DEVELOPING INNOVATIVE CARE PATHWAYS

Name of Project	Project Goal & Description	Location	Organization/ Group
Adult Residential Facility (ARF) Liaison	The Departments of Health and Social Development, in collaboration with EM/ANB will introduce the role of the Community Liaison Nurse to Adult Residential Facilities (ARFs) across New Brunswick, with the overall goal of enhancing collaboration around the care needs of all residents. This project aims to demonstrate that improvements to care team communication and client outcomes/experience will result in seniors being able to remain at home safely and independently for an extended amount of time.	Province Wide	Department of Health & Department of Social Development
Non-Hospital Cataract Surgery	The Department of Health has a goal to reduce the volume of seniors waiting for cataract surgery and decrease the wait time for cataract surgery. This project aims to meet this goal by performing cataract surgery in a surgi centre type setting i.e. outside of hospital. The project will test the capability of a non-hospital ophthalmology surgery centre to improve access to cataract surgeries and the impact this approach will have on reducing wait times for hospital-based surgeries.	Bathurst Zone	Department of Health
Long Term Care assessment redesign	The Department of Social Development will redesign and enhance long term care generic assessment tool to provide better support to workers with a goal to facilitate aging in place by providing clients and their families with as much useful information as possible at the time of assessment which will see the assessment completed on-site with clients.	Fredericton	Department of Social Development
Coordinated Aging in Place Services (CAPS) through Integrated Primary Health Care	The goal of the pilot project is to identify the impact of a comprehensive, multi-disciplinary service within primary health care that provides proactive, chronic illness and frailty management services for 'at-risk' community seniors. The pilot will utilize the registered nurse, occupational therapist, and social worker to complete required clinical assessments, develop and implement patient-centred action plans & interventions, and provide on-going follow up and self-management support to the senior and their caregiver. The pilot aims to improve the use of primary health care services for the prevention and management of frailty in seniors, improve awareness and navigation of community resources & services for seniors & caregivers, reduce avoidable hospital admissions, and improve the senior's quality of life and safety.	Miramichi	Horizon Health Network - Central Miramichi Community Health Centre

Radiography on Wheels	This project will pilot a mobile X-Ray service for participating nursing homes and provide select diagnostic imaging services to nursing home residents in a coordinated fashion in a familiar environment, giving seniors and/ or caregivers the option of having scheduled and emergent X-Rays provided in the nursing home, as opposed to being transferred to hospital via ambulance to have the service performed.	Saint John Region	Loch Lomond Villa, Inc.
CHARM Study - Coordinating transitions from hospital for older adults with fractures: An interventional mixed methods study.	This project will have patient navigators for adults 65+ who are admitted with a fracture to acute care Orthopedic Units at Level 1 & 2 Trauma Centres to help prevent the need for hospital readmission allowing them to continue to age in place safely. The patient navigators will work collaboratively with the healthcare team to help facilitate and coordinate discharge of the patient to any location from that unit. The patient navigator will enure that the patient and/or family or receiving hospital unit/facility have all the resources, programs, and supports in place needed for a safe and effective transition from the Orthopedic Unit. Their role will also be to ensure follow-up care and documentation is in place at the time of discharge so the transition in care is a smooth one. This will also include ensuring that the patient, family, and the appropriate receiving healthcare team are able to follow the discharge plan.	Saint John Regional Hospital & Moncton Hospital	Trauma NB, Horizon Health Network & UNB SJ
Collaborative Use of Data to Enhance Aging-in-Place (CDEAP)	The goal of this project is to enable seniors to age-in-place for longer through an enhanced partnership between the Department of Social Development and Kindred Home Care, New Brunswick's largest provider of home care services. The purpose is to improve collaboration, coordination, and communication between members of the care teams, thereby facilitating proactive care interventions which will allow seniors to remain at home safely and independently for an extended amount of time. The project will have Kindred's Home Support Workers, Care Coordinators, and Care Managers report on observed changes in client status and share this information with Social Development Social Workers through a secure digital platform. This will make the most up-to-date client information readily available to care teams and allow for intervention before health declines or incidents occur.	Fredericton	Kindred Home Care & Department of Social Development

Primary Care Networks/Primary Care NB	The New Brunswick Primary Care Network will become the health system's front door for any New Brunswicker that does not currently have a primary care provider. The Network will register eligible clients, coordinate scheduling and triage, manage patients looking for a new primary care provider due to issues with current provider and permanently assign patients based on complexity of needs. This will provide timely access to primary care leveraging health system partners and existing physical infrastructure. The project will look at if this approach reduces the utilization of the Emergency Departments and walk-in-clinics in the province. Every participating clinic or primary care provider will have access to a cloud-based Electronic Medical Record (EMR) and virtual care platform to ensure continuity of care.	Province Wide	Department of Health
Enhanced Community Pathway	The goal of this project is to reduce unnecessary emergency department (ED) visits and hospitalizations to alleviate Alternate Level of Care (ALC) in hospitals. The intent is to provide a rapid integrated assessment process in order to access short-term integrated health and social supports to stabilize a crisis. This will allow for the development of a joint ongoing health and social care plan focused on keeping seniors in their homes and communities. This will create an alternate community-based option for seniors at risk of hospitalization by collaborating with existing resources, building on the knowledge and expertise of the Extra-Mural Program and the Department of Social Development. An enhanced integrated approach could improve collaborative practice with the whole care team (Primary Care Provider, EMP and SD) as well as increasing and sharing knowledge and understanding of available supports in their communities	Southeast New Brunswick	Department of Health

IMPROVING SOCIAL AND BUILT ENVIRONMENTS

Name of Project	Project Goal & Description	Location	Organization/ Group
Care-services navigation & care-skills development program for informal caregivers of seniors and seniors aging in place in New Brunswick	The goal of this project is to help seniors and informal caregivers to access and navigate services so they can continue delivering care to their loved ones at home using safe practice. The New Brunswick Community College in Saint John will design and updated curriculum for care-services navigation & care-skills development to be delivered in multiple settings, virtually and face-to-face. This will be done in collaboration with long-term care through a student-led program in combination with Senior Day Centres at Long-Term Care facilities. The project will measure impacts of the program participation on perceptions of caregiver isolation, support, and senior-care navigation skills.	Saint John, Sussex, Hampton, Kingston Peninsula, Grand-Bay-Westfield, and St. Stephen	New Brunswick Community College, Saint John & UNB SJ
Piloting a Community Connectors Program to Address Social Isolation and Loneliness among Older Adults in New Brunswick	The goal of this project is to reduce participants' level of isolation and loneliness. The intent is to train participating drivers of the Meals on Wheels program to be Community Connectors. The drivers will learn how to identify and address isolated and lonely seniors, refer them to pre-existing community activities and provide coaching and follow-up.	Fredericton	St. Thomas University
Addressing determinants of senior well-being and reducing social isolation	The goal of this project is to improve the current understanding of healthy aging, develop new insights, and foster the development, implementation, and assessment of novel solutions with partners in the community. Through a collaborative approach between New Brunswick Community College (NBCC), the University of New Brunswick Saint John campus (UNBSJ), and community partners the project will seek to demonstrate a scalable and economically sustainable model focused on the emotional and social well-being of seniors living at home and in community settings. .	Saint John, Fredericton, Moncton, Miramichi, St. Andrews & Woodstock	New Brunswick Community College and The University of New Brunswick - Saint John
Identification of Risk and Development of an Evidenced-Informed Strategy for the Safe Reintegration of Families into Long-term Care Homes	The goal of this project is to produce evidence-informed resources to support safe visits in homes. This project will design and evaluate educational documentary media on infection prevention and control practices; test the efficacy of alternate modes (virtual/documentary films) of delivery for education and training on COVID-19 restrictions in different homes and different populations and create a Toolkit of documentary educational films (videos), pamphlets, posters, and information sheets on safe visiting in long term care facilities during a pandemic.	Saint John & Moncton	The University of New Brunswick

INCREASING INDEPENDENCE, QUALITY OF LIFE, AND PROMOTING HEALTHY LIFESTYLES

Name of Project	Project Goal & Description	Location	Organization/ Group
Community Based Fall Prevention Clinics	The goal of this project is to reduce to reduce the number of falls during program participation and have seniors remain at home longer. The Fall Prevention Pop-Up Clinic is a community-based service for seniors living in the community, residential facilities, or assisted living, that delivers fall prevention services to smaller communities in NB to allow seniors access to direct patient care close to home.	Grand Lake area of New Brunswick (Minto)	Horizon Health Network - Queens North Community Health Centre
Lifting Frailty in New Brunswick	The goal of this project is to evaluate if resistance training exercise can improve seniors' physical (independence) and psychosocial ability and to evaluate sex differences among participants from different types of residences and different frailty levels. The aim is to determine if participating in an exercise program with resistance training and blood flow restriction benefits people living with frailty who live either in their own home, an assisted living facility, or a special care home.	Fredericton, Moncton & Edmundston	The University of New Brunswick
Good Life with OsteoArthritis in Denmark (GLA:D®)	The goal of this project is to provide physiotherapy treatment to patients with severe osteoarthritis using a method from Denmark referred to as the GLAD. The aim is to improve pain symptoms, decrease medication use (opioids and knee injections), improve quality of life, delay surgical intervention. This should improve the gap in osteoarthritis care and decrease surgical wait times for joint arthroplasties. The model calls for education and exercise as the first line of treatment. This conservative management approach will focus on a proven supported self-management model. Implementation of GLAD Canada, an evidence-based program for the treatment and management of osteoarthritic symptoms will help manage and slow the progression of osteoarthritis, improve patient outcomes (increase function, decrease pain), and reduce the need for total joint replacements and opioid use.	Five HHN facilities 1.TMH 2.SJRH 3.DECRH 4.URVH 5.MRH	Department of Health

USING COMMUNITY APPROACHES TO REDUCE HEALTH INEQUALITIES

Name of Project	Project Goal & Description	Location	Organization/ Group
Evaluate the impacts of a community strategy to increase resilience and access to services in French for French-speaking seniors in the Greater Saint John Region	The goal of this project is to ensure that Francophone seniors living in Saint John receive the services they need to stay home longer. This project will assess (1) the impact of a centralized Francophone place of engagement (2) a community support and guidance service for Francophone seniors and (3) assess the impact of efforts to support private or subsidized organizations offering services to seniors in the Saint John region to stimulate more offers in French.	Saint John	Association Régionale de la Communauté francophone de Saint-Jean (ARCf de Saint-Jean)
Piloting patient navigation for people with dementia, their caregivers, and members of the care team	The goal of this project is to support people with dementia (PWD), their informal caregivers, and the care team through in-person and online navigation services to improve health and system outcomes and enable aging in place. The aims are to increase the knowledge of health and social services and resources; improve access to health and social services and resources through connection to in-person and online navigation services; decrease social isolation and loneliness; promote positive experiences with health and social care systems for PWD, their informal caregivers, and the care team by improving communication pathways that promote the integration and coordination of care; and assess the facilitators and barriers to implementing a patient navigation program for PWD, their informal caregivers, and the care team in New Brunswick.	Province Wide in both Regional Health Authority locations	The University of New Brunswick, Horizon Health Network & St. Thomas University
Civic engagement for health among older adults: A strategy for aging in place	The goal of this project is to develop a programming model serving the community of Saint Andrews and surrounding areas, identifying the processes allowing seniors to use their knowledge, skills and voice to extend access to allow aging in place. The intent is to determine how rural/smaller communities (within New Brunswick and across the country) can employ a blueprint for civic engagement that supports the realization of not a singular program, but a collection of programs and services that will truly support Aging in Place in a community hub model. The blueprint can serve as a tool to initiative and motivate communities to take action to bring multiple Aging in Place priorities to fruition within a collective impact framework, rather than awaiting further development of government programming.	Saint Andrews & surrounding area	Pasmaquaddy Lodge Inc.

USING SUPPORTIVE TECHNOLOGIES TO FOSTER HEALTHY AGING AT HOME AND IN OUR COMMUNITIES

Name of Project	Project Goal & Description	Location	Organization/ Group
Data informed quality of care improvements in NB long term care homes.	The goal of this project is to improve care to long term care residents through data driven and evidence-based decisions. This project will build on the work being done by already established communities of practice on a provincial scale for NB nursing homes. The aim is to continue to see successes in the areas of reduction of falls, restraint use and inappropriate use of antipsychotics, with improvements in management of pain and resident quality of life indicators.	Province Wide	New Brunswick Association of Nursing Homes
Proactive Care for Persons with Dementia: Using In-Home Passive Sensors to Reduce Caregiver Stress and Promote Aging in Place	This project will investigate if the implementation of a passive monitoring system in the homes of older adults who live with Alzheimer's Disease and related dementias (ADRD), can improve the caregiving experience for those acting as their informal caregivers. The overall goals of this project are to reduce feelings of stress and burden for caregivers and to enable individuals living with ADRD to safely and comfortably live in their home and community. By allowing informal caregivers to passively monitor their loved one's activities of daily living, watch for abnormalities, and deliver proactive care, community-dwelling older adults with ADRD/memory loss can continue to age in place.	Fredericton and surrounding area	The Centre for Innovation and Research in Aging
Aging and Thriving in Place at Home utilizing Digital Care Coordination and Virtual Care to foster Self-Care, Socialization, Family and Community Involvement	The goal of this project is to increase the efficiency and capacity of in-home care services through use of a Virtual Care platform in the community, to support seniors and decrease reliance on hospitals, allowing seniors to safely age in place at home. The project will pilot the Virtual Care and Care Coordination platform in the homes of older adults identified as at-risk for hospitalization and are seeking to age in place. The platform will monitor vital health data, life-style behaviors and co-morbidities using connected medical devices. The platform will also encourage independence and facilitate the delivery of individualized, person-centered care. The project aims to demonstrate that Virtual Care can play a vital role in the care continuum in NB. Secondary goals are to replace/increase in-home care services with remote care services, to support informal & formal caregivers, reduce overall costs of care services and improve efficacy through continuous outcome monitoring and verification of services provided.	Saint John, Fredericton & Moncton	Routinify Corporation

Reconnecting with GENIE: Evaluating the impact of a telecommunications portal on social isolation experienced by residents living in long-term care in New Brunswick	The goal of this project is to implement and evaluate the impact of a telecommunications portal on social isolation experienced by older adults living in long-term facilities in New Brunswick. A total of 10 long-term care homes will be assigned to either a control or intervention group. Long Term Care (LTC) residents, their family members, and LTC staff will participate in this study to provide various perspectives on the telecommunication portal (called "GENIE"), which was designed to help older adults living in long-term care to maintain social connections with their families and community. The project will draw on several psychosocial and health outcomes by using surveys, interviews, and interRAI data.	Province Wide	The Centre for Innovation and Research in Aging
Implementing Virtual Reality in Advanced Falls Prevention: Building Resilience and Balancing Risks	The goal of this project is to use Virtual Reality (VR) to motivate exercise and to increase strength and balance, reducing falls risk by increasing functional capacity and to challenge balance control and to help reduce fear of falling and improve the self-appraisal of balance abilities. The project will include participants living in either a nursing home or within the community. The project will explore the feasibility and acceptability of using VR based exercise in persons with a VR headset. Participants will perform challenging balance tasks in a secure environment based on real-work balance tasks. The project also aims to gather information about post-implementation acceptance.	Moncton, Fredericton, Miramichi & Saint John	Université de Moncton, Campus de Moncton
A Pharmacy Hospital Discharge Transitions of Care Project to Facilitate Transfer of Care between Pharmacy Practice Setting and Improve Patient Medication Knowledge and Medication Experience at Hospital Discharge.	The goal of this project is to provide better support to seniors who are discharged to home from the hospital to manage their medications safely when they return home – to avoid unnecessary medication related hospital admissions. A secure messaging technology platform will improve communication between hospital and community pharmacy settings, and with patients and their families. Community pharmacies will receive more detailed information from the hospital about medication changes made during the hospital admission, as well as the rational behind the changes. A hospital pharmacist will participate in discharge planning and attempt to identify issues with medication coverage and availability before the senior leaves the hospital.	Fredericton & surrounding area	Horizon Health Network

Enhancing service access for seniors through effective use of technology with service providers - Improving Partnerships Sharing Information to Improve Services to Older Adults	The goal of this project is to develop a new and improved process and technology solution for obtaining / delivering / requisitioning home support services and Special Care Home / Nursing Home beds for seniors so they can remain at home safely for as long as possible or allow faster placements for seniors. Through the timely matching of client needs with service providers in the community, seniors should be able to get access to services faster. This approach should increase the likelihood that seniors can stay safely in their homes longer and reduce risk of hospitalization. The aim is to facilitate sharing of information on bed availability between partners and the Department of Social Development in real time to allow a faster placement of seniors in long term care facilities (if beds are available) and improve transparency on vacancies. This should reduce the administrative burden on social workers so they have more time to the care of seniors.	Fredericton & Saint John	Department of Social Development