Healthy Seniors Pilot Project | Projet pilote sur les aînés en santé

G023

Enhanced Community Pathway

Last updated: August 2024

Summary

- During a health or social crisis, seniors who lack easy access to primary healthcare and social supports often resort to already-strained emergency departments (EDs) to receive care. However, seniors in the ED do not always receive the care that best addresses their needs. Rapid assessment of seniors' health needs, followed by timely navigation to services that combine health and social supports, may better meet the needs of seniors at risk of hospital admission.
- This program introduced a rapid access pathway to short-term supports for seniors who had recently experienced a crisis caused by an urgent health and/or social issue. Known as the Enhanced Community Pathway (ECP), the program referred eligible patients to a joint Social Development (SD) and New Brunswick Extra-Mural Program (EMP) team, who assessed the patient within 24 to 48 hours of the referral. Based on the assessment, the SD/EMP team developed a care plan that outlined recommended health and social supports for the patient. The care plan was implemented within 48 to 72 hours of the referral in collaboration with a group of healthcare professionals known as the Care Team. Patients could access ECP supports free of charge for up to 30 days.
- The goal of the program was to reduce ED utilization and rates of hospitalization for at-risk seniors, helping them remain in their homes and communities.
- Survey and interview data was collected from 26 ECP patients (majority female; average age 81 years). Administrative data was also collected from EMP on 153 patients referred to the ECP. Patients in this sample who received ECP supports were separated into four time periods for analysis – Time 1 (November 2022 – March 2023), Time 2 (April – June 2023), Time 3 (July – September 2023), and Time 4 (October – December 2023). Additional administrative data was obtained from the Department of Health (DH) for 55 ECP patients discharged from the program between January 2023 and September 2023, covering the 90-day period before their ECP enrollment and the 30 and 90 day period after their ECP discharge. Demographic details were not collected for the administrative data samples.
- 16 Care Team members and 6 assessment team members also provided data for the project.

HSPP Focus Area	Developing innovative care pathways
Project Start & End Date	July 15, 2021 – March 31, 2024
Organization/Agency	Department of Health, New Brunswick Extra-Mural Program, Social Development
Location	Southeast New Brunswick (Zone 1)
Principal Investigator(s)	Evangeline Hallam

Indicator	Impact / Outcome / Result	Quote
Full findings are described in project reporting but are not presented as part of this summary. Please contact the project principal investigator for more information.		
Usage of In-home Services	• Analysis of EMP administrative data indicates that the proportion of referrals to the ECP increased from Time 1 to Time 2 before decreasing slightly in the succeeding periods. • The proportion of referrals from EMP increased over time, while the proportion of referrals from other sources, including SD, Ambulance New Brunswick, and primary care physicians, decreased from Time 1 to Time 4. • The percentage of referrals who accepted ECP services after completing assessments decreased from 79% to 32% between Time 1 and Time 4. This decrease is due to a higher percentage of referrals that did not meet the program requirements, alongside an increasing percentage of patients who opted out of receiving ECP services.	*"I think some patients who may have 'fallen through the cracks' in the past may be captured by this program."*

Indicator	Impact / Outcome / Result	Quote
Healthcare System Barriers	• Based on EMP administrative data, assessments were generally completed within the target 24-hour timeframe (78% in Time 1 to 92% in Time 4). However, there was a decrease in the implementation of care plans within 72 hours of the referral (52% in Time 1 to 15% in Time 4). • These timelines compare favourably to SD's usual processes: SD's median time to initial contact for long-term care (LTC) is 6 days and their median time for the first service requisition for LTC is 47 days, contrasted with a median time of 4.8 days from ECP referral to first service requisition. • During surveys and interviews, patients/family members and Care Team members expressed appreciation for the speed of the assessments and implementation of the short-term supports.	*"Very surprised by the speed and how quickly services were put in place."*
Repeat Usage	• Analysis of DH administrative data suggests that there was a decrease in ED visits in the 30 and 90 days following patients' ECP discharge. • Between 57% and 77% of seniors remained in their homes during the same time period. • However, there was an increase in hospitalizations and alternate level of care hospitalizations in the 30 and 90 days following ECP discharge.	*"[W]ith the help of the Enhanced Community Pathway, we have been able to keep these patients in their own home and avoid crisis admission to hospital for nursing home placement."*

Methods and Comparison

Patients and their family members were surveyed and interviewed on their experience with the program. The project also used administrative data to compare patients' ED, hospital, and LTC utilization prior to, during, and in the 30 and 90 days following discharge from the ECP.

Conclusions and Lessons Learned

- Findings suggest that rapid integrated assessment and provision of short-term supports through the ECP helped seniors in crisis avoid ED admission and remain in their homes. However, more research is needed to assess the program's impact on hospitalization rates. While the data revealed an increase in hospitalization rates following patients' ECP discharge, the project was unable to assess the effects of other factors such as seasonality and co-existing health conditions.
- Lack of program awareness among current and potential referral sources may have resulted in a lower number of referrals than originally anticipated alongside a higher number of inappropriate referrals.
- Internal processes and lack of immediate availability of external agencies and service providers contributed to delays in the initiation of short-term supports following timely initial assessments.

Recommendations

- Draw on lessons learned to integrate the ECP into regular SD/EMP practice.
- Promote program awareness among current referral sources while broadening the range of new referral sources.
- Before instituting a province-wide rollout of the program, consider and plan for regional variations in the availability of short-term supports and community resources.

Next Steps

Enhanced Community Pathway has received Healthy Seniors Pilot Project bridge funding to fund the program beyond March 2024.

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