OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

IT'S TIME TO ACT

A REVIEW OF ASSISTED LIVING IN B.C.

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MESSAGE FROM THE SENIORS ADVOCATE

Assisted living can be a desirable option to support seniors as they age. The ability to have your own private living space but share meals and activities with others can be ideal for those seniors who find it more challenging or isolating to remain in their own home but are not in need of long-term care.

Over the past 25 years, British Columbia has seen tremendous growth in assisted living. During this time, tens of thousands of seniors have been able to enjoy the benefits that come with the shared amenities and companionship that assisted living offers. However, with this growth has come challenges related to affordability, system capacity and regulatory oversight.

Over the course of this review, my office examined a number of home and community care records, legislative changes, adjudicative decisions as well as the issues and concerns that have come to our office from seniors and their families. This review also examined previous reports on assisted living authored by various stakeholder groups in B.C.

Through this review, we found:

- There is significant confusion in the public, within the industry and amongst regulators on what is assisted living covered by the Community Care and Assisted Living Act and what is independent living or supportive living and covered by the Residential Tenancy Act. The result of this confusion has left some seniors without the protections and oversight of the Community Care and Assisted Living Act or the Residential Tenancy Act, making them vulnerable to uncontrolled rent increases and eviction.

- There has been a 2% increase in the total number of assisted living units in the past five years, almost exclusively in the private pay market. This increase has not kept pace with population growth, especially in the number of publicly subsidized assisted living units, where the rate of assisted living units per 1,000 population (75+) has decreased 15% in the last five years.

- There has been a 52% increase in spending for publicly subsidized assisted living in the past five years but no increase in either the number of units or level of support provided. At the same time, the proportional waitlist for subsidized assisted living units is 50% longer than long-term care.

- The current cost of a publicly subsidized assisted living unit at 70% of a senior's annual income is proving increasingly difficult for low-income seniors given the additional costs residents pay.

- There is no recognized protection related to cost increases in private pay assisted living. Seniors have reported annual increases of up to 15% leaving some unable to afford the charges for the additional support services that they need to live safely.

- The current regulations for both publicly subsidized and private pay assisted living do not require a minimum level of staffing, specific training or clinical oversight, resulting in a wide range of service delivery models and concerns about unmet needs.

- There are no required standard clinical assessments or related standard reporting for residents of private pay assisted living, although these data do exist for publicly subsidized assisted living.

For residents who live in publicly subsidized assisted living we found:

- There are currently 4,520 seniors (65+) living in publicly subsidized assisted living. The average age at time of admission is 81 years and residents stay, on average, for about three years.

- Overall data trends are showing residents in publicly subsidized assisted living are becoming increasingly frail with more care needs. Compared to five years ago, there is a higher proportion of residents with cognitive decline and residents needing more assistance with their activities of daily living.

- The proportion of residents who use a wheelchair has increased 24% over the last five years.

- Despite rising acuity over the last five years there has been no increase in service levels.

- Most residents continue to live in assisted living until they pass away. On average, 11% of residents directly transfer to long-term care each year.

It has been over 20 years since the Community Care and Assisted Living Act was introduced. It is timely for the Province to begin a comprehensive review of its overall effectiveness and make the necessary changes to reflect current and future needs of the growing seniors population. This review will need to consider:

- The regulatory revisions required to meet the need for oversight and protection balanced with the rights of autonomy. The current system does not have the clarity and transparency that is needed and is lacking in some areas such as staffing requirements and reporting. This work will require seniors' independent living and assisted living to be more clearly differentiated than it is currently.

- The application of the Residential Tenancy Act needs to be enforced for all tenancy related matters; no senior should be left without the regulatory protection of either the Residential Tenancy Act, the Community Care and Assisted Living Act or potentially both.

- In addition to tenancy protections under the Residential Tenancy Act (RTA), the regulatory review must address the need to offer some protection against unreasonable cost increases for services in the private pay market that may not be addressed by the RTA. Without this, residents of assisted living are at risk of being unable to afford much needed support services.

- We must build more capacity in publicly subsidized assisted living to meet current and future demand. Assisted living is less costly than long-term care and helps seniors continue to live relatively independently. To date, government has not committed to increase the number of subsidized assisted living units despite the long waiting lists and evidence that some people in long-term care could be referred to assisted living.

There is clearly some significant work that lies ahead and I hope this review will serve as a catalyst for this to begin.

As always, I want to thank the dedicated team at the Office of the Seniors Advocate for their work in bringing this report together. In particular, I want to thank my long-time colleague Robin McMillan, former Director of Assisted Living Services at the Ministry of Health, for her insights and guidance.

Sincerely,

Isobel Mackenzie
Seniors Advocate
Province of British Columbia

INTRODUCTION

In North America, assisted living is a generic term used to describe a living arrangement where residents live in an apartment-like unit, often with a separate bedroom and small kitchen, in a building also offering hospitality services such as meals in a common dining room, organized social activities and weekly housekeeping. Some sites will offer personal assistance and nursing services while others will leave residents to arrange their own support services should they need them. A variety of terms are often used to describe the concept of assisted living including 'retirement home', 'seniors independent living' or 'supportive living'. Assisted living, as a model, is distinct from long-term care where 24 hour nursing care is available and all residents have physical and/or functional health challenges.

Assisted living appeals to seniors who no longer want to manage a household, want to share meals and activities with other seniors and have help with some of their personal assistance services if needed. The loss of a spouse is often the catalyst for a senior to move to assisted living, although it is also an arrangement that can suit many couples as one or both develop personal assistance needs.

Assisted living has existed as a housing option in the United States for more than 40 years, but is a relatively newer concept in Canada, growing in popularity over the past 25 years. In British Columbia, the term 'assisted living residence' has a specific legal definition tied to legislative oversight and regulations passed in 2002.

In B.C., an assisted living residence and unit(s) must be registered with the province under the Community Care and Assisted Living Act (CCALA). The requirement to register is met when the operator of the building, in addition to hospitality services, also provides assisted living services for the resident. If the operator does not provide assisted living services and the tenant has personal needs but hires an outside agency, there is no requirement for the residence and unit(s) to be registered. There are many sites offering assisted living-like services such as meals, weekly housekeeping and social activities that are not registered and are not regulated other than under the BC Residential Tenancy Act (RTA). They are not providing assisted living services for residents, although the resident may hire an outside agency to provide them with personal support.

While assisted living in B.C. is regulated, it does not have the same rigour of oversight and reporting as long-term care. In accordance with the legislation, it is legally required that assisted living residents have the capacity to manage their own affairs and should this no longer be possible, they will, as required by law, leave assisted living and likely transition to the higher level of care and oversight provided in long-term care.

Assisted living can offer significant relief to the long-term care and acute care systems because it can provide a less intensive and thereby less costly alternative for seniors who develop modest personal assistance needs as they age. The purpose of this review is to examine the current status of assisted living in B.C., look at past and current trends, assess the effectiveness of the current model, and, if necessary, make recommendations for improvement.

ASSISTED LIVING IN BRITISH COLUMBIA

In 2002, the provincial government introduced a system of residential continuing care that included two distinct levels of service: long-term care and assisted living. Long-term care was intended to serve seniors needing complex care and assisted living was introduced as a social housing option for those with moderate support needs. Assisted living provides seniors with accommodation, hospitality and assisted living services that enable them to maintain their independence. Assisted living services can vary and may include assistance with bathing, grooming, dressing, mobility and other tasks delegated by a health care professional.

In B.C., assisted living units must be registered with the provincial Assisted Living Registry. Registered assisted living units are either publicly subsidized or private pay and can be operated by a private company, a not-for-profit society (NFP) or by a regional health authority (HA).

In B.C. assisted living must provide the following basic services to those who live in a registered unit:

- a private housing unit with a lockable door;
- two meals per day, one of which is the main meal;
- access to basic programming such as games, music and crafts;
- weekly housekeeping in the unit;
- laundering of towels and linens;
- access to laundry for personal use;
- heating or cooling as necessary to maintain the safety and basic comfort of the residence; and
- 24 hour emergency response system.

In addition, an assisted living residence must provide at least one or more of the following assisted living services to those who live in a registered unit:

- regular assistance with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene;
- central storage of medication, distribution of medication, administering medication or monitoring the taking of medication;
- maintenance or management of resident cash resources or other property of a resident;
- monitoring of food intake or adherence to therapeutic diets;
- structured behavioural management and intervention; and
- psychosocial supports or intensive physical rehabilitative therapy.

There is no limit on the number of assisted living services an operator can offer to those who reside in a registered unit but the majority of residents are most commonly offered only two: support with activities of daily living and medication management.

MOVING INTO ASSISTED LIVING

The CCALA and the Assisted Living Regulation define who can and cannot live in assisted living. These elements impact both publicly subsidized and private pay residences. The CCALA defines who is **not** allowed to live in assisted living as a person who:[1]

- is unable to make, on their own behalf, decisions that are necessary to live safely;
- cannot recognize an emergency, take steps to protect themselves in an emergency (such as pushing a call button) or follow directions in an emergency;
- behaves in a manner that jeopardizes the health or safety of others; or
- requires, on a regular basis, unscheduled professional health services.

The only exception to these criteria is when the person has a spouse who is living with them and the spouse can make these decisions on their behalf. If the spouse is temporarily away from the residence, another adult can reside in the unit to support the resident.

The Regulation requires all operators to carry out entry screening to determine whether assisted living is an appropriate level of support for each individual. Separate from the legal requirements, different entry practices exist between publicly subsidized and private pay assisted living sites.

British Columbia has both assisted living that is paid for privately by the resident and subsidized assisted living where the resident pays 70% of their income; the health authority provides any needed additional funding to meet the operators cost of delivering the service. Regardless of whether the assisted living unit is subsidized or private pay, the same regulatory oversight through CCALA is applied.

PUBLICLY SUBSIDIZED ASSISTED LIVING

Publicly subsidized assisted living sites are funded by health authorities and fall under both health authority policies and the Ministry of Health home and community care policies. The ministry policies set out that assisted living is appropriate for a senior who:

- requires both hospitality and personal assistance services;
- meets the criteria described in the CCALA;
- are at risk in remaining in their current living environment; and
- has agreed to pay the assessed client rate.[2]

Health authority case managers determine a person's eligibility for publicly subsidized assisted living based upon suitability criteria defined by their health authority. Currently, there is no standard eligibility criteria across the five B.C. health authorities but generally, the principle of triage is applied with those at greatest risk ranking as the highest priority for placement.

[1] Government of BC. Community Care and Assisted Living Act (CCALA), Section 26.1
[2] BC Ministry of Health. Home and Community Care Policy Manual, Chapter 5, Section B.1, Page 1.

In publicly subsidized assisted living, a person is assessed by the health authority using the RAI-HC assessment tool to determine the level of support required given their current health status, cognitive and physical functioning and other needs. Once the person has been approved, they can identify a preferred assisted living site; they may move into an available unit or may be placed on a waitlist depending on their stated wishes. Health authorities manage their own waitlists and each have different methods.

PRIVATE PAY ASSISTED LIVING

In private pay assisted living, there are no defined suitability criteria or assessment processes and the RAI-HC assessment is not required. While private pay assisted living is subject to the same regulatory oversight as publicly funded sites, this oversight does not specify or require clinical oversight, or regulate staffing levels or training requirements for staff.

LEGISLATION AND REGULATION OF ASSISTED LIVING

Assisted living became part of the formal health services continuum of care in B.C. in the early 2000s. In 2002, the Province created the CCALA (the Act) and Regulation to establish and regulate both assisted living and long-term care in B.C. After public consultation, government decided there would be limited legal oversight of assisted living as compared to the extensive regulation that applied to long-term care. The Act was passed in 2002 and came into force in 2004.[3]

An independent Office of the Assisted Living Registrar (OALR) was created in 2003 to register and monitor assisted living units. The mandate of the office was limited to undertaking regular reviews, investigating complaints, and publishing information about substantiated complaints and enforcement decisions including registration termination. The goal was to protect the health and safety of people living in assisted living by developing administrative policies and educating owners and operators to foster safe practices. In 2012, the OALR was integrated into the Ministry of Health and is now called the Assisted Living Registry (Registry). The Act requires the Minister of Health to designate an assisted living registrar. Currently, the Registrar is an Assistant Deputy Minister of Health. The Registrar delegates staff to carry out the work of the Registry.

[3] Province of BC. Community Care and Assisted Living Act Background [Online] https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/laws-related-to-health-in-bc/community-care-assisted-living-act

Although the Act set out the six 'prescribed services' that operators could provide to residents, the original Act restricted operators to providing a maximum of two prescribed services to residents. If/when a resident required more than two prescribed services (or a prescribed service was not provided by the residence), they were no longer eligible to remain in assisted living because they needed a higher level of care, such as long-term care.

The Office of the Seniors Advocate and other key stakeholders identified concerns regarding the prescribed service limitations including premature transfers to long-term care if a person required more than two prescribed services or making a person ineligible if they required a prescribed service not offered by the operator. The Office of the Seniors Advocate recommended government amend legislation to allow residents to receive any and all of the services outlined in regulation.

In response, the provincial government brought forward legislative changes through the Community Care and Assisted Living Amendment Act in 2016, with the goal to offer more flexibility and choice for older adults in assisted living while also increasing protections.[4] All of the Community Care and Assisted Living Amendment Act (2016) provisions were brought into force on December 1, 2019. The updated Act removed the limit of two 'prescribed services' (renamed as 'assisted living services'), enhanced the regulatory powers of the Registrar, and defined who was not eligible to live in an assisted living setting. The Regulation established minimum health and safety requirements for operators to follow that further protected and promoted the health and safety of residents.

BRIEF TIMELINE

COMMUNITY CARE AND ASSISTED LIVING

[4] BC Ministry of Health, An Action Plan to Strengthen Home and Community Care for Seniors, p. 4

ENHANCED LEGISLATIVE OVERSIGHT

The updated CCALA increased the Registrar's authority to:

- register and inspect both registered and unregistered assisted living sites;
- investigate complaints and conduct regular residence reviews; and
- publish information about substantiated complaints and enforcement decisions.

The updated CCALA set out when the Registrar must not register a residence, and it allowed the Registrar to attach conditions to a new registration to protect the health and safety of residents. It expanded the Registrar's inspection rights (previously inspections had to be complaint focused) and allowed the Registrar to enter, inspect and act quickly to protect residents, if the health or safety of residents is at imminent risk. In addition, the legislation now contains language to prevent resident abuse.

The new Regulation creates legal standards for all aspects of assisted living that increase safeguards for residents. The Registrar can now intervene if an operator does not meet these standards. For example, the regulation established three classes of assisted living residences - mental health, seniors and persons with disabilities and supportive recovery. If an operator is housing several classes of residents (or non-residents such as tenants in independent living) in the same building, the areas must be separate.

The overall goal of the updated legislation was to increase flexibility and enhance protections in assisted living. While some amendments allow seniors who need additional types of assistance to receive them in assisted living, the definition of who is not eligible may continue to force people in assisted living who have dementia, significant mobility challenges or needing palliative care to move to long-term care.

ASSISTED LIVING SERVICES

In the updated Act, the list of assisted living services remains the same with the addition of 'other types' service category to allow for the expansion of the types of assisted living services if needed. However, the restriction of providing a maximum of two assisted living services has been removed so operators can now legally provide residents with more services and supports. The intent of this change was to provide flexibility allowing people to stay in assisted living longer and preventing or delaying a move to long-term care if they required more than

two assisted living services. However, the CCALA amendments do not mandate operators to offer additional services. Operators are free to choose which and how many services they offer at a site. Currently, most operators in B.C. are registered to provide two assisted living services to residents: support with activities of daily living and medication management.

There has been very little progress to date on increasing the number of assisted living services offered by assisted living operators: health authorities, not-for-profit organizations and private businesses. As of March 2023, only 10% of assisted living sites offer more than two services despite the legislation change in 2019. Most assisted living operators have not expanded service due to staffing challenges, particularly in hiring specialized staff such as dieticians, behaviour modifications specialists and recreation therapists. Assisted living operators who have publicly subsidized units have not received additional funding from health authorities to expand services beyond temporary funding to support COVID-pandemic measures and funding to provide additional services to residents awaiting placement in long-term care.

TRENDS IN ASSISTED LIVING SITES, UNITS AND RESIDENTS

NUMBER OF ASSISTED LIVING SITES AND UNITS

Assisted living sites may be operated directly by a health authority, by a third party under contract to a health authority, by a fully private entity with no financial relationship with the health authority or a combination of these. These sites can have all residents living in a registered assisted living unit or they can have a mix of some units registered while others are operated as independent living units and not subject to oversight by the Registrar.

There are 206 assisted living sites in B.C. of which 136 offer subsidized or a combination of subsidized and private pay assisted living. The remaining 70 sites offer private pay only. Of these 206 sites, there are a total of 8,428 registered assisted living units with 52% (4,415) publicly subsidized and 48% (4,013) private pay.

Of the 136 assisted living sites that offer publicly subsidized assisted living:

- 5% (7 sites) are operated by health authorities
- 38% (52 sites) are private for-profit
- 79% of these sites have both subsidized and private pay units
- 57% (77 sites) are not-for profit organizations
- 30% of these sites have both subsidized and private pay units
- 53% (72 sites) have only subsidized units

Of the 4,415 subsidized units:

- 4% are operated by health authorities
- 64% by non-profit organizations
- 32% by private companies (for-profit operators)

TABLE 1: NUMBER OF ASSISTED LIVING SITES/UNITS AND INDEPENDENT LIVING UNITS, AT MARCH 31

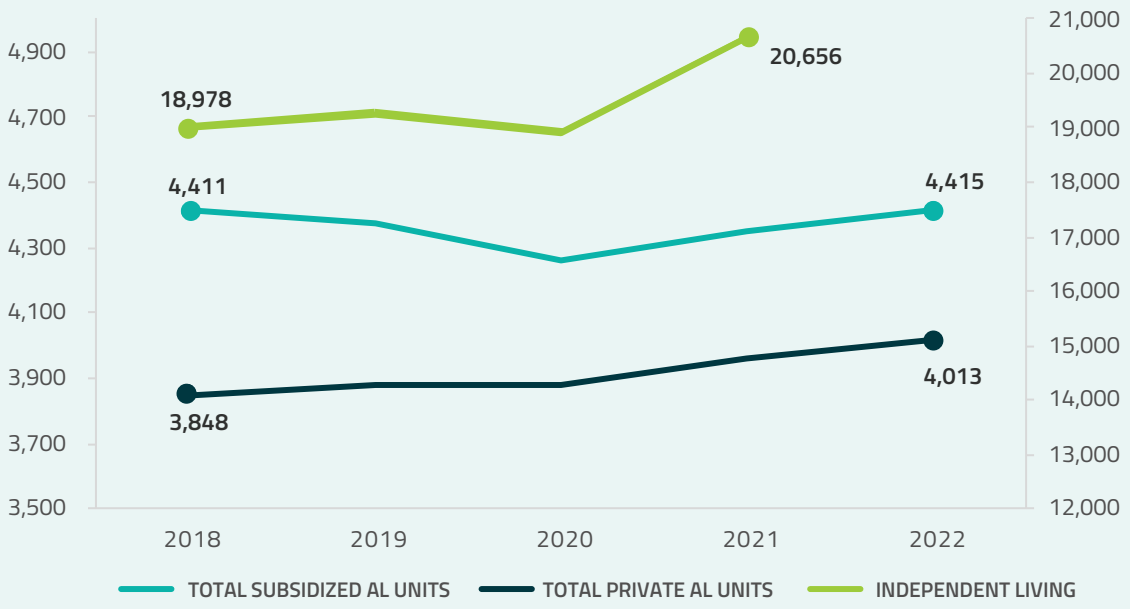
	2018*	2019	2020	2021	2022	% CHANGE IN 5 YEARS	% CHANGE IN LAST YEAR
SUBSIDIZED AL SITES	**138**	**137**	**133**	**136**	**136**	**-1%**	**0%**
SUBSIDIZED AL UNITS	4,411	4,372	4,262	4,347	4,415	0%	2%
PRIVATE AL UNITS	1,324	1,302	1,297	1,319	1,276	-4%	-3%
PRIVATE AL SITES	**82**	**76**	**73**	**69**	**70**	**-15%**	**1%**
PRIVATE AL UNITS	2,524	2,573	2,585	2,645	2,737	8%	3%
TOTAL AL SITES	**220**	**213**	**206**	**205**	**206**	**-6%**	**0%**
TOTAL SUBSIDIZED AL UNITS	4,411	4,372	4,262	4,347	4,415	0%	2%
TOTAL PRIVATE AL UNITS	3,848	3,875	3,882	3,964	4,013	4%	1%
INDEPENDENT LIVING**	**18,978**	**19,248**	**18,892**	**20,656**	**n/a**	**9%**	**9%**

NOTE(S): *Data has been corrected for 2018 due to reporting error. ** Canada Mortgage and Housing Corporation (CMHC) discontinued the survey in 2021, therefore 2022 data is not available. The % change is comparing 2021 to 2018 and 2020.

In the past five years, the total number of assisted living units in B.C. increased by 2%. This slight increase is attributed to the growth in private pay units as growth in publicly subsidized units remains relatively flat.

During this same timeframe, there has been a decrease of 6% in the overall number of assisted living sites in B.C., from 220 to 206. The number of publicly subsidized sites fell from 138 to 136 (1% decrease) and the number of private pay sites fell from 82 to 70 (15% decrease) despite an 8% increase in the number of units in private pay sites. The total number of subsidized assisted living units has remained relatively unchanged, with only four more units, while the total number of private pay assisted living units has increased by 4% or 165 additional units. Seniors have access to approximately the same number of publicly subsidized units as they did in 2018 but the seniors' population (75+) has increased by almost 18% in that same period.

FIGURE 1: NUMBER OF ASSISTED LIVING AND INDEPENDENT LIVING UNITS, 2018 TO 2022 AT MARCH 31



NOTE(S): Independent Living is not reported by CMHC after 2021.

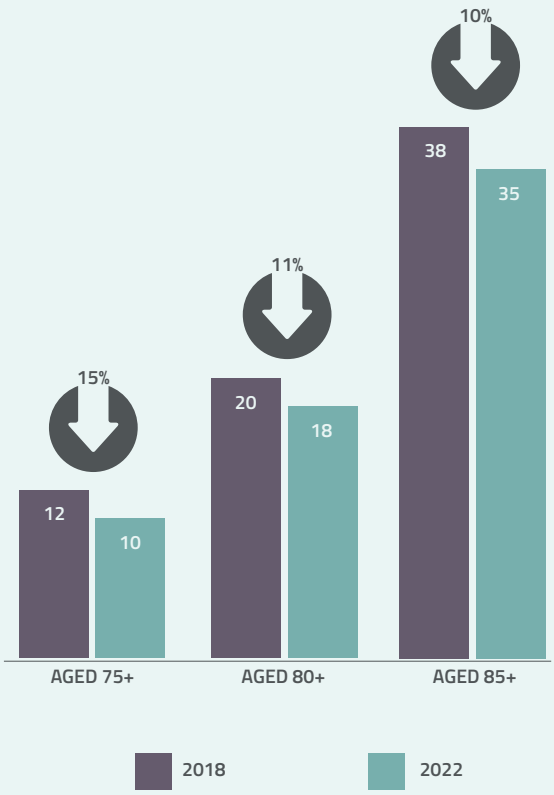
Many private seniors' living operators provide independent living and/or assisted living. Independent living is for seniors who are living independently who can manage most of their daily tasks with little or no assistance. When we look at trends in the private pay seniors living market, we also see an increase of 9% or 1,678 additional independent living units from 2018 to 2021.[5]

[5] Canada Mortgage and Housing Corporation (CMHC) discontinued the survey in 2021, therefore 2022 data is not available.

TRENDS IN ASSISTED LIVING UNITS RELATIVE TO THE SENIORS POPULATION (75+)

In B.C., the percentage of the population aged 65 and over continues to grow and is projected to steadily increase. By 2040, the 75+ population, a key demographic for assisted living is projected to represent 14% of all British Columbians, up from 8.5% in 2022. As we age, we are more likely to need more supports including more access to housing and care options like assisted living. For this reason, it is crucial that the services to support seniors such as assisted living grow sufficiently to meet the needs of the growing population.

FIGURE 2: PUBLICLY SUBSIDIZED ASSISTED LIVING UNITS PER 1,000 POPULATION, 75+, 80+ AND 85+, 2018 AND 2022



NOTE(S): Population in 2018 (updated April 2023) is an estimate. Population in 2022 (updated April 2023) is a projection.

Over the past five years, B.C. has experienced a relative decline in the rate of assisted living units per 1,000 seniors' population with the greatest decline in the subsidized assisted living units. As shown in Figure 2, when we look at the rate of units per 1,000 population for ages 75+, 80+ and 85+ over the last five years, it is very clear we are failing to keep pace with an aging population and that fewer seniors have access to publicly subsidized units. In 2018, there were 12 units per 1,000 (75+) and that number has dropped to 10 units per 1,000 (75+) in 2022. This is similar to the experience in seniors subsidized housing offered by BC Housing where the rate of units per 1,000 (55+) has also decreased 5% in the same time period.

LACK OF PUBLIC INVESTMENT IN ASSISTED LIVING

The last major capital investment for publicly subsidized assisted living was in 2002 when the province, through BC Housing, implemented the Independent Living BC (ILBC) program in partnership with the federal government, health authorities and the private and non-profit sectors. This partnership committed to building 3,500 assisted living units.

At that time, the federal government provided the province with $88.7 million over five years in capital funding for affordable housing, including $62.5 million earmarked for seniors' supportive housing and assisted living.[6]

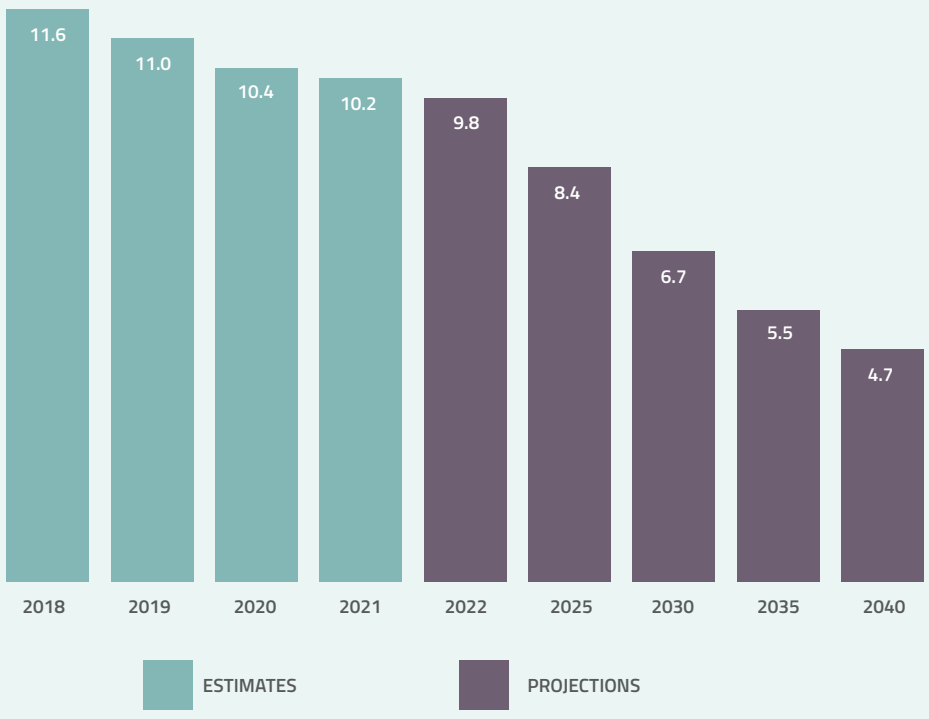
[6] Longhurst, A. Assisted Living in British Columbia: Trends in access, affordability and ownership. p. 17.

The province committed to a $29.7 million annual contribution towards the costs of units built under this agreement.[7] It is critical that the provincial government take into account that without substantial new provincial capital investment, there will be significantly less access to publicly subsidized assisted living in the next 10 to 15 years than there is currently.

No major provincial capital investment since 2002 in publicly subsidized assisted living in B.C.

As illustrated in Figure 3, if the Province continues with having the same number of publicly subsidized assisted living units currently available per 1,000 75+ population today, by 2040 the rate per 1,000 75+ population drops to 4.7 units.

FIGURE 3: PROJECTED RATE OF SUBSIDIZED ASSISTED LIVING UNITS PER 1,000 75+ POPULATION, 2018 TO 2040



NOTE(S): Population before 2022 (updated April 2023) is an estimate. Population in and after 2022 is a projection.

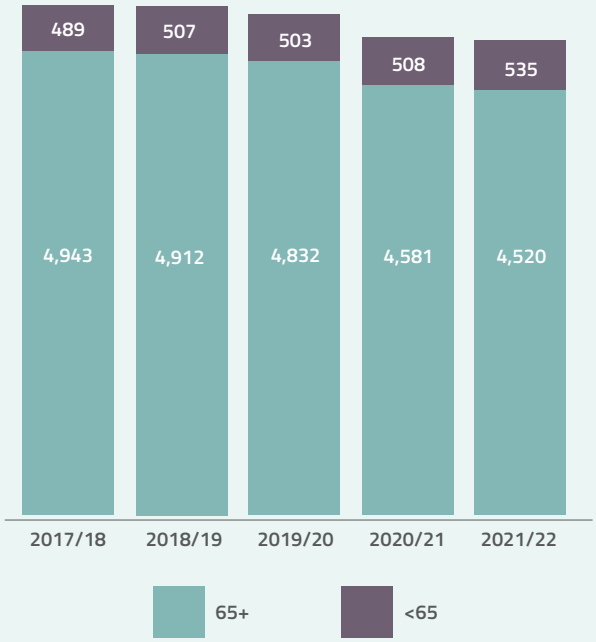
[7]Government of Canada and Government of BC: 564 New Assisted Living Units Allocated for Seniors. Joint News Release. December 16, 2003.

TRENDS IN THE NUMBER OF PUBLICLY SUBSIDIZED ASSISTED LIVING RESIDENTS

Overall, there are over 5,000 clients that live in publicly subsidized assisted living each year.[8] While assisted living is aimed at seniors, the last five years has seen a 9% decrease in the number of clients who are 65 and older and a corresponding increase in the number that are under 65.

Currently, of the age 65+ residents in publicly subsidized assisted living, the average age at time of admission was 81 years of age and residents live in assisted living, on average, for about three years. However, this varies across health authorities ranging from 2.8 years in the Interior to 3.7 years on Vancouver Island.

FIGURE 4: NUMBER OF CLIENTS IN PUBLICLY SUBSIDIZED ASSISTED LIVING, 65+ AND <65, 2017/18 TO 2021/22



NOTE(S): 1) B.C. totals are the sum of unique client counts in each health authority and are therefore not unique client counts. 2) NHA data was submitted by NHA because their data in HCCMRR were incomplete in 2021/22. Data for other health authorities were extracted from HCCMRR.

ACCESS TO PUBLICLY SUBSIDIZED ASSISTED LIVING

As of March 31, 2022, there were 785 clients waiting for placement in publicly subsidized assisted living. The number of clients waiting for publicly subsidized assisted living has fluctuated in the past five years, with the largest share in the Interior and the North.

[8] All client count figures are from the Home and Community Care Minimum Reporting Requirements (HCCMRR) and submission from Northern Health Authority.

TABLE 2: NUMBER OF CLIENTS WAITLISTED FOR PUBLICLY SUBSIDIZED ASSISTED LIVING, AT MARCH 31

	2018	2019	2020	2021	2022	% CHANGE IN 5 YEARS
INTERIOR HEALTH	191	223	231	167	213	12%
FRASER HEALTH	131	148	116	57	71	-46%
VANCOUVER COASTAL HEALTH	183	142	138	88	81	-56%
VANCOUVER ISLAND HEALTH	77	40	107	52	88	14%
NORTHERN HEALTH	222	317	328	343	332	50%
BRITISH COLUMBIA	**804**	**870**	**920**	**707**	**785**	**-2%**

When we compare the waitlist between publicly subsidized assisted living and publicly funded long-term care, we found that seniors have even less chance of being admitted to assisted living in a timely manner than they do in long-term care. The waitlist per 100 subsidized beds/units for publicly subsidized assisted living is 50% more than the wait list for long-term care. The waitlist for publicly subsidized assisted living is 18 people per 100 units compared to 12 people per 100 long-term care beds.

WAIT TIMES FOR PUBLICLY SUBSIDIZED ASSISTED LIVING FROM ASSESSMENT TO PLACEMENT

Wait times are a reflection of the availability and responsiveness of publicly subsidized assisted living, and evidence shows there is a paucity of publicly subsidized assisted living within B.C. The average wait time from the time of assessment to placement in publicly subsidized assisted living varies by health authority and ranges from 62 days in Fraser Health to 456 days in Northern Health. On average, clients tend to wait longer to access assisted living in Interior Health and Northern Health and shorter wait times in Fraser and Vancouver Coastal.

TABLE 3: WAIT TIMES (DAYS) FROM ASSESSMENT TO PLACEMENT FOR PUBLICLY SUBSIDIZED ASSISTED LIVING, 2018 TO 2022

	2018	2019	2020	2021	2022	% CHANGE IN 5 YEARS
INTERIOR HEALTH	150	141	138	130	138	-8%
FRASER HEALTH	116	100	87	84	62	-46%
VANCOUVER COASTAL HEALTH	170	153	124	124	79	-54%
VANCOUVER ISLAND HEALTH	106	103	100	121	97	-9%
NORTHERN HEALTH	340	378	353	439	456	34%

PUBLICLY SUBSIDIZED ASSISTED LIVING

Most publicly subsidized assisted living is a partnership between health authorities, BC Housing and private and non-profit housing operators. Health authorities are funded to provide the cost of personal assistance services. BC Housing provides funding to private and not-for-profit operators for rent supplements or subsidies and funding towards capital developments. Upon review, investments in assisted living settings have been made, however, they have not resulted in more publicly subsidized units or expanded care for residents.

The Ministry of Health provides funding for assisted living to each health authority as part of the budget to deliver home and community care (HCC) services. In 2021/22, health authorities spent a total of $130.8 million on assisted living services, representing 3% of the total HCC expenditures ($4.81 billion). Assisted living is one of the lowest areas in home and community care spending by health authorities compared to home support (14%) and long-term care services (60%).

In the past five years, the overall spending in assisted living funded by Ministry of Health increased by 60%, while the number of publicly subsidized units has remained the same. The majority of increased spending occurred during the pandemic years, where total health authority spending increased by 40% between 2019/20 and 2021/22. This is largely attributed to costs associated with COVID-19 measures including wage leveling for contractors, rising costs from inflation, and increased staffing costs for wages and benefits. For example, about $7 million was spent by Island Health to support visitation in assisted living for screeners and greeters and $700,000 in wage leveling last year. Northern Health supported $2.1million in start-up and initial operating costs for a new assisted living site and $700,000 for COVID related costs (i.e., wage leveling).

In addition to Ministry of Health funding, BC Housing allocated $25.5 million, on average, between 2018/19 to 2020/21 in funding to 95% of all publicly subsidized units (i.e., where there is a financial relationship) under the Independent Living BC (ILBC) program across all five health authorities. In fiscal year 2021/22, BC Housing spent $32 million, which included $6 million in renovations for one site in the Fraser Health authority region.

Independent Living BC (ILBC) is the province-wide program for the development of publicly subsidized assisted living units that launched in 2002.

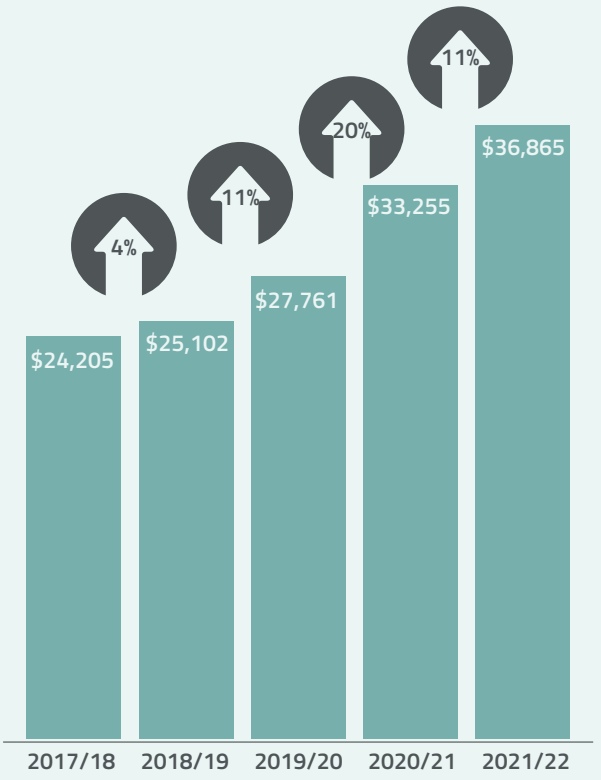
ILBC is a partnership between BC Housing, provincial health authorities, the Canada Mortgage and Housing Corporation (CMHC), and non-profit and private-market housing providers. It is a subsidized, assisted-living program that provides housing with support services to seniors and people with disabilities.

Overall, total public spending in assisted living funding was $162.8 million in 2021/22, a 52% increase from the last five years.

TOTAL ASSISTED LIVING EXPENDITURES PER PUBLICLY SUBSIDIZED UNIT

The total provincial assisted living expenditures per subsidized assisted living unit, including BC Housing, has increased in each of the past five years. The largest year over year rate (20%) was in 2020/21 due to COVID-19 related pandemic costs (i.e., wage leveling, screening) and annual inflationary and staffing costs.

FIGURE 5: ASSISTED LIVING ACTUAL EXPENDITURES PER SUBSIDIZED UNIT, B.C., YEAR OVER YEAR GROWTH, 2017/18 TO 2021/22



NOTE(S): 1. Expenditure includes Ministry of Health/Health Authority and BC housing
2. BC Housing expenditures include all costs that directly contribute to units through ILBC projects (i.e., projects for new development, capital renewal projects, one-time grants, operating subsidies/rental assistance to societies/tenants).

WHO LIVES IN PUBLICLY SUBSIDIZED ASSISTED LIVING IN B.C.?

DEMOGRAPHIC PROFILE

In order to ensure that publicly subsidized assisted living is an appropriate placement, potential assisted living residents participate in a Residential Assessment Instrument (RAI-HC) assessment at admission, annually and/or when there is a change in their health condition. Health authority clinicians use the RAI-HC assessment tool, which uses standard assessment scales to measure a client's overall health status and clinical and functional needs to ensure personal service plans are developed according to their specific needs. The assessment information provides a snapshot of who is in publicly subsidized assisted living and allows comparison of trends over time.

Based on the latest assessment information,[9] the current profile of seniors (65+) in publicly subsidized assisted living shows the following:

- 85 years old on average (81 years on admission)
- 71% are female
- 16% are married
- 66% live alone
- 3% self identify as Indigenous
- 8% require language translation
- 25% have dementia (mild to severe)
- 29% have diabetes
- 73% have hypertension
- 19% have congestive heart failure
- 49% have MAPLe 4/5 (at risk or very high risk for long-term care placement)

In comparing these results with those of five years ago, we see some changing patterns in the demographic information:

- the proportion of females has decreased by 4%
- the proportion of residents who are married increased by 14%
- the proportion of residents with dementia has remained unchanged
- the proportion of residents with diabetes has increased by 14%
- the proportion of residents with congestive heart failure decreased by 7%
- the proportion of residents using a wheelchair has increased by 24%

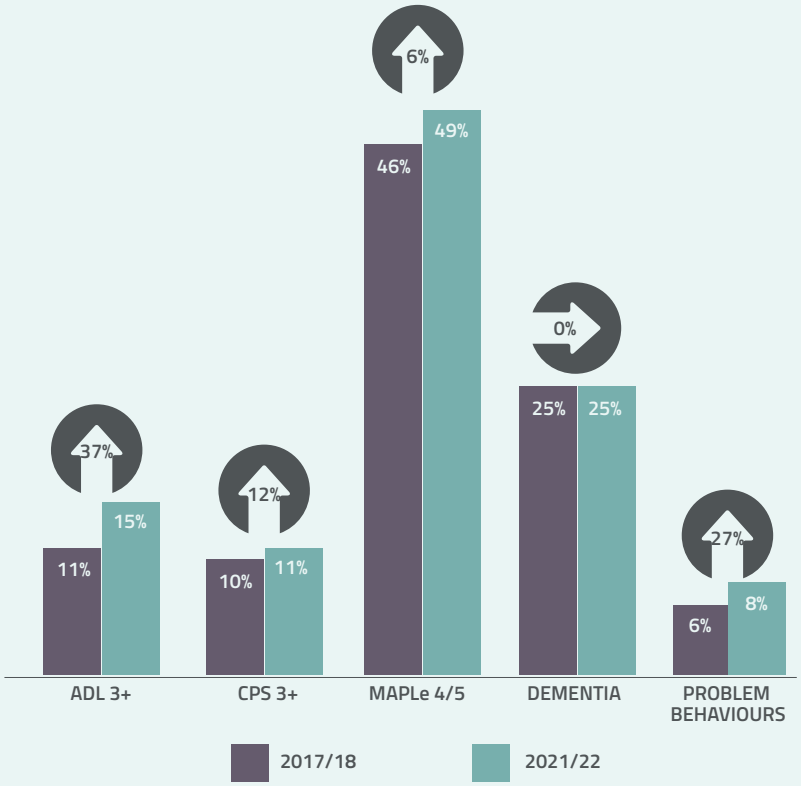
[9] Ministry of Health. Home and Community Care Minimum Reporting Requirements (HCC MRR) and Home Care Reporting System (HCRS)

CLINICAL INDICATORS

In addition to looking at the demographic profile, we also looked at the clinical data from the RAI-HC assessment to analyze measures across several clinical indicators:

- **Activities of Daily Living (ADL)** where an increasing score indicates a higher need for support with activities like bathing, dressing and eating;
- **Cognitive Performance Score (CPS)** where an increasing score indicates a higher need for support with making decisions, remembering tasks and solving problems;
- **Method for Assigning Priority Levels (MAPLe)** where a higher score (out of five) indicates higher urgency in allocating care and/or placement in long-term care;
- **Dementia** where a resident has been clinically diagnosed with Alzheimer's disease or other types of dementia; and
- **Problem Behaviours** where a higher score indicates a greater frequency and diversity of problem behaviours.

FIGURE 6: CLINICAL CHARACTERISTICS OF RESIDENTS (65+), 2017/18 AND 2021/22



These measures give a sense of the frailty and complexity of clients. Aging increases the risk of a senior developing frailty, which typically includes the presence of three or more of the following indicators:

- unintentional weight loss
- muscle loss and weakness
- fatigue
- slow walking speed
- low physical activity[10]

[10] Canadian Frailty Network. What is Frailty? [Online] https://www.cfn-nce.ca/frailty-matters/what-is-frailty/

The proportion of residents with a CPS 3+ has increased 12% over the past five years, indicating there is a higher proportion of residents with cognitive decline. The proportion of residents with an ADL 3+ (needing moderate to significant assistance) increased 37% in the same time period which is significant. This means there are more people needing close assistance to get out of bed, wash or bathe and get dressed. In addition, they will likely need a walker and possibly a wheelchair.

The proportion of residents who use a wheelchair has increased 24% over the last five years. An increase in wheelchair use indicates not only an increase in frailty of residents and the need for additional staff support, but also ensuring the building infrastructure and units, especially older buildings, meet the accessibility needs of residents. This includes accommodating wheelchairs or walkers in hallways, dining rooms and common areas, wider doorways and features such as modified cabinets in the bathroom and kitchenette.

The percentage of residents with a MAPLe score of 4+ increased 6% indicating individuals require a level of care that is provided by long-term care or increased home support services. The prevalence of residents with dementia or Alzheimer's disease has remained unchanged at 25%, while the prevalence of residents with problem behaviours increased 27%.

MEDICATION USE

Most older adults tend to take more medications than younger people because they are more likely to have more than one chronic health condition such as diabetes, arthritis, chronic pain and high blood pressure.[11] While medications are often necessary to help manage acute and chronic health conditions, the use of multiple medications may pose a higher risk of side effects or harm to older adults. Assisted living residents are responsible for getting their own prescriptions from their doctor, while the assisted living operator may assist with medication management. There is little oversight and monitoring of the type and frequency of medications such as antipsychotics, antidepressants and hypnotics administered in assisted living. Overall, the medication use of residents in publicly subsidized assisted living has increased over the past five years. The percentage of residents taking nine or more medications (i.e., polypharmacy) has increased 4%.

[11] Canadian Institute of Health Information (CIHI). Drug use among seniors in Canada. [Online] https://www.cihi.ca/en/drug-use-among-seniors-in-canada

TABLE 4: MEDICATION USE OF ASSISTED LIVING PUBLICLY SUBSIDIZED RESIDENTS (65+), 2017/18 AND 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22	% CHANGE IN 5 YEARS
% TAKING 9 OR MORE MEDICATIONS	54%	53%	54%	56%	56%	4%
% TAKING ANTIPSYCHOTICS WITHOUT A DIAGNOSIS OF PSYCHOSIS	4%	4%	5%	6%	6%	29%
% TAKING ANTIDEPRESSANTS	34%	35%	37%	37%	37%	8%
% TAKING HYPNOTICS OR ANALGESICS	49%	52%	53%	54%	55%	14%

Assisted living residents need to be able to make decisions related to safety or have a spouse present who can do so for them. This generally excludes people with a known diagnosis of dementia. Antipsychotic medications are sometimes used to manage difficult behaviours associated with dementia and are associated with an increased risk of side effects including sedation, falls and fractures, drop in blood pressure, stroke and death.[12] There continues to be a widespread problem with the inappropriate use of antipsychotics among older adults without a diagnosis of psychosis.

In 2021/22, 6% of assisted living residents and 28% of long-term care residents were taking antipsychotics without a diagnosis of psychosis. This proportion has increased by 29% and 10% respectively over the past five years. Behavioral care planning as well as environmental factors can assist with managing challenging behaviors related to cognitive changes. This need is likely to persist and increase as our population ages and requires more complex care.

SOCIAL ISOLATION AND LONELINESS

Seniors were particularly vulnerable to social isolation and loneliness during the COVID-19 pandemic and 29% of assisted living residents reported feelings of loneliness at that time; there has also been an overall reported increase of 22% over the past five years. Assisted living operators play a key role in ensuring adequate engagement and social opportunities for people who call assisted living home. Improvements in this aspect of experience can help improve seniors' cognitive function and support their physical, mental and emotional well-being.

[12] Canadian Institute of Health Information (CIHI). Use of Antipsychotics Among Seniors Living in Long-Term Care Facilities, 2014. [Online] Use of Antipsychotics Among Seniors Living in Long-Term Care Facilities, 2014 (cihi.ca). 2016.

Operators told us that people in assisted living are engaging less in group activities due to mobility issues, cognitive decline, and general frailty. They felt that there is an increasing need for qualified therapeutic recreational professionals. Two health authorities are piloting the use of occupational therapy and physiotherapy to assist resident activation and rehabilitation. One health authority has piloted funding an operator to hire a recreational therapist position.

HOSPITAL UTILIZATION

Although every effort is made to ensure personal assistance needs are met at home, residents in assisted living access care at hospitals similar to the rest of the population. We looked at unscheduled admissions to hospital over the past three years for assisted living residents, and in particular falls that resulted in fracture or injury requiring an overnight stay in acute care. We found that:

- 40% of assisted living residents experienced one or more hospitalizations. This rate has remained relatively unchanged over the last three years; and
- Of the assisted living residents who had one or more hospital stays, about 84% returned to their residence and 16% transferred to long-term care after hospitalization.

There is a slight increase (2%) in the percentage of assisted living residents who transfer to long-term care after hospitalization in the last three years. Based on a three-year average, the majority of unplanned hospital admissions for assisted living residents are attributed to:

- circulatory conditions (16%)
- general symptoms such as cachexia (muscle wasting and weight loss) and fatigue/malaise (13%)
- respiratory conditions including chronic obstructive pulmonary disease (COPD), influenza and pneumonia (13%)
- injuries (13%)
- urinary infections (8%)

[13] Assisted Living Registry, Assisted Living Regulation - Fact-Sheet Transition Plan and Planning [Online] https://www2.gov.bc.ca/assets/gov/health/accessing-health-care/assisted-living-registry/transition-plan-and-planning.pdf- Accessed May 2, 2023.
[14] Figures count clients as direct transfer when admission into LTC happens within two days of discharge from assisted living.
[15] Canadian Frailty Network. What is Frailty? [Online] https://www.cfn-nce.ca/frailty-matters/what-is-frailty/

TRANSITIONING FROM PUBLICLY SUBSIDIZED ASSISTED LIVING TO LONG-TERM CARE

While the majority of seniors in assisted living will live there until they pass away, some need to transition to the higher level of care offered in long-term care. As their needs change and they may no longer meet the criteria for assisted living, residents and their caregivers may start to look at possibilities for transferring to a more suitable level of care. Under Section 4 of the Assisted Living Regulation, operators are required to develop a transition plan for residents who will be moving out of assisted living because:[13] their needs can no longer be met; they can no longer live safely; they no longer need assisted living services, and/or they have stated their intention to move out.

In 2021/22, 11% of subsidized assisted living residents directly transferred to long-term care[14] and this trend has held relatively constant over the past five years. When we followed a cohort of residents for five years, we found that for seniors (65+) living in publicly subsidized assisted living between 2018 to 2022, the majority (57%) had either died or were still residing in assisted living and 43% had been transferred to long-term care where they were either still residing or had died.

Overall, data is showing seniors in subsidized assisted living are becoming increasingly frail with more care needs. Frail seniors are more vulnerable to the impacts of minor illnesses and are at higher risk of hospital admission and needing complex care. They are also more likely to fall and experience injury.[15]

Frailty is an age-related, multi-determined health state. As the degree of frailty increases, the risk for adverse health outcomes increases. It relates to aging across the life-course....it is never too late to get fit, less frail...

- Dr. Kenneth Rockwood

As we examine the current state of subsidized assisted living and plan for the future, it is clear that operators must be supported to provide expanded services to residents as their personal assistance needs change. This flexibility will enable assisted living residents to age in place and remain at home as long as possible, mitigating the need for expensive complex care/long-term care and/or hospital admission. The expanded services allowed within the enhanced CCALA allow this from a statutory perspective and operators, health authorities and community partners now need to put processes in place to provide these services.

For those who reside in private pay assisted living, similar to those who reside in private pay long-term care, there are no data or reporting requirements to tell us about the health conditions, hospitalization experience or length of stay of private pay assisted living residences. As a result, we cannot compare those who live in subsidized assisted living with those who reside in private pay.

COST OF ASSISTED LIVING FOR RESIDENTS

In B.C., seniors in publicly subsidized assisted living pay a monthly rate equal to 70% of their after-tax income (government pays the operator the difference between the amount the resident pays and the actual cost of the assisted living services). The rate covers the rental accommodation, hospitality services, assisted living services and emergency response. Unlike long-term care, the rate does not include the cost of medications, equipment, medical supplies or a third meal (some sites do provide three meals, but is not required) or personal laundry.

There is no restraint that is currently recognized on what private pay assisted living operators can charge and residents pay 100% of costs. The costs for private pay assisted living can vary widely across the province depending on the location, size of the unit and the level of personal services required by the resident. Most private pay assisted living operators charge a flat amount each month for rent and hospitality services and then charge for each individual service that a resident might require.

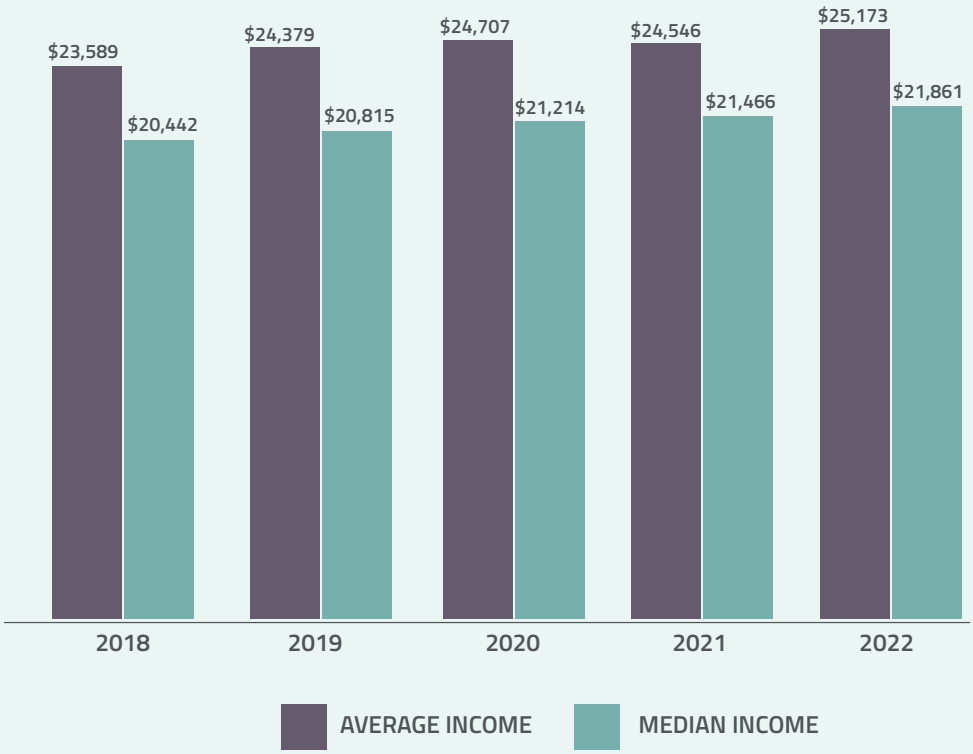
In both publicly subsidized and private pay assisted living, there are other optional costs that are not included in the monthly rate. Examples include: medications, medical equipment and supplies, household supplies, planned outings or special events, personal laundry and grooming services such as hair and nails.

CLIENT FEES IN PUBLICLY SUBSIDIZED ASSISTED LIVING

The Ministry of Health's policies and client rate formula for publicly subsidized assisted living are intended to ensure that all B.C. seniors, regardless of their income, can afford publicly subsidized assisted living with those greatest in need and urgency placed first.

Last year, the average client fee in publicly subsidized assisted living was $1,468 per month or $17,621 per year and the median client contribution fee was $1,275 per month or $15,303 per year. Based on these amounts, we calculated the average and median after-tax income for assisted living residents to be $25,173 and $21,861. These income amounts are similar to seniors living on low incomes who rely on government pensions such as Old Age Security (OAS) and Guaranteed Income Supplement (GIS).

FIGURE 7: ESTIMATED AVERAGE AND MEDIAN INCOME OF RESIDENTS IN PUBLICLY SUBSIDIZED ASSISTED LIVING, 2018 TO 2022



The Ministry of Health adjusts the minimum client rates for publicly subsidized assisted living annually. As of January 2023, the minimum monthly rate for a single senior is $1,093 and $1,666 for a couple.[16]

However, the maximum client rate is not regulated in the same way. The maximum client rates are determined by each health authority and are "based on a combination of the market rent for the housing and hospitality services for the geographic area where the client is receiving assisted living services and the actual cost of the personal care services for the client."[17]

[16] Based on the monthly maximum total amount for single person (or couple) of OAS and GIS on July 1 of the year two years prior multiplied by 0.70 and rounded down to the nearest $0.10.
[17] BC Ministry of Health. Home and Community Care Policy Manual, Chapter 7, Section B.2, Page 2.

Table 5 shows the range in maximum client rates across the province, from $2,350 to $4,765 for single persons and from $2,850 to $8,112 for couples. In some health authorities, the maximum client rate for a single person is higher than the regulated maximum client rate for publicly subsidized long-term care residents, which is set at $3,847. In some cases the maximum rates (assisted living) are similar to those in private pay assisted living sites. It is evident there is opportunity to review and streamline rates in light of affordability and variation.

TABLE 5: HEALTH AUTHORITY MAXIMUM CLIENT RATES FOR PUBLICLY SUBSIDIZED ASSISTED LIVING, AS OF JANUARY 2023

	SINGLES	COUPLES	GENERAL INFORMATION
IHA	$3,243 - $4,765	$3,743 - $8,112	The rate for couples depends on their type of accommodation (studio or one bedroom) and whether one or both residents are receiving care.
FHA	$3,839 - $4,465	$4,339 - $4,990	The rate varies only by type of accommodation.
VCHA	$2,350 - $3,530	$2,850 - $4,030	Rates vary by both type of accommodation and whether the residence is rural or urban.
VIHA	$3,250	$3,750 - $4,750	The single rate is the same regardless of accommodation and the couple rate varies depending on whether one or both residents are receiving care.
NHA	$2,732 - $3,622	$4,464 - $5,354	The rates do not vary by community or site. The highest amount represents the cost of a two-bedroom unit.

CLIENT FEES IN PRIVATE PAY ASSISTED LIVING

The BC Seniors Living Association (BCSLA) 2017 survey on the cost of private pay assisted living reported median rental rates for a studio at $2,558, one bedroom at $3,818 and two bedrooms at $3,775. A more recent survey of private pay assisted living costs in B.C. by Comfort Life, reported costs for select communities starting from $2,700 and up to $4,500 or more per month. These costs do not include any personal assistance services needed by the resident which would either be covered under the home support program if appropriate or charged as an additional fee. The cost of private pay assisted living can be cost prohibitive and unaffordable for most low to moderate income seniors.

TABLE 6: SURVEY OF PRIVATE PAY ASSISTED LIVING COSTS OF COMMUNITIES IN B.C.

	STARTING COST/ MONTH	ESTIMATEDANNUAL COST	1 HR PERSONAL ASSISTANCE /DAY	TOTAL COST
VICTORIA	$4,510	$54,120	$14,600	$68,720
VANCOUVER	$4,070	$48,840	$14,600	$63,440
BURNABY	$3,800	$45,600	$14,600	$60,200
NEW WESTMINSTER	$3,150	$37,800	$14,600	$52,400
KELOWNA	$2,700	$32,400	$14,600	$47,000
KAMLOOPS	$3,220	$38,640	$14,600	$53,240
RICHMOND	$4,200	$50,400	$14,600	$65,000

NOTE(S): Personal assistance costed at $40 per hour for 1 hour per day.

AFFORDABILITY

One of the many concerns the Office of the Seniors Advocate hears from seniors in publicly subsidized assisted living is not having enough money to pay for items that are not part of the monthly fees: these include but are not limited to the following:

- Cable, phone and internet connection and monthly fee
- Cost of additional groceries (only two meals are provided per day)
- Transportation and parking fees
- Personal grooming services and toiletries (i.e., hair, foot care)
- Tenant insurance
- Social outings
- Guest meals and suite rentals
- Personal laundry services
- Fees for pet damage and cleaning
- Administration fees associated with a service (i.e., medication delivery)
- Medications
- Equipment and supplies

To illustrate the financial hardship that many seniors living on fixed incomes face, a single senior who pays the median monthly client rate ($1,275) for publicly subsidized assisted living will have about $550 remaining to cover expenses not included in their monthly fees, but some of these are covered in long-term care. For example, assisted living only covers for two meals, not three, like long-term care. Also, long-term care will cover the costs of basic supplies like incontinence products, meal replacements, routine medical supplies, general

hygiene supplies (i.e., soap, shampoo, toilet paper) and 100% coverage for eligible prescriptions and medical supplies for permanent residents.

TABLE 7: COST TO A SINGLE SENIOR FOR PUBLICLY SUBSIDIZED ASSISTED LIVING VS LONG-TERM CARE (BASED ON MEDIAN ASSISTED LIVING CLIENT RATE AND INCOME), 2022

	ASSISTED LIVING	LONG-TERM CARE
MEDIAN ANNUAL INCOME	**$21,861**	
MONTHLY INCOME	**$1,822**	
CLIENT CONTRIBUTION FEE (70%, 80%)	**$1,275**	**$1,457**
EXPENSES		
GROCERIES (i.e. BREAKFAST, SNACKS)	$150	INCLUDED
MEDICATIONS AND PERSONAL SUPPLIES	$185	$50
CLOTHING AND PERSONAL ITEMS	$100	$75
PHONE, CABLE, INTERNET	$80	$60
TRANSPORTATION	$50	$30
SOCIAL ACTIVITIES AND OUTINGS	$40	$20
TENANT INSURANCE	$20	INCLUDED
TOTAL EXPENSES	**$625**	**$235**
BALANCE	**($78)**	**$129**

NOTE(S): See Appendix 3 for table notes..

With rising costs due to inflation, the remaining amount of income after modest living expenses for residents in publicly subsidized assisted living may not be adequate. As the example illustrates in Table 7, a senior earning the median income of $21,861 will spend more out-of-pocket to cover expenses in assisted living than long-term care. This is another example of the financial incentives for some seniors to move to long-term care earlier than necessary because of the lack of government assistance to help seniors live independently at home.

PRIVATE PAY ASSISTED LIVING CAN BE UNAFFORDABLE FOR MANY SENIORS

Private pay assisted living can be unaffordable for low to moderate income seniors, not only because of the monthly accommodation and hospitality fee, but also the personal assistance service charges that are in addition. Assisted living operators provide a fee list to residents for the cost of additional services such as medication assistance, dressing changes, morning and/or evening support, escort to meals and safety checks. These fees vary and can be per month, per service or by time blocks (i.e., 15 mins). Table 8 shows examples from three private pay assisted living operators for some of their hospitality and personal assistance service fees.

If a resident were to need assistance with getting up and dressed in the morning and evenings, help with getting to the dining room for meals and medication assistance each day, they would pay an additional $20,700 annually to Operator A. If they need more, they will have to pay more.

TABLE 8: EXAMPLES OF PRIVATE PAY ASSISTED LIVING SERVICES FEES:

PER SERVICE	PRIVATE OPERATOR A	PRIVATE OPERATOR B	PRIVATE OPERATOR C
CARE			
MEDICATION ASSISTANCE (1x DAILY)	$11.50	$10.35	$10.00*
BATHING	$23.00	$21.97	$20.00
ESCORT TO MEALS	$11.50	$8.10	$3.50
SAFETY CHECK	$11.50	$7.71	$5.00
GENERAL SERVICES (15 MINS)	$11.50	N/A	$12.00
HOUSEKEEPING			
PERSONAL LAUNDRY	$9.45	$15.99	$15.00
MEAL TRAY SERVICE	$5.25	$8.05	$5.00
ADDITIONAL HOUSEKEEPING (15 MINS)	$9.45	$18.17	$25.00 (1 HR)

NOTE(S): *up to 2x daily

In 2020, the average and median income for B.C. seniors (65+) was $47,660 and $32,990 and for older seniors (85+) it was $43,360 and $28,930 respectively. About one in four seniors live on less than $20,000 compared to a minimum wage earner of just over $30,000.

Table 9 illustrates the scenario of a single senior at three different incomes levels. It compares the cost of private pay assisted living at $3,500 and estimates of the additional living and personal care (i.e., daily home support) expenses and fees. As shown, even a senior with an income of $80,000 has very little income remaining to afford any additional service fees in assisted living or life expenses.

TABLE 9: SCENARIO OF ESTIMATED COST TO A SINGLE SENIOR FOR PRIVATE PAY ASSISTED LIVING

INCOME	SENIOR A	SENIOR B	SENIOR C
ANNUAL INCOME	**$35,000**	**$55,000**	**$80,000**
AFTER TAX INCOME	$32,500	$47,400	$64,700
MONTHLY INCOME	**$2,708**	**$3,950**	**$5,392**
MONTHLY EXPENSES			
ASSISTED LIVING FEE	$3,500	$3,500	$3,500
LIVING EXPENSES	$625	$625	$625
DAILY 1HR HOME SUPPORT	$920	$1,200	$1,200
TOTAL EXPENSES	**$5,045**	**$5,325**	**$5,325**
BALANCE	**($2,337)**	**($1,375)**	**$67**

NOTE(S): See Appendix 3 for table notes..

The cost of private pay assisted living can quickly outstrip the cost of publicly funded long-term care, where rates are capped at $3,847 per month. Some seniors prefer to pay more for the benefits of private pay assisted living. However, there will be others for whom it is cost prohibitive and, given the lack of publicly subsidized assisted living, will find themselves instead in long-term care even when their needs might be met in an assisted living setting.

TENANCY PROTECTION FOR PRIVATE PAY ASSISTED LIVING AND INDEPENDENT LIVING

Most British Columbians who rent their homes have rights and protections set out in the BC Residential Tenancy Act (RTA). This Act sets standards and protections for both tenants and landlords related to rent increases, evictions and other issues, and provides an avenue for dispute resolution through the Residential Tenancy Branch (RTB). The RTA also clearly defines who is not covered by the Act. Historically, it has been assumed that residents who live in seniors independent living or supportive housing are covered by the RTA and those who reside in assisted living are afforded the protections of the Community Care and Assisted Living Act (CCALA), but are not covered by the RTA.

Through this review, it was found that some operators of supportive or independent living have excluded their residents from the RTA but have not registered them with the Assisted Living Registry. This has effectively left a group of seniors without any protections against eviction, rent increases or any other landlord/tenant issues. Should a senior in this setting find themselves in receipt of an eviction notice, an unreasonable rent increase or any other landlord/tenant issue they would not be able to seek remedy from the RTB as their tenancy has been deemed exempt from the RTA. At the same time, they cannot seek remedy from the Assisted Living Registrar as they are not a registered assisted living resident under the Act. The RTB issued a policy directive in February 2023 clarifying seniors supportive and independent living as they relate to the protections of the RTA.[18] It is unknown at this time how many operators, if any, have reversed their practice as a result of the policy directive.

Despite the long-held practice of excluding assisted living from the protections of the RTA, this review found no language in either the RTA or the CCALA to support this exclusion. Since the inception of the CCALA it has been widely assumed assisted living was exempt from the provisions of the RTA. This assumption was reinforced by the provincial government when it passed the Tenancy Statutes Amendment Act (Bill 27) in 2006. This would have extended the RTA to explicitly include residents of assisted living residences, (to date, the amendments have not been enacted) and again in the 2012 *The Best of Care* report by the provincial Ombudsperson where the need to include assisted living in the RTA was recommended.

The RTA designates certain tenancies to be excluded from its application. These **exclusions** are found in Section 4 of the Act and include:

(g) living accomodation

(i) in a community care facility under the Community Care and Assisted Living Act,

(ii) in a continuing care facility under the Continuing Care Act,

(iii) in a public or private hospital under the Hospital Act,

(iv) if designated under the Mental Health Act, in a Provincial mental health facility, an observation unit or a psychiatric unit,

(v) in a housing-based health facility that provides hospitality support services and personal health care, or

(vi) that is made available in the course of providing rehabilitative or therapeutic treatment or services.

[18] Province of B.C. Residential Tenancy Policy Guideline: 46. Transitional Housing, Supportive Housing, Health Facilities, and Rehabilitative and Therapeutic Housing. [Online] February, 2023. ttps://www2.gov.bc.ca/assets/gov/housing-and-tenancy/residential-tenancies/policy-guidelines/gl46.pdf

Some may assume that assisted living is explicitly excluded under g(i), however this is specific to a community care facility. In the CCALA, '**assisted living residence**' means a premises or part of a premises, **other than a community care facility**:

(a) in which housing, hospitality services and assisted living services are provided by or through the operator to 3 or more adults who

(i) are not related by blood or marriage to the operator of the premises, and

(ii) do not require, on a regular basis, unscheduled professional health services, or

(b) designated by the Lieutenant Governor in Council to be an assisted living residence;

Exclusion based on section 4(g)(v) of the RTA is arguably pertaining to long-term care facilities providing personal health care to individuals who may not have decision making capacity. Care in these settings is provided by regulated health care professionals. Both criteria are specifically excluded from application to assisted living, and operating as a health facility without appropriate licensing is in violation of other provincial statutes. In assisted living legislation, there is no language to support the provision of personal health care. The CCALA refers to the provision of hospitality services and assisted living services only.

Given the existing language in the legislation it is unclear that an amendment to specifically include assisted living in the RTA is required as it can be argued it is covered under existing legislation. Further discussion on the issue is required with the Ministry of Health, the Ministry of Attorney General and the Ministry of Housing.

WHAT ARE WE HEARING FROM SENIORS?

Over the last three and a half years, the Office of the Seniors Advocate has been contacted many times by seniors facing unaffordable rent increases outside of the amount allowable by the RTA. In several instances, the person contacting the Office of the Seniors Advocate was doing so on behalf of an entire building, raising the concern for dozens of other seniors. Data from the Office of the Seniors Advocate's Information and Referral phone line shows an increasing trend since 2019 in complaints related to unaffordable rent increases in both independent living and assisted living settings, often paired with confusion as to whether the RTA applies to a given residence and the jurisdiction of CCALA. The trend has particularly risen over the last three years as inflation has increased yet rent increases under the RTA have been capped below inflation, creating a significant financial incentive for landlords to argue they are RTA-exempt. [19]

[19] See e.g. Residential Tenancy Regulation, B.C. Reg. 477/2003, s. 22.1.

When a private pay assisted living or independent living tenant takes an issue such as a large rent increase through the RTB dispute resolution process, some landlords have successfully argued that independent living and private assisted living settings are excluded from provincial tenancy protections. For those in independent living, this leaves the senior absolutely no protections, no regulatory oversight and no avenue for recourse should they find themselves in need of assistance. In assisted living settings, they are limited to support with respect to their services under the jurisdiction of the Assisted Living Registrar. In these two examples, the tenant could be summarily evicted, have their fees doubled or tripled, find their autonomy reduced and have no adjudicative body from which to seek remedy.

JOYCE'S STORY

Joyce lives in a private seniors independent living residence that provides help with laundering bedding, housekeeping and two meals a day as part of her service package. She is 92 and does not use the internet. She has a fixed income and some savings. Joyce recently received a letter from her residence notifying her that in two months, her monthly service fees and rent will be increasing by 13.5 percent. These increased costs were attributed to inflation. Joyce cannot afford these charges in her monthly budget, and questions whether her rent can be increased that much at once. She reached out to the operator for clarification and was told that the Residential Tenancy Act does not apply to her unit. She is worried about having to move and reaches out to the Office of the Seniors Advocate for advice.

Joyce's story of rent increases is but one example of the many raised by those who contact the Office of the Seniors Advocate. Not all increases are as high as those reflected in Joyce's story, but most are in excess than what is allowed under the RTA.

MONITORING QUALITY OF SERVICES IN ASSISTED LIVING

The Assisted Living Registrar (Registrar) is responsible for registering assisted living residences, monitoring their operations and ensuring operators promote and protect the health and safety of residents to whom they provide services. The Registrar can take legal actions if needed when an operator is not promoting and protecting the health and safety of residents.

The Assisted Living Registry (Registry) acts on behalf of the Registrar and publishes information about assisted living sites. Public information includes a summary of a complaint, the findings from an investigation, actions taken by an operator and information on an assisted living operator who is not meeting their health and safety responsibilities to residents.

Registry staff assess registration applications and recommend registrations, conduct site visits (both publicly subsidized and private pay assisted living sites), investigate complaints or reportable incidents and investigate if an unregistered assisted living site is being operated (i.e., independent living units).

NO MECHANISM TO MEASURE COMPLIANCE TO CCALA AND ASSISTED LIVING REGULATIONS

The 2019 CCALA amendments strengthened the investigative powers of the Registrar. Registry staff can now conduct inspections or site visits to monitor an operator's general compliance with the Act and Regulation. The Registry reviews all incident reports and complaints, and site inspections may result from these occurrences. However, there is no regular scheduled audit program, which would confirm compliance with the regulations. For example, the Regulation requires that prospective residents must be screened to ensure they are eligible for assisted living as set out in CCALA at the start of a residency and that residents receive policies concerning common areas, visitors etc. It also requires that a personal service plan must be developed within 30 days of any new resident's residency.

The development and implementation of a regular audit program would allow the Registry to review practice, conduct regular site visits for adherence to regulations by operators and ensure residents are receiving quality services. This would proactively support operators to better understand their responsibilities, ensure transparency and accountability in the system and provide seniors and their families with information to help inform decisions and instill confidence that their loved ones are safe and receiving quality care.

Since the changes to the CCALA in 2019, the total number of site inspections carried out has increased from 76 in 2019/20 to 84 in 2021/22. This represents 41% of all assisted living sites. In publicly funded long-term care we routinely see over 85% of sites inspected on an annual basis.

RESIDENT SATISFACTION SURVEYS

The Assisted Living Regulation requires operators in both publicly subsidized and private pay assisted living to conduct annual resident satisfaction surveys of all residents. The operator (registrant) must make a record describing the findings of the survey. However, the Regulation does not provide operators with any specific satisfaction measures or set out what information an operator is required to collect; most operators develop their own surveys.

Some health authorities receive summary results from publicly subsidized assisted living operators, while others do not receive any. A standard survey has not been developed nor required by the Regulation. At this time, the Registry does not monitor compliance whether an operator completes the annual survey. They can only assess the results of the survey during a complaint investigation and if relevant to the complaint.

Resident satisfaction surveys are a valuable tool and offer opportunities for residents to provide feedback and input into the quality of services and assistance provided in assisted living. The Assisted Living Regulation should be strengthened to include:

- a standard satisfaction survey
- the requirement for operators to submit the results of the survey to the Registry
- the requirement for operators to take action on negative feedback

CONCLUSIONS AND RECOMMENDATIONS

Assisted living is an important housing option to support us through the aging process. Many seniors and their families feel assisted living is a good choice for those who need some support with their activities of daily living but not the higher level of support provided in long-term care. It is also an option that is cost effective for the government. Publicly subsidized assisted living provides a supported living environment at half the cost of long-term care and a fraction of the cost of acute care. However, both publicly subsidized and private pay assisted living in B.C. have different but significant issues limiting their ability to meet the needs of all those who both want and would benefit from this type of housing.

The time to take action on assisted living is now. Our population is continuing to age and if we fail to address how this will impact the demand for affordable assisted living in the future, we will further exacerbate the pressures on our more costly long-term care and acute care systems. The lack of growth in publicly subsidized assisted living over the past five years is already being felt in long-term care. The waiting list and waiting times for long-term care are growing and we continue to have more than 10% of long-term care beds occupied by seniors who could be supported in a less costly setting such as assisted living. In addition, the current system is confusing to the public, operators and regulators.

We must address the systemic issues that are present in assisted living today with the goal of meeting the future needs of our aging population. It is recommended that government take the following critical actions:

1. **Significantly increase the capacity** of the publicly subsidized assisted living program with more units and expanded services. The demand is clear, and the cost effectiveness is compelling.
2. **Reduce the confusion** that seniors and their family members experience as they navigate assisted living and other congregate living arrangements. The public, the operators and the regulators need to clearly know what is assisted living, what is not and what services, oversight and protections apply to whom. Mixing different types of residencies in one building makes it difficult to achieve clarity. Consideration must be given to requiring all residents in a congregate setting to be under the same classification of tenancy.
3. **Provide explicit tenancy protection** under the Residential Tenancy Act for all residents in all congregate living settings including assisted living.
4. **Address affordability** issues in both publicly subsidized and private pay assisted living.
5. **Strengthen the effectiveness of current monitoring and enforcement systems** as they relate to quality assurance, resident safety and value for investment in publicly subsidized assisted living.

These recommendations offer a roadmap on the issues that need to be addressed if we are to develop an assisted living program in B.C. that is fair, transparent, accountable, affordable and keeps pace with growing demand. As we look to the future with our growing waitlists and costs in long-term care, now is the time to re-invest in a publicly subsidized assisted living program that meets the needs of our aging population.

APPENDIX 1 - DESCRIPTION OF INDEPENDENT LIVING AND ASSISTED LIVING IN B.C.

	INDEPENDENT LIVING	ASSISTED LIVING PUBLICLY SUBSIDIZED AND PRIVATE PAY
NUMBER OF UNITS IN BC	**20,656**	**8,428 units**
DESCRIPTION	▪ Private pay self-contained housing (rented or owned)	▪ Private self-contained housing, hospitality and assisted living services
SERVICES	▪ Varies between operators ▪ Additional fee-for-service ▪ Services offered by the operator may include: hospitality services (meals, housekeeping, linen services), 24-hour emergency response and a range of social, recreational activities ▪ Person may qualify for publicly subsidized home support services or they can hire private services	Operator must provide: ▪ assisted living services ▪ minimum of two meals per day ▪ basic activity programming ▪ weekly housekeeping, laundering of towels and linen, access to laundry equipment for personal laundry; ▪ a 24-hour emergency response system Operator may provide: ▪ additional hospitality and personal assistance services at additional cost
FUNDING	▪ Private pay (people can apply for limited rent subsidy by BC Housing SAFER program)	▪ Publicly subsidized (income-tested) ▪ Private pay (people can apply for limited rent subsidy by BC Housing SAFER program)
ENTRY REQUIREMENTS	▪ Determined by operator	▪ Person be able to make decisions that are necessary to live safely (determined by health authority or operator)
REGULATORY OVERSIGHT (RELATED TO RESIDENCE AND SERVICES)	▪ Residential Tenancy Act ▪ Residential Tenancy Regulation ▪ Strata Properties Act	▪ Community Care and Assisted Living Act ▪ Assisted Living Regulation
POLICY (RELATED TO RESIDENCE AND SERVICES)	▪ Wide range including Municipal Standards (health and safety, maintenance)	▪ Ministry of Health, Home and Community Care and Health Authority policies (for publicly subsidized assisted living)
COMPLAINTS PROCESS	▪ Residential Tenancy Branch (for tenancy disputes) ▪ Residency Tenancy Dispute Resolution process ▪ Ombudsperson ▪ Provincial Courts	▪ Assisted Living Registry ▪ Health Authority Patient Care Quality Office and Review Board (for publicly subsidized assisted living) ▪ Patient Care Quality Review Board (for publicly subsidized assisted living) ▪ Ombudsperson ▪ Provincial Courts

APPENDIX 2 - GLOSSARY

ACTIVITIES OF DAILY LIVING (ADL) SCALE: The activities of daily living scale rates residents on their ability to perform a number of daily activities without assistance including washing, dressing, using the washroom and bathing. It provides a measure of the client's self-performance status based on items that reflect stages of loss (early, middle and late loss). A six-point scale is used with the higher scores representing a progressively greater loss of ability.

ASSISTED LIVING (AL): Assisted Living is a form of housing in which an apartment-like dwelling is combined with hospitality (meals and light housekeeping) and certain assisted living services. It can be seen as providing a middle congregate living option between independent living and long-term care.

ASSISTED LIVING RESIDENCE: A residence that provides housing, hospitality and assisted living services to three or more adults who are not related by blood or marriage to the operator of the premises.

ASSISTED LIVING REGISTRAR: The role of the Assisted Living Registrar is to register residences, to monitor their operations, and to work with operators/registrants to ensure that they protect the health and safety of residents to who they provide services. It is also the Registrar's role to take action, if needed, in circumstances where the operator is not protecting resident health and safety.

ASSISTED LIVING REGISTRY: The Assisted Living Registry, on behalf of the Registrar, assesses applications, answers questions, provides information and education, monitors operators for compliance with the Act and Regulation, investigates complaints and reports of unregistered assisted living residences and publishes information about assisted living residences.

CAMPUS OF CARE: A campus of care includes more than one level of housing, services and care. Different levels of care may be located in a single residence (in different areas) or group of buildings (e.g., assisted living services in one building and long-term care services in an adjacent building).

CLIENT RATE: Is the daily or monthly rate charged to a client for home support, assisted living, family care home, long term care services, including short-stay services, or adult day services.

COGNITIVE PERFORMANCE SCALE (**CPS**): The cognitive performance scale describes the cognitive status of a resident from a score of 0 indicating cognitive ability being fully intact, to a score of 6 indicating very severe impairment. CPS measures the ability of a person to make their own decisions, manage medications and money, and organize their day.

COMMUNITY HEALTH WORKERS (CHW) are also known as care aides, health care assistants or assisted living workers. They are frontline care providers in a variety of institutional and community settings including home support services, assisted living residences and long-term care facilities. To be eligible to work as a CHW in any publicly subsidized health care setting in BC, applicants must be registered with the BC Care Aide & Community Health Worker Registry.

CONTINUUM OF CARE: The continuum of care model is used to illustrate a range of care to seniors as their needs evolve across primary care, home care, independent living, assisted living, long-term care and hospital care.

FRAILTY: a state of increased vulnerability and functional impairment caused by cumulative declines across multiple systems.

INDEPENDENT LIVING (**IL**): is also referred to as private retirement homes and active living housing complexes. Usually includes some meals and hospitality services and may include some assistance with activities of daily living. IL for seniors is not publicly subsidized in BC.

INDEPENDENT LIVING BC (**ILBC**): Provincial program for the development of publicly subsidized assisted living units. ILBC is a partnership between BC Housing, regional health authorities, the Canada Mortgage and Housing Corporation (CMHC), and non-profit and private-market housing providers. Despite being called Independent Living BC, the program focuses on providing assisted living units for low-income seniors.

METHOD FOR ASSIGNING PRIORITY LEVELS (**MAPLe**): The MAPLe scale is a predictor of admission to long-term care and indicates possible caregiver stress. It differentiates clients into five priority levels, based on a broad range of indicators from the RAI data. A MAPLe score of over 3 is used as a strong indicator of need for long-term care.

OPERATOR: The assisted living operator is the company, individual, or non-profit society which owns and operates an assisted living residence. The operator enters into a contract with the health authority to provide assisted living services for publicly subsidized assisted living residents.

PERSONAL ASSISTANCE SERVICES include assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, cueing, bathing, grooming and toileting, as well as specific delegated nursing and rehabilitation tasks.

PRIVATE PAY RESIDENTS pay a fixed rate for the cost of their accommodation and services entirely from private means and enter into a formal tenancy agreement.

PUBLICLY SUBSIDIZED RESIDENTS pay a client rate, equivalent to 70% of their after-tax income, with the balance of the cost of their accommodation and services being subsidized by government.

RESIDENT: An adult who receives housing, hospitality services and assisted living services at an assisted living residence.

RESIDENCY AGREEMENT: the contract between the operator and an individual resident that sets out all of the expectations, rights and obligations of the resident and assisted living operator, including the services to be provided to that individual person, the charge to the client for those services and the conditions under which a client and/or spouse will be required to move out of an assisted living residence.

TENANT: The person(s) who signed a tenancy agreement to rent residential premises. If there is no written agreement, a tenant is the person who made a verbal agreement with the landlord to rent the residential property or site and to pay rent.

TENANCY AGREEMENT: is an agreement whether written or oral, expressed or implied, between a landlord and a tenant respecting possession of a rental unit, use of common areas and services and facilities, and includes a licence to occupy a rental unit.

APPENDIX 3 - DATA SOURCES

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TABLE NOTES:

TABLE 7: COST TO A SINGLE SENIOR FOR PUBLICLY SUBSIDIZED ASSISTED LIVING VS LONG-TERM CARE (BASED ON MEDIAN AL CLIENT RATE AND INCOME), 2022

1. See Figure 7: Estimated Average and Median Income of Residents in Publicly subsidized Assisted Living, 2018 to 2022.
2. Groceries are costed at $5.00 per day in AL for breakfast, snacks and household supplies. These items are all included in LTC.
3. Medications are estimated at $100 for personal and medical supplies, over-the-counter medication and $85 per month for incontinence supplies. In LTC these items are all included but we have estimated approximately $50 for items of personal preference.
4. Clothing and personal items includes specialized clothing and other personal needs which we have estimated as being somewhat less in LTC as clients are less active.
5. Phone, cable and internet are based on basic plans and is lower in LTC as most residents don't use the internet.
6. Transportation covers a bus pass, HandyDART and one or two taxi rides each month for medical or social appointments. In LTC we estimated $30 for one taxi trip per month.
7. Social activities are estimated at $10 per week in AL for one class or a coffee out and at $20 in LTC to participate in any activities.
8. Basic tenant insurance is required in AL but not in LTC.

TABLE 9: SCENARIO OF ESTIMATED COST TO A SINGLE SENIOR FOR PRIVATE PAY ASSISTED LIVING

1. After tax income is estimated using Wealthsimple tax calculator at Wealthsimple Tax | Free Online Tax Filing Software 2022 | CRA Netfile Certified
2. The assisted living fee is based on the estimated costs in Table 6.
3. The living expenses are found in Table 7.
4. The daily cost for one hour of home support is calculated as the maximum daily rate for a client on Home Support for one hour of care ($30.67 for a client with $35,000 income and $40 for a client with $55,000 or $80,000 income) and $40 as the approximate cost per hour for those using private care.

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NOTE: Unless otherwise stated, online material was accessed between January and June 2023.

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