“WHAT WE ALL WANT”

A Review and an Urgent Proposal for Change in New Brunswick’s Long-Term Care System

New Brunswick Seniors’ Advocate

Défenseur des aînés du Nouveau-Brunswick

Office of the
New Brunswick Seniors' Advocate

P.O. Box 6000

Fredericton, NB, E3B 5H1

Toll Free: 1.888.465.1100

Local: 1.506.453.2789

Fax: 1.506.453.5599

www.nbseniorsadvocate.ca

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“I am thinking… of a patient in a geriatric ward
I once heard crying out to his mother, dead
For half a century, “I’m frightened! Hold me!’
And of a boy-soldier screaming it on the beach
at Dieppe, of Nelson in Hardy’s arms,
of Frieda gripping Lawrence’s ankle
until he sailed off in his Ship of Death…
It’s what we all want, in the end
Not to be worshipped or admired,
not to be famous, not to be feared,
not even to be loved, but simply to be held”

~ Alden Nowlan

AN INTRODUCTION

It was Alden Nowlan, that most plain-spoken of our poets, who reminded us of the shared humanity at our very core. Nowlan could not have come from anywhere but New Brunswick – he was all at once blunt, informal, and deeply humanistic. He found the one thing that we all have in common. It holds true from the youngest among us to the most aged, from scenes of sweeping history and bloody combat to the most quiet and mundane of moments. We need to be seen, and we need to know that someone cares. And, of course, long-term care is more than just care at the end. We can spend years needing help and support from others, and those years matter just as much as any other.

So let me tell you the story that stays with me the most, after all these months of hearing stories from seniors and families, after all the pages of scholarly articles, after all the briefings from experts.

Let me tell you about a woman who wanted a banana.

I interviewed a number of interns and nursing students in the undertaking of this review. Of all the things I think I have learned in my years of public service; it is that the real truth often comes from those lowest on the organizational chart. I held two jobs in the Legislative Assembly before the one I have now. I was a cabinet minister in my 30s. And in my teenaged years, I was a student Page, bringing coffee and notes to MLAs. As a cabinet minister, people spoke more respectfully to me. As a Page, I heard the unvarnished truth more often. Those with power often let the teenager who fetches the coffee sink into the scenery, invisible, benign, and harmless. It is often those without power who see the system with its guard down, before the nabobs and the spin doctors have polished it into something more fit for public consumption. They see the things that would normally get cleaned up before someone like the Seniors' Advocate comes calling.

And this one new health care worker I spoke to was assigned to help care for an elderly lady in a hospital. Let's call her Mrs. Baker. Mrs. Baker should have been in a nursing home, really. She knew it. The doctors and nurses knew it. But she was waiting in that bed for the day when space would become available. She sat in a hospital designed for urgent care, a place where staff were too few, and quite overworked, charged with responding to crisis after crisis, surviving by necessity with the mantra that the worst cases, those with life and limb at risk, must seize their attention.

It is the kind of place where, if you are helpless but stable, your needs might always be on tomorrow's list of priorities. Even when tomorrow becomes today, you may find you are always on the list for the next tomorrow.

On this particular today, what Mrs. Baker had was the attention of the most junior of the staff, who collected her meal tray and spoke to her kindly. And on this particular today, in front of this most junior staffer, Mrs. Baker began to cry.

She was not demanding the greatest of care, or the most comfortable of surroundings, or a miracle cure. What she wanted was a banana.

"I'm sorry to cry," she explained, "but at home every day I have a banana with my breakfast." She had been asking every day, every person she saw, on every form they offered her, if she could have a banana with breakfast. And after eight days, in this place where she was not supposed to be and where she was reliant upon others to define her day, that she could not even have this most simple of her routines caused her to cry piteously in front of a stranger sixty years her junior. She was mortified at losing her composure, and her privacy, but she could not stop crying.

You might be amazed, reading this report, that after all this time and with so many places I could start, that I am starting with a missing banana. I wonder, though, how many of us take for granted the many tiny blessings that come with being young and healthy enough to make our own decisions. When we come home after a workday, don't we all value the freedom to do what makes us happy? Life isn't often the big joys of a tropical vacation or a high-end restaurant. It is the quiet and privacy of our couch when we need to be alone. It is the cold beer or the sneaky cookie when we choose. It is the freedom to live in a home that reflects who we are and what makes us content.

It's having the simple pleasure of eating a banana when you want one, isn't it?

That young health care worker stopped at the convenience store the next morning, the most ordinary of Circle Ks, and she delivered to Mrs. Baker what a three-billion-dollar care system apparently could not. That morning Mrs. Baker joyfully received five bananas, enough for five mornings where some small and personal routine was as she wanted it to be. She was heard. Her happiness mattered to someone else for a moment. And she was held in a caregiver's mind long enough to be cared for. It's what we all want.

Now, I will try my utmost in this report to tell you of other things I have learned, things I did not know or understand when my office started to plan the report you are reading now. I will explain how putting all those people in hospital beds when they should not be in hospital beds has led to a situation where people who are urgently sick, scared and in pain may not be sure someone will help them. I will explain to you how we often wind up with people in long-term care who should really be living in their own homes, but we wouldn't make the small expenditure that might have saved a bigger one. I will explain to you how all too often, social workers are made to explain what the rules will allow before they can explore what a person

needs. I will share what I have learned from people on the front lines, how too many rules and too few staff have created a system where none of us are completely sure we will get the health care we need.

Perhaps, if I can do my job well, I can explain why I have come to believe that it does not have to be this way, how choices made over a number of years have caused the system to crack slowly, and then suddenly break all at once. I certainly will try to share with you the efforts of so many helpers and health care workers who still try to keep their humanity and do the equivalent of finding a banana for a desperate patient even when it would be easier to tune all the misery out because they cannot possibly fix it all.

In this report, I may talk about things that go beyond the long-term care system, too. That's because the more I asked why Mrs. Baker couldn't get a banana, the more I learned that the answers aren't all that different from why Mr. Leblanc has spent twenty-four hours sitting in a hospital waiting room in pain, and why little Timmy can't read and can't get an assessment done, and why the school called child protection seven times worried about little Emma and she still comes to school scared and filthy. It's why the senior, the academic expert, the hospital administrator, the special care home operator, the family caregiver, the social worker, and the community activist all asked me if this is going to be yet another report that makes everyone nod their head in agreement for two days and then vanishes like it never happened.

It's because the problem is not really that the people in the health care system don't know what to do. It's that the New Brunswick government is organized in a way that doesn't let them succeed. If one Mrs. Baker doesn't get a banana, you buy bananas. If a thousand Mrs. Bakers can't get a banana, maybe this isn't really about bananas. It's about governance models that fail over and over but are never called upon to answer for it.

If I do my job effectively, you will be a little angry because it does not have to be this way. We aren't supposed to have hospitals that can't see sick people because they are dealing with seniors who shouldn't be there, any more than we should have schools where nearly half of children don't learn to read, or social assistance systems that don't truly know how many people they helped find work, or child protection systems who don't know how many of the children they help wind up in college and how many wind up homeless. Our grandparents' generation believed that government could get someone on the moon. Today, we're surprised if government can get someone a banana. It shouldn't be normal to expect so little.

In fact, the Government of New Brunswick is still organized around management principles which originated in the 1990s when government determined cost control was the dominant public policy challenge. This was an era when accounting firms designed social welfare rules and the organizational principles of manufacturing companies were applied to long-term care systems. This particular and peculiar reorganization met the goals of the 1990s. It will not, however, meet the multiple social system failures of the 2020s without a thorough rethinking.

In the era when our current governance model evolved, the Premier of the day famously said that "the era of people first and money second ended when the money ran out." If so, perhaps "the era of money first and people second" ended when people started dying in hospital waiting rooms. At the very least, maybe we need to enter an era where we ask ourselves if we can design a system where both outcomes matter at the same time.

At the very least, we should be able to muster a program design that can get Mrs. Baker a banana before she cries in frustration. I hope that by the end of the report, you will be a little angry that we haven't been able to do better than where we are right now, because without anger we have resignation, and I do not think we should resign ourselves to the idea that we should not expect more from government.

But perhaps, by the end of this report, you will also be a little bit hopeful, because it turns out that there are things that can be done, that lie within our power to achieve, which would make the system kinder and better.

I also want to focus on those ideas because there are no villains in this story. If tomorrow any one of us were magically in charge, it would not all get better overnight. Most problems are not that simple, and this system certainly is not. If I am being honest, sometimes those choices over the years were made because we, the citizens, demanded different expenditures and no new costs and we did not really want to hear about the consequences.

It remains easy for many of us to look away now, too, because who wants to believe we will be the one languishing forgotten in a bed, hoping someone is kind enough to notice that we really miss our morning banana? To be human is to know that we are all mortal, but often we strive to forget that future reckoning so that we can find the joy in the present. Who wants to dwell on the gnawing question of what will happen to each of us if we become old and lose the independence that we fought so hard to have from the moment we were babies driven only to walk on our own so we could decide where we would be, and what we would reach for? Who wants to contemplate losing that cherished autonomy which we pursued as soon as our eyes could focus?

So it falls to me to share with you the stories that haunt me most, of the elderly patient who cried when a nurse's shift ended because he was afraid that he would wait hours for staff to notice that he needed to be taken back to his bed, of the senior who sits home alone for days with only the glow of the TV for company, of the man disabled by a car accident who was found on the floor one morning because he rolled desperately out of his soiled bed after waiting hours to be changed? Who wants to reflect upon this challenge if it means staring at the ugly fact that it could have been our parents? Or us?

Let's do better.

We cannot allow seniors to be made invisible by their lack of independence, to be forgotten. Every one of us should be fully ourselves with every moment we are blessed to be in this

world. Our last days of life are no less precious than our first days, when most of us had parents nearby who thrilled to our every coo and cry. We should all have the ability to be cared for, to find the small pleasures that make us feel happy and safe and heard, to be held in the care and concern of someone else.

As Alden Nowlan wrote, it's what we all want. The best way to have what we want when we are weak is to passionately demand it for others when we are strong. It is my privilege to share with you how we can do just that.

Kelly A. Lamrock, K.C.
Seniors' Advocate

WHAT WE HEARD AND WHAT WE LEARNED

A Summary of The Long-Term Care Review Consultation Process and The Emergent Themes

Background Context

Aging demographics in New Brunswick are even higher than the national trend. Here, 23% of the population is over 65 (up from 19% in 2015). We have the oldest population in Canada.

When this Office launched the review of long-term care in February of 2023 it was based on obvious and urgent concerns over the continuing stability and viability of the current long-term care system in New Brunswick. Most immediately concerning were gaps in managing the system, brought into stark relief by the effects that the COVID-19 pandemic had on vulnerable populations, in particular seniors and residents of long-term care facilities. Staffing, governance, and infrastructure were initially identified as key areas of instability which led us to ask the question: How structurally sound is this system, not only in the face of unexpected and unprecedented pressures (like a global pandemic) but more generally over the next 10 years and beyond as long-term care faces significant demographic shifts and pressures? In the next twenty-five years the number of Canadians aged over 85 is expected to triple, and cases of disability and dementia are expected to rise significantly. During that same period, the number of older adults requiring some form of support is expected to double, while in the number of close family members available to offer informal care is expected to lessen by a third. In 2016 the number of Canadians over 65 years of age was just under six million. In 2021 the number was over seven million. In 2037, the number is predicted to be well over eleven million. Aging demographics in New Brunswick are even higher than the national trend. Here, 23% of the population is over 65 (up from 19% in 2015). We have the oldest population in Canada. Not only that, but New Brunswick has the second highest rate of disability in Canada at over a quarter of its population.

Furthermore, for the first time in history the number of people aged under 15 is fewer than the number of people over 65. The demographics reveal a vanishing pool of family members to provide support. It is also predicted that over the next 10 years 120,000 New Brunswickers will be exiting the workforce. All of these numbers lead naturally to the crucial question: is New Brunswick prepared? Inadequate planning for a long-term care system inevitably leads to both the suffering of a vulnerable population, and it also leads to significant spillover effects and dysfunction in systems meant to serve the wider community. As just one prominent example, inadequate long-term care increases strain on hospitals and urgent care networks, which increases burnout, absenteeism, and an exodus of workers from the healthcare system, which in turn contributes to increased burdens placed on family and informal caregivers. The effects permeate our whole society, which is why I felt this review of the long-term care system was urgently needed, and why I feel actions on its recommendations are imperative.

The Review Process

The process of this review included feedback from experts, stakeholders, and the public through extensive consultations. A public portal was launched to seek submissions about long-term care from New Brunswickers. Formal submissions were solicited by our office from organizations with a stake in the long-term care sector. We reached out to those working in the system with an invitation to provide us with their concerns and suggestions via interviews. An advisory committee was constituted to provide input and comment on findings as we proceeded. The research component relied on compiling data from global resources, as well as Canadian and provincial findings, resulting in an extensive literature review. We mined multiple years' worth of data from our own casefiles at the Advocate's Office. A comprehensive jurisdictional scan of current Canadian law and policy relating to long-term care was also undertaken. The process resulted in:

- Over 300 submissions received from the public.
- Over 50 formal submissions received from organizations.
- Over 30 one-on-one interviews undertaken.
- Over 350 casefiles reviewed.

300+

submissions received from the public.

50+

formal submissions received from organizations.

30+

one-on-one interviews undertaken.

350+

casefiles reviewed.

The Results

The long-term care system reflects the fact that it wasn't set up in a cohesive way. If someone had a blank canvas today, it surely wouldn't look like our present system. There are now hospitals with administration and planning that is centralized to a large degree but which themselves evolved from a system full of small hospitals once run by local governments and, in some cases, even charities. There are care facilities like nursing homes and special care homes that evolved rather organically, some facilities being set up privately for profit, some being set up by foundations and run by volunteers, some being more planned and institutionally funded, and all with their own governance structure and history.

Then there are two government departments involved: The Departments of Social Development and Health. The Department of Social Development itself was a creation born of reorganization some twenty-five years ago, where it was decided to gather together numerous very different social services that used to be the purview of different government departments. At the time, the unifying principle was that all of the Department's units were ones which involved giving people financial support for social services. That's why units as distinct as early childhood education, nursing homes, disability supports, social assistance, and child protection all wound up together. At different times, and to varying degrees, the Department was asked to not only cut cheques to individuals to pay for these services, but also to design the programs to meet various policy objectives. In some cases, these services evolved within the Department of Social Development. Others evolved out of the formerly separate Departments of Health and Community Services, who oversaw hospital care and extra-mural care, respectively. Both those programs now interact with the long-term care system.

Basically, the long-term care system is not something that was planned and launched. It is something that was stitched together artificially among various components that developed *ad hoc* to respond to needs as they developed. The key now is to create something cohesive out of all those parts. We must create a system that is attentive at all times to who it serves, that defines and measures results, and that treats people kindly and predictably even when their needs or circumstances change. There are no magic wands. We start with the system we have. But we must reconfigure it.

In this report we have chosen not to draw hard and fast rules about which government Department or entity runs things. It's important to have good people supported by good resources, working within good facilities and services, with good regulations, structures, and objectives. Which part of government designs those, or what the sign on the Departmental door says, is not the important part of the system. The results are, and must be, the important part.

During this review, we have identified several interconnected themes, which will be explored in-depth in the remaining chapters of our report. Those are:

- Governance
- Accountability
- Assessment and Affordability
- Person-centered Care
- Human Resources Planning
- Removing Disincentives to Aging in Place
- Diversity and Demographics

"Actions speak louder than words, but not as often."

~ Mark Twain

THE CHALLENGES FACING LONG-TERM CARE

If the number of reports on long-term care were directly proportionate to New Brunswickers' satisfaction with the system, our task would be easy. That is not the case. There have been many reports. Yet New Brunswickers feel anxious about the system that will await us as we age and need help. That anxiety, and the desire of citizens to be heard, came through loud and clear in our consultations. We learned far more than we anticipated and we are grateful for the dedication of every person who participated in this review to improve long-term care in our province.

Looking at the extensive feedback received, certain patterns emerged. Our process provided all New Brunswickers with a portal for suggestions and submissions. We selected a number of these for more in-depth interviews to drill down into the experiences and ideas they wanted to share with us. We also received a number of in-depth briefs from stakeholder groups whose expertise in the sector is undeniable.

What follows are the areas where change seems most fundamental to giving New Brunswickers a system they can count upon. We identified the following structural challenges within the New Brunswick long-term care system.

1. The system has a governance model that keeps all the elements of the system (health authorities, home care, nursing homes, special care homes, financial support, inspections) separate. But each area has highly centralized governance. By contrast, healthy long-term care systems integrate all the types of care but *decentralize* governance so that people in the system (social workers, nurses, managers) are empowered to make decisions and answer for results.
2. There is no common model of accountability, no clear priority indicators, and no link between what we measure and how we manage.
3. Citizens who need help affording care must restart the process and deal with all new criteria and programs for even slight changes in the type of care they need, which causes uncertainty and slows down response times.
4. The system has a lack of incentives and support for person-centred care. We often look at new inputs into the system but don't measure and hold the system accountable for the things that affect the quality of a person's life.
5. There is poor human resource planning, and often targets are set based upon cost control considerations with no modelling of future demand.
6. Instead of making small expenditures and providing supports that would assist people with aging at home, an array of unnecessary rules and red tape within the system often makes it difficult to avoid institutional care. When things get worse, aging adults must then rely upon finding more expensive care within a facility.
7. The system is often so bogged down in the crisis of the day that no one is modelling what the demand will be in the future, so there is a lag time when it comes to having the required care and human resources in place when demographics shift.

These seven systemic problems have led to the seven themes in our long-term care recommendations.

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SEVEN SYSTEMIC PROBLEMS HAVE LED TO THE SEVEN THEMES IN OUR LONG-TERM CARE RECOMMENDATIONS.

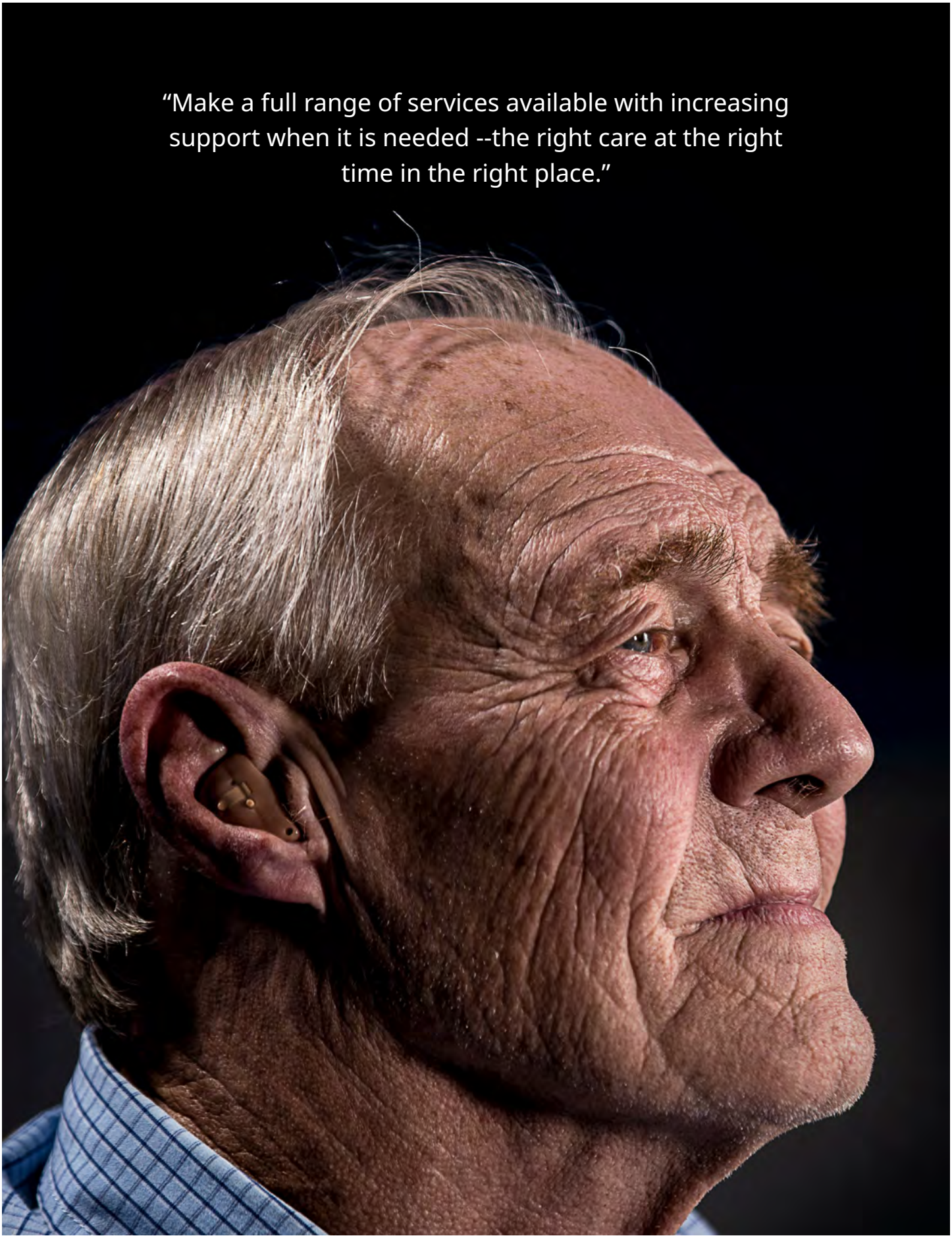
THEME ONE:
Governance that provides one integrated, predictable system

It has been said in a variety of ways that New Brunswick does not have an integrated long-term care system but rather a series of private operators and public sector silos that are not aligned. This seems true. In fact, each of the silos of the long-term care system developed in its own way separate from the others. Nursing homes, special care homes, home care – these all developed from local operations into a patchwork provincial system. As already noted, even the Department of Social Development was originally created by merging a number of government operations into a common department of income support programs. In some cases, the management silos exist within the Department itself. This lack of systemic coherence is a lingering vestige of the pre-Equal Opportunity reality in which many social programs were provided by local government.

If the goal is to have a system where people move seamlessly and predictably through it based upon their needs, this presents some problems. As we will see in other areas, a lack of collaboration and integration of these silos has led to a confusing assessment process, duplication in assessments and planning, and citizens in need being stranded between silos.

Long-term care requires an integrated governance structure that oversees all service providers in a coherent way. The governance system should be integrated, responsive, and built in a way that encourages community-based collaborations and local solutions.

> *"We had a very difficult time sorting through all the bureaucracy to get our parents assessed. They've undergone so many different assessments and each time it's a maze of details. It involves a lot of waiting, and phone calls etc. It's confusing and it is frustrating."*


“Make a full range of services available with increasing support when it is needed --the right care at the right time in the right place.”

THEME TWO:
Accountability

One of the consequences of the silo-based system is that how institutions are accountable can vary from sector to sector and even from facility to facility. As noted in previous reports of the Advocate, a culture of excessive deference to private sector operations has led to gaps in accountability.

Ensuring that every policy is effectively enforced, and that key information is reported, is not just a bureaucratic preoccupation. When seniors and their families do not have faith that effective accountability measures are in place, then people become reticent to report gaps in service for fear of reprisals and retaliatory discharge.

What tends to happen is that administrative decision-makers will point to reporting documents with dozens of data indicators in order to "show" how the system functions. This is fine, as far as it goes. What never seems to happen, however, is the crucially important managerial follow up, where government selects a few key indicators from the data that must improve in order to ensure success, and then empowers the people on the front lines to focus on and improve those key indicators of success.

There is a need to look at issues like inspection resources and regular data reporting to spot small area variations. The lack of human resources has also caused issues – while the absence of Registered Nurses is routinely noted by inspectors, the frequency of the problem has led to a lack of real consequences or expectations. Past reports have noted this problem as well. Governance which empowers managers in the community is an important element of human-centred services.

> *"There seems to be no overarching database or online system that would collect data and information on residents and enable proper health analysis and consistent communication of residents' health situations among staff – and also to do proper forecasting of future needs."*

"Nursing homes are failing to meet the required minimum safe staffing ratios. There is an insane amount of days when there isn't even a Registered Nurse on duty ....."

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"Too many people are taking too many different kinds of medications without being monitored adequately for drug interactions and overdoses. I have counselled many people who have been on over twenty prescriptions that made absolutely no sense as to why. People are placed on pain killers too often without finding out what is causing the pain. Pain is a symptom, not a condition. Restraints are used unnecessarily without any consideration for the person and [their] autonomy."

THEME THREE:
Assessment and Affordability

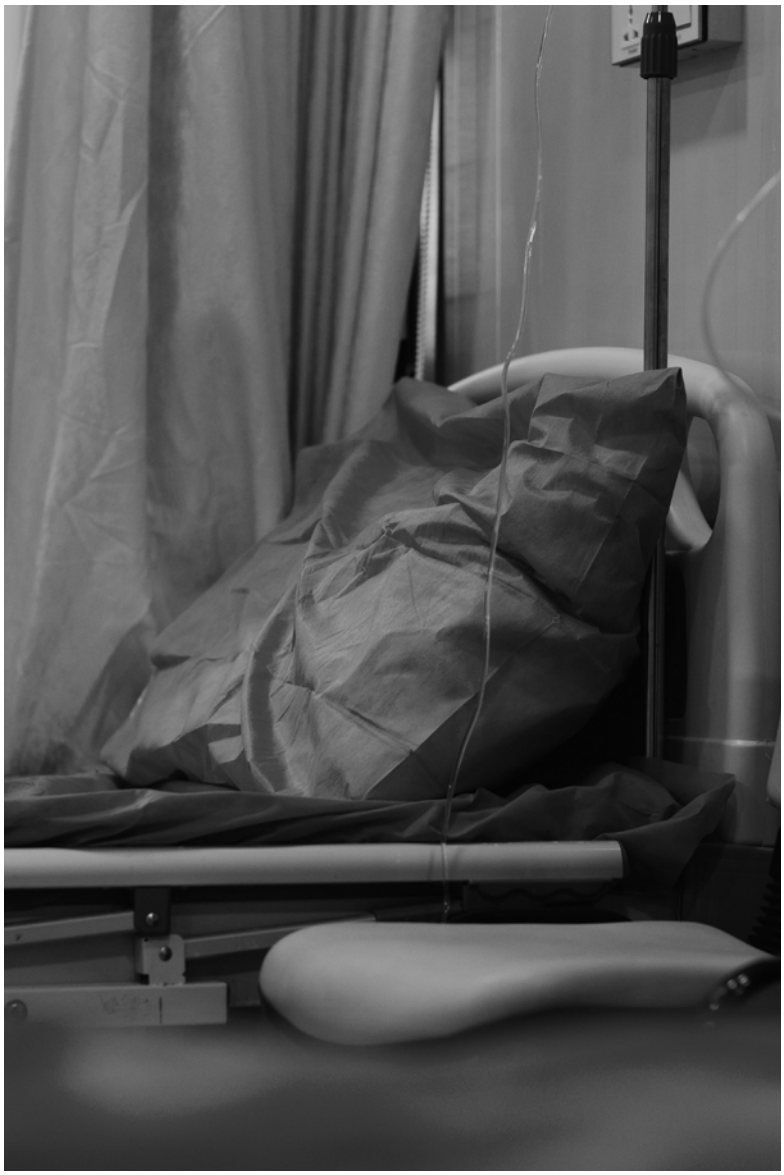
Being able to afford and access the care we need as we age is an issue that understandably causes anxiety for many families. One of the recurring themes we heard was that the silos in governance have led to an incoherent system of needs assessment and financial support. It is hard to plan for what we cannot predict, and when assessments change and must be redone every time a person's needs change, predictability is impossible.

Best practice points to models with one single point of entry into long-term care. That entry point can encourage early planning for aging in place and one single assessment for financial assistance. If the patient's resources do not change, a standard contribution formula should apply to all facets of long-term care as people move through the system. New Brunswick's long-term care sector needs such a single point of entry.

Additionally, an affordability lens needs to be brought to the system. Not only does anxiety around costs exact a human toll, in some cases the creation of affordability barriers drives people into more expensive urgent care solutions, resulting in a higher cost to government in both dollars and operational efficiency.

Alternate levels of care, or the presence of seniors who need long-term care being placed in urgent care hospital beds, is proving to be a major operational issue for both the urgent care and long-term care systems. Clear timelines and planning for resolution of this problem needs to be part of the plan.

> *"The absence of [cost] caps in New Brunswick leads to the use of upcharges in the sector. These upcharges make certain special care homes out of reach for low-income residents and very expensive for the rest. This creates access problems to a public service and a two-tier system in this sector of funded long-term care. It is two-tier in the sense that, based on income levels, some do not have access to the publicly funded service provided by special care homes."*



"It takes so long and expectations of paperwork, financial information delays it further."

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"The current system of people waiting up to a year in hospital beds for a nursing home placement needs to end."

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"We've been waiting over a year for a home assessment. He's ok in his home but they might be able to point out safety or other issues that would improve his quality of life."

THEME FOUR:
A Person-Centred System of Care

In a quality care system, the assessment process starts by reviewing what the person needs. In a dysfunctional system, assessment starts with what the system has to offer. Too many New Brunswickers are reporting that their journey started with a review of what the system has to offer, and the citizen gets wedged into whatever can be done. This is not how a quality system operates.

Long-term care is more than just a bed. It is a system of supports that allow a person to continue to enjoy life where their interests, preferences, and autonomy matter. We heard from many citizens who feel that they or their loved ones have a place in the system, but not a full life.

When planning occurs in a crisis response scenario, important steps get overlooked. These steps are often the things that help people retain their autonomy. Part of life is being able to enjoy the things we love to do, being able to make our own choices about how to spend our time, and continuing to have new experiences that engage us. Those little preferences – the things that make us fully human – need to find space in care plans and the system must support them.

"I want an adequate level of care which will enable me to maintain my dignity. I do not want to be left in urine-soaked clothes, or left with a meal in front of me when I can't manage to feed myself. Also, I'd like to feel safe and not have other residents roaming in and out going through my things or being aggressive."

◆◆◆

"Not sure why we still use the term 'homes' because they have become institutions."

"All of the little things that make people feel more dignified are important: Brush their hair, brush their teeth after every meal, wash their faces and hands after meals, take a snack when they wish, let them lie down for a nap and get up again in an hour or two without hearing 'If you lie down, you'll have to stay there until tomorrow', 'We don't have time', or 'We don't have staff'."

THEME FIVE:
A Long-term Human Resources Plan

Long-term care is not just an income support program. It is a human services system. Any system with an intended output of human happiness must have a diverse set of skills in its workforce, and working conditions that encourage people to make care their profession, not just a transient job. While some steps have been taken to increase wages in some sectors, the retention of staff and the professionalization of their training remains an urgent area for action.

Just as the New Brunswick early childhood education sector underwent a rethinking of the skills needed to fully serve children's learning, the human resources planning for long-term care needs to evolve with an eye to the full spectrum of human development.

> *"In many special care homes we are caring for nursing home clients. We provide wound care, IV antibiotics after being trained by EMP, administration of all medications, palliative care etc. We have some very complex residents requiring way more than the allotted 1hr of licensed care a week. My Personal Support Workers are going above and beyond for the same wage as a fast-food restaurant!"*

“We need to be much more diverse in who works in nursing homes. There are a lot of hours between daily personal care and the three meals. We need recreation specialists every day. We need mobility specialists and clerical support. The current funding for these positions is grossly underfunded. Government has made an attempt to deal with these gaps but by not funding adequately, it will never be quality support. The current admission process and the many other social concerns of every resident are being fielded by registered nurses, one of the most scarce professionals. They need to be realigned to care. Human resource specialists are non-existent in NB’s nursing homes. There are critical attendance, competency, harassment, and abuse issues in nursing homes yet no professional support for these issues. Health and Safety specialists are needed. They exist in every other sector and even encompass an entire department in acute care, yet once again, no recognition of the necessity or funding in nursing homes.”

THEME SIX:
Eliminating the Wrong Incentives that Lead to the Wrong Care

We have heard tremendous support for the government's announced direction of focusing on aging in place. Expanded home care and the 'nursing home without walls' concepts are finding a lot of support in theory. However, it is unclear that there are governance and income support models in place to support this transition.

We hear too many stories of a small accommodation at home being denied because it does not fit a formula, only to send the citizen into a longer assessment process and a more expensive level of care. Incentives should match the desired outcome, and the system needs the flexibility and the processes to ensure that we aim the most support toward keeping people in the least institutional level of care that meets their needs. There is also a need to provide programs that encourage family and community support by understanding the needs of those potential partners. Respite care, training, and connections to services for families are areas to explore, as is a needs assessment of the not-for-profit sector.

A governance model with integrated continuums in manageably-sized communities is part of the solution. Regulations that give front-line social workers and others the flexibility to make common sense accommodations rather than just follow rigid processes is another key part. Having local decision-makers who can make creative arrangements with the volunteer sector based upon a community's strengths is another international model worth exploring. Most importantly, aligning incentives with outcomes is a significant part of a long-term care system that works.

> *"The assessment tool provides one hour to assess a person for supports. All the research demonstrates that more planning is required, including bringing family together to explore solutions. This one hour model leads to unnecessary nursing home and special care home placements."*

"Evidence tells us that many of those who are in an Alternate Level of Care bed (the majority of them with dementia – 60-80% depending on the community) have landed in the hospital and are to be placed in long-term care, not exclusively because their care needs require that level of care, but rather because supports for family and friend care providers are not available in the community. Investing in the long-term care system requires formal recognition of the role of family care providers in the system, and an investment in community supports and programs."

THEME SEVEN:
Providing the Right Care to Diverse Communities

There is no one-size-fits-all solution in long-term care. Different people will need different supports. New Brunswick's recent success in population growth also brings with it a future for long-term care that will need to be more responsive to diverse needs.

For starters, long-term care does not just affect seniors. Many people with disabilities must plan for their own care long before age 65, and they also have aspirations, goals, and a need for autonomy which cannot be met by just finding an available bed in a seniors' facility. The lack of a unique strategy aimed at younger New Brunswickers with disabilities is a glaring omission with a human cost.

Communities such as First Nations, newcomer communities, and the LGBTQ2SIA+ community all have unique needs and attitudes toward what healthy aging entails. In each of these communities, there are also unique strengths and possibilities for partnerships that allow everyone to age in a way that respects their identity and humanity at all stages in the process.

There is no one-size-fits-all solution in long-term care.

Different people will need different supports.

HOWEVER...

This section began with a reminder that other reports have failed to effect change, even when these past reports were largely agreed with upon their release. People in the system who talked to us were keenly aware of this and were concerned by this recurring failure.

In preparing this and other reports, the Advocate has noticed that many social services are failing at the same time. Many of these failures seem to be the result of common illogical problems, that government repeatedly succumbs to, regardless of department. We could in this report just direct recommendations to the Departments of Health and Social Development, but this seems inadequate. It would be doing the many New Brunswickers who participated in this review, and those who will rely upon it, a disservice not to note that many challenges in the long-term care system are strikingly similar to failings in other social programs. This report will therefore also look at the role that the structure and central management of the Government of New Brunswick plays in the overall success or failure of social policy in our province.

After all, if one of the foundational problems in government is that it operates in silos, the Advocate should not then feed recommendations into those silos. Consequently, for the first time, a report of the Advocate will begin with recommendations to the Executive Council Office and the Department of Finance and Treasury Board, the two entities at the centre of government. This is because our investigation has concluded that the failures of past initiatives and reports, in long-term care and other social programs, lie with a government that is organized in ways that doom social departments to fail. The Departments which run social programs can only be held accountable if they operate within a government structure that supports social policy success. This is the barrier that must be changed.

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THE VITAL QUESTION: WHY DOES REFORM KEEP FAILING?

Or “How It All Broke”

It is important to reflect upon the strengths of government in New Brunswick. After all, every single day hundreds of people who rely on a system of care have good experiences. Many more people can afford care than could a few decades ago. There are scores of positive stories unfolding daily.

Every day in New Brunswick, thousands of trained staff provide care in schools, daycares, nursing homes, special care homes, youth centres, group homes, and hospitals and they do excellent work. We have high-quality training programs with many qualified instructors. Many nursing homes and special care homes have governing boards staffed with dedicated community volunteers who care greatly about their work. Many community organizations have employees and volunteers who work tirelessly to provide support and kindness to seniors who live independently.

Each year, the Government of New Brunswick spends millions of dollars assisting families who need help. Just last year, government spent millions more on long-term care. Even in hospitals where seniors wait in beds when they should be in long-term care, the staff still expends energy and time trying to make that experience as good as it can be. The Departments of Social Development and Health have many people working in leadership roles who are actively trying to find solutions to the problems we will talk about in this report.

These things do not just happen. In many countries that do not have developed institutions, governance, and training centres, our problems would be ones they would welcome. All of this should be remembered when we talk about improvements.

Our public services are a huge reason why Canada is a great place to live. It is not only free markets and free societies that make Canada great – it is that we have married

freedom with a social safety net that provides the social stability, equality of opportunity, and limited protection from risk that makes our free market function. If we consider all the reasons why we are fortunate to live in Canada, the predictability and reliability of services is a major one. There are countries where one cannot be certain that healthcare will arrive, that the ambulance will come, that the streets will be safe, that the schools will open. Canada should never be one. When citizens begin to worry that social services will be predictably there, trust in government breaks down and our stability is threatened. New Brunswick should never see such failings.

On too many fronts today, from emergency rooms that can't respond to emergencies, to schools that are failing to teach children to read, to childcare spaces that don't exist, there is a growing worry that services will not be there when we need and depend upon them. When it becomes second nature to assume government services will not deliver the basics, when we spend time planning for government services to fail, trust and community begin to break down. We are getting close in New Brunswick to sleepwalking into that abyss.

Why? Why is there a pervasive sense that multiple social structures are breaking down at once? Why are we normalizing having seniors languishing in hospitals when they are not there for any reason tied to their interests or their medical needs?

Last year, we started to look within the long-term care silo.That report will follow. However, the more we examined the cases where the system failed New Brunswickers, the more it became clear that some of the problems in long-term care cannot be separated from a general breakdown in governance and social services across multiple Departments and social services. A challenge for government watchdogs such as the Advocate's Office is that, even as we rightly criticize government for acting within artificial silos and failing to collaborate across Departments, often our reports continue to examine problems *within* those artificial silos.

This report is not going to look only at one social service within its silo. Instead, it is our goal to place some of the failings of the long-term care system within the larger context of failures in governance in New Brunswick. Even the best recommendations for change will fail unless we address why government keeps failing across multiple social programs.

There are reasons why too many seniors languish in hospital beds. The reasons are often similar to why too many social assistance recipients are still living in poverty after years, why nearly half of children going to school cannot read, and why a growing number of people living in New Brunswick are experiencing homelessness.

There are reasons why too many seniors are forced into institutional care rather than supported in staying at home. These reasons are often similar to the reasons why too many children in care wind up homeless, why too many children with special needs become adults on social assistance, and why the criminal justice system and the family courts are overwhelmed.

There are reasons why nursing homes and special care homes struggle to find qualified staff to ensure that seniors can have a high quality of life. Many of these reasons are the same as the reasons why parents are passing up jobs due to a lack of childcare, why youth mental health crises presenting at hospitals are at record highs, and why critically ill people are suffering in hospital waiting rooms.

If it sometimes seems like multiple social structures are breaking all at the same time, that our childcare waitlists exploded at the same time our mental health crises metastasized and our hospital waiting rooms backed up and our classrooms became unmanageable and our family court wait times grew ever longer and our psychologists and social workers vanished and our long-term care system became unreliable, you are not imagining it. If it seems like it all broke at once, it did. That's because the same root causes, the same failed assumptions of government, finally hit all the big social ministries at once.

If it seems impossible that there has never been competent leadership at the Departments of Health, Education, Social Development, Justice, or Public Safety, you would be correct. There has often been highly competent leadership in those Departments. However, that leadership exists within systems designed at the centre of government which put those leaders into models that reward irrational behaviour and punish anyone who even defines a social problem, let alone dares try to solve it. Not because people at the centre have been incompetent either, but because the structure and processes in which they work exist in a world separate from the social outcomes we expect government to achieve.

Lest anyone attempt to find partisan satisfaction in that, let it be said that the decline in the functioning of our social programs was not started in recent days. Rather, for thirty years the government of New Brunswick has embraced governance, budgeting, and planning models designed to avoid accountability for social outcomes while focusing on uniformity and bottom lines.If politically there is blame, it is that obvious flaws in how we govern have been pushed down into 'catch-all' programs. If the primary health care system fails, the emergency room will deal with it. If family intervention programs fail, the classroom teacher will deal with it. If a family falls into poverty for lack of training and support, the social assistance system will catch it. If mental health programs fail, family services will catch it. If multiple systems fail, the police and courts will catch it.

Is any of that, really, any different than saying "if seniors don't get home support and the nursing homes are full, the hospital will catch it?" For thirty years governments have ignored warnings about the failures of programs let people fall through the cracks and instead, issued special warrants to fund the nets that catch them: the urgent care hospitals, the courts, family protection.

Then, the nets all started breaking at once.

It is awkward to preview a long-term care report by looking at the general governance model of New Brunswick. Yet if we do not examine the common threads of system

failure, none of the system-specific recommendations will matter. This is because this report has left us convinced that *the failings in long-term care are also the failings in how New Brunswick social programs have been governed*. The programs can only be fixed by fixing flaws with general government. *The centre of government cannot order a department to fix the problem when the centre is a large part of the problem.*

Now, we are at a crossroads. We can comfort ourselves with the same fatuous nonsense that the system is perfect, but the people must improve. "If only people stopped coming to the emergency room." "If only families did better by their aging parents." "If only children had discipline these days." "If only the homeless and the addicted faced real consequences." "If only parents were a little better." "If only the civil servants managed smarter." It seems we can always point the finger at the people who need the services and put off asking these hard questions for one more year, one more budget cycle, one more election. But in reality we can't. Because *the people aren't failing the system. The system is failing the people.*

There is an old story every lawyer hears in law school, a tale that every criminal defense lawyer tells a jury when the lawyer wants to plant the seed of doubt, the germinal idea that their client is wrongly accused. In this tale, a man stands under a streetlight, looking for his wallet. A kind stranger helps the man look. After a half hour, the stranger asks, "Are you sure you dropped your wallet here?". The man replies that, no, he actually dropped his wallet in the alley across the street.

"So why are we looking under the streetlight?" asks the stranger.

"Well, the light is just so much better here," comes the answer.

This report starts with our governance failings at the centre of government because that's where we dropped our wallet. The social Departments – Health, Education, Social Development -- just happen to be where the light usually shines. The solutions start with our most flawed assumptions of governance.

There are five broad governance issues within the Government of New Brunswick that run through a number of strained social systems. These are the flaws that, while affecting several social outcomes, are acutely relevant to the long-term care system and its challenges. They are:

1. Human resource planning is often detached from service standards and future needs. Training targets and programs are funded upon immediate vacancies, not emerging trends. Often, staffing targets are viewed first through a cost control lens rather than focusing on the objectives and outcomes for citizens.
2. The budgeting process is almost completely detached from objective targets, measurable standards of social outcomes, or even reality. Often the budget base is last year's status quo, and budgeting exercises are played out with fiscal scenarios but without any reference to actual measurable social outputs.
3. While financial outcomes are tracked with regularly updated data, clear goals, and with the expectation that managers will have and use discretion to meet the measurables, social policy outcomes are rarely measured or tracked and are almost never established as boundary conditions. Most Departments do not have hard targets for policy outcomes, and many social programs cannot define success.
4. Government generally holds employees accountable for following rules, but not accountable for results. Training programs and workplace procedures place a high emphasis upon limiting variability of process rather than encouraging clear objectives and employee discretion. The result is that public servants are rewarded for being rule followers and discouraged from being problem solvers.
5. We avoid preventative planning and investment in optional programs that might prevent crises. We then fund the inevitable crises. Often, the budget for services that must respond exceeds the budgeted amount, and government gets used to special year-end adjustments. We fund the crisis after the fact and avoid spending on the prevention.

Each of these issues represents systemic flaws within government. They will require central leadership and explicit direction, across multiple Departments, to remedy.

The language in this report is blunt. It may ruffle feathers. However, no one should see this report as an attack upon any one actor in the system. In fact, the reason why this appeal is so urgent is because there are no obvious scapegoats.

If there were incompetent people leading the bureaucracy, they could be replaced by competent people. If there were incompetent people elected to run government, they could be unelected. If government had just made unconscionable cuts to social programs, one could call to out the money back.

In fact, there are caring and competent people in all government departments, and in the Legislature. Certainly the majority in the last twenty years have been that. The rate of funding increases in the last few years have been as much if not more than those in the decade before, and much more than the stingier budgets of the 1990s.

What if the governance system itself was set up to defeat effective social policy governance. What if there are good people and decent resources, but the system is set up on incentives and assumptions so perverse that they have no chance to succeed?

At some point, when hospitals tell people who are sick and in pain to stay away unless they are risking life and limb, when parents can't work because of two year waitlists for child care, when homeless people freeze to death, when people die in hospital wait rooms, when teenagers in mental health crisis flood emergency rooms, when those same emergency rooms rush them out because seniors who need long-term care are taking up urgent care beds, when family courts are backed up and leave children in uncertainty for months, when child protection files repeat the same sorry outcomes, when people turn to social assistance for a hand up but instead stay there for generations, when schools are almost as likely to fail to teach a child to read as to succeed, when hundreds of children are sent home from school indefinitely because the school doesn't know what to do for them, when the wait list for those children to see a psychologist is years long, when the affordable housing wait list is as long as the mental health wait list, when the biggest budget increase is for police and prosecutors because government feels the streets are no longer safe, when we get, well….here, isn't that the time to ask if maybe there's something broken in our social policy governance.

If this all feels a little blunt, well, imagine how all those children, teenagers, families, seniors and vulnerable adults feel. The language here is not because any one person has failed. It's because we are all failing, collectively, and it's time to stop bailing the boat out and ask where all the water is coming from. There's got to be a better way.

So, here goes….

Governance Flaw #1: The Lack of Effective Human Resource Planning

In a sensible system, governments would establish an acceptable service standard in social programs, model the demand for the service, calculate the number of professionals needed to meet the standard, and then budget accordingly. Where gaps between the standard and available resources exist, training program funding and spaces should be correlated with the resources needed to meet the standard.

In New Brunswick, nothing like that happens. It is amazing how many critical programs are delivered without any hard targets for staffing, beyond "let's all do our best".

Let's take, for example, psychologists. We know that there has been a spike in the number of young people presenting at emergency rooms in crisis. We know that this speaks to a lack of primary care and early intervention capacity within the mental health system. Nearly three-quarters of school psychologist positions are unfilled and wait times for primary mental health care are high. So, you might expect that somewhere in government, someone has at their fingertips certain important facts. How many people are likely to require mental health services? What is an acceptable wait time, based on the acceptable length of time before a mental health issue deepens into a crisis which will require more (and costlier) interventions? Combining the demand with the acceptable wait time, how many psychologists (or other paraprofessionals who could meet some of that demand more efficiently and affordably) are needed? Do our enrollments, or recruitable surplus professionals in other jurisdictions, add up to that needed number? If not, after applying any models we might know of for greater efficiency or better delivery, how many spaces will we need to fund in our training programs given the likely retention and recruitment rate?

You would think that, if you asked those questions, there would be an answer. And in New Brunswick, you would be wrong. If you ask for that modelling, you will almost always get a list of all the programs, initiatives, and other things that government is doing to hopefully increase the number of psychologists. Some of these activities reflect considerable effort. However, effort is not the same as results. "We are working hard hoping to fix this" is not the same as "We need to produce X number of psychologists and our current pace of success is consistent with getting there". If you ask how many of any one professional we need and how we know we are going to have them, the governing culture in New Brunswick returns the bureaucratic equivalent of an Error 404 message. It might as well have a perspiring fiddlehead offering a plucky thumbs-up and proclaiming, "We're working on it!"

In the case of psychologists, the critical shortage is made more maddening when one realizes that the doctoral programs in New Brunswick are *both admitting and graduating as few as two graduates a year in clinical psychology*. There are not many more graduates being produced in educational psychology, either. The most popular undergraduate program in New Brunswick liberal arts universities is psychology most years, yet for all of these hundreds of interested and qualified young people, we do not generate actual psychologists. It does not require a statistical regression analysis to know that, if you need dozens of psychologists and you are adding two per year, by the time you fix the teen mental health crisis that generation will need more gerontologists. Yet this incuriosity in the adequacy of training spots coincided with professional associations adding new requirements for mandatory doctorates and more stringent supervision before admission to the profession. In this case, absent a functioning School of Psychology that manages the admission to the profession as medical schools do, we are at risk of reaching such a critical shortage of psychologists that we will lack both practicing psychologists as well as the people qualified to supervise and admit new psychologists.

Government sometimes explains the lack of training spaces by offering a list of recruitment programs. Again, however, we do not have numbers to show progress of these programs or available recruitable psychologists. On a macro level, a 'recruitment only' approach to professional shortages seems inadequate. If recruitment alone would work, we would be able to identify jurisdictions where the problem is that they have too many psychologists, or nurses, or doctors, or other scarce professionals. If such a jurisdiction is handy, they are extraordinarily circumspect. We are unaware of any recent debates in any North American jurisdiction centred around the question "How do we get rid of all these extra doctors?"

The impact of this culture upon long-term care is clear. Some years ago, the New Brunswick Nurses Union produced a report clearly establishing the vital role that Registered Nurses play in long-term care. Without these nurses playing a part in developing and executing care plans and supervising other care providers, the system will likely not produce results because there is not the leadership and problem solving available to other front-line workers to make their efforts available. Lest anyone write the NBNU conclusion off as self-serving because of their legal responsibility to advance the employment conditions of nurses, the report noted that many care facilities were operating without meeting government's own standards for Registered Nurses per patient. In fact, the NBNU report found that the shortfall was so widespread as to cause inspectors to simply stop writing it up. While the Department of Social Development has submitted that the failure to meet the standard was and is regularly noted, our consultations still found a pervasive sense that the shortfall has been normalized to the point where there are no meaningful consequences for a practice which government claims is unacceptable.

Further, the shortage of staff for nursing home and special care homes has led to a situation where beds and infrastructure exist but cannot be accessed because of a lack of staff. Yet no current plan exists which identifies staffing numbers tied to freeing up those beds and a training plan to get us there. For all the recruitment programs announced with fanfare, no one has hard numbers modelling future demand, service standards, and hard targets for the number of nurses or other health professionals needed, let alone a capacity model for how to achieve these.

In many ways, our human resources models are still built to solve an austerity problem rather than a service shortage problem. This dates back to a 1990s approach to health care, a period in which the government of New Brunswick reviewed most social programs with an eye to reducing expenditures and did not quantify social impact for reasons both operational and political. As the premier of the day famously said, "people first and money second ended when the money ran out." The human resources modeling practices used reflects this three-decades-old ordering of priorities which tied human resource planning to financial targets, but decoupled them from models of demand and service standards.

Essentially, in the 1990s, governments were confronted with a question of how to control costs in a demand-driven system. In our health care system, for good reasons, there is an element of cost which is simply driven by how many people demand a service. If patients present at a hospital or a doctor's office or a similar service portal, they will receive a service and government will incur an expense. Under the terms of the *Canada Health Act*, those services are provided without direct cost to the patient. They are paid for from government revenue through Medicare, which is a public health insurance plan. In a pure market economy, demand might be controlled by attaching a price to health care services or by the insurance provider rationing those services. Of course, health care is not a market commodity, and Canadians rightly do not want the social consequences we see in countries where those private sector controls of price and rationing are used to deter people from accessing primary or urgent health care when they feel that they need it. In short, government did not, and should not, change the fact that the service is free.

To explain why this changed the human resources model, it might be helpful to imagine a wedding reception where the host is providing guests with an open bar. The eventual cost of that open bar, if all drinks are provided free of charge to the consumer, will be driven only by demand. If the host sees that the cost is getting out of control, there would be ways to regulate the final bill. One could begin charging for the drinks, which might cause some people to rethink demand. Or one could ration the service by, say, giving each guest a fixed number of drink tickets regardless of what they actually need. With bar service, these are fine options. Applied to health care, these methods may deter people from needed care because they can't afford it, or they may abandon the person who has acute and complex health care needs.

How would one control the cost of an open bar if charging money or limiting drinks is unacceptable? The third option would be to limit the number of bartenders handing

out drinks. If one reduces the number of bartenders qualified to serve people from six down to, say, three, the wait times for drinks will go up, but the slower pace of services will control costs. In fact, the long lines may also reduce demand in the way that higher prices would – some guests may see the long wait and decide that they don't really want the service at all, or will find other ways to meet their needs.

In the 1990s, government essentially controlled health care costs by reducing the number of providers and portals, thus increasing wait times to slow the annual rate of use of health care services. Hospitals were closed. The billing number system for physicians became more restrictive and imposed limits by region upon how many people could practice medicine. Enrollments in medical, nursing, and other health programs were capped, and this trickled down to college programs for other health services professions. The wait times that resulted were a feature, not a bug, of this plan. The annual cost of health care was now predictable, because the system could only dispense services at a certain rate. The growth of health care costs was (somewhat) controlled.

None of this is to denigrate the need for sound budgeting or good fiscal management. Uncontrolled budget deficits have other social impacts which can legitimately be considered. Fiscal targets should be established and, in the normal course, should be met. The point in noting that the fiscal target alone drove human resource planning is to highlight what government stopped measuring and stopped considering in setting human resources targets.

What government did not do, during this period, was set standards with hard targets for acceptable wait times. They did not calculate the social or future costs of delay, and they did not model future demand relative to the immediate training restrictions. Some of this was due to the policy decision to emphasize the fiscal targets in response to the perceived crisis, which was a legitimate policy choice. Some of this was no doubt political as well. After all, if you have a standard for an acceptable wait time and you increase it in order to lower human resource hirings, then you would have to admit that you moved the standard upward by design. Then you would have to admit that the longer wait was a policy choice, and those calculations would become discoverable through right to information requests. So, it was better for government to simply curtail the number of health care professionals and know that some wait times would go up, but not set hard targets for what that trade-off would be. That way, no one was actually accountable for the result, but one-off solutions could be found when the wait time grew so high as to cause public anger. However, this made the test for wait times simply what the public would bear, not a standard driven by health-related outcomes.

The unintended consequence of this was that once the human resources caps and limits became the norm and the training spaces were limited, it affected the professional and educational plans of citizens. Once jobs and training spaces become limited, the supply of people considering the profession also becomes limited. Psychologists are a good example of this – it is now an accepted truth that only a handful of people will be accepted into doctoral programs, and so now young people don't even embark upon the

steps that might let them consider the profession. Once we tried to dry up the number of providers in the 1990s, we also discouraged those who might have become health care professionals in the 2020s.

Here, too, government generally chose to avoid accountability for the logical consequences of its actions by decentralizing the decisions and avoiding standards and measurement. Funding of universities and colleges was reduced, and government avoided setting targets for the number of people who were trained and the number of spaces available for future professionals. Even today, when we asked the Department of Post-Secondary Education, Training and Labour for information on how the number of spaces and/or seats in professional programs correlates to the number of vacancies to be filled, they replied that they do not allocate funding on the basis of spaces or seats.

Again, in any sensible system, one looks at the projected demand for a service and sets standards for how quickly that number of people should get the service. You then calculate how many professionals it would take to provide the service to X number of people within the acceptable time limits. You then look at the expected retention rate of new graduates in the needed professions, apply that rate to the number of vacancies, and determine how many people you need to train. You then sit down with the training institutions and determine what they need for resources to provide that many training spaces. At each juncture, of course you engage in sensible discussions about the most cost-efficient way to do things, about what the lowest acceptable standard will be, and you hold providers accountable for any inefficiencies in how they deliver the needed training or service. But you start with a sense of what the service must be, at a minimum, and what the minimum reasonable cost is. You don't give someone $10 to prepare a four-course lobster dinner and then act shocked – shocked – when they return from the store with a tuna sandwich. You set standards and then you calculate the most efficient funding model.

That's what healthy processes do. It just is not what the Government of New Brunswick does, because thirty years ago our funding model was built around the policy imperative of hard fiscal targets with the political imperative of not knowing the impact to the point of accountability. Political credit was taken for the fiscal target at the centre, and the buck was passed on to the downstream providers – health regions, hospitals, school districts, colleges, universities – to announce the consequences. If government increased funding later, they nebulously claimed it would lead to "more "and "better" but avoided having to set a target for what was expected, because then they would have to provide answers if the target changed for the worse. If this worked to avoid making politicians answer for the social consequences of fiscal targets, it also infested the bureaucracy with the same credo. The financial targets can be set and met, and social outcomes are best not measured. In fact, as we shall see, the public servants tasked with calculating the fiscal targets are a completely different set of people than the public servants held accountable for the service delivery.

The purpose here is not to relitigate the urgency of the 1990s fiscal crisis today. Those policy trade-offs were democratically discussed, and choices were made. However, if the challenge changed in 2024, the governance model didn't. We are trying to get a bureaucracy built for 1994 to solve the challenges of 2024. If the effect seems about as effective as trying to pump up a high school dance today with the Macarena, that's because the time lag is every bit as dramatic.

We continue to hear about the coming demand for long-term care. This will lead not only to demand for traditional care professions such as nurses, but (as we shall see) new skill mixes in growth areas such as home care, dementia care, and recreational therapy. Yet if today you asked to see numbers for service standards, future demand, and training program enrollments in the hope that those numbers would have something to do with each other, you would be disappointed.

It is almost as if we are afraid to ask the question, because knowing the answer might create a responsibility to enact radical change. Of course, eventually a lack of future planning creates fiscal problems as well. A failure to train enough nurses will eventually lead to overpaying for travel nurses in numbers suspiciously close to the original training shortfall. As we shall see, the same culture of incuriosity extends to our budgeting process, where we have completely decoupled the fiscal framework from accountability for the social outcomes.

Governance Flaw #2: The Curious Detachment of the Budgeting Process from Reality

There are budget targets which government must hit each year. Through the budget, the Government of New Brunswick establishes what are acceptable outcomes on a variety of important policy questions. What is an acceptable amount of spending, given that each dollar must ultimately be paid by New Brunswick citizens? What is an acceptable level of deficits for which we will borrow, or surpluses which we must achieve? What revenue and expenditure targets must each component department and program achieve if New Brunswick is to meet its overall targets? What amount of debt should be repaid in order to achieve flexibility and future stability?

These are all worthy questions. They are important, because they predict outcomes that have real impacts upon the quality of service and policy options in years to come. They set targets which directly address how much citizens will be asked to pay in taxes and fees. Because these outcomes matter, the budget establishes measurable targets with clear numbers. The Department of Finance and Treasury Board, and the Executive Council Office collectively share the responsibility for setting these targets and enforcing measurements and reporting which make sure that the targets are not forgotten as the year unfolds. The budget they prepare should have the effect it predicts, and if the numbers do not match the reality, we hold those departments accountable, and ultimately the elected members of the Executive Council who oversee that process.

However, budgets are not only fiscal documents. They represent a balance of how we meet our fiscal goals and our social policy goals. After all, if a budget were only an expenditure control document, the task would be easy. We would simply enter zeros on every line (save for a few employees to print the budget with all those zeros), we would add a bit of revenue for the printing and debt repayment, and all would go well. The reason we have a budget process is to make distinctions between needs and wants, to determine what government *needs* to do in order to justify the money it takes from citizens. The numbers don't simply set limits on expenditures – they tell us what government has decided it must do in providing services and addressing collective needs, from roads, to safety inspections, to schools, to long-term care.

So, when the central authorities in government – the Departments of Finance and the Executive Council Office –release a budget, they are in fact communicating two decisions that they are tasked with: they are warranting that the financial limits they have set will have impacts that meet our fiscal goals – stability, borrowing, sustainability, justifiable

taxation; they are also warranting that when they assign a number to a social priority by funding it at the determined budgetary level, they have chosen that number because they know what the goals are and have determined its adequacy.

After all, a budget cannot be simply a random set of numbers that we are willing to spend because, hey, why not? The combined budgets of the "Big Three" social departments – Health, Education and Early Childhood Development, and Social Development – are given just over $7Billion per year. That is over $8,000 requested from each New Brunswicker, nearly $15,000 demanded from each New Brunswicker of working age. It would be a disservice to tell those who pay the tab that the expenditure was set only because we wrote down numbers and then limited them based upon fiscal goals. The budget is government's assurance that we have determined what services residents should be able to count upon, and that what we are spending will meet those commitments. That means that those who prepare the budget should know what the social objective is, how many people will need to receive what service in what frame of time, and what success will look like if the program meets its objectives.

So, when we ask the departments charged with preparing the budget why they have chosen a particular number to spend, we should hear from the Departments of Finance and Treasury Board and the Executive Council Office that they received and understood models of what is to be done, for how many people, and what is to be achieved. If money is added, we should know what standard is expected to be reached. If funds are limited, we should know what standard they have determined is acceptable to balance the social and fiscal objectives. Otherwise, when the government claims that a budget invested "more" in a program, all it means is that we decided to spend more money and wrote down a bunch of numbers until one looked good.

In short, if the departments who prepare the budget and enforce the fiscal plan have the power to determine what we will spend or not spend on a social objective, they should share in the accountability for whether or not the plan met the objective. It is nonsensical to say that the most critical decisions – the financial parameters and where the money will be allocated – are made at the centre of government but only the officials at the social departments are held accountable for outcomes. Decoupling authority from accountability is (always) a bad idea.

To spell it out in simple terms, imagine if two people are responsible for hosting a steak dinner, and the objective is to ensure that everyone has steak. Person A sets the budget. Person B buys the food and prepares the meal. When we arrive, we see five people eating and one hundred angry people milling about hungry. The person preparing the budget points at the person organizing the dinner and says "we gave them money, so don't look at us!"

The question is, of course, whether or not the person preparing the budget made a wise decision when they set the number. The person setting the budget should be able to tell us how many people they were preparing to serve, what they assumed the ingredients

cost, what the acceptable quality and speed of service was, the number of staff required to achieve the goal, and how much those staff would need to be paid. If these budget assumptions were correct, and the person preparing the meal hired a limousine to go the grocery store and then decorated elaborately instead of buying food, we have a delivery problem. If the person setting the budget assumed that we could buy filet mignon for $1 per pound, we have a budget problem. And if no one can tell us what they assumed for any of the inputs, we have a complete governance failure.

In most cases in New Brunswick where we examine a failure of social services and systems, neither the department nor the central authority can offer any objective measurement to determine if we have a delivery or a budget problem. That means that we are systemically living in a continuous governance failure.

In April 2023, after the release of the 2023-24 Budget, the Advocate's Office asked the Department of Finance and Treasury Board some questions to see if basic modelling was done before determining expenditures. We generally focused on what could be seen as 'positive' announcements in that resources were increased, not cut. This was a deliberate choice, done to encourage answers which were expansive and not defensive. The responses were rather revealing.

- We noted the presence of several tax incentives for landlords to lower input costs and thus lower rent costs passed on to tenants and to stimulate housing development, and asked what indicators would be measured to track the impact upon affordability, and if there were any results that would need to be met for the program to be continued. The Department of Finance responded with an affirmation of the goal and declined to name even one indicator that would be measured to determine success or failure. This means that a multimillion-dollar initiative was launched without any sense of what, exactly, the result would be. Common sense would dictate that one should know what result one wants before millions of dollars are spent, rather than spending millions of dollars and then figuring out what might happen, or worse yet, what did happen after the money was already spent.
- We noted a $1.7Million parcel of new funding for First Nations mental health initiatives and asked for any specific needs assessments that were done to arrive at that number. In short, what were the numbers of people in the targeted group waiting for services, what was the acceptable service delivery time before these problems became worse and strained other systems, what the connection was between these needs and the expenditure, and what results would we see if it worked. The Department of Finance responded only that there would be new initiatives and that the government was "moving forward". If "forward" meant there was any particular result or need that would be addressed, it was unclear. What was done in this case was a funding of inputs, but no sense of results.
- We noted that the new budgeted amount for Child Protection Services was lower than the actual expenditure from the year before, and asked for the basis for this prediction with specifics on what drove the previous demand and what real changes government

was basing the change in measurable outcome upon. The Department of Finance replied only that the previous year had higher caseloads and costs per case, and if that situation happened again, they would simply add more during the year. There was no information provided as to why caseloads and costs were higher, what upstream investments might have avoided the surge in child protection inputs, or if there was any particular basis for the assumption that the caseloads would go down that could be measured. The only possible consequence of this odd budgeting – writing down a number that was wrong last year and making a wish upon some star that it won't happen again – is to put the Department of Social Development in a state where they are uncertain of their resources to make strategic change for eleven months of the fiscal year before shrugging and spending millions more at the end in the least strategic way imaginable.

- We asked about what should have been a good-news announcement in Education – the addition of $10.1Million to add additional behaviour mentors, resource teachers, guidance counselors and social workers to address classroom composition. The Department of Finance repeated the inputs and announcements of what the inputs were, but could not provide any modelling of how many classes were compositionally challenging, what the numbers were of children requiring service and the expected response time before the problem caused more complex problems, or what factors went into measuring positive changes in classroom composition. Essentially, it was a list of new expenditures that could be announced politically, but included no expectations of results operationally.
- With regards to long-term care, we asked specifically for modelling and benchmarks of seniors in alternate levels of care (which is to say in hospital beds with no medical purpose for continuing admission). We wanted to know what the numbers were and what an acceptable or predicted decrease in the number of seniors stuck in hospital beds would be. This would accomplish two things – it would assure us that there was an outcome which must be met rather than a wish, and if the Department was prepared to predict the result, it would mean they had found where the backlog was and knew what would have to be provided to address it. Regrettably, the Department of Finance could not provide us with any of that. They mentioned only that last year had resulted in 35 transfers from hospitals to nursing homes, but they set no targets for the year to come. If there was any evaluation of how their fiscal decisions would actually address the issue, this was kept to themselves. They repeated that they were committed to improvements in assessments and home care and were recruiting staff successfully from the Philippines. Where these new staff members would go and what result would be expected was, apparently, unknown. Once again, the input was repeated with no reference to predicted, measurable, or expected results.

That last answer shows precisely why we are not confident that recommendations aimed at the Departments of Health and Social Development alone would solve the serious problems in long-term care. The central governance model is fundamentally flawed because the budget and financial oversight process is completely detached from any

concept of results. The answer from the Department of Finance with regard to long-term care is lacking in the same way that the answers were lacking on classroom composition, First Nations mental health, housing affordability, and child protection. At some point, continuously hammering the party line of departments, while ignoring the fact that their resources and operational rules are completely unaligned, makes no sense. That is why we are examining the central governance model in our quest to figure out why so many past recommendation reports on long-term care have gone unfulfilled.

We know that there are over 300 seniors in hospitals that should not be in hospitals. We know that this has tremendous impacts upon their quality of life, because in a strained institution built for urgent care, their daily needs as fundamental as bathing and bed changes, let alone recreation and social opportunities, are often put off. We also know that their ongoing presence is affecting the quality of emergency care, leaving patients in hallways, in waiting rooms, and sometimes at home in pain and discomfort which cannot be addressed in a timely fashion. In short, we know this is an urgent situation.

If the situation is urgent, what is an acceptable target? As mentioned before, the Department of Finance, when asked what target its financial decision was based upon, could tell us only that in the previous fiscal year, 35 seniors moved from hospitals to nursing homes. Even if no additional alternate level of care patients arrived during that same time, this pace would create a decade-long window to resolve the current caseload. In fact, we have since been provided with data from the Department of Social Development noting that the Department of Finance chose to only provide us with the results of one targeted project rather than the overall number of patients transferred from hospital to nursing homes, which was 1,065 from April 2023 to February 2024. When asked what the overall impact upon the waitlist had been, we were told that, overall, the waitlist had grown from 740 to 949 and the number of seniors left waiting in hospitals had grown from 431 to 480.

It is indicative of the problem that, when explaining its budget, the Department of Finance cited only one program it had funded and one year later Social Development provided us with the global number of patients placed. After all that, it was not until our office asked specifically for the waitlist numbers (the original point of our question about the budget) that we received numbers showing that the waitlist had actually grown by 28.2% and the number of seniors left waiting in hospital had gone up by 11.3%. This essentially means that, at the time they were asked to explain their budgetary decisions around addressing this urgent problem, the Department of Finance did not even think to check if the waitlist numbers were getting better or worse, even though those numbers were knowable. This is precisely what we mean by the disconnect between the budget process and the actual results that impact New Brunswickers. If the budget was not set with reference to the waitlist trends, what on Earth could have been the basis for the budgetary decision?

Even if we leave aside the human cost of that window, there are additional questions a prudent budget maker would ask before making resource decisions. What models exist

for speeding the pace? What would be the result if a hard target were set to resolve the situation? What regulatory changes could speed the pace? Are there other funding options, such as increased special care home or home care capacity which might increase that pace? Most crucially, if we accept the status quo, what additional costs would be created by that window in terms of urgent care resources, additional human resources to manage alternate level of care patients, and spillover strain on the primary care system?

A prudent budget maker would ask those questions because the fiscal resources directed to this challenge will determine costs and results throughout the health care and long-term care envelopes. The policies and structures of Treasury Board and the Executive Council Office include how fiscal flexibility is transferred and how employees are trained and incentivized in terms of measuring and getting results. One would think that the centre of government operations would model social outcomes, tie funding to results rather than inputs, and structure operations around meeting social and fiscal targets.

Instead, the budgeting process involves using the previous year's number without assessment of result, providing funding increases or decrease without modelling the social impact, and then, when the unrealistic budget assumptions drive unanticipated costs (like a lack of long-term care capacity creating desperate, crisis-driven expenses in urgent care), a special warrant is issued at the end of the fiscal year when the money can least be used for structural change. Then, as the Department of Finance advised us in their explanation of child protection funding in 2023-24, the next year's budget ignores the special warrant and returns to the previous year's flawed assumptions without examining what factors might cause the assumption to be flawed.

That flawed process for allocating resources to social programs might be partly why the social programs do not achieve meaningful reform or improved results. In a high-functioning government, the cycle would look like this:

1. The Department of Finance models various fiscal scenarios and projects the consequences, short and long term, of various models of spending, revenue and balance scenarios and recommends the optimum fiscal targets.
2. The Executive Council Office models various social and operational scenarios and leads line departments in modeling social outcomes and indirect costs driven by various funding scenarios and recommends optimum areas for budget investment with predicted results for which departments will be accountable.
3. With both the fiscal and social centres of government providing models to Cabinet, Cabinet provides the essential fiscal and social outcomes through a budget which funds results, not just lists new spending inputs and activities.
4. Line departments develop key indicators and targets for performance and empower officials throughout the department to make decisions to meet their unit's social and fiscal outcomes.
5. The Departments of Finance, Treasury Board and the Executive Council Office collaborate upon measuring the results on the key indicators and begin the process with updated baseline assumptions, measured results of past expenditures, and identified areas for investment tied to projected and modelled results.

This sort of budget cycle would depend upon a healthy creative tension, and equal mandates to project and model outcomes, between the Department of Finance and an Executive Council Office with a healthy policy apparatus. Instead, the centre of government has increasingly harmonized Finance and the Executive Council Office into one entity which sets fiscal targets but has neither the capacity nor the curiosity to measure how those fiscal decisions impact social policy outcomes. Essentially, the Executive Council Office that should develop a central vision for social policy and support social departments has first been hollowed out from policy expertise, and now absorbed in its mandate and leadership into the Department of Finance and Treasury Board. What should be a creative tension is now total domination, where Finance and Treasury Board has grown dominant enough to ignore the normal checks and balances – even the limits of its own competence and knowledge.

The result is that the Department of Finance guards all the power to make final decisions over how to resource social programs but has none of the accountability for outcomes *– even when the lack of analysis leads to unexpected social outcomes that then drive up financial costs.*

The result of this is shown in the budget explanations we were given by the Department of Finance. There are no social policy goals, measurements, or results. All the budget process does is use a baseline which itself is not tied to results, decides which activities that politically must be funded and announced, funds as many of those activities as the fiscal limits will allow without an assessment of the impact and then, when asked what results they expect, lists all the new activities without any prediction of what results those activities will generate. Then adherence to numbers designed with no assessment of results which becomes more operationally important than results.

We are managing $7billion worth of social programs with a fiscal approach we would not accept from a household contractor. Imagine having this conversation with your plumber:

You: *Thank you for coming. You can see that the sink is shooting water everywhere. Can you stop the flooding?*

Plumber: *You should know that I have budgeted $5,000 for this job. Please send it now.*

You: *Is the sink structurally sound? Is there a specific part you need to replace or fix?*

Plumber: *I am committed to sound and efficient sinks. Once you give me $5,000 I will monitor the effectiveness of my activities and maximize the results.*

You: *OK, sure, but why is $5,000 the number? You must know what parts of the sink need improvement to stop the result of flooding. What result will you predict?*

Plumber: *With $5,000, you will be funding several anti-flooding initiatives, including a new anti-leaking support program, the hiring of two new plumbers' apprentices to enhance service and responsiveness, and I will pilot a new washer replacement program in the lower portion of the pipes.*

You: *So, it is the washers that need to be replaced? If we replace all of them will the flooding stop?*

Plumber: *It's a pilot project. We will carry out the activity and monitor the results.*

You: *What results would lead you to replace the rest of the washers?*

Plumber: *I cannot say at this time, and the report on that is not ready to be released.*

You: *I just want the flooding to stop. Why should I give you $5,000?*

Plumber: *On my last job, my team put in three hours work. With your $5,000, we will be increasing the apprentices' time on task by 67% to 5 hours.*

You: *On the last job, did the flooding stop after three hours?*

Plumber: *You know, I did not ask. But this will be more funding and more hours, so clearly I am committed to stopping the flooding.*

You: *I'm not going to give you $5,000 until you know what the problem is and have a plan to fix it, and are prepared to be accountable for the result, which is that the water from the sink stops flooding my house.*

Plumber: *OK, just give me $4,000. But I may take an extra two days to fix the sink.*

You: *If I wait two days, won't the flooding wreck my floor?*

Plumber: *I don't know. It might.*

You: *How much will that delay cost me?*

Plumber: *I don't know. That would be reflected in the budget for the Department of Flooring, and that's not my responsibility. But I just saved you $1,000.*

You: *How can I know if that's worth it if I don't know what the delay will cost me?*

Plumber: *OK, OK…just give me $3,000.*

You: *Why would I give you $3,000 if you don't know what the result will be?*

Plumber: *Remember, the previous budget was $5,000. I just found an efficiency of $2,000. This is the new fiscal responsibility.*

You: *This is crazy!*

Plumber: *Oh, yeah? If this is crazy, why am I projecting a $3,000 surplus?*

This, in an only slightly-exaggerated form, is how the social program budgeting process works in New Brunswick – fiscal goals driving an arbitrary list of numbers, spending concessions driven only by the political need to fund some kind of action, and no assessment of the link between activities and results.

None of this misalignment started recently. Again, many of these decisions to drive social policy decisions through the accounting wing of government without impact assessment began in the mid-1990s. Indeed, one could make a strong case that the budgets in the last six budget cycles have been far more generous in terms of top-line social spending than the budgets of the mid-1990s. Yet they have been far worse in delivering meaningful social outcomes, with several social structures such as urgent care, family courts, child protection, inclusive education, housing, and long-term care teetering into near-chaos with unmanageable wait times that destabilize budgets and communities alike. This is not because today's government is less generous, but because thirty years of budget models working without proper modelling have divorced even generous budgets from actual results.

Insisting on a strong social policy unit within the centre of government is not a disguised way of saying there should be stronger arguments for more spending. Solid fiscal management is essential and has not always been present in government, either. Government is right to insist upon sustainable spending, limits on borrowing and debt, retaining fiscal room for crises, and limiting the revenue it takes in taxes and fees to what is necessary. These are important goals, and government does not have to apologize for doing them well.

The point is that a strong and innovative social policy analysis function in the budget process actually makes the fiscal goals possible. First, because when the big three social departments account for $7Billion in annual spending, there is no long-term fiscal stability without social planning. Second, when a social goal must be met with fewer dollars, the ability to assess the problem and find innovative ways to target root causes is more important, not less.

Finally, if the centre lacks the ability to see unintended consequences and costs passed between departments, eventually the fiscal goals will fail as well. That is partly because a failure to address social problems with a plan will usually lead to more spending in a political panic. It is also because with no central assessment of social expenditures, departments also create expenditures for other departments. If the Deputy Minister of, say, Social Development is told to save ten dollars, but the solution will create a fifty-dollar problem for the Department of Health, that is not Social Development's problem. So, if Social Development turns down a $500 home care service and the senior winds up in a significantly more expensive hospital bed, that is fiscally compliant but ultimately fiscally stupid. If Education puts a child on partial days and can't pay for services to help them get back to school, and the parent loses her job but goes on social assistance because she must stay home with the child, that is fiscally compliant but ultimately

fiscally stupid. A strong policy outcome unit at the centre of government supports the fiscal goals because they understand impacts of spending decisions in a way that the Department of Finance does not.

In short, the centre of government runs on a model that gives the Department of Finance ultimate authority on which social expenditures get funded, but it is not accountable for, aware of, or curious about the results. And it would seem, right now, that no one is responsible for social policy results. Government only measures whether the rules were followed, and the budget was met. The result, as we shall see, is a culture of compliance rather than a culture of results.

Governance Flaw #3: Following Rules Instead of Getting Results

Or: "The Operation Was a Success but the Patient Died"

If a person with a disability needs government support, they first must decide what bureaucratic category they fit into. There are three places they could go for intake, depending upon whether or not they need income support, housing, or personal support. Once they speak with an intake officer, they answer questions. The questions are not designed to assess what they need. The questions are designed to see if they fit into the criteria for the program. If their income is too high, that usually ends the conversation. The dialogue is generally driven by the intake officer listing what the program needs from the person in order to let them in the door.

We have public policy aims in disability support. We want people with disabilities to live as independently as possible, to be able to provide as much income for themselves as possible, to have a good quality of life. Even if we left the human considerations aside, government has an interest in minimizing people's future needs for social assistance, institutional care, and medical complications.

Despite those clear public policy goals, there is no intake process that establishes what the person needs to live as independently as possible, or to get employment, or to stay healthy. There is no intake process that requires an officer to look at the consequences of refusal or contemplate what will happen next. That is a job for the next intake officer.

There is also no process for leaving a program other than ceasing to qualify. You might think that, if a person with a disability qualifies for support and with that support is able to find a job that works for them, that those programs would include transition planning to an outcome that is one of the goals of the program. You would be wrong. The Advocate's office has dealt with files where people with disabilities turn down work opportunities because there is no plan to transition out of income support. They are told that if they work and exceed the income threshold, even by a little, that health or housing benefits will vanish immediately. Once the case worker cannot tick all the right boxes, the program ends, and the person must search for a new program. There is no transition path out of income support programs. You are either in or out, even though real life rarely puts any of us into easy categories of 'total dependence' or 'total independence'.

The person issuing the decision on eligibility usually has no discretion to look at the outcome and adjust the answer. It may seem nonsensical, from a policy standpoint, to discourage opportunities to work by removing supports. However, the outcome is not the

point. The issue is eligibility for a program. The only remedy to loss of one program is to start ticking boxes for another program. Even if a program meets fewer needs at greater costs, the eligibility drives the outcome.

If a senior needs support while aging, they must first decide which bureaucratic category they fit into. Home support, for example, has a different intake process than institutional care programs such as nursing homes or special care homes. Income support, transportation support, medications and extended health benefits, even certain one-time benefit programs – these all have separate intake and evaluation processes that are tied to eligibility requirements rather than the evaluation of what the senior needs.

In many cases, income thresholds and calculations of available resources change, depending upon what the person is applying for. One would think that the available resources would not change based upon what the need is. In real life, money does not appear or vanish from our wallet depending upon whether or not we are in the grocery store or at the gas pumps. Yet many support programs for seniors change how need is calculated based upon whether they need medications or a lift chair or a home care worker.

One would think that we would start with a goal – to maximize independent living for as long as possible and avoid institutional care and deteriorations in health that increase costly health care interventions. So, one would think that a common process would allow an intake worker to assess what supports allow a person to greatest opportunity to stay in good health and live at home, and make whatever determination meets those goals best and most efficiently. Again, one would be wrong. It is possible in New Brunswick to fail to qualify for renovations to a home or subsidies to a family member for care, but to qualify for a larger subsidy to enter a special care home. It is possible to be denied help with affording medications but to be able to be treated for the resulting health crisis at a hospital, where you can be admitted and receive the medication without cost as long as you occupy a scarce and costly hospital bed.

To move these examples out of the long-term care realm, the same behaviours repeat outside of government. For a quarter century prior to 2022, if a single parent on social assistance wished to share an apartment with another single parent on social assistance, so that they may save enough money to pay for an after-school recreation program for their child and a bus pass to get the child there, that would have been denied because it does not meet the criteria in the social assistance manual. Even though the policy was finally and correctly changed in 2022 to allow for non-conjugal roommates, there is still a long policy regulating who may live with whom to save money. Adult children moving back to help a parent, or romantic partners choosing to share accommodations, or single parents moving in with their parents to weather a tough time, all are subject to scrutiny and reduction of their payments. The degree of micromanagement of social assistance recipients' living arrangements even extends to limits on how long a domestic violence survivor can live with family after getting themselves and their children out of harm's

way. Nine months is all right, apparently, but a tenth month of staying with their family will lead to reductions in the support they and their children receive. They can lose their own independent claim to income support if they need a tenth month.

Those that lose their income support claim, or have it reduced, for being in the wrong kind of relationship with the people they share housing with might still qualify for a separate housing unit subsidized sufficiently to allow them to afford it. The person who takes away their monthly support would not necessarily check, because that is an entirely different assessment program. They might also qualify, through a different set of criteria, for a subsidy for their child for the after-school program, but if they get a part time job to pay for the bus pass to get the child there, they might lose the subsidized housing.

Alternatively, if this single parent fleeing domestic violence wanted to stay with parents long enough so that they could save enough to buy a suit for a job interview and have the parents watch their children while they look for a job, or even save up enough for a damage deposit or a car that might open up cheaper housing options, that would be immediately punished by the loss of their independent social assistance eligibility. They could remain on the program and get subsidized housing, apply elsewhere for childcare subsidies for a full program instead of the few hours they needed, and then take mandatory job training at a higher cost. Of course, if they get a job then the supports might vanish. No one can be sure, because each decision has its own intake and eligibility and is determined by the needs of the program, not whether or not it actually helps the parent get a job and get off of social assistance. Eventually, people on social assistance learn to avoid asking “will this help me get a job and become self-sufficient”? That would be punished. Making sure to ask first “will this keep me eligible for the program?” is a better question than doing any independent life planning in New Brunswick.

We could say that the economic unit policy, the policy that stripped benefits back dollar for dollar if people lived with friends and still restricts people living with adult children or aging parents, is one of the stupidest, most self-defeating pieces of policy ever dreamed up by a consultant (in this case, those noted social policy wizards at Arthur Andersen, a multinational accounting firm known for finding efficiencies in business processes, hired by the McKenna government in the austerity years.) We could say that because, actually, the Department of Social Development would have no evidence to contradict that statement. Of course, if they knew that under the policy more parents on social assistance left social assistance for work, and that fewer of their children became future users of social assistance, that would prove us wrong. If they showed that certain regions had better rates of promoting self-sufficiency, that would bolster their case.

However, the Department of Social Development has no idea, because the policy was adopted without evaluation criteria tied to policy results. They also do not track results, such as whether or not people eventually leave social assistance for work. They simply track whether or not their employees comply with the policy when determining what families get. There is no planning, led by trained social workers, to determine the needs of a family based upon outcomes of promoting work and ensuring their children succeed

in school. The social worker can only look at programs and see if the family happens to tick the right boxes. Does it work? Honestly, no one even defines what it would look like if the program "worked". No one defines results. We just know we complied with the process, not whether the process actually saved money or helped people long-term.

In short, we know that from 1997 to 2022, no social worker let anyone move in with a roommate without clawing back $300 from them. Whether or not the $ 3,000,000,000 spent on social assistance since the policy was launched is working was apparently not as important as knowing that we got that $300. This is, apparently, what sound fiscal management looks like. We may have wasted $3Billion without achieving anything, but we wasted it exactly as the manual tells us to.

What has been described here is an example of rules-based governance, and it infests the long-term care system for the same reasons it defeats many social policy initiatives in New Brunswick. Government may claim it has a goal – get seniors out of hospitals and into nursing homes, get people off social assistance and into work, get children out of poverty and into college, get people off the streets and into housing. It even announces new programs designed to meet those goals and creates buckets of money to meet the goals. But we fail, over and over, because the one thing the Government of New Brunswick will never do is allow a front-line worker to change the rule to get the result. When rules clash with results, rules win in the New Brunswick government.

In fact, the Executive Council Office training model was originally built around a model meant to ensure that rule compliance and uniformity of action is valued over problem solving. The promotion of Lean Six Sigma (LSS) as the currency for public service training is the manifestation of centralized, rule-based governance at the expense of innovation and discretion.

Lean Six Sigma is adapted from manufacturing processes, most notably from the Japanese electronics sector in the late twentieth century. It is premised upon the use of centralized "black belts" to design and rework processes which can be implemented with relative uniformity, eliminating variations and deviations from the process downstream. It combines ideas for centralized program design (the "Six Sigma" part) with clear incentives for frontline workers to eliminate deviations from process and "wasteful" extra steps (the "Lean" portion). While data is used by the centralized "black belts" to continuously refine process, it does not waver from the central concept that process should be centralized and uniform at all times.

To be fair, there have been significant efforts to diversify and improve training in recent years. There has been an awareness that the aims of Lean Six Sigma Training might not translate well to all areas, and there have been efforts to expand training options to include problem analysis, data measurement and other skills. However, it is accepted that Lean Six Sigma, as originally conceived, was a program introduced to implant

manufacturing principles into government for the purposes of cost control, and that the certification remains one that is broadly supported and used for training across governmental departments today.

In fact, New Brunswick jumped upon the Lean Six Sigma bandwagon as a tool for social policy when its limitations were already being noted in its original manufacturing application. As the *Harvard Business Review* noted over a decade ago, the uniformity that is a feature of LSS can often be a barrier to innovation when periods of change or disruption occur. Uniformity may avoid someone making a deviant error, but it also keeps frontline actors from coming up with innovative solutions. Even in its manufacturing birthplace, LSS proved less useful once technology and changing needs required innovative new goals rather than constantly tweaked processes.

Further, the LSS ethos of eliminating variations in process as inherently wasteful is a bad fit for social problem solving. Uniformity may be a virtue when workers are to churn out identical television sets from a market-tested central design aimed at pleasing the targeted market share of consumers. It is a poor fit for social programs, which deal with human beings who insist on being distinctive individuals with infinitely variable circumstances. Even well-intentioned efforts to diversify with training staff largely steeped in LSS are likely limited in how successful they can be, because there is such a mismatch between programs. Once you start from the premise that variance always equals waste and processes should first be perfected in central planning, you are not going to train for innovation and flexibility in a results-driven model. The process needed to help someone move from social assistance to stable work, or to assist children with unstable homes and families, or to help an aging citizen maximize their happiness and independence in their home community is not always clear or uniform. LSS is designed for a system where the decision-making skills are with the central designers and the implementation is aimed at reducing variation among less-trained workers. Social programs often have highly-trained team members – social workers, nurses, teachers – delivering the service. Constraining their discretion may minimize their ability to find creative ways to problem solve that are right for the individual, and the resulting rulebound paralysis may actually harm recruitment and retention of these professionals. Such an Orwellian depersonification may be easier to manage, but at what cost? We know the answer, the cost (both human and financial) is high. The model of social governance which has shown better success – one where results, rather than rules, govern and where employees can innovate and even deviate and compete to meet the result – is the opposite of Lean Six Sigma principles.

The Reinventing Government (ReGo) philosophy of governance is one which highlights results-based governance, decentralizing management to give front-line professionals discretion to make results-oriented decisions even if they vary from the centralized process. It still holds people accountable, but for results rather than uniform rule-following. Clear goals are assigned and measured, such as getting seniors from hospitals into appropriate long-term care, increasing the number of seniors who can live at home,

or moving families from social assistance to work, or reducing the number of children in care who are homeless at age 21 and increasing the number of children in care who achieve post-secondary education. Individuals are free to vary rules within the financial parameters based upon what best meets the needs of each individual person. The results are measured and those who prove most successful and innovative share their ideas with others. Different approaches, even competition to best meet the social outcome, is encouraged. In this sense, the ReGo approach is every bit as evidence driven as LSS, but its focus is on using data for innovation and results for the citizen, not uniformity of a process within a centralized bureaucracy.

It is possible to imagine a world in which front-line social workers are given global budgets per client and are empowered to make decisions on a case-by-case basis that best meet the needs of an individual senior to help them stay longer in their home and get support services to keep them active and socially engaged in the community. It is even possible to imagine that central government would spend less time pretending that any one set of rules will work for every family, and instead setting key outcomes and measuring which regions and workers meet the goal the best. It is possible to imagine the same ethos being applied to social workers lifting families out of poverty, social workers helping vulnerable children plan a future, health care workers reducing the seniors stuck in hospital beds, or teachers teaching children how to read. Now, imagine if the leadership at the large social ministries was tasked with defining the mission, measuring outcomes, promoting solutions, and holding the regions responsible for outcomes instead of rules.

In such a world, the internal staff time spent on Lean Six Sigma training to produce conformity to failing rules might instead be used to fund governance models built upon innovation and flexibility. What if a health region received money to innovate and apply some of the Healthy Seniors pilot project ideas to see if they could keep more seniors at home, longer, and that specific data were generated to report on the outcomes? Imagine if we funded innovation at the point of service and the Executive Council Office supported the innovation, rather than imposing rules to enforce process uniformity. Imagine if red tape reduction wasn't just a concept we apply to services and business, but if we also reduced red tape for those whose output is healthy seniors, or educated children, or self-sufficient families.

In such a world, the system would begin to see collaboration and information sharing between departments. In the fifteen years since former Advocate Bernard Richard pointed out the devastating effects that a lack of co-ordination between departments can have upon citizens, there have been repeated efforts to develop Integrated Service Delivery (ISD). ISD is designed to make sure that dumb outcomes don't happen because the citizen's needs require multiple departments to share information and provide services, and the two departments are caught up fighting over whose rules apply and whose budget gets charged for the service. Government keeps looking for some new rule or protocol to promote cooperation between departments. This is doomed, because

the central rules are the problem. If civil servants are accountable only for following siloed rules and staying within siloed budgets, the incentives all run against collaboration *because collaboration always means departing from siloed rules and competing for savings in siloed budgets.*

For example, if a social worker assesses a request for giving a senior citizen weekly transportation to a clinic, if the expense means going over budget or departing from program criteria, the call must be no, because they are accountable for following rules. If the lack of transportation means that the senior's health declines and they wind up in a hospital bed waiting for long-term care at ten times the cost, that is not the social worker's problem because it is now someone else's problem. The workers did what they are accountable for, which is following the rules and staying within budget. There is no reward for solving the problem, and likely consequences for trying. As for the fact that the senior citizen is now less happy and costing the system more, well, no one is accountable for that bad result.

It is easy to draw parallels between the long-term care problem and other times government follows the rules and gets dumb results. Public servants are responsible for ensuring that the young person aging out of care does not get 'YES' funding unless they meet the rules. No one is accountable if they wind up homeless or unemployed, but someone else must fix those problems at greater expense. Public servants are responsible for making sure that the services a child with dyslexia needs do not exceed the siloed budget, but if the child graduates and needs intensive training to be employable, that's another department's problem and no one is accountable. Hospital managers are responsible for the budget and the procedures. If a senior winds up in tears because they can't get a banana no matter how many times they ask, well, who is accountable for that? The rules were followed, and the banana budget was respected. The tears of the client are no one's responsibility.

If people must answer for the result – keeping the senior at home, making sure the child reads, keeping the young person off the street, getting the damn banana – then there is an incentive to collaborate with other departments if the result improves. If you only answer for inputs, no one works together. If everyone answers for the results, people make daily choices to work together.

Right now, the civil service is organized on the same principle as if we told a basketball team that everyone is responsible for running to the right place, but no one cares about the final score. Everyone is running the play, going through the motions. No one cares if we're losing by 50 points. If the centre of government wants results, it needs to define those results and provide incentives.

In a results-oriented world, someone calling Social Development to begin planning their supports as they age might start by having a conversation about what they need and what they and their family can do, instead of a list of criteria to see if they fit the pre-existing programs. That person doing the assessment would know that their career

advancement depends on keeping the senior home, not just following the rules. What if we asked the bureaucracy to meet the needs of the citizen, instead of evaluating how the citizen might meet the rules of the bureaucracy? Innovation and results are far better than uniformity and compliance. It is too bad that our government is set up at the centre for the wrong priorities.

Of course, this shift from rules to results would require strong support for departments with meaningful data, regular reporting, and a mechanism to use data to set incentives for front-line workers. It would also require flexibility at the regional and local level for people on the front lines to meet the objective. It would mean a culture that tolerates different solutions in different places, and even managed competition within government agencies to see who best innovates and meets the objective. It would mean that pilot projects always have a clear timeline and clear measurable goals which, if met, will predictably lead to the program being scaled province-wide. Right now, pilot projects are often cited to deflect criticism and to claim something is being done but have no measurable goals and no clear triggers for being approved to scale on a larger basis. Many simply linger on for years with no sense as to why the pilot was ever launched or what questions it sought to answer in the first place. Worse yet, we have no idea what it means to have a 'successful' pilot, because there is no predictability in outcome application.

It would mean even rethinking government's relationship with the non-profit sector and asking if funding local initiatives and measuring the results and challenging groups to earn funding might work (in fact, government generally requires significant reporting from non-profit agencies to ensure results from money spent. Government just does not apply the same lens to itself, or predictably reward non-profits with more funding for meeting the goal). It would mean a culture of accountability where we are willing to measure results and know how we are doing in real time, just like we do with financial indicators. It would mean a culture where public servants have a new covenant where they get more freedom to do the job, but more accountability for the results.

That culture does not yet exist within the Government of New Brunswick. But it could.

Governance Flaw #4:
Little Data, Less Analysis, No Follow-Up

Let's return to the earlier analysis of the Department of Finance's response to the Advocate's inquiry regarding alternate level of care patients – those patients occupying hospital beds when their medical needs and quality of life dictate that they should be in long-term care and not an urgent care setting. As noted, when asked to provide modelling and benchmarking used for budgeting, the only analysis provided was that, the previous year, 35 alternate level of care patients were successfully transitioned out of hospital. The current pool of ALC patients in hospital is 300. Applying that pace to the existing caseload, this would suggest a window of over a decade before all seniors are in appropriate placements. This would be true even if no patients were added to the list, an assumption for which the government did not even offer data.

It would seem logical to conclude that the patients stranded in hospital beds require staff, care, and resources. As well, we know that the presence of these patients creates additional strain on the urgent care system, because the lack of capacity for the hospital's urgent care function and the staff diverted to their care adds new burdens throughout the health care system. What is the additional cost for recruitment of staff, managing and triaging in less-than-ideal medical settings, adding staff at other points in the system? Is this even a more affordable model? If those costs were modelled, we might be able to compare the cost of increasing the pace of placement to the cost of not increasing the cost of placement. We might even know how long we have to reduce the number of alternate level of care patients before the system begins to collapse. What wait time at hospitals is acceptable before there are other risks and other costs created by the lack of a functioning urgent care system?

> *"They told me 'Leonard, we know you're great.*
> *We just don't know if you're any good.'"*
>
> ***~ Leonard Cohen***

What is interesting is that the government of New Brunswick does not appear to know the answer to these trade-offs. Yet there are trade-offs being made all the time without data or information. For instance, the Departments of Health and Social Development have recently adopted a protocol to be used when a hospital is at critical capacity, which is defined by a set of criteria that truly would suggest that delays and service lags would

put lives at risk. When this designation exists, a number of rules and procedures can be shortened or changed to free up beds by moving seniors to long-term care beds so that capacity is restored in a hospital.

That trade-off is understandable when a crisis has arisen, but it begs a question – what things can be done in an emergency to hit a hard outcome target that were not being done before? And can we learn from that to apply the same calculations to decisions that might avoid the crisis, rather than respond to it? After all, no one would place a senior in a facility that was unsafe. So, if the placement can be done in crisis, it could conceivably be done safely when not in crisis. What is being done differently? Do we talk with families about sensible supports to expand the zone of acceptable placements, even if those supports exist outside of established programs? Do we support families better? Do we undertake a more nuanced look at the actual staff and services instead of just looking at how the level of the placement is categorized? Do we approve staffing solutions we would not otherwise? Even if the exact steps might not be universally sustainable if permanent, identifying those inputs that change the result is a valuable exercise for planning programs.

What is really happening in that trade-off is that now a **hard outcome target** is being set by government. When all the system failures create an unacceptable emergency, then there is an outcome target which must be met no matter what, and now the public servants managing and providing the service are free to make the necessary decisions to get the result. Necessity is the mother of invention.

So, if necessity is the catalyst for innovation, why wouldn't government use data to create necessity before everything collapses? Why not set a **hard outcome target** before the crisis and see if the system responds with innovation? We really don't know how innovative the system would be, because right now no one holds the system accountable for results.

For example, we know that emergency room physicians and administrators are noting the profoundly negative effects that a high level of alternate level of care patients are having upon the urgent care system in New Brunswick. We know that moving 35 people a year will not resolve the problem for decades. What if we said there must be 100 beds freed up this year, because avoiding the crisis is even better than managing the crisis. Would, for example, we authorize Social Development's front-line staff to make different decisions to support seniors at home or to provide more resources and flexibility to long-term care institutions? Would departmental leadership begin looking at downstream savings; for instance, would the Department of Health and its health authorities look at providing funding for these initiatives if it knew that Social Development staff was accountable for freeing up its capacity and avoiding the crisis expenditures that arise now?

Let's apply that logic to other social programs. If a hard outcome target was applied to a clear indicator in alleviating poverty, what would we do differently? For example, what if

we told Social Development that in 2030 we must see at least 500 more children whose families currently receive social assistance graduate with an average above 70% and pursue post-secondary education? What different questions would social workers ask? What flexibility to support children would administrators give them? How much more urgently would Social Development staff respond to requests from school principals to collaborate and support families?

We don't know because we do not use hard outcome targets in any area but budgets and policy compliance. The rule and the budget are tangible. We know what behaviour is unacceptable in those areas. What social outcomes are unacceptable? And what would front-line workers do differently if we had hard targets?

Choosing those targets with care is important. The examples above are chosen because a good indicator encompasses a number of inputs. If seniors stay in their homes longer, we likely know that community supports have improved, and home care is accessible. If children in care are succeeding academically, it likely means that other supports are working. If people on social assistance are finding work and staying in the workforce, other factors are being done well. A well-chosen hard outcome target allows us to pick the thing that must change and, if it does, it means other positive changes occurs. It separates the 'what' must be done from the 'how' it must be accomplished.

Right now, even when government engages in data collection, there is a tendency to make the publication of indicators the end rather than the means. When we get data from a group like the Canadian Institute of Health Information (CIHI), it generates some stories, and we agree that government will consider it all and we will look at it all again in three years. However, rarely does government take the step of identifying key numbers that must change and agreeing that the system will be accountable for it at every level.

For example, the last CIHI report indicated that New Brunswick was far outside national norms in the use of antipsychotic medication in long-term care facilities. Some regions were even outside the New Brunswick norm. This may be one of the indicators which tells us if other inputs are being done well. The overuse of medication can suggest that other inputs – staffing ratios, early detection metrics, mental health supports, recreation opportunities, even proper nutrition provision – are lacking. Past reports on long-term care have suggested that these very inputs are where there are concerns.

This would be precisely the kind of **hard outcome target** which would make sense to adopt, because if other things are breaking down and causing an over-reliance on medication, then people on the front lines would naturally work on fixing those other indicators. Yet over a year since the headlines died down, government has not definitively stated if this area variation is a cause for concern, let alone set targets. This failure to use data to set priorities and hard targets is precisely what we mean by lacking a culture of measurement and accountability.

Government would have to ensure that the capacity to measure and report on those indicators exists at the centre of government. Departments would have to have

incentives and flexibility to meet the hard outcome target and even to know which region or community is achieving change the most quickly. That would mean investing in data at the centre of government operations.

There may be those who have read this section and are about to protest that this is a recipe for fiscal anarchy, that one cannot have social targets to be met regardless of cost. To be clear, no one is suggesting that fiscal targets are a bad thing. New Brunswick needs fiscal targets, because otherwise programs are not sustainable and interest on the debt can begin to take resources away from other areas. At some point, over-taxation can actually cause declining revenues if economic activity slows. These things remain true. In fact, the centre of government has shown that hard targets, good data, proper incentives, and training and monitoring from the centre can all be effective tools. The suggestion is that we also apply these very good tools to social policy and build that capacity at the centre of government. Both things matter equally, and there should be a balance. If the Department of Finance bureaucratically swallows the Executive Council Office whole, then we do not have a balance or a creative tension. We have hard targets for budgets and no minimal standards for how people get treated. And that shapes how managers on the front lines make decisions.

There is also a fiscal logic to measuring results. For example, in the last ten years we have spent approximately $1.8Billion on social assistance and income support programs. If we asked government if these programs moved people from social assistance to work, government would not know. If we asked government if children who grew up on social assistance avoided winding up on social assistance when they became adults, they would not know.

From a purely financial standpoint, if you could spend $1.8Billion on income support programs and not know if anything changed or spend $1.9Billion and know that over half the children on social assistance would never need it themselves, wouldn't you do the second thing?

In the last ten years, we have spent nearly $1.5Billion on child protection services. If you asked government how many children who were in the system grew up and were self-sufficient, or how many avoided having child protection involved with their children, government would not know. And yet these data exist in other countries and other jurisdictions. These data can be tracked.

From a purely financial standpoint, if you could spend $1.5Billion on child protection and not know if anything changed or spend $1.7Billion and know that over half the children in care were self-sufficient adults and competent parents, wouldn't you do the second thing?

We are not sure what to call spending over $3Billion on child protection and social assistance and not knowing what the results were, but we would go through a pretty large list of adjectives before we got to "fiscally responsible".

Could hard operational targets work in social policy? Could there be a benefit to drawing some lines, and saying that some outcomes are simply not acceptable? Are there some social problems, like illiteracy or seniors trapped in inappropriate hospital beds or children in the care of the government living on the streets that are simply unsustainable, as unacceptable as a department running millions of dollars over budget?

We should find out. After all, "do the best you can" is not a performance indicator. "We are recruiting really hard for doctors" is not a performance indicator. "We are committed to helping children succeed" is not a performance indicator. A mantra of continuous improvement is only effective if you have standards for the pace and priorities of that improvement. Otherwise, government will always be a broken elevator with a sign that endlessly claims, "We're Working On It!"

When you have a performance indicator and you are serious, you measure and monitor. Every Deputy Minister is asked for monthly updates on whether or not they are meeting the budget target. That's fine. Do we ever ask the Deputy Minister of Social Development how many people on social assistance got and kept a job each month? Do we ever ask the Deputy Ministers of Education for monthly updates on how many children with personalized learning plans received the defined services? No? If not, why are we surprised when those results default to platitudes like "we are committed to continuous improvement"?

"We are doing the best we can" is not a performance indicator. It's a cop out. And as we shall see, sometimes those cop outs are allowing unsustainable practices to continue until they damage our social and fiscal outcomes.

Governance Flaw #5: Funding the Crisis, Starving the Solutions

The five governance flaws listed here are all interconnected. If we model human resources poorly, we often cannot have service standards. If we have no service standards, we cannot do proper budget modelling for social expenditures and outcomes. If we do not budget around social outcomes, we cannot give outcome targets to departments. If we cannot give outcome targets to departments, then we manage through rule compliance instead of results-oriented management.

All of these lead to the most significant flaw of all. Because we do not have outcomes to budget around, we often overpay for addressing crises and underbudget for the things that might have avoided the crisis in the first place.

If we return to the budget explanations the Department of Finance provided the Advocate following the release of the 2023-24 budget, we can see one of the best examples of crisis-driven funding, which we touched upon earlier. The Department noted that the previous year's funding for child protection was too low, because the number and complexity of cases went up. Yet they still used the previous year's number as the basis for funding and funded the program at less than the previous year's actual expenditures. There was no prediction made that the actual number would go down. There was no exploration of why it went up. The Department simply said that if the number was too low again, a special warrant would be issued, and the difference would be covered. In other words, "Don't worry about the budget number, because we don't mean it and we don't expect it to reflect reality."

As a management principle, this is ridiculously unfair to officials at the Department of Social Development. If the senior leadership in that Department wanted to look at why the numbers were going up and come up with solutions that might lower the case volume, this funding model eliminates any opportunity to solve either the social or the financial problem. It might be worth having the Department of Social Development look at the cases that drove the costs, look for common indicators that a family is likely to go into crisis and challenge its other units to avoid those factors. It might even be as simple as a staff or process reorganization. However, this management instruction is to basically nickel and dime the status quo for the first ten months of the year, and then write an unplanned check when it is too late to use those extra funds to actually change the outcome. This is financially bad practice. It also adopts a morally questionable stance of stating that funding to help children will arrive only after their safety and development is in danger, which is hopefully not what the Department of Finance intended as an operating principle. After all, that would be a ghoulish way to intentionally budget.

What this strange example also reveals, however, is that the organizing principle of social spending in New Brunswick is that chaos is rewarded and planning is discouraged. Because the programs that are granted an automatic funding hack for running over are the programs which government must fund based solely on demand, not by design. They are the programs that are the safety net for all our other social policy failures and their funding really cannot be controlled short of intentional system failures.

By that, we mean that child protection is a program built upon a mandatory response to a set of facts. Child protection services must legally kick in when the safety or development of a child is in danger. Once those facts exist in reality, the government must provide the service. If a child is in danger, the legal obligation falls upon the government to investigate. If the safety or development of a child is proven to be in danger, an independent court will order the Minister of Social Development to take custody and provide services.

This is different from programs like family support services, where government can move the eligibility requirement or control whether it is offered at all. For example, family resource centres exist in each region and offer a variety of programs to promote child development, parental information, and family support. Their budget is driven by government's willingness to pay. Even if people want the services, and even if there is a demonstrated need or demand, if government does not feel the budget allows for the expenditure, then the program will not occur.

Of course, in this scenario the children and families who might use the service do not disappear. They simply do not receive the service. They might be kept off the government's books as far as funding the services. They will, however, appear at other junctures when they cannot be ignored. If the child is in danger, the child protection system must respond. If the child protection system seeks a court order, Legal Aid must get involved and support the parent if they have no money. If the child presents at an emergency room, the service must be provided. When the child registers at kindergarten, the educational services must be provided. If the family breaks up and the parents dispute custody or access or child support, family court must take the case. These are all services which drive expenditures that government cannot control.

One might argue that government **ought to** fund the family resource centre services because it might avoid a situation where the government has **got to** fund the child protection file. In fact, we could think of programs that avoid crises as the **"Ought-To" Programs**, and the programs that require a crisis response as the **"Got-To" Programs**.

In many social policy areas, we can intuit the relationship between the **"Ought-To" Program and the "Got-To" Program.**

- Government **ought to** fund programs to support families caring for aging relatives and providing home supports to increase independence, but they don't have to. If the family brings the aging relative to an emergency room because they cannot safely look after themselves, government has **got to** provide urgent care services.
- Government **ought to** ensure that seniors in long-term care have recreation programs and recreation specialists who will help them stay active and healthy. If the senior's health declines and they need urgent care, the government has **got to** respond at the emergency room.
- Government **ought to** provide funding to ensure secure housing for children aging out of care and facing independent living and financial shortfalls. If the young person winds up homeless and gets caught stealing or trespassing to provide for themselves, government has **got to** fund the response of police, courts, and probation services.
- Government **ought to** ensure early childhood screening and access to services. If children present at school without learning and behaviour plans in place, government has **got to** provide educational services.
- Government **ought to** ensure that high school graduates have the necessary literacy and numeracy skills to open up work opportunities. If people do not have employable skills and apply for social assistance, government has **got to** provide that service.
- Government **ought to** ensure that there is a functioning system of primary care with access to family medicine and mental health services. If people instead present at an emergency room in crisis, government has **got to** provide the service.

One could continue, but the point is likely made. Some services in government are driven solely by forces beyond government's control, and those programs will have the least controllable budgets. Those services – provincial courts, policing, emergency rooms, child protection, family courts, social assistance programs, schools – often serve as a catch all for gaps in other services. Eventually, those in need of help arrive at places that cannot say no. Oftentimes many of these services are designed to provide assistance, and some of them are designed to provide negative incentives. However, they all cost money. The cost of incarcerating someone in a jail is often more than the cost of educating them in school. If you underfund the Ought-To's long enough, eventually the Got-To's will cost more.

These services which cannot say no can generally be cost-controlled in two ways – reduction of service standards or increases in wait times and backlogs. Both can be done for a while, but when these approaches hit a wall, the impact can be sudden.

If we look at the services under the greatest strain in government, they are the "Got-To's". These are the services which are strained and understaffed. Emergency rooms, family courts, mental health crisis response, social welfare and retraining programs, services for students with exceptional needs in schools, child protection, and hospitals are all

where the strain is most acute. All have been through the two stages of coping – first through cost and staff reductions in the programs that control the demand for them, then through testing the limits of wait times to the point that other social costs kick in. The "Got-To's" not mentioned here – policing and criminal courts – have seen the strain resolved with a budget increase ten times the rate of inflation. This extraordinary option may not be fiscally available for all the programs mentioned here.

If all the "Got-To's" are strained at the same time, it is a reasonable hypothesis that government, since the years when the restraint framework became the central governance model, has starved the programs that could reduce demand on the safety nets until the nets all broke. One thing which makes this an even more plausible hypothesis is that the Government of New Brunswick has not had any structural process of assessing the long-term impacts of budget decisions and foregone social expenditures.

Even now, it is possible to see examples of a lack of long-term planning through trends that are not being examined with actual evidence and modelling. For instance:

- We have seen an exponential increase in the number of young people presenting with Autism Spectrum Disorder (ASD). What would be the likely impact of a large young adult population with ASD upon social welfare, health care, and public safety systems? What would be the most critical outcomes today to minimize those future impacts? And how can we budget for educational and social services without knowing those projections?
- The number of young people presenting at emergency rooms with depression, anxiety and/or suicidal ideation has more than doubled in recent years. What would be the future impact of these higher caseloads if the root causes are not addressed, and the teenagers become young adults? What will be the future impact upon non-optional social services such as family services, public safety, and health care? What would be the most critical outcomes to minimize those future impacts? And how can we budget for health and social services without knowing those projections?
- Hundreds of children are either in the care of the Minister of Social Development and/or part of a household where the breadwinner(s) receive social assistance. What is the recurrence rate of these children themselves needing these services as adults? What will be the future impact upon non-optional social services such as family services, public safety, and health care? What would be the most critical outcomes to minimize those future impacts? And how can we budget for family, educational, and social services without knowing those projections?
- The coming generation of seniors, the Gen X'ers, has a different demographic profile than previous generations in terms of chronic health conditions, aging comorbidities such as dementia, and different social and cultural factors ranging from family structure and support to cultural diversity. What will this mean for demand for long-term care, and if that demand is not met what is the future impact upon hospitals and

social services? What would be the most critical outcomes to minimize those future impacts? And how can we budget for long-term care services and human resources training budgets without knowing those projections?

We find ourselves today with a mismatch between capacity, staffing and funding, and the demand and pressures on the long-term care system. Will these problems be avoided in the future? If the same structural problems – lack of modelling, budgeting divorced from outcomes and data, a preference for rules over results, a failure to consider expenditures in light of their long-term social impact – persist, why would the result be any different? The Departments of Health and Social Development cannot transcend a system of rules and resources that does not match what we are asking them to achieve.

In this sense, the governance flaws have come full circle. The Government of New Brunswick does not set service standards or social outcome benchmarks when creating its budgets. As a result of that, line departments do not have clear outcome priorities or regular data to track results, so the managers lurch from crisis to crisis and front-line workers follow procedures rather than pursue better outcomes. Because we do not measure outcomes, incentivize results by funding what works, or model future impacts when setting benchmarks and hard outcome targets, we do not know which programs and results are driving future strain on the safety net programs. Departmental managers are only accountable for meeting this year's financial targets, but no one (including those setting and enforcing the targets) has the time, capacity, or incentive to consider future impacts upon other departments and services.

If it seems like everything broke at once, it may be *because the procedures common to all those strained services, rather than the services themselves*, are where the flaws lie.

As a result of this analysis, the Advocate is directing the first set of recommendations at the central governing agencies, the Executive Council Office and the Department of Finance and Treasury Board, to improve the structure and process around central governance of social programs.

Recommendations to the Executive Council Office and Department of Finance and Treasury Board

1. The Executive Council Office and the Department of Finance and Treasury Board should ensure administrative separation between the functions of ECO and FTB and create a social policy branch within the Executive Council Office. This change in mandate does not have to require new positions or new expenditures if the existing expertise exists within government. The Social Policy Office should be tasked with the following:
    - Modelling demand for key social programs and setting acceptable service standards,
    - Supporting line departments in developing human resource and financial projection models consistent with demand and service standards,
    - Establishing and monitoring hard outcome targets for key social programs and priority outcomes,
    - Modelling future social impacts and scenarios based upon the results of existing social programs and supporting the budget process with impact assessments,
    - Supporting line departments in collaboration, innovation and best practices,
    - Leading the "Reinventing Government Initiative" defined herein.
2. The Executive Council Office, once administratively independent and through its Social Policy Branch, should lead a Reinventing Government Initiative based upon the following activities and principles:
    - Defining results and creating accountability mechanisms for departments, programs and employees based upon results rather than rule compliance,
    - Supporting departments in developing, monitoring, and reporting Social Outcome Targets, which are measurable key performance indicators that define minimal acceptable results in areas of social services,
    - Restructuring social programs to respond to client needs rather than rigid intake conditions,
    - Rewarding rather than punishing interdepartmental collaboration and supporting Integrated Service Delivery through a supportive regulatory scheme defined herein,
    - Decentralizing decision-making authority and administrative discretion with clear outcome targets for accountability,

- Modelling community-based program delivery with the non-profit sector and/or regional governance models,
- Ensuring that budget dollars are aligned with, and reward, measurable results rather than simply funding inputs and programs,
- Promoting innovation by identifying and resourcing units whose work most positively impacts the Social Outcome Targets,
- Standardizing departmental reporting, transparency, and updating of progress on Social Outcome Targets.

3. The Executive Council Office and the Department of Finance and Treasury Board should be given distinct senior leadership to ensure that both fiscal and social outcomes and targets are fully developed and harmonized.
4. The Executive Council Office and the Department of Finance and Treasury Board should develop a template for pilot projects used in line departments, with requirements for a clear definition of what is being evaluated, what information will be measured, how the proposed program could be scaled if successful, and what benchmarks are required in order for the program to be considered for scalability.
5. The Department of Finance and Treasury Board should ensure that all negotiating mandates for collective agreements undergo a Social Policy Impact Assessment by the Executive Council Office, including a review of how non-financial procedures and protocols will impact the delivery of services and the realization of Social Outcome Targets.
6. The Executive Council Office and the Department of Finance and Treasury Board should lead the Departments of Post-Secondary Education, Training and Labour, Health, Education and Early Childhood Development, Social Development and Public Safety in a Human Resources Summit by Summer of 2025. This summit should result in the development of sound human resource projections through 2040 based upon projections of demand and service standards. Those projections should result in a costed, funded, and predictable mandate for universities and the New Brunswick Community College based upon numbers of seats and graduates, with targets for graduates and retention to which future funding for training institutions is linked.
7. The Executive Council Office and the Department of Finance and Treasury Board should undertake an external review of training programs, including Lean Six Sigma, to ensure that they are aligned with decentralized and empowered problem solving in government.
8. The Executive Council Office and the Department of Finance and Treasury Board should ensure that demand projections, service standards and projected Social Outcome Targets for key social programs and new social investments are included in the supporting budget documents, commencing with the 2025-26 Budget.

9. The Executive Council Office and the Department of Social Development should commission an extensive, external review of the relationship between the Government of New Brunswick and the non-profit sector. Rather than a report on funding the status quo, the review should look at potential new structures for delivery of social outcomes through community and non-profit organizations, including the consideration of Social Impact Bonds and other emerging practices internationally.
10. The Executive Council Office and the Department of Finance and Treasury Board should ensure that a Memorandum to Executive Council (MEC) is prepared by Spring of 2025 seeking permission to draft statutory amendments and regulations standardizing the authority and regulatory triggers for Ministers of social departments to require interdepartmental collaboration on complex individual cases, based upon the statutory and regulatory provisions used in the new Child and Youth Well-Being Act.

Advocate's Afterword on Governance

In this report, I used some blunt language. I'm not looking to hurt anyone's feelings or make anyone wear all *(gestures vaguely)* … this. I just think that the problems with social policy in the New Brunswick government are real, complicated, and serious. I describe them (I hope) in language that's easy to follow.

There are two things I'd like to avoid. One is that the people who work hard in government every day will feel attacked. The other is that some people will forget that this is a look at how things evolved over thirty years and just try to blame someone today.

To those working hard in government today, I want you to know that I'm addressing the system because I think it defeats the efforts of good people. What's that thing my kids say about hating the game but not the player? It's cooler when they say it, but it's true. If the problem was just that people aren't good at their job, I wouldn't be so worried. The fact is that we have a lot of good people, and the system keeps producing the same problems. Good people shouldn't have to work in a poorly designed system.

If tomorrow I was suddenly in charge of everything, these problems would still largely be there. Heck, we kind of tried that once. Some good things got done, but the structure wasn't magically fixed. That's just like now. So, how about we all ask ourselves if we're all trapped in rules that make certain problems happen over and over again?

Also, if the problem was just that government needs to spend more money, I could have just said that. To be honest, the rate of increases in social spending for the last five years compares pretty favorably to the five before that, and very favorably to the years 1993-1999 when all these structures I describe were put in place. And even those years when everything was cut and weird systems were created, New Brunswick did many of the same things other places were doing. That's the thing about bad systems – they're usually so common that we don't even notice we're in them until some jerk says something blunt. I'm paid to be that jerk. Hi.

Anyway, it's a blunt report because if I used the same language that government reports usually use, people won't notice. I wanted us all to snap out of the routines for a second and really think about what we're doing here. So, the language is unusual. That's the only reason.

Besides, the people who really get hurt when this goes wrong don't usually get heard. Remember that poor woman crying because she just wanted her morning banana? The media doesn't show up for her. Deputy ministers and MLAs don't always listen. Same for scared kids and worried moms and homeless people. My job is to get heard when they don't. So, I'm being blunt. It's not because I think I'm some genius who figured it all out. It's just my job to try to get your attention when the people who need all this to work can't. Because they're hurting.

OK, on with the report…

THE ADVOCATE'S RECOMMENDATION REPORT ON THE LONG-TERM CARE SYSTEM IN NEW BRUNSWICK

The long-term care system reflects the fact that it wasn't set up in a cohesive way. If someone had a blank canvas today, it wouldn't necessarily look like this. There are hospitals, which are now fairly centralized and planned but which themselves evolved from a system full of small hospitals once run by local governments and even charities. There are care facilities like nursing homes and special care homes that each have their own history and story. It all evolved rather organically, some facilities being set up privately for profit, some being set up by foundations and run by volunteers, some being more planned and institutionally funded, and all with their own governance structure and history.

Then there are two government departments involved. Social Development itself was sort of a creation of reorganization twenty-five years ago, with a lot of very different services that used to be in different departments getting all kinds of stitched together. At the time the unifying principle was that all of its units were ones which involved giving people financial support so they could receive or provide social services. That's why units as distinct as early childhood education, nursing homes, disability supports, social assistance, and child protection all wound up together. At different times and to varying degrees, the Department was asked to not just cut cheques to individuals to pay for these services, but also to design the programs to meet various policy objectives. In some cases, these services evolved within Social Development. Others evolved out of the formerly-separate Departments of Health and Community Services, who oversaw hospital care and extra-mural care. Both those things now interact with the long-term care system and are part of that community.

Basically, the long-term care system is not something that was launched. It is something that was stitched together artificially among various components that developed more organically. The key now is to create something cohesive out of all those parts, one that remembers who it serves and defines results and treats people kindly and predictably even when their needs or circumstances change. There are no magic wands. We start with the system we have.

We have chosen not to draw hard and fast rules about which government department, or which type of entity runs things. It's important to have good people supported by good resources working in good facilities with good regulations and structures and clear objectives. Who designs those, or what the sign on the door says, is less important than what happens when.

To reiterate, it is through the following seven themes that we will review challenges and make recommendations:

- Governance
- Accountability
- Assessment and Affordability
- Person-centred Care
- Human Resources Planning
- Removing Disincentives to Aging in Place
- Diversity and Demographics

Theme One
Governance

Theme One: Governance

The policy goal in governance should be to replace centralized silos with community-based units with responsibility for the entire LTC continuum of care.

As we age, our need for care may change several times. At some points, we may need support with daily tasks or mobility to stay at home. We may be self-sufficient at home but need transportation and recreation assistance to have a decent quality of life. We may need to access institutional care at some point, but those needs can also change based upon our health and our family supports. For non-seniors with disabilities, the support needed may also be a fluid and evolving situation. New opportunities for work, a change in the primary health care we access, or shifting recreation and social needs can change the supports we need.

In a high-functioning long-term care system, the assessment of needs would drive the service and people would move easily throughout various types of care. The funding, accountability, standards, and financial support services would remain constant everywhere. The discretion to match the person to the right care would be decentralized, with front-line staff empowered to serve the individual but all having equal resources to do so. The citizen would be in the same system regardless of the type of care needed.

Through our review, it was clear that the opposite situation exists in New Brunswick. The current state of the LTC system is highly centralized within the Department of Social Development and organized in vertical silos. Regulation, oversight, assessment, and funding are all determined by units with separate responsibility for home care, special care homes, nursing homes and ALC patients in hospitals. The result is that individuals do not travel between silos easily or without significant disruption. Planning the individual's journey through the aging process is not done in a coherent way.

Yet within each of these silos, management and administrative discretion is also highly centralized. Each silo has its own criteria for entry and financial support, not all of which are aligned. At times, the greatest struggle is finding some place where the citizen fits – and the citizen must match the entry. There is minimal discretion for front-line workers like social workers and nurses to assess the individual and make the care fit the citizen. Human resources cannot be assigned easily through different sectors to match demand.

Our comprehensive review revealed clear shortcomings in the current model of Long-Term Care governance, prompting the need for a comprehensive redesign. This redesign must aim to establish a robust and integrated system that gives priority to this report's subsequent sections/ recommendations on accountability, person-centred care, workforce development, and inclusivity for diverse communities.

A governance model should support decision-making and discretion for the mix and delivery of services at the level closest to the citizen and community. The standardization of resources and accountability should happen at the centre of the program. Managers should steer, but front-line workers should row.

When considering a renewed governance model for LTC, it is important to first understand and define the relationship between the Department of Social Development and the Department of Health. Both are crucial in governing LTC because it involves coordination and collaboration between two key entities responsible for different aspects of healthcare and social support. This relationship is vital for ensuring both the medical and social dimensions of care are addressed, leading to better outcomes and an improved quality of life for individuals receiving long-term care.

It was clear through our review that there are deep fractures between these two entities when supporting a person through the aging continuum. The result is a reactive system that has reached the point of crisis due to lack of hospital capacity and limited human resources available in community and residential care.

> *"I was told by my social worker that if my mother's care needs change due to her dementia, and she is deemed unsafe to be living at home, take her to the hospital, she will stay there until a LTC placement is available for her…That wait could be weeks or months."*

That statement shows the flaw at the heart of long-term care governance. Even a change in severity with an ongoing condition leads to a person having to repeat administrative steps at a time of significant crisis. Yet the planning is put off by design for when the person's condition worsens, which would be the worst possible time to engage in care decisions. Once again, we see a situation where someone will be in the hospital, which has the least responsive care to the person and the most costly and disruptive result for the system. As we shall see, if someone in high need is left stranded in a hospital, the

issue may not be that there are not people available to care for them or places where they could be cared for. It is that those people and places are pre-sorted into rigid, separate silos where the person must magically match the silo, rather than one system that has discretion to assemble the care for the person.

Addressing the critical relationship between community homecare and the overall governance structure is imperative to mitigate the detrimental impacts on the healthcare system. The current reactive approach to long-term care planning and the allocation of resources has led to tangible challenges which we all see today, such as overcrowded emergency rooms and individuals occupying hospital beds unnecessarily. A startling fact is that 25% of the average bed days in hospitals are consumed by individuals who have been medically discharged, highlighting the urgency for a more proactive and integrated approach to long-term care governance. Such a proactive and integrated approach to long-term care governance would support the better allocation of resources and take the immediate strain off limited hospital capacity. This in turn would improve the overall well-being of aging adults in our community.

If the structures between different types of care are arbitrary and rigid, then people cannot move freely from one type of care to the next. It is for this reason that we are proposing a governance structure which integrates oversight of all long-term care mechanisms --home care, special care home, nursing homes – into one authority. While the types of providers may vary by community, having their funding, mandate, and oversight handled by a common authority would reduce these types of arbitrary barriers.

To operationalize this, we must move to a model that clearly defines and measures collaboration between the Department of Health and the Department of Social Development. This can best be achieved by having specialized long-term care authorities which are organized in a way that is integrated, nimble, community-based, and administratively flexible. Communication on patient mobility should happen at the level of hospital managers and the long-term care authority, each with decentralized power to match the care to the patient. Currently, communication occurs between two large, centralized bureaucracies with highly distinct subunits. The Long-Term Care Authority can develop a structured framework that outlines the roles, responsibilities, and mobility between types of care and would define how they work together to create an integrated approach to care.

Robust collaboration between the Departments of Health and Social Development should align regulations to promote decentralized discretion and minimize conflict between departmental oversight. This should facilitate joint planning, resource allocation, and information sharing to enable a smooth transition of individuals from hospital care to community-based, and between different types of community-based care.

> *"We finally got the call that a LTC placement was available for my dad after he was waiting in hospital for 3 months, unfortunately he had to wait in that hospital bed for an additional 3 weeks because the list of equipment he needed at his care home was only provided at the time of discharge...If his hospital social worker was the same as the one from social development, this could have been avoided"*

We heard countless stories such as this and therefore key considerations must be given to policy reforms which prioritize interdepartmental collaboration, community care expansion, and streamlined discharge planning.

One additional issue that must be addressed is the need to ensure that scarce human resources can easily get to where the needs are. The uneven way in which various care sectors developed, combined with inattention by government when setting employment conditions, has led to some situations which do not serve citizens well. In particular, health care workers are often compensated better at the most institutional levels of care, but areas like home care and special care homes struggle to operationalize space because of staff shortages. There needs to be a plan launched to standardize worker compensation and conditions across care sectors so that long-term care authorities can get workers where the care needs are, rather than try to steer patients into rigid silos. Recruitment can remain a central function, but on-the-ground mobility should be localized and minimize disruption from arbitrary silo distinctions.

As we aim to create a new way of governing LTC, the main goal should be to make sure the objectives of LTC align with specific service standards. This requires setting up a system for making decisions, being accountable, and being transparent. The model should aim to foster a more responsive, effective, and compassionate long-term care system that emphasizes centralized standards, training, and funding, while maintaining decentralized delivery and oversight.

Recommendation 1.1

A new *Long-Term Care Act* should be adopted integrating the LTC system at all points, with co-ordination at a more decentralized, community level. Part of the *Long-Term Care Act* should establish a number of Long-Term Care Authorities who manage defined authority within the *Act*, each having a distinct subset of citizens for whom they deliver services. The number should be large enough to ensure localized collaboration and delivery and to reflect linguistic obligations and community diversity, but small enough to ensure that governance talent and skillsets are not spread too thinly.

Recommendation 1.2

The new long-term care authorities should be established along the following parameters, and within the governance model the Department of Social Development's role should be as follows:

- **Establishing funding formulas for regional bodies**
  The department will be essential in creating ways to fund regional authorities. Their role includes making sure that money is distributed effectively, matching the needs of specific geographical areas throughout the province.
- **Establishing standards for service, accountability and reporting**
  It will be incumbent upon the Department to set robust standards for service quality, accountability, and reporting, and to ensure that Long-Term-Care Authorities adhere to prescribed benchmarks in delivering care to the individuals under their purview. Contracts should be outcome-based, indexed on clear quality of life indicators.
- **Income support for individuals**
  The department will be responsible for providing financial assistance to individuals within the LTC system. This support is designed to specifically address the financial challenges associated with medical care and connection to their community. The department should work to ensure that individuals in the LTC system receive the necessary financial resources to meet their individualized needs, thereby enhancing their overall well-being within the framework of long-term care.
- **Centralized recruitment, training, and professional standards for staff**
  The Department will lead centralized recruitment, training, and the establishment of professional standards for staff within the Long-Term Care Authorities, ensuring a consistent and well-qualified workforce across the system.
- **Dispute Resolution**
  The Department will define clear and efficient dispute resolution processes for service users and feedback mechanisms that allow the individual, their family, and service providers to provide input on the quality of care.
- **Facilitating inter-regional contracts and collaboration**
  The department will play a critical role in facilitating collaboration between regional authorities to support efficient resource allocation for both financial and human resources, increase their ability to address broader systemic challenges, and to support the sharing of best practices and innovations in the sector.

Regional LTC Governing Authorities will oversee various aspects of the Long-Term Care (LTC) system, with specific responsibilities aimed at ensuring the highest standards of care and support. The detailed breakdown of their oversight responsibilities is as follows:

- **Identifying and contracting with providers**
  Regional Authorities are tasked with the crucial responsibility of identifying and contracting with providers for a spectrum of services, including home care, special care homes, and nursing homes. This involves a meticulous process of evaluating and selecting providers that align with the specific needs and standards set forth by the LTC system. The goal is to establish partnerships that contribute to the well-being of individuals receiving long-term care.
- **Managing partnerships with community agencies**
  In addition to formal providers, the Authorities are responsible for managing partnerships with community agencies that offer home support and transportation services. This entails integrating service standards into contracts with these agencies, ensuring that the services delivered meet the defined quality benchmarks. By fostering collaborations with community entities, the Authorities contribute to a more holistic and community-based approach to long-term care.
- **Inspections, accountability, and standard oversight**
  Authorities are mandated to conduct inspections and enforce accountability measures for all LTC providers under their jurisdiction. This includes regular assessments of facilities and services to ensure compliance with established standards. By upholding rigorous accountability and setting high quality standards, the Authorities promote a safe and secure environment for individuals receiving long-term care.
- **Needs assessment and citizen planning services**
  Regional Authorities are involved in conducting comprehensive needs assessments to understand the unique requirements of individuals in their regions. This data informs strategic planning to effectively address citizen needs. Additionally, the Authorities can partner with local community agencies to facilitate individualized citizen planning services.
- **Mobility and standardization of workers**
  Authorities should be given support to standardize worker compensation and conditions and to facilitate collaboration between care providers in assignment of health care workers.
- **Professional development**
  To attract and retain a skilled workforce in LTC, regional authorities are responsible for continued professional development. This will involve establishing programs and initiatives that enhance the skills and knowledge of professionals working in home care, special care homes, and nursing homes. By prioritizing ongoing professional development, the Authorities will contribute to the continuous improvement of the quality of care provided across the regional LTC system.

Recommendation 1.3

Regional Boards should have the following governance model:

- Appointing and forming Boards within Regional Governing Authorities requires a thoughtful and varied approach to ensure effective oversight and governance. Throughout the review process, concerns have been raised about the challenges in New Brunswick when it comes to finding qualified individuals to staff these boards. And yet with the right support, training, and a clear understanding of roles, the recruitment process can be made both targeted and straightforward. The reality is that our LTC system requires an all-hands-on-deck approach since the ubiquity of ageing means it is a system that we will all interact with at some point in time.
- Boards should be made up of individuals with a mix of essential professional skills and backgrounds, emphasizing expertise in quality care, needs planning, change management, community partnerships, and lived experience. This diverse composition ensures a comprehensive understanding of the various aspects of long-term care and facilitates informed decision-making.
- Regional boards can acknowledge the significance of involving communities and management at a local level. They should set up specific initiatives to genuinely connect with communities. These initiatives should aim to encourage collaboration, understanding, and responsiveness within smaller, more manageable regions. This approach ensures a more personalized and customized approach to long-term care, promoting community engagement and consideration of the distinct needs and dynamics of each region.
- Additionally, it will be imperative that Regional LTC Governing Authorities respect linguistic communities of interest and acknowledge the autonomy of First Nations Communities. In so doing, the Authorities demonstrate a commitment to cultural sensitivity and inclusivity, recognizing the diverse linguistic and cultural landscape within their jurisdiction.

To enhance the effectiveness of regional authorities, there should be a focus on continuous training and support. Training programs should be designed to equip Board members with the necessary knowledge and skills related to their roles and responsibilities. This includes staying abreast of evolving best practices in long-term care, understanding the intricacies of needs-planning, and developing proficiency in change management and community partnerships. Continuous learning opportunities contribute to the ongoing professional development of Board members, ensuring they remain well-prepared to navigate the complexities of the system.

Recommendation 1.4

The Department of Social Development and Department of Health should launch a collaborative governance system that aligns healthcare and social services affecting long-term care. This process should be aimed at administrative barriers that may impede collaboration or impact individuals moving through the LTC continuum, particularly for those that are medically discharged but still occupying a hospital bed (ALC patients). This should include collaboration with the Department of Finance and Treasury Board to harmonize working conditions and compensation for staff doing the same job in different types of care. The regulatory review should be done at the same time as the drafting of the *Long-Term Care Act*, with both statute and regulatory reform available to Cabinet through a Memorandum to Executive Council no later than Fall 2025.

Recommendation 1.5

The new *Long-Term Care Act* should entrench the statutory rights of aging adults, fostering a comprehensive framework that will prioritize their well-being and autonomy as follows:

- To age at home where possible
- To have support in remaining independent, active, and maintaining social inclusion within their communities
- To enjoy access to educational, religious, cultural, and social activities
- To be treated with respect and dignity
- To receive timely access to health care
- To live in safe environments free of physical, mental, emotional, and financial abuse
- To have an effective and confidential system for reporting violations of their rights

It should also entrench the rights of persons with disabilities within the disability support system and long-term care system as follows:

- To live in inclusive housing options which provide for their social, intellectual, and emotional inclusion in the community
- To receive full and timely access to health, educational, and vocational services
- To receive services such as supported decision-making and advocacy in a manner and forum which maximizes their independence
- To live independently and with autonomy to the greatest extent possible
- To enjoy access to educational, religious, cultural, and social activities
- To live in safe environments free of physical, mental, emotional abuse
- To have an effective and confidential system for reporting violations of their rights

Recommendation 1.6

The Department of Social Development should, based upon the rights entrenched in statute, develop Key Performance Indicators (KPIs) for authorities to adopt and report on through a public dashboard annually. These KPIs should also be connected to the Social Outcome Targets used in the annual budgeting process, as discussed in Recommendation 8 made to the Executive Council Office and Department of Finance and Treasury Board earlier in this report.

Recommendation 1.7

The Department of Social Development should provide funding and support for the establishment of service delivery arrangements, including the use of social impact bonds, through partnerships with the non-profit sector at the regional level. This can be structured through the Non-Profit Sector Inquiry identified in Recommendation 9 made to the Executive Council Office and Department of Finance and Treasury Board earlier in this report.

With rights reflected in the legislation, and Social Outcome Targets identified and utilized in a transparent way in the budgeting process, partnerships with the community non-profit sector can begin to look at arrangements where funding for service delivery is provided through agencies with the flexibility to innovate and the clear accountability that comes through establishing and measuring targets. One way to achieve this may be through using social impact bonds, which are a delivery model showing promise in Europe. Through these approaches, community groups are challenged to do a better job than government bureaucracies in meeting outcomes for patients. Each agency has flexibility in how they deliver the results with resources equalized between regions. This marries the innovation and competition for ideas of a private delivery system with the equality and accountability which comes from public management. This would contribute to a more collaborative and community-driven approach to long-term care that matches solutions and priorities to the community's needs.

Government – NGO Partnerships, such as social impact bonds, serve as catalysts for innovation and scalability, moving successful practices from community-based initiatives into broader applications across regions. Offering both a financial and organizational framework, these partnerships align with community-driven long-term care initiatives, combining financial incentives with positive social outcomes. Promoting both collaboration and accountability, partnerships such as social impact bonds can contribute to the development of effective, sustainable, and community-centred solutions for long-term care.

This new governance model strives to replace fragmented and centralized bureaucracies with one integrated model where discretion is decentralized, allowing for a system that serves patients rather than one where the patients shape their needs to serve the system. Resources are also essential, but the structure and incentives the system creates ultimately determine whether the system succeeds. This proposal sets up structures and incentives for decision-making which will give resources a chance to succeed.

2

Theme Two
Accountability

Theme Two: Accountability

It was clear in our consultations that there is a strong perception among service users and their families that the system does not inspire confidence that honest feedback and complaints can be given without fear of reprisals. Past reports have highlighted this fear, and the Advocate's Office has heard this concern on numerous files. When a system deals with vulnerable people, this perception must be dealt with.

In general, the change in both performance indicators and inspections should lead to a culture change – to move from micromanagement of process to measurement of results, and to eliminate arbitrary distinctions between the regulation of different types of facilities and between for-profit and non-profit operators.

Why Accountability Matters

An overarching principle of a system of care and support for vulnerable individuals is that it must inspire public confidence. This is understandable – families place tremendous trust when they house a vulnerable loved one in a location where they are dependent upon others for their happiness and safety. In this regard, the current system is not working. There have, of course, been improvements. There are certainly happy stories every day. What we heard in our interviews, however, is that front-line staff are often overwhelmed trying to compassionately deal with crises while there may be ongoing issues elsewhere in a facility.

In the feedback we received, the public repeatedly stressed the absolutely essential need to allow people the opportunity to age with dignity and autonomy, and to be the recipients of compassion and a high standard of care. A well-functioning long-term care system that meets these essential needs will inspire public confidence. This starts with good governance, but it also requires a reflexive transparency that is open to public scrutiny and sees feedback through the lens of opportunities to build trust, not threats of criticism.

The long-term care system is a public trust. Long-term care services are designed to meet the needs of individuals who are unable to fully care for themselves due to age, illness, or disability. The system's commitment to caring for these vulnerable groups reflects a societal trust to ensure their safety, dignity, and well-being. The government plays a primary role in funding and regulating long-term care services. This involvement is based on the principle of welfare and the belief that society has a responsibility to care for its members who are in need. The regulatory frameworks and funding mechanisms are established in the public trust to ensure that care is accessible, affordable, and of high quality. In turn, long-term care providers are held to high ethical standards and are accountable to regulators, the public, and the individuals they serve. This accountability is a cornerstone of the public trust.

The long-term care system operation must therefore be subject to public oversight through mechanisms like inspections, investigations, audits, and reporting requirements. These mechanisms should not be extraordinary. They should be seen as a regular part of the system, as much a part of the daily charge as serving meals and cleaning facilities. This transparency helps to build and maintain trust among the public, care recipients, and their families that the system is working in their best interest.

Everyone in this system must welcome accountability, because each aspect of the system wields power over vulnerable people and with that power must come the need to answer for how it is wielded.

Achieving Transparency

Transparency and public oversight are fundamental components of the long-term care system that underpin public trust. These aspects ensure that operations are conducted in an open manner, with mechanisms in place for accountability, quality control, and involvement of stakeholders. One thing we heard repeatedly from people within the system is that the number of inspectors is too few to do this necessary work. The result is an insufficient amount of spot inspections necessary to build a culture of accountability. Inspections of facilities is an area that many individuals and organizations singled out for criticism during our consultations.

It will be our strong advice that this function should be better resourced, localized, and subject to increased reporting and spot inspections. The possibility of inspection at any time tends to focus the mind, and the certainty that eventually inspectors will come tends to keep standards high. As one experienced manager put it during our process, steps that inspire "management by walking around", interacting and observing, is good practice that can often nip worrisome flaws and omissions in the bud. Right now, this does not occur.

The report of the Association francophone des aînés du Nouveau-Brunswick made it clear that families have seen too much anecdotal evidence of inadequate and innutritious meals, shortfalls in personal care, and a lack of recreation and socialization which is worrying. Families feel neither safe reporting violations nor confident that inspectors will find the flaws they hear about.

Most jurisdictions, including New Brunswick, require that the results of inspections be made publicly available, allowing for public scrutiny and informed decision-making by potential residents and their families. Nursing Home Inspection Reports in our province have a comprehensive template, collecting information on the facility's administration, resident services, human resources, and the safety of the building. Nursing homes are subject to unannounced annual inspections in each zone by the Department of Social Development's Liaison Officers. However, while it is the Department's policy to complete and publicly post annual inspections in every nursing home, we receive numerous reports of this not being done in practice. The same is true for Special Care Homes where it would appear, unfortunately, there exists an even greater incidence of failure to inspect and publicly report. This gap between policy and practice may speak to adequacy of inspection resources.

When inspections happen it is unclear how indicators are used to drive governance, or whether sustained attention is paid to area violations or clusters of similar failings.

> *"The inspection process in nursing homes is inconsistent across zones, unpredictable from one inspection to the next. If there were an accountability framework that homes could benchmark against and know where they stood throughout the year, then it wouldn't be such a "who knows?" situation every year... the process is far too subjective."*

The current lack of transparency in the system's operations reflects a reluctance to publicly report on crucial matters. This in turn leads to a lack of useful engagement with stakeholders in the system, those being the people receiving services, their families, and various organizations that push for improvements.

It concerns us that from within the system came a minority, but certainly not rare, view that public reporting of poor outcomes is unnecessary. From this viewpoint, failures to adequately care for a patient are learning opportunities rather than calls for action, and indeed scrutiny and criticism can interfere with improvement to prevent future mistakes. We do not consider this a tenable position. Transparency and oversight mechanisms drive improvements in care quality by holding providers accountable for meeting established standards and addressing deficiencies.

Requiring that every Law and Policy is Effectively and Equally Enforced

The Advocate has previously pointed out in a report to the Legislature that there is at times "a reticence to act" within the Department of Social Development regarding regulating the long-term care sector. This is largely a problem with governance. But assuming that we as a province will now address the necessity of fixing that governance problem, it will be necessary to ensure that the administration of the governance structure, and its associated rules, is functioning appropriately.

Nursing Homes and Adult Residential Facilities (such as Special Care Homes) in New Brunswick are licensed in accordance with the *Nursing Homes Act* and the *Family Services Act*, as well as various Regulations under those Acts, a collection of Departmental Standards, and Directives Manuals. Appropriate administration requires the regulation of these facilities. It also requires developing policies, practice standards, and protocols for the functioning of long-term care facilities. And it requires providing for sufficient levels of inspection, investigation, and reporting.

We have concluded repeatedly that deference to the uniquely universal 'private' nature of nursing homes and special care homes in this province has created an administrative oversight problem in long-term care. Our office has too frequently been presented with an attitude within the Department of Social Development that implies a hesitance, even an inability, to utilize the statutory and regulatory powers clearly conferred upon the Minister. As we said in a previous review involving inadequate supervision of residents at risk of violence, even when the facility is private, the trust is always a public one. The public sector must rigorously embrace its oversight role.

Long-term care facilities are to be subject to regular inspections by government or designated agencies to ensure compliance with health and safety regulations, quality of care standards, and residents' rights. Facilities must meet specific standards to obtain and maintain their operating licenses. These standards cover aspects such as staff qualifications, facility safety, and care protocols. And facilities are required to report incidents, such as accidents, injuries, or cases of abuse, to relevant authorities. This requirement is meant to ensure that issues are addressed promptly and that patterns of concern can be identified and rectified. Yet, regarding all these controls, we repeatedly see trepidation by the Department in enforcement. This culture must change and standardized training of, and increased investments in, inspectors will communicate this. There should be no examples of rules which are not enforced.

Addressing the Problem of Rules over Results

Services in the long-term care system should be measured by objectives. This is a system that requires thinking outside the box, not rigid obedience even when the result does not serve the resident well. Successes in the long-term care system must be judged by overall outcomes based on clearly communicated goals to the benefit of the clients.

We are not calling for more bureaucracy. The system needs flexibility. However, we are calling for better measurement of *results*. As stated in The Vital Question section of this report, Outcome-Based Targets and Key Performance Indicators are necessary to create more decentralized authority and more patient-centred use of discretion by workers closest to the patient. A system which both defines and measures results will achieve them. A system which does not empower employees to work to results will fall back on getting only compliance with rules.

Moreover, a culture shift away from a medically focused and institutional model of care to a person-centred model of care will lead to better outcomes for all, and this requires the kind of tailored flexibility that family would provide.

It is also intriguing to us that, as frequently as government touts red tape reduction processes to for-profit businesses, government rarely uses those same mechanisms to review the daily work of social program providers such as health care professionals within the long-term care system. Professionals in the system are too often forced to sacrifice care to administrative duties. Often documentation is demanded in the place of inspections, and there is no protocol for reviewing or using the documentation for improvement. While documentation is fundamentally important to the recording and evaluation of care, it cannot replace care itself.

The culture in the long-term care system is currently one that prioritizes adherence to rules over results. If data is kept that allows regions and workers to be measured on results, front-line workers can be given more discretion. It is highly likely that a trained, caring professional can evaluate the needs of the older persons they work with far better than someone in an office can write a rule that predicts the universal needs of all older persons. Of course, there are aspects of the system that require compliance and consistency, but the general goal must always be good results for the client.

"The Social Development system is significantly stressed with extremely high caseloads. Social Workers are forced to prioritize the most difficult and critical cases while still undertaking the administrative tasks related to determining eligibility for services and processing financial benefits. This makes it nearly impossible to focus on good planning, bringing family and service providers together, nursing home/special care home diversion or system avoidance."

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"Flexibility is a key tenet of long-term care, however too often individuals hear the phrase 'We don't do that'."

Developing Consistency and Collaboration in Services and Operations

As we've previously noted, a culture of excessive deference to private sector operations has led to gaps in accountability. For example, there are numerous examples of arbitrary and unexplained distinctions between the regulation of different types of facilities, such as nursing homes and special care homes.

A guiding principle must be that every decision made in the system is made according to the affirmation of autonomy and the best interests of the older adult. Professionals should be trained to apply the rules with liberty, not with overly fearful restraint.

> *"There is no continuum of care in long-term care. There are significant silos between Social Development, hospital corporations, the NB Extra-Mural Program with little formal collaboration."*

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> *"Professionals in the current system work very hard to ensure the needs of our vulnerable seniors are met but often feel depleted, and discouraged when they are not able to achieve all of their work due to limited care hours, limited staff, and complicated care plans."*

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> *"No matter what the policy or regulation, operators report interpretations by regional office staff that often differ between staff and certainly amongst regions. This leads to confusion if not frustration for operators, residents, and resident families."*

The ways in which service providers in the long-term care system are held accountable for their services presently varies between aspects of the system, from region to region, and from operator to operator. There should be standardization of standards across all types of care at the regulatory centre of the system, with responsive and sustainable inspection and oversight capacity within the community.

Providing Security for Input, Feedback and Complaints without Fear of Reprisal

A public trust does not mean the public should be asked to blindly trust. Trust must be earned by the administrators. Patients, residents and their families must feel empowered to have input into decisions about their lives and the ability to freely complain about quality, or ask for reconsideration of a decision. This is not something that can be left to a vague refrain of "of course you can provide feedback" – there must be standards and legal provisions to ensure protection when people make complaints.

When older adults and their families do not have trust that effective accountability measures are in place, they become hesitant to report problems. Those problems are then left unseen in the system and are not corrected. In the worst scenarios, older adults are left in harmful or even dangerous situations because the fear of them being discharged outweighs the fear of what is happening to them in the facility.

Recent reports such as those from the New Brunswick Nurses Union and the Association francophone des aînés du Nouveau-Brunswick have stressed the dangers of residents and their family supports being too afraid to voice concerns, due to fears of retribution or discharge from a facility.

The system also needs to in-build input mechanisms from those working within it. Long-term care as a system deals with issues that are unpredictable, and new challenges will always emerge which must be continually addressed. The Department of Social Development should implement feedback mechanisms to hear from professionals who should all be advocating for better policies, standards, and decisions.

Most importantly, seniors in such vulnerable circumstances need to know they have the right to complain, that it's okay to complain, and that there is a simple process in place for them to do so. They need to be able to express their concerns and criticisms. And they should be assured that their concerns will be carefully considered and responded to. They should know that the regulatory authority will track the number and nature of complaints and know how, and how quickly, those concerns are addressed and resolved.

"Residents need to be heard and involved with day-to-day decisions."

Ensuring That Key Information Is Collected, Analyzed, Publicly Reported, and Acted Upon

As mentioned earlier, accountability should be based on imperative outcomes rather than processes. It doesn't matter so much *how* the system gets to wherever it needs to go, as long as we can see that it is getting there. But the Department of Social Development simply does not know all the information it should know. The Department needs to know how the system is functioning, and this requires adequate data collection.

Regular, publicly accessible, and standardized reporting on Key Performance Indicators is a crucial aspect of a functioning system. And those Key Performance Indicators should be based on client experience.

It is good news that government is working on a "digital transformation project" to align data systems not only across all its regions, but also to align these with other Departments. The current silos of data are a major stumbling block in attempting to fashion a holistic system.

> *"I would love to see an accountability structure that would be driven through resident quality of life surveys. For instance, if you want to know if the home has enough staff available, ask the residents questions like 'does your call bell get answered in a timely fashion'. This question is one of the interRAI quality of life standardized questions that can be benchmarked across other jurisdictions and can drive care improvements. All NB nursing homes have access to the survey now, but there is no standard that they are required to use this evidence-based tool to measure quality of life."*

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> *"Ability NB has asked Social Development to track the number of seniors turning down at home services due to the high co-payment. The have stopped tracking and releasing that info. Ability NB estimates that 50% of our senior clients who are recommended home supports by medical professionals are unable to pay the co-pay and wind up living at risk even when a cost-adjustment is made. The formula is archaic and not reflective of real costs."*

Implementing Constant Improvement in the System

In The Vital Question section of this report, we noted that government needs at its centre a Social Policy Unit which looks at current demographic trends and models how they might change demand and delivery of social services in the future. Few sectors have been harmed as much for the lack of this modelling capability as long-term care, which seems to be constantly lurching from crisis to crisis due to a lack of capacity and a mismatch between capacity and the people in need of service.

Adaptation and improvement within the long-term care system are critical for addressing the evolving needs of the population it serves, incorporating new knowledge and technologies, and responding to feedback and challenges. This continuous process is essential for maintaining the quality, relevance, and efficiency of care.

Public trust is maintained through the system's ability to adapt and improve in response to changing societal needs, advances in medical knowledge, and feedback from care recipients and their families. This dynamic aspect of the long-term care system reflects a commitment to continuous improvement in the quality and delivery of care.

Whether a government department or a regional authority is providing the service, they need to be supported in activities such as responding to demographic changes, incorporating technology, looking at emerging practices, and preparing for emergencies and public health crises. Starting with the restraint years of the 1990s, it has become a frequent mantra to fund front-line services but to treat skills in managing social services or analyzing policy as "administrative waste" which can be rooted out without consequence. We are now seeing the consequence that even when government invests in capacity and front-line workers, it lacks expertise to plan and organize in order to maximize those investments. Rebuilding the shattered policy and planning function of government is as critical to the quality of care as are the people on the front lines.

Recommendation 2.1

Budgets for inspections should be increased through a comprehensive per capita funding formula. Levels of staffing of the assessment and standards units should be sufficiently robust as to allow for regular and thorough inspections, including unannounced or 'spot' inspections. The Department of Social Development should undertake a cross-Canada review of best practices for educating and training reviewers.

Recommendation 2.2

Public reporting standards should be updated. Standards should be the same for both for-profit and not-for-profit providers in all long-term care sectors.

Recommendation 2.3

Both nursing homes and special care homes should be expected to have regular, publicly accessible, and standardized reporting on Key Performance Indicators. At least a third of those metrics should speak to patient experience and satisfaction, with opportunities for patients and their families to provide confidential feedback without fear of reprisal. A repository of both current and past reports should be online in an easily discoverable format. Historical reports and trends should be available, regardless of changes in ownership.

Reports should be built around Key Performance Indicators which are standard and clear. In general, accountability frameworks should be built around outcomes and results rather than processes – the Department should measure what was accomplished more so than how it was done. An example of a key performance indicator framework would be as follows:

- Target scores for client satisfaction with services
- Target impact scores for positive impact of services on health (including mental health, physical abilities), and quality of life
- Target scores for LTC in-home clients reporting increased ability to live as independently as possible at home and involvement in the community
- The percentage of aging adults and adults with a disability who refuse services due to cost of co-payment (target: less than 10% annually)
- The percentage of adults with a disability under age 65 admitted to long-term care homes (target: less than 5% annually)
- Numbers of persons waiting for long-term care admission by region
- Length of long-term care stay, year over year
- Long-term care hours of care delivered per resident per day
- Use of anti-psychotic or sedating medications and a tracking of annual trends
- Number of adverse incidents per year and a tracking of annual trends

Recommendation 2.4

The Department of Social Development should contract an independent small-area variations study of procedures and outcomes every five years, with an emphasis on patient-focused measures such as use of medications and adverse incidents.

Recommendation 2.5

The *Long-Term Care Act* should include legislative protection for whistleblowers and establish an offence under the *Provincial Offences Procedures Act* for anyone who attempts to interfere with the complaints process through intimidation or reprisal, both real or perceived.

Recommendation 2.6

The Department of Social Development should develop and provide mandatory standardized training in effective governance and public accountability for authorities and boards of long-term care and special care homes. This should include both orientation training and continuing education. The Department should also develop provincial standards for the qualifications and continuing professional development of boards and CEOs of long-term care and special care homes.

Recommendation 2.7

Discharge procedures should be reviewed and automatic reviews of discharges by an independent office at the Department of Social Development should be entrenched in legislation. This should include a requirement to advise the Office of the Senior Advocate of discharges.

A long-term care system that is capable of adapting to challenges and learning from experiences is more resilient and better prepared to face future uncertainties. Professionals in the system should actively be looking for problems in pursuit of continual improvement. A comprehensive quality assurance regime is required for continuous learning to improve the system.

3

Theme Three

Assessment and Affordability

Theme Three:
Assessment and Affordability

There are two clear problems with the process of assessment which arose over and over in our consultations. First, too often the assessment of individual needs is mixed in with an assessment of what funding is allowed. This discourages an honest discussion of individual needs and underutilizes the skills social workers bring to the process of planning for aging.

In the journey toward accessing long-term care, assessment and affordability serve as the gatekeepers to entry. Yet our inquiry unveiled a sobering reality, that the process is flawed, prioritizing the assessment of a person's financial means over their authentic requirements for care. The result is imbalanced delivery of standardized care based on financial metrics rather than crafting tailored plans that address individuals' unique needs, thereby hindering the optimal allocation of care resources for the enhancement of quality of life.

> *"To deny it is a broken process is to deny reality. Yet this is the key process in getting the right person in the right facility at the right time."*
>
> ***~ New Brunswick Senior***

During our review, we had the chance to meet Sue, a 37-year-old who has resided in a special care home for the past decade. Prior to moving in, Sue had aspirations of securing a job in retail, volunteering at her local theater club, and obtaining her driver's license. Despite being well-cared for during this time, Sue expressed dissatisfaction with her current situation. She is not working due to the financial claw-back and barrier to transportation. She participates in community group activities unrelated to her theater interests only once or twice a week. She has also yet to acquire her driver's license.

Additionally, Sue has not learned basic life skills such as cooking and doing laundry independently because those activities are restricted at the special care home due to health and safety regulations.

With the appropriate support, Sue would thrive in a community setting and be able to take control of her life. The crucial question for individuals like Sue is: what off-ramp to care should be established, and how should this assessment be conducted?

We met the Brown Family during the review, who were praying for a call regarding long-term care placement. Both husband and wife were in their 90s, with only one daughter living an hour away out of town. Kay Brown had dementia, and her condition was rapidly deteriorating. Jon, her husband, was the primary caregiver, and the strain of caring for his wife was significantly impacting him.

During the financial assessment, it was determined that the co-pay amount for care would leave Jon in a precarious financial situation. The "off the record" recommendation was for the couple to consider divorce as a means to alleviate this financial burden. However, after 70 years of marriage, this obviously would never be a viable option for them. It is clear in this scenario: the on-ramp to care was to find a bureaucratic loophole to get in the door. This speaks to the comments we made in our Vital Question recommendations regarding the problems with rule-based discretion and centralized authority.

Currently in New Brunswick there are 1,863 adults with disabilities living in special care homes. In addition, we have over 900 seniors waitlisted for nursing home placement across the province. How many of the 1,863 adults with a disability are like Sue, trapped in a system that over supports what their needs are, while limiting connection to their community? And of the 900 seniors waitlisted, how many are in desperate situations like the Brown family, under-supported and praying they get the call, but faced with impossible choices in order to access much needed care?

This predicament arises from a flawed approach where the assessment of individual needs intertwines with what funding is allowed. Our leveled system of care discourages honest discussion of individual needs/goals and underutilizes the skills social workers bring to the process of planning for care. Consequently, individuals find themselves in a system of care that may either inadequately meet their needs or provide excessive support, further emphasizing the necessity for a more nuanced and person-centred approach to care planning.

Some of our previous comments about the lack of independent social policy development and modelling at the centre of government are applicable here. We know from the numbers that currently 17% of adults eventually require an advance level of care. Looking at these costs and publicly-available income data, one could determine if that is likely to pose an affordability problem for the average family taking into account citizens' median

income and capacity for savings. Yet we found no record of this type of modelling ever being done, because we define the financial parameters without even aligning them with projections of need.

Government cannot always fulfill every need, but that should not keep us from honestly assessing what the need is, whether that be an individual's need or our collective needs as a community. This idea of separating honest assessment of needs from the work of imposing financial constraints is central to our recommendations.

Recommendation 3.1

The Department of Social Development should decouple needs assessment from the contributions of service participants and departmental funding. The assessment of needs should be done at the regional level and establish the individual's needs and goals clearly before the government's financial support formula is applied by the provincial Department.

Separating needs assessment from funding considerations represents a fundamental shift towards a more ethical and person-centred approach to care. By decoupling financial constraints from the assessment process, the focus shifts towards prioritizing the well-being and individual needs of those requiring care. Care plans should be driven by the specific needs and goals of each individual, rather than being dictated by budgetary limitations.

Implementing oversight at the regional level ensures alignment with provincially regulated service standards, providing a framework for consistency and quality of care across different regions. This regional oversight also facilitates the connection between individuals in need of care and assessors/planners who understand local needs and resources. Tailored care plans should be developed collaboratively and reflect the person's unique circumstances and preferences, fostering a sense of ownership and empowerment in the planning process.

By separating needs assessment from funding considerations and establishing regional oversight, the care system becomes more responsive and attuned to the diverse needs of individuals. This approach not only enhances the quality of care provided but also promotes a culture of respect, dignity, and person-centredness within the care framework, ultimately improving the overall well-being and satisfaction of those receiving care.

Recommendation 3.2

Disability service and income support legislation should be modernized to provide adequate and essential assistance for individuals with disabilities. The level of assistance should meet the following criteria:

- Enabling recipients to achieve optimal independence in employment
- Enabling recipients to receive housing and living support which meets their specific needs, allows easy access to accessible transportation, and allows them to live with safety and dignity
- Providing sufficient support to ensure full participation in the community

This legislative update would act as a pathway for adults with disabilities who are inappropriately placed in special care homes, lacking autonomy and control over their lives, to transition out. Consequently, it would alleviate pressure on existing care facilities and help address the urgent placement needs of seniors on nursing home waitlists. These results should be tracked and be the subject of clear targets.

In modernizing this legislation, a holistic approach will be crucial, recognizing the interconnectedness of housing, employment, and community participation in supporting individuals with disabilities. Transition planning is essential, providing resources and support services to facilitate the smooth implementation of the new legislation and assist individuals in transitioning out of inappropriate placements in special care homes. Ongoing monitoring, evaluation, and collaboration among regional authorities and community organizations will ensure effectiveness in meeting the needs of individuals with a disability. Through proper planning and support, this strategy aims to create a more inclusive and responsive care system that meets the diverse needs of individual New Brunswickers.

Recommendation 3.3

A standard template for Personalized Aging Plans should be developed by the Department of Social Development to assist Long Term Care Authorities in supporting residents. Areas to be addressed should include a holistic approach to needs assessment that considers physical, mental, emotional, and social well-being. The Personalized Plan should consider not only medical requirements but also factors such as personal interests, cultural preferences, and the desire for independence.

Through our review we heard countless examples of the lack of individualized planning and support. The more likely it is that planning and assessment happens at the crisis point, the less likely it is that the person's needs will be met. Building towards a system where having an aging plan at 65 is the norm, culturally and bureaucratically, would be a positive step. As it stands currently, the assessment process has become a transactional experience versus a space to ensure the plan is reflective of the person's wants, needs, and natural support system.

> *"All the research demonstrates that more planning is required including bringing family together to explore solutions. This 1-hour model leads to unnecessary nursing home and special care home placements."*

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> *"Flexibility is a key tenant of long-term care, however too often individuals hear the phrase "We don't do that." This comes from a rigidity around a department's budget and a lack of knowledge of flexible, individualized supports on the part of Social Development."*

In the development of personalized aging plans, it's essential to draw upon successful models already in place in New Brunswick. One such model is the Disability Support Plan (DSP) utilized for individuals aged 19-65, which offers a person-centred and flexible approach to goal planning, and which could serve as a blueprint for aging plans. The DSP is a flexible planning tool that fosters a deeper understanding of individuals' goals, preferences, and personal interests. By mimicking key aspects of the DSP within the template for Personalized Aging Plans, regional initiatives can benefit from a proven approach that prioritizes individual autonomy and well-being. This includes incorporating mechanisms for ongoing assessment, support, and adjustment to ensure that the aging plans remain responsive to the evolving needs and aspirations of older adults. By leveraging the strengths of the DSP and tailoring them to the unique challenges and opportunities of aging, regional efforts can effectively enhance the quality of life and support for older adults in a manner that aligns with person-centred principles.

There may also be a benefit to looking at partnerships between long-term care authorities and the non-profit sector to promote and deliver the planning process. In a number of regions, the personal expertise and nimble operations may lie with NGOs already working with seniors. Creating these sorts of norms is often best achieved in areas where the social capital already exists.

Once implemented, regional training programs should be carried out to familiarize care providers, social workers, and other relevant stakeholders with the template. This training should emphasize the importance of adopting a person-centred approach and respecting individuals' autonomy and preferences throughout the planning process. Regular updates and revisions to the template should be conducted based on feedback from users and emerging best practices in aging care.

Mechanisms for monitoring and evaluating the implementation of Personalized Aging Plans should be established. This should involve regular reviews of individuals' plans to assess their effectiveness in meeting stated goals and addressing evolving needs. Feedback from individuals, caregivers, and service providers should be solicited to identify areas for improvement and inform ongoing refinements to the template and the planning process overall. Through these measures, the development and implementation of a standard template for Personalized Aging Plans at the regional level can offer tailored support to individuals in aging with dignity and autonomy.

Financial Affordability Recommendations:

Financial affordability was a constant theme throughout our review. It became evident that there is a disparity in individuals' financial capacity to contribute across various care settings. This discrepancy can lead to people being forced into more expensive institutionalized settings due to financial constraints. We also found the process of financial assessment lacked the very basic principles of fairness, responsiveness, and efficacy. We need to move towards a financial assessment where individuals can make decisions based on their care needs rather than financial limitations.

"Lower-income seniors end up being diverted into Nursing Homes (fully subsidized) when this is not the assessed level of care they require. This takes away Level 3A (Nursing Home) beds from seniors who really do require this level of care. As a result, nursing home beds are in short supply leaving many waiting in hospital as Alternate Level Care (ALC) patients which puts immense strain on the health care system."

Recommendation 3.4

The Department of Social Development should implement a single common assessment for individual contribution. The financial capacity of an individual to contribute should be a constant whether they are receiving home care, specialized care, or nursing home care. There should be no need to repeat the financial assessment process simply because the individual's needs have changed. The financial assessment tool should be designed with support from providers, social workers, community service organizations, and public policy experts.

It simply does not make operational or even financial sense for these processes to be repeated purely because the type of care required evolves. Availability of resources, however defined, is not a variable that shifts based upon where the care is provided or who provides it. The numbers are constant. Repeated assessments add stress for families, waste scarce professionals' time, and undermine confidence in the system by making the whole process seem artificial.

Our findings revealed that the discrepancy in financial assessments often results in individuals opting for nursing home care over home care due to the co-pay for home care services potentially pushing them into poverty. To rectify this, the assessment process for financial contributions should be standardized and consistent across all care settings, ensuring that an individual's financial capacity remains constant regardless of the type of care they receive.

At the centralized level, a cost-benefit analysis would determine the financial threshold at which home care becomes a more cost-effective option compared to nursing home placement. Considerations such as the cost of home care services, nursing home fees, and potential savings in healthcare expenses associated with home care should be part of such a review. We also must bridge the pay gap between homecare providers, special care home providers, and nursing homes.

> *"Government paying $14/hour to families to "self-manage" their care is simply not enough to hire a top-quality staff person."*

We found that several service participants were needing to 'top-up' pay of homecare providers in order to retain them.

A threshold of financial contribution needs be created to incentivize home care over costly nursing home placement, promoting aging in place while ensuring affordability and accessibility of care services for individuals.

The financial assessment process should be guided by the principles of fairness, responsiveness, and efficiency, ensuring that resources are allocated where they are most needed to optimize the well-being of individuals in the community. Assessment should include enhanced eligibility for home care services and assess their financial contribution based on income and affordability criteria. This assessment should also consider individuals' preferences for self-managed supports, giving individuals greater control over their care while ensuring equitable access to home care services and support across different regions. This approach promotes aging in place, enhances individual autonomy, and optimizes the allocation of resources to improve the well-being of individuals in the community.

Recommendation 3.5

The Department of Social Development should develop a simplified assessment for families above the income level for subsidies to save time for families and preserve scarce human resources.

Recommendation 3.6

The Department of Social Development should regulate the use of 'upcharges' by providers with a hard cap on daily charges across all sectors. This should begin by ensuring that the current rates of individual maximum contribution are enforced as hard caps across all parts of the long-term care continuum, including special care and memory-care homes.

We also heard repeated concerns about the daily rate charged to citizens and the impact of additional 'upcharges' upon the principle of equal access. A comprehensive review of current upcharge practices must be conducted, identifying maximum contribution rates for individuals as per existing regulations. Regulations enforcing these rates as hard caps on daily charges should be developed in consultation with stakeholders while ensuring alignment with legal requirements. Monitoring mechanisms will be established at the regional level to ensure compliance, and stakeholders will be informed of the new regulations with guidance on implementation.

"These upcharges make certain special care homes out of reach for low-income residents and very expensive for the rest. This creates access problems to a public service and a two-tier system in this sector of funded long-term care. It is two-tier in the sense that, based on income levels, some do not have access to the publicly funded service provided by special care homes."

Certainly, we see significant merit in proposals to cap daily rates charged to families in the range of $77-83 per day, depending upon legitimate complexities in the type of care. We would tie these numbers to levels, but we will be addressing inflexibility of level-based care definitions in a subsequent chapter. If the cost is to deviate from that range, it should come through an open and transparent process. A thorough review of existing contribution formulas and daily rate caps across the long-term care continuum must be conducted, with stakeholders given opportunities to provide input. The findings of this review should be made public and used to inform revisions to contribution formulas and daily rate caps, ensuring fairness and transparency in long-term care financing.

As part of this ongoing process, refusal rates should be tracked, along with reasons for refusal, to ensure that there is accountability for policies and rates. Refusal rates tell us a significant story about the challenges people face when trying to access long-term care services. By tracking who is refusing care and why, we gain essential insights into the obstacles that individuals are encountering. These insights are vital for policymakers

to develop targeted solutions that address specific barriers, such as affordability or availability of resources and quality of care. In essence, refusal rates paint a clear picture of the gaps in our long-term care system that need to be addressed.

Of course, user fees alone cannot be considered without also looking at the capacity of providers to maintain quality standards and retain experienced staff. Government funding and contributions remain part of that equation. As noted earlier, we have great concerns that arbitrary distinctions in funding levels between types of care, such as nursing homes and special care homes, is creating an unbalancing of recruitment and retention of experienced staff, and also creating needless barriers to moving patients to the right care in available beds. We are urging government to review and harmonize funding models between sectors to create a level playing field and similar commitments to all points in the care continuum. It would be a misalignment of goals and actions to aim to have patients in the least institutional care possible and then to underfund those less-institutional levels of care.

Recommendation 3.7

Within one year, the Department of Social Development should establish an independent and transparent review process (with opportunities for public input) for contribution formulas and daily rate caps at all points along the long-term care continuum. Advocates for aging adults, persons with a disability, families and clients, as well as providers should be heard as part of this independent review and recommendation process.

Recommendation 3.8

Within one year, the Department of Social Development should establish a process to track the number of individuals refusing long-term care funding and their reasons for the refusal, including measuring refusals due to inability to afford the co-payment or lack of qualified human resources.

Recommendation 3.9

The Department of Social Development should initiate forthwith a review of funding models between long-term care sectors to ensure equal capacity between providers to recruit and retrain skilled staff and to ensure flexibility of patient and staff movement throughout the continuum of care.

This section contains recommendations to address some of the most common concerns and complaints we heard from New Brunswickers. The uncertainty and needless repetition of the financial assessment system, the lack of transparency and predictability in fees, and the specter of being unable to afford care is a very real concern for families. These recommendations speak to those concerns.

4

Theme Four
Person-Centred Care

Theme Four:
Person-Centred Care

When we reviewed more than 350 cases in preparation for this report, we divided them among our initial four areas of focus: Governance and Public Administration, Human Resources, Quality and Humanity, and Funding and Affordability. These four pillar areas appeared in our Long-Term Care Review Abstract, before we grew these areas to the seven you see presented here.

Overwhelmingly, when we reviewed the casefiles, it was Quality and Humanity that emerged as the area concerning the majority of complaints: 63%. These are largely addressed here under "person-centred care" (PCC). They are also inter-woven through all the other themes. These preoccupations speak to the quality of the experience a person has living in long-term care. This same concentration of concerns about the individual experience of living in care run through other recent reports in New Brunswick. The fact these issues recur with such frequency and intensity is concerning. If person-centred care, which is always acknowledged as a good thing, had been effectively implemented or maintained or grown as a result of any of these numerous reports and recommendations over the past 20 years, would each and every new report or paper or recommendation include the cry to make the systems more person-centred? It is hard to believe that this would be the case in a healthy system.

To turn back to the introduction, how does a system respond when one of the comforts that helps a resident feel like they are still cared for and in control is being able to have the ritual of a morning banana? Other sections of this report speak to the questions of governance, incentives, and resources that ensure that Mrs. Baker gets her morning banana. Person-centred care speaks to the things that make a system likely to ask, know, and care about Mrs. Baker and her morning ritual in the first place.

Long-term care is not simply a bed, or a room. It is a system of supports that allow a person to continue to enjoy life where their interests, preferences, and autonomy matter. We heard from many citizens who feel that they or their loved ones have a bed in the

system, but not a full life. Every one of us has our own rhythms, rituals, preferences, and traditions that make us truly who we are. The freedom to know what makes us comfortable and fulfilled is what makes us fully human. It is central to the idea of dignity and respect. Who among us hasn't cringed at the stories of flight delays, when we see travelers stuck in airports at the holidays, lacking control over their surroundings, missing daily rituals and even cherished holiday traditions with no ability to assert their routine. Who among us could be happy living permanently in such a state, knowing that this was our future? That is the kind of helplessness and desperation too many New Brunswickers feel when they live within the long-term care system. Loss of control over what we eat, when we might lie down, even when we bathe or see loved ones is a state that is not conducive to mental or physical health.

The idea of "person-centred care" is easy to use or weave into public relations documents. It is harder to achieve. In a quality system, rules and regulations serve the needs of service users, not vice versa. Measurements are tied to user experience and measure results, not adherence to processes. The system is open and responsive to feedback from service participants, local managers, community partners...and especially the residents. Most importantly, standards exist to make sure that people do not have to fear aging in areas where their needs are unmet and the care is not responsive to their requirements for a happy, fulfilling life.

Person-centred care is one area that should both underpin and be woven through every aspect of a long-term care plan. Originally depicted by Edith Balint in 1969 as "understanding the patient as a unique human being", person-centred care has been an evolving concept which can often make understanding and implementation tricky. In its essential form, the goal of person-centred care is to bring back the personhood of individuals into care models. It is a commitment at all levels of care to uphold their dignity by providing autonomy, choice, and control; by respecting decision-making and doing good. Person-centred care refrains from medicalizing people by reducing a person to merely their symptoms and/or disease. It is easier to define than to implement largely because person-centred care is a commitment to a whole-scale systematic philosophy that requires support along with a well-planned structure and implementation plan.

In a quality system, rules and regulations serve the needs of patients, not vice versa. Assessment measurements are tied to patient experience and these measure results, not adherence to processes. The system is open and responsive to feedback from patients, local managers, and community partners. Most importantly, standards exist to make sure that people do not have to fear aging in areas where their needs are unmet and the care is not responsive to their requirements for a happy, fulfilling life. The tale of the banana of our introduction, and its depressing familiarity and consistency with other personal stories which we heard, suggests that our healthcare system is not particularly person-centred. At the very least, it is not consistently so, and without consistency trust vanishes. And when vulnerability exists without trust, anxiety and discomfort is the human response.

We wish to draw particular attention to the plight of Alternate Level of Care (ALC) patients – those patients who are in a hospital bed due to unavailable long-term care – must be transitioned urgently. An urgent care system is not built for supporting a daily quality of life even at the most ideal of times. These are far from ideal times. Our urgent care system is under tremendous strain and the people who work in it are burning out. It is providing an unacceptable level of care for the patients in those hospital beds and dangerously limiting the ability of the urgent care system to meet its function. There is little chance that those needing regular, attentive non-urgent care can get it.

The time spent without hard targets for reducing the number of ALC patients is unacceptable. This process has revealed too many cases of desperate and vulnerable people reduced to pleading and crying because they cannot get simple kindnesses like returning to bed or having soiled clothes and linens changed. We will be urging targets and timelines to remedy a situation which is causing suffering in both urgent and long-term care systems.

Long-Term Care Act

Person-centred care is not a mythical or nebulous achievement – there are established patient-centred organizations that provide consultation services for the development of person-centred care services at all levels of organization – the world Health Organization itself has also developed a policy framework for person-centred healthcare. 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. One of the greatest structural components is culture, which requires knowledge of what person-centred care is (and is not), and a commitment to enacting it fully across the whole healthcare system including, but not limited to, long-term care, is necessary.

Recommendation 4.1

The new *Long-Term Care Act* should establish, in its preamble, a clear definition of "person-centred care" with principles consistent with the criteria enumerated in this report and informed by the rights contained in the *United Nations Declaration on the Rights of Older Persons* and the *United Nations Convention on the Rights of Persons with Disabilities*.

Person-Centred Care as a System

Person-centred care incorporates three levels of integration: structure, process, and outcome. Structure begins at the healthcare system level; process includes the patient-healthcare provider level. Outcome is the third part of a successful person-centred care plan, and incorporates the patient, healthcare provider, and healthcare system level. As we have noted elsewhere in The Vital Question section, developing clear Key Performance Indicators, and providing both discretion and flexibility to front-line service providers is essential.

The majority of our following five recommendations are related to the foundational level of patient-centred care: the structural level. However, each level provides feedback necessary for every other level to work. Patient-reported outcomes are imperative for implementation of person-centred care systems if they are to be effective. Outcomes need to be standardized and regularly administered, and the results should be available for review. Results of outcome assessments feed back into all the higher levels, but by the same token, without the structure and process for patient-centred care being effectively in place, the system won't work successfully.

Recommendation 4.2

The Department of Social Development should, in defining and reporting Key Performance Indicators, include measurable indicators of patient-centred results in the following areas:

- Structures and cultures which encourage assessment of the person's full spectrum of needs
- Presence of educational and recreational programs
- Presence of health promotion and prevention programs
- Workforce training and procedures consistent with PCC centred
- Effective integration of health information technology to support PCC
- Feedback processes which cultivate communication
- Team accountability for respectful and compassionate care
- Patients engaged in managing their own care
- Access to timely and predictable care
- Patient-reported satisfaction and outcomes

Recommendation 4.3

The Department of Social Development should develop, implement, and regulate mandatory training for Social Development and Extra-Mural Program social workers and hospital discharge planners to improve person-centred (and family-centred) planning and navigation of community supports and services.

Recommendation 4.4

The Departments of Health and Social Development should develop and standardize personnel training in dementia and mental health care across the long-term care continuum.

Recommendation 4.5

The Departments of Health and Social Development should develop and standardize key personnel training in neurodiverse-affirming practices for autistic adults in care across the long-term care continuum. Engaging with the post-secondary sector in realization of this recommendation is advised.

Recommendation 4.6

The Department of Social Development should develop and deliver a quality assurance survey to all long-term care program clients and their families every two years to evaluate client experience with the program, the impacts of the program, and to identify recommendations for continuous improvement, with regular public reporting of results.

Levels of Care

Care needs exist on a continuum, not always with neat categories. The current system of defined levels of care do not reflect the fluid and changing needs of seniors. They may well contribute to slow and overly-bureaucratic placement of patients and to delays not in the person's best interests. The governance proposal in this report has highlighted the need to remove sub-silos within the long-term care system and harmonize staff working conditions so that staff can move more easily to where they are needed. This should be coupled with increased discretion and flexibility in defining levels of care.

As mentioned, all seven thematic areas identified in this report are interconnected and change at the assessment and affordability level will be necessary to produce a more humane approach to service provision that incorporates home services where appropriate, and an increase in the services provided if and only when necessary for the safety and health of the person requiring them. The need for reassessment each time a person's health circumstances change is a barrier for seniors and their families to comfortably and confidently navigate the LTC system while feeling safe and empowered to do so.

In the current system, many people only begin to acquaint themselves with the long-term care system when they are suddenly in need of services. When a person and their family find themselves needing to navigate an already confusing system in a time of heightened stress, this is not conducive to making timely and informed decisions. A proactive model for continuing care as people age can be seen in Denmark. At 75 years old, all citizens of Denmark are eligible to receive a home visit twice a year to assess functional mobility and offer information, training, and services aimed at staying functional at home. These visits are carried out by Danish municipalities and are aimed at preventative care. A benefit of this model is a connection between municipalities and their community members, and these visits can offer functionality monitoring and general LTC information such that when more intensive interventions are required citizens are better prepared and already acquainted with the system. Some variation of this service, geared toward the New Brunswick senior community, might be an intriguing additional service to be eventually incorporated into the Nursing Homes Without Walls model.

We support removing the currently restrictive levels-of-care model with one that promotes personalized flexible and holistic care.

Recommendation 4.7

The current model of restrictive levels of care should be reviewed with an eye to developing a more flexible system of matching enumerated patient needs to home capacities. The Department of Social Development should implement a phased approach to transition LTC from a leveled system to a person-centred assessment and holistic model of care. This will provide much needed clarity for families, physicians, discharge planners, and social workers.

Hours of Care

There is always room for good management practices which maximize the efficient use of staff time. One reason why we have suggested a simplified and integrated approach to intake, for example, is that social workers are too scarce and valuable to be tied-up undertaking duplicate and overly-bureaucratic processes. At some point, however, the funded hours of care matter. A compassionate and humane minimum for hours of care can make the difference in the things that matter to all of us in terms of quality of life. It can affect how often a person is bathed, how much recreational time they have, how much social interaction they engage with, and how much time they spend interacting with others instead of alone. This rubric is important.

In 2023 Nova Scotia pledged to ensure every LTC facility maintains a staffing mix sufficient to satisfy at least 4.1 hours of care per resident (which is in line with the current Canadian national standards). New Brunswick's 2022 commitment to 3.3 hours of care is behind Canadian national standards.

It is important to note that the Nova Scotia Nurses' Union released a statement in 2023 applauding the move but highlighting that the recommended 4.1 hours of care per patient was already 15-years out of date. The mandated hours of care, therefore, should be reviewed on a schedule informed by and in consultation with the New Brunswick College of Physician and Surgeons and the New Brunswick Nurses Union to ensure that hours of care in long-term care facilities are keeping pace with evolving best practices based on medical research.

Pilot programs of a supported workforce supplying 4 hours of care per patient resulted in reported increases in worker satisfaction and a reduction in worker burnout. As noted in The Vital Question section of this report, the tragedy is that the pilot project did not have clear criteria for success or a plan developed to scale what works.

We are persuaded that increasing the hours of care received by individual patients in long-term care to be in-line with the current Canadian guidelines, and paving the way for these hours of care to evolve in line with best practices, can only be beneficial to New Brunswickers who both provide and receive care.

Recommendation 4.8

By May 2024, a costed plan should be presented to the Legislative Assembly to increase the hours of care in long-term care facilities to 4 hours a day by the 2025-26 fiscal year. Subsequent independent reviews of the prescribed hours of care by an external reviewer should commence in 2027 and continue every two years thereafter.

Alternative Level of Care

Alternative Level of Care is a designation assigned to patients inhabiting a hospital bed that no longer require acute care in a hospital setting, but who are not able to be discharged due to ongoing disability. 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. There is currently an ALC crisis in New Brunswick, which is both exacerbating hospital bed shortages for acute care patients in the community and is exacerbated by a shortage of long-term care supports (both in-home and in care home settings). In our consultations we heard from many hospital-based medical professionals who are beyond alarmed at the ALC numbers, noting that ALC patients are impacting every department in every hospital in the province. This is not simply a problem affecting access to hospital services for New Brunswickers needing emergency interventions and surgery. Unnecessary hospital stays have a huge impact on the health of older people – the longer a vulnerable adult remains in a hospital setting as an ALC patient the greater the risk of functional decline, delirium, falls, and infections, all while incurring disproportionate healthcare costs.

While improving access to home care services and increasing the staffing retention required to increase nursing home spaces will take time to implement, a workable plan needs to be implemented to appropriately care for ALC patients right now. This problem is not one that is unique to New Brunswick, but the impacts on the New Brunswick healthcare system are stark due to the strain the system is currently under, compounded also by the fact that New Brunswick has the highest proportion of seniors per capita in the country. One option that has been successfully implemented in several Ontario hospitals is the creation of a separate ward for ALC patients, designed with seniors needs front of mind. These are not acute care beds, and acute care resources and machinery are absent from these beds, freeing up their use for acute and emergency beds. These wards can offer the support that ALC patients require, as well as discharge planning, and continuing care monitoring. This is not an alternative to long-term care supports, nor should it be viewed as an alternative to nursing home placement, should that be required. However, it does offer humanity and care for ALC patients while the LTC system expands capacity and at the same time aims to reduce the number of ALC patients inhabiting acute care beds. Specific training in geriatric care is necessary for medical and staffing teams that manage these wards, and this training should not be overlooked. These wards could offer valuable in-hospital training opportunities in geriatric care for nursing and medical staff and students, which can be broadly applied within the New Brunswick medical service system.

It has been estimated that providing more timely care at home, in the community, or in nursing homes could save Canada $2.3Billion just from the savings on ALC-designated hospital bed expenditures; figures for New Brunswick specifically are unavailable but by logical extension significant savings to the provincial healthcare budget must follow.

Recommendation 4.9

A clear, costed action plan, establishing hard targets each six months for reductions in the number of patients in Alternate Levels of Care, should be presented to the Legislative Assembly by June 2024.

Recommendation 4.10

The Departments of Health and Social Development should forthwith produce service standards for patients currently in Alternate Level of Care, setting out what are acceptable standards for hours of care, patient experience, and responsiveness to patient needs.

Long-Term Care Supports and Settings

We all want the option of remaining in our own homes for as long as possible. Every piece of gerontological research into the wishes and desires of older people reports this same conclusion. Canadians today are living longer and in relatively better health than any generation previously. Old models of nursing home care and end-of-life planning no longer apply to the demographics of today's seniors.

Unfortunately, Canada is behind almost all other OECD countries in terms of LTC spending and LTC planning, which leads us to the current situation of a lack of LTC resources delivered in a format that is not desirable to the people who find themselves in need of them. The aging demographics for Canadians will continue to increase rapidly until at least 2050, so this is not a problem that will solve itself.

Attention to connecting seniors with community services, and developing and expanding community services, is necessary to keep people active in their homes and connected to their community. Services like weekly or monthly community health drop-in clinics, with integrated specialist teams, could be a way of getting preventative services into communities. Information sessions, financial planning and service connection could be incorporated, with community service navigators on hand to assist.

At some point in a person's life, remaining at home may no longer be an option. We heard from many seniors that moving into a residential care facility is one of their greatest fears as many view nursing homes as frightening, monolithic institutions bereft of kindness and humanity. They see these as places one goes to die in anonymity and solitude. While we know that nursing homes and the people who staff them are typically compassionate and dedicated to their vocation of caring for seniors, they are stretched to capacity and the typical nursing home format of many residents in large single buildings presents some undeniable issues.

As a result of the ongoing COVID-19 crisis, significant cracks that had been repeatedly spackled over in the past betrayed deep structural instabilities in the long-term care edifice, in particular, the type and organizational structure of nursing home and care home facilities came into sharp focus for review. While large, enclosed, hospital-ward-like housing might have been historically the most logical in terms of logistics and management, monolith style nursing facilities with shared rooms and non-private bathrooms, housing residents in numbers greater than 50, were the facilities that fared the worst in terms of infection rates and mortality. Staffing inconsistencies, for-profit ownership, and low wages all compounded the poor health outcomes experienced in nursing and care homes during the pandemic, and the results of this extraordinary set of global circumstances can be extrapolated to the status quo: if problems were made worse by the pandemic such that they were no longer able to be ignored, then the problems already existed, and they need to be addressed going forward if we are to achieve a person-centred and humane long-term care system.

Non-traditional housing strategies for long-term care residences have existed for many years, and many European countries have been investing in their establishment since the 1980s. The essential elements of these models 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 small size, single physical entry point, and consistent staff per residence (staff rarely work across houses) all contribute to limiting the spread of infectious diseases, and foster a consistent, trusting, and home-like setting for residents. For a more comprehensive overview of alternative models for senior housing, please refer to the literature review provided on the Office of the Advocate website. One model that has a significant amount of research behind it is the *Green House Project*, which has been adapted by Quebec as 'Maisons des aînés'. While the Quebec interpretation seems aimed at housing more residents than the ideal Green House number of 10-12, it still appears a good transition model away from large-format housing and towards small house nursing homes.

We would urge a review of design standards and project guidelines which support the idea of smaller, less-institutional housing and residential facilities, even for special care homes and nursing homes. Generally, social housing models which promote residential and community vibes over institutional ones have been more effective on a number of indicators. On the social housing side, we have noted the success of models like the 12 Neighbours project in Fredericton which emphasize smaller structures and enhanced privacy, dignity, and independence even while supporting clusters which allow for shared services and a sense of community. We would further note that even a centrally-administered 'residence' can still have a cluster of smaller dwellings, or even put people living with supports at home under their administrative scope.

Linking back to the Alternative Levels of Care dilemma, new strategies for dementia care are warranted and need to be quickly realized. In Canada in 2011 35% of patients designated ALC were over 85 and 25% of those had dementia; jumping ahead 11 years, in 2022 50% of ALC patients were over 80 and 47% of ALC patients over 85 had a dementia diagnosis. Globally we are encountering a unique situation: there is a large population of people aging into the senior demographic and the senior demographic is living longer due to medical and health advances, such that a dementia diagnosis at some time in a person's life is becoming more common. As such, strategies like dementia care villages and long-term care centres where the physical design aims to ameliorate reactive behaviors and fearfulness associated with dementia, while promoting autonomy, have also been a focus of alternative residential planning strategies since the 1990s.

Places like The Netherlands and Germany have invested in the village concept (e.g., the Hogeweyk Care Concept) where housing is in small-house formats organized into safely enclosed villages that replicate the communities that seniors with dementia may be familiar with. This format increases safety due to wandering and the adaptive

design features built into the model aim to reduce confusion, stress, and reactive behavior associated with unfamiliar environments while maximizing autonomy. By recreating common and social spaces which replicate comforts of younger days, the impacts of dementia have been mitigated or slowed. For current generations of seniors, this sometimes has meant replicating malt shops, movie-viewing spaces, and other familiar social settings. Perhaps the Gen Xers can dream of spaces that call to mind the entertainment arcades and the food courts of shopping malls past.

Similarly, there are a variety of within-residential care home concepts that perform similar functions (e.g., the Butterfly Model and the Eden Alternative) that should be explored in dementia-specific housing facilities offered in New Brunswick. Reduction in reactive behaviors due to anxiety from environmental stressors has downstream benefits in reducing overmedication or medical restraint usage and improved quality of life and humanity.

The point is that innovations allowing movement away from facilities that look and feel like institutions, and towards places that feel comfortable, is a necessary goal of long-term care planning. We are calling on government to ensure that this type of planning is explicitly part of the mandate of the long-term care system and assigned to departments for innovation and incorporated into future Requests for Proposals and standards for building and licensing.

Recommendation 4.11

The Departments of Social Development and Health should collaborate with regional health and long-term care authorities to establish standards and pilots for "Social Geriatrics" offices to surround family doctors with other community resources and agencies to allow them to support families in aging at home and assist hospital discharge planners to connect patients with services in their community.

Recommendation 4.12

The Departments of Social Development and Health should collaborate with the Department of Government Services to create standards for future development of nursing homes and special care homes which deinstitutionalize long-term care in favour of smaller, less institutional; more residential-style spaces. Attention should be paid to emerging best practices in memory and dementia care, which suggests that spaces that place residents in settings familiar from their younger days will improve quality of life and reduce negative incidents. Quebec's version of the Green House Project model should be considered as a template.

5

Theme Five

A Long-Term Human Resources Plan

Theme Five:
A Long-Term Human Resources Plan

It is an unfortunate fact, but one that should come as no surprise to anyone, that we in the global West have a culture problem when it comes to the care of senior citizens. There has been a sustained cultural shift away from seeing the value of our elders and, more often than not, seniors are viewed as a high-needs group to be compartmentalized and managed. Just as our seniors are a vulnerable and often marginalized group, so too are those who do the majority of the work of caring for seniors: a comparatively high proportion of Personal Support Workers (PSWs) are women and people with visible minority status, as well as people with an existing disability, and older working people - that is, workers over 50 years old. Put another way, the long-term care sector is tasked to assist a vulnerable minority group, predominantly using the labor of other vulnerable minority groups.

> *"...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 longstanding 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."*
>
> ***~ Dr. Debra van Hoonaard, New Brunswick Nurses Union in 2020***

Across health care sectors, New Brunswick is facing an acute shortage of key professionals. This is not a recruitment problem – if it were, there would be some lucky jurisdiction with a surplus of health professionals. This is a training problem, and the time has come to stop using "the best we can do" as the standard for improvement. Instead, there needs to be an honest accounting of actual need and a training plan worked out with post-secondary institutions and professional associations with hard targets and expansion of our training capacity. Then, and only then, will retention initiatives be an effective tool in staffing our care systems.

> *"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 Health Policy Studies report in 2020.***

Training and Career Support

As we have emphasized, all these areas pertaining to long-term care are interconnected. In 2023 it was reported that over half of the waitlisted seniors for a long-term care bed placement were in hospital as ALC patients and that while there were almost 250 empty beds technically available in the long-term care system, these were unavailable for use due to staffing shortages. Human resources, or a lack thereof, have a direct impact on multiple facets of the LTC system that impede functionality.

The majority of people employed in the daily work of caregiving in the long-term care sector are personal support workers; data from the Ministry of Long-Term Care in Ontario put the number at almost 60% in 2018. OECD data also shows that a large proportion of personal support workers are part-time or casual. This may contribute to the low recruitment in the sector and act as a barrier to long-term career planning thus negatively affecting retention. Limited career advancement opportunities are a common theme emerging from research on support care workers in the industry and as such this is an area that needs to be addressed when thinking about long-term sustainability within the sector.

In New Brunswick there are no set standards for personal support workers, despite several public and private colleges offering a diploma in personal support work, with a certificate of accreditation. The problem is that accreditation is entirely voluntary in this province and not a required prerequisite for work as a PSW. To make long-term care work attractive, and thereby increase supply, recruitment, and retention, this lack of standards and lack of a clear pathway towards professionalization must be addressed. Voluntary certification, while an important step, does not address the inconsistency in skills among personal support workers who perform the bulk of daily LTC work. The lack of specific minimum education requirements for personal support care workers in New Brunswick limits implementing standards of education and experience, as well as regulation and advancement grids. This needs to be addressed at the policy level, where minimum education and training requirements are set, and these are tied to renumeration and professional advancement.

> *"While there is currently no wage scale tied to [PSW] certification, advocates on behalf of the occupation continue to reinforce that the key issue in rendering the occupation of a personal support worker as a viable and interesting career choice is that salaries become commensurate with qualifications..."*
>
> ***~ Get Certified NB***

In other parts of the country there are targeted programs of tuition relief or grants to study in professional areas that are underrepresented and essential – one example is Ontario's Learn and Stay Grant program which provides funding for students studying several designated postsecondary programs in underserved communities. The grant requires that successful applicants continue to work for some specified duration both in their field of study and within communities designated through the program. Similar 'return of service obligation' study grants exist in numerous other countries, for example Australia's Medical Rural Bonded Scholarship scheme (now the Bonded Medical Program). Such programs would be a novel idea to support supply and recruitment for a number of underserved industries with a guaranteed commitment from graduates to remain both in the field of study and in province for a predictable period of time, greatly assisting predictability and planning by the province for the LTC workforce.

Recommendation 5.1

By the Spring of 2025, the Departments of Post-Secondary Education, Training and Labour, Health, Social Development, and Education and Early Childhood Development should convene a Training Summit with post-secondary institutions and professional associations in the areas of numerous health professions including doctors, nurses, psychologists, care workers, and other scarce professions. The Departments of Health and Social Development should be prepared with projections of actual staffing needs to meet clear care standards. The goal of the summit should be to establish, by Fall 2025, a costed model of expansion of New Brunswick's training capacity for consideration in the 2025-26 Budget process.

Recommendation 5.2

The Departments of Health, Social Development, and the New Brunswick Community College system should collaborate on a plan to raise the skills and compensation levels of skilled care workers in long-term care. Skills profiles should be developed for home care workers, personal support workers, and staff for nursing and special care homes which take into account the holistic needs of aging adults and adults with a disability. An enhanced model to train and certify these workers should be developed through NBCC and CCNB, and the Departments should develop a Quality Improvement Funding Support Program to assist providers in paying a wage to skilled care workers at a level which will retain workers in the sector ($22-24/hour). Special attention should be paid to the desired expansion of the home care sector and the need for more diverse skill sets, including increased demands for dementia care and neurodivergence-affirming care for individuals on the Autism Spectrum.

Recommendation 5.3

The Department of Social Development should collaborate with providers on a Quality Workforce Initiative, which will focus on the recruitment, retention, and job satisfaction of long-term care professionals. This should include developing career progression paths, continuing professional development, appropriate mental health support, and human resources feedback mechanisms. It should include a component to ensure the continuing professional development of facility managers.

Community Paramedicine

Innovative ways of using the existing paramedical infrastructure to enhance long-term care service delivery has great potential for preventative long-term care in the community, as well as alleviating some strain on the hospital system in New Brunswick. As a relatively new and evolving healthcare model, community paramedicine already has found traction in countries like Australia, the UK, and the USA, as well as here in Canada. Essentially, it allows paramedics and EMTs to operate in expanded roles by assisting with public health, primary healthcare, and preventive services to underserved populations in the community. Started as a grassroots movement among paramedics who recognized the need for new services that emphasized a more proactive and preventative approach to care, the originators of the concept saw how utilizing paramedics in expanded roles could fill gaps in care within communities.

There are currently several iterations of community paramedicine programs in operation in Ontario, Alberta, Saskatchewan, and British Colombia. These programs serve both rural and urban communities and have been largely successful. Closer to home, Nova Scotia piloted a practitioner-paramedic-physician program where paramedics expanded their services in a remote area with a lack of access to community healthcare and an aging population. As a result of that program annual trips to emergency departments fell by 40% in that community and annual healthcare expenses per person fell by almost 57%; in 2005 the Nova Scotia government formally established community paramedic competencies. The Nova Scotia example shows the intersection and potential of in-community LTC services and community paramedicine.

> *"...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, Nolan and Sinha 2018***

We would submit to government that the direction set with aging-in-place initiatives, such as the Nursing Home Without Walls Program, are sound in their concept. Building human resource models that put the people and skills where future growth is predicted is work that should begin now.

Recommendation 5.4

Training programs, professional development, and the provincial human resources plan should pay particular attention to promising practices in supporting aging at home, including a focus on community paramedicine.

Healthy Seniors Pilot Project

The Healthy Seniors Pilot Project (HSPP), jointly led by the Department of Social Development and the Department of Health via the Seniors and Healthy Aging Secretariat, was approved in 2018 and funded by a $75 million agreement between the Government of NB and the Public Health Agency of Canada. The call for proposals closed on May 11, 2021, and in November 2021 the Minister of Health announced the creation of Nursing Homes Without Walls to facilitate aging in place, which is one pilot project that we know began through the pilot program. While mention was made of the HSPP, no update on the other pilot projects in the program was made at that time.

> *"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."*
>
> ***~ Office of the NB Seniors and Healthy Aging Secretariate***

We know there are 67 projects underway relating to the HSPP, but updates on what those projects are, how close to completion, and whether there are plans for expansion or implementation may have to wait until March of 2025 at the earliest. Based on the results of the Nursing Homes Without Walls pilot, which has so far been expanded twice to include more participating communities, the final results of the Healthy Seniors Pilot Project should be exciting to review when finally released. This is again a common flaw in New Brunswick governance – many excellent pilot programs are conceived, but they do little more than provide political talking points in the place of real action because they are not accompanied by a true commitment to measure results and to act with scaling ideas when they are proven to work. Given the incredible innovation and compassion which New Brunswickers have shown through the Healthy Seniors Pilot Project, this would be an excellent place to begin changing our woeful governance culture around pilot projects. Thus, we are issuing a recommendation related to advancing, acting upon, and continuing the Healthy Seniors Pilot Program.

Recommendation 5.5

The Department of Health should ensure a final, integrated report on the projects funded by the Healthy Seniors Pilot Project, with determinations as to scalability. A similar program should be relaunched with a focus on aging at home, with a particular focus on supporting multidisciplinary delivery models and social inclusion of aging adults and adults with a disability.

6

Theme Six

Removing Disincentives to Aging in Place

Theme Six:
Removing Disincentives to Aging in Place

As we have already said, the consultation process revealed tremendous support for the aging in place direction announced by the government. Expanded home care and the Nursing Homes Without Walls concepts are finding a lot of support in theory and, certainly, other models should continue to be considered and this model must be further evaluated. But the aim of the Nursing Homes Without Walls pilot is clearly supported by the New Brunswickers we heard from. As noted in our comments in The Vital Question section of this report, too often small expenditures that might promote the goal of aging at home are blocked by inadequate funding and slow, needlessly bureaucratic approval processes without measuring or incentivizing results among public servants. Clear direction for managers to align policy goals with incentives is needed, as is flexibility and administrative discretion for people on the front lines.

A governance model with integrated continuums in manageable-sized communities is part of that process and has been explored earlier in this document. Regulations that give front-line social workers and others the flexibility to make common sense accommodations rather than simply following rigid processes is another key part. Having local decisionmakers who can make creative arrangements with the volunteer sector based upon a community's strengths is another international model worth exploring that seems perfectly aligned with supported expansions of programs like Nursing Homes Without Walls. Aligning incentives with outcomes is a significant part of proposing a long-term care system that works.

Aging In Place from a Costing Perspective

One in five seniors is estimated to be living in residential care with needs similar to individuals who are supported in the community. Put another way, 20% of seniors in residential care settings are only prevented from aging in place due to a lack of availability or access to community supports or programs. In-home supports are by far the least costly intervention moving up through the system, and yet home support is hard to access due to the current model that incentivizes institutional care, due to the inflexibility of the social support system in New Brunswick. This is an example of the issues raised in The Vital Question, in that these budgets are often determined without modelling the savings which may occur in future years because of these upstream investments.

The preponderance of research supports the idea that aging at home is not only what seniors desire, but also that when programs are put in place that enable seniors to do that, there are multiple downstream benefits both to the community and to the healthcare system overall. Home care programs improve health outcomes, foster greater satisfaction among seniors themselves, reduce costs to the healthcare system in general, and alleviate unnecessary strain on emergency and hospital infrastructure. It should be telling that 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. Where the Canadian provinces have discretionary control over their healthcare and long-term care spending, New Brunswick could become a leader in Canada by following suit.

What can be a barrier to the delivery of in-home and community-based care is accessibility, and accessibility is two-fold. There is the element of a lack of services available which needs to be addressed, but there is also a financial barrier where supports are mired in outdated income assessment models that are tied to rigid funding boxes associated with inflexible methods of supply. As noted earlier, in a results-oriented system, as opposed to a rule-oriented system, front-line workers should have flexibility to choose the mix of services and supports, and family provider supports, which would keep a person at home instead of in more institutional care, rather than simply looking to see if any siloed program is applicable. In an effective system, the supports that best meet the policy goal are always applicable.

One key fear we heard is the Sophie's Choice of needing services but being forced by financial circumstances or ability differentials to be removed from a spouse or partner. In a civilized society this choice should not be one that anyone living with a disability, one that could be managed by additional accommodations and support, should be afraid of. Fear of seeking services where the outcome might be separation from loved ones is a barrier in exploring preventative care, which leads to more serious interventions being required by the time an individual is forced to enter the system, for example through

hospitalization. Once funding becomes more flexible, money can become available for a diversification of support resources and fear of the system is reduced such that the system, as a whole, becomes proactive.

We would also note that increasing the number of seniors living at home with family support will also require some strategic review of adult protection services for scope and responsiveness. While this is a separate program which could found its own review, it should be noted in this section that keeping more seniors at home will come with a requirement for resources to make sure that they are safe at home.

Our recommendations reflect our belief that programs can be reviewed and restructured to align incentives with outcomes.

Recommendation 6.1

The Department of Social Development should modernize the long-term care services income testing policies to meet the following policy goals:

- Co-payments which make aging at home accessible and are set in consideration of long-term benefits to government of avoiding institutional care as long as possible
- Realistic and evidence-based consideration of disability and health expenses
- Acceptable targets for the timeframe for financial reviews
- Minimization and gradual elimination of involuntary separation requirements

Recommendation 6.2

In light of changes to the housing market and inflationary pressures, the Department of Social Development should increase NB Housing assistance program threshold for supporting home modifications from $175,000 to $350,000. Service standards should be established to ensure a maximum request processing time of 90 days.

Recommendation 6.3

The Department of Social Development should ensure that the long-term care program allows for flexible individualized benefits including:

- Transportation costs (e.g., mileage for workers, bus passes) to medical appointments, recreation, and social connections
- Technical aids not covered under programs for low-income seniors to help reduce the hands-on care needed by seniors and to support independent living. The Nova Scotia Continuing Care program should be used as a guide:
  1. grab bars
  2. lift chairs
  3. mobility scooters
  4. reachers
  5. adapted cooking and eating devices

Recommendation 6.4

The Department of Social Development should review its manuals for social workers and front-line staff to allow for more use of global, per-service user budgets and decentralized authority for front-line staff to approve supports that encourage aging at home. Standardized cost-benefit analyses which consider the cost of denying, as well as granting, requests should be developed to guide front-line staff.

Aging In Place from a Community Support Perspective

As mentioned, accessibility can take the form of financial barriers as well as the form of a lack of services or a lack of clear navigation of services available, and both can be a barrier to the delivery of in-home and community-based care. In both urban and rural environments, access to services remains a hurdle across the globe. New Brunswick is a largely rural province, and the population is significantly spread out: almost 50% of New Brunswick seniors live in rural communities, which is more than double the national average. The three main urban centres of Fredericton, Moncton, and Saint John are sometimes prohibitively located for rural communities to easily access services in a timely or regular manner and often resources in rural communities are stretched thin.

There are two concepts aimed at increasing accessibility to care that deserve further investment and expansion. One was developed as part of the Heathy Seniors Pilot Project in New Brunswick: Nursing Homes Without Walls. The other is a program that has had marked success in many countries with large and sparse rural populations like the USA, Australia, and Great Britain, as well as success in some Canadian provinces, particularly Nova Scotia: community paramedicine. There are some promising results in the utilization of existing paramedical professionals and paramedical infrastructure through community paramedical programs, and the Nursing Homes Without Walls pilot program seems to be expanding within the province despite only being introduced very recently.

The Nursing Homes Without Walls concept is uniquely underpinned by 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.

Without proper supports, seniors released into their own homes without adequate care risk becoming progressively homebound. Research shows that homebound status is associated with a greater risk of death, independent of functional impairment or comorbidities and research has also identified the need to extend health care services from hospitals and clinics to the homes of vulnerable individuals. Nursing Homes Without Walls seems to be filling that gap by bringing care services into the community. 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 is likely to be higher in New Brunswick due to the higher proportion of seniors in the community); 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, specifically: higher rates of hospitalisation, increased risk of falling, and premature

institutionalisation. Improved community and home-based support for older adults should address healthy and independent living, which will improve both patient and systematic outcomes, and will over time save the health care system significant spending.

Community and 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 would also reduce ALC numbers.

The following three recommendations relate to the provision of community-based navigation and supports for access to services available, while fostering community connection between service providers and seniors needing clear information and assistance to access services. We also recommend expanding community-based services already explored in the Nursing Homes Without Walls concept.

Recommendation 6.5

The Department of Social Development should fund Long-Term Care Authorities to engage Community Inclusion Coordinators. By working at the local level, these coordinators will enhance people's ability to age in place while staying socially connected by supporting service and housing navigation for aging adults and adults with a disability.

Recommendation 6.6

A Non-Profit Partnership Secretariat should be established within the Department of Social Development to support LTC authorities in developing partnerships with non-profit providers to improve the aging at home experience and to expand the capacities of special care homes and long-term care homes to provide for the social, emotional and recreational needs of patients. The Secretariat should also be empowered to develop province-wide agreements with provincial non-profit organizations for standardized service across regions. This should be linked to Recommendation 9 made to the Executive Council Office and the Department of Finance and Treasury Board.

Recommendation 6.7

The Departments of Health and Social Development should ensure that the Nursing Home Without Walls program is expanded and even better defined. Flexible standards for allowing care homes to assume responsibility for individual support and programming while using the home as a *de facto* bed within the home should be developed to ensure quality of care and efficient use of vital positions such as Registered Nurses, paramedics, rehabilitation specialists, and recreation specialists.

Unpaid Caregivers

The contribution of unpaid caregivers to long-term care is both vitally important and often overlooked. 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 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 per resident in a New Brunswick nursing home, 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), 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. Feedback from our consultations noted that this benefit was not nearly enough to support the unpaid caregivers that the system relies upon to supply free labor, often at the expense of their time and careers, but 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 benefit scheme was quietly discontinued in 2019.

The aggregate public sector cost to replace unpaid care with public care in Canada in 2019 was calculated be just under $9Billion (taking into account both salary and overhead costs). Based on direct salary alone (at an assumed $18/hour), it would cost $5.4Billion to replace unpaid care in Canada. Numbers for New Brunswick specifically are unavailable, but one can assume the cost to the province would be significant. These numbers are presented here simply to illustrate how much we are reliant on the labor of unpaid caregivers to support the system as it currently exists. 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.

We urge government to support unpaid caregivers and family members by formalizing the value unpaid caregivers bring to the province.

Recommendation 6.8

By January 2025, the Department of Social Development should develop an enhanced provincial plan for wage replacement and respite care for family members and designated caregivers who are supporting a loved one aging at home and should establish a system of key performance indicators to track and ensure that the supports are sufficient to foster and to increase the participation of families and designated caregivers.

Recommendation 6.9

The Department of Social Development, through supporting Long-Term Care Authorities, should establish a provincial caregiver's network with a focus on in-person and online support with a focus on emotional support and navigations of services and benefits.

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Theme Seven
Planning for Diversity

Theme Seven:
Planning for Diversity

As noted in our comments in The Vital Question, the Government of New Brunswick does not have adequate procedures, staff, or resources in place to model future demographic impacts. We have seen the price this can exact upon health care systems already. We urge government to consider ways to create an inclusive and compassionate environment for the diverse New Brunswick population.

New Brunswick Adults with Disabilities

Adults with disabilities are a 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 assistance with daily living over the course of their lives. We need to support and consider adults with disabilities in any discussion about improving long-term care delivery in New Brunswick. The disability rate in New Brunswick is currently 26.7%, and adults with disabilities are 22.7% more likely to be designated ALC, which is actually higher than the average for seniors (19.9%). Given that there is a significant number of adults with disabilities in New Brunswick who are living both within communities and also in long-term care facilities, and given that the research into the needs of adults with disabilities 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 focusing long-term care back into home-based and community-based endeavors for New Brunswick adults with disabilities.

It should also be noted that the numbers of adults in New Brunswick who have a developmental disability is increasing steadily, as better awareness and diagnostic approaches are developed. It is important the LTC strategy embraces the concept of neurodiversity, recognizing the diverse ways individuals think, learn, and experience the world. LTC must be neuro-affirming and safe for this community.

In 2021 the Disability Rights Coalition (DRC) sued the province of Nova Scotia over the right of people with disabilities to live in the community and the subsequent Nova Scotia Court of Appeal decision found that there was systemic discrimination in Nova Scotia against persons with disabilities in the provision of social assistance. No such case has been brought in New Brunswick, but we know that there are significant numbers of adult with disabilities living in nursing homes and special care homes where this living situation does not reflect their desire for fulfilling and autonomous living by being cared for and supported in their communities. We have an opportunity in New Brunswick to remedy a discriminatory system right now.

We urge government to not just rhetorically support people with disabilities, but to take concrete steps to realize the rights of adults with disabilities in New Brunswick to live more wholly and intentionally in the community, while receiving the supports they are entitled to.

Recommendation 7.1

By January 2025, the Department of Social Development should release a plan to transition all adults with a disability who are under the age of 65 out of special care home or LTC placement and into small, supported living options (ideally 2-3 individuals per housing option).

Recommendation 7.2

By January 2025, the Department of Social Development should commission an external review on the adequacy of LTC services for neurodiverse adults.

New Brunswickers with Requirements Specific to Culture

New Brunswick is becoming more diverse as migration and immigration continue to expand our population. Immigration to New Brunswick over the past 24 months has broken numerous records. While immigration has been growing steadily over the past decade, it has been reported that growth in New Brunswick's population during the past 24 months has outstripped population growth seen in the entire preceding 29 years, and it's almost entirely due to immigration (primarily from China, India, and the Philippines). Newcomers bring much needed skills, culture, and diversity to our communities, but our long-term care system has historically been centred around the majority population, which is Eurocentric and Christian and, more recently, secular. Newcomers bring with them their own unique cultural and religious expectations and requirements for person-centred care, which must be reflected in revisions to the long-term care sector of New Brunswick going forward.

We submit that all New Brunswickers, regardless of culture and belief, should receive sensitive and appropriate care within the long-term care system.

Recommendation 7.3

The Department of Social Development should partner with groups such as the New Brunswick Multicultural Association to consult and develop a profile of future users of long-term care. This study should look at cultural attitudes and service needs of growing newcomer communities within New Brunswick. An ongoing professional development curriculum for boards, managers, and staff should evolve from this process, as should standing guidelines and measurements for inclusivity of all types of long-term care.

Recommendation 7.4

The Department of Social Development should work with training institutions and programs, and review their own training processes, to ensure that capacity for cross-cultural communication exists throughout the public service and in any future human resources plan.

LGBTQIA2S+ Seniors in New Brunswick

Cultural sensitivity is not limited to a country or origin or a belief system. The evolving culture of persons identifying as LGBTQIA2S+ means that the society many seniors grew up in is vastly different and more accepting than it was mere generations ago. This culture of acceptance and pride must be reflected in the care our LGBTQIA2S+ seniors can expect to receive as they age into the long-term care system, and appropriate supports and sensitivity are required from a LTC system in order for it to be inclusive of the unique needs of LGBTQIA2S+ New Brunswickers. The government of Canada acknowledges that LGBTQIA2S + seniors are a group susceptible to social isolation due to the culture of invisibility many experienced while young.

It's important to reflect that a person who turned 75 in 2023 was 21 years old when homosexuality was decriminalized in Canada in 1969; the youngest seniors at 65 in 2023 would still have been old enough to understand criminality and internalized fear of getting 'caught' at the time the law was changed. The key point here is that while it may seem unimaginable to us now, every New Brunswicker aging into the senior demographic right now and for the next ten years was born into a world where homosexuality was considered a criminal offence. The impact of growing through formative years with the knowledge that expressing one's authentic self could be punished with criminal charges, and the associated stigma that carried, is a reality that has had major long-term impact on many lives.

On the other side of the coin, this formative environment has also created complex attitudes towards LGBTQIA2S+ within the senior demographic itself. Spaces and services must be delivered in a manner that promotes safety and trust, while acknowledging the struggle many LGBTQIA2S+ seniors went through in their youth to be able to express their authentic selves both within society and among their peers.

These policy considerations must also be forward-looking. Today, there is greater acceptance among younger generations, and as a result of this wonderful fact, there are more people who identify openly as LGBTQIA2S+ and have built their family lives around that reality who will be seeking long-term care. Policies such as involuntary separation, recreation, and institutional design may have ramifications for this group that should be considered in advance.

In 2022 two long-term care homes in Toronto have opened 'Rainbow Wings' at their facilities to address the need for dedicated spaces for LGBTQIA2S+ seniors. This idea could easily be implemented in existing long-term care spaces, in consultation with the LGBTQIA2S+ community of New Brunswick.

Finally, as of 2018 there were no official statistics relating to the number of LGBTQIA2S+ seniors in Canada, let alone New Brunswick. Many LGBTQIA2S+ seniors report feeling overlooked by traditional Pride celebrations and activities, and indeed there doesn't appear to be any dedicated official organization in New Brunswick representing LGBTQIA2S+ seniors, specifically. A reluctance to self-identify due to past censure may be

a factor in this lack, as older folks may perceive many Pride organizations are predicated on the assumption of being 'out'. By reaching out to the community and engaging with LGBTQIA2S+ seniors through sensitive and confidential consultation channels, New Brunswick has the opportunity to position itself as a leader in understanding, creating space for, and fostering community connections to enhance the mental and physical health of LGBTQIA2S+ seniors in our community.

Recommendation 7.5

The Department of Social Development should undertake surveys of LGBTQIA2S+ populations and develop plans for a long-term care sector which will see an increase in the next 20 years of individuals with diverse gender identities and sexual orientations.

Recommendation 7.6

The Department of Social Development should ensure that capacity for LGBTQIA2S+ cultural sensitivity should be added to the competencies for skilled care workers in the human resources plan.

New Brunswick First Nations Communities

As it pertains to First Nations peoples, it has been noted that the Canadian health system is a complex mixture of policies, legislation, and relationships. In point of fact, First Nations peoples are included in the per capita allocations of funding from the federal fiscal transfer and are thus entitled to access insured provincial and territorial health services as residents of a province or territory. The system is oftentimes confusing and this impacts navigation of available services for which all New Brunswickers are entitled to. What is necessary is a greater focus on the provision of long-term care services that are culturally and linguistically sensitive and accessible for the First Nations peoples of New Brunswick.

There is a glaring gap in long-term care service provision in this province that provides care in the language of First Nations elders, as long-term care is only mandated to be provided in the two officially recognized languages of the province, English and French. As has been noted and supported by research, second language skills deteriorate as age advances, such that many seniors return to their birth tongue as they become increasingly elderly. The fear of being unable to communicate while in a vulnerable state is a real and concerning one for many First Nations elders in New Brunswick. Another common anxiety is of receiving care in a place that has no specific capacity to address trauma sustained by past discriminatory culturally-related policies experienced by generations of First Nations peoples who are now aging into long-term care, discriminatory policies that have been acknowledged both federally and provincially in Canada.

It is time for New Brunswick to create a pathway towards First Nations elder care within New Brunswick that ensures no one experiences a lack of compassion and culturally inappropriate care, disconnected from community as elder First Nations peoples.

Recommendation 7.7

The Departments of Health and Social Development, in collaboration with the Aboriginal Affairs Secretariat, should initiate a process with the Government of Canada and New Brunswick First Nations governments to establish a long-term care infrastructure plan to ensure aging in the community. Trilateral agreements in education which ensured the ability of First Nations governments to co-manage funds should be considered as a template.

Recommendation 7.8

Consideration should be given by the Department of Social Development to establishing, with full participation of First Nations governments, a First Nations Long-Term Care Authority (or Authorities), with the power to modify provincial programs to provide for family and respite care programs consistent with First Nations family needs, to offer social and cultural programming for seniors which is linguistically and culturally appropriate, and to develop smaller care facilities within First Nations communities which can provide care in the community while accessing support from nearby larger facilities and institutions.

In Conclusion
Advocate's Afterword

In Conclusion— Advocate's Afterword

This has been a daunting report to write. This is partly because the system is large, complicated, and far-flung, having developed through a lot of different processes with a lot of distinct histories. That alone would make this a challenge.

I can also say that of all the topics I have ever reviewed in my three decades of public policy work, I have not seen many that would match this one in terms of the urgency of the work, the anxiety of the people affected, and the skepticism that one report will change anything. I must communicate this hard truth to government – people are genuinely shaken by the state of our health care services. The confidence that we will all be okay if we are unable to care for ourselves, whether by sudden affliction or gradual decline, has been badly disturbed. For the first time I can remember, people openly express a fear that they will be old or sick and that help will never really arrive. That confidence or trust, once diminished, is hard to get back. People have expressed concern that maybe government just cannot get the job done.

For all that, I have never wavered in my belief that whatever is wrong with New Brunswick, it can be fixed by what is right with New Brunswick. A lot of us are here because we love this place, with all its contradictions, clashes, and challenges. We know that being small can make us nimble, being tested makes us creative, and that being in smaller cities and towns makes us closer to, and more caring about, our neighbours. Will we need to be flexible, creative, and caring? We sure will. Are we built for it? Damn right we are.

There is one other bit of Maritime culture that will serve us well: we are blunt, honest, and not all that into messing around with platitudes. We know that hard truths can be delivered with love, and that comforting slogans can often mask indifference to the challenge.

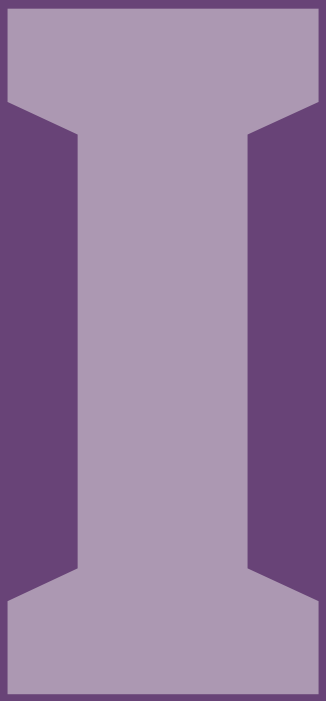
I have not filtered the concern and fear that we have heard. Where experience has taught me something, I've said it bluntly. I have had the blessing of years of being up close when the system made mistakes and even adding my own. And if you love a place and want the best for it, you should share all those sweet mistakes and hard lessons as honestly as you can.

There's a lot of work to be done, and some hard thinking to do. This report has perhaps hit the reader with more of this than expected. If I did not believe in my soul that we could do better, then there would be just cause to stay silent. It is my wish that every blunt observation and urgent appeal will be seen as a gesture of love of, faith in, and hope for New Brunswick.

We can do this.

SUBMITTED to the Legislative Assembly this 13th day of March, 2024

Kelly A. Lamrock, K.C.



Appendix I
Table of Recommendations

APPENDIX I - TABLE OF RECOMMENDATIONS

The Advocate’s Recommendations on the Long-Term Care System in New Brunswick

Theme One: Governance

Recommendation 1.1

A new *Long-Term Care Act* should be adopted integrating the LTC system at all points, with co-ordination at a more decentralized, community level. Part of the *Long-Term Care Act* should establish a number of Long-Term Care Authorities who manage defined authority within the *Act*, each having a distinct subset of citizens for whom they deliver services. The number should be large enough to ensure localized collaboration and delivery and to reflect linguistic obligations and community diversity, but small enough to ensure that governance talent and skillsets are not spread too thinly.

Recommendation 1.2

The new long-term care authorities should be established along the following parameters, and within the governance model the Department of Social Development's role should be as follows:

- **Establishing funding formulas for regional bodies**
  The department will be essential in creating ways to fund regional authorities. Their role includes making sure that money is distributed effectively, matching the needs of specific geographical areas throughout the province.
- **Establishing standards for service, accountability and reporting**
  It will be incumbent upon the Department to set robust standards for service quality, accountability, and reporting, and to ensure that Long-Term-Care Authorities adhere to prescribed benchmarks in delivering care to the individuals under their purview. Contracts should be outcome-based, indexed on clear quality of life indicators.
- **Income support for individuals**
  The department will be responsible for providing financial assistance to individuals within the LTC system. This support is designed to specifically address the financial challenges associated with medical care and connection to their community. The department should work to ensure that individuals

in the LTC system receive the necessary financial resources to meet their individualized needs, thereby enhancing their overall well-being within the framework of long-term care.

- **Centralized recruitment, training, and professional standards for staff**
  The Department will lead centralized recruitment, training, and the establishment of professional standards for staff within the Long-Term Care Authorities, ensuring a consistent and well-qualified workforce across the system.
- **Dispute Resolution**
  The Department will define clear and efficient dispute resolution processes for service users and feedback mechanisms that allow the individual, their family, and service providers to provide input on the quality of care.
- **Facilitating inter-regional contracts and collaboration**
  The department will play a critical role in facilitating collaboration between regional authorities to support efficient resource allocation for both financial and human resources, increase their ability to address broader systemic challenges, and to support the sharing of best practices and innovations in the sector.

Regional LTC Governing Authorities will oversee various aspects of the Long-Term Care (LTC) system, with specific responsibilities aimed at ensuring the highest standards of care and support. The detailed breakdown of their oversight responsibilities is as follows:

- **Identifying and contracting with providers**
  Regional Authorities are tasked with the crucial responsibility of identifying and contracting with providers for a spectrum of services, including home care, special care homes, and nursing homes. This involves a meticulous process of evaluating and selecting providers that align with the specific needs and standards set forth by the LTC system. The goal is to establish partnerships that contribute to the well-being of individuals receiving long-term care.
- **Managing partnerships with community agencies**
  In addition to formal providers, the Authorities are responsible for managing partnerships with community agencies that offer home support and transportation services. This entails integrating service standards into contracts with these agencies, ensuring that the services delivered meet the defined quality benchmarks. By fostering collaborations with community entities, the Authorities contribute to a more holistic and community-based approach to long-term care.
- **Inspections, accountability, and standard oversight**
  Authorities are mandated to conduct inspections and enforce accountability measures for all LTC providers under their jurisdiction. This includes regular assessments of facilities and services to ensure compliance with established

standards. By upholding rigorous accountability and setting high quality standards, the Authorities promote a safe and secure environment for individuals receiving long-term care.

- **Needs assessment and citizen planning services**
  Regional Authorities are involved in conducting comprehensive needs assessments to understand the unique requirements of individuals in their regions. This data informs strategic planning to effectively address citizen needs. Additionally, the Authorities can partner with local community agencies to facilitate individualized citizen planning services.
- **Mobility and standardization of workers**
  Authorities should be given support to standardize worker compensation and conditions and to facilitate collaboration between care providers in assignment of health care workers.
- **Professional development**
  To attract and retain a skilled workforce in LTC, regional authorities are responsible for continued professional development. This will involve establishing programs and initiatives that enhance the skills and knowledge of professionals working in home care, special care homes, and nursing homes. By prioritizing ongoing professional development, the Authorities will contribute to the continuous improvement of the quality of care provided across the regional LTC system.

Recommendation 1.3

Regional Boards should have the following governance model:

- Appointing and forming Boards within Regional Governing Authorities requires a thoughtful and varied approach to ensure effective oversight and governance. Throughout the review process, concerns have been raised about the challenges in New Brunswick when it comes to finding qualified individuals to staff these boards. And yet with the right support, training, and a clear understanding of roles, the recruitment process can be made both targeted and straightforward. The reality is that our LTC system requires an all-hands-on-deck approach since the ubiquity of ageing means it is a system that we will all interact with at some point in time.
- Boards should be made up of individuals with a mix of essential professional skills and backgrounds, emphasizing expertise in quality care, needs planning, change management, community partnerships, and lived experience. This diverse composition ensures a comprehensive understanding of the various aspects of long-term care and facilitates informed decision-making.
- Regional boards can acknowledge the significance of involving communities and management at a local level. They should set up specific initiatives to genuinely connect with communities. These initiatives should aim to encourage collaboration, understanding, and responsiveness within smaller, more manageable regions. This approach ensures a more personalized and customized approach to long-term care, promoting community engagement and consideration of the distinct needs and dynamics of each region.
- Additionally, it will be imperative that Regional LTC Governing Authorities respect linguistic communities of interest and acknowledge the autonomy of First Nations Communities. In so doing, the Authorities demonstrate a commitment to cultural sensitivity and inclusivity, recognizing the diverse linguistic and cultural landscape within their jurisdiction.

Recommendation 1.4

The Department of Social Development and Department of Health should launch a collaborative governance system that aligns healthcare and social services affecting long-term care. This process should be aimed at administrative barriers that may impede collaboration or impact individuals moving through the LTC continuum, particularly for those that are medically discharged but still occupying a hospital bed (ALC patients). This should include collaboration with the Department of Finance and Treasury Board to harmonize working conditions and compensation for staff doing the same job in different types of care. The regulatory review should be done at the same time as the drafting of the *Long-Term Care Act*, with both statute and regulatory reform available to Cabinet through a Memorandum to Executive Council no later than Fall 2025.

Recommendation 1.5

The new *Long-Term Care Act* should entrench the statutory rights of aging adults, fostering a comprehensive framework that will prioritize their well-being and autonomy as follows:

- To age at home where possible
- To have support in remaining independent, active, and maintaining social inclusion within their communities
- To enjoy access to educational, religious, cultural, and social activities
- To be treated with respect and dignity
- To receive timely access to health care
- To live in safe environments free of physical, mental, emotional, and financial abuse
- To have an effective and confidential system for reporting violations of their rights

It should also entrench the rights of persons with disabilities within the disability support system and long-term care system as follows:

- To live in inclusive housing options which provide for their social, intellectual, and emotional inclusion in the community
- To receive full and timely access to health, educational, and vocational services
- To receive services such as supported decision-making and advocacy in a manner and forum which maximizes their independence
- To live independently and with autonomy to the greatest extent possible
- To enjoy access to educational, religious, cultural, and social activities
- To live in safe environments free of physical, mental, emotional abuse
- To have an effective and confidential system for reporting violations of their rights

Recommendation 1.6

The Department of Social Development should, based upon the rights entrenched in statute, develop Key Performance Indicators (KPIs) for authorities to adopt and report on through a public dashboard annually. These KPIs should also be connected to the Social Outcome Targets used in the annual budgeting process, as discussed in Recommendation 8 made to the Executive Council Office and Department of Finance and Treasury Board earlier in this report.

Recommendation 1.7

The Department of Social Development should provide funding and support for the establishment of service delivery arrangements, including the use of social impact bonds, through partnerships with the non-profit sector at the regional level. This can be structured through the Non-Profit Sector Inquiry identified in Recommendation 9 made to the Executive Council Office and Department of Finance and Treasury Board earlier in this report.

Theme Two: Accountability

Recommendation 2.1

Budgets for inspections should be increased through a comprehensive per capita funding formula. Levels of staffing of the assessment and standards units should be sufficiently robust as to allow for regular and thorough inspections, including unannounced or 'spot' inspections. The Department of Social Development should undertake a cross-Canada review of best practices for educating and training reviewers.

Recommendation 2.2

Public reporting standards should be updated. Standards should be the same for both for-profit and not-for-profit providers in all long-term care sectors.

Recommendation 2.3

Both nursing homes and special care homes should be expected to have regular, publicly accessible, and standardized reporting on Key Performance Indicators. At least a third of those metrics should speak to patient experience and satisfaction, with opportunities for patients and their families to provide confidential feedback without fear of reprisal. A repository of both current and past reports should be online in an easily discoverable format. Historical reports and trends should be available, regardless of changes in ownership.

Reports should be built around Key Performance Indicators which are standard and clear. In general, accountability frameworks should be built around outcomes and results rather than processes – the Department should measure what was accomplished more so than how it was done. An example of a key performance indicator framework would be as follows:

- Target scores for client satisfaction with services
- Target impact scores for positive impact of services on health (including mental health, physical abilities), and quality of life
- Target scores for LTC in-home clients reporting increased ability to live as independently as possible at home and involvement in the community
- The percentage of aging adults and adults with a disability who refuse services due to cost of co-payment (target: less than 10% annually)
- The percentage of adults with a disability under age 65 admitted to long-term care homes (target: less than 5% annually)
- Numbers of persons waiting for long-term care admission by region
- Length of long-term care stay, year over year
- Long-term care hours of care delivered per resident per day
- Use of anti-psychotic or sedating medications and a tracking of annual trends
- Number of adverse incidents per year and a tracking of annual trends

Recommendation 2.4

The Department of Social Development should contract an independent small-area variations study of procedures and outcomes every five years, with an emphasis on patient-focused measures such as use of medications and adverse incidents.

Recommendation 2.5

The *Long-Term Care Act* should include legislative protection for whistleblowers and establish an offence under the *Provincial Offences Procedures Act* for anyone who attempts to interfere with the complaints process through intimidation or reprisal, both real or perceived.

Recommendation 2.6

The Department of Social Development should develop and provide mandatory standardized training in effective governance and public accountability for authorities and boards of long-term care and special care homes. This should include both orientation training and continuing education. The Department should also develop provincial standards for the qualifications and continuing professional development of boards and CEOs of long-term care and special care homes.

Recommendation 2.7

Discharge procedures should be reviewed and automatic reviews of discharges by an independent office at the Department of Social Development should be entrenched in legislation. This should include a requirement to advise the Office of the Senior Advocate of discharges.

Theme Three:
Assessment and Affordability

Recommendation 3.1

The Department of Social Development should decouple needs assessment from the contributions of service participants and departmental funding. The assessment of needs should be done at the regional level and establish the individual's needs and goals clearly before the government's financial support formula is applied by the provincial Department.

Recommendation 3.2

Disability service and income support legislation should be modernized to provide adequate and essential assistance for individuals with disabilities. The level of assistance should meet the following criteria:

- Enabling recipients to achieve optimal independence in employment
- Enabling recipients to receive housing and living support which meets their specific needs, allows easy access to accessible transportation, and allows them to live with safety and dignity
- Providing sufficient support to ensure full participation in the community

Recommendation 3.3

A standard template for Personalized Aging Plans should be developed by the Department of Social Development to assist Long Term Care Authorities in supporting residents. Areas to be addressed should include a holistic approach to needs assessment that considers physical, mental, emotional, and social well-being. The Personalized Plan should consider not only medical requirements but also factors such as personal interests, cultural preferences, and the desire for independence.

Recommendation 3.4

The Department of Social Development should implement a single common assessment for individual contribution. The financial capacity of an individual to contribute should be a constant whether they are receiving home care, specialized care, or nursing home care. There should be no need to repeat the financial assessment process simply because the individual's needs have changed. The financial assessment tool should be designed with support from providers, social workers, community service organizations, and public policy experts.

Recommendation 3.5

The Department of Social Development should develop a simplified assessment for families above the income level for subsidies to save time for families and preserve scarce human resources.

Recommendation 3.6

The Department of Social Development should regulate the use of 'upcharges' by providers with a hard cap on daily charges across all sectors. This should begin by ensuring that the current rates of individual maximum contribution are enforced as hard caps across all parts of the long-term care continuum, including special care and memory-care homes.

Recommendation 3.7

Within one year, the Department of Social Development should establish an independent and transparent review process (with opportunities for public input) for contribution formulas and daily rate caps at all points along the long-term care continuum. Advocates for aging adults, persons with a disability, families and clients, as well as providers should be heard as part of this independent review and recommendation process.

Recommendation 3.8

Within one year, the Department of Social Development should establish a process to track the number of individuals refusing long-term care funding and their reasons for the refusal, including measuring refusals due to inability to afford the co-payment or lack of qualified human resources.

Recommendation 3.9

The Department of Social Development should initiate forthwith a review of funding models between long-term care sectors to ensure equal capacity between providers to recruit and retrain skilled staff and to ensure flexibility of patient and staff movement throughout the continuum of care.

Theme Four:
Person-Centred Care

Recommendation 4.1

The new *Long-Term Care Act* should establish, in its preamble, a clear definition of "person-centred care" with principles consistent with the criteria enumerated in this report and informed by the rights contained in the *United Nations Declaration on the Rights of Older Persons* and the *United Nations Convention on the Rights of Persons with Disabilities*.

Recommendation 4.2

The Department of Social Development should, in defining and reporting Key Performance Indicators, include measurable indicators of patient-centred results in the following areas:

- Structures and cultures which encourage assessment of the person's full spectrum of needs
- Presence of educational and recreational programs
- Presence of health promotion and prevention programs
- Workforce training and procedures consistent with PCCcentred
- Effective integration of health information technology to support PCC
- Feedback processes which cultivate communication
- Team accountability for respectful and compassionate care
- Patients engaged in managing their own care
- Access to timely and predictable care
- Patient-reported satisfaction and outcomes

Recommendation 4.3

The Department of Social Development should develop, implement, and regulate mandatory training for Social Development and Extra-Mural Program social workers and hospital discharge planners to improve person-centred (and family-centred) planning and navigation of community supports and services.

Recommendation 4.4

The Departments of Health and Social Development should develop and standardize personnel training in dementia and mental health care across the long-term care continuum.

Recommendation 4.5

The Departments of Health and Social Development should develop and standardize key personnel training in neurodiverse-affirming practices for autistic adults in care across the long-term care continuum. Engaging with the post-secondary sector in realization of this recommendation is advised.

Recommendation 4.6

The Department of Social Development should develop and deliver a quality assurance survey to all long-term care program clients and their families every two years to evaluate client experience with the program, the impacts of the program, and to identify recommendations for continuous improvement, with regular public reporting of results.

Recommendation 4.7

The current model of restrictive levels of care should be reviewed with an eye to developing a more flexible system of matching enumerated patient needs to home capacities. The Department of Social Development should implement a phased approach to transition LTC from a leveled system to a person-centred assessment and holistic model of care. This will provide much needed clarity for families, physicians, discharge planners, and social workers.

Recommendation 4.8

By May 2024, a costed plan should be presented to the Legislative Assembly to increase the hours of care in long-term care facilities to 4 hours a day by the 2025-26 fiscal year. Subsequent independent reviews of the prescribed hours of care by an external reviewer should commence in 2027 and continue every two years thereafter.

Recommendation 4.9

A clear, costed action plan, establishing hard targets each six months for reductions in the number of patients in Alternate Levels of Care, should be presented to the Legislative Assembly by June 2024.

Recommendation 4.10

The Departments of Health and Social Development should forthwith produce service standards for patients currently in Alternate Level of Care, setting out what are acceptable standards for hours of care, patient experience, and responsiveness to patient needs.

Recommendation 4.11

The Departments of Social Development and Health should collaborate with regional health and long-term care authorities to establish standards and pilots for "Social Geriatrics" offices to surround family doctors with other community resources and agencies to allow them to support families in aging at home and assist hospital discharge planners to connect patients with services in their community.

Recommendation 4.12

The Departments of Social Development and Health should collaborate with the Department of Government Services to create standards for future development of nursing homes and special care homes which deinstitutionalize long-term care in favour of smaller, less institutional; more residential-style spaces. Attention should be paid to emerging best practices in memory and dementia care, which suggests that spaces that place residents in settings familiar from their younger days will improve quality of life and reduce negative incidents. Quebec's version of the Green House Project model should be considered as a template.

Theme Five:
A Long-Term Human Resources Plan

Recommendation 5.1

By the Spring of 2025, the Departments of Post-Secondary Education, Training and Labour, Health, Social Development, and Education and Early Childhood Development should convene a Training Summit with post-secondary institutions and professional associations in the areas of numerous health professions including doctors, nurses, psychologists, care workers, and other scarce professions. The Departments of Health and Social Development should be prepared with projections of actual staffing needs to meet clear care standards. The goal of the summit should be to establish, by Fall 2025, a costed model of expansion of New Brunswick's training capacity for consideration in the 2025-26 Budget process.

Recommendation 5.2

The Departments of Health, Social Development, and the New Brunswick Community College system should collaborate on a plan to raise the skills and compensation levels of skilled care workers in long-term care. Skills profiles should be developed for home care workers, personal support workers, and staff for nursing and special care homes which take into account the holistic needs of aging adults and adults with a disability. An enhanced model to train and certify these workers should be developed through NBCC and CCNB, and the Departments should develop a Quality Improvement Funding Support Program to assist providers in paying a wage to skilled care workers at a level which will retain workers in the sector ($22-24/hour). Special attention should be paid to the desired expansion of the home care sector and the need for more diverse skill sets, including increased demands for dementia care and neurodivergence-affirming care for individuals on the Autism Spectrum.

Recommendation 5.3

The Department of Social Development should collaborate with providers on a Quality Workforce Initiative, which will focus on the recruitment, retention, and job satisfaction of long-term care professionals. This should include developing career progression paths, continuing professional development, appropriate mental health support, and human resources feedback mechanisms. It should include a component to ensure the continuing professional development of facility managers.

Recommendation 5.4

Training programs, professional development, and the provincial human resources plan should pay particular attention to promising practices in supporting aging at home, including a focus on community paramedicine.

Recommendation 5.5

The Department of Health should ensure a final, integrated report on the projects funded by the Healthy Seniors Pilot Project, with determinations as to scalability. A similar program should be relaunched with a focus on aging at home, with a particular focus on supporting multidisciplinary delivery models and social inclusion of aging adults and adults with a disability.

Theme Six:
Removing Disincentives to Aging in Place

Recommendation 6.1

The Department of Social Development should modernize the long-term care services income testing policies to meet the following policy goals:

- Co-payments which make aging at home accessible and are set in consideration of long-term benefits to government of avoiding institutional care as long as possible
- Realistic and evidence-based consideration of disability and health expenses
- Acceptable targets for the timeframe for financial reviews
- Minimization and gradual elimination of involuntary separation requirements

Recommendation 6.2

In light of changes to the housing market and inflationary pressures, the Department of Social Development should increase NB Housing assistance program threshold for supporting home modifications from $175,000 to $350,000. Service standards should be established to ensure a maximum request processing time of 90 days.

Recommendation 6.3

The Department of Social Development should ensure that the long-term care program allows for flexible individualized benefits including:

- Transportation costs (e.g., mileage for workers, bus passes) to medical appointments, recreation, and social connections
- Technical aids not covered under programs for low-income seniors to help reduce the hands-on care needed by seniors and to support independent living. The Nova Scotia Continuing Care program should be used as a guide:
  1. grab bars
  2. lift chairs
  3. mobility scooters
  4. reachers
  5. adapted cooking and eating devices

Recommendation 6.4

The Department of Social Development should review its manuals for social workers and front-line staff to allow for more use of global, per-service user budgets and decentralized authority for front-line staff to approve supports that encourage aging at home. Standardized cost-benefit analyses which consider the cost of denying, as well as granting, requests should be developed to guide front-line staff.

Recommendation 6.5

The Department of Social Development should fund Long-Term Care Authorities to engage Community Inclusion Coordinators. By working at the local level, these coordinators will enhance people's ability to age in place while staying socially connected by supporting service and housing navigation for aging adults and adults with a disability.

Recommendation 6.6

A Non-Profit Partnership Secretariat should be established within the Department of Social Development to support LTC authorities in developing partnerships with non-profit providers to improve the aging at home experience and to expand the capacities of special care homes and long-term care homes to provide for the social, emotional and recreational needs of patients. The Secretariat should also be empowered to develop province-wide agreements with provincial non-profit organizations for standardized service across regions. This should be linked to Recommendation 9 made to the Executive Council Office and the Department of Finance and Treasury Board.

Recommendation 6.7

The Departments of Health and Social Development should ensure that the Nursing Home Without Walls program is expanded and even better defined. Flexible standards for allowing care homes to assume responsibility for individual support and programming while using the home as a *de facto* bed within the home should be developed to ensure quality of care and efficient use of vital positions such as Registered Nurses, paramedics, rehabilitation specialists, and recreation specialists.

Recommendation 6.8

By January 2025, the Department of Social Development should develop an enhanced provincial plan for wage replacement and respite care for family members and designated caregivers who are supporting a loved one aging at home and should establish a system of key performance indicators to track and ensure that the supports are sufficient to foster and to increase the participation of families and designated caregivers.

Recommendation 6.9

The Department of Social Development, through supporting Long-Term Care Authorities, should establish a provincial caregiver's network with a focus on in-person and online support with a focus on emotional support and navigations of services and benefits.

Theme Seven:
Planning for Diversity

Recommendation 7.1

By January 2025, the Department of Social Development should release a plan to transition all adults with a disability who are under the age of 65 out of special care home or LTC placement and into small, supported living options (ideally 2-3 individuals per housing option).

Recommendation 7.2

By January 2025, the Department of Social Development should commission an external review on the adequacy of LTC services for neurodiverse adults.

Recommendation 7.3

The Department of Social Development should partner with groups such as the New Brunswick Multicultural Association to consult and develop a profile of future users of long-term care. This study should look at cultural attitudes and service needs of growing newcomer communities within New Brunswick. An ongoing professional development curriculum for boards, managers, and staff should evolve from this process, as should standing guidelines and measurements for inclusivity of all types of long-term care.

Recommendation 7.4

The Department of Social Development should work with training institutions and programs, and review their own training processes, to ensure that capacity for cross-cultural communication exists throughout the public service and in any future human resources plan.

Recommendation 7.5

The Department of Social Development should undertake surveys of LGBTQIA2S+ populations and develop plans for a long-term care sector which will see an increase in the next 20 years of individuals with diverse gender identities and sexual orientations.

Recommendation 7.6

The Department of Social Development should ensure that capacity for LGBTQIA2S+ cultural sensitivity should be added to the competencies for skilled care workers in the human resources plan.

Recommendation 7.7

The Departments of Health and Social Development, in collaboration with the Aboriginal Affairs Secretariat, should initiate a process with the Government of Canada and New Brunswick First Nations governments to establish a long-term care infrastructure plan to ensure aging in the community. Trilateral agreements in education which ensured the ability of First Nations governments to co-manage funds should be considered as a template.

Recommendation 7.8

Consideration should be given by the Department of Social Development to establishing, with full participation of First Nations governments, a First Nations Long-Term Care Authority (or Authorities), with the power to modify provincial programs to provide for family and respite care programs consistent with First Nations family needs, to offer social and cultural programming for seniors which is linguistically and culturally appropriate, and to develop smaller care facilities within First Nations communities which can provide care in the community while accessing support from nearby larger facilities and institutions.