SENIORS ADVISORY COMMITTEE

Wednesday, September 17, 2025 at 7:00pm
Salmon River Committee Room
4th Floor, 20338-65 Avenue, Langley, BC

M I N U T E S

Present:
S. Hedao, Alternate Community Co-Chair
Councillor T. Baillie, Council Co-Chair

T. Baty-Thomas, A. Nierop, S. Tingley

In Attendance:
P. Crump, Langley Seniors in Action
M. Lin, Fraser Health
G. Ponce, Langley Division of Family Practice
W. Rachwalski, Langley Seniors Resource Centre

Staff:
M. Gunn, Planner, Community and Policy Planning
A. Jensen, Manager, Strategic and Social Planning
C. Longhi, Recording Secretary

ACKNOWLEDGEMENT OF THE TRADITIONAL TERRITORIES OF THE COAST SALISH PEOPLES

S. Hedao acknowledged the Traditional Territories of the Coast Salish People.

A. APPROVAL AND RECEIPT OF AGENDA ITEMS

1. Seniors Advisory Committee - September 17, 2025

Moved by A. Nierop,
Seconded by S. Tingley,
That the Seniors Advisory Committee approve the agenda and receive the agenda items of the September 17, 2025 meeting.
CARRIED

B. ADOPTION OF MINUTES

1. Seniors Advisory Committee – June 18, 2025

Moved by T. Baty-Thomas,
Seconded by S. Tingley,
That the Seniors Advisory Committee receive the Notes of the June 18, 2025 meeting.
CARRIED

2. Seniors Advisory Committee – May 21, 2025

Moved by T. Baty-Thomas,
Seconded by S. Tingley,
That the Seniors Advisory Committee adopt the Minutes of the May 21, 2025 meeting.
CARRIED

C. DELEGATIONS AND PRESENTATIONS

1. **G. Ponce, Primary Care Network Manager**
Langley Division of Family Practice
See Attachment A

G. Ponce, Primary Care Network Manager, provided an overview of the Langley Primary Care Network (PCN). The PCN works collaboratively to provide team-based primary care, support patient attachment to providers, and improve access to services across Langley. The network includes 41 Patient Medical Homes and 145 Primary Care Providers throughout the Township and City of Langley. Since September 2023, 17,472 patients have been attached through the Health Connect Registry, with 4,767 still on the waitlist. Current wait times for attachment are approximately six to nine months.

PCN services are available by referral for patients 18 years and older who are attached to a Langley provider. Pharmacy services include medication assessments, reconciliation, and post-hospital discharge support. Mental health counselling is offered free of charge for mild to moderate conditions such as anxiety, depression, caregiver fatigue, grief, and life transitions. Social work services are also available, with a focus on resource navigation, advocacy, and support for housing, financial, and caregiving challenges. In addition, an osteoporosis and bone health program offers individualized consultations with a registered nurse, pharmacist, and dietitian, along with recommendations for testing, pharmacotherapy, and lifestyle adjustments.

Upcoming initiatives include programs on menopause and perimenopause, metabolic syndrome, and a Pharma Day for seniors. Planned staffing additions will include a social worker, clinical exercise physiologists, an Indigenous health liaison, an Indigenous registered nurse, and a knowledge keeper. Registration for attachment is available online through the Health Connect Registry or by calling 8-1-1.

C. DELEGATIONS AND PRESENTATIONS

2. M. Lin, Frailty Pathway Project Lead
Fraser Health
W. Rachwalski, Manager of Community Services
Langley Seniors Resource Centre
See Attachment B

M. Lin, Frailty Pathway Project Lead, provided an overview of the Social Prescribing program in Fraser Health, which supports adults 65 and older by linking them to community and health resources through Seniors Community Connectors (SCCs). SCCs help seniors navigate services by creating tailored wellness plans and connecting them to appropriate supports across acute care, primary care, assisted living, home health, and community settings. Fraser Health supports the program through education, standardized processes, promotion, evaluation, and collaboration with community partners.

The integration of social prescribing has improved access to community resources, created more holistic care plans, strengthened communication between healthcare and community providers, and increased support capacity for older adults and their families.

W. Rachwalski, Manager of Community Services at the Langley Seniors Resource Centre, outlined how the program supports individuals. Services include assistance with housekeeping, volunteer drivers, telephone buddies, and visitor programs. The program is especially beneficial for those without nearby family, as social prescribers provide a face-to-face connection while also coordinating with families when possible.

Discussion ensued and the following comments were provided:

Funding for required supplies is provided through the Hope Fund, which supports initiatives to help older adults thrive. Additional support is available through donations, and a café associated with the program can provide meals for participants.

Each social subscriber is allocated a budget of $100,000. The Township of Langley has two social subscribers, whereas not all communities have more than one.

The term “prescription” is used to highlight the supportive, recommendation-based nature of the program.

W. Rachwalski will review potential gaps in Township of Langley’s recreation offerings for seniors and report back with recommendations to ensure seniors’ needs are being met.

Discussion also noted the value of partnerships with youth, the importance of planning for extreme weather events, and the role of the new community centre, which could include a dedicated seniors’ area.

Referrals to social prescribers may come through medical providers, phone or self-referral, the 2-1-1 Community Resources line, or online referral forms

C. DELEGATIONS AND PRESENTATIONS

submitted by doctors. The Committee also highlighted a gap in connecting emergency services, such as fire and police, with the program when they encounter residents in need during calls.

D. REPORTS

1. Co-Chair Reports

E. CORRESPONDENCE

F. WORK PROGRAM

A. Jensen provided an update on the 2025 Seniors Advisory Committee Work Program, noting that only October and November remain, with some items still to be addressed.

1. Housing

A. Jensen advised that P. Fassbender, Consultant, has been invited to the November Senior Advisory Committee meeting to discuss the various housing programs implemented in the Township of Langley over the past several years. Information will also be compiled on the different types of housing initiatives that have taken place.

He further reported that he has not yet received a response from HappiPad, a service that connects homeowners with extra space to individuals seeking housing.

2. Seniors Workforce

No report

G. COUNCIL REFERRALS

H. OTHER BUSINESS AND ITEMS FOR INFORMATION

I. NEXT MEETING

Date: Wednesday, October 15, 2025
Location: Salmon River Committee Room
4th Floor, 20338-65 Avenue, Langley, BC
Time: 7:00pm

J. TERMINATE

Moved by A. Nierop,
Seconded by S. Tingley,
That the meeting terminate at 8:57pm.
CARRIED

CERTIFIED CORRECT:

Community Representative Co-Chair

Council Representative Co-Chair

Langley Primary Care Network

PCN OPERATIONS MANAGER: GLAIZA PONCE

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Langley
Division of Family Practice
An FPSC initiative

WHAT IS A PRIMARY CARE NETWORK (PCN)?

- Partnership between the BC Ministry of Health, Langley Division of Family Practice, Fraser Health, Physicians, NPs, Allied Health and Community Organizations that are working together to provide primary care services.
- Together, they enhance patient care using a team-based approach to care. Support each other and work to their strengths and link patients to other parts of the system.



LANGLEY PRIMARY CARE NETWORK

Township of Langley, Willoughby, Walnut Grove, Fort Langley, City of Langley, Brookswood, Murrayville, Aldergrove



41
Patient Medical Homes



145
Primary Care Providers
(GP and NP)

Langley PCN is in Year 3 of Implementation

- Early Draw Down of 3 FTE Clinical Counsellors in 2021PCN Service
- Plan was submitted January 2023
- other PCN Services officially launched October 2024

PATIENT ATTACHMENT OVERVIEW



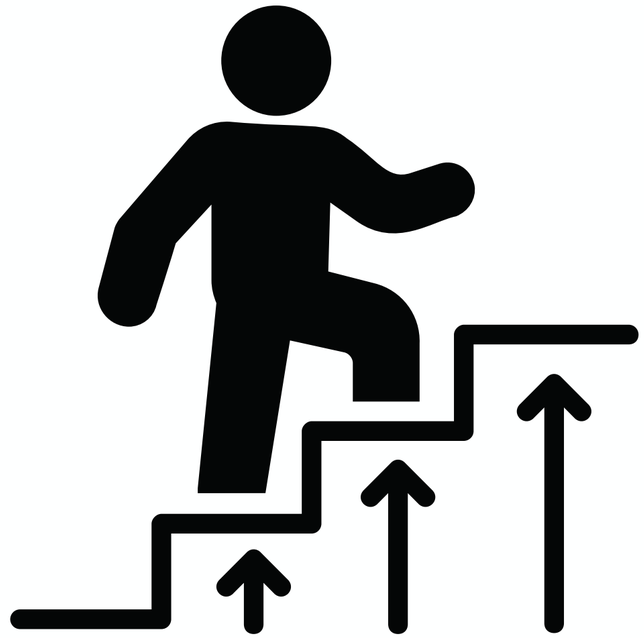
WHAT ROLE DO WE PLAY IN THE PROVINCIAL ATTACHMENT INITIATIVE

- Work with local healthcare providers to match patients with a suitable general practitioner or nurse practitioner.
- Match patients based on healthcare needs and personal preferences.
- Our goal is to make sure everyone in our community has access to continuous, long-term primary care.

OUR PROGRESS

Since April 2024, LDFP transitioned to the Health Connect Registry

Total attached since September 2023: 17,472
Active cases/waitlist: 4,767
Current wait time: 6-9 months
wait times can vary



HOW TO REGISTER OR UPDATE INFORMATION

Register

- Online through the Health Connect Registry (HCR)
- Call 8-1-1 to speak to a representative

Update Information

- Contact Information
- Residential Address
- Preferences (e.g. language, distance, gender)



MEET OUR TEAM

Clinical Pharmacist
Chris Goryniuk
Annie Vo

Registered Nurses
Kam Gura
Priscilla Stafford

Registered Social Worker
Corinne Horvath

Clinical Counsellors
Ildiko Magyar
Nav Sharma
Karin Rai

PCN Manager
Glaiza Ponce

Member and Community Engagement Manager
Kaitlin Frost

FHA PCN and UPCC Manager
Janine LaPierre

PCN Referral Coordinator
Tania Coppetti
Valerie Diaz

Attachment Team
Meyling Moreno
Maicah Jocson
Jennifer Chace
Wincy Wan

PCN Project Coordinator
Manita Dhaliwal

Private Contract through **Oakhill Counselling and Mediation (Psychologist and 3 Clinical Counsellors)**

HOW TO BE REFERRED TO PCN SERVICES

Speak with your Family Doctor or Nurse Practitioner for a referral to the Langley Primary Care Network

- Must be 18 years and older
- Attached to a Langley Primary Care Provider
- Without extended benefits
- Fall within the mild to moderate range



SERVICE DELIVERY

- Services offered in-person, telephone or virtually

CLINICAL PHARMACY



REASONS FOR REFERRAL

Medical complexity

- polypharmacy
- chronic disease management
- condition refractory to treatment or with limited therapeutic options

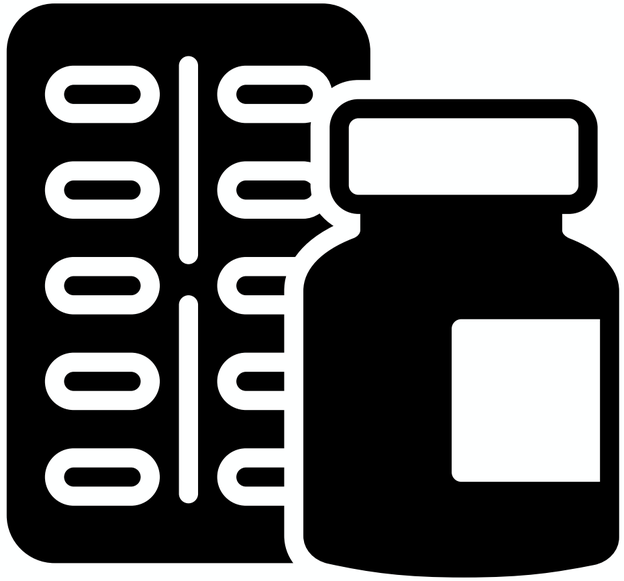
Need for care coordination

- recent discharge from hospital
- medication discrepancies
- medication titration
- barriers to medication access or optimal use



SERVICES

- Conduct comprehensive assessment of medications for efficacy, safety and adherence issues
- Provide guidance, recommendations and monitoring for medication changes
- Coordinate transitions of care
- Collaborate with primary care providers and other healthcare team members



CLINICAL COUNSELLOR



REASONS FOR REFERRAL

- Mild to Moderate Mental Health and/or Substance Use Conditions
- Anxiety
- Depression
- Life Transitions
- New Family and Social Roles
- Care Giver Fatigue
- Meaning & Purpose
- Grief and Loss
- Health Anxiety/Concerns
- Isolation
- Loneliness
- Marital Strife/Conflict



SERVICES

- Free and Confidential
- 1:1 Therapy: 6-8 sessions
  - Psychoeducation
  - Improve Self-Awareness
  - Build Coping Skills
  - Connection to Self-Help/Community Resources

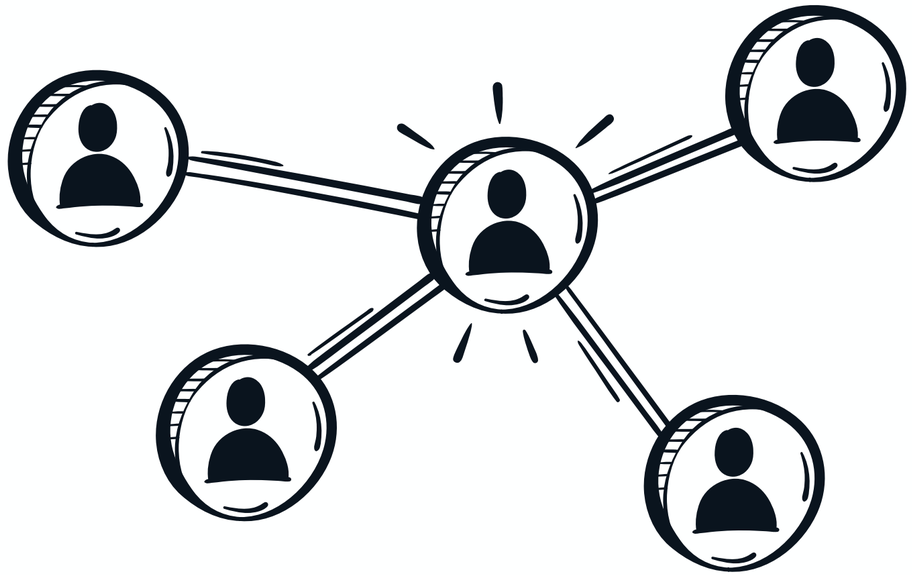


REGISTERED SOCIAL WORKER



REASONS FOR REFERRAL

- Financial Concerns
- Housing and Food Security
- Advanced Care Planning
- Caregiver Support
- Accessing Health Services
- Ministry Services (ie/client is on PWD)



SERVICES

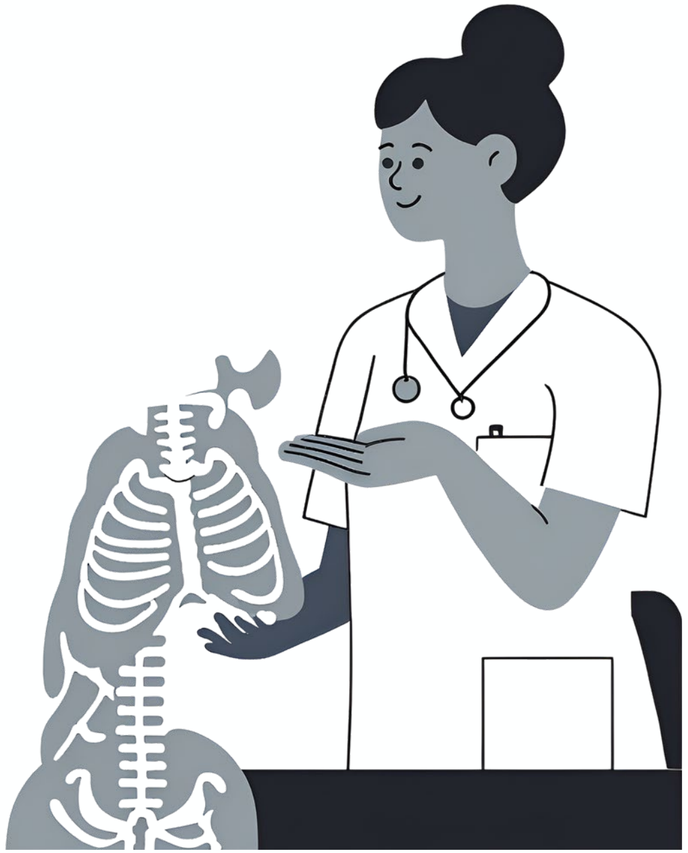
- Resource Navigation and Referrals
- Care Coordination
- Collaboration with Primary Care Team
- Advocacy of all kinds!

FRAGILITY FRACTURE PREVENTION PROGRAM



REASONS FOR REFERRAL

- Adults 50 + and older
- Diagnosed with Osteoporosis or Osteopenia
- Fragility Fracture (Fracture Caused by Weak Bones)
- Perimenopausal and menopausal age
- Frailty
- Parental hx of Hip Fractures
- Androgen Deficiency
- Rheumatoid Arthritis
- Glucocorticoid Use



SERVICES

- 1:1 consult with a **Registered Nurse, Pharmacist and Dietician**
- Review of Risk Factors for Low BMD and Fracture Risk
- Review the Importance of Bone Health, Affect of Lifestyle Choices and Connection to Programs and Resources
- Recommendations
  - BMD Testing, Bloodwork, Initiating Pharmacotherapy and Lifestyle Modifications



HOSPITAL DISCHARGE PROGRAM



REASONS FOR REFERRAL

Patients being discharged from Unit 2S at Langley Memorial Hospital can be referred to the discharge program by a Family Physician, Hospitalist, LMH Pharmacist, or a Patient Care Coordinator



Patients at higher risk for medication related complications:

- Polypharmacy, Complex Chronic Conditions, Recent Hospitalization within 30 days, Cognitive Impairment or Lack of Social Support, High-Risk Medication Regimens, **Attached to Langley Provider,** 18+ year old

SERVICES

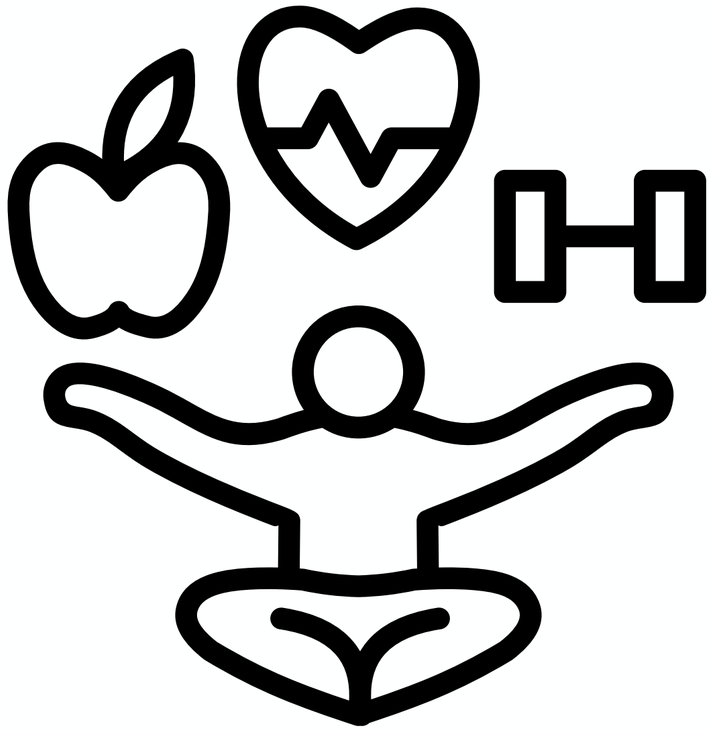
- Medication Reconciliation
- PharmaNet Review
- Patient Education
- Communication with MRP
- Follow up

Pharmacist-led post-discharge interventions improve medication adherence, reduce adverse drug events, and significantly lower readmissions rates



Upcoming Programs

- FFPP Group Program partnered with Langley Senior Resource Society
- Pharma Day for Seniors
- Menopause/Perimenopause Program
- Metabolic Syndrome Program



Upcoming Services

- 1 FTE Social Worker
- 2 FTE Clinical Exercise Physiologist or Kinesiologist
- 1 FTE Indigenous Health Liaison
- 1 FTE Indigenous Registered Nurse
- 1 FTE Knowledge Keeper


Q
&
A

THANK YOU

FOR COMING

Social Prescribing in Fraser Health



Margaret Lin, RN
Regional Project Lead
Fraser Health
Sep 17, 2025

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Fraser Health provides care on the traditional, ancestral and unceded lands of the Coast Salish and Nlaka’pamux Nations and is home to 32 First Nations within the Fraser Salish region.



What is Social Prescribing

acute care hospital

primary care clinics

assisted living

community, home health

virtual care



Healthcare provider

- physicians
- nurses
- allied health teams



65+



Seniors Community Connector (SCC)

Staff in each community organizations

Intake and Tailored wellness plan





Continous follow up and report

How did it start?

- In 2019, the BC Ministry of Health funded a new program through United Way British Columbia (UWBC).

- FH CARES team and UWBC partnered to enable collaboration with local nonprofit organizations and Divisions of Family Practice.

- This led to the creation of a new peer support role, the **seniors community connector (SCC)** , to help older adults navigate services.

- Now, there are 21 SCCs situated in 14 community organizations in the Fraser Health region; about 100 SCCs throughout BC

Fraser Health Change Leads' Roles

Funding & Support

United Way British Columbia

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Support via

Staff Education

Partnerships and connection building

Promotional/ Marketing materials

Process Standardization

Public awareness

Process and outcome evaluation

acute care hospital

primary care clinics

assisted living

community, home health

virtual care

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Healthcare provider

- physicians
- nurses
- allied health teams



Seniors Community Connector (SCC) in community organization

Intalke and Tailored wellness plan



Community Resources or health authority teams

Fraser Health Change Leads' Roles

- Education
  - for healthcare provider
  - for Seniors Community Connectors
  - for the public
- Standardization of referral process and program development
- Promotion and Awareness —social media, news, posters, pamphlets
- Evaluation of program impact
- Collaboration with organizational partners and explore different partnerships
- Consultation and Advocacy for healthcare-community collaboration

Engagement process

Plan: Plan the test or observation, including a plan for collecting data

- **Identify care teams** based on readiness and needs
- **Identify leads and champions** in each care setting
- **Arrange** meetings with team leads
- **Prepare** education materials
- **Invite** SCCs to engagement sessions

Do: Try out the test on a small scale

- **Conduct** education sessions
- **Teach** social prescribing model
- **Share** knowledge translation materials
- **Share** client stories and case studies
- **Send** email with key info and resource attached, invite team for next engagement



Study: Set aside time to analyze the data and study the results

- **Conduct follow-up sessions** with care team every 2-3 months to engage feedback
- **Analyze** concerns and suggestions shared
- **Discuss** findings with SP team and SCCs, co-explore potential improvements/solutions

Act: Refine the change, based on what was learned from the test

- **Re-design** knowledge translation materials that better address users' needs
- **Adjust** engagement approaches and wordings as needed
- **Share-back** potential ideas with health care teams

Change Leads' Roles

Co-creation

- Co-learning
- Brokering
- Address power differentials
- Co-design
- Tailored support

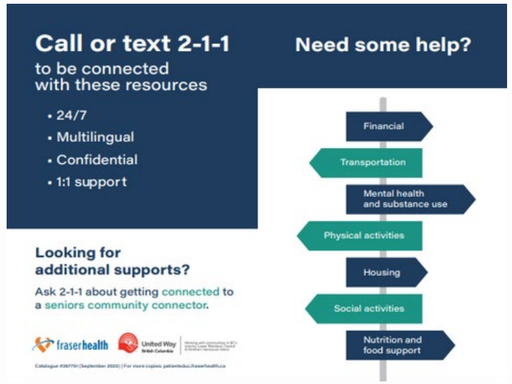
Sustaining change

- Grow and sustain relationship
- Build capacity
- Cultivate leadership

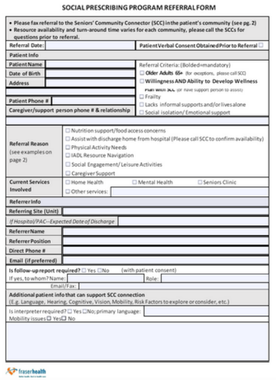
Ongoing improvement

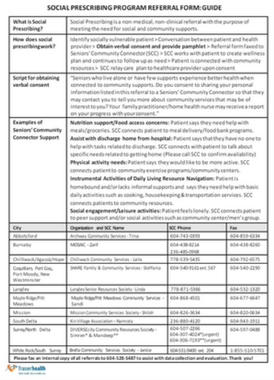
- Assess need and context
- Apply and integrate implementation science approaches

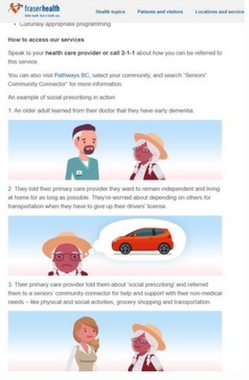
Social Precribing materials

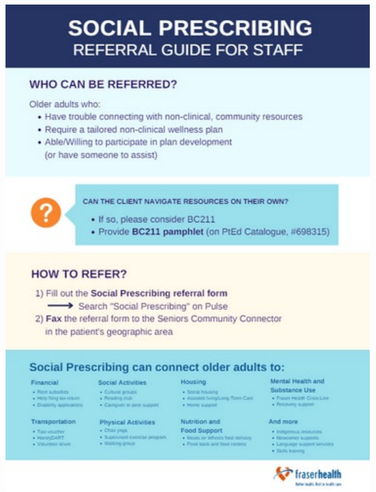


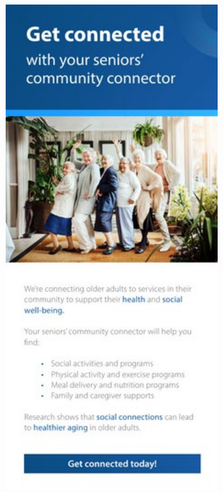


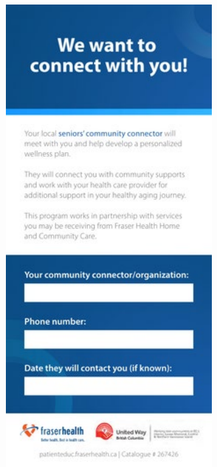
















Impact of integration

Healthcare providers



- Increased understanding of social prescribing and community resources
- Ability to identify suitable clients AND provide appropriate resources
- Standardized tool that fits their workflow

Community Service Providers



- Receives suitable referral
- Better communication with healthcare teams
- Increased capacity to support older adults and families
- Community needs are acknowledged and built into tools

Older adults & Caregivers



- More older adults accessing community resources
- More Holistic plan including both healthcare and social considerations
- Goal: Better health and quality of life

MSHRBC grant 2025

- Earlier 2025, MSHRBC launched a 2-phase research grant to advance work and innovations in home and community health

- Fraser Health wants to:
  - 1) Formally evaluate the process and impact of social prescribing
  - 2) Help other health authorities build process/change management team so they can connect better with their communities

- Partners:
  - United Way BC
  - SFU
  - UBC
  - all SP community connectors
  - 5 health authorities

MSHRBC grant 2025

Timeline:

- May-Oct 2025: develop tools, work with partners & make a 3-year plan
- Jan 2026-Dec 2028: if successful, start full plan with 1 million grant

Some key work for the 3 years:

- Establish a provincial Seniors Advisory Group for Equity, to inform all work
- Establish a provincial governance structure with all partners to improve social prescribing together
- Evaluate the outcome of social prescribing
- Each participating health authority to have a team that works directly with the community connectors
- Improve social prescribing process and standardize evaluation

Thank you!
Any comments/ questions?



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