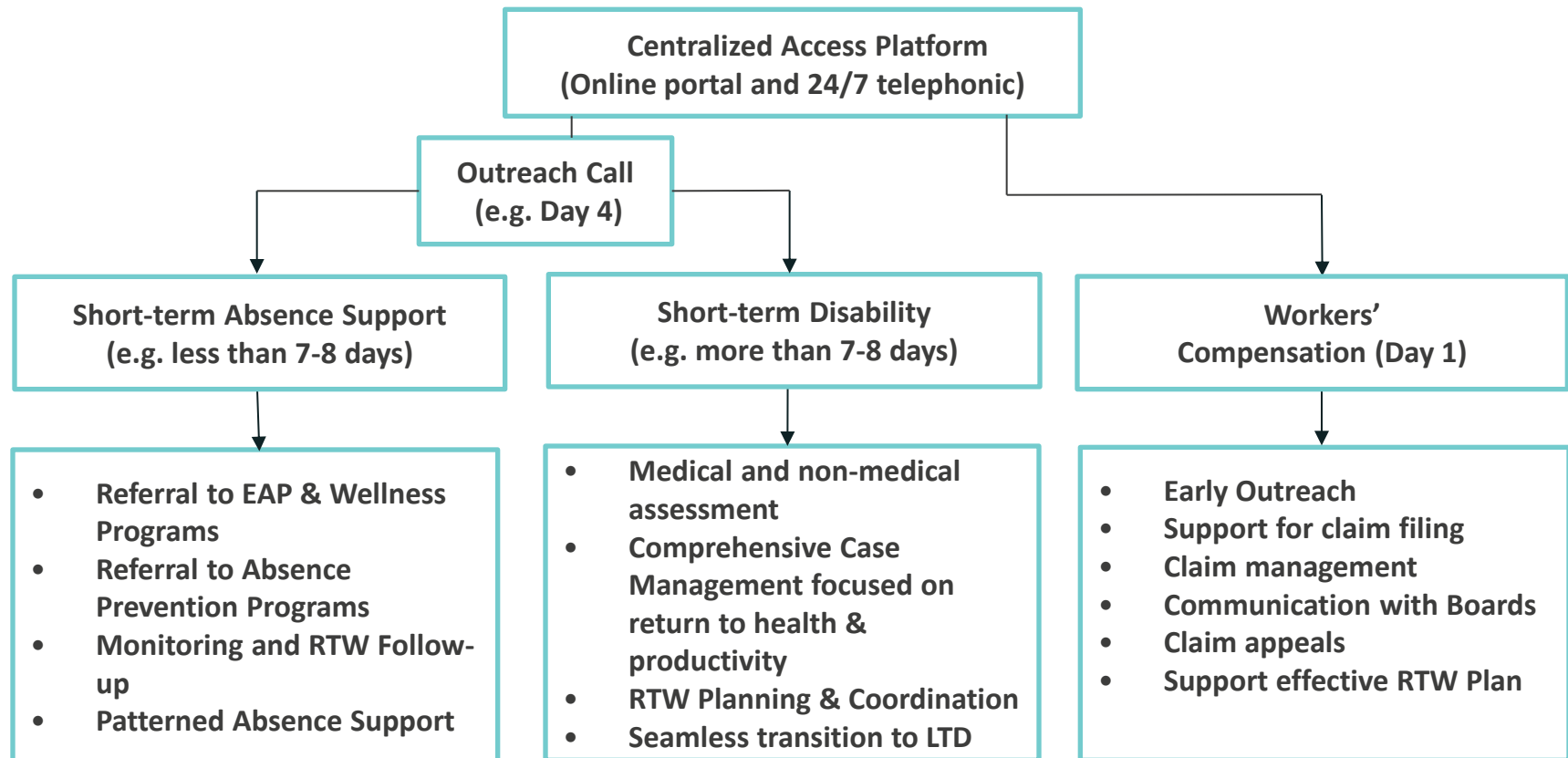
Impacting Better Results



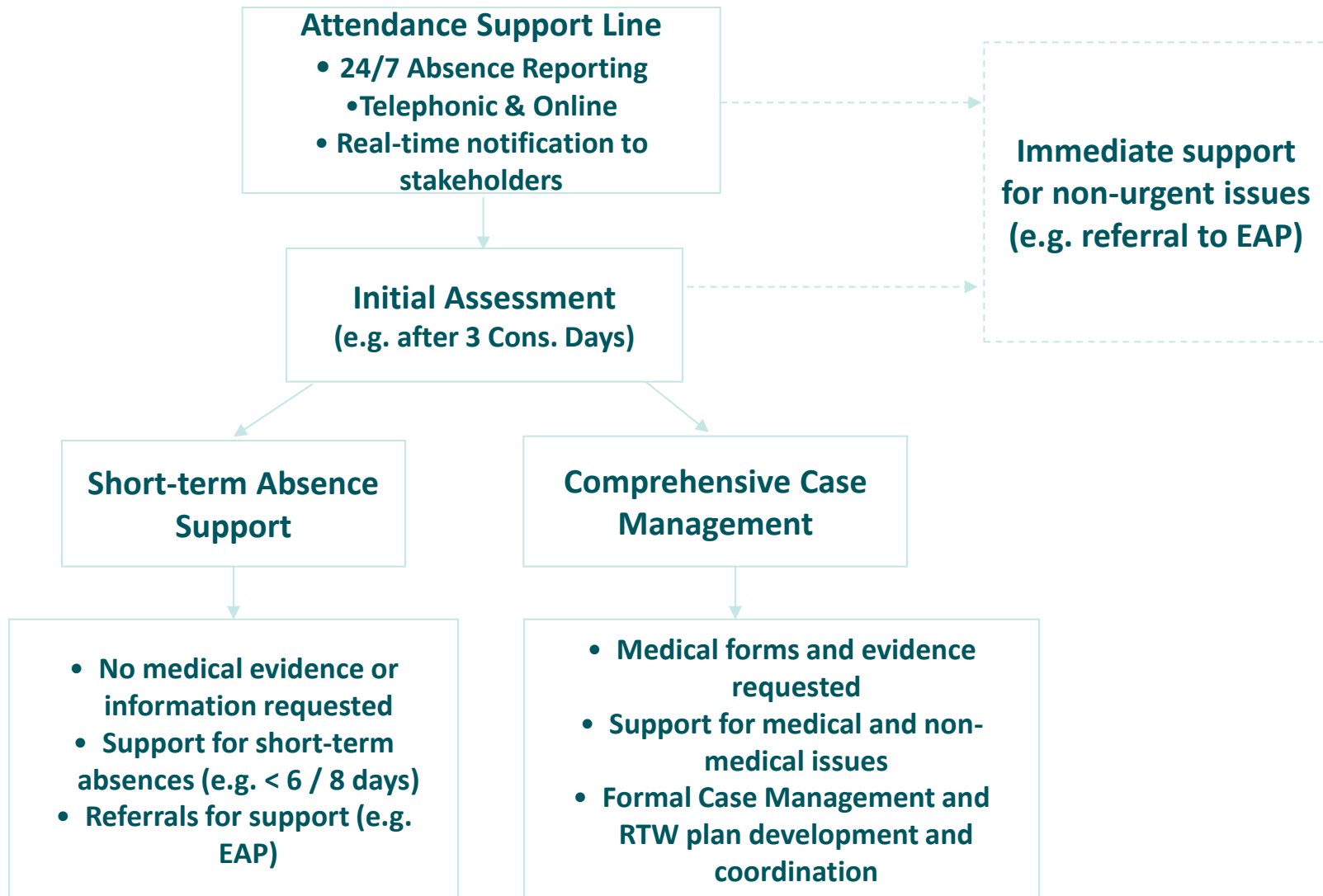
Integrated Absence Management Model

GOVERNANCE: Policy, Practices, Measures, Reporting

PREVENTION: EAP, Health & Wellness, Education and Training, Health & Safety



Integrated Absence Management Model



Case Management



Estimated Budget

- **Attendance Reporting (optional)**
 - \$300,000
 - › Assumes ~45,000 absences reported / year through telephonic access
- **Case Management Services:**
 - \$400,000
 - › Assumes 12% of employees meet trigger point (TBD) for intervention and case rate of \$500 and support resources
- **Implementation and Technology**
 - \$100,000
 - › Technology development, reporting, and maintenance
 - › Custom process mapping, protocol development, change management



Case Study in Canadian Public Sector: *Canada Post Corporation*

Case Study - Canada Post

Context

- Postal Transformation (redefining business model)
- Aging population with high level of sick leave credits
- Many young supervisors with no experience in disability management
- Adversarial system - significant number of union grievances and public complainants

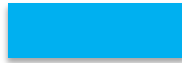
Opportunity Gap

- Significant operational issues caused by absenteeism and workplace accommodations
- Inconsistent management of disability claims
- Reliance solely on a medical model for assessing disability versus employee support and prevention
- Entitlement philosophy - need to shift culture from sick leave entitlement to wellness and income protection

Developed a Strategic Plan for Transition

Transition Timeline

Expand and enhance employee support/prevention services



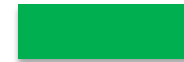
Align to industry best practice standards NIDMAR



Implement new disability management provider & processes



Conduct Postal Transformation disability management audit and strategic direction



Work with unions to transition from sick leave to STD programming



Implement new STD program and maximize cost savings

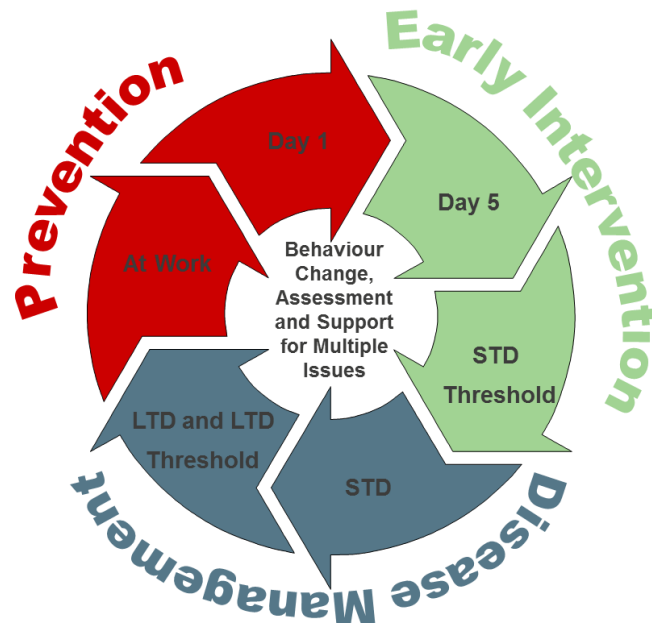


Maximized Utilization of Prevention Programs

Example: Employee Assistance Program (EAP) has a direct impact on Sick Leave

- 60% of employees who used their EAP reported they would have missed work without EAP assistance ¹
- Potential avoidance of 41,900 lost days if applied to all 5,021 closed sick leave cases

Best Practice Model:
integrated approach to
absence management



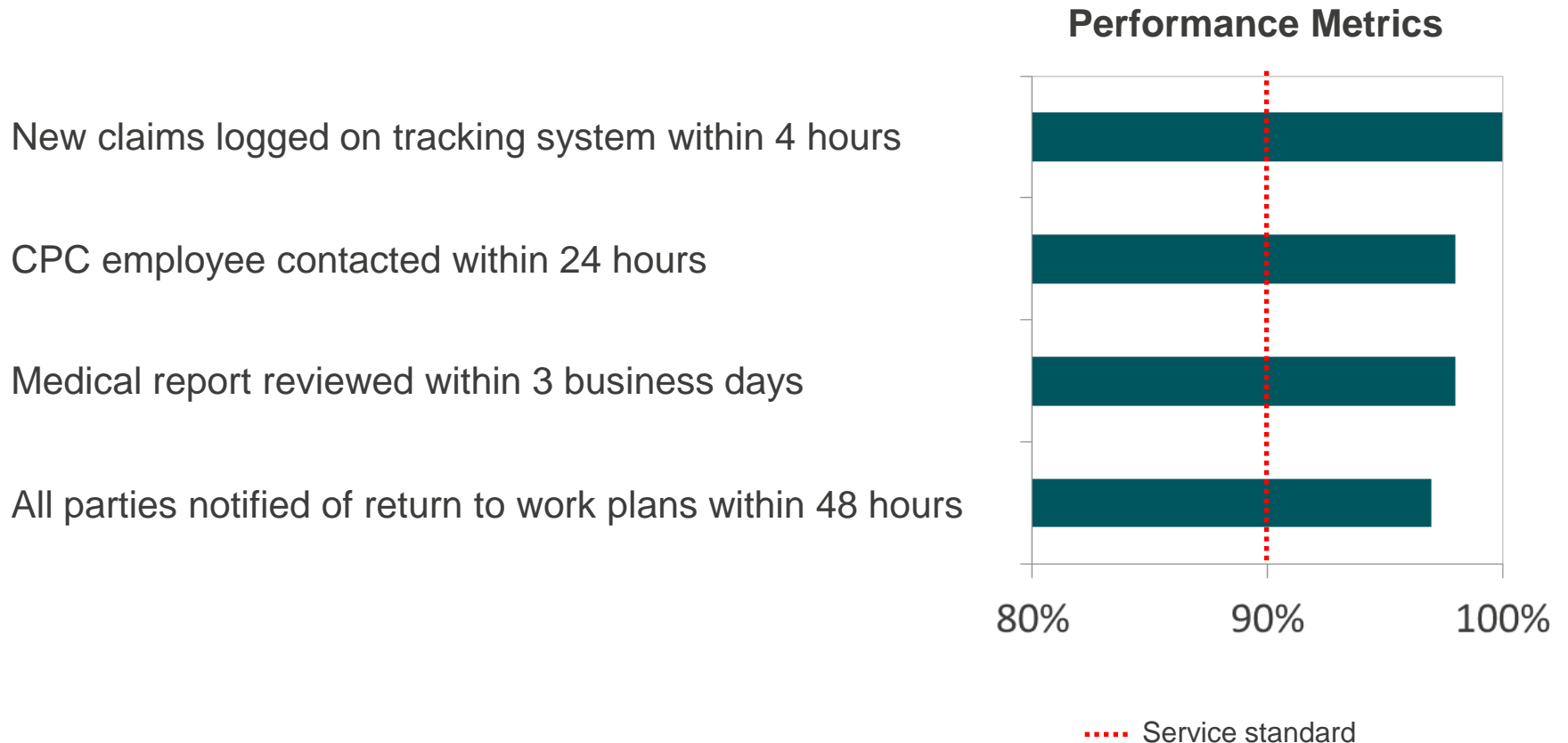
¹ based on a sample of 479 surveys
for closed counselling cases

Special Accommodations in the Workplace were Reviewed and Streamlined

Program Review¹ of Permanent Partial Disability (PPD) Claims



Implemented a Disciplined Process for Sick Leave and Disability Management





Case Studies in the Canadian Private Sector:

Proven Practices to Impact Better Outcomes

Case Study – National Airline

Context

- Significant issues regarding absenteeism for Flight Attendants
- Unionized environment - CUPE very active
- 14 day waiting period before Short Term Disability benefits begin

Opportunity gap

- Absenteeism 6 times national average
- Focus on replacement of worker rather than dealing with underlying issue

Solution

- Attendance Support from Shepell-fgi starting at day 1
- Leveraged EAP in absence management process
- Training for managers on Managing Absenteeism & Mental Health First Aid
- Manager support

Financial Outcomes

- **34% decrease** in average absence duration
- **41% decrease** in total number of absent days

Case Study – Utilities

Context

- Utility sector company with 3,100 employees
- Unionized environment
- Employees spread across Canada

Opportunity gap

- Fragmented and inefficient delivery of employee health services
- Lack of metrics and reporting – costs believed to be out of control
- Reliance solely on a medical model for assessing disability
- Union issues regarding attendance management reporting and manager intervention

Solution

- Fully integrated Health Management program including Attendance Support Line, Short Term Disability (STD) and Workers' Compensation claim management, EAP services and wellness services. Support in accessing benefit program.
- Worked with five of their unions to ensure a high level of engagement in program

Customer experience

- **38% decrease** in average duration of closed cases for STD
- **27% decrease** in number of WCB days lost per claims
- **69% decrease** in new LTD cases



**Supporting our Clients with Best and
Proven Practices**

Supporting Canada's Leading Employers

We are proud to support many of Canada's largest and most notable organizations with a range of Organizational Health Solutions.



Organizational Variables that Impact Absenteeism

- **Plan Design**

- Policy, CBAs
- Benefits Schedule

- **Plan Administration**

- Forms
- Process

- **Plan Support**

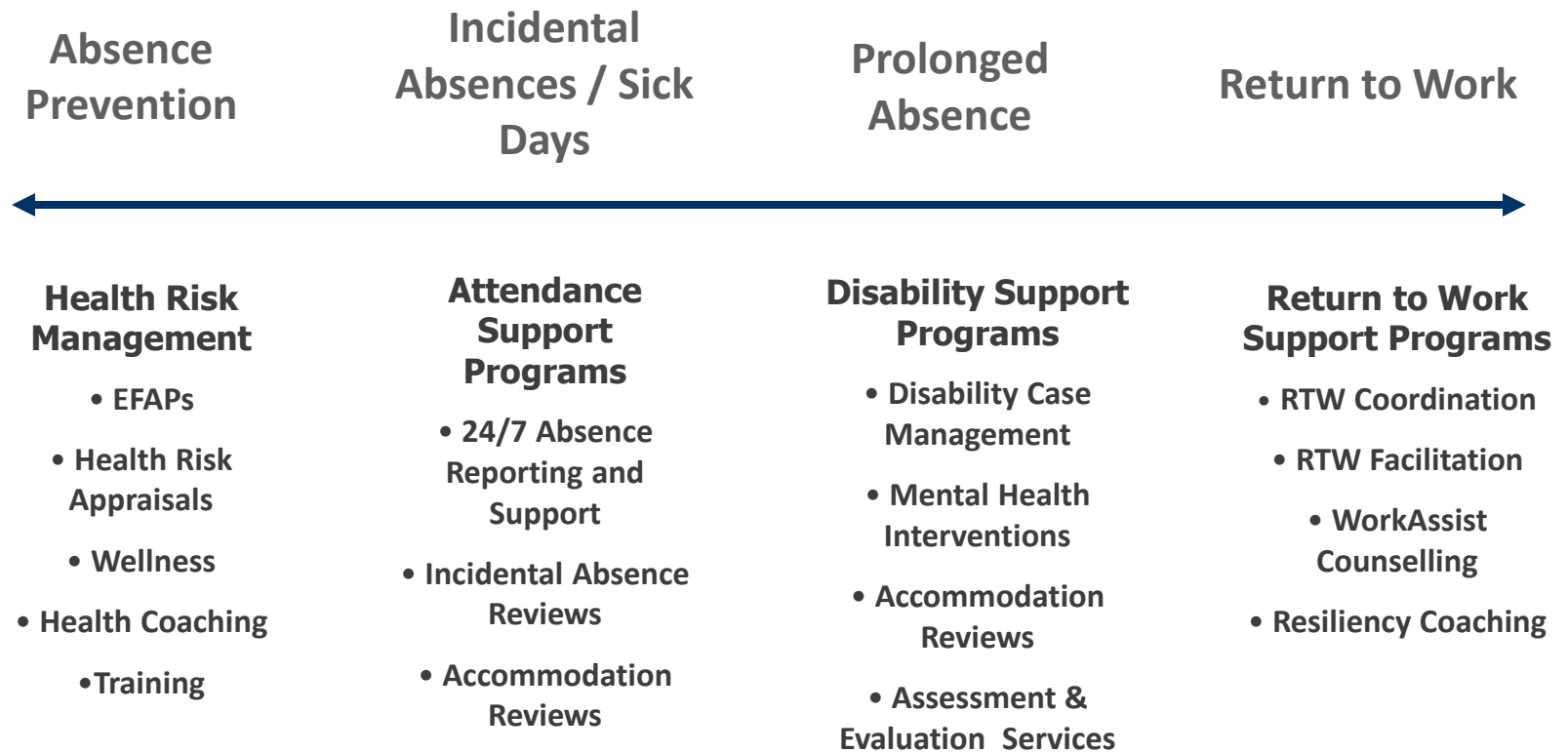
- Mental Health
- Return to Work

- **Organizational Culture**

- Entitlement
- Engagement



Integrated Solutions to Maximize Outcomes



Consultation, Design, Delivery.
Monitoring, Evaluation, Improvement.

Experience and Ability to Deliver Results

Largest provider of Organizational Health Solution services:

- 805,000 inbound calls annually & 200,000 outbound calls
- Handling over 110,000 attendance and disability (occupational and non-occupational) cases per year
- Supporting over 135,000 medical interventions annually
- 12,000+ face-to-face RTW facilitations
- 250 case managers and allied health management professionals
- National network of in-house medical consultants
- 40+ RTW Facilitators, 2,300 mental health experts
- In-house legal and paralegal resources dedicated to health practices

We have a proven track record building long-term relationships with our clients, with a retention rate of over 98%.

Commitment to Best Practices

Our commitment is to not only follow best practices, but to lead the development of innovative and high impact solutions.

- National Institute of Disability Management & Research (NIDMAR)
- Mental Health Advisory Board
- Internal Medical Consultants
- Innovations & Research Group
- Strategic Partnerships
 - University of Fredericton
 - CAMH, MDAO
 - Medaca, Baycrest, Cogniciti



Thank you!
