Long-Term Care in New Brunswick: Where we are and where we need to go

"As Canada's population ages and the complexity of patients' needs continues to increase, health care systems will need to adapt resource allocation to ensure improved patient care and system efficiency". – Michael J. Nolan MA, Katherine E Nolan BHSc, Samir K. Sinha MD DPhil

Preliminary note: This review is not exhaustive, there are many areas of long-term care that form to make the whole and a full assessment of them all has the potential to take more time than the present OCYSA long-term care review project has to summarize, formulate its report, and offer recommendations. What follows is a scan of some areas relating to long-term care in Canada (and specifically New Brunswick where possible) from the available publicly accessible data. Focus has been applied to areas of potential relevance with regards to formulating a pathway towards a better, more person-centered vision of long-term care service provision for New Brunswick. Areas of interest may emerge from the review process that refocus some parts of this literature scan, and this document may be amended ongoing, based on consultation with experts, community members and groups, and stakeholders.

Canada's ageing population and long-term care considerations

The 2016 census put the number of Canadians over 65 years of age at just under six million. Updated numbers for 2021 now have that population numbering just over seven million, or 19% of the total population. In the period between 2016 and 2021 an almost 20% change of persons over 65 was observed (Statistics Canada 2022), indicative of the rapidly ageing population in general. As of 2021, people over 85 represented 861,395 or 2.3% of the total Canadian population. It is predicted that by 2037 the population of Canadian seniors will grow by 68%, with the number of Canadians aged 75+ doubling (CIHI 2021a). In New Brunswick, the demographic proportions differ slightly from the national trend. Here, 22.8% of the population is over 65 (177,160 individuals – up from 19% of the population in 2015) and 2.5% are over 85 (19,040 people). We have, in New Brunswick, the oldest population in both Atlantic Canada, and

in Canada overall, which is why it is imperative to make sure long-term care is functioning here for New Brunswickers both now and going forward as we all inevitably age into needing it.

At the same time as the ageing population is increasing, the number of people aged under 15 is less than the number of people over 65, this inversion occurring for the first time in Canadian history back in 2015 (and at that time the differences were only slight - 16% under 15 and 16.1% over 65). Presently, across Canada, those under 15 represent 16.3% of the population (contrasted with the 19% over 65 mentioned earlier); in New Brunswick, this figure is lower: 14.3% of the NB population is under 15, contrasted with 22.8% over 65 (all figures taken from Statistics Canada). The median age in Canada is 41.9, while the median age in New Brunswick is almost 47; at the same time the proportion of households made up of couples with children has decreased from 25.6% in 2011 to 21.9% in 2021 – long-term care review and improvement is not just a concern today but will need to be an ongoing endeavor as the median New Brunswicker of 2021 will be turning 65 in a short 20 years. Addressing the strengths and deficits of the current system, and then building upon that foundation to improve quality and scope of service is essential. The National Institute on Ageing compiled a report in 2019 on the future cost of long-term care in Canada (MacDonald et al. 2019), where they used micro-simulation modelling methods to make projections about the ageing demographic in Canada. They predict that by 2050 there will be 120% more older adults requiring home care support, and over the same period there will be a 30% reduction in close family members potentially available to provide unpaid care (MacDonald et al. 2019).

The combination of declining fertility (resulting in a decreasing pool of available unpaid caregivers per senior, in addition to a decreasing pool to replacement labor as retirement removes workers from all sectors) and a demographic cohort that is ageing relatively rapidly as a proportion of the population is one factor in the need to reassess how we approach long-term care; one other major consideration is the greatly increased longevity and vigor of Canadians over 65. People are living longer, and in better health, than ever before and yet that added longevity also means the health concerns that accompany ageing are also experienced over a longer timeframe and are increasingly complex as time passes. New Brunswick itself faces additional challenges in this regard, with lower general health and a higher incidence of complex

medical conditions than the rest of Canada (Hull 2023). With an increased focus on home and community-based care programs, folks should be both able to, and encouraged to, age longer and safer, with higher levels of contentment, in their own homes and communities. Indeed, the vast majority of research indicates this is the preference of older people, and the outcomes are supported by research (e.g., Fulmer et al. 2021, MacDonald et al. 2019, Sinha 2020). Traditional approaches to long-term care that are facility-based may be appropriate for people needing advanced care, but there is currently a gap in services between people who need *gradually* increasing assistance and those requiring more acute care.

At the same time, we are seeing challenges (both ongoing and emergent) around access to programs and facilities for those in need. In New Brunswick, there are 29 long-term care beds per 1,000 people aged 65 and older (CIHI 2021b), but this number is not broken down across nursing home facilities versus special care home facilities. There are 70 (CIHI 2021c) or 71 (Radio-Canada 2022) or 72 (NBANH 2023) licensed nursing homes in New Brunswick, represented by the non-profit employer association the New Brunswick Association of Nursing Homes (NBANH). Of these nursing homes, 100% are privately owned, with 14% owned by for-profit organizations and 86% owned by non-profit organizations (CIHI 2021c). There are ca. 400 Special Care Homes in New Brunswick, representing about 7,000 beds (NBSCHA 2023). These are owned and operated by private, for-profit organizations and individuals per the licensing requirements of New Brunswick, the regulation and licensing of same overseen by Social Development. What is less clear, however, is how much oversight is actually afforded to Special Care Homes. When asked about the status of a proposed Special Care Home initiative by the CBC, the response from Social Development was: "Special care homes in the province are privately owned and operated…[we] recommend you either reach out to the facilities directly or the New Brunswick Special Care Homes Association…" (Blanch, CBC News 2022). While this particular issue was unrelated to long-term care specifically, it raises a concern with regards to how well integrated and cooperative the long-term care system effectively operates within New Brunswick. Ideally, the department overseeing long-term care in the province should be aware of, and able to address, any initiatives or operations linked to any and all of the organizations overseen.

Mentioned earlier, what people actually want is (and should be) a large and vitally important piece of the long-term care policy blanket. A survey by the National Institute on Ageing found that almost 100 per cent of seniors said they hope to age at home, as opposed to moving to a long-term care facility (Sinha 2020). While comparable data is less clear for New Brunswick, figures obtained from Ontario's Ministry of Health show that providing home care is also half the price of a long-term care bed — roughly $100/day compared to $200/day — and far less costly than a hospital bed, which costs approximately $700/day (Johnson, Foxcroft & Pederson, CBC News 2022). Home care clients in Canada receive, on average, 4.9 hours of care a week (as opposed to the 3.3 mandated hours[1] in nursing home facilities as of April 2022 in New Brunswick). According to the Canadian Medical Association, even if that number was increased to 22.2 hours per week, to reflect higher needs clients, it would still be cheaper than institutionalized care (CMA-Deloitte Report 2021). The future of long-term care may not be best served by private investment into more and more beds, at increasing cost; the increasing wave of research-based data shows that in-home programming is both ethically and economically beneficial and preferable for seniors and adults with disabilities requiring long-term care (McDonald et al. 2019, NIA 2019).

This situation was seen in practice in Denmark where, during the 1980s, that country identified a trend which is evident across the world today – increasing numbers of elderly people and a declining workforce, coupled with a decreasing resource of available family members to support their ageing relatives. What followed was a significant overhaul of the long-term care system. Significant investment and structural changes towards an array of home and community-based services (HCBS) reduced the need to construct new nursing home facilities (NIA Report 2019), and adaptive dwellings specifically designed for the needs of older people were mandated to replace nursing homes (Stuart & Weinrich 2001) such that the number of nursing homes beds actually decreased by 30% between 1985-1997, while the number of people

[1] Nova Scotia pledged in 2023 to ensure every LTC facility maintains a staff (RNs, LPNs and CCAs) to satisfy at least 4.1 hours of care per resident (which is in line with the new Canadian national standards); however, the NS Nurses' Union notes that 4.1 hours of care per patient is already 15-years out of date (CUPE Nova Scotia, Feb 2023). Pilot programs of a supported workforce supplying 4.1 hours of care per patient resulted in anecdotally-reported increases in worker satisfaction and a reduction in burnout.

65+ in Denmark remained stable (Stuart & Weinrich 2001). In 1985, Denmark was spending a large amount on long-term care and by 2001, the growth in LTC expenditures had leveled off, overall expenditure had dropped as a percentage of GDP, and expenses for the over-80 population decreased and appear to be decreasing still, compared to North America (Stuart & Weinrich 2001); Denmark seems to demonstrate that the investiture into alternative services and housing for elders seems to be successful in controlling costs for long-term care, as well as increasing security for both elders and their families (after 20 years of implementation – Stuart & Weinrich 2001), which should be cause for consideration globally as we face the same crisis of ageing. The move towards HCBS and supportive housing rather than institutional infrastructure allowed Denmark to both contain its growing health care spending, as well as significantly reduce the overall demand for nursing home care while delivering more care in the community (NIA Report 2019). Denmark, in fact, was able to avoid building any new nursing homes for close to 20 years, while also being able to close thousands of hospital beds due to reduced need (DIW Berlin, 2010). The country also saw a 12% reduction in its overall long-term care expenditures to the 80+ population during the first decade of its new approach (Stuart & Weinrich, 2001). The shift to HCBS in Denmark resulted in, between 1985 and 1995, a long-term care expenditure drop of 8%, from 2.4% of GDP to 2.2%; over the same time period GDP expenditure in the US (the comparator in the study) rose 53% (from 1.03% to 1.59%) – the differential magnitude based on proportion of elders in the US was not enough to account for this, the savings were real (Stuart & Weinrich 2001). During this same period the ratio of total expenditure for the 65+ population (as an aggregate) increased 8% in Denmark, versus 67% in the US (Stuart & Weinrich 2001). Currently, Denmark spends about 2.5% of its GDP on publicly funded long-term care health services (the proportion of GDP appears to be holding steady, neither increasing nor decreasing significantly) and of that long-term care funding, 36% is spent on care in designated buildings (e.g., nursing homes) and the remaining 64% is spent on home and community-based care, which is the reverse of the OECD long-term care funding average expenditure of 65% on care in settings like nursing homes and only 35% on home and community-based care (NIA Report 2019, based on OECD figures reported for 2017). By contrast, here is the spending situation in Canada, according to the National Institute on Ageing report (NIA Report 2019):

Canada spends 1.2% of its GDP on publicly funded LTC compared to the average OECD figure of 1.7%; in Canada we spend 87% of LTC investment in designated buildings and only 13% on home and community-based care; Canada's spending growth rate for LTC services (2005-2015) was also significantly behind other developed countries. OECD average: 4.6%; Canada's spending growth rate: 2%, which is at or below the rate of inflation (NIA Report 2019, based on OECD figures reported from 2017). Regardless of *how* long-term care is improved going forward, the most basic requirement is going to be greater fiscal investment both federally and provincially.

Person-centered care: not just a buzzword, but a philosophy, a system, and a practice.

Discussions around long-term care typically at some point reference a need to focus on person-centred care (PCC). But in consultation with some New Brunswick healthcare providers, there is a feeling that PCC has become something of a buzzword without a true understanding of what it is and how to implement it effectively. Indeed, for some healthcare workers, the mention of PCC seems like a burden, one more thing to add to an ever-increasing list of actions to implement. Some general clarity on person-centred care might be useful and will be briefly summarized here.

Originally depicted by Edith Balint in 1969 as "understanding the patient as a unique human being" (Santana et al. 2017), person-centred care has been an evolving concept which can often make understanding and implementation tricky. In its essential form, person centered care means "bringing back the person into care, and by doing that reinforcing the ever-present ethical demand to uphold dignity, providing autonomy, choice, and control, respecting decision-making and doing good" (Edvardsson 2015), and refrains from reducing a person to merely their symptoms and/or disease (Santana et al. 2017). At a global level, the Word Health Organisation itself has developed policy frameworks for person-centered healthcare (see resources list at the end of this document). Effective implementation of person-centred care across the continuum of care remains a challenge to most healthcare systems (Santana et al. 2017), and a conceptual framework towards implementation that is comprehensive, especially with respect to foundational changes needed for success, has been developed out of research carried out here in Canada (Santana et al. 2017). The particulars of this guide are detailed, but successful

implementation of a person-centred framework for healthcare can be broken down into three domains, each of which builds on the domain before it and all of which are interdependent: Structure, Process, and Outcome (Santana et al. 2017). To take the liberty of paraphrasing their central thesis, structure is foundational to successful implementation of person-centred care; without structure, you cannot build process; without process, you cannot measure outcomes. Without due diligence applied to the implementation of each domain, successful person-centred care models are doomed to fail to meet their full potential. The framework presented by this research is organized like a roadmap and clearly sets out detailed information surrounding the several important features of each domain, and how they interact. What I think may be useful to understanding the scope of successful person-centered care is to provide the requirements at each of the three domains broadly here (all taken from Santana et al. 2017):

- Structure (at the Healthcare system/Organizational Level)
  - Create a PCC culture
  - Co-design the development and implementation of educational programs
  - Co-design the development and implementation of health promotion and prevention programs
  - Support a workforce committed to PCC
  - Provide supportive and accommodating PCC environments
  - Develop and integrate structured to support health information technology
  - Create structures to measure and monitor PCC
- Process (at the Patient-Healthcare Provider Level)
  - Cultivate communication
  - Engage in respectful and compassionate care
  - Engage patients in managing their own care
  - Integration of care
- Outcome (at the Patient – Healthcare Provider – Healthcare Systems Level)
  - Access to care
  - Patient-reported outcomes

The concept behind person-centred care, while very integratable within existing healthcare systems, does require some structural changes in how we think about healthcare. The benefits are measurable, but it will take a commitment to apply person-centred care to the existing healthcare system from the foundation up. One of the key aspects to PCC is that it is flexible and creative, and should not become reductionist and standardized (Edvardsson 2017), which should be reassuring from an implementation viewpoint. The province of New Brunswick has committed in numerous reports to prioritizing person-centred care, and it can be done creatively (e.g., new approaches to healthcare, such as telehealth/e-health platforms can facilitate PCC and need to be consistently utilized and accessible to the public) as long as due attention is paid to the structural foundation underpinning person-centred care implementation moving forward. There are established patient-centred organizations, like Planetree (Stone 2008; see also resources list) that provide consultation services for the development of PCC services – frameworks and guidance exist, but governments and organizations need to commit to the structural prerequisites of person-centred care to enable a system to develop where process and outcomes can be achieved (Santana et al. 2017). Perhaps the greatest structural component is culture, which requires knowledge of what person-centred care is (and is not), and commitment to enacting it fully across the whole healthcare system including, but not limited to, long-term care.

Returning to the beginning of this section, where more than one voice has expressed concern with the concept of person-centred care being reduced to a buzzword without true meaning, this perhaps was never the intention but confusion existed around defining the term and clear pathways towards implementation. The concept of person-centred care is something everyone can relate to, in its simplest form. What must happen now is that governments and policy makers and healthcare providers need to collaboratively commit to this cultural shift in practice. Existing systems need to be open to accepting and/or creating innovative models that "are conducive to providing incentives to support and practice PCC" (Santana et al. 2017).

Alternative Levels of Care (ALC) – a growing concern.

The comprehensive 2019 report released by the National Institute on Ageing identified some areas of concern regarding ALC in Canadian hospital settings (NIA Report 2019). ALC is designated when a person is occupying a hospital bed but no longer needs the intensity of resources typically provided in that setting (NIA Report 2019, with data from CIHI in 2017). ALC designations capture people who are waiting to return home or to another setting to receive rehabilitation or long-term care and the ALC designation is most commonly applied to individuals who are being transitioned from acute care to nursing home care settings (Jutan et al. 2013). Specifically:

- On any given day, it is estimated that ca. 7500 patients with ALC designations account for 14% of the total number of hospitalized Canadians (Sutherland, Crump & CHSRF 2011).
- Older adults waiting for nursing home care are more likely to be designated ALC → 90%
    - But spend less time as ALC-designated in hospital → median 28 days (NIA Report 2019 with data from CIHI 2017).
- Older adults waiting for home care services are less likely to be designated ALC → 58%
    - But spend more time as ALC-designated in hospital → median 34 days (NIA Report 2019 with data from CIHI 2017).
- Some medical professionals (Simpson et al. 2015) estimate that providing more timely care at home, in community or in nursing homes could save $2.3 billion just from the savings on ALC-designated hospital bed expenditures (which is about 1/3 of the Canada-wide federal designated budget earmarked for improving access to home and community care).

In New Brunswick the number of ALC-designated patients in hospital is much higher than the national average and is closer to one-in-four, as reported by the Telegraph Journal in January 2023, with the waitlist for a long-term care bed at 811 people, 444 of whom are in hospital (Province changes nursing home bed priority process). It should be noted that the Coalition for Seniors and Nursing Home Residents' Rights reported in the same article that there were as many as 277 empty nursing home beds in the province, but that these cannot be used due to a staffing shortage. Putting things in perspective, Lim Fat and colleagues argue that "ALC status is

an indication of system failure in care quality and equity, placing vulnerable adults at further risk of functional decline delirium, falls, and infections, while incurring disproportionate healthcare costs" (Lim Fat et al. 2022), due to the increased risks associated with decline facing ALC-designated elderly patients the longer they remain in a hospital setting. They maintain it is important to advocate for measures of policy reform to address the overgrowing ALC population and the strain on the healthcare system in Canada.

Exploring the ALC situation in Canada, a procedural review by Sutherland and Crump (2013) observed that post-acute care, specifically a lack of capacity and flexibility of post-acute care, was directly related to the 'gridlock' facing hospitals. Hospital beds, by the very nature of having a fixed number of them, are the log-jam points of accessing the acute care system, and reducing the number of acute care beds being occupied by ALC patients is only possible when ALC patients have somewhere to be safely discharged to. It is also worth noting that Canada has one of the lowest numbers of hospital beds per capita of the OECD nations (Frank & Molnar 2022), which only exacerbates an already delicate situation. The situation as it was in 2011, which inspired the procedural review of ALC was thus: 35% of all ALC patients were 85+ and roughly 25% of ALC patients had been diagnosed with dementia (Sutherland & Crump 2013); as it stands now, over 50% of ALC patients are 81+ (CIHI 2021d) and of patients 85+, 46.8% have dementia (Lim Fat et al. 2022). One ALC patient occupying an emergency room bed denies access to that bed to four patients per hour (representing a real strain on the health care system that has many understandably concerned), however, while the public under 65 are gravely impacted by the ALC crisis the ALC patients themselves are suffering from that very designation. For an ALC patient, the prolonged wait in a hospital setting for post-acute care both prolongs that person's exposure to an environment that increases the likelihood for secondary disease acquisition (Baker et al. 2004, Lim Fat et al. 2022), and discharge delays for frail patients can lead to a rapid deterioration in health which necessitates additional acute care and/or premature admission to long-term care (Sutherland & Crump 2013). The options for reducing ALC patient numbers in hospital outlined by Sutherland and Crump are three-fold (and reflect the general conclusions of most contemporary reports):

1. Build more capacity. The advantages in theory follow that additional beds allow for a greater number of admissions and a reduction in elective surgery wait times, as well as theoretically improved access to acute care. They emphasize that this is both a costly and temporary fix – without addressing the underlying problem of safe and effective transferal of ALC patients to timely post-acute care, the 'more beds' approach could simply lead to more beds being occupied by ALC patients, which tracks against the projections of increasing numbers in the senior demographic cohort (expected to peak only in 2050, according to Statistics Canada in 2022).
   - There is an option to the build more model, wherein 'build-more' also applies to increased spending to expand post-acute care, however this also carries some risks and impediments: the specific types of post-acute care most needed would have to be identified, and infrastructure put in place to address the gap without under- or over-estimating the financial investment required to deliver the required level of service (from a policy standpoint). A lack of strong clinical evidence supporting appropriate post-acute care makes this task difficult and funding-policies, rather than patient needs, dictate patient post-acute care in most cases (Buntin et al. 2009; note: this study relates to research carried out in the United States). Sutherland and Crump (2013) note that this expansion of post-acute care may be 'an expensive experiment with no guarantee of success'.
2. Integrated care. Closer relationships between acute and post-acute care operators have been proposed as a method to improve the efficiency and effectiveness of healthcare resource use, as well as reducing failures of transitional care between settings (see Sutherland & Crump 2013 for further resources). In effect, this option might pressure the need to reduce ALC patient numbers by introducing administrative authority (or financial incentives) to ensure patients are treated at the lowest-cost care provider appropriate for their condition (Sutherland & Crump 2013). To date across Canada, this has been one of the driving factors behind regionalization of provincial healthcare, but the process seems not to have realized the goal. There is a demonstrable lack of integration among clinical guidelines, coordination, technology facilitating integration, integration/utilization

of non-physician healthcare professionals, and dissemination of information – all of which are necessary to an integrated model (Leatt et al. 2000), and this lack of integration can be seen in New Brunswick also. With regards to integrated care, there are a couple of things to bear in mind:

- Much of this research is based in the US and may not be completely generalizable to Canada. Effective implementation and integration of electronic record-keeping is poor in Canada, and there is a barrier and/or disconnection between the many private post-acute care providers and the public community-based mission of the hospitals.
- A pilot program in Quebec dubbed SIPA (Services Intégrés pour les Personnes Agées en perte d'autonomie) was similar to the PACE (Program of All-inclusive Care for the Elderly) pilot in the US. In the PACE model, organisations developed an integrated care program for people 55+ who have complex needs and where care is provided in the community rather than in a nursing home setting. PACE providers receive a capitated monthly payment for each patient under care, and thus had a financial incentive to keep people out of hospital. The results were significant reductions in hospital utilization and improved quality of care (see Sutherland & Crump 2013). In the Quebec SIPA pilot, the performance of community-based multidisciplinary teams that were integrated across health and social services were compared to 'usual' care. The finding was that the costs of community-based services were higher for integrated care, but facility-based costs were lower and there was a 50% reduction in ALC occupancy (Beland et al. 2006).
- Broader implementation may be limited due to the fact that these programs extend beyond the scope of simple healthcare and into social services (e.g., helping people find work and affordable housing, as well as navigating available government assistance programs); an additional limitation may be that these pilot programs integrated policies that focused on incentives to align providers with integrated models of care, and as such the integrated care systems may be underdeveloped.

3. Financial incentives. While not the norm in Canada, creating financial incentives to improve the quantity, quality, and/or effectiveness of healthcare has some evidence of success in other countries (e.g., Street & Maynard 2007), where it has been shown that healthcare institutions do respond effectively to such incentives. Canada's publicly funded healthcare is historically funded through global budgets. This creates incentives for cost controls, but also creates a situation where hospitals and post-acute care providers are at risk for changes in the volume or complexity of patients (Sutherland & Crump 2013).
    - Problems occur when there is an incentive to 'push' patients from acute care into a post-acute care system that is at this time limited in capacity. However, similar incentives could be developed for post-acute care providers to admit ALC patients as well as enabling these providers to create capacity for ALC patients.
    - While identified as a viable strategy for Canada, especially as it could be related to community-based care programs, Sutherland & Crump (2013) identified some barriers. The primary barrier is the *essential* need that these programs be closely monitored via regular, timely, and reliable data, to ensure that patients are not being discharged from hospitals prematurely, or being discharged into inappropriate settings. Again, this would require significant investment into procedures that link current practice guidelines and patterns of care; here perhaps would be an opportunity to streamline data collection with clinical guidelines, as well as links to data from telehealth program implementation.
    - Problematic for any incentive-based option, and imperative for this operation to work, would be the implementation of mechanisms that would <u>ensure</u> post-acute providers were prevented from only admitting less costly patients or flat-out refusing care to complex and costly patients. Sutherland and Crump (2013) state that these problems could be avoided by 'risk-adjusting' co-payments based on the clinical complexity or care needs of the patient. Once again, this could be facilitated by an effective electronic record-sharing program across care providers.

The takeaway from this Canadian review of ALC mitigation is that senior ALC patients in hospital beds is a problem that has remained unaddressed for more than a decade (Sutherland & Crump 2013). They said this in 2013 and, as we are engaged with this review in 2023, it is safe to say that the problem persists and remains inadequately addressed. The other takeaway seems to be that, essentially, efficiency improvement is the best pathway towards cost-effectiveness. Regardless of the manner in which it is achieved, reduction of ALC patients in acute care settings will save the healthcare system money *but only if the method effectively addresses the systematic cause of high ALC occupancy*. To take the liberty of paraphrasing, cosmetic fixes are doomed to fail unless underlying causes are proactively identified and addressed on an ongoing basis. Any combination of the options explored above might prove the best way forward, but what needs to be emphasized is that any of the policy alternatives suggested are most likely only maximally effective in concert with pointed ALC-reduction measures, like expanding primary care, improving continuity of care, and reducing avoidable hospital admissions (Sutherland & Crump 2013) – points that link to both procedural and cultural changes in the delivery of long-term care in Canada, and New Brunswick. We do have some evidence that community and secondary care provision can have significant impacts on reducing the effects of ALC occupancy on the healthcare system and improving healthcare outcomes for seniors (e.g., Frank & Molnar 2022; Lim Fat et al. 2022; Molnar 2021).

Reducing ALC time spent in hospital must also be a high priority for the sake of seniors' wellbeing and not limited to discussions on the ALC strain on the system. This means making sure there are proper and effective supports at the community level and follow-up monitoring measures in place for seniors returning home post hospitalisation. Without proper supports, seniors released into their own homes without adequate care risk becoming progressively homebound. Research findings from the United States show that homebound status is associated with a greater risk of death, *independent* of functional impairment or comorbidities (Soones et al. 2017); the result of a major study concluded that there is a need to "extend health care services from hospitals and clinics to the homes of vulnerable individuals" (Soones et al. 2017). It is estimated that about one quarter of Canadians aged 75+ have at least one unmet need associated with their activities of daily living (and this number may be underestimated);

unmet needs among seniors are associated with a variety of personal adversities, injuries, depression, and death, as well as being correlated with increasing systematic health care costs (e.g., higher rates of hospitalisation, increased risk of falling, and premature institutionalisation) (Sinha 2020). Improved home-based support for older adults must address healthy and independent living, which will improve both patient and systematic outcomes, and will over time save the health care system significant expenditure (Sinha 2020). Home-based supports should also aim to be significantly focused on preventative measures and rehabilitation, as seen in many European countries, to reduce the instances of preventable hospitalizations and premature entry into the long-term care system. Prevention and rehabilitation in home settings would seem to have a direct impact on reducing unnecessary hospitalizations and thus bringing down ALC numbers.

Go cautiously: how much should New Brunswick invest in for-profit nursing home models?

It has been projected that by 2035 Canada will require an additional 199,000 nursing home beds to address the care needs of the baby-boomer generation as they transition into higher levels of assistance required (Gibbard 2017). New nursing home bed stock will need to be added to every province to meet this demand. As has been previously stated, the special care home sector in New Brunswick is entirely private and for-profit, while the proportion of private for-profit nursing homes currently stands at 14% (the remaining 86% being private non-profit). With the introduction of private for-profit nursing homes in New Brunswick, and the financial allure that private sector investment often brings, it is important to examine whether or not private for-profit nursing homes truly represent an ethical option for planning around long-term care solutions.

The COVID-19 pandemic was globally devastating and disproportionately affected vulnerable groups, in particular elderly people in care home settings (Comas-Herrera et al. 2020). The reasons for this seem to be two-fold: nursing home residents typically are more frail than the general population, often with multiple chronic diseases and functional limitations, making them more susceptible to infection (Comas-Herrera et al. 2020); the second factor relates to the physical structure of traditional nursing homes themselves as congregate living environments,

often with many residents and staff living and working in close quarters and sharing facilities limiting the ability to contain infection spread (Kruse et al. 2021). The pandemic, while an extreme and unprecedented event, allows us to use health outcomes in care settings to assess the viability and strength of these settings and logically extrapolate that if outcomes were significantly poor during a pandemic, there are most likely underlying weaknesses to be mindful of. There are three organizational models for nursing homes: public, private non-profit and private for-profit. We can ignore the public model, as New Brunswick does not have any public nursing home facilities. We must therefore look at the general outcomes comparing the two types of private nursing homes. The 2020 New Brunswick Nurses Union's report on the long-term care sector warned that for-profit nursing homes perform poorly compared to non-profit outfits in practically every significant category, as well as underperforming in terms of value for money (Hull 2020). The review of Kruse and colleagues (2021) found that the relationship between all nursing homes and performance during the COVID-19 outbreak was complex, with three mediating factors: organizational factors (like size, chain affiliation, design standards), process (appropriate staffing, access to resources like PPE) and contextual factors. Once controlled for, the picture was not overwhelmingly clear, but several features are noteworthy in the context of future policy decisions relating to nursing home profit format:

- Negative COVID-19 outcomes were positively associated with larger homes; for-profit nursing homes are more likely to be larger.
- Negative COVID-19 outcomes were positively associated with chain-affiliated homes (due to staff potentially working across locations); for-profit homes are more likely to be chain-affiliated.
- Negative COVID-19 outcomes were positively associated with understaffed and under-resourced facilities; for-profit homes are more likely to suffer staffing and equipment shortages (due to the profit motive to promote financial savings through the reduction of labor costs and equipment expenditure, particularly as efficiency maximization results in running 'lean' in terms of stocked equipment, and the subsequent high cost of equipment in a high-demand scenario like a pandemic subsequently discourages the additional expenditure to restock – a bit like a PPE-preparedness catch-22).

To reiterate, the pandemic is an extreme example, but performance in a high-stress situation can be revealing in terms of the robustness of a profit model format and whether or not emphasis is placed on quality of care and service delivered to vulnerable clients versus maximizing profitability for corporate investors: who is *really* being served by the organization is an important question to ask. A for-profit provider is defined as an organization that operates with the objective to generate profits. A non-profit provider is expected to serve a social purpose and as such are theoretically prohibited from distributing their profits to other entities (Kruse et al. 2021).

Given the projected future need for additional nursing home beds (the true number required may be mitigated by alternative strategies like home and community-based care and adapted housing facilities, but the sheer size of the presently ageing generation will require additional nursing home beds and this must be addressed), and given that New Brunswick already has a mix of for- and non-profit service providers, there are two options to consider in terms of policy moving forward (Kruse et al. 2021):

1. Simply put, disincentivize for-profit operators in favour of non-profit (or public) nursing homes; or:
2. Improve the regulation of the underlying factors (outlined above) that appear to affect the quality of care delivered by for-profit providers.

Whether or not the province of New Brunswick ultimately decides to move away from private for-profit organisations, introducing clear and firm policy on size, minimum staffing standards, minimum staffing education and training, equipment stocks, and financial transparency (as examples and these are by no means the only areas requiring strong regulation and minimum standards to be set and adhered to) will enable improved outcomes among the existing private for-profit facilities, and provide clear expectation management when it comes to soliciting new nursing home facilities. The benefit of forming, implementing, and enforcing these policies across the entire long-term care sector is the resulting elevated, predictable, and standardized level of care our older citizens can rely on and trust regardless of the profit model governing the home they might find themselves in. One final recommendation, which will

enable the above, is the investiture in better public data collection to facilitate enhanced quality outcome monitoring of the measures of interest (Kruse et al. 2021). This outcome monitoring must be predicated on a clear set of desired outcomes for all care facilities and be consistently monitored, regardless of the business model of each facility.

Alternative models of senior housing show promise in both quality of care and experience, as well as reducing incidence of transmissible infections versus 'traditional' Nursing Home settings.

Following on from the above, attention needs to be paid to the physical format of long-term care facilities moving forward. As briefly mentioned, one indicator for how well a facility performed during the pandemic in terms of infection rates and health outcomes was the size of the facility itself. Larger nursing homes (>50 beds) fared the worst in terms of COVID-19 infections and mortality during the pandemic (Zimmerman et al. 2021), which can be used as an indicator of overall performance and exposure to risk for residents under 'normal' conditions. Proposed longer-term solutions to mitigating threats in the event of future wide-scale infection events focus on nursing home quality, staffing, and physical design. Countries like Denmark have invested in nontraditional adapted housing strategies since the 1980s (e.g., DIW Berlin 2010, NIA Report 2019), with positive results and in the wake of the COVID-19 pandemic, nontraditional small house nursing homes have come into focus more broadly.

One type of nontraditional nursing home is the Green House model, which is licensed by The Green House® Project (Green House Project). What makes this a useful example is not only that there is existing research on the efficacy of this particular model, but that model has an existing framework already in place and 20-years of implementation data to refer to. The Green House model is a prescriptive model of residential long-term or rehabilitative care, where residents are termed 'elders' and not patients, clients, or residents (Zimmerman et al. 2016). The essential elements of the model are centred around the core values of: 'real home' (e.g., small size, meals prepared in a central open kitchen, elder-directed living), 'meaningful life' (e.g., elder control over times they wake, eat and sleep, as well as providing access to activities in the broader community), and 'empowered staff' (e.g., staff consisting of self-managed teams of certified nursing assistants). The Green House® Project (GHP), in its own words, is "a not-for-

profit organization founded on the belief that everyone has the right to age with dignity. GHP seeks to protect this right by destigmatizing aging and humanizing care for all people through the creation of radically non-institutional eldercare environments that empower the lives of people who live and work in them" (Who We Are - GHP). In practice, while initial costs to establish Green House homes was higher, and the operational costs appear higher than traditional nursing homes (8% higher, based on data from the US), there seemed to be an overall decrease in healthcare spending associated with Green House homes possibly due to increased overall satisfaction of residents leading to fewer hospitalizations and hospital re-admittances, and fewer medical interventions (Zimmerman et al. 2021, Zimmerman et al. 2016). This aligns with other research suggesting that ageing satisfaction is associated with improved health outcomes and reduced healthcare spending (e.g., Nakamura et al. 2022). In addition, staff turnover appears to be reduced in Green House homes (Zimmerman et al 2021), possibly due to the emphasis of an empowered workforce and reduced burnout due to the smaller size of the home, the staffing mix, and the ratio of residents to staff.

Using the recent pandemic as an indicator of the overall robustness of long-term care facilities, the features of nontraditional small house nursing homes that appear to be impactful in terms of preventing and controlling infection are:

- Small size (10-12 residents);
- Consistent and universal staff assignments (limiting ancillary staff and thus uncontrolled movement into and out of the facility);
- Private rooms and bathrooms;
- Smaller overall space;
- Single, central entry point.

In terms of consequences, Green House/small nursing homes had markedly better outcomes than traditional nursing homes for infection and mortality during the COVID-19 pandemic (to date), and this held true compared to both traditional nursing homes with more than 50 beds and traditional nursing homes with less than 50 beds (Zimmerman et al. 2016). Differences in outcomes not directly related to COVID-19 infection prevention and psychosocial wellbeing may be driven by for-profit status, which we have established is repeatedly linked in

the literature with lower nursing home quality (Zimmerman et al. 2021). Green House homes are markedly less likely to be for-profit – in the US only 18% of Green House homes were for-profit, versus 69% of traditional nursing homes (Zimmerman et al. 2019) – and Green House homes are more likely to pay their certified nursing assistants higher wages than traditional nursing homes (Zimmerman et al. 2019). While this research comes from studies conducted in the US, the potential for Green House homes is being highlighted as a viable option in reinventing the LTC sector in Canada (Mancini 2021) with Quebec apparently committing to a version of the model, announcing in 2022 plans to open 46 facilities, known as Maisons des aînés, which would house 3,480 people (see: Quebec's nursing homes are betting big on the 'Green House' model). However, updates on the progress of the plan are difficult to find, and data would be limited at this point, such that assessing the impacts on the LTC sector in that province will take time. In the absence of freely accessible information, it should be noted that the Quebec investment into Maisons des aînés cannot possibly be a true Green House experiment, as 46 houses allowing for a maximum of 12 residents each could only house 552 elders, and not almost 3,500. More details of the specific model proposed by Quebec would be necessary to determine how close to a non-traditional nursing home these Maisons truly are, but it is encouraging to see the small house nursing home format being considered in Canada, given the success of nontraditional nursing home formats in other parts of the world.

Of course, there are other formats for non-traditional nursing homes that are equally valid and warrant further exploration – the appeal of the Green House example is that the framework already exists and has been studied and peer-reviewed over some years. The Green House model is one of several alternative housing models for long-term care called 'Homelike' models of care. As the name suggests, these facilities designed to feel less like medical institutions and more like homes. Mandatory features of homelike facilities are not strictly defined, but common elements of homelike care models include: small group living clusters; high staff-to-patient ratios; staff wearing casual clothes instead of uniforms; homelike furnishings; and natural elements such as plants, natural sunlight, and access to the outdoors (Gray & Farrah 2019). Philosophically and behaviorally, the sense of home is determined for residents through:

- psychological factors like: feeling acknowledged, preservation of habits and values, perception of autonomy and control;
- social factors like: interactions and relationships with staff, other residents, family and friends, pets;
- the built environment itself: existence of both private and public space, having personal belongings, access to technology, overall look and feel of the facility, outdoors spaces, location within community (Gray & Farrah 2019).

An updated review (Goring & Loshak 2021) found that comparison power was limited by the relative lack of large-scale research studies into comparing traditional versus homelike facilities. However, it is indicated there are benefits for homelike care over traditional care facilities in terms of: increased safety, increased overall wellbeing (statistically significant in one study comparing residents in Sweden versus Canada), decreased use of psychotropic drugs and restraints among dementia patients, and increased social engagement (Goring & Loshak 2021). They note that positive outcomes may also be intrinsically linked to adequate staffing as well as underpinning philosophies of the homelike care facilities (e.g., systematic and structural commitment to person-centred care models).

Other models of homelike care include the Butterfly Model, popularized in the United Kingdom and developed there by Meaningful Care Matters (formerly Dementia Care Matters). This model of care focuses on emphasizing the dignity of residents, in particular their emotional health and their community membership, and seeks to build a lifestyle around residents with dementia which reflects their unique needs and personalities. According to Prima Care Living Solutions, the private long-term care organization managing the first Butterfly Model accredited home in Ontario, the Butterfly model "…focuses on delivering emotion-focused care that connects with people in a dignified, human way. It addresses the holistic needs of the individuals and supports quality of life for each person living with a dementia across the whole of their lived experience." (Primacare Living Solutions). Butterfly Model living spaces are personal and engaging, with bold colours and homelike décor. The program has been widely adopted in the UK and is gaining traction in Ontario (CBC October 2018), but criticisms of the model lie in the

lack of evidence-based peer-reviewed research testing the model against traditional methods to clearly elucidate and evaluate the advantages of the program (CADTH 2019; CBC October 2018).

Eden Alternative is another homelike model of care based in the US which centers around seven fundamental aspects of care (identity, connectedness, security, autonomy, meaning, growth, and joy), which are surrounded and connected by 10 actionable principles aimed to alleviate distress associated with loss of ability within those seven aspects that are associated with ageing and age-related illness. The focus for this model is to move away from a hierarchical, or medicalized, model of care. The foundation boasts a 60% reduction in staff turnover, reduced antipsychotic drug use, higher performance ratings compared to non-Eden nursing homes, and significant positive impact on clinical measures, quality of life, financial outcomes, and overall well-being, which does seem to be supported by research (Galina & Haseltine 2019). Developed in the 1990s by Dr. Bill Thomas (who also developed the Green House Project), the Eden Alternative model is adaptable as residential, home, or community care for not only the elderly or people living with dementia, but the housing and care model could also be implemented to serve and support individuals living with mental health, cognitive, or developmental challenges (CADTH 2019).

The Hogeweyk Care Concept (also known as Dementia Villages) grew out of adaptations to a traditional nursing home in the Netherlands in the late 90s and early 2000s (CADTH 2019). The goal was to deinstitutionalize, transform, and normalize" care for people with advanced dementia (CADTH 2019). The space is comprised of 23-27 townhouses, each one representing one of seven common differing typical Dutch lifestyles and residents are placed in the most appropriate setting, a decision made in consultation with the resident and their family (CADTH 2019, Vinick 2019). Residents manage the household and carry out activities of daily living as they are able, with support and encouragement by staff (Vinick 2019). The village is a secured residential facility and residents are not able to leave the village unaccompanied but the design avoids false exits or locked doors that can confuse residents. Additionally, the other features of the village, like restaurants, cafes, a supermarket, a pub, are open to the community and the residents families, increasing the engagement and integration between the community and the residents (CADTH 2019, Vinick 2019). The Hogewyk village has also served as an inspiration for

other Dementia Village concepts (e.g., Germany's Tönbeön am See) as well as furthering the conversation around what ageing with dignity can look like and how it can be achieved (Haeusermann 2018). The Hogeweyk model uses many adaptive design features aimed at reducing stress and maximizing autonomy of elderly dementia residents and many of these features can be applied to existing long-term care settings to improve the lived experience of dementia patients without the need to adopt the entire Dementia Village concept which might be limited by logistical impediments (Vinick 2019).

Home Care – Do alternative healthcare delivery methods like 'nursing homes without walls' and paramedicine offer potential for both remote and urban communities in New Brunswick?

There are an estimated 1 in 5 seniors in residential care that have needs similar to those of individuals that are supported in the community. In other words, 20% of long-term care residents are only limited from ageing in place by lack of availability or access to community supports or programs (CIHI 2021a); while there are several factors that increase the likelihood of a person being admitted to residential care (these include in decreasing order of influence: cognitive impairment, a need for physical assistance, living alone, a caregiver who is unable to continue, and wandering behaviors), the single greatest factor is being assessed in a hospital setting rather than in the community. Seniors with moderate priority are 8.7 times more likely to be admitted to residential care and seniors with very high priority are 3.5 times more likely to be admitted to residential care (CIHI 2021c). The importance of ageing at home with appropriate support, while reducing social isolation are repeatedly emphasized as key areas for empowering seniors and increasing positive outcomes (McDonald et al. 2020)

In 2015/16 the New Brunswick Department of Social Development, in collaboration with the Department of Health, launched a three-year strategy called 'Home First' that was to be a plan for sustainable healthy ageing services for New Brunswick seniors, focusing on three pillars: healthy ageing, appropriate supports and care, and a responsive, integrated, and sustainable system. The strategy was set out in a 21-page document (PNB Report 2015) featuring 36 total initiatives across the three pillars, but updates on the status of these initiatives are not available through the Home First portal, with the exception of one initiative offering information about

community engagement and fall prevention, and another relating to the availability of a minor ($1500) home improvement grant to low-income seniors enrolled in a home-safety assessment program[2].

The two departments also supported the Council on Ageing to develop an ageing strategy for New Brunswick (New Brunswick Council on Ageing 2017), addressing short-term sustainability and long-term transformational change. The strategy was to be the foundational framework guiding action on issues affecting seniors and the ageing experience in New Brunswick. The report was comprehensive and laid out a pathway towards implementation of change and improvement in the long-term care sector. It is not clear at this point how much of that report has been implemented or put into a process of action.

The exact date is unclear, but around 2018 a $75 million agreement was reached between the Government of NB and the Public Health Agency of Canada to embark upon the Healthy Seniors Pilot Project (HSPP), jointly led by the Department of Social Development and the Department of Health via the Seniors and Healthy Ageing Secretariat. In February 2021 it was announced that 39 applied research projects had been approved under the HSPP, representing almost $50 million of the total investment. The call for proposals closed on May 11, 2021, and results were to be communicated once the review and approval process was complete. As of May 2023, no further information on what these projects are appears on the HSPP page in the Social Development section of the GNB website. As of November 2021, during

[2] The Home First portal of the GNB Social Development page has a total of three sub-pages (as of August 2023); one concerns connecting to community services, one concerns reviewing safety awareness, and the other concerns a minor repairs grant. Each one is less an access point to resources and more general information. For example, under Accessing Community Services, the page tells you it's good for your health to be active in the community; they direct you to a telephone number to call to find out about activities in your community, or they helpfully tell you to go look at bulletin boards at the grocery store or other shops in your community. There is also a link to take you to Senior Resource Centers, which leads you to a page devoid of any content. Clicking on the reviewing safety awareness link, you are given some information on the hazards of falling and how to avoid them (the answer is keeping up with home maintenance and adding adaptations). You can apply for a home visit (presumably to assess the potential hazards in your home, although this is never clearly stated) but there is no link or phone number to arrange such a visit – this information is found over in the Supports NB page (which is not linked to). The third link is the minor home repairs grant, where you need to have already completed the Seniors Health, Well-being & Home Safety Review to be eligible. There are also links to three 'resources' for the Home First program, all of which are versions or subsections of the Home First strategy document itself, and do not offer new content. Going by the information found over on the Supports NB website, the entirety of the Home First program, as of 2023, is about being assessed for minor adaptations to the home to make it safer and then possibly applying for the $1500 grant.

a press release about new services for seniors, then-Minister of Health Dr. Dorothy Shephard did not mention the Home First program but did mention rolling out a plan for extending social services and creating 'nursing homes without walls' to facilitate ageing in place. While mention was made of the HSPP, no update was made at that time (Ibrahim, H. 2021 CBC); it would appear by scrolling through their website that the University of New Brunswick has potentially 66 projects relating to the HSPP, but finding a lack of any official press release from the government or any information on the HSPP page of the GNB website about the program is troublesome and misses an opportunity for the community to be made aware of any positive initiative outcomes or plans for implementation[3].

What can be surmised from these three initiatives by the Government of New Brunswick is that effort and research has been applied to finding workable solutions around offering expanded home and community-based care options, in line with current best-practice knowledge. Understanding why these programs have stalled or fallen short of their goals is a question that can only be addressed by the Departments of Health and Social Development, but one impediment might be a lack of innovative ideas for implementation and gaps in service provision in remote locations as well as overly burdened urban centers. To reiterate, currently, the preponderance of research supports the idea that ageing at home is not only what seniors desire, but that when programs put in place that enable seniors to do just that, there are multiple knock-on benefits to both the community and to the healthcare system. Indeed, most OECD countries have initiated some form of 'deinstitutionalization' of their long-term care sector in recent years, with more than half of the OECD countries transferring public long-term care spending away from residential care and towards home-based care (OECD 2020). Home care programs improve health outcomes, foster greater satisfaction among seniors themselves,

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[3] The NB Seniors and Healthy Aging Secretariate office provided the following information on the current status of the HSPP projects: "HSPP was funded by Public Health Agency of Canada to support applied research with the goal to support healthy aging. Under the portfolio we currently have 67 funded projects that are piloting different interventions and approaches. Projects have until March 31, 2024 to complete their research and this will be followed by [a] final year to do an analysis and evaluation of the overall HSPP portfolio." An email request for more information about the status of the budget, the projects themselves, plans for implementation of promising pilots, or a timeline for making result-based recommendations was not returned (June 2023).

reduce costs to the healthcare system in general, and alleviate unnecessary strain on emergency and hospital infrastructure (there are many research papers that report these facts, but why not cite the Province of New Brunswick itself: HOME FIRST, a report delivered in 2015). This research is freely available and there is no real need to rehash it here. What *can* be a barrier to the delivery of in-home and community-based care is accessibility. In both urban and rural environments, access to services remains a hurdle across the globe. There are some promising results, including within Canada, in the utilization of existing paramedical professionals and paramedical infrastructure through community paramedical programs.

The concept of 'nursing homes without walls' mentioned by the former Minister of Health is a concept that came from unique research conducted in New Brunswick (Dupuis-Blanchard & Gould 2018) and is one known program that was funded by and developed under the Healthy Seniors Pilot Project. Specifically, it refers to the idea that nursing homes, by virtue of already being in the community, would be able and willing to expand their services into the community as a way of facilitating home and community care; indeed preliminary research that first identified what services seniors felt were needed to age in place found that nursing homes in the four initial focus communities believed that the services identified by seniors could be offered either by expanding services into the community or by having community seniors attend the nursing home for activities (Dupuis-Blanchard & Gould 2018). The concept was turned into a pilot project with the stated goal being to enable older adults to remain in their homes longer by giving them access to supports and services offered by participating local nursing homes. Services differ by community after consultation both with the local nursing homes about the existing services they provide, as well as the needs of the local community seniors (ResearchNB 2023). The program started as a pilot study in 2019 with four participating nursing homes, which was expanded in 2022, stating that by 2023 16 nursing homes would be participating in the project (GNB 2022). In October 2023 the Government of New Brunswick announced that the Nursing Homes Without Walls program would be expanding, with a predicted 20 participating nursing homes joining the program by the end of the year (GNB 2023). Innovation like Nursing Homes Without Walls is a great example of taking exiting infrastructure and maximizing its

potential to benefit the New Brunswick community and hopefully the program will see continued support and success.

Community paramedicine began as a grassroots movement among paramedics who recognized the need for new services that emphasized a more proactive and preventative approach to care and saw how utilizing paramedics in expanded roles could fill gaps in care within communities, especially as paramedics had the flexibility to create and apply these services (Nolan et al. 2018). There are two paradigms within existing community paramedicine programs: a preventative/follow-up care model and a reactive model (Guo et al. 2017). The preventative model aims to reduce the incidence of unscheduled/emergent care by working collaboratively with physicians and other primary care services to offer assistance with chronic disease management, health promotion/education, and early intervention. The reactive model is one where paramedics respond to calls for unscheduled care (via traditional 911-type dispatch services), and a patient is subsequently treated for low-acuity presentations in their own home and any necessary follow-up care is referred to the patient's general practitioner (ideally).

There are various iterations of these community paramedicine programs already functioning in Australia, the UK, the US and here in Canada (Guo et al. 2017, Nolan et al. 2018). Nova Scotia has a practitioner-paramedic-physician model in place on Long and Brier Islands, to overcome challenges faced by these remote island communities that had both limited and complicated access to larger community centers. These programs intersected with long-term care models as the population of these island communities stood at 50% over the age of 65 when the program started. Paramedics expanded the services they were able to provide, through collaboration with a nurse practitioner and a physician, access to more complex care (e.g., wound care and immunization) as well as community health education promotion (e.g., injury prevention, access to services and supports). In 2005 Emergency Health Services in Nova Scotia established community paramedic competencies (Guo et al. 2017). As a model for remote centers, or communities facing a shortage of primary care services, this program offers a guide for other Atlantic provinces, like New Brunswick, towards community paramedicine implementation. The implementation of this Nova Scotia community paramedicine program resulted in a reduction of annual trips to emergency departments by 40% and decreased the

overall annual expenses for health care from $2380 per person to $1375 (Nolan et al. 2018). There are also various iterations of community paramedicine programs (serving both urban and rural communities) in place in Ontario, Alberta, Saskatchewan, and British Columbia. As of 2014 over 50% of Ontario residents had access to community paramedicine programs within their communities/municipalities and in 2016 the British Columbia Health Minister announced an expansion from the eight initial communities included in the prototype phase of their rural and remote paramedicine project to incorporate 72 communities (Guo et al. 2017). Saskatchewan offers a mobile Primary Health Bus service in Saskatoon which is designed to reduce barriers to healthcare faced by people who are geographically, socially, economically, or culturally isolated. The service has been successful in building relationships with community residents (Guo et al. 2017).

Nolan and colleagues describe the current situation most succinctly:

> *…as Canada's population ages and the complexity of patients' needs continues to increase, health care systems will need to adapt resource allocation to ensure improved patient care and system efficiency. The promise and potential of paramedicine practice to evolve beyond traditional emergency response is being realized across Canada and beyond…that will further advance the delivery of health care and the overall sustainability of our healthcare systems* (Nolan et al. 2018)

New Brunswick has a uniquely rural spread in terms of population, which creates challenges in access to services, including long-term care. Nearly half of the seniors in New Brunswick live in rural communities (more than double the national average), which makes centralization of services basically impossible (Hull 2020). We need to be innovative and think outside the box to address gaps in long-term care service provision, and perhaps community paramedicine has unrealized potential for New Brunswick and the provision of in-home services for seniors.

Adults with Disabilities and Long-Term Care

There is one group that falls under the long-term care umbrella but who are not necessarily encompassed within the senior bracket. These are adults with permanent and long-term disabilities who require daily assistance with living over the course of their lives. These Canadians needs to be acknowledged and supported and must be considered in any discussion about improving long-term care delivery in New Brunswick.

Though many of the points raised here are transferable, we should note that the disability rate is 26.7% in NB (S. Wagner, *pers. comm*.) and adults with a disability are represented within LTC facilities as follows (all data provided by Inclusion NB):

- There are approximately 475 adult residential facilities in the province providing care and services to roughly 7,000 residents, and not all of these residents are seniors.
- Special care homes provide care to about 4,000 seniors as well as to 1,863 adults with disabilities.
- Memory care and generalist care homes provide care to 532 people.
- Community residences provide care to about 595 people, the majority of whom are adults with a disability.
- Persons with a disability are 22.7% more likely to be designated ALC (a percentage which is higher than the average for seniors, which is 19.9%)

A report was recently undertaken (Bartnik & Stainton 2023) in the wake of a Nova Scotia court case in which the Disability Rights Coalition (DRC) sued the province of Nova Scotia over the right of people with disabilities to live in the community. In 2021, the Nova Scotia Court of Appeal decision found that there is systemic discrimination in Nova Scotia against persons with disabilities in the provision of social assistance. The DRC and the Department of Community Services (DCS) through the Disability Supports Program (DSP), then initiated a review process with independent experts (Bartnik & Stainton 2023) to develop and recommend a remedy to end this discrimination and change the way that supports are provided in Nova Scotia. This report produced 6 key recommendations:

- Build a new system of individualized planning and support coordination to drive more person-directed and local community-based supports and services;

- Implement the closing of institutions;
- Build a broader system of community-based supports and services – a home and life in the local community;
- Implement a province-wide multidisciplinary support program with regional hubs including other clinical supports to support local options;
- To use individualized funding as the basis of the transformed system with "backbone" support functions;
- An overall strengthening of the whole disability system capacity to enable transformation to a human rights approach.

Research by Esteban and colleagues (2021) assessed the professional practices aimed at promoting the right of people with intellectual disabilities and extensive support needs to live and participate in their community, alongside other related rights, such as that to privacy or to habilitation and rehabilitation. Their results reveal that people with extensive support needs receive less support in terms of guaranteeing their right to independent living and privacy, and that emphasis must be placed on the importance of performing well-planned deinstitutionalization processes that are not just limited to mere relocation in other spaces (Esteban et al. 2021). Organizations that provide care for people with intellectual disabilities should transform their support model from a traditional approach to rehabilitation into one that is linked to the rights gathered in the Convention, and to the improvement of individual quality of life.

Given that there are a significant number of adults with disabilities living within communities and also in long-term care facilities, and given that the research into the needs of these significant members of our society emphasizes the great importance of non-institutional services and community engagement, the research supports the goal of increasing access to services outside of traditional care home settings and putting long-term care back into home-based and community-based endeavors.

Final Note on Seniors, Support Care Workers, Informal Caregivers, and Culture

Consultation throughout this review has brought up time and again the idea that there is a culture shift necessary in the long-term care delivery sector – that the culture of long-term care homes, the silos that represent different aspects of long-term care, the departments overseeing long-term care, its regulation, and the citizens requiring access to it; all these different 'offices' within the long-term care network need to work collaboratively and transparently, and not competitively. The term 'culture' is an interesting one, as it can often be used to reflect the mood within an organization but at its root it refers to whole communities. Within the western hemisphere, there has been a sustained cultural shift away from seeing the value of our elders – they are a high-needs group to be compartmentalized and managed. The Ministry of Long-Term Care in Ontario highlighted this "social devaluing of elders and elder care" (MLTC 2020, p. 23). Seniors are a vulnerable and often marginalized group. So too are those who do the majority of work caring for seniors: a comparatively high proportion of Personal Support Workers (PSWs, or Continuing Care Workers – CCWs – in some jurisdictions) are women and people with visible minority status, as well as people with an existing disability, and older-age (workers over 50 years old) working people (Zagrodney 2023), all representing vulnerable minority groups themselves. These workers need to be supported and valued in order to be able to deliver high-quality work in this culturally important sector: we'll all end up here eventually, what kind of long-term care do we want when we need it? When our loved ones need it? This is a fundamental and important question that cannot be avoided. Culturally, the long-term care sector services a vulnerable minority group, using the labor of other vulnerable minority groups. Vulnerable minority groups are more likely to be overworked, underpaid, underrepresented, and underserviced, so it is perhaps not surprising that the long-term care sector has not been prioritized as it compounds several uncomfortable realities that are historically easier to ignore than to address comprehensively. This is put much more succinctly by Dr. Debra van Hoonaard in the New Brunswick Nurses Union report on long-term care reform:

> *…it is time for the province to recognize that many of the problems we have in nursing homes result from the undervaluing of care work, in general, and the undervaluing of people as they get old. There is a long-standing practice of underpaying work that is traditionally done by*

> *women, and the RNs and other staff who work in nursing homes are the recipients of the legacy of both the undervaluing of women's work and the stigma of being old and infirm. On top of that, residents of nursing homes are invisible and, until the current pandemic, easy to ignore. Nursing homes have been easy targets of cost cutting, but the time has come to end this practice* (Hull 2020, p, 6).

New Brunswick was one of the few Canadian provinces that did not submit comprehensive long-term data to CIHI until 2020 (Hull 2020), and as such "reliable provincial data on long-term care in New Brunswick remains sporadic and troublingly hard to find" (Hull 2020, p. 31), which we found had not much changed in 2023. There is an impending crisis in terms of staffing in the long-term care sector that has been highlighted globally (e.g., OECD 2020), as well as in Canada (e.g., MTLC 2020, Zagrodney et al. 2023) and quite comprehensively by the New Brunswick Union of Nurses (see Hull 2020 for a comprehensive and sobering review). While specifics surrounding PSW workers specifically in New Brunswick are hard to catalogue (as PSWs are unregulated and largely un-reported upon in this province), there are some statistics surrounding workers in the long-term care sector for the OECD, as well as Ontario, that one can assume extrapolate approximately to the situation in New Brunswick:

- Across OECD countries, women represent >90% of the LTC workforce (OECD 2020);
- Median age of LTC workers is 45 and OECD countries face two challenges: 1) attracting younger workers and, 2) retaining workers aged 50+ (OECD 2020);
- Foreign-born workers tend to be overrepresented in the long-term care sector. On average in OEDC countries, the share of foreign-born workers employed in long-term care represents twice the overall share of foreign-born workers in the population, with Canada (at 34%) noted among the countries with the highest share (OECD 2020);
- Foreign-born workers in long-term care are often young and highly skilled in their home countries but take lower skilled work for less renumeration out of necessity. Canada is noted by the OECD as one such place where

overqualification of foreign-born workers in long-term care has been documented (OECD 2020).

The OECD noted the following in terms of attracting and retaining workers to the sector:

> *LTC jobs suffer from a lack of status and recognition. The poor image of LTC is an important barrier to recruitment, especially for young people who tend to stigmatize LTC professions as low- or unskilled, and men who may traditionally regard LTC jobs as "women's work". Several countries have implemented advertisement campaigns to change the mindset on LTC by presenting a positive side of ageing and promoting the good aspects of LTC careers. Image campaigns can also be used to promote "values-based recruitment": they underline important values needed to work in LTC, such as empathy, and highlight workers' capacity to make a difference on small things. They show a more positive and joyful side of LTC and emphasize its key contribution to the society* (OECD 2020).

The long-term care staffing study that came out of Ontario (MLTC 2020) highlighted several areas for improvement, as did a recent paper aggregating PSW demographics across Canada as a whole (Zagrodney et al. 2023).

- The majority of people employed in the daily work of caregiving in the long-term care sector are personal support workers (almost 60% in Ontario in 2018; MLTC 2020), and a large proportion are part-time or casual. This might contribute to the low recruitment in the sector as a barrier to long-term career planning. Often PSWs are not fully acknowledged as part of the critical long-term care team and efforts should be made to fully integrate PSWs, as well as formalize pathways to professionalize the PSW role in the sector (MLTC 2020);
- Given that a significantly high proportion of PSWs were female and also considering unpaid caregivers are predominantly female, policymakers should consider recruitment strategies that expand beyond the "historically gendered

recruitment pool" (Zagrodney et al. 2023, p. 676), where a care infrastructure could be created that would interdependently support both family caregivers and the PSW workforce by extension;

- Understanding the demographics of the workforce: younger PSWs need greater support in the form of health benefits and childcare; older PSWs would largely benefit from employment where health benefits were afforded, especially as the lack of health benefits inbuilt into the system negatively affects a workforce with a relatively high risk for workplace injuries, for example injuries related to physical strain (Zagrodney et al. 2023). Health benefits and improved workplace health and safety measures are especially needed for home care workers (as a subsection of long-term care workers designated as personal support workers, distinct from registered workers like nursing professionals or medical professionals) as these workers in the long-term care sector tend to have both lower salaries and lower levels of health benefit coverage overall (Zagrodney et al. 2023);
- Limited career advancement opportunities are a common feature of research into support care workers in the industry (e.g., Baughman & Smith 2012, Zagrodney et al. 2023), which is an area that needs to be addressed in terms of long-term sustainability within the sector. The vastly varying requirements for personal support care workers between jurisdictions limits implementing standards of education and experience, as well as regulation and advancement grids. To make long-term care work attractive, and thereby increase supply, recruitment, and retention, this lack of unifying standards and a clear pathway towards professionalization must be addressed;
- Education specifically focused at the PSW-level might be especially important for workers in the long-term care sector, and indeed might be more important than work-experience and higher levels of education alone, given the specialized needs of long-term care recipients (MLTC 2020, OECD 2020, Zagrodney et al. 2023).

The OECD, the MLTC, and the NBNU have all offered pathways to addressing the global staffing shortages that are keenly felt in the long-term care sector. Indeed, the NBNU outlined 38 recommendations specifically for New Brunswick (Hull 2020). Perhaps these resources would be a good place to start when it comes to staffing and long-term care in New Brunswick. Of interest is one idea several OECD countries are exploring, with positive results:

> *Since 2011, a few countries have implemented strategies to offer unemployed people job opportunities in LTC…as LTC is mostly a low-skilled sector, these have been opened to a large pool of applicants, including former LTC staff and unemployed people without a care background. Japan has introduced basic LTC training courses targeting middle-aged and older workers to prepare themselves to return to work after a long break, and provides support for beginners to take LTC training courses. This led to an increase of 320 000 in the number of LTC workers between 2011 and 2015 and contributed to the acceleration of growth in the number of new workers in the LTC market* (OECD 2020)

The contribution of unpaid caregivers cannot be ignored when discussing long-term care. The vast majority of unpaid caregivers are women who contribute countless hours and *billions* of dollars' worth of unpaid labor to the delivery of long-term care, and again these caregivers need to be aided and valued with real, tangible supports. From 2018, eligible New Brunswickers could apply for a caregiver benefit, intended to support "people who provide informal care to help seniors and people living with a disability remain independent". Only the primary informal caregiver was eligible for the benefit, which amounted to $106.25 per month. If an unpaid caregiver were to be delivering the 3.3 hours/day currently mandated be given per resident in a New Brunswick nursing home (for the sake of using a number deemed by the province as a reasonable amount of care), that would mean the government benefit was worth $1.06 per hour. If an unpaid caregiver were to be giving care on a strictly part-time basis (20 hours a week,

the current benchmark to qualify for the Nova Scotia Caregiver Benefit of $400/month[4]), this would mean the benefit was worth $1.33 per hour. An estimated 75% of home care given to seniors is met by unpaid caregivers (MacDonald et al. 2019). This benefit was clearly insufficient to go any way toward compensating the unpaid caregivers the system relies on to supply free labor, often at the expense of their time and careers, however the fact that the benefit existed at least reinforced to those doing this work that their contributions were deemed valuable. Unfortunately, in New Brunswick this small but important benefit scheme was quietly axed in 2019 (Steele 2019). Just for reference, the aggregate public sector cost to replace unpaid care with public care in Canada in 2019 would be just under $9 billion (taking into account both salary and overhead costs). Based on direct salary alone (at an assumed $18/hour), it would cost $5.4 billion to replace unpaid care in Canada (MacDonald et al. 2019). Caregiver benefits are needed, and they in turn need to reflect the value unpaid caregivers bring to the system and acknowledge the personal, financial, and emotional costs caregivers incur for the support they supply. Provinces, particularly New Brunswick, need to acknowledge the contribution and respite that unpaid caregivers inject into the long-term care sector by supporting their efforts with real and significant renumeration and support.

[4] Caregiver Benefit (novascotia.ca/dhw/ccs/caregiver-benefit.asp)

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(CIHI 2021b) Canadian Institute for Health Information. *How many long-term care beds are there in Canada?* [infographic]. Accessed May 2, 2023.

(CIHI 2021c) Canadian Institute for Health Information. *Long-term care homes in Canada: How many and who owns them?* [infographic]. Accessed May 2, 2023.

(CIHI 2021d) Canadian Institute for Health Information. *Hospital Stay Extended Until Home Care Services or Supports Ready* [indicator]. Accessed June 1, 2023.

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Additional Resources:

- About Planetree and Person-Centered Care
- CMA LTC -Final Report March 5 (1).pptx
- Community Paramedicine (bcehs.ca)
- CUPE NS President Calls for 4.1 Hours of Hands-On Care Daily - CUPE Nova Scotia
- The Eden Alternative
- Framework for countries to achieve an integrated continuum of long-term care (who.int)
- Green House Project
- Healthy Aging and Long-Term Care Act, SNB 2018, c 8, <https://canlii.ca/t/53mm7>
- Hours of care in nursing homes will increase to 3.3 hours per resident by April 2022 (gnb.ca)
- Inclusion NB
- Long Term Care | novascotia.ca
- New benefit for primary informal caregivers (gnb.ca)
- New Brunswick Health Council Act, RSNB 2016, c 104, <https://canlii.ca/t/52wpm>
- New study: Cost and demand for elder care to double in the next 10 years | CMA
- News Articles - COALITION FOR SENIORS AND NURSING HOME RESIDENTS' RIGHTS (nbcoalitionforseniors.org)
- Nova Scotia 2023-24 Business Plan - Seniors & Long-Term Case
- People-centred health care: a policy framework (who.int)
- Primacare Living Solutions | Dememtia Care
- The New Brunswick Special Care Home Association (nbscha.ca)
- The Forgotten Generation Report 2019 (theforgottengeneration.ca)
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Notes:

1. The Office of the New Brunswick Seniors' Advocate has identified four main areas of focus for the review: Governance and Administration, Human Resources, Quality and

Humanity, and Funding and Affordability. The Office has also outlined five guiding principles to be mindful of when reviewing and enacting policy changes concerning long-term care in 2023:

a. That the long-term care sector offers predictable and reliable service that New Brunswickers can understand and plan upon and around as they age;
b. That the long-term care sector places seniors and other New Brunswickers who need support in a setting which maximizes their independence and humanity;
c. That the long-term care sector is governed in a way that promotes accountability and easy navigation;
d. That the long-term care sector promotes equality and ensures access, regardless of income, language, or geography;
e. That the long-term care sector ensures sustainability and predictability to the public which funds the system.

2. The WHO (2015) emphasizes that all long-term care systems (additional emphasis mine):
    - Must be affordable and accessible
    - Must uphold the human rights of care-dependent older adults
    - Must have their national governments take responsibility for the stewardship of long-term care systems.
    - *Should* enhance older people's intrinsic capacities
    - *Should* be person-centered
    - *Should* treat the workforce (both paid and unpaid) fairly and give it the social status and recognition it deserves.