ATTACHMENT 1

Assisted Living Review 2004
Summary of Basic Findings and Conclusions

1. The Independent Living Initiative as part of the wider Home and Community Care sector changes has been underway for 29 months and will take an almost equal length of time to complete.

2. As of September 30, 2004 VIHA had closed or downsized 597 existing residential care facility beds.

3. As of September 30, 2004 VIHA had added back 105 residential care beds and 207 assisted living units for a total of 312 units.

4. As of September 30, 2004 there has been a net loss of 205 residential care and assisted living units or 6.9% of the March 31, 2002 inventory.

5. The majority of closed and downsized facilities housed extended care and high intermediate care residents while the majority of their replacements (assisted living) cater to medium and low disability residents.

6. Residential care and assisted living are currently undersupplied. The Ministry of Health's Planning Model suggests a current shortfall of 325 combined units. The shortfall is a result of closing too many residential care beds too quickly and not having the alternatives (including assisted living) in place. This was predicted in 2002 and is in large part a function of the provincial government's fiscal restraint. The situation resembles the practice of most governmental "deinstitutionalization programs" where it fails to provide the alternatives ahead of the reductions in established programs.

7. In addition to assisted living residences, other home and community programs were to be enhanced (expanded) to offset reduced residential care.

8. Mentioning two programs, home support services and adult day centres. Home support has seen a 9% (205 person) average monthly increase in total clients over the last two years with a 2% increase in the total volume of services. Home support is increasingly going to higher care needs people at the expense of lower care needs persons.

   Adult day centres have seen a small 5% (20 person) increase over the last two years with a 1.2% increase in total days of attendance. Similar to home support services there has been a shift toward higher disability clients at the expense of lower disability residents.

9. There is a raft of changes being introduced in home and community care programs including respite services and primary care which will aid "community capacity" to help more people stay at home. They will take time to become established and their actual effect is unknown.

10. One of the main effects of the undersupply of residential care (and assisted living) is in the hospitals. While consistent information is difficult to obtain there are obvious signs of back-ups of people assessed and waiting residential care placement in hospitals. While shortages of residential care may not explain all the hospital back-ups it is a major factor.

11. Information on the numbers of people waiting by location and their average waiting times are included in the revised Wait List Summary Report. Highlights for 2003/04 include:

    - 80% of residential care placements occur within 90 days (down from 94% the previous year). Ninety days is the benchmark wait time for residential care placement.
    - The average wait time for persons placed in any given month is 48 days from hospital and 60 days in the community. These wait times are only for those placed in each reporting period which is 27% of the total number waiting. These short wait periods reflect that 55% of people placed are urgent placements and only 59% receive their preferred placement.
    - 195 people were not placed in the month reporting period, up 58% from 2002/03.
    - Of the 195 people unplaced each month, 116 are in hospital (79 the previous year) and 79 are in the community (46 the previous years).
    - Average wait times for those not placed in any given month is 91 days in hospital and 88 days in the community (no comparable data for the previous year).
    - The first five reporting periods for 2004/05 show a continuation in the trend of both increasing numbers waiting and increasing wait times in both in hospital and the community.

12. A review of annual statistics for the hospital based specialty geriatric programs shows most programs operating at virtual full capacity and evidence of considerable increases in the average length of stay for patients waiting residential care placements.

13. The effects of the current undersupply of residential care are also being felt in the seniors' independent housing market. The survey found that most residences have seen increasing disability amongst incoming residents, overstaying of residents requiring residential care, pressure from hospitals to accept patients above and beyond their capacity and higher costs. In some instances this is posing problems for residences which want to maintain their independent elderly mandate.

14. The remaining residential care facilities are also facing changes to a higher dependency in their residents. For the most part they have seen no operating funding increases to reflect higher acuity residents and insufficient capital funding to upgrade their buildings.

15. VIHA has another 258 units of assisted living approved or proposed with most of the completions by late 2005 or early 2006.

16. The next five years sees a high rate of growth of the over 85 populations (17% or 1,607 persons) which creates additional demand on assisted living and residential care.

17. The Ministry of Health Services appears to be encouraging Health Authorities to adopt a "high shift of residential care to community scenario" meaning the maximum feasible shift from residential care usage to assisted living. The high shift numbers for the Capital Region equate to 3,100 units with 2,300 residential care and 800 assisted living units.

18. There are currently 2,753 units, including 2,560 residential care and 193 assisted living units.

19. Inventory projection to 2006 is 3,077 total units including 2,580 residential care and 497 assisted living units. Forecast supply will therefore be slightly below the planning model with an oversupply of residential care (280) and an undersupply of assisted living units (303 units). From observations of how the system is operating in 2004 with the current number of residential care beds, questions about the effectiveness of assisted living to substitute for residential care, it is unrealistic to consider any further losses of residential care units (with or without additional assisted living units). The Ministry's high shift to community scenario is questionable.

20. Notwithstanding the reduction in publicly funded residential care, there has been very little private pay activity. Most of the private pay development has occurred in the independent housing sector and to a lesser extent, assisted living.

21. Additional assisted living units and various community initiatives including more respite, community bathing, adult day services and improved primary care have promise for the future. Their slowness in development has caused the problems being seen today and there is uncertainty of whether they can be supplied at levels sufficient to compensate for reduced residential care.