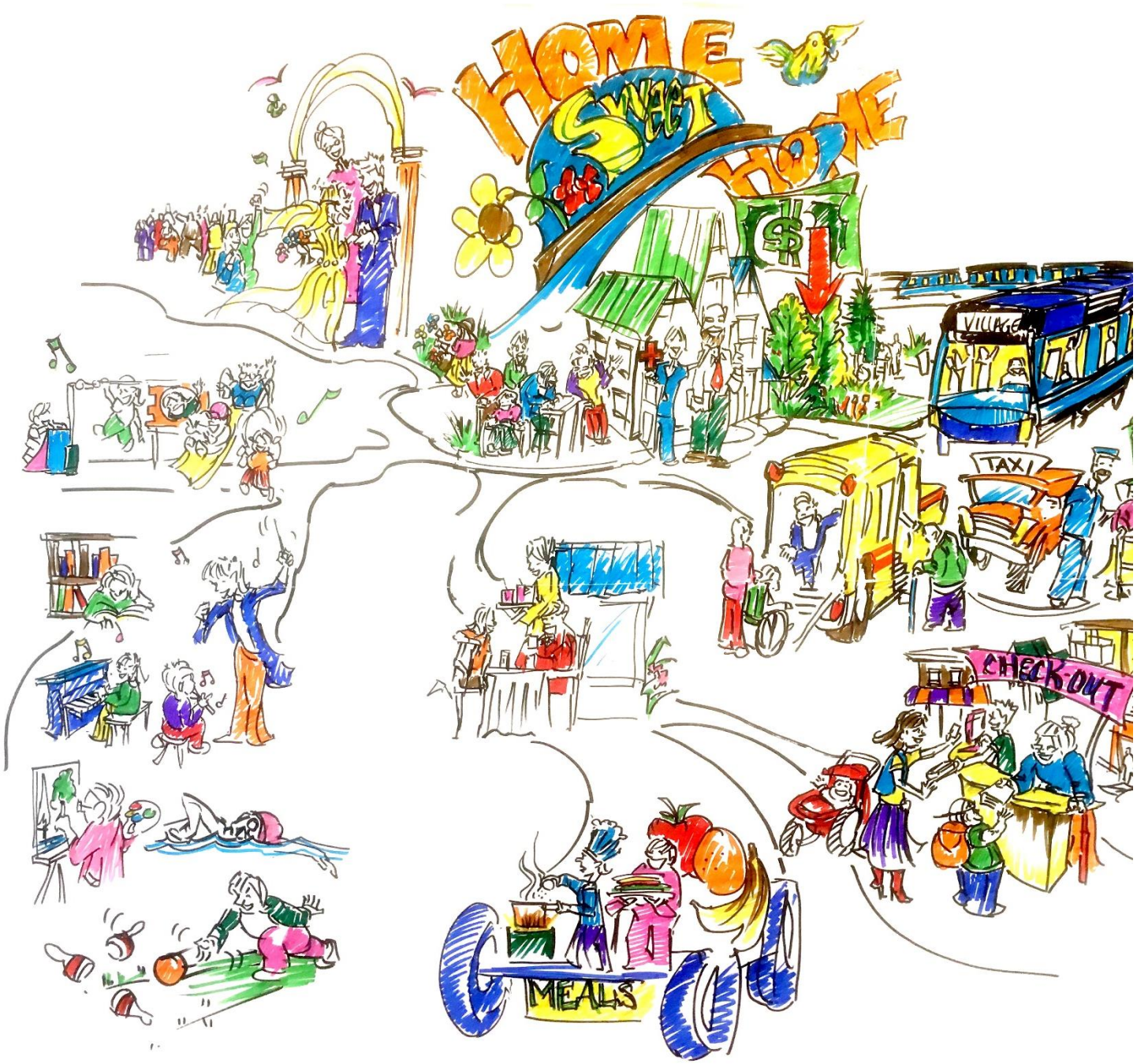

What We Heard Report

COMMUNITIES OF CARE WORKSHOP

September 14, 2018

urban matters

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Appendices

Introduction

On September 13, 2018, the BC Care Providers Association (BCCPA) gathered a diverse set of stakeholder partners together to envision how we better integrate care into our cities and towns that promotes connectedness between families and neighbours, improves health outcomes, supports workers, and makes efficient use of financial resources. Participants held important knowledge in community development, and included local government staff, elected officials, managers of assisted living and care facilities, academia, transportation providers, and health authorities, and others involved in providing care, housing, and community infrastructure. A complete list of attendees is provided in Appendix A.

In towns and cities across British Columbia, the traditional model of seniors' care homes are often located on the fringes of communities, apart from other amenities and services which might be used by seniors in care and other members of the public. Such design has real impacts on how we think about care homes and seniors who need care. The consequences can be social isolation, as many seniors in care have limited ability to travel, and it can be a barrier for family members and friends who would want to visit. It creates systemic inefficiencies, as services which are vital to many segments of the population, not just seniors in care, are too far apart. As our population ages it is imperative that we change that, and better integrate care into the heart of our communities.

The alternative is for health and non-health services for seniors to be integrated into the heart of a bustling community. The central facet to a 'Care Hub' is a seniors care home acts as the centre for the delivery of a wide range of seniors' services. The Care Hub may exist as a Campus of Care or be managed in collaboration by a network of care homes. In some cases, services are co-located, but in other instances they may exist separately as part of a formal integrated network.

The Communities of Care Workshop was designed to explore the Care Hub model by:

- raising awareness among participants about best practices in creating these hubs in other communities;
- defining the conceptual framework for establishing care hubs in both urban and rural contexts;
- confirming the potential risks and opportunities in creating continuing care hubs throughout BC, and;
- identifying a set of next steps to accelerate the implementation of continuing care hubs in BC.

The Workshop was held in Kelowna, British Columbia at the Four Points Sheraton Hotel, and lasted from 8:30am to 4pm. Workshop participants were engaged and animated throughout. The following summarizes the exercises over the course of the workshop.

Schedule and Activity Overview

INSPIRATION - THE NIVERVILLE MODEL

Daniel Fontaine, President of the BCCPA provided an overview of continuing care hub research and outlined the Niverville Model, an example of a care hub that is working well in Manitoba. For more information See Appendix B.

EXPLORING THE CONTINUING CARE HUB VALUE PROPOSITION

Participants brainstormed the assets people would benefit from accessing in a continuing care hub by considering the following questions:

- What is our continuing care hub value proposition?
- What are the programs, products and/or services available that create value for community?
- Do these differ in urban versus rural communities (health versus non-health)?

Participants were asked to participate in one of two categories: urban and rural contexts.

IDENTIFYING THE CLIENT (END USER)

Participants were preassigned a group that was diverse and focused on either the rural or urban context. Groups consisted of 6-8 people. Each participant stayed in their group for the remainder of the small group activities.

Keeping in mind the value proposition discussion, participants listed 'end users' that it would desire interacting with the continuing care hub and why they would access this service.

DRAWING OUT CHANNELS AND RELATIONSHIPS

Each group considered how the supports, programs, services and/or products get from the value proposition to the 'client'. In this case, the channel is largely the co-location of services but what are the ways that it will occur (e.g. program onsite, service onsite, delivery service, etc.). Participants were asked to consider both technological and physical spaces.

IDENTIFYING PARTNERS

Each group answered the following questions related to their care hub model:

- Who are your key partners and/or suppliers needed to make this continuing care model work?
- What key resources do we require from them?
- What key activities do they perform?

Participants were encouraged to consider the types of partnerships required, for example joint ventures, alliances, supplier/buyer etc.

MAPPING RESOURCES

Each group considered how to realize a care hub:

- What do we need to make the model work?
- What are the assets needed (e.g. financial, physical, intellectual, human, etc.)?

UNDERSTANDING COSTS & REVENUE STREAMS

In relation to the model that had been developed by their group over the course of the day, the groups considered both costs and potential revenue streams for their care hub.

Costs:

- What are the entire costs to operate the continuing care hub you have defined?
- What are the most important costs?
- What are the most expensive resources?
- What key activities are the most expensive?
- Are the costs fixed or variable?
- Are there economies of scale?

Revenue Streams:

- How do you bring money to this opportunity?
- What is the strategy to gather that revenue?

BARRIERS TO IMPLEMENTATION

Participants discussed and outlined reasons why care hubs do not exist currently.

MAKING IT WORK & CHANGE AGENTS

At the end of the day, the entire group discussed opportunities to realize communities of care and care hubs in British Columbia and identified change agents to support the shift. Prompting questions raised by the facilitators included:

- What are the most important things we must do to make this model work?
- What are the key activities we will need to become expert at to bring this together?
- What are some of the risks they may encounter? How do they resolve them?

Care Hub Workshop Feedback

The feedback for the workshop is divided into two sections:

- Part 1: A summary of feedback from each activity
- Part 2: A brief summary of each of the 6 groups – particularly focusing on the core elements of the care hub that the group collaborated to create.

Appendix C includes the verbatim feedback for each exercise.

PART 1: SUMMARY OF FEEDBACK FROM EACH ACTIVITY

EXPLORING THE CONTINUING CARE HUB VALUE PROPOSITION

Participants were divided into two categories for this exercise, one each representing the rural and urban context.

On sticky notes, participants brainstormed the assets people would benefit from accessing in a continuing care hub by considering the following questions:

1. What is our continuing care hub value proposition?
2. What are the programs, products and/or services available that create value for community?
3. Do these differ in urban versus rural communities (health versus non-health)?

The following highlights key responses from both the Rural and Urban Contexts.

1. The Continuing Care Hub Value Proposition:

- Integrate the hubs into the community and encourage stronger connections amongst seniors and community members.
- Improve and integrate medical and social services through colocation of services.
- Increase positive health outcomes at a lower cost.
- Create accessible and equitable spaces and services.
- Establish employment opportunities provide revenue generation to support programming.

2. Programs, Products and Services that Create Value for the Community:

	URBAN	RURAL
QUALITY OF LIFE	Focus on inclusion and connection through activities, community events, multi-generational spaces, and access to transportation.	Inter-generational activities and access to transportation, as well as recreation and rehabilitation services are recurring themes in lowering social isolation.
MEDICAL CARE	Provide access to a range of services, including: to dialysis, rehabilitation, primary health care, dental clinic, counselling, denturist.	Address needs of those with dementia. Co-locate the progression of housing and care needs. Provide dialysis, mental health, and dental services. "Take determinants of health approach vs health being silo'd"
COMMUNITY ASSETS	Provide pharmacy, food (restaurants/bakeries/coffee shops), entertainment (art/music), transportation, daycare, and recreation (pool, fitness) services.	Encourage independent living and inter-generational interaction. Offer space for recreation, training, education, and volunteering. Make space dementia friendly, pet friendly, as well as child/youth friendly.

3. Urban Versus Rural Communities:

Both the rural and urban groups came up with similar responses to the value proposition and the types of products, programs and services that a care hub would contribute to its surrounding community. However, the Rural group discussion highlighted the importance and opportunity of the care hub generating economic and employment activity for the community. Whereas the Urban group focused on the challenges of creating inclusive spaces that support integration in a 'vertical' campus or high rise design. The conversation highlighted the importance of design in urban continuing care hubs.

IDENTIFYING THE CLIENT (END USER)

Participants were preassigned a group that brought together diverse perspectives and experience focused on either the rural or urban context. Each of the six groups consisted of 6-8 people. Participants stayed in their group for the remainder of the small group activities.

Keeping in mind the value proposition discussion, participants listed 'end users' that it would desire interacting with the continuing care hub and why they would access this service.

Clients include:

- Those using the services, those paying for them, and those providing them.
- Given the focus on mitigating social isolation, main interest groups include:
    - Seniors
    - Seniors' family members
    - Healthcare providers
    - Staff
    - Volunteers
    - Youth
    - Service providers
    - Community members.

DRAWING OUT CHANNELS AND RELATIONSHIPS

Each group considered how the supports, programs, services and/or products get from the value proposition to the 'client'. In this case, the channel is largely the co-location of services but what are the ways that it will occur (e.g. program onsite, service onsite, delivery service, etc.). Participants were asked to consider both technological and physical spaces.

Space:

- Intended to promote multi-generational interaction, access to rehabilitation, recreation, and health services, as well as access to transportation
- A variety of ways the clients may interact within different spaces:
    - A Community Hub – brings community members to a hub to access services and amenities
    - Care Hub – integrates medical services for seniors and community members
    - Residence – includes a variety of spaces for accommodation. Some identified the importance of developing tiered accommodation with varying levels of care to encourage an aging in one place philosophy, even as needs of the individual shift. Residence.
- During the space discussion, several groups considered how to integrate services performed for seniors in the community (within private homes) could be integrated with the Care Hub model.

- Activities to be performed:
    - A large variety of activities were highlighted, including community events, night classes, retail services, arts, and care programs.
    - Proposed activities also have a regulatory dimension to them and require supportive zoning and licensing.
- How will clients feel?
    - Seniors, as the core clients, are meant to feel connected, respected, and part of the community.
    - Respect, connection, safety, and a sense of belonging are recurring themes.
    - The community is meant to feel more integrated through shared spaces and experiences in a multi-generational, multi-service setting.

IDENTIFYING PARTNERS

Each group answered the following questions related to their care hub model:

- Who are your key partners and/or suppliers needed to make this continuing care model work?
- What key resources do we require from them?
- What key activities do they perform?

Participants were encouraged to consider the types of partnerships required, for example joint ventures, alliances, supplier/buyer etc.

Participants highlighted a series of different partnerships. Key ones identified by multiple groups include:

- Health authorities
- BC Housing
- Indigenous organizations
- Transportation organizations (BC Transit or Translink)
- Health care practitioners
- Local government
- Community leaders
- Seniors' organizations
- Private companies (TELUS for communications for example)
- Urban planners, engineers, and designers
- Service providers
- Volunteer organizations
- Financial institutions
- Developers
- Advocacy organizations such as BCCPA.

MAPPING RESOURCES

Each group considered how to realize a care hub:

- What do we need to make the model work?
- What are the assets needed (e.g. financial, physical, intellectual, human, etc.)?

Groups had the following feedback:

- The model requires considering different expenses including: maintenance cap-ex, insurance, property taxes, contract costs, legal, permits/licenses, time, R&D, service providers, wages/benefits, and land.
- Some of the assets needed were identified as: IT, media communications, training, advertising, relationship building, expertise, coordination, person-centered approach, access to transit, as well as mission and values alignment.

UNDERSTANDING COSTS & REVENUE STREAMS

In relation to the model that had been developed by their group over the course of the day, the groups considered both costs and potential revenue streams for their care hub.

COSTS	REVENUE
▪ What are the entire costs to operate the continuing care hub you have defined? ▪ What are the most important costs? ▪ What are the most expensive resources? ▪ What key activities are the most expensive? ▪ Are the costs fixed or variable? ▪ Are there economies of scale? Key costs include: ▪ Land ▪ Capital costs ▪ Operation costs, ▪ Cost escalation, ▪ Staff salaries and benefits, ▪ Supplies ▪ Food ▪ Maintenance Fixed costs include: amortization, contracts, marketing, transportation/transit, utilities, permits, and insurance. Variable costs include: legal costs, taxes, and equipment upgrades.	Revenue Streams: ▪ How do you bring money to this opportunity? ▪ What is the strategy to gather that revenue? Highlighted revenue streams include: ▪ Philanthropy ▪ Private sponsorship ▪ Tax breaks ▪ Innovation subsidy ▪ Support through Corporate Social Responsibility programs, ▪ Client paid rents ▪ Service revenue ▪ Retail sales, ▪ Government funding ▪ Private programs (daycare for example), ▪ Research/grants ▪ Blending private and subsidized client services, ▪ Day programs ▪ BC Housing ▪ Shared space rentals.

BARRIERS TO IMPLEMENTATION

Participants discussed and outlined reasons why care hubs do not exist currently.

Feedback:

- The lack of a clear business case was identified as a major challenge. Some of the key questions to consider include whether tenants can afford to pay for rent, the extent of the start-up costs, what the priorities for funding allocation are, as well as the estimation of both the cost of living and the cost construction.
- It was highlighted that the system of care for seniors currently operates in silos. This is a challenge in terms of coordination, defining clear leaders, and building partnerships.
- Lack of political will and the presence of bureaucratic barriers were also recognized. These represent regulatory challenges and design limitations in terms of zoning, permits, and licenses.
- This project has an added layer of complexity due to the health and safety considerations it must account for.
- There is a general sense of risk aversion, which is further compounded by a lack of positive models and evidence of success.

- There are several concerns as to the perception of the project, whether it is a band-aid solution, how it addresses values of health and well-being, what the value of elders is within the community, and the extent of the culture shift needed to address stigma around seniors.

MAKING IT WORK & CHANGE AGENTS

At the end of the day, the entire group discussed opportunities to realize communities of care and care hubs in British Columbia and identified change agents to support the shift. Prompting questions raised by the facilitators included:

- What are the most important things we must do to make this model work?
- What are the key activities we will need to become expert at to bring this together?
- What are some of the risks they may encounter? How do they resolve them?

Feedback:

- Making this model work requires educating City Council and the community on the importance of the Care Hub.
- The Care Hub must be made a political priority beyond health departments and it must focus on those most impacted by lack of access.
- Take zoning into consideration, evaluate what can be leveraged, and take on one barrier at a time.
- Bring community partners in early, create a shared vision, confirm that it is what the community wants, and align actions with it through human centered design thinking.
- The question of accessibility and transportation must be addressed.
- Champions/Change Agents include: BCFPA, CALTECH, LG/PROV/FED, BCNPHA (NP Housing Providers).

PART 2: SUMMARY OF EACH GROUP

	IDENTIFYING THE CLIENT (END USER)	DRAWING OUT CHANNELS AND RELATIONSHIPS	IDENTIFYING PARTNERS	MAPPING	COST	REVENUE	BARRIERS
GROUP 1	These include employees, students, family, children, volunteers, healthcare providers, and service providers.	Focused on making it a community gathering place with entertainment, as well as access to technology and transportation. Proposed activities revolved around regulation, zoning, and licensing. Connection, safety, and respect were recurring themes on how clients should feel.	Other partnerships mentioned: CMHC, primary care networks, warranty providers, animal related organizations, faith community, employees/ employers, social enterprises, and philanthropists (Vancouver FND).	Expenses identified include: building, operational evolution, energy, capital cost, occupational risk, equipment, stabilization period. Assets identified include: culturally specific groups.	N/A	Other revenue streams mentioned include: lottery, cannabis, casino, telethon, up selling (i.e. care credits), billboard, and cell tower.	Other barriers recognized include: amount of time that it will take to get the project going, cultural barriers, conflicting priorities, lack of employees and skilled workers, and fear of old age.
GROUP 2	To be determined by the community. End users include family members, seniors, and care facility staff.	Focused on the space's role as a Community Hub, health service provider, and residence that provides safety, inclusion, and access. Proposed activities included governance/regulatory, licensing, thought leadership, and innovation. Clients are meant to feel connected, respected, and as contributing members of the community.	Other partnerships mentioned include: municipalities, BIAs, non-profits, developers, and P3 projects.	Other expenses identified include: risk tolerance. Other assets identified include: expertise, approvals/validation, and flexibility.	Proposed a Mixed Model framework (non-profit & for profit) Capital: Capital Campaign, BC Housing, Fed Grants, Legacy and Foundation. Operational (Financing): rents, clients pay, M´H Funding, user fees, service revenue, commercial rents, retail sales.	Other revenue streams mentioned include: M'H funding, capital campaign and legacy, user fee, and commercial rents.	Other barriers recognized include: care homes are often isolated, starting from scratch is expensive, organizational NIMBYism, and everyone is busy in their silo
GROUP 3	Clients include everyone in the community, dementia patients, family members, workers, staff, and volunteers.	Space can include a restaurant open to the general public that offers catering and cooking classes. The space is meant to be open to the resident elders/seniors, family members, general public, and staff.	Other partnerships mentioned include: legal and accounting professionals, suppliers, architects, and planners.	Other expenses identified include: flexible space (rent out yoga and dance space). Other assets identified include: anchor tenants.	Economy of scale: staff salaries and benefits, supplies, land/ building, operating costs, transit/transportation, and contracts.	Other revenue streams mentioned include: private businesses, health authority, room rental, catering, private programs, fundraising, private residents, events, gift shops, and restaurant.	Other barriers recognized include: increased capital cost, difficulty recruiting partners in a downtime economy, perception that non-acute care is not a priority, and stigma with "for profit" model.
GROUP 4	Clients include elders, elders' families, new immigrants, children, and staff.	Focused on inclusion, promoting personal connection, and efficiency for the users. Proposed activities include distribution of resources, record information, offer Adult Day Program, create partnerships, day activities, night classes, care programs, and retail services.	Other partnerships mentioned include: joint ventures, alliances, home support companies (i.e. companions), clubs, sports, Alzheimer's Society of BC, child care, Safe Care BC, pharmacy, chiro, acupuncture, and dentists.	Other expenses identified include: utilities, staff, and planners. Other assets identified include: imagination, creativity, problem solving, funding, staff, and families.	Key costs include: land, design, developer, operation staff, transportation, and food.	Other revenue streams mentioned include: selling optional services (i.e. cable, telephone, internet) and residents creating items for sale.	Other barriers recognized include: resources focused on supporting existing vision and not re-vision, staffing crisis, safety requirements, time required to do partnerships, fear of the unknown, and inefficient use of transportation resources.
GROUP 5	Clients include those using the services, those paying for them, health service providers, educators, families, seniors, neighbours, and students.	The space's location is critical and meant to function as a community center and/or neighbourhood house. Proposed activities include recreation, education, overnight stays for family, as well as providing access to technology and transportation.	Other partnerships mentioned include: politicians, business associations, and school board.	N/A	Most important costs include wages, benefits, and energy. Other costs to be considered include structure and land, as well as programming and green space.	Other revenue streams include: rent out multi-purpose space, reach out to all levels of government, low-income housing, and discounted expenses such as municipal tax.	Other barriers include: challenge of relocating from existing infrastructure.
GROUP 6	Seniors are the core clients and one must consider their proximity to services, medical needs, socio-economic background, and cultural needs.	Space is meant to facilitate intergenerational integration through housing, Care Hub, and home care services. Proposed activities include Uber for seniors, Facebook and social media platforms, membership programs, pet therapy, food services, and financial literacy programs.	Other partnerships mentioned include: Ministry of Child/Youth, seniors' housing, MOH/MOMH, MOT, MO Housing, communications (TELUS, BELL, Rogers), power (Hydro/Fortis), hotels, Airbnb, and POP.	N/A	Highlighted a Vancouver based example where the most important costs included labor, property cost, and construction/ renovation. The amenities in this example included: grocery, pub, theatre, day care with children, rooftop garden, art/music therapy, pharmacy, primary care clinic, student housing, and chapel.	Other revenue streams mentioned include: social responsibility investments/ sponsors, daycare, salon, theatre, day programs, garden rental, atrium event rental, and music teaching rental.	Other barriers include: need for a proactive health policy and lack incentive to change behaviour.

Appendices

APPENDIX A: COMMUNITIES OF CARE WORKSHOP PARTICIPANTS

APPENDIX B: THE NIVERVILLE MODEL

APPENDIX C: VERBATIM FEEDBACK

CREATING COMMUNITIES OF CARE

PARTICIPANT LIST

Maria	**Howard**	CEO	Alzheimer Society of B.C.
Barbara	**Lindsay**	Director of Advocacy and Education & Marketing & Communications	Alzheimer Society of B.C.
Jodi	**Mucha**	Executive Director	BC Healthy Communities Society
Matthew	**Brodie**	Development Manager	BC Housing Management Commission
Michael	**Flanigan**	Vice President, Development & Asset Strategies	BC Housing Management Commission
Jill	**Atkey**	CEO	BC Non-Profit Housing Association
Danielle	**Harriott**	Regional Transit Manager, Operations	BC Transit
James	**Dusik**	Vice-President, Business Banking	BMO Bank of Montreal
Steven	**Jensen**	Regional Vice-President, Business Banking - BC Interior and Vancouver Island	BMO Bank of Montreal
Riz	**Gehlen**	Owner/Operator	Carefree Manor
Ryan	**Stempfle**	Director, National Business Development	Centric Health
Natalie	**Serl**	Acting Social and Community Development Supervisor	City of Kamloops
Linda	**Stride**	Recreation, Health and Wellness Supervisor	City of Kamloops
Michelle	**Kam**	Sustainability Coordinator	City of Kelowna
Ryan	**Smith**	Manager, Community Planning	City of Kelowna
Aly	**Devji**	Director of HR/Operations/Associate Administrator	Delta View Habilitation Centre Inc.
Chris	**Alionis**	Key Account Manager	Fortis BC
Celeste	**Mullin**	Vice President, Corporate Business	Golden Life Management
Stuart	**Gerber**	Vice President, Asset Management	H&H Total Care Services Inc.
Lenore	**Pickering**	CEO	Hawthorne Seniors Care Community
Janine	**Karlsen**	Owner	Home Instead Senior Care Kelowna and Penticton
Aaron	**Miller**	Corporate Director Population Health	Interior Health
Karen	**Omelchuk**	Residential Health Services Administrator - North Okanagan	Interior Health
Ann Marie	**Leijen**	CEO	Rebalance Rehab
Karen	**Baillie**	CEO	Menno Place

Sue	**Bedford**	Director, Community Care Licensing and Assisted Living	Ministry of Health
Jennie	**Deneka**	Chief Operating Officer	Pacific Reach Seniors Housing Management
Jo-Ann	**Tait**	Corporate Director, Seniors Care and Palliative Services	Providence Health Care
Ray	**Pradinuk**	Principal	Stantec Architecture
Eleonore	**Leclerc**	Architect	Stantec Architecture
Tessa	**Forrest**	Manager, Access Transit Planning	TransLink
Connie	**Jasper**	Health Manager	Tsilhqot'in National Government
Colin	**Reid**	Assistant Professor	University of British Columbia
Kathy	**Doull**	Operations Director, Vancouver community	Vancouver Coastal Health
Melanie	**Reinhardt**	President	Vantage Living
Thomas	**Konek**	Councillor	Westbank First Nation

BCCPA STAFF

Daniel Fontaine, CEO

Mike Klassen, Vice President, Communications & Stakeholder Relations

Michael Kary, Director, Policy & Research

Cathy Szmaus, Director, Events & Administration

CREATING COMMUNITIES OF CARE

In towns and cities across British Columbia, seniors' care homes are often located on the fringes of communities, apart from other amenities and services which might be used by seniors in care and other members of the public. As our population ages it is imperative that we change that, and better integrate care into the heart of our communities.

WHY DOES THIS MATTER?

- This has real impacts on how we think about care homes and seniors who need care.
- It can result in social isolation, as many seniors in care have limited ability to travel. It can also be a barrier for family members and friends who would want to visit.
- It creates systemic inefficiencies, as services which are vital to many segments of the population, not just seniors in care, are too far apart.

WHAT IS THE ALTERNATIVE?

Imagine instead, a place where health and non-health services for seniors were not set on the edge of town but integrated into the heart of a bustling community. In addition to being efficient and affordable, these communities will help to reduce social isolation faced by seniors, while bolstering existing health services. Furthermore, they will attract family members and others from the community by providing a range of services and amenities.

WHAT IS A CARE HUB?

While the notion of a Care Hub is not intended to be prescriptive, there is one central factor – seniors care home acts as the centre for the delivery of a wide range of seniors' services. The Care Hub may exist as a Campus of Care or be managed in collaboration by a network of care homes. In some cases, services are co-located, but in other instances they may exist separately as part of a formal integrated network.

No exhaustive list of services exists, rather stakeholders are limited only by creativity. However, Care Hub services may include medical/health services – such as primary care, chronic disease management, rehabilitation, sub-acute care, dialysis, oral care, foot care, home health care services, and specialized geriatric services which could be collaboratively delivered with hospital and community partners – along with non-medical supports such as adult day/night programs, non-profit services and amenities available to the general public such as restaurants, daycare, theaters, pubs, senior-friendly transit options and senior drop-in centres. Some models may even integrate on-site housing for workers.

A CANADIAN EXAMPLE: NIVERVILLE

Niverville is a small town of approximately 4,500 people located 25 kilometres south of Winnipeg.

The Niverville Heritage Centre (NHC) is not only a residential care home, it has quickly become the heart of the community. NHC describes itself as "a community owned, not for profit corporation that is focused on social enterprise." At over 300 employees, the NHC is now one of the largest employers in the community.

On site are a number of services that you would not normally associate with residential care including two large community banquet halls, full service restaurants open to the public, a children's daycare, a primary care clinic and a dental clinic.

Although NHC is technically a non-profit, they use many for-profit principles and have developed similar business units to help generate additional revenue. For example, all net revenues generated from Hespeler's Cookhouse and Tavern, a business unit run by NHC, goes back to support the delivery of care. They have also leased out office space to a number of tenants which also produces a steady revenue stream to the Society.

WHAT'S NEXT?

The BC Care Providers Association (BCCPA) is pleased to be bringing together over 35 representatives from organizations who hold important knowledge in community development. Through a facilitated day-long dialogue we will explore care hub models and the medical and non-medical services they could provide as well as discuss the opportunities and challenges as to how these sites are planned, built, financed, regulated, and serviced by transportation. We will look at ways to better support this integrated community approach within both an urban and suburban/rural context.

Your feedback will inform a paper that will be developed by the BCCPA summarizing today's event.

ABOUT THE BCCPA

The BC Care Providers Association (BCCPA) has represented non-government care providers for over 40 years. We work with well over 350 residential care, home care, assisted living and commercial members across the province. Our members provide care for over 25,000 seniors annually and creates more than 18,000 direct and indirect jobs across the province.

Exploring the Continuing Care Hub Value Proposition

September 14th, 2018

Feedback Notes

Urban

- Community resilience
- Available resources – knowledge of healthcare
- Connections: past, present, future
- Integrated in community
- Diversity
- Convenience
- Sharing urban economy more viable
- Make the hub the center of health and not somewhere where people are sent away from the community
- Accessibility – universal design
- Central gathering spots to make the hub part of the broader community
- Green and reflective space
- Efficient transportation
- Breaks down stigma
- Urban Diversity
- Connecting different parts of community
- Increase understanding of others
- Seniors pooling and thinking = thoughts
- Connecting different perspectives
- Strengthen community, family ties Vibrancy in care communities
- Self-sustaining neighborhoods "Niverville"
- Enhanced care systems & resources
- Services all in one place
- Efficiency
- Integrations
- Community integration
- (increase) Health outcomes (decrease) cost
- Equity
- Levels of affordability
- Sustainable
- Economic value
- Employment opportunities
- Economic base
- Increase healthier staff, healthier residents = lowers cost higher efficiency
- Language experts
- Service design
- Bring community to vertical
- Vertical campus
- Density

Suburban/Rural

- Financial management services
- Financing options
- Values
- Governance model
- Regulations – how many? Different acts…
- Health Authority
- City planning
- Sustainability
- Finance – BMO
- Technology – e health
- Commercial businesses for profit, independent
- Revenue generating – pharmacy, physio, dentist, massage

Quality of Life - Urban

- Quality of Life
- Urban
- Organized community events
- Social clubs for seniors, youth, children, and family
- Transportation options that allow for spontaneous travel
- At risk youth, foster kids
- Social connection decrease loneliness
- Social health
- Decrease isolation
- Connected
- Builds care
- Improve engagement
- Social wellness

- Social inclusion
- Build relationships
- Multi-generational
- Builds the sense of knowing thy neighbor
- Inclusion
- Improve sense of community intergeneration
- Inclusion
- Intergenerational opportunities, programming, childcare

Suburban/Rural

- Recreation for seniors – traditional, non-traditional, rec therapy, market
- Transition support
- Recreation programs
- Rehabilitation programs
- Music
- Intergenerational programs – i.e., gardening, arts
- Transportation is key when family lives far away
- Ease of access to community transportation
- Transportation
- Primary care
- Adult daycare
- Rehabilitation
- Connection with nature
- Day programs
- Respite opportunities
- Education of ageing for community
- Spirituality
- Intergenerational (non-family) interaction – connection with community
- Job creation
- Activities that engage people of all capabilities
- Opportunities for people in the community to play a role
- A place of inclusion – belonging for people with dementia
- Jobs for seniors
- Increased social connectedness, reduce social isolation
- Co-locate community supports – e.g. Alzheimer's Society
- Partnerships with non-profit and charities to support mission and services
- Programs customized to meet needs, rural/urban, large/small
- Multi-generational, kids/seniors together is great

Medical Care - Urban

- Hearing clinic
- Primary care networks with physicians for both residents and the community
- Dialysis onsite, and other medical services
- Expertise
- Rehabilitation
- Meals on wheels
- Medical clinic, dental clinic, rehab, counselling
- Telehealth
- Denturist
- Diagnostics
- GP/nose practitioner
- Primary health
- Primary care clinics
- Outpatient physio
- Maid center
- Spiritual counselling
- Access to health care clinicians
- Staff, i.e. specialized cooks – OT, PT, chaplains, SW, NSG
- Amenities within walking distance (generally meaning higher density)
- Dialysis

Community Assets - Urban

- Music therapy
- Arts – music, theater, literature
- Equipment, wheelchairs, walkers, lifts
- Recreational facilities
- Retail
- Restaurants and services that the public want to use and value
- Bakery
- Library
- Coffee shop, and deli
- Large buildings, chapels, halls, dining areas

- Swimming pool
- Library
- Transport
- Transportation – buses, people movers
- Recreation, pool, gym, ping pong etc.
- Post office
- Playground
- Student housing
- Parks and recreation
- Food, and entertainment – restaurants, coffee shops, pub
- Commercial ventures in community
- Bowling
- Pharmacy
- Education facilities – all levels
- Childcare
- Fitness, aquatic recreation
- Art studio
- Police, fire, ambulance
- Music lesson rooms for young kids
- Cities need network of neighborhood life
- Community/roof-garden top (outside volunteers co-adopting gardens and res)
- Transit hubs (airport)
- Neighborhood embeddedness
- Worker housing
- Transportation
- Library, café, general store
- Day care (kids)
- Pet shop
- One stop shopping
- Fountains

Suburban/Rural

- Dialysis support
- Mental health/substance use
- Clinical triage for seniors instead of hospital E.R
- Engage physicians
- Dental services
- Support for families who care for a person with dementia
- Meals on wheels
- Take determinants of health approach vs 'health being silo'd
- Mark care transitions less disruptive, co-location progression of housing and care options
- Include staff as target market
- Care staff who understand dementia and are trained to provide appropriate care

Suburban/Rural

- Pet friendly
- Community space (park, activity center, etc.)
- Community gardens
- Movie theatre
- Hospice beds/rooms
- Primary care clinics
- Community walking paths
- Men's sheds
- Hair salon, barber, spa, etc.
- Physio, massage services
- Medical building/clinic
- Pets
- Elder-Connect 0 local community hubs linked to volunteer network
- Outdoor space
- Childcare
- Spiritual space
- Flexibility to personalize entry ways to care units – e.g.: art
- Low income housing
- Adaptable design for age in place – wider wheel chair and scooter areas
- Work force housing
- Once bedroom vs. studios
- Coffee shops
- Computer areas, training for seniors
- Age friendly, dementia friendly, child/youth friendly
- Volunteer hub
- Restaurant/pub
- Step down – beds/suites
- Guest suites for visitors
- Independent living
- Library
- Student housing
- First nations

- Culturally meaningful care
- Elementary, middle, and high schools
- Access to skilled labor
- Research – university integration
- Workforce sharing
- Local hiring, training, and FN employment

- Training center
- Education space
- Safety/reputation
- Education/schools
- Staff housing or first responders housing

Identifying the Client (End User)

Group One - Seniors

- Employees
- Students
    - K-university
- Family
- Children
- Volunteers
- Community customers
- Grocery
- Transit used
- Faith
- Doctors
- OT, PT
- Pharmacy
- Equipment providers
- Service users
  Retail, dental, coffee shop, spa, bank, tech, library, pub

Group Two

- Family members
- Seniors
- Determined by community
- Care facility staff

Group Three:

- Everyone
- Dementia patients/residents
- Anyone in the community (0 – end of life)
- Workers, staff, volunteers
- Family members

Group Four:

- Elders
- Family of elders
- Towns people/neighbors
- Children
- New immigrants
- Staff
- Event planners
- Students
- Post-secondary instructions

Group Five:

Person
    - Using the service
    - Paying for the service
- GP's
- Medical services/allied health
- Educators
- Daycare, children, parents
- Families
- Live in students – universities
- Neighbors
- Funders – community
    - Remove the line that has been constructed keeping seniors from the community
    - Communities that care
- Seniors
    - Living within
    - Living outside
    - Scale of community

Drawing out Channels and Relationships

Group One:

- Green space
- Technology
- Several transports option
    - One dedicated to seniors
- Celebration
- Pets
- Concerts

- Faith
- Library
- Music
- Specialty Care
- Community gathering place
- Sports

Activities they perform:

- Zoning
- Licensing
- Funding Silos
- Silos – lack connection
    - Health
    - Transportation
    - Arts

How will our clients feel?

- Respected
- Trusted
- Valued
- Contributors – useful
- Loved
- Connected
- Not treated differently
- Safe
- Engaged
- Independent
- Not alone or isolated

Group Two:

- Space
- Access
- Communication
- Transportation
- Usability
- Welcome – Inclusion
- Safety – Security
- Contribution – Familiarity
- EU – Pride
- Community Hub
- End used multiples locations in relation to hub
- Residence – Educational, recreation, social, health clinic. Public, services

Activities they perform:

- Governance/regulatory
- Approvals process
- Licensing
- Creative linkages
- Thought leadership
- Innovation

How will our clients feel?

- Connected
- Respected
- Comfortable
- Happy
- Health
- Part of a community
- Safe
- Engaged
- Active
- Feel that they matter
- Autonomy
- Contributing
- Freedom
- Normal

Group Three:

- Residents elders/seniors >
- Family members >
- Staff of the community >
- General public >
- > restaurant in a campus of care
    - > general public
    - > catering
    - > cooking classes

Group Four:

- Inclusive community
- Inclusion
- Personally connected
    - Seniors don't feel isolated and alone – mobilizing the board community around them
    - Safety
    - Decisions we may not agree with to the at risk
- Home for life
- New understanding of the users
- Safety without smothering
- Efficient for users
    - Transport
    - Record information
    - Distribution of resources

        - Reduce bureaucracy
    - Clear mission
    - Passionately honored by all who deliver the programs

Adult Day Program

- Seniors elders
- Health professionals
- After school programs
- Day activities
- Night classes
- Care programs
- Partnerships with transit
- Retail services
- Outdoor space
    - Walking trails
    - Community gardens

Group Five:

Community of Care:

- Locations are critical
    - Community center, neighborhood house
        - Rehab step down
        - Social recreational education integration
    - Brings in techs, GPS
- Services
    - Overnight stays for families
        - Access:
            - Technology
            - Education
            - Transportation
            - Guest services

Group Six:

- Seniors
    - Within proximity to convent services
    - With care/medical needs
    - Socio-economic
    - Cultural
- Intergenerational housing for families and intergenerational services with care hub
    - Workers
    - Volunteers
    - People connected with seniors
    - students
- Surrounding neighborhood drawn into the care hub
- Amenity end-users = wide reach
    - Schools
    - Day cares
    - Pet shops

Home Care Services

- Connecting communities:
    - Uber for seniors
    - (s)tinder
    - Facebook platform
        - "what's happening" - community resilience
    - Membership cards
        - Rewards programs for using services to the care hub spot
        - Seniors "privileges" – "front of the line"
            - Benefits joint ventures
- Care hub – built on central community:
    - Food provisions
    - Service provisions
- Doggy day care:
    - Pet therapy, decreased loneliness, keep familiar intact
- Finding Financial means:
    - 'in kind' services
    - Social real estate investment
    - Create a 'buzz' for future investment in the 'care hub' – guarantee a 'spot' "Freedom 85"

Identifying Partners

Group One:

- CMHC
- Primary care networks
- Other providers – housing & care
- BC Care Providers
- Warranty providers – structures
- Cultural organizations
- Training organizations – schools, post sec, trades
- Faith community

- Animal related organizations
- Volunteers organizations
- Labor
- Government, all levels – FED, PROV, MUNIC, LOCAL
- Banks – capital
- Health authorities
- Engineers and designers
- Academics
- Seniors and Families
- Construction trades
- Employees/Employers
- Retail and Commercial partners
- Social enterprises
- BC Transit, Hydro, Crown
- TELUS Comm.
- Indigenous organizations
- Trans-link, other transport organizations
- Architects – consulting energy modelling
- Philanthropists – Vancouver FND.

Group Two:

- BC Housing
- Municipalities
- Healthy Authority
- BIAs
- Non-profits
- Developers
- Design team
- Family members, residents, public
- Care providers
- Retail
- Experts
- Licensing
- Energy (affordable)
- P3 projects

Group Three:

- Health authority/FNHA – legislation, contract
- BC housing – alliance and joint venture
- Local gov't – regulatory, zoning
- Doctors of BC – physicians for HUB
- Bank for money
- Societies – training and volunteers
- Private business – money and resource
- Transportation – planning, design, and advice
- Architects, designers, and planners – innovation, and design
- Community – buy in and support
- Local First Nations – input, a cultural event and cultural society
- Legal/accountant – business functions
- People (OT/PT/Nurse) – work at the hub
- Suppliers – supply resources

Group Four:

- Architects
- Designers
- Urban planners
- Interior designers
- Retail
- Community
- Home support companies, companions
- Engineers
- Non-Profits / For Profit
- Service providers
- Community associations and services
- Clubs
- Sports
- Recreation
- Child care
- Library
- Alzheimer's society of BC
- Transit authority
- Municipality
- Health authority
- Housing components – BC housing
- Health care practitioners
- Families
- Safe Care BC
- Work Safe and other regulators
- Pharmacy
- Foot care
- Physio
- GP's
- Chiro
- Acupuncture
- Dentists

Group Five:

- Community
- All levels of government
- Health authority
- Financial institutions – financing
- Development community – adjacent services
- Local leaders and influences
- Politicians
- Medical services
- Business associations – adjacent services
- School board
- University/college –learning center onsite
- Childcare center – intergenerational activities
- BC housing – BC transit – BC ambulance, emergency response
- Architects – healthy community design
- Seniors organization – programs

Group Six:

- Municipalities, First Nations
- Feds – "seniors housing"
- Provincial
- Ministry of child/youth
- MOH/MOMH
- MO Housing
- MOT
- Utilities/infrastructure providers
- Communications – Telus, Bell, Rogers
- Power – Hydro/Fortis
- Urban/Health community planers
- Financial institutions – tax advisors
- Legal
- Community service providers
- Schools, universities
- Hotels, hotel infrastructure, Airbnb
- POP

Mapping Resources

Group One:

- Culturally specific groups
- Media communications
- Land
- Building
- IT
- Operational evolution - consistent change
- Maintenance capex
- Replacement reserve
- Energy
- Insurance
- Property taxes
- Contract costs
- Legal
- Permits/licenses
- Fit out social enterprise
- Soft costs
    - Time
    - R&D
    - Relationship building
- Wages/benefits
- Capital cost
- Travel
- Training
- Advertising
- Occupational Risk
    - Vacancy
    - Incident
- Communication
- Stabilization period
- Care
- Food
- Equipment
- Transport
-

Group Two:

- Expertise
- Land
- Coordination
- Approvals/validation
- Political influence/lobbying
- Flexibility > person centered
- Risk tolerance

Group Three:

- Transit nearby
- Flexible space (rent out: yoga, dance)
- Anchor tenants (physician, pharmacy, salon…)

- Activities - services for people on site and to attract those offsite to come to space

Group Four:

- Expertise:
  - Utilities, regulatory bodies
  - Planners
  - Imagination, creativity, problem solving
  - Missions and values alignment
    - All take dementia – friendly education
  - Everyone buys into the vison
    - The way their employees understand the vision
- Funding:
  - For profit partners
  - Retail to invent in accessible and engaging community
  - Lenders/banks
  - Developers
- Care Providers:
  - Staff (difficulties in getting staff)
  - Families – companionship, insight into the family members in care

Cost

Group One:

Group Two:

- Land and Capital Costs
- Owner and overhear costs
- Cost escalation
- Financing
- Operationalizing
  - Staffing
  - Setup and supplies

Mixed Model (Non-Profit & For Profit)

Revenue

Capital

1. Capital Campaign
2. BC Housing
3. Fed Gants
4. Legacy and Foundation

Operational (Financing)

1. Rents
2. Clients pay
3. M'H Funding
4. Safer
5. User Fees
6. Service Revenue
7. Commercial Rents
8. Retail Sales

- Land – 8,000,00
- AL - 75
- ADR – 50
- Seniors housing – 50
- Outreach
  - M and W
  - Home care
- Amenities
  - Rec Centre
  - Ed space/library
  - Coffee shop

Group Three:

- Staffing – salary, and benefits – economy of scale
- Supplies – variable – economy of scale
- Operating costs – variable – economy of scale
- Amortization – fixed
- Contracts – fixed – economy of scale
- Land/BLDG – capital lost – economy of scale
- Transit/transportation – fixed – potential economy of scale
- Marketing – fixed (potentially $$)
- Legal costs – variable
- Taxes – variable

Group Four:

- Land
- Design
- Developer

- Operation staff
- Transportation
- Food

Operating

- Maintaining community engagement
- Up to 75%
- Staffing
- Care
- Food
- Clean
- Hospitality
- Maintenance
- Equipment upgrades
- Transportation
- Utilities
- Marketing and communications
- Management of various entities
- Insurance

Fixed Up-front Development

- Permits (time is land cost)
- Public hearing
- Community consultation
- Archeological assessment
- Environmental
- Building
    - Design
    - Construction
    - Approvals
- Landscape transportation infrastructure
- Community buy in to the vision
- Interior furnishings
- Network infrastructure
- Security (fire)
- Operations permits
- Insurance

Group Five:

100 People – Armstrong

- Structure and Land - $20M
- Programming and green space - $5M
    - $25M-$30M
- Services – wages – benefits - $9M-$10M
    - $250/pp/pal
- Most important costs = expensive
    - Wages
    - Benefits
    - Energy

Group Six:

Vancouver Based Example:

CAPEX

250,000,00/320 RC

60AL

10IL

= 7,812/client

Amenities Included:

- Grocery
- Pub
- Theatre (100 seats)
- Day care with children
- Adult day program
- Rooftop garden
- Art/music therapy – rent
- Atrium – events
- PC clinic
- Pharmacy
- Student housing (10)
- Chapel

OPEX

$250/day/RC

$200/day/AL

$200/day/IL

Most important costs:

- Labor
- Property cost
- Construction/reno
- Pope

Revenue

Group One:

- Lottery
- Government
- Cannabis
- Casino
- Lease revenue strategic
- Value added service
- Sponsorships/branding
- Philanthropy
- Tax break, grant, energy rebate

- Subsidy – cross funded/nonfunded
- Innovation subsidy
- Creating technology to be sold
- Maximize evaluation
- Sell
- Mothership – shared costs
- Up selling – care credits
- Telethon
- Alternative space
- Movie
- Billboard, cell tower

Group Two:

- Rents
- Client pays
- M'H funding; Safer
- Capital campaign and legacy
- Service revenue
- Commercial rents
- User fee
- Retail sales
- BC Housing
- Feds

Group Three:

- Private businesses
    - Leases
    - Services
        - Liquor license
        - restaurant
    - Commercial spaces
- Health authority – contract to provide services
    - Gift shops
        - Visitors
- Room rental
    - Event
    - Companies
- Catering
    - Community
    - Seniors/elders and family
- Private programs – day care
    - Community
    - Companies
- Investments
    - Capital
    - Life lease
- Fund raising
    - Interesting partners, supplies
    - Community
- Private residents (life lease?)
    - Residents/rental fees
- Research/grants
    - Academic partners
    - Private partners
- Volunteers (cost avoidance)

Group Four:

- Broadening clientele
    - Good marketing
    - Value proposition
- Blending of private and subsidized from client's revenue from selling
- Selling optional services (up sell)
    - Cable vision
    - Telephone
    - Internet
- Donation or contribution to social responsibility of the entire endeavor and vision
- Triple bottom line
- Residents creating items for sale
    - Art work
    - Honey
    - Teaching classes people pay for
- Bringing in schools
    - Reduction of costs
- Benefits of living in an inclusive community
    - Snow angels' example

Group Five:

- Leave space (retail)
- Health authorities - families
- Private pay – independent living
- Rent multipurpose space
- Discounted expense – municipal taxes
- All levels of gov't
    - Grants and subsidies
    - BC care quality of life
    - Future cost avoidance
- Love income housing (offset by grants)

- Funders, donors, philanthropy

Group Six:

- Private pay care services
- Lease
- Social responsibility investments/sponsors
- Amenities
    - Physician clinic
    - Physio clinic
    - Pharmacy
        - Partnership
- Daycare
- Salon
- Theatre
    - Rent to schools, families, sports teams, work/team building
- Day programs – activities
- Music teaching rental/services
- Garden rental
- Atrium event rentals

Barriers

Group One:

- Not proven business model, harder to attract capital
- Amount of time and coordination required among so many stakeholders
- Zoning, licensing, regulation
- Competing interest and lack of courage
- Undue risk
- Larger equity cheque
- Mixed use/zoning not as common
- Complexity of health and safety
- Perception
- Cultural barriers
- Regulations permits, HA approval
- Lack of funds
- Sport from government and health authority
    - Health
    - Building infrastructure
- Lack of time to innovate, partner, and build
- Conflicting priorities
- Overall deal complexity and appetite for risk tolerance
- Organizational restrictions
- Environment, geotechnical limitations
- Regulations, licensing, health authority
- Tim and resources, land to build
- Finances – capital(lack)
- Manpower – lack of employees, skilled workers
- Zoning
- Mixed use
- Land use restrictions
- Government regulations
- Ability to finance and meet equity requirements
- Proven business cases?
    - Ned and demand
    - Revenue/cost model
- Cost of land
- Attracting and retaining staff
- Cost of start up
- Land costs
- Rick aversion
- Political intransigence
- Not a political priority
- Lack of knowledge of partners/opps
- Fear of old age
- Stress about costs
- Communities want renewal
- Lack of imagination
- Lack of coordination body or leader
- Ministries disconnect
- Silos

Group Two:

- Culture
- Regulations
- Consistent driver?
- Costs
- Risk
- Care homes often isolated
- Where to start to make them more attractive, community hub?
- Expensive, starting from scratch
- High cost of living… can tenants afford user fees
- Operating cost increase
- focused on care, staging afloat

- Cost
- No coordinating forces
    - Silo'd approach
    - Municipal, provincial, federal, lender, private – all hard to coordinate
- Staffing resources
- Organizational NIMBYism
- Hard to break barriers
- Everyone's busy in their silo
- Use existing hubs to build upon
- Land
- DCC waivers
- Parking relaxations
- NIMBY

Group Three:

- Increased capital cost
- Increased risk associated w/add space
- Increased complexity w/add partners
- Lack of vison
- Regulations – design limitations (zoning time, permits)
- Recruiting/retaining staff
- Difficulty at recruiting partner in a downtime economy
- Communities /perception
- Perceived challenges
- Lack of resources and positive models
- Perception that non-acute care is not a priority
- Stigma w/ "for profit"
- Community scale/location
- Money/funding (to do better than the minimum established)
- Vision shared with team
- Families

Group Four:

- Costs
- Complexity
- Bureaucracy of funding sources
    - Inflexibility
    - It goes to acute
- It's different
- The trap of the band-aid – instead we must completely reimagine
- Many partners, stakeholders
- Resources focus on supporting existing vision not re-vision
- Staffing crisis
- Safety (often)
    - Trumps choices
- People also need sol'ns now so long-term plans may not be priority
- Many have been personally impacted, do not see need
- Regulation compliance
    - e.g. food safety often preludes elder involvement in meal prep
- Time required to do partnerships
- Fear of unknown/will it work?
- Inefficient use of transportation resources
- The way funding is distributed/cont. of funding
    - E.g. fund for a care home not associated amenities
- Zoning regulations
- Poor transit connections
- Unknown from a client perspective – unproved
- Big idea that requires several moving parts, so needs champions to raise interest and show possibilities and bring others on – or like the Manitoba example: requires an entity like a municipality seeing things as a solution to big/complex problems they are facing
- Feels like such a big job – requires a group of 'dreamers' to get the ball rolling

- Might seem regulations and money are prohibitive
- Concern that it takes more energy than is possible for the committed people to get anything going – seems like to many barriers
- Dreamers and do-its, we need both
- So many options, hard to see which one will be successful without a lot of preparation

- Complexity

Group Five:

- Funding – priorities for allocation
- Macro prob – care home today
- Society
    - Values of health and well being
    - Value elders
- Siloed institutions and gov't agencies, interests
- - stigma of for-profit organizations in housing (independent living)
- Community development – long term, leader ship can be short-term
- Regulations > licensing
- Costs
    - Construction
    - Of projects
    - How to keep affordable
- How to 'mix' POPNs – L vs A/L, vs RES
- Existing infrastructure
    - Challenging to relocate

Group Six:

- Business case
    - Zoning
    - Licensing
- Resources
- Time
- Skilled staff to execute on these project
- Stake holders
- Stigma around senior's culture shift
- Long term change integration
    - Need common of collective
- Proactive health policy
- Lack incentive to behavior
- Need gov't buy in
    - Federal
    - Provincial
    - Municipal
- Opportunity cost 12% vs 6% ROL
    - Needs social responsibility
    - Improve future for our seniors and children
- Lack of evidence of success – need pilot/success story

Making it Work

Educating City Council and Community

- Importance of care hub

Political priority

- Not just health departments
- Don't hear much about heath
    - Shift health lends
        - Priority care transformation
        - "how do we ride the wave"
- Media dialogue
- Focus on people most impacted by the lack of access to care – "sandwich generation"
    - Seniors

Alliances

- CALTECH
- BCCPA
    - Find a finder and build on
- Think small then think big
    - Champion
        - Large
        - Mid
        - Small
- Zoning
    - What is already existing – how can we leverage this
    - Ground work
    - Take on one barrier at a time
        - Concrete
        - Create evidence
- Human centered design thinking
- Share vision with politicians – own the vision – vison alignment
- Licensing needs to be at the table (they are!)
    - Work in silos
- Industry association – work with them on one barrier at a time
- Break stories down to a human leave
    - Politicians get to
- Bring community partners in early
    - OCP process good time to think about those elements
    - Find key champions with L.G
- System alignment across muni' so it's a level playing field

Do we have the market?

- Media attention to feel the vision of the hub…

- Had there been a process to engage the users
    - Design approach
    - Yes – re providence health – 2-year process
    - Feel confident that this vision is in line with what people want

Mobility Laws

- Need to empower seniors to use transit services instead of handi-dart
- Pool vehicle resources
- Awareness of how transit buses have been retrofitted for accessibility
    - Many seniors don't know this, so they rely on handi-dart
    - This puts pressure on handi-dart spaces for those who use the most
- Redesign buses
    - Jen to add her story
    - Procurement/bus manufactures

Champions/Change Agents

- BCFPA
- CALTECH
- LG/PROV/FED – champion
- BCNPA – NP Housing providers – housing independent seniors
    - Can't provide support staff to seniors, but no where to move them
    - Age in place – stay in the same community