



ALBERTA ASSOCIATION
ON GERONTOLOGY

Improving the Lives of Older Albertans

NEXT PRACTICES FOR POPULATION- FOCUSED CARE & ENVIRONMENTS FOR CONTINUING CARE

November 24 - 25, 2025



System and Sector Renewal Creates Immediate and Lasting Value for People and a Refocused Health System

Next Practices Forum Report
February 3, 2026

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EXECUTIVE SUMMARY

The Forum, Next Practices for Population-Focused Care and Environments in Continuing Care: Communities for Wellbeing, took place on November 24 and brought together 90 participants for in-person learning and discussion. This was followed on November 25 by a study tour of Good Samaritan's Innovation Project, Small Homes Reimagined, with 55 participants. Attendees represented a cross-section of leaders from community and continuing care, association leadership, Ministry of Assisted Living and Seniors Services (ALSS) and Assisted Living Alberta (ALA), and organizations involved in care centre support and design.

The Forum was designed the Forum as a collective impact initiative, with a shared focus on strengthening community and continuing care to advance Alberta's goals for a refocused health system. Speakers shared exemplars from across the province, and two keynote speakers contributed national perspectives (see Appendix A for speaker biographies).

Alberta's Call to Action is clear:

- **Changing needs and public expectations:** Alberta's population is growing and aging, with changing expectations for care. While most people want to live at home, demand and waitlists continue to grow for community programs and environments that support people living with complex care needs.
- **Ministry and ALA priorities for a refocused health system:** Addressing long-standing funding challenges and expanding options for aging in the right place are essential to improving experiences for residents and clients, family caregivers, and staff. These actions are also critical to supporting appropriate use of acute care by preventing unnecessary admissions and enabling discharge to the most appropriate setting.
- **The time is now for sector renewal:** There are clear opportunities to improve experiences and perceptions of continuing care for people who access and work within the sector. Innovation and increased service capacity can remove barriers to access and deliver proven returns on investment for a refocused health system. Ongoing workforce challenges underscore the need to better support staff if service expansion goals are to be realized.

System and Sector Renewal is the intended outcome of transforming continuing care to deliver new value for people, including residents and clients, family caregivers, and staff, while supporting a refocused health system.

We are challenged by the vision of communities for living well where institutions once stood, supported by:

- Continuing care homes where Still ME is individuals and families experience, and where staff want to work, and are supported to bring their best.
- A range of options that meet the diverse needs of individuals who are aging in the right place, within urban and rural communities across Alberta rather than in acute care.
- Strong community connections that enhance service delivery and strengthen communities.
- Updated policies that support Health System sustainability, innovation, and integration.

The overarching conclusions from the Forum are as follows:

- Next Practices are beginning to take hold; they mobilize provincial goals for aging in the right place and improving individual and caregiver wellbeing through lives of changing needs, with new approaches to optimizing human resources.
- Investment is required to address current issues and to sustain opportunities for change.
- The return on investment from continuing care services and culture change is real and ongoing.
- Trust in Alberta's health system will be strengthened through actions taken now.

Forum learning proposes three strategies to inform action and return on investment to achieve Alberta's goals.

Strategy 1: Commit to a Multi-Faceted Framework for Action for System and Sector Renewal and New Value for People and a Refocused Health System

Schematic 1 shows the intersection of the three spheres of focus for the Forum: culture change and person-centered practices for diverse populations; environments for living; and support for aging in community.

- It is through the intersection of these three spheres that the vision of care centres as communities for living becomes a reality, and the full impact of the Alternative Level of Care (ALC) strategy is achieved and sustained.
- The light blue outline in the schematic reflects the strength drawn from integrating these initiatives within communities, supporting innovation in project development, improving experiences for people, and contributing to communities where people want to live and work.
- Initiatives presented through the Forum showcased what is possible with Next Practices, as summarized in Table 1.
- System and sector renewal has implications across all health system agencies, including:
 - Assisted Living Alberta: enhanced ability to deliver on its transformation framework, with providers within ALA supported by more sustainable services and environments that enable recruitment and retention.
 - Acute Care Alberta: greater certainty in achieving goals related to access and quality.
 - Recovery Alberta: opportunities to partner in mobilizing specialized programming for people with complex mental health and addiction needs.
 - Primary Care Alberta: clearer and value-adding options for physicians and care teams supporting people in the community.

Investment in the renewal sector must address long-standing issues within community and continuing care homes, such as care hours and funding adequacy, to improve work environments and increase access to services. The return on investment is real. The overarching outcome is the restoration of public trust in the intent of Alberta's refocused health system.

Schematic 1: System and Sector Renewal-Optimizing Community and Continuing Care for People (Residents/Clients, Caregivers, Staff) and System Gain

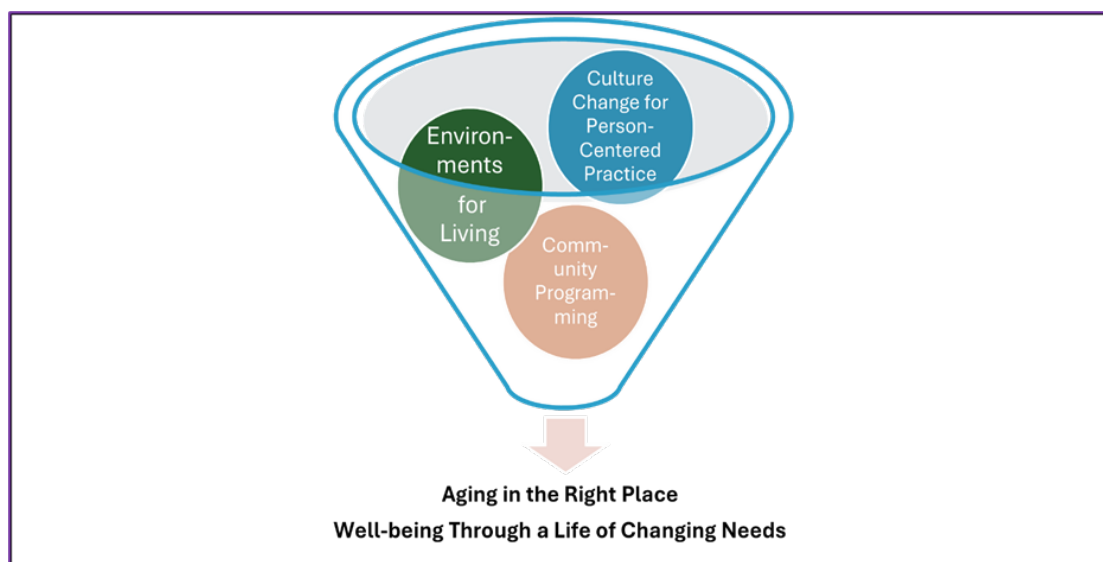


Table 1: Framework for Action: Opportunities for Impact

WHAT WE HEARD REGARDING ACTION TO OPTIMIZE COMMUNITY AND CONTINUING CARE					
IMPACTS	Improves Quality of User Experience & Service Reputation	Enhances Workforce Recruitment & Retention & Caregiver Resilience	Reduces Barriers to Care Centre Admission & Optimizes Occupancy	Prevents Emergency Department Visits & Acute Care Admission	Facilitates Acute Care Discharge & Identification of the Most Appropriate Discharge Location
CULTURE CHANGE IN CARE CENTRES: FROM task- and safety-first care TO person-centered & person-directed care , supporting inclusion of persons living with dementia (an international priority and the largest future group of care centre residents), and enabling people to live well with complex dementia and mental health and addiction needs (two emerging priorities).	X	Foundational to creating capability for change & delivering new results.	X	X	X
ENVIRONMENTS FOR LIVING: FROM institutions TO Communities for Living Well , through modernization of existing care centres and new builds that recognize the diversity of resident needs, with incentives to respond to Alternative Level of Care (ALC) needs and to enhance household design using small home concepts for greater flexibility and support.	X	X	X	X	X
MULTI-FACETED CAPACITY TO SUPPORT AGING IN THE RIGHT PLACE a. Enhancing Living at Home for Individuals and Caregivers <ul style="list-style-type: none"> • Home care innovation • Adult day support, with benefits across the lifespan • Comprehensive community programs (CHOICE) focused on maintaining community living b. Innovation Supporting Living Well in Independent and Assisted Housing <ul style="list-style-type: none"> • Home care innovation (Naturally Occurring Retirement Communities (NORCs) and enhanced lodge care) • Collaborative projects integrating housing and care c. Transitional Programming to Support Evolving Needs and Appropriate Discharge Planning <ul style="list-style-type: none"> • Home care innovation (Destination Home and wraparound supports) • Comprehensive community programs (CHOICE/C3) with a restorative focus • Transitional and sub-acute programs in care centres 	X	X	X Achieved through campuses of care	X	X
COMMUNITY-CENTRIC PLANNING with increased investment in community and social supports, and action to strengthen connections with health services to build community capacity. (cross-reference: Alberta.Communities.in.Action; Showcasing.Grassroots.Leadership.and.Impact, AAG/Healthy Aging Alberta, December 2025)	X	X		X	X

The Ministry of Assisted Living and Seniors Services (ALSS) and Assisted Living Alberta (ALA) have identified priorities for action, each of which is supported by opportunities identified in Table 2. Continued evolution of Ministry policies reinforces expectations for an integrating health system.

Table 2: Ministry Priorities to Optimize Community and Continuing Care and Mobilize Sector Renewal

Priority Initiatives	Considerations from Forum Input
<p>Continuing Care Funding Review: Economics for Sustainability **Foundational to moving forward for quality of care & supportive work environments (a Priority in ALA input sessions, the Still Me Leaders Forum & this Next Practices Forum)</p>	<ul style="list-style-type: none"> ▪ Recognize increasing care needs by addressing gap between current and required hours & updating the Program-Based Care Funding methodology and Program-based funding to reflect business costs for sustainability ▪ Create flexibility to support residents with changes in need to stay in place with short-term funding increases, rather than requiring a move ▪ Recognize implications of economies of scale differences with urban and rural service delivery ▪ Engage a Small Homes Working Group to develop and demonstrate funding model implications for small homes.
<p>Capital Development Strategies: Updating Existing & Adding New Capacity **Enables culture change; addresses problematic environments that foster negative impressions & create barriers to admission; increases capacity with options to meet increasing diversity of needs.</p>	<ul style="list-style-type: none"> ▪ Recognize value of small home concepts as extensions of Design Guidelines for Households given their benefit to enhance care & staff outcomes and increase flexibility in meeting current and future care needs in rural and urban settings. ▪ Innovate in supporting cross-sector projects (across housing and care sectors, with community and private partners). ▪ Create incentives for projects that provide space for community-focused programming.
<p>Capacity Planning for Community & Continuing Care **Addresses citizen desires to age in community; recognizes the importance of supporting caregivers (key to post-acute discharge & sustaining community living)</p>	<ul style="list-style-type: none"> ▪ Learn from existing programs (Adult Day Programs; CHOICE/C3) to expand options for community living and increase access to meet diverse needs. ▪ Develop capacity plans that promote community-centric planning, including exploration of learning re “nursing homes without walls”. ▪ Optimize ease of access and appropriate use of services with new approaches for case management with system navigation information that clarifies terminology and care opportunities. ▪ Collaborate with Alberta Seniors on a parallel investment strategy for community-based services.
<p>Continued Evolution of System Design and Polices **Modernize the policy environment to support change</p>	<ul style="list-style-type: none"> ▪ Priority areas for attention based on Forum input: <ul style="list-style-type: none"> ○ Remove case management differences between Cont. Care A & B to enhance care outcomes and environments for teamwork & staff satisfaction. ○ Strengthen system-focused case management, taking the opportunity with new system navigation tools to work toward clearer & user-friendly language. ○ Review resident accommodation policies across Continuing Care A, B, C and Lodges to harmonize payment expectations in support of an integrating system. Consider new (higher) payments for new, larger private rooms for equity across environments & financial viability with enhanced environments. • Identify “Innovation In & Sustainability of Affordable Housing, Community and Continuing Care” as a priority in the next iteration of the Rural Health Action Plan.

Strategy 3: Mobilize Culture Change Through Provider and Partner Collaboration and Initiatives that Change and Sustain Experiences for People (Residents/Clients, Family Caregivers, Staff)

Opportunities identified through the Forum are outlined in Table 3. A focus on the experiences of people is central to the desired outcomes of system and sector renewal. Expectations for person-centered practice and human resource development are also core requirements within accreditation standards.

A sustained focus on human resource development and on supporting family caregivers is essential to workforce sustainability. Without the people who deliver and support care, intended improvements in service capacity cannot be realized.

Table 3: Mobilizing Conditions for Enhanced Experiences for People

Initiatives In Proposed Order of Priority	Opportunity
Culture Change for Person-centered Practice Through intentional staff development and practice change (as illustrated by Brenda Strafford Foundation - Centre for Learning, Innovation and Quality (CLIQ) and Keynote Speaker Suellen Beatty)	Prioritize increases in continuing care funding to address current issues & change environments for enhanced retention and recruitment attractiveness Optimize the experiences, effectiveness and satisfaction for staff with culture change education, leadership development and practice change (see return on investment from Eden's study, described in Section 4) Share learning across partners, identifying implications for system-wide policy and practice changes
Human Resource Planning & Development with Alberta Health's Workforce Plan, ICCER (Institute for Continuing Care Education & Research) and provider-initiated demonstration initiatives A foundation for having the people to support intended increases in service capacity	Identify workforce needs and implications for role optimization and education with increasing breadth of continuing care workers (mental health workers, community support workers, multi-skilled workers) Develop demonstration projects for scale and spread of innovations in staffing models and use of technology to change approaches to work
Caregiver Strategy Key to sustaining caregivers? primary enablers of aging in the right place	Implement priorities in the Caregiver Strategy to enhance environments in care homes and communities for caregiver engagement and improve access to community-based supports

Moving forward from the Next Practices Forum is a collective effort, with learning from the Forum as reported in this Report as a resource.

Table 4 provides a summary of actions for Ministry, ALA and Providers.

Table 4: Advancing System & Community & Continuing Care Sector Renewal

Next Practices Forum—for immediate & ongoing change	Mobilized by Ministry ALSS & ALA Strategies for System & Sector Change	Sector/Provider Leadership for Culture & Practice Change
Person-Centered care & programming to meet needs of diverse populations ...and change the experiences for people (residents/clients, staff, family caregivers)	<p>**Continuing Care funding to support increasing needs & costs</p> <p>**Environments for Living—modernize current & new builds</p> <p>**Policy Change-System design & terminology</p>	<p>**Culture Change—education & practice change</p> <p>**Human Resource Development—to retain & recruit</p> <p>**Caregiver Strategy—to enhance existing & new supports/practices</p>
Environments for Living ..change the experiences for people & improve access to a range of continuing care options	<p>**Capacity Planning & Capital Funding Plans (as above)</p> <p>**Continuing Care Funding, with recognition of rural/urban differences in economies of scale & implications of a range of neighbourhood models including small home concepts</p> <p>**Policy Change, to address barriers to operating efficiency and effectiveness</p>	<p>**Above, with a focus on human resource development to support new expectations & increases in capacity.</p> <p>**Demonstration projects with learning from small home concepts</p>
Community Programming ...supporting aging in the right place for system gain & changing the experience for residents/clients & caregivers	<p>**Capacity Planning & investment in a range of options, linked with community</p>	
Responding to the Urgencies of ALC (Alternative Level of Care) Needs & Sustaining Changes in How the System Works	<p>**ENABLED BY THE ABOVE ACTIONS and cross-Agency collaboration</p>	<p>**Partnering for change and sustainability; building and rebuilding trust with residents/clients</p>

The Payoffs

- Alberta leading the way in system and sector renewal for community and continuing care, with improved quality and access for older Albertans and increased attractiveness as an employer.
- A transforming health system enabled by strong community and continuing care, supporting priority outcomes including a person-centered and sustainable Alternative Level of Care strategy, and strengthened partnerships with Acute Care, Primary Care, and Recovery Alberta.
- Return on investment for communities and for the health system, benefiting both the system and service providers.
- Opportunities to build public trust by demonstrating that Albertans will experience tangible benefits from a transformed health system.

AAG's Stakeholder Collaborative Committee reviewed the Next Practices Report at its January 27 meeting. The Committee identified four key messages supporting forward movement on the learning and priorities outlined in this Report.

1. Community and Continuing Care as Central to System Transformation

Enabling the future through system and sector renewal

The Next Practices Forum captures a shared moment of recognition across Alberta's community and continuing care ecosystem. This sector is foundational to the sustainability of Alberta's health system. Community programming, adult day supports, restorative models delivered in community and care centre settings, supportive housing innovations, and new models of continuing care are already generating measurable value. However, access remains inconsistent, capacity is constrained, and providers continue to face financial vulnerability.

"We as a sector can renew and evolve every day, but if we do not have system renewal happening across the spectrum, we are going to be hard pressed to make it work."

2. The Reality of Need and Urgency Through Lived Experience

Committee members emphasized the urgency of action, grounded in lived experience across the system. Examples shared during the discussion included:

- "Transition Services are now calling the wait list the 'desperation wait list.'"
- "The waitlist in Calgary for adult day programs is 2,300 right now."
- "Depending on where you live in the province, you may not be able to access the same level of supports. There is a lack of consistency."
- "Equity of access to non-medical supports such as Meals on Wheels, transportation, and caregiver supports does not exist."
- "Some communities have no idea where to start. Connecting them with another community that has a successful program was really meaningful."

3. Designing for Experience

SCC discussion highlighted the importance of starting with the experience of people and working backward. This approach supports the development of coordinated, inclusive, and responsive pathways, rather than fragmented or institution-driven solutions.

4. Our Opportunity: The Time Is Now

Alberta has momentum, innovation, and commitment across communities and providers. Sustaining this renewal will require continued partnership, investment, and shared action. This collective effort is essential to ensuring that quality of life becomes the defining measure of success in continuing care, and that goals for a transformed health system are realized.

Video recordings of Forum keynote presentations are available on the AAG website under the Resources tab in System Transformation, including:

- Evidence-Based Approaches to Modernizing Care Centres, Robert Wrubowski
- Creating Communities Where Institutions Once Stood, Suellen Beatty

ACKNOWLEDGEMENTS

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PREAMBLE

The Next Practices Forum had a two-part implementation strategy.

Day One was an on-site session with participants interacting with panels of speakers on the Forum’s topics. A closing speaker, Dr. Jaason Geerts from the Canadian College of Health Leaders, engaged attendees with a presentation, “Taking up the Leadership Challenge”.

- The day was recorded. An AI-generated summary of content presentations and the discussions, with validation by AAG note-takers, has been used to create this Report.
- The two keynote presentations are provided on the AAG website.
- Forum Speakers noted in the Appendix are available as resources. If required, contacts may be made by contacting AAG.



Day Two involved a study trip with a bus trip to Good Samaritan South Ridge Village in Medicine Hat for Good Samaritan Society’s (GSS) innovation site for their project, “small homes reimagined”.

- The 3-hour bus trip provided time for learning (the presentation on history of small homes in Alberta) with small group and individual reflection.
- The on-site visit was hosted by the Good Samaritan Society (GSS) Innovation Team with presentations and a tour of the renovated cottage. Information in this report is based on this information.



Credit for photos: Steve Kovacic and Kelly Baskerville

Participants expressed satisfaction with the Forum experiences, shared learning and collegial atmosphere.

INTRODUCTION

Forum Objectives and Opportunity to Mobilize Transformation in Alberta

The Forum had 3 objectives:

1. To deepen learning about transformation opportunities from the Still Me Leaders Forum for inclusion of people living with dementia and considering special needs of persons with complex mental and the impact of the care center environment.
2. To engage participants in identifying implications for Ministry/ALA's current change priorities (capital redevelopment, capacity planning and continuing care funding), anchored with the imperatives from the Alternative Level of Care strategies.
3. To mobilize action through participation in the Forum and through follow-up as identified in this Report—across the Ministry/ALA and providers for the changes we need to see.

The Report introduces the concept of “System and Sector Renewal” as an overarching outcome to energize continuing care providers and partners and the Ministry in delivering on immediate and ongoing transformations informed by changing needs, evidence and experiences, and demonstrated impacts for a transformed continuing care sector.

Purpose and Overview of the Report

The Report is a resource document to inform change.

- The Executive Summary provides an overview of the Forum along with summaries of key themes from the presentations and discussions organized for action.
- The Report, section 3, provides key themes from each presentation and implications for action.
- Section 4 of the Report outlines evidence for Return on Investment.
- The Appendices provide bios of speakers, resources to support specific actions.

THE FORUM: CALL TO ACTION

Need for Change

The Forum builds on the Still Me Leaders Forum held in May 2025 with the following goals for change:

- Participant input set out a Vision of HOPE, a key word in Alzheimer Calgary's movement for change: Health, social and community services, and communities where:
 - Individuals living with dementia experience acceptance and understanding ("Still Me")
 - With a relational approach to care/support enabling individualized approaches to wellbeing and safety
 - Care environments for living (like small homes and neighborhoods) are places where residents can be at their best enjoying relationships with each other and family members and employees can feel supported and flourish
 - Collaboration occurs among services in the community for support/care at the right time and in the right place through a journey of changing circumstances and care needs
- Action Must Start Now, with 4 strategies:
 - i. ALL Providers, Educators, Community Partners, Associations: Take action to mobilize shared mindsets, foundational to the way forward.
 - ii. Ministries and Agencies: Create the conditions for change, addressing priority funding issues for community supports and staffing in congregate living.
 - iii. Ministries with Service Providers, Educators, and Associations: Empower and support people with culture and practice change.
 - iv. Ministries and Demonstration Project Proponents: Demonstrate Next Practices toward systemic policy change.

Residents in Alberta's Care Homes and their Caregivers underscore the need for change.

- Alzheimer Calgary and the Alzheimer Society of Alberta & NWT shared the following themes about what matters to Persons Living with Dementia and their caregivers:
 1. Communication and Consultation— “being part of the care team”
 2. People don’t want to feel guilty for having a family member in care
 3. Person-centered care, not treating people like they are “socially dead, understanding the true meaning of “behaviours” and how to support
- Caregivers involved in Alberta’s Caregiver Strategy echo the above comments. They also identify the following experiences as contributors to hesitancy to see care homes as a positive resource:
 1. Loss of control and role; Placement feels like losing identity, not gaining support.
 2. Inconsistent or rushed care; Observing unmet needs reduces trust.
 3. Communication gaps; Silence or unclear information is interpreted as risk.
 4. Feeling unwelcome or monitored; Especially during COVID, families were treated like intruders.
 5. Staff under strain; Caregivers see burnout, turnover, and lack of training.
 6. Pandemic trauma; Visitor bans caused harm, social isolation, and erosion of trust... “Decisions were made without us — we were told after.”

Continuing Care Home providers acknowledge these realities; they also have been clear in advocacy to the Ministry of ALSS and ALA about the need to address long-standing funding issues and modernize system design and system policies.

Expectations for Change: Ministry of Assisted Living & Seniors Services and Assisted Living Alberta (ALA)

The Minister for Assisted Living & Seniors Services announced 3 strategies for change in the continuing care sector in October 2025: Updating continuing care funding, capital reinvestment, and capacity planning.

ALA’s Assisted Living Framework (December 2025) outlines a province-wide strategy to transform care delivery which encompasses the above priorities for continuing care and extends the opportunity for added value by this sector—and follow-through on learning from this Forum. The framework focuses on 4 priorities:

- expanding supports that help people remain safely at home
- improving hospital diversion and discharge
- modernizing funding so dollars follow patients rather than buildings
- driving the most significant expansion of continuing care spaces in Alberta’s history

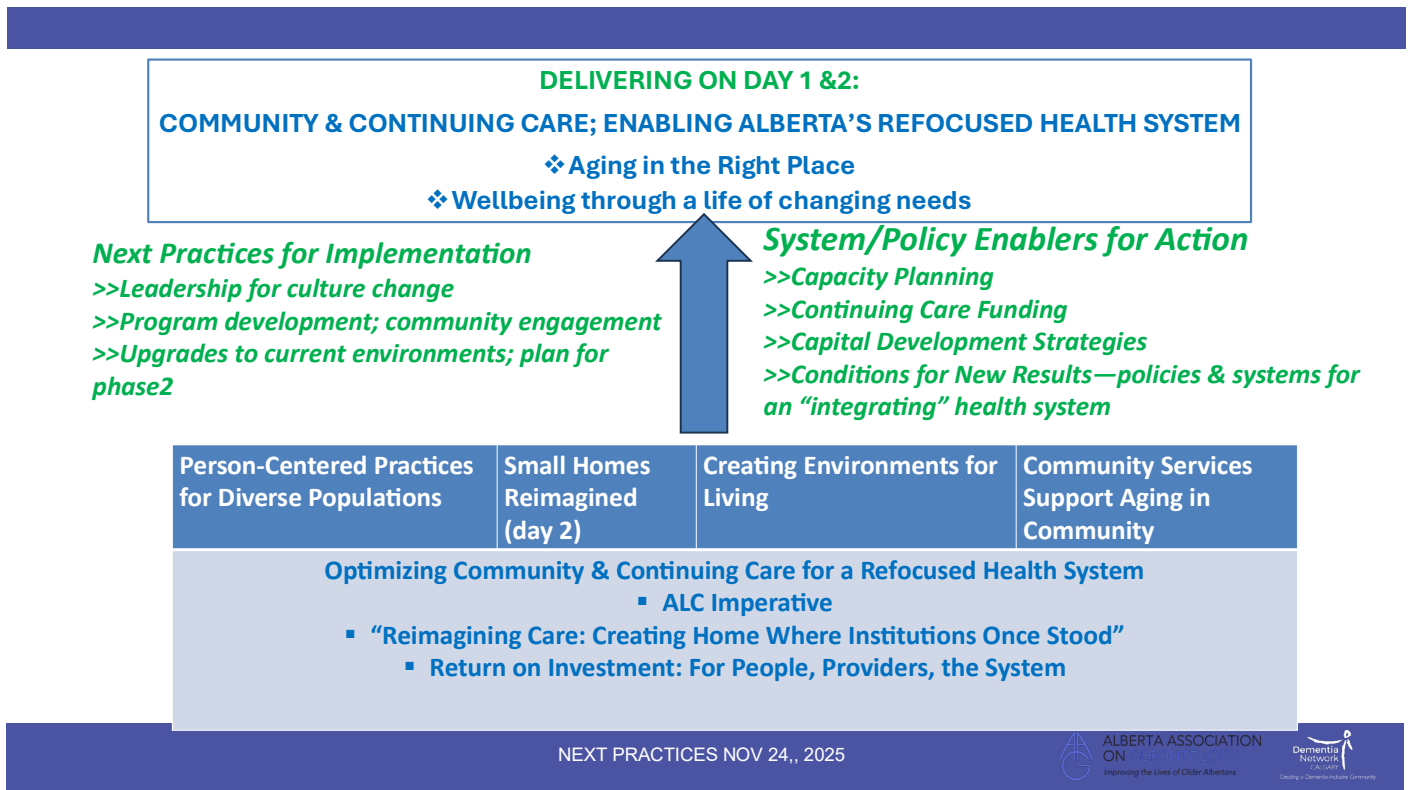
Opportunities for Change: Next Practices for System and Sector Renewal

The Forum focused on “Next Practices”.

In moving forward with systemic change, health system change agents are encouraged to focus on “Next Practices” which demonstrate explicit changes in practice, supported by emergent policy development and mobilized by system-wide knowledge translation initiatives (Zayna Khayat, in her webinar July 2025, “Modernizing Health Systems Through Innovation, IEDP/Rotman)

The plan for the Forum is illustrated in Schematic 2.

Schematic 2: Plan for the Next Practices Forum



The Forum Proceedings section of the Report provides a summary of learnings, opportunities and implications for implementation for each of the Forum Topics. These have been summarized in the Executive Summary for ease of action planning and implementation.

Implementing Person-Centered Practices for Diverse Resident Populations

Desegregating Care for Persons Living with Dementia (PLWD)

Overview

The Brenda Strafford Foundation (BSF) is undertaking a major shift from traditional locked dementia care neighborhoods toward inclusive, dignity-centered, non-secure environments. This work reflects global trends—prominent in the Netherlands, Australia, and Japan—toward desegregation and community-based dementia support. With Alberta’s dementia population rapidly increasing, BSF is rethinking long-standing assumptions that secure spaces are inherently safer.

Insights From Engagement

BSF conducted focus groups and surveys with staff, families, leadership, physicians, and transition services. Key findings include:

- Locked = Safer is a deeply ingrained belief, though many residents in secure units are not elopement risks.
- The decision to place residents in secured areas often occurs during moments of crisis or delirium, not based on ongoing need.
- Staff and families express fear of incidents, media scrutiny, and liability.
- Safety concerns often relate to falls, care needs, or nighttime behaviours—needs that can be supported without locking doors.
- There is a need to redefine “safe” to include autonomy, dignity, meaningful engagement, and supported risk-taking.



Cambridge Manor Pilot: Transitioning Willingham to an Inclusive Neighborhood

Cambridge Manor has two 30-bed secure neighborhoods. Upon reviewing all 60 residents:

- Only 13–14 residents truly required secure supports.
- The remainder were placed there due to habit, fear-based decision making, or outdated criteria.

This inspired a soft transition plan to transform the Willingham neighborhood into an inclusive, non-secure space while maintaining safety and engagement.

Elements of the Transition Plan and Initial Results

1. Collaboration & Stakeholder Engagement
Involvement from Alberta Health Services, mental health teams, families, staff, and leadership.
2. Updated Admission Criteria
Shifted from default secure placement to individualized, needs-based profiles.
3. Transition Champions
Staff and key family members who provide education and act as primary contacts.
4. Individualized Care Plans
Meaningful daily activities designed through interdisciplinary teamwork (nursing, recreation, restorative care, kitchen, housekeeping).
5. Workflow Redesign
 - Decentralized medication administration to enhance dignity.

- Innovative programs like resident-led cooking and “grocery shopping.”
6. Technology & Infrastructure Considerations
 - Exploring broader wander guard zones.
 - Considering community-integrated safety tools inspired by the Netherlands (e.g., volunteer networks or resident-tracking apps).
 7. Continuous Monitoring

Quarterly assessments and ongoing communication to maintain momentum and adjust plans.

Implementation Opportunities: Core to Service Delivery Renewal

Unlocking neighborhoods has been part of BSF’s strategic plan for two years, supported by research, innovation initiatives, and best-practice reviews. This transition aims to fully integrate dementia care into non-secure operations and influence broader system change across Alberta.

Implementation Implications: Core Principles Moving Forward

- Preservation of dignity and pursuit of happiness
- Individualized, inclusive, community-oriented care
- Supportive risk-taking rather than restrictive safety
- Collaborative, interdisciplinary problem solving
- Continuous engagement with residents, families, and care partners

Care for Persons with Complex Dementia and Mental Health and Addictions

Three leaders—Steve Friesen (Bethany Care Society), Barb Kathol (Carewest), and Salimah Walji-Shivji (AgeCare)—presented insights into delivering care for residents with complex dementia and mental health needs.

Across organizations, common themes emerged: rising complexity, younger and more male populations, increasing mental health and behavioural challenges, with the need for purpose-built environments, specialized staffing, harm reduction approaches, and meaningful engagement.

All speakers emphasized that traditional long-term care designs and models often fail this population, requiring program redesign, staff competency development, and strong collaboration with families and community partners.

Implementation Opportunities and Experiences

Steve Friesen – Bethany Care Society

- Bethany’s Complex Dementia Care program has been operated for nearly 40 years; moved to a purpose-built site (Riverview) in 2018.
- COVID-era safety priorities disrupted original open, community-integrated design intentions.
- Admission: dementia with complex, unpredictable behaviours; goal = stabilize and transition.
- 50% of residents transition within a year, many within six months.
- Recent data shows younger, more physically capable, predominantly male residents, remain in the program, creating new safety and care challenges.
- Incident data increased around 2021, aligning with demographic shifts.
- Emphasis on:
 - redefining safety with family/resident input
 - technology integration (sensors, workforce support)
 - building clinical competencies and team development
 - reviewing whether existing criteria and assessments meet today’s population needs.

Barb Kathol – Carewest

- Carewest operates several complex mental health programs across two main sites:
 - Signal Pointe (clustered bungalows)
 - Rouleau Manor (multi-floor mental health and addictions-capable environment).

- Populations increasingly younger and ~75% male.
- Core approaches:
 - Care planning before admission, cohorting residents thoughtfully
 - Environmental modifications for staff and resident safety
 - Meaningful, structured recreation, tailored to a younger, diverse population
 - Resident choice focus
 - Partnership with Recovery Alberta for psychiatric and clinical support
 - Strong emphasis on harm reduction (safe smoking, alcohol, cannabis)
 - Violence and suicide risk assessments integrated into care
 - Safety planning, including “Elopement go-packs” containing a few essentials for residents who choose to not return to their living space overnight
 - Focus on staff safety, competency, and specialized education
- Outcomes include improved stability, transitions to non-secure units, increased independence, and some discharges back into community. Benefits of integration of programs and populations include success in shared activities, friendships, and meaningful engagement.

Salimah Walji-Shivji – Agecare

- Agecare SkyPointe originally placed a 32-bed mental health program on the 4th floor of a large long-term care/supportive living building—and it failed (environment and staffing unsuited).
- COVID exposure accelerated crises: inability to isolate, aggression, and unsafe conditions.
- Solution: build SkyPointe 2, a purpose-built, 96-bed mental health community (inspired by Claresholm Centre for Mental Health and Addiction) with:
 - 32-bed rehab program
 - 32-bed long-term mental health
 - 32-bed secure mental health
- Strong partnership with Alberta Health Services.
- Program strengths:
 - Single rooms, safe design, meaningful amenities (gym, art room, woodworking, tuck shop)
 - Mental Health Support Workers (psychology, social work, corrections backgrounds)
 - High resident engagement; community-like functioning
 - Chore-based operations building pride and ownership
 - Independence-focused mealtime model
- Ongoing challenge: food costs and preventing residents from overspending on outside food.
- Major barrier: lack of appropriate community placements for step-down, causing longer lengths of stay.

Implementation Implications: (Cross-Organization Themes)

Revisit Admission Criteria & Assessment Tools

- Update to reflect younger, more complex mental health profiles.
- Include mental health and violence risk tools systematically.

Strengthen Workforce Competency

- Expand training in mental health, addictions, trauma-informed care, and de-escalation.
- Continue developing mental health support worker roles.
- Invest in frontline and mid-leader development.

Redefine Safety

- Shift from restrictive models toward collaborative, dignity-focused definitions of safety with residents and families.
- Build environments that support safe autonomy rather than containment.

Expand Harm Reduction Policies

- Support safe tobacco, cannabis, alcohol use, clear policies for staff and resident safety.

Enhance Meaningful Engagement

- Offer younger-adult-appropriate recreation (gym, art, woodworking, community outings).
- Increase one-to-one engagement models.

Integrate Technology & Environmental Design

- Explore sensor systems, improved surveillance, and purpose-built spaces.
- Review environmental risks regularly as populations shift.

Improve System Flow

- Advocate for more step-down community homes or supportive housing options.
- Reduce bottlenecks in transitions when residents no longer require complex mental health care.

Strengthen Inter-Agency Collaboration

- Ongoing partnership with AHS, Recovery Alberta, families, and community agencies.

Summary of Opportunities and Implications (speakers and participant reflection)

Importance of Wholistic Approaches to Capacity & Service Delivery Planning

- Discussion emphasized that effective capacity planning in continuing care is not about counting beds, but about understanding resident needs, appropriate discharge destinations, community integration, and the ability to support diverse populations—including complex mental health, dementia, and younger adult cohorts.
- Speakers highlighted successful approaches to co-mingling populations, the importance of workforce and leadership capacity, collaboration across partners, caregiver involvement, and nimbleness in using existing resources.
- Community acceptance, person-centered models, and building strong relationships with caregivers and community neighborhoods were identified as essential to improving the reputation of continuing care.

Enablers for Culture & Practice Change for Person-centered Practice

- Frontline Leadership development (including adaptive leadership), collaboration, and relentless communication.
- Awareness and education for staff, residents, and families.
- Understanding population needs and using technology (sensory tools, pain assessment tech) to anticipate and respond to complexity.
- Collaboration—problems are solvable when partners work together, not in silos.
- Nimbleness with staffing resources, many improvements come from shifting existing staffing models (e.g., Mental Health Support Workers).
- Community acceptance comes from active participation, opening buildings to the public, and being a real member of the neighborhood.
- Integrated person-centered models that deeply engage families and caregivers. Gender-related cohorting handled by being nimble and adapting to population shifts (e.g., all-male neighborhood emerging naturally).
- Caregiver involvement must begin at diagnosis and continue through the care journey.
- Support Change with appropriate funding (all specialized programs were program funded); Still Me Forum spoke to imperative of addressing concerns with current funding for Cont. Care A & B.
- Environments matter: work needs to be done to modernize existing care centres; new design guidelines address important needs such as privacy and households for living.

Action Items

Elevate Capacity Planning, promoting nimble, adaptive models

Move beyond bed counts to population needs, transitions, and appropriate discharge destinations.

Strengthen Workforce & Leadership

Invest in frontline leadership development and workforce development for culture change

Expand education, training, and new discipline pipelines (e.g. mental health workers)

Use Technology Strategically

Adopt sensory, pain assessment, and environmental technologies that reduce complexity.

Build Collaborative Problem Solving Tables and Community Integration

Bring partners together for shared solutions; avoid silos.

Note: recommendations from Still Me Forum regarding the importance of improving continuing care funding for effective team-based care and improving care environments for living.

Modernizing Existing Care Centres

Speaker: Robert Wrublowski (recording of presentation on AAG Website)

Robert is a Canadian architect, specializing in Continuing Care. He has been extensively involved in research on the assessment of current buildings for quality of life and clinical outcomes, and plans for improvement.

Core Beliefs & System-Level Challenges

- Culture change requires alignment of operations + environment + policy (“three-legged stool”).
- Operational culture change must come first; environment alone cannot fix outdated care models.
- Major barrier: government inertia and lack of engagement—not necessarily providers.
- Alberta appears more open to change than Manitoba.

Assessment & Standards Work

- EASE (Environment Audit Scoring Evaluation) tool: evidence-based, derived from ~1,000 research papers.
 - Categories include layout, ambience, environmental attributes, assist measurement, and orientation.
 - Used in revising Canadian Standard Association standards (Z8000, Z2000, Z8004).
 - Recommends public review participation, especially around dignity of risk.
- Findings from Using EASE
 - Many older facilities are highly institutional with large units (20–60 people); research strongly supports small households.
 - Households require space recaptured from existing rooms (e.g., removing 3–6 rooms to create hearth of the home spaces).
 - Hearth = living room + dining + therapeutic kitchen; kitchens critical for socialization and resident engagement.

Proposal Strategy with 3 Levels of Renovation

- Robust: Full conversions into households, reconfiguring units, removing rooms, adding residential kitchens, creating outdoor access.
- Moderate: Updating tub rooms, replacing nursing stations with lounges, adding household activity spaces.
- Low-cost “small but powerful” changes:
 - Colour/contrast improvements.
 - Wayfinding through murals and themed wings.
 - Residential door treatments and memory boxes.
 - Lighting upgrades (many rooms far below recommended 800 lux).
 - Replacing stainless steel grab bars with powder-coated bilateral bars.
 - Removing institutional décor.

Opportunities with Alberta’s New Design Principles

- Small households (maximum of 16; ~12 residents ideal).
- Residential kitchens (not commercial-only).
- Central, unobtrusive staff perches instead of nursing stations.
- Direct outdoor access (e.g., balconies on upper floors).
- Correct lighting and contrast for aging eyes.
- Power-grasp capable grab bars properly placed.
- Offset bedroom door alcoves for better wayfinding and wheelchair movement.

Summary and Implications

It is time for a research-driven transformation of long-term care from institutional wards to small, home-like households that support person-centered care. The key message: positive change is possible at any scale and should begin immediately, even without full system buy-in.

Action Items

For Operators / Care Home Leadership

- Begin operational culture change (PCC/RDL training, workflow redesign) before environmental renovations.
- Conduct an EASE assessment for each unit to identify highest-impact areas needing improvement.
- Prioritize design changes based on EASE A1/A2 scores (major deficiencies).

For Policy Makers / System Stakeholders

- Increase engagement with providers on culture change and provide support for design modernization in addition to new builds
- Review EASE-based evidence to inform policy and funding decisions.
- Participate in public review of CSA Z2000 and other standards (esp. dignity of risk).

For Staff & Families

- Participate in creating memory box contents and personalized décor.
- Provide feedback on renovation priorities and resident experiences.

New Builds; New Value

Four leaders representing Alberta organizations—AgeCare, Sherwood Care, Good Samaritan Society, and Trochu Housing Corporation—shared insights on designing and building modern, person-centered continuing care environments. Despite different scales and models, all emphasized neighborhood design, community integration, flexibility, and staff-centered planning.



Continuing Care Home Rebuilds (with a portion of capital costs paid by ALSS Ministry)

Salimah Walji-Shivji - AgeCare

- Builds its own communities through a sister construction company, enabling consistency, alignment, and rapid learning.
- Designs integrate:
 - Person-centered care • Safety • Accessibility • Staff wellness • Energy efficiency • Technology
 - Intergenerational spaces (daycare) • Community partnerships (e.g. for adult day programs)
- New builds + renovations must occur in parallel to maintain capacity.
- Priorities include flexible units/ neighborhoods, proper clean/dirty separation, balconies, daylight, back-of-house efficiency, long-term maintainability.
- Staff input and lessons learned databases drive design decisions.
- Neighborhood sizes are typically 16 residents, but design allows variation.

Kathy Fortunat - Sherwood Care

- Not-for-profit, 56-year-old single-site provider focused on deep relationship-based care.
- New project: 6-storey, 210 continuing care beds + 13 hospice suites, based on a 14-bed small household model.
- All private rooms with private bathrooms.
- Each household includes kitchen, dining, living, balcony, and outdoor access.
- Strong community integration with surrounding senior housing.
- Additional features: bistro, large multipurpose hall, rehab space, improved staff & volunteer spaces.
- Future plans: adult day program, potential childcare, home care hub.

Dr. Katherine Chubbs - Good Samaritan Society

- Early Canadian pioneer of small home models (see Day 2)
- New “West Village” project: fully small home campus replacing an aging facility.
- 20 small homes, each with 14 bedrooms, kitchen/dining, socialization spaces, arranged in a circular layout for intuitive mobility and safety. Every household has outdoor space (balconies).
- Main floor includes restaurant, mini-grocery, daycare, multipurpose hall, culturally oriented chapel.
- Deep Indigenous engagement—one full floor with culturally specific homes for First Nations, Inuit, and Métis communities. Intentional inclusion for LGBTQ2S+ and marginalized groups.
- Campus includes head office and extensive staff amenities as well as space on the ground floor for ambulatory programming (CHOICE + Seniors Health Clinic) and a potential Child Care space.

Cross-Cutting Themes

- Neighborhood / household models are central to quality of life.
- Community-integrated campuses (daycares, bistros, multipurpose halls) reduce isolation of residents and increase engagement with the community.
- Cultural safety and inclusion must be built into design from the start.
- Staff-centered design (rest areas, efficient workflow, consistent room layouts) is essential for recruitment and retention.
- Flexibility and future-proofing considerations protect long-term viability (convertible and scalable households, future focused construction/ infrastructure).

Multi-Component Centre in Rural Alberta: Trochu

Sam Smalldon - Trochu Housing Corporation

The Trochu Senior Supportive Living project represents a community-led, financially complex, and deeply integrated redevelopment combining health care, housing, and social connection in a rural setting.

The Project: Trochu Senior Supportive Living Facility (name intentionally temporary until a donor naming opportunity).

- Site: 15-acre greenfield—designing a “community within a community.”
- Total: 74 units, integrating three levels of housing/care:
 - 40 units SL4/4D (24/7 care) in units of 10/household
 - 16 lodge units
 - 18 independent living (market life lease) -to support rural residents without care needs and to achieve financial scale

Economics & Funding

- Project began in 2018 → 7 years to reach construction.
- Inflation pushed costs from \$30M → \$45M.
- Funding mix:
 - \$5M life lease contributions
 - \$21M multi-ministry government grants (Continuing Care Capital Program + Affordable Housing)
 - \$20M borrowing (secured with municipal guarantees)
 - \$2M capital campaign (community has already contributed \$1.2M)
- Opening target: July 1, 2027.

Stakeholders & Governance

- Truly community-driven: Town of Trochu, Kneehill County, Saint Mary’s Foundation, Covenant Health, provincial government (3 ministries), federal supports, local MPs/MLAs.
- Private sector declined due to lack of profit; housing management body and previous operators were unable to proceed.
- A new municipal not-for-profit corporation was created to lead the project.

Design & Care Model

- Smallest neighborhood size among peers::10-resident pods (two per floor) for dementia & 24/7 care.

- Dementia care is located on the main floor.
- Lodge and independent units designed for spaciousness and dignity (600 sq ft vs. legacy 300 sq ft).
- Future-proofing:
 - Lodge units are designed to convert into apartments (full kitchen rough-in).
 - 15-acre site allows expansion of 24/7 and market housing as demographics change.
- Central main floor common space intentionally designed to bring together all housing types.

Philosophical Foundations

- Focused on community, dignity, aging in place, and meeting diverse needs (low-, moderate-, and market income).
- The design is grounded in community governance and ownership.
- Defines work as social enterprise—creating sustainable, long-term community benefit.
- Video created by the project team reinforces message: seniors built our communities; this project is “our promise” to them.

Key Themes

This is a unique example of a rural community creating a modern, multi-level seniors’ campus by assembling partnerships, financing, political support, and local buy-in over nearly a decade. The project balances quality, sustainability, and affordability, ensuring residents can age in their community rather than being displaced to cities for care. This is a legacy project—built by the community, for the community, to honour its seniors.

New Builds: Summary of Opportunities and Implications

Future-proofing for Changing Expectations: Key Themes from Panel Discussion

- Rural communities offer unique opportunities but require tailored funding and policy support.
- Alberta must modernize outdated care categories and policies to support integrated, flexible, resident-focused models.
- Community mapping and relationship-building are essential for rural care planning
- By 2035, demand for long-term care beds will peak, so buildings must be adaptable afterward.
- Small home households (10–16 residents) allow repurposing into supportive living, cooperative housing, or specialty care; Large institutional models cannot adapt, limiting long-term value.
- Future-proofing requires flexible interior design—avoid unnecessary walls so spaces can change function over time.
- Community & social connection key, especially in rural areas where people have lifelong relationships.
- Mixed-income, mixed-need environments strengthen community life.
- Campus-style developments help sustain occupancy and create care ecosystems.
- A new funding model for small homes is crucial - outcomes should drive funding, not inputs.
- Differences in accommodation fee expectations across Continuing Care Homes A, C and Lodges and specialty programs confusing; not aligned with expectations for an integrating system and increasing array of room sizes.
- Operators must be able to pivot quickly to avoid vacant capacity.

Overall Implementation Implications

- Neighborhood designs, campus-style, community-integrated designs are widely recognized as the most effective for both rural and urban settings.
- Integrated programming for common spaces supports social cohesion and common community focus across all housing types.
- Workforce planning is required for effective 24/7 care neighborhoods and dementia units.
- Alberta has a major opportunity to align funding, language about different care options, and system design and policies to support these models—and rural communities are ready to lead.

Small Homes Reimagined (Day 2)

History of Small Home Development in Alberta

Marlene Raasok provided an overview of the history of small home development in Alberta during the bus trip to Medicine Hat.

- GSS pioneered the small homes concept in Canada. They opened their first “cottage model” care home, Wedman House in 1994 in Edmonton, with 6 detached cottages of 10 residents in a village associated with a Supported Living Care Centre. GSS continued this concept in 8 locations in rural Alberta, for a total of 236 cottage spaces. These were focused on care for persons living with dementia, initially Supported Living 3; now Continuing Care B residents.
- In the late 1990’s/early 2000’s, further development took place bringing spaces with the small homes concept in Alberta to close to 400.
 - Carewest developed a 48-space home (4 houses;12 people) with dementia focus with a day program & 6 respite spaces-- now converted to a program funded site for complex mental health).
 - Bethany added Harvest Hills in Calgary with 60 spaces in a cluster of 6 homes.
 - Capital Care developed Laurier House and McConnel House (each with 36 beds in neighborhoods of 12).
- All four providers report high resident and staff satisfaction, BUT operating challenges due to funding that does not recognize economies of scale and the flexibility to operate these environments. Occupancy challenges are being experienced by GSS in some rural sites due to the need for higher care than is currently funded.

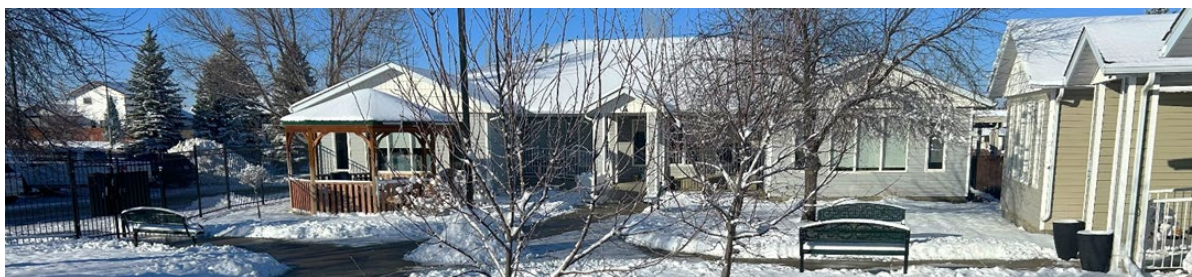
Recommendation 7 in the MNP Report of April 2021 recommended a small home strategy for Alberta (with change in funding) to increase options for care in urban and rural Alberta. An initial call for proposals in 2023/24 was cancelled.

The research project being undertaken by GSS, “Reimagining Small Homes” is an opportunity to update thinking in support of new value from existing small homes and 2025/26 capacity planning and development.

- Three new capital builds (GSS West Village and Sherwood Care and Bethany Calgary) are in construction with neighborhoods of 14 (previous design guidelines), with a requirement to confirm operating and funding approaches. A multi-service site in Trochu, also under construction, has two 10-bed neighborhoods for continuing care.
- Alberta’s 2025 design guidelines for care homes call for households of 16 (up from 14 in 2023 guidelines).

GSS Innovation Project, “Small Homes Reimagined”

Presented by the GSS Team: Candice Gibson, Cheryl Sarazin, Scott Chubbs. Highlights from their presentations and the tour of the renovated cottage follow:



Reasons for the Project: Need to evolve practices to address increasing resident acuity; desire to improve staff satisfaction with greater clarity re expectations in support of a small home culture; and inform operating models for sustainability of different small home designs.

--the project was developed as a demonstration project with support from the EXTRA Fellowship Program of Healthcare Excellence Canada. It is midway in implementation.

Drivers for Change and the Scope of Project Work: Enhance resident experience (person-centered/directed practice; the mealtime experience, recreation); enhance effectiveness of the Multi-Skilled Worker (MSW) staffing model (with Standard Operating procedures and enhance orientation about culture change expectations through Good Sam’s Being and Belonging approach and onboarding), and optimize the existing environment for greater resident engagement and home-like settings.

Results: Changes in the care approach, staff expectations and renovations have been completed in one cottage at South Ridge Village. Note, this is a complex with 3 cottages, each with 10 residents, in a village environment adjacent to the Care Center with three levels of care (Continuing Care A & B and Alternative Level of Care) and an Adult Day Support Program—a “true village” supporting people in the community.

Implementation is now underway in the demonstration cottage:

- Focus is dementia care, Continuing Care B.
- Staffing model for 10 residents: 2 Staff (MSW) on Days and Evenings; 1 on Night (with back up from main centre if required). MSW’s are Health Care Aides with enhanced training. For Cont. Care B, case management is by AHS Home Care.

System design with separation of case management is problematic since this takes away from a cohesive on-site team and creates communication challenges.

- Renovation enhanced opportunities for resident involvement in cooking and social activities and enhanced features for a home-like environment. The large outdoor courtyard shared by the three cottages offers a secure environment of residents.
- Initial experiences of residents and families is positive; staff report satisfaction with clear position descriptions and Standard Operating Procedures (SOP) for their cottage. SOP’s enhance quality management allowing focus on residents and their caregivers and their experiences.

Next Steps: Evaluation of outcomes (next 6 months) to inform spread and scale– resident satisfaction, admission flexibility, staff satisfaction and retention, impact on medication use, management of infectious issues and transfers to acute care.

**Note, experience from other innovators with Small Homes (i.e. Sherbrooke Community in Saskatchewan, Greenhouse Model in the U.S.) demonstrate higher resident satisfaction, higher staff satisfaction and retention, greater admission flexibility, reduced system costs (medication use, infectious outbreaks, transfers) than typical nursing home care.

Models for Implementation: Dr. Chubbs

- The Small Homes Concept extends culture change for person-centered care to person-directed care with more opportunity for resident engagement and wellbeing in smaller, home-like environments with consistent staff working as multi-skilled workers.
- GSS sees three types of application for the small homes concept:
 - a. In standalone settings/cottages of 10-15 residents or as clusters of neighborhoods for smaller centres
 - b. In small homes attached to care centres or care/housing developments
 - c. In multiple small homes aggregated in larger care centres (including in multi-story settings) with opportunities to respond to needs of different populations and share case management or professional staff for higher care.

Study Tour participants provided feedback on 4 questions:

1. What Value Do Small Homes Add?

- Enhanced Resident Wellbeing & Caregiver Experience
 - Home-like, human-scale living: Creates comfort, calmness and familiarity.
 - Personalized, dignity-centered care: Residents are known as individuals with unique needs and preferences.

- Strong relational care: Deeper staff–resident–family relationships improve trust and responsiveness.
- Better environments for complex needs: Supports dementia, behavioural needs, trauma and mental health, palliative and end of life care/hospices.
- Employee Engagement, Satisfaction, Recruitment & Retention
 - More meaningful work: Staff experience purpose, ownership and stronger connections to residents.
 - Healthier, calmer work environment: Smaller teams improve communication, stability and workload balance.
 - Skill growth and professional development: Multi-skilled roles expand capability and autonomy.
 - Strong recruitment story: Model attracts people seeking relationship-driven work.

2. Which Populations May Benefit Most?

- People with cognitive, behavioural or mental health needs: Small homes match the need for predictability, calm and individualized care.
- Younger adults or lifestyle-specific group: Supports autonomy, routines and independence.
- Culturally diverse and equity-seeking groups: Less institutional, more welcoming environments.
- Rural and “small community” delivery: Aligns with familiar living styles, people stay close to home.
- Can Small Homes Concept Contribute to Modernizing Existing Centres? Yes, if infrastructure allows: Some buildings can retrofit into smaller cottage-style layouts; some cannot.
- Adds flexibility for both urban and rural systems: Helps reduce density, supports local access and improves transitions.

3. What’s Needed to Optimize & Scale?

- Funding and policy need realignment: The model requires different funding structures and flexibility.
- Policy and regulatory modernization: More flexibility to allow aging in place, unbundled funding and shared risk.
- Workforce development: Training, SOPs, wages and support for multi-skilled relational care.
- Infrastructure and facility modernization: Retrofits to enable cottage clusters and home-like environments.
- Public, family and system-wide education: Clarity on what small homes are and how they function.

4. What Areas are There for Further Consideration by the GSS Study Group?

- Input from Robert Wrublowski to strengthen guidance for environmental changes
- Considerations re optimal mix of residents, including any special considerations regarding attention to mental health needs, diversity and inclusion of special populations (e.g. indigenous)
- Management of safety considerations in the households; agreements regarding risk

TER FROM THE CEO

The Small Homes Concept: Summary Opportunities and Implications

The Small Homes Concept brings together culture change + environments for living to optimize care outcomes with 3 key features:

- (a) person-directed practice (Greenhouse/U.S.— “Deep knowing” of the residents; Eden—full evolution of a continuum of culture change)
- (b) supported by consistent teams of Multi-Skilled Workers who engage residents in living to their best abilities and empower staff to bring their best
- (c) in home-like neighborhoods with 10-16 residents with private rooms and kitchens/dining room space, living room/socialization spaces, and access to the outdoors.

These characteristics extend intent of Alberta’s design guidelines with different configurations to optimize capital projects in urban and rural Alberta

- Implementation of the Small Home Concepts have been proven to enhance resident care outcomes with flexibility to meet needs of different populations over time.
- The staffing model of Multi-Skilled Workers adds an option to address human resource needs.
- Small home concepts have the potential to add value to modernizing existing care centers.

Addressing funding issues for Continuing Care A & B with recognition of economies of scale will be fundamental to ongoing viability of care homes. Changing the design of case management for Continuing Care B is another systemic change that will benefit all continuing care.

Capital projects currently underway with neighborhoods of 14 or less (GSS West Village, Sherwood Care) and Trochu and existing small homes provide experience to inform new funding & accountability models for sustainability of small homes.

Economics of Sustainability

In the absence of Leah Lechelt, Dr. Katherine Chubbs presented priority observations from work by the Christian Health Association of Alberta regarding required changes in funding for continuing care:

1. Hours of care have not kept pace with increasing needs of residents in Cont. Care A and B. Funded direct nursing hours currently average 3.4 versus the nationally recognized target of 4.5 hours for safe care.
2. Funding methodologies do not reflect business costs; differences between funding approaches for Cont. Care A and B are problematic and penalize care center operators offering both levels of care.
3. System design which separates case management for Cont. Care B from on-site teams is problematic and affects efficiency and quality of operations.

Sustainability of small homes will be enhanced by the above changes with recognition of economies of scale and increased flexibility in accountabilities.

Summary of Opportunities and Implications

Alberta is positioned to lead in creating new and improved options for continuing care homes that move from institutions to environments for living, underpinning sector renewal.

Recent expectations for capacity planning linked to community needs is forward thinking.

- There are opportunities for further development of robust multi-service capacity plans and linking findings where it is possible in care home redevelopment/campuses of care.
- This also provides a framework for examining unique opportunities in rural Alberta for cross-sector partnerships and optimizing under-used capacity.

Alberta's New Design guidelines provide forward momentum for improved environments. Implementation of small home concepts with smaller households add options (particularly in rural Alberta) and for complex care needs such as mental health deserve and enhanced flexibility to serve a range of populations (including palliative and end of life care).

The current focus on new builds for new capacity needs to be complemented by a focus on modernizing existing care centers to ensure that sector renewal and change in caregiving capacity and care experiences occur across the system.

Alberta's work related to funding model redesign needs to consider flexibility for rural and urban environments given that different economies of scale.

System policies related to resident room accommodation need review; the differences regarding resident payment responsibilities in Continuing Care A versus B are confusing and inconsistent with expectations for integration across sectors. Current resident room rates for private rooms do not align with the different spaces now being built – and the increased costs of operation for larger buildings.

Across Alberta, continuing care providers are offering ambulatory programs which complement home care and support aging in the right place.

Comprehensive Ambulatory Programs (CHOICE/C3) and Adult Day Support

Katherine Chubbs - Good Samaritan Society – CHOICE Program & Seniors Clinic

CHOICE Program

- CHOICE = Comprehensive Home Option for Integrated Care of the Elderly.
- Long-standing, small but impactful multidisciplinary program to keep medically complex seniors at home.
- Two Edmonton sites, 90 registrants each; day programs + short stays; specialized dementia programming.
- Services include medical care, rehab, NP support, transportation, and overnight respite/diagnostics.
- Strong social benefits reported by participants.
- Goal: prevent hospital and long-term care admissions and improve quality of life.

Seniors Clinic

- Specialized clinic serving seniors with complex medical/social needs; offers long, comprehensive visits and multidisciplinary care.
- Hidden “gem” known mainly to hospital-based geriatrics.
- Serves ~1,200 clients annually; helps keep seniors at home.
- Moving into an integrated space at West Village to co-locate with CHOICE for efficiency and profile.
- Integration requires design challenges but improves collaboration, visibility, and access in high-need areas of Edmonton.

Aileen Wong - Capital Care – CHOICE Restorative Program

- CHOICE has four streams: mainstream, mental health, dementia, and restoration.
- Restorative program launched November 2021:
 - Short-term, intensive, ambulatory rehabilitation.
 - Clients keep their own physicians/pharmacies—removes a barrier to participation.
 - Focus on functional goals, independence, community ties.
 - Does not require Home Care registration to attend.
- Client profile: 55+, medically stable, complex health needs, often post-hospitalization functional decline.
- Offers PT, OT, recreation, NP access, case managers, and caregiver support.
- Strong collaboration with Parkinson’s clinic → many referrals for mobility decline.

Outcomes

- Served 410 clients: average stay 237 days.
- 51% reduction in emergency room visits during program enrolment.
- 60% reduction in emergency room visits within 6 months post-discharge.
- 97% reduction in inpatient admissions after participation.
- High satisfaction (91–95% on various indicators).
- Many clients discharged home (with or without Home Care) or move to other CHOICE programs.

Barb Kathol - Carewest – C3 Program

- C3 = Comprehensive Community Care Program
- C3 modelled on CHOICE but hasn't grown as strongly in Calgary.
- Major participation barrier: geography and travel distance.
- Two locations now; expansion planned into downtown via Bridgeland site.
- Notes that program design must adapt to the needs of different neighbourhood demographics.
- On program location:
 - Being inside care centers can create synergy but is not essential.
 - Off-site locations (e.g., mall) can work well and may be more cost-effective.

Adult Day Support

Carrie Erickson - Alzheimer Calgary – Club 36 Adult Day Programs

- Advocates that adult day programs are essential, not optional.
- Waitlists for dementia-specific programs are long (6–8 months), often causing people to become too advanced to participate.
- Benefits for people with dementia:
 - Social engagement, reduced loneliness.
 - Cognitive stimulation, physical activity, routine, purpose, identity.
 - Emotional and behavioural stabilization.
- Benefits for caregivers:
 - 'Respite that prevents burnout (key determinant of ability to keep person at home).
 - Reduced anxiety and depression.
 - Helps sustain caregiving at home longer.
- Benefits to the health system:
 - Reduces Long-term Care placement, Emerg. Dept visits, and hospital admissions.
 - Cost-effective compared to institutional care.
- Hallmarks of strong programs:
 - Small, relationship-rich environments.
 - Skilled dementia-trained staff; Purposeful, ability-focused programming.
 - Integration with caregivers and broader community partners.
 - Flexibility (not all participants can manage full 6-hour day).
- Calls for expansion, flexibility, more dementia-specific capacity, and involvement of people with dementia in design.

Summary of Opportunities and Implications

The session highlights the critical role of community-based, non-residential supports—CHOICE, C3, Seniors Clinics, restorative programs, and adult day programs—in helping older adults (especially those with complex conditions or dementia) remain safely at home and out of hospitals or long-term care for as long as possible.

From a Caregiver perspective, Sharon Anderson provides four important perspectives:

- New U.S. research: the stress level of the caregiver—not the medical status of the patient—is the strongest determinant of whether someone stays at home after hospital discharge.
- Adult day programs are:
 - The most cost-effective respite for caregivers.
 - The most cost-effective source of socialization for clients.
- CHOICE and C3 are Alberta's versions of the U.S. PACE model are one of the most effective models for enabling seniors to remain in their community homes.
- Day programs in care homes also reduce fear of long-term care by familiarizing people with care homes.

Key themes and Implementation implications include:

- Capacity Planning: Needs to consider capacity increases for multidisciplinary programming –both for maintenance and restorative care with options for different populations. They complement home care and have high flexibility and can be implemented quickly.
 - Restorative and rehabilitation-focused care reduce ER use and inpatient admissions.
 - Adult day programs provide dual benefits: cognitive, emotional, social, and physical support for clients, and essential respite that significantly reduces caregiver stress—the top predictor of institutionalization.
- Policy and System Navigation Processes Need Attention: Demand is growing, but awareness, accessibility, geography, transportation, and rigid program structures remain major barriers.
 - Innovate with service delivery models to increase flexibility.
 - Review transportation policies as well as distributed locations to reduce barriers to attendance.

- Locating programs in care centers has benefits (access to hospitality support and overnight respite; familiarity with the care center,) but community-based/standalone sites can work just as well.
 - Campuses of care and living create opportunities for community integration.
 - The “nursing home without walls” concept being pioneered in New Brunswick with knowledge mobilization supported by Healthcare Excellence Canada has a place in Alberta to optimize cross-sector partnerships and access.
- Community innovation (e.g., dementia-inclusive golf, “Misfits” program) demonstrates the value of local creativity. Expand use of community programs as practicum sites for health and social services students.

Alternative Level of Care (ALC) Strategy

Imperatives for Action

Kimberly Nickoriuk – Senior Program Officer, Assisted Living Alberta (ALA)

Assisted Living Alberta (ALA) is Alberta’s new provincial assisted living agency established as a key pillar of the overall refocusing of Alberta’s health care system.

After targeted work to coordinate support to transition ALC patients with a stay over 300 days, the work continues to reduce ALC numbers, now prioritizing patients over 100 days in acute care.

- Philosophy of Care: Focus on holistic, wraparound supports combining medical, non-medical, and social services to enable individuals to live in the environment they define as “home.”
- ALC Challenges: Many patients have complex medical and social needs, lack housing or caregiver support, and may be institutionalized due to long-term acute care stays.
- Approach to Capacity Planning:
 - Maintains temporary capacity Request for Proposals and aligns with continuing care facility directory.
 - Uses AI/algorithms to match patient needs with facility capabilities while considering patient choice.
 - Monitors & adjusts programs for high-complexity patients (bariatric, dialysis, neurocognitive, etc.).
 - Works closely with the Capacity Planning team for proactive, preventive measures (e.g., bariatric support, Alberta Obesity Network).
- Innovation & Community Integration:
 - Explores home-based care options, client-directed home care, and barrier-free home designs.
 - Emphasizes building support in the community to reduce need for institutionalized care.

Key Focus: Reducing long-term ALC stays, ensuring patients receive care in appropriate settings, celebrating successful transitions, and implementing systems for ongoing care management.

Health Cities Initiative

“The Alternate Level of Care (ALC) Project is a Government of Alberta, Ministry of Assisted Living and Social Services (ALSS) initiative, with implementation led by Health Cities. Launched in May 2025, the initiative addresses one of Alberta’s most pressing health system challenges: individuals who no longer need hospital-level care but remain in hospital beds due to a lack of suitable alternatives. Working with Alberta’s provincial health agencies, service providers, innovators, and communities, the initiative supports the co-development of transitional and longer-term care models for these patients.” -Health Cities website



Reg Joseph – CEO, Health Cities

Health Cities is a non-profit Canadian organization that works to find innovative solutions to make healthcare better for people, easier for providers, and more effective for communities. Several current projects are underway.

- Collaboration with ALA:
 - Works on the ground testing solutions with operators and patients.
 - Aligns efforts with ALA policy and funding drivers to ensure innovative models are scalable and integrated into the system.
- ALC Initiatives:
 - Funding grant from the Ministry to focus on bottlenecks, integrating care across settings, and speeding transitions.
 - Emphasis on testing innovative approaches that integrate with existing systems rather than isolated pilots.
 - Rolling open call for initiatives over 2.5 years, with the first funding portion distributed by January.
- Capacity Planning:
 - Forward-looking “smart capacity” to retrofit existing spaces and plan future builds.
 - Collecting insights from caregivers and providers to design walkable, barrier-free communities with technology integration.
- Technology Integration:
 - Leveraging AI, dashboards, and digital tools for navigation, data sharing, and monitoring.
 - Examples include geofencing for dementia care to enable safe community access.

Summary of Opportunities and Implications

- ALC Challenges: Patients with complex needs, lack of supports, and long-term acute care stays pose challenges to the healthcare system.
- Solutions Approach:
 - Comprehensive wraparound supports combining medical, non-medical, and social care.
 - Temporary and permanent capacity planning.
 - Technology-enabled solutions for patient monitoring, navigation, and care coordination.
- Collaboration: Alignment between ALA, Health Cities, capacity planning teams, and community operators is critical. Health Cities and ALA to align initiatives, share insights, and integrate innovative solutions into existing systems. Cross-agency collaboration helps to de-risk pilot ideas and align with policy/funding frameworks.
- Innovation & Forward Planning: Smart capacity, community integration, and preventive care models are key to long-term sustainability.
- Patient-Centered Care: Emphasis on individualized care planning, choice, dignity, and reducing ALC days while improving quality of life. Continue internal education to shift acute care culture toward care planning and wraparound supports.
- Build public awareness and support through sharing of success stories of ALC transitions to stakeholders and the public.



Keynote: Creating “Communities for Living” Where Institutions Once Stood

Speaker: Suellen Beatty

Current State & Challenges

- Most older adults (85% of Canadians, 96% of Canadians 65+) want to avoid long-term care; in the U.S., 61% would rather die than move into a nursing home.
- Canada spends 87% of long-term care funds on institutional care vs. 13% on home & community care.
- People fear institutional care due to:
 - Loss of autonomy, independence, and identity
 - Rigid routines, unfamiliar staff, lack of privacy and dignity
 - Emotional isolation, boredom, and helplessness
- Physical care is often sufficient, but emotional and relational wellbeing is lacking.

What People Want

- To remain at home with autonomy, choice, and familiar routines.
- Relationship-based care with consistent, trusted caregivers.
- Small household settings with home-like environments, meaningful activities, purpose, and opportunities for growth.

Culture & System Issues

- Current institutional model is task-focused, efficiency-driven, and staff-controlled, rather than resident-directed.
- Culture problem perpetuates itself; changing the culture is a leadership challenge.
- Terms and language used in care reflect institutional mindset (e.g., “frontline staff,” “wandering,” “exit-seeking”).

Solution Approach: Culture Change

- Shift from institutional medical model to “communities for living.”
- Example: Eden Alternative (22 countries, flexible, principle-based approach)
 - Focus on resident-directed living, autonomy, relationships, purpose, growth, home-like environment.
 - Goal: Reduce loneliness, helplessness, and boredom.
 - Seven domains of wellbeing: autonomy, identity, connectedness, security, growth, meaning, joy.
- Example: Sherbrooke Community Centre (Saskatoon)
 - 323 residents, 600 staff, 250 volunteers; multiple small-house and community-based models.
 - Integrated childcare (Oak Trees and Acorns) and intergenerational programs (I-Gen classroom).
 - Community engagement: volunteerism, clubs, art programs, gardening, outings, and local events.
 - High staff retention (mid-90s) and engagement (82% vs. 25–36% elsewhere in healthcare).
 - Daily life focuses on resident interests and normalization of leisure and purpose.
 - Measurement includes resident/family/staff experience, relationship continuity, partnerships, reduction of institutional creep, and clinical outcomes.

Overall Summary—The Vision for Renewal

Suellen Beatty emphasizes that the dominant institutional long-term care model does not meet the desires of older adults who seek autonomy, familiar environments, meaningful activity, and relationship-based care. The culture in most care homes perpetuates inefficiency, task-focus, and institutionalization rather than resident-directed living. Culture change—supported by leadership, staff engagement, and innovative models like the Eden Alternative—is critical. Sherbrooke Community Centre demonstrates a successful example of embedding small-house living, intergenerational programming, community engagement, and resident-directed culture. Leadership, empowerment, and relationship-centered approaches are the foundation for meaningful, sustainable change.

Action Items

Leadership

- Commit to leading culture change from institutional to community-based care.
- Empower staff and caregivers to direct resident experiences rather than enforcing rigid routines.

Resident-Centered Care

- Prioritize autonomy, choice, purpose, and emotional wellbeing in daily routines.
- Implement small-house and home-like environments where feasible.

Community & Intergenerational Engagement

- Integrate programs like childcare, schools, and community events to foster inclusion.
- Support residents in pursuing personal interests and meaningful activities.

Staff Engagement & Retention

- Invest in staff education and development.
- Measure and track staff engagement and satisfaction; address institutional burnout.

Culture Change Measurement

- Track resident, family, and staff experience.
- Monitor continuity of relationships, opportunities for growth, and community partnerships.
- Audit for “institutional creep” and reinforce home-like elements.

Innovation & Best Practices

- Adopt proven culture change frameworks like the Eden Alternative.
- Share successes and lessons learned across homes and communities.



MOVING FORWARD

Summary Themes and Action Planning for a Journey of System and Sector Renewal

Opportunities and implications for implementation from Forum presentations and discussions have been summarized in Tables 1, 2, and 3 in the Executive Summary.

A summary of opportunities and responsible parties is provided in Table 5.

Table 5: Partners for a Journey of Sector Renewal

Next Practice Themes—for a journey of sector renewal	Mobilized by Ministry of ALSS & ALA Strategies	Provider Leadership for Culture & Practice Change
<p>Person-centered care and Programming to meet needs of diverse populations</p> <p>...and change the experiences for people (residents/clients, staff, family caregivers).</p>	<p>**Continuing care funding</p> <p>**Environments for living</p> <p>**Policy Change</p>	<p>**Culture change</p> <p>**Human resource development in support of changing expectations</p> <p>**Caregiver Strategy</p>
<p>Environments for Living</p> <p>...change the experiences for people (as above) and increase access to a range of continuing care home options.</p>	<p>**Capital Strategies</p> <p>**Continuing Care funding with recognition of rural/urban differences in economies of scale & implications of neighborhood models</p>	<p>**Above development, with a focus on human resource development to support new expectations and increases in capacity</p> <p>**Demonstration projects with learning from Small Homes Concepts</p>
<p>Community Programming</p> <p>... enabling aging in the right place for system gain and changing the experiences for residents/clients and family caregivers</p>	<p>**Capacity planning & investment in a range of options, linked with community</p>	<p>**Collaboration with communities and cross-sector partners</p>
<p>Responding to ALC (Alternative Level of Care) Imperatives.</p>	<p>**Enabled by the above actions</p>	<p>**Enabled by culture change and enhanced by community connections that exemplifies “moving from institutions to communities for living”</p>

Return on Investment

The overall outcome of multi-party action is sector renewal, with gains for people being served, staff, communities, and providers with sustainable services with new reputations. Investment is required.

For a refocused system, return on investment in community and continuing care is real:

- Brenda Strafford Foundation Bow View Nursing Home’s study on return on investment shows that for every dollar invested in the care center (long-term care and Adult Day Support), there is a return of \$2.50 in value to the system, with most of the benefit accrued to the hospital system.
- In this study, when the Adult Day Program is broken out from the whole, there is a return of for 1.896 for every dollar invested in this program.

The Eden Alternative has published a Return on Investment Summary: “It can be different and It’s worth it” (available from Suellen Beatty). The following are quotes from this document:

“Current practice in long-term care is based on a confusion of care, treatment and kindness. Lying at the root of this confusion is the medical model’s fixation on diagnosis and treatment. It guarantees that the majority of our resources are spend on the war against disease when, in fact loneliness, helplessness, and boredom decay our home residents’ sprit. A genuine commitment to improving residents’ quality of life demands that we correct these problems.” (“Life worth living” by Dr. Thomas, founder of the Eden Alternative).

“Evidence collected by the Eden Alternative from homes that have embarked on a sustained journey of culture change for relationship-focused care show reduced staff turnover and improved staff satisfaction, key contributors to improved resident satisfaction and higher occupancy.”

Forum Presentations related to specialized services for dementia care and mental health & addictions, small homes, and community -based programs (CHOICE, Adult Day Support) all show reduced/delayed admissions to acute care. Evidence (locally, nationally and from the USA) from the small homes concept also shows positive return on investment in staff retention and reduced system costs (medication use, infection control costs, hospital transfers).

These are the outcomes possible with system and sector renewal.

An Environment of Collective Action in Alberta— Leading the Way for Sector Renewal

Ministry Priorities for Change (Continuing Care Funding, Capital Strategies, Capacity Planning, Policy Evolution) are opportunities for immediate action.

Provincial Initiatives/Partners and Associations continue as Agents of Change—through advocacy, continued sector-wide learning and through marking progress at upcoming conferences. The Institute for Continuing Care and Education (ICCER) will offer a collaborative model for organizations to share their learning in innovation, implementation and evaluation

Continuing Care Providers have Opportunities for Immediate and Ongoing Change –learning from each other, making change and strengthened through ministry initiatives.

Note: Demonstration opportunities for the Small Home Concept are noted in the Report.

AAG--website provides the Report and keynote presentations. A webinar is planned on The EASE Tool for February/March 2026.

APPENDIX A: Speaker Biographies - Resources for Ongoing Change

Speaker Bios (in order of presentation) DAY 1

Catherine
Laing

Catherine Laing is Vice President of the Dr. Barrie Strafford CLIQ, where she leads a powerhouse team driving innovation, research, and transformation in health and aging care. With a passion for connecting ideas and people, Catherine fosters global partnerships, champions data-informed decision making, and ignites collaboration across sectors. Her work bridges innovation and impact, turning bold ideas into tangible improvements in quality of life and care. She is deeply committed to building a learning ecosystem that inspires progress locally, nationally, and internationally.

Avneet
Cheema

Avneet Cheema is a forward thinking healthcare leader with over 15 years of progressive experience in long-term care, clinical operations, and organizational transformation. A Registered Nurse, she is passionate about system innovation, quality improvement, and advancing person-centered care. In her current role as Director of Learning and Development at The Brenda Strafford Foundation, Avneet fosters a culture of growth, collaboration, and excellence in care.

Kristina
Beyaert

Kristina Beyaert is Executive Director of Bow View Manor and has over 25 years of healthcare experience. and nearly a decade in senior leadership across various continuing care settings, Kristina is dedicated to enhancing the quality of life for residents, caregivers and staff. Her work reflects a deep commitment to person-centred approaches that honour individuality, dignity, and inclusion across aging.

Steve
Friesen

Steve Friesen is Executive Director of Research and Innovation at Bethany Care Society. In this role, Steven leads strategic initiatives that integrate research, quality improvement, and innovation to advance person-centered care and service delivery across the aging continuum.

With over two decades of experience in Alberta's public and non-profit health care sectors, Steven has held leadership roles in research, evaluation, and quality systems development spanning primary care, acute care, and continuing care. His 15-year career at Bethany has presented numerous opportunities to advance the role of innovation through strategic partnerships with residents, family caregivers, staff, post- secondary institutions, and industry—addressing sector, organizational, and program- level challenges and opportunities.

Salimah
Wali-Shivji

Salimah Wali-Shivji, KC, is the Chief Executive Officer of Agecare, where she leads with a mission-driven focus, inspiring teams to achieve excellence while fostering innovation in long-term care. She began her career as a social worker before transitioning to law. Salimah held important legal roles at Alberta Health Services, including General Counsel, before becoming CEO of Agecare in January 2024. With degrees in Social Work and Law, along with an ICD.D. designation and the honour of King's Counsel, she is committed to continuous learning. Her achievements include Avenue Magazine's Top 40 Under 40 and various awards

Barb
Kathol

Barb Kathol is the Chief Operating Officer at Carewest Innovative Health Care. During her healthcare career, Barb has held many leadership positions including Senior Operating Officer for the Peter Lougheed Centre and Alberta Kidney Care-South and Transplant programs, Senior Program Officer with the Connect Care Clinical Operations team, Executive Director including for the Emergency Department, Medicine, Ambulatory areas, Gastroenterology services, Allied Health, and many other subspecialty programs. Barb holds a Master of Nursing from the University of Calgary and a Bachelor of Nursing (with Distinction). In addition, she is a graduate of the AHS Executive Education program. In addition to her current role, Barb is The President of the Board of Directors for the Alberta Association of Nurses, a member of the Mosaic PCN Board of Directors, and is a volunteer with the Calgary Food Bank.

Leslie
Myles

Leslie Myles is the Calgary Zone Lead, Seniors, Palliative and Continuing Care – Assisted Living Alberta. She is a seasoned health care leader with over three decades of experience across clinical nursing, operational expertise, and system transformation. Her career spans Scotland, Libya, and Canada, with leadership roles in Alberta Health Services and Carewest. She holds a Master's in Leadership, a Health System Improvement Fellowship, and the CHE designation. Passionate about building teams applying values-based leadership and the LEADS framework, she brings a collaborative, people-centered approach to improving care for Albertans.

Robert Wrublowsky

Robert Wrublowsky is a seasoned architect with over 35 years of experience focusing on designing environments for long-term care. He previously managed a mid-sized firm before pioneering EASE, an Environmental Assessment tool emphasizing person-centered care. His innovative work has garnered recognition from leading researchers like Dr. Margaret Calkins and Dr. Micheal Kaup, resulting in an ARCOM grant from the National Alzheimer Society to study the impact of environmental design on LTC resident quality of life. EASE has become a nationally recognized resource in evaluating and guiding LTC environmental strategies. Robert has served on the Manitoba Chapter of the Alzheimer Society's board for six years and actively contributes to three CSA standards—Z8000, Z8004, and Z305. Additionally, as the sole Canadian member of the American CSA equivalent, the Facilities Guidelines Institute, he participated in updating design guidelines for nursing homes in response to the COVID-19 pandemic. An accomplished speaker and author, Robert's work includes peer reviewed articles, design guidelines, and white papers, all aimed at enhancing best practices in long-term care environments.

Kathy
Fortunat

CEO of Sherwood Care, a private, not-for-profit long-term care home in Sherwood Park, Alberta. With 40+ years in healthcare, she champions holistic, person-focused care and including AI tools like PainChek and research programs such as Music Connects Us. Sherwood Care is expanding with 14-bed households to personalize the unique care needs of persons served. Kathy serves as Vice Chair of CHAA and was awarded the Queen Elizabeth II Platinum Jubilee Medal.

Katherine Chubbs

Dr. Chubbs is President and Chief Executive Officer of The Good Samaritan Society. She has worked in a wide variety of clinical settings as a frontline nurse, manager, and executive leader. She has completed a diploma and degree in Nursing, a Northern Nursing program, a master's degree in health studies-Leadership and is a Certified Health Executive. She holds an executive Doctoral degree in Business Administration with a specialization in Healthcare Management.

Sam
Smalldon

Sam Smalldon is President Trochu Housing Corporation. Sam has been providing leadership, management, and governance support for social enterprises as a consultant through Keys2Housing Communities, a federally incorporated not-for-profit organization in Canada. He has overseen the construction of three seniors housing capital projects in rural Central Alberta, comprising over 250 units of mixed seniors housing. Sam has played key owner representative and project management roles in at least 10 large capital projects. He holds a CPA and an MBA and is currently pursuing a PhD in sustainability for social enterprises. He believes in social enterprise solutions and is dedicated to helping not-for profits achieve their goals.

Irene Martin
Lindsay

Irene Martin-Lindsay has been the Executive Director of Alberta Seniors and Community Housing (ASCHA) since 1994 and is the Association's first and only Executive Director. Over more than three decades, she has played a central role in the transformation of Alberta's seniors and community housing sector. Irene brings deep experience across the private and public sectors, with a background that includes corporate law, management, and administration. Known for her practical, matter-of-fact approach, Irene is deeply committed to innovation and to supporting ASCHA members through strong leadership and responsive advocacy.

Aileen Wong

Aileen Wong is the Chief Operating Officer of CapitalCare, one of the largest publicly owned continuing care organizations in Alberta, serving 1,389 residents in continuing care and 500 clients in community care. She is a registered nurse with 35 years of experience, including 15 years in progressive healthcare management and leadership roles. Aileen has been with CapitalCare since 2014, serving in several leadership positions, including Site Director at two centres. Her previous roles include Director of Patient Relations for the Edmonton Zone and Site Director with Extendicare.

Aileen is a strong champion of person-centered care across both community and facility-based settings and is committed to balancing quality and safety. She actively pursues opportunities to enhance care and services for residents and staff through innovation and continuous improvement, and she is a strong advocate for people receiving the right care, in the right place, at the right time, in partnership with community partners.

Carrie
Erickson

Carrie Erickson is Director of Programs at the Alzheimer Calgary, bringing 20+ years in older-adult services to design evidence-based learning & support initiatives, lead operational excellence, and provide strategic oversight of the Club 36 adult day program for people living with dementia.

Reg
Joseph

Reg Joseph brings over 20 years experience spanning healthcare, technology and innovation. As CEO of Health Cities, Reg is focused on developing new models for healthcare innovation to drive better accessibility for individuals, reduce overhead on clinicians and drive better health outcomes. Throughout his career, Reg has held a variety of roles across the biotechnology, information technology and investment banking sectors. He has founded and served on boards of several IT, biotechnology and healthcare technology companies and remains an active angel investor. Reg currently sits on the Board of Directors of BioTalent Canada and the Board of Governors University.

Kimberley Nickoriuk

Kimberly Nickoriuk is a Senior Program Officer for Assisted Living Alberta, ALC Transitions and Integration, in Red Deer, AB, where she supports system-level improvements in care transitions for adults. With a focus on collaboration across health and community sectors, Kimberly works to enhance integration and continuity of care for aging populations. Her work aligns closely with gerontological nursing values, emphasizing dignity, person-centered care, and sustainable supports for seniors.

Suellen Beatty

Suellen Beatty is the CEO Emeritus at Sherbrooke Community Society in Saskatoon and a Global Partner with the Eden Alternative in Western Canada. Suellen has a Bachelor of Science in Nursing and a Master of Science from the University of Saskatchewan. Suellen was awarded a Meritorious Service Medal from the Governor General of Canada, a Centennial Medal from the Lieutenant Governor of Saskatchewan, the status of “Distinguished Alumnus” from the University of Saskatchewan, College of Nursing, the Athena Leadership Award, and a “Woman of Distinction Award for Management” from the YWCA,

She has trained over 5000 Certified Eden Associates in three day and online training courses. Suellen consults organizations on leadership, environmental design and culture change. Through the Sherbrooke Learning Centre, Suellen has hosted many visitors from around the world who come to see the Eden Alternative® Philosophy in practice and the design of the Sherbrooke Villages. Sherbrooke has received Milestone 4 Status with the Eden Alternative.

Dr. Jaason Geerts

Dr. Jaason Geerts is Vice President of Research and Leadership Development, Canadian College of Health Leaders (CCHL); an associate at the Centre for International Human Resource Management (CIHRM), Cambridge Judge Business School; an adjunct professor at the Telfer School of Management (University of Ottawa). Jason earned a PhD from the University of Cambridge and three postgraduate degrees from the University of Toronto and Cambridge.

He is a TEDx and keynote speaker; he publishes in international peer reviewed journals and the Globe and Mail; and he has given interviews for CBC national news and CTV news. He was an invited expert consultant for the International Hospital Federation (IHF) and a WHO symposium on pandemic recovery. His model of leadership in a crisis is the theoretical basis for a current \$450,000 CIHR grant.

Jaason is also a program director and instructor at the Telfer School of Management (UOttawa) and the Schulich School of Business (Toronto). Jaason is also a qualified teacher

Candice
Christenson

Vice President and Chief Clinical Officer began her career with The Good Samaritan Society in 2007 and has served in various leadership roles primarily focused on operations and service delivery. Her journey in health care has been driven by a passion for quality care fostered through a collaborative approach to standardization and process improvement. In addition to continuing care, her background in nursing includes experience in acute care and public health. Candice has over 18 years of management experience in the continuing care sector in Alberta & British Columbia.

Candice is a Registered Nurse with a Bachelor of Science in Nursing degree from the University of Alberta, a Post-Baccalaureate Diploma in Management, and an Executive Master of Business Administration degree from Athabasca University. Candice is also a Certified Health Executive (CHE) from the Canadian College of Health Leaders.

Cheryl
Sarazin

Vice President and Chief Quality Officer at The Good Samaritan Society with over 30 years in healthcare including leadership roles since 2003. Cheryl Sarazin is a dedicated nurse leader committed to improving care and outcomes. She has held key leadership roles in rural acute care, continuing care as well as senior and executive roles in corporate healthcare quality and patient safety positions.

She holds a Master of Science in Nursing with a focus on Leadership and Healthcare System Management and is a Certified Healthcare Executive. To further enhance her leadership to further organizational quality improvement, she is currently enrolled in the Healthcare Excellence Canada EXTRA program. Cheryl's leadership philosophy centres on empathy, collaboration, and evidence-based practices. Passionate about mentoring future nursing leaders, she believes in the power of teamwork to drive positive changes in healthcare.

Scott
Chubbs

Director of Capital Management and Maintenance. A devoted Inuit of Labrador, Scott has spent over 30 years in the construction field. His leadership career has spanned the country, and he has served at all levels of government, including several years working for the Department of National Defense. Scott is a red seal tradesman and has an extensive background in the trades having completed post-secondary programs in Carpentry and Building Construction, Restoration Carpentry, Refrigeration and Air Conditioning Mechanic, and Construction Supervision. He has also completed a Computer Specialist diploma and the Facilities Management Administration program. He is currently completing the EXTRA program through Healthcare Excellence Canada.

Leah
Lechelt

Leah has been the Executive Director of the Christian Health Association of Alberta (CHAA) since 2017, where she has led the association's research into funding model redesign, including extensive data collection and analytics. Prior to this, Leah managed a health care consulting firm for 15 years with a focus on system redesign and change leadership. Client projects included establishing the province's first primary care networks and leading the world's first head and neck cancer research collaborative, bringing together hundreds of Alberta patients and clinicians.

Leah holds a Master of Science degree in Public Health and a Bachelor of Commerce degree. She is a Certified Management Consultant and is internationally accredited in change leadership, strategic communications, stakeholder engagement and process improvement.