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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:

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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:


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
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?

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<td>INTEGRATION</td>
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<td>Maintaining Wellness</td>
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<td>Pooling Resources</td>
<td>Prolonging Independence</td>
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<td>Delivering Health Services to Community in Long Term Care Facility</td>
<td>Social Supports</td>
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### 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 compiles 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.

**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 & Kristansson, 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 into 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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