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VETERANS' LONG-TERM CARE NEEDS

A REVIEW OF ASSISTED LIVING OPTIONS FOR VETERANS

VETERANS OMBUDSMAN
REVIEW | FEBRUARY 2014

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Foreword

The content and findings of this paper were based on extensive open-source research and a review of available literature on Veterans health issues and the current state of Assisted Living in Canada, both in the public and private sectors.

The methodology and sources include:

- a review of Veterans Affairs Canada's (VAC) Veterans Independence Program, the Long-Term Care Program and the supporting legislation including the *Veterans Health Care Regulations;*
- a review of VAC's *Evaluation and Audit of the Veterans Independence Program* (July 2011) and the *Long-Term Care Community Facilities Audit* (February 2012);
- analysis of statistical information provided by VAC, Statistics Canada and the Canada Mortgage and Housing Corporation;
- consultation with the Veterans Ombudsman Advisory Council and other Veterans' stakeholder organizations; and
- consultations with regional health authorities who provide and manage senior and Veterans' health care at the local and provincial levels.

Online sources consulted and publications reviewed included the following:

- numerous provincial, regional and municipal health department websites regarding available assisted living health care services and supporting legislation;
- several private sector assisted living provider websites;
- Academic publications and research papers on gerontology and the state of assisted living in Canada and the United States;
- the Report of the Gerontological Advisory Council entitled *The Future of Health Benefits for Canada's War Veterans – Keeping the Promise;*
- Dr. Marcus Hollander's Continuing Care Research Project for VAC and the Government of Ontario;
- The Royal Canadian Legion's *Review and Determination of Housing Issues for Veterans and Seniors;*
- Dr. David Walker's report to the Ontario Ministry of Health and Long-Term Care: *Caring for Our Aging Population and Addressing Alternate Level of Care*
- McMaster University's Social and Economic Dimensions of an Aging Population research program's paper: *The Private Cost of Long-Term Care in Canada – Where You Live Matters;*
- U.S. Department of Health and Human Services' *Trends in Residential Long-Term Care – Use of Nursing Homes and Assisted Living and Characteristics of Facilities and Residents;* and
- World Health Organization's *Global Age-Friendly Cities: A Guide.*

Introduction

The challenges raised by the aging of Canada's population are well documented. The 2011 Canadian Census reveals that the number of seniors aged 65 and over increased 14.1 percent between 2006 and 2011 to nearly 5 million. Seniors also represent 14.1 percent of the Canadian population – a ratio that is projected to grow in the future. In addition, Statistics Canada reports that of all the five-year age groups that are enumerated, the 60 to 64 year-old group experienced the fastest growth rate increase at 29.1 percent, reinforcing the belief that population aging will accelerate in Canada in the coming years as the large baby boom generation, those born between 1946 and 1965, reaches 65 years old.[1]

It is commonly accepted that as the Canadian population gets older, the frequency and complexity of age-related health problems will also increase. This is true not only for the general population, but also for Veterans whose health status and medical conditions can be, and often are, related to their history of military service.

Historically, health care has been accessed based on individual needs and, where outside funding from government is not available, the ability to pay for the services that are required. Seniors, as well as older and younger Veterans who require varying levels of support due to their medical status, can be unique in that their health care needs are often interwoven with shelter requirements, and their desire to maintain their dignity and independence within their own residences for as long as medically possible. The health care services that are made available to these groups of clients (excluding acute care requirements) are normally delivered on a continuum, from independent living in one's home at one end of the spectrum to institutional long-term and palliative care at the other end.

There are a myriad of health care and housing options available for seniors and Veterans in Canada that fall somewhere in between the two extremes described above. It is those options, more commonly known as assisted living, which will be explored in this review, both in the publicly funded and client-paid sectors.

The review of assisted living options for Veterans is the third in a series of three papers produced by the Office of the Veterans Ombudsman (OVO) that examines the provision of health benefits by VAC to our Veterans, family members, survivors and caregivers. To complement this paper, the Office has published two related reviews:

> *Veterans' Long-Term Care Needs: a Review of the support provided by Veterans Affairs Canada through its Long-Term Care Program*[2] and *Veterans Long-Term Care Needs: a Review of the support provided by Veterans Affairs Canada through its Veterans Independence Program.*[3]

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[1] Statistics Canada, *The Canadian Population in 2011: Age and Sex*, *2011 Census* (Ottawa, Ontario, May 2012)

[2] Veterans Ombudsman. *A Review of the Support Provided by Veterans Affairs Canada Through Its Long-Term Care Program*, 2013.

[3] Veterans Ombudsman. *Veterans Long-Term Care Needs: a Review of the support provided by Veterans Affairs Canada through its Veterans Independence Program*, 2014.

Background

The provision of health care services for seniors and Veterans of all ages is a complex issue for both the federal and provincial levels of government. While the burden of funding health care rests primarily with the provinces, the federal government currently provides benefits to Veterans through a number of programs administered by VAC such as the Veterans Independence Program (VIP), Long-Term Care Program (LTC), and the Treatment and Supplementary Benefits (Programs of Choice), amongst others.

While the VIP and the LTC each address a specific health care need for Veterans, there may be a gap that exists in cases where it is no longer medically advisable or safe for a Veteran to reside at home because of failing health or increasing care requirements, but they are not unhealthy or disabled to an extent that would require them to be cared for in a long-term care facility. The addition of an assisted living option would not only benefit the Veterans whose health care needs would be better met, but would likely also afford the Federal Government a more cost-effective health care option than long-term care currently offered under the VIP as Intermediate Care. The cost for the VIP for fiscal year 2011/2012 was approximately 357 million dollars, of which 57 million was attributed to Intermediate Care costs.[4]

While this paper focuses primarily on provincially funded assisted living programs, in the privately funded sector there are numerous assisted living options marketed to Veterans and other seniors. Those options are generally quite expensive and not within reach for a large segment of the population. When faced with a declining health situation and the high cost of care, individuals can generally apply to their local health authority for financial assistance and placement in a facility that meets their approved care needs.

In order to qualify, applicants must meet basic eligibility requirements, and then undergo a health needs assessment and a means test to determine their eligibility for subsidized health services and housing. Unfortunately, there is a high demand for these services, so waiting lists and “first-bed available” policies for long-term care are common. Such policies require applicants to accept the first suitable bed that becomes available regardless of the preferences of the client or the location of the facility. Failure to accept the offered bed in a reasonable amount of time usually results in the client going to the bottom of the waiting list unless exceptional circumstances exist.

In order to assess the suitability of an assisted living option for Veterans, this review will examine the following areas:

- the concept of assisted living;
- assisted living housing options available across the country in both the public and private sector;
- the eligibility, accessibility and cost factors associated with the various options;
- the health care benefit programs currently offered by VAC; and

[4] Veterans Affairs Canada, *Facts and Figures*, December 2012

- whether assisted living is a viable and cost-effective alternative care option that is appropriate for certain Veterans, and bridges the gap between VIP and LTC.

Assisted Living: the Concept

As Canada's population ages, greater numbers of seniors will require ever-increasing levels of care. By 2031, the proportion of seniors in the population is projected to rise to 23 percent from the 2011 ratio of 14.1 percent. It is believed that by 2021, 29 percent of Canada's seniors will be in the 75 to 84 year-old age bracket while 13 percent will be age 85 and over.[5]

As of March 2012, an estimated 118,200 of Canada's War Service Veterans (WSV) were still alive. Of that number, approximately 107,600 served in World War II and 10,600 in Korea. The age of all War Service Veterans ranges from 75 to over 100 years, and the majority (85 percent) are male. The average age of Korean Veterans is 80. The average age of WWII Veterans is 88.[6]

These demographics suggest that the Canadian health care system will face pressures from seniors in the coming years because of their increasing numbers and the likelihood that their health will deteriorate and make it difficult, if not impossible, for them to remain in their homes. While most seniors may prefer to remain in their own homes, the reality is that many will not be able to do so without substantial support from the health care system. The same can be said for Canada's Veterans as many of them fall into this demographic cohort.

The desire to remain in one's own home cannot be understated. For seniors and Veterans alike, the ability to live in their own home represents more than just a roof over their heads. It symbolizes independence and reinforces their ability to make their own decisions. It is a tangible representation of their individuality and a guarantee of privacy. But more than anything else, it provides a safe haven for them to enjoy their golden years and live out their lives amongst their loved ones with dignity.

Further, remaining in one's home affords seniors and Veterans with a number of other intangible benefits that might be difficult to measure, but are essential elements in the maintenance of physical and emotional well-being, including:

- the ability to be supported directly by their partners or spouses;
- the maintenance of independence through the management of their own affairs;
- the proximity of family support;
- a network of friends and other seniors; and
- familiarity with their environment and surroundings.

All Canadian provinces and territories provide home care services and support that can assist seniors to remain in their homes as long as possible. The demand for home care is expected to increase, which may impact the provinces' abilities and financial resources to deliver this service. This is particularly significant for seniors and others with serious health conditions and disabilities that rely heavily on home-based care services

[5] Statistics Canada, *The Canadian Population in 2011: Age and Sex*, *2011 Census* (Ottawa, Ontario, May 2012)
[6] Veterans Affairs Canada, *Facts and Figures*, December 2012

for scheduled medical supervision and assistance with their activities of daily living (ADL). Were it not for these supports, many high-care individuals would have no alternative but to seek admission to a long-term care facility.

Long-term care facilities and publicly funded nursing homes have long been a part of the Canadian health care landscape. All provincial health ministries support long-term care programs in their jurisdictions, but there is increasing pressure to control the high cost of providing such care. Additionally, long waiting lists and wait times are a reality of the current long-term care system. Where long-term care beds are filled to capacity, many regional health authorities have instituted "first bed available" policies that require prospective long-term care patients to accept the first bed made available to them regardless of location or the patient's personal wishes. If they choose not to accept the bed offered to them, they are either removed from the waiting lists or deferred for a lengthy period of time before they can re-apply for admission. This can create additional stress for seniors who must remain in their own homes when their health is as such that they should be in a long-term care facility. They could also feel obliged to accept accommodation outside of their area of familiarity or, in rural areas for example, long distances away from family and friends. In some cases, because many long-term care facilities are operating at or near capacity, beds are being offered to only the frailest patients, leaving many needy seniors to find alternate care in the more expensive privately run retirement homes. Realistically though, many seniors simply cannot afford this type of care or accommodation.

Assisted Living for Seniors: A Definition

In order to have a common understanding of the concept of assisted living, it is important to define it and, if possible, place it on the existing Canadian care continuum. It will become evident that arriving at a universally accepted definition of assisted living is challenging and quite complex; there appear to be many interpretations of the term in use both in the publicly-funded and privately-funded sectors.

The concept of assisted living has emerged in recent years to fill a perceived gap in the housing/care continuum. It is a model of housing and care that has existed for many years in the United States and is becoming more prevalent in Canada. While assisted living is appropriate for anyone who, by virtue of their physical or emotional health status, can benefit from the medical and support services that are offered, the largest proportion of assisted living clients are in or approaching their senior years.

In its simplest form, assisted living refers to care that combines housing, support or hospitality services, and health care for people who require assistance with ADL and instrumental activities of daily living.

Activities of daily living could include:

- personal hygiene and bathing
- eating and meal preparation
- getting dressed
- laundry
- functional mobility

Instrumental activities of daily living could include:

- housekeeping
- taking medication as prescribed
- managing financial affairs
- shopping outside the residence
- the use of technology
- transportation

Because provincial health ministries regulate assisted living programs and facilities, the Canadian federal government does not, as a rule, define assisted living. The U.S. Department of Health and Human Services does describe assisted living as a care model that:

> "…emphasizes resident autonomy and privacy in a homelike, congregate community setting. Services typically include assistance with ADL, which include such personal care activities as bathing and dressing, but may be "unbundled"--provided by the facility or others on a fee-for-service basis, rather than included in the cost of residence. Long-term care, on the other hand,

concentrates more on medically-oriented services and disability rather than on providing a home-like living environment."[7]

On the care continuum, assisted living generally falls between home care at the lower end of the assistance spectrum and long-term care at the higher end. Because of the many different versions of assisted living in use in both the publicly-funded and privately-funded sectors, it is extremely difficult to place it accurately on the housing/care continuum. This can lead to confusion for anyone contemplating assisted living as an option and trying to differentiate it from the services offered in a conventional nursing home.

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[7] U.S. Department of Health and Human Services, *Trends in Residential Long-Term Care: Use of Nursing Homes and Assisted Living and Characteristics of Facilities and Residents,* Brenda C. Spillman, Korbin Liu, Carey McGilliard. November 2002.

Assisted Living: Eligibility, Accessibility and Cost Overview

Assisted living as a general care option is not suitable for everyone, as care needs differ from individual to individual. Generally, persons seeking assisted living options can no longer reside in their own homes because the state of their health has changed or declined significantly. Because of the increased demands that can be placed on spouses, family or friends, and the limitations of home care supports, seniors are forced to seek out alternative levels of care in order to cope with the medical challenges they may be facing. Although staying at home is no longer a safe option for them, they can fall short of the admission criteria for long-term care facilities and the intensive medical requirements that such facilities support.

Assisted living services for Canadian seniors are available in both the publicly funded and privately funded client-paid sectors. How subsidized services are delivered and paid for varies widely from province to province, from region to region and often from city to city. As the provinces are responsible for the provision of health care services under the *Canada Health Act*[8]*,* where it is available, subsidized assisted living is almost always at least partly funded by the provincial ministries of health through an arrangement with a local or regional health authority. The client usually pays for the room and board aspect of assisted living while the provincial government, in partnership with regional health authorities, takes care of the health care services that are part of the client's approved health care plan, prepared by the client's health care case manager. The client must pay for any other requested services that are not covered in the approved health care plan.

In order to be admitted to a publicly subsidized assisted living facility or program, clients normally undergo a standard health care needs assessment administered by the local or regional health authority. A case manager reviews the assessment and determines the level of care that each client requires then suggests the most appropriate level of care to meet the client's needs. Depending on the health status of the client, the case manager can suggest any one of several options on the health care continuum available in that specific jurisdiction. These options can range from remaining in the home with or without home care supports, to seeking admission into an assisted living program of some type, to applying for placement in a long-term care facility.

In many jurisdictions, the cost of room and board in an assisted living facility must be borne by the client. Where the client cannot afford the high cost of care and financial assistance is available, a means test is administered in order to determine how much the client will pay.

Generally, all sources of income and assets are taken into account, although some jurisdictions exclude Veterans' benefits from the calculation of net income and assets. Whether or not the client owns a home or other significant assets (investments, RRSPs, RESPs, insurance policies, etc.) can also be taken into consideration, sometimes resulting in the requirement to dispose of any number of assets to pay for their share

[8] Canada Health Act (R.S.C., 1985, c. C-6).

of the cost. Once the calculations are completed, the client can be asked to pay as much as 80 percent of their net monthly income as their contribution to the cost of shelter and care. That ratio does vary widely across the country, as does the formula used to calculate the ratio, but it is almost always based on the mandatory disclosure of assets, income sources and income tax return information.

Because of the high level of medical care and the requirement for professional medical personnel, long-term care is generally the most expensive of the care options available. It is ideally suited to clients who have the highest care needs and a requirement for intensive 24-hour per day medical observation and supervision. Home care, the least expensive option, is often recommended for seniors who can safely stay in their homes but need less costly support with their activities of daily living.

Assisted living can represent a cost-effective alternative, bridging the gap between long-term care and home care. Depending on the extent of the clients' needs and their ability to shoulder some of the costs, assisted living can be more cost effective for the provinces to finance than long-term care.

An example of a situation that could be addressed by assisted living is where an individual requires a high level of support to stay home safely, but not the extent of support provided by long-term care. Increased availability of assisted living could better address the individual's needs and serve as a more cost-effective alternative to providing the high level of support required to enable the individual to remain at home.

This is significant for VAC, as their health programs exist to address the needs of Veterans with health and social needs that are not adequately met through provincial health care systems or, individuals whose need for care is the result of a service-related injury. If cost savings can be realized by utilizing lower-cost assisted living options rather than long-term care (only when appropriate), there will be a strong incentive to do so.

One could conclude that there are additional advantages to be gained by provincial health authorities supporting assisted living. By increasing financial support and resources for assisted living, it is likely that many seniors who would have previously been recommended for long-term care could enter an assisted living care option, thereby reducing the strain on long-term care facilities, shrinking waiting lists, and ensuring that long-term care spaces are given to those frail patients who need them the most. Additionally, those seniors who are no longer able to stay in their own homes but require increased levels of care could access an alternative, and likely more appropriate level of care sooner, reducing the overall stress on the regional health authorities providing home care, on the long-term care system, on the families, and most importantly, on the seniors themselves.

Canadian Assisted Living Models

A review of existing assisting living models in Canada reveals that there are many different delivery models to consider, both in the publicly and privately-funded sectors. In order to understand their relationships to one another, and to facilitate a comparison to the type of support offered by long-term care and home care, we will examine several different models in terms of accessibility, eligibility and cost, but also from the assistance and support perspectives. Instead of looking at assisted living from a provincial, regional or population based perspective, this methodology enables the reader to more easily assess the various models and determine whether they are appropriate and cost-effective alternatives to long-term care and home care.

For the purposes of this review, eligibility will refer to the locally imposed criteria that a client must meet in order to be admitted to an assisted living model.

Accessibility will refer to whether wait lists or first-bed available policies exist for an assisted living model or facility. The length of waiting times are generally not found in the literature as they are a function of local vacancy rates and market conditions.

Cost will refer to the amount charged for monthly accommodation and services in a given assisted living model, if known. If the costs are solely paid for by the governing health authority, on a co-pay basis with the client, or solely paid for by the client, they will be identified as such. When a means test is administered to determine the co-pay amount for a client, the means test will be described in order to foster an understanding of the limits of the government subsidy.

Publicly Funded Assisted Living Models

Our research identified many different publicly funded models of assisted living in use across the country. The following table not only demonstrates the diversity of assisted living approaches found across the country, but also illustrates the variances in eligibility requirements, accessibility and cost of shelter/care. A comprehensive description of each assisted living model that was examined for this review can be found in Annex A.

Province	Name of assisted living model	Features	Eligibility	Accessibility	Cost	Means Test
British Columbia	Independent Living BC (Public)	Accessible apartments with meals and personal care, assistance with ADL, housekeeping and 24-hour emergency medical response.	Applicants must be competent. They need additional support but do not require institutional care. They must be at risk in their current environment.	Through Regional Health Authority. Health needs assessment and means test is mandatory. Waiting lists based on assessed priority.	70% of after-tax income. Combined income used for couples. Minimum $888 (single) or $1,418 (couple) per month.	Yes
Alberta	Designated Supportive Living (DSL)– Level 3 and Level 4 (Public)	Level 3 – Room and board with assistance with ADL and low-level medical care. Level 4 – Room and board with complex medical care.	Level 3 – Applicant can no longer safely stay at home, but is medically and physically stable. Level 4 – Complex medical needs managed safely on-site by a licensed practical nurse.	Through Local Health Authority. Needs assessment by Case Manager (Registered Nurse). DSL not appropriate for patients who are a risk to themselves or others. Subject to availability and waiting lists.	Room and board $1,650-$3,000/month.	Subsidy available but subject to means test.
Saskatchewan	Personal Care Homes (Private)	Privately owned and operated assisted living model. Generally provides assistance with ADL, room and board and basic emergency response.	No collective eligibility requirements as these facilities are privately owned. Medical needs assessments are conducted by the individual facility.	Availability driven by demand, occupancy, whether the client's needs can be met, along with their ability to pay.	Market driven	N/A
Manitoba	Supportive Housing for Seniors (Private facility, public health case managed)	Primarily for seniors, provides assistance with ADL. "Resident Companions" support clients at all times.	Clients usually require assistance managing physical limitations or conditions such as dementia.	Through Regional Health Authority, needs assessment used. Application directly to the residence of the client's choice. Subject to availability and vacancy.	Room and board $1,000-$2,500/month depending on the local housing market.	N/A

Province	Name of assisted living model	Features	Eligibility	Accessibility	Cost	Means Test
Ontario	Assisted Living for High-Risk Seniors (ALHRS) (In-home, public) or Assisted Living in Supportive Housing (ALSH)(Congregate living, public)	Attendant services, personal care, essential homemaking and an emergency response system.	ALHRS (in-home): Enriched in-home services for frail clients who do not need 24-hour care. Allows a higher-care client to remain in the home ALSH (congregate): Clients do not require 24-hour care but needs can't be met on a scheduled visit basis alone. Generally higher care needs than ALHRS.	Through the Community Care Access Centers (CCAC) Case Manager, health needs assessment used. Each support service requested has its own eligibility requirements. Subject to availability, waiting lists prioritized according to client condition and CCAC criteria.	ALHRS – Clients pay room and board, as they are cared for in their home. ALSH – Rents according to local market for non-profit housing ($600-$1500/month). Approved medical services are paid for by CCAC.	Subsidy available subject to income test.
Quebec	Intermediate Resource (Private facility, public health referral)	Privately run apartment-type facility providing assistance with ADL, meal preparation, personal hygiene and housekeeping.	Clients with decreased independence or who need assistance of up to three hours per day with their ADL. Not usually a permanent living arrangement – more often used as a transition model.	Local Health and Social Services Center refer clients. Health needs assessments used to determine eligibility. Intermediate resources not common across the province. Limited availability.	Maximum client co-payment of $1,132.80/ month.	Yes, when applying for a subsidy.
New Brunswick	Special Care Homes (Privately owned and operated for profit, public health case managed)	ADL such as dressing, bathing and grooming, assistance with housekeeping tasks such as cleaning, laundry, meal preparation and respite care.	For clients who require supervision and assistance with ADL but do not require high levels of care or supervision. Some special care homes offer enhanced services to seniors with dementia or physical frailty who require help with many ADL and IADL.	Accessed through Family and Community Health Services. Health needs assessment used. No information available for waiting lists.	Rates vary from facility to facility due to the for-profit status.	Yes, when applying for a subsidy.

Province	Name of assisted living model	Features	Eligibility	Accessibility	Cost	Means Test
Nova Scotia	Community Residence or "Residential Care Facility" (RCF) (Public)	CR – Family home for rented unit for three or less seniors. Assistance with ADL and minimal supervision. RCF – Supervision and personal care for 4 or more seniors.	Primarily for clients who have decreased physical or mental abilities, who require supervision or assistance with ADL.	Continuing Care Coordinator uses health needs assessment to develop an approved health care plan with services. Waiting lists a function of availability.	CR – $50.50/day RCF - $61.50/day Co-pay arrangement with the client.	Yes when applying for a subsidy.
Prince Edward Island	Community Care Facilities (Private, public health case managed)	Privately owned or co-op facilities for five or more residents provide assistance with ADL, housekeeping, meals and hygiene services.	Clients should not require 24-hour/day supervision or medical care.	Accessed through Home Care Office. Health needs assessment used to prepare an approved health care plan and services. Accessibility according to availability and vacancy.	Clients approved for these services can apply to the facility of their choice. Costs are market-driven.	Yes when applying for a subsidy.
Newfoundland	Personal Care Homes (Private, public health case managed)	Privately owned facilities that provide residents assistance with ADL and personal care.	Eligibility determined by the Regional Health Authorities through the administration of a health needs assessment.	The Health needs assessment determines the client's suitability for long-term care services generally. Accessibility depends on availability/vacancy	Costs are market-driven, however clients can apply for subsidies during the assessment process.	Yes when applying for a subsidy.

Private Sector Assisted Living

As the senior population demographic continues to increase in numbers, the privately owned and operated for-profit housing sector is readying itself to meet future demand. It is anticipated that the baby boomer cohort (those persons born between 1946 and 1965[9]), who will soon retire and need a different type of shelter than they've been accustomed to, will require ever-increasing levels of care to go along with their chosen housing option.

The retirement living industry in Canada tends to market its products along a similar shelter and care continuum as was described when reviewing publicly funded assisted living. In terms of housing, there are a number of options available in a wide price range:

- independent living
- retirement home
- retirement communities
- independent supportive living
- assisted living
- long-term care
- Alzheimer care
- palliative care

Similarly, the types of services that are available to seniors vary from one option to the next, but are essentially market-driven in terms of pricing.

It is not unusual to find retirement facilities that cater to more than one level of care. It is quite common to come across a retirement facility that caters to low, medium or high care clients in the same facility, and one that may also have contractual arrangements with the local health authority or other organization to provide subsidized assisted living to certain seniors who qualify. You can also find retirement buildings that are co-located with apartment buildings whose occupants are only tenants, with little or no demand for health support services other than perhaps emergency response.

There is an abundance of choices available to someone searching for a retirement home or an assisted living facility in the privately-funded sector. Most retirement homes or assisted living facilities in Canada operate at or near capacity most of the time. In spite of the high occupancy rate, there is an intensely competitive market amongst providers trying to attract potential clients.

The Canada Mortgage and Housing Corporation (CMHC) Seniors Housing Report (2012) reveals that the vacancy rate of standard spaces in seniors' housing residences remained relatively unchanged at 10.6 percent

[9] Statistics Canada, *Generations in Canada – Age and Sex, 2011 Census,* p.1

in 2012, compared to 10.7 percent in 2011.

The average rent for bachelor units and private rooms where at least one meal is included in the rent was $1,966 per month in 2012 across the country compared to $1,903 in 2011. Quebec posted the lowest average rent in 2012 at $1,410 while Ontario posted the highest average rent at $2,699.

Taking into account that total shelter care costs are normally based on rent plus a package of health support services, the average rent for a heavy care unit was $3,378 in 2012, down from $3,503 in 2011. The most expensive province in Canada was British Columbia at an average heavy care cost of $5,525.

Range of costs for privately-funded independent living home across Canada:[10]

British Columbia:	$1,510 to $5,209
Alberta:	$2,318 to $2,989
Saskatchewan:	$1,542 to $3,542
Manitoba:	$1,901 to $2,746
Ontario:	$1,489 to $5,586
Quebec:	$1,286 to $1,855
Maritimes:	$1,593 to $2,251

Eligibility for these facilities is often determined using similar health care needs assessment instruments as in the publicly-funded sector. Facility care coordinators will use the assessments to determine the suitability of the client to the facility for which admission is being sought. While the care coordinators will provide an opinion as to the suitability of the residence, it is generally up to the client to determine whether the facility they choose is the right one for them.

[10] Comfort Life, http://www.comfortlife.ca/financial-legal/retirement-cost

Programs offered by Veterans Affairs Canada

Over the years, VAC has sponsored various types of benefit programs that address the shelter/care needs of Veterans.

Veterans Independence Program

Under the Veterans Independence Program (VIP), formerly the "Aging Veterans Program", Veterans Affairs Canada manages its flagship home care and health support program.

> "The national Veterans Affairs Canada (VAC) home care program assists qualified Veterans, still-serving Canadian Forces (CF) disability pensioners[11], surviving spouses/primary caregivers, and certain civilians to maintain their health, quality of life and independence in their own home for as long as possible. At the point where care in the home is no longer possible, the VIP will assist in providing care in long-term care facilities in the community of the Veteran."[12]

The program objectives of the VIP are to:

- offer supportive service and intervene only to the extent that health needs cannot be met through personal and family support, or through provincial and community programs;
- recognize the right and responsibility of the individual to remain at home for as long as it is reasonable, safe and practical to receive VIP services;
- promote personal independence as well as personal and family responsibility in planning and providing care appropriate to the Veteran's health needs;
- encourage an independent lifestyle to whatever degree possible; and
- meet the health needs of Veterans in a cost-effective manner.

The VIP provides funding as a contribution towards health care support to Veterans in their homes. Under the home care benefit program a Veteran can receive funding for assistance with both activities of daily living (ADL) and instrumental activities of daily living (IADL) such as:

- ADL:
  - nutrition
  - personal care and hygiene
  - health and support services
- IADL:
  - housekeeping

[11] As a result of regulatory changes that have been enacted since the *Evaluation of the Veterans Independence Program (VIP), Final July 2011,* Audit and Evaluation Division, (VAC - July 2011) was published, still-serving Canadian Forces disability pensioners are no longer serviced by the VIP, and are the responsibility of the Department of National Defence

[12] Veterans Affairs Canada, *Evaluation of the Veterans Independence Program (VIP), Final July 2011,* Audit and Evaluation Division, (VAC - July 2011).

- ground maintenance
- transportation
- home adaptations

It is important to note that under the VIP, eligible Veterans who are residing in assisted living facilities, whether publicly subsidized or privately funded, can continue to receive VIP home care benefits even though they are not living in their privately-owned homes.

When Health Needs Increase – Continuation of Benefits

When the health status of a Veteran changes to the extent that they have been assessed as having a Type II or greater health need, and an appropriate bed is not available or the Veteran chooses for one reason or another to remain in the home, the program may allow for the continuation of home care benefits.

> "Type II Health Need: Means the need of a person for personal care on a continuing basis under the supervision of a health professional, where the person has a functional disability, has reached the apparent limit of recovery and has little need for diagnostic or therapeutic services."[13]

> "The intent is to recognize and take into consideration the client's right to self-determination in their choice of care setting, while striving for optimal health outcomes and being mindful of responsible spending". [14]

However, this provision is not intended to provide long-term chronic care in the Veteran's residence.

Intermediate Care

Amongst its benefit programs, the VIP provides funding as a contribution towards intermediate care, formerly known as Nursing Home Intermediate Care (NHIC). Intermediate care is the provision in a community facility, other than in a contract bed[15], of:

- daily nursing and personal care under the direction or supervision of qualified medical and nursing staff;
- assistance with the activities of daily living, and any social, recreational and other related services provided to meet the psychosocial needs of the residents of the facility; and
- accommodation and meals.

Eligibility for intermediate care is dependent on the Veteran's client-type and whether they meet one or more of

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13 Veterans Health Care Regulations, SOR/90-594, Sec 2 definitions, see also Annex B of this report

14 Veterans Affairs Canada, *Veterans Program Policy Manual, Continuation of VIP Services at Home,* policy directive, Jan 2008

15 Veterans Health Care Regulations, SOR/90-594, Sec 2 definitions, "contract bed" defined as a bed that is set aside in a community facility pursuant to a contractual arrangement entered into by the Minister for the adult residential care, Intermediate care or chronic care of certain veterans.

VAC's many eligibility criteria. Intermediate care is normally provided to a Veteran to meet a Type II health need.

Intermediate care can also be used when a Veteran's health is deteriorating to a point where they require long-term care immediately and they are unable to access it in a timely fashion. It can also be used when a Veteran has been discharged from a higher care level facility (acute care or otherwise) and is transitioning back to his home, but still requires a level of care and supervision that might not otherwise be available through home care supports.

Intermediate care closely resembles chronic care in that both types of care must be provided by a health professional. The difference between the two is in the level or amount of care the recipient needs.

Adult Residential Care (pre-1993, grandfathered)

In 1993, the Adult Residential Care Program that had previously been available to Veterans was removed as a VIP service. Those Veterans who were approved for the Adult Residential Care Program prior to the 1st of July 1993 were grandfathered for this type of care.[16] Adult residential care consists of care provided in a health care facility to meet a Type I health need.

"Type I Health Need: Means the need of a person for personal care and supervision on a continuing basis, where the person is ambulant or independently mobile but has decreased physical or mental faculties."[17]

Adult residential care was designed to address the Veteran's need for:

- personal and supervisory care;
- assistance with the activities of daily living, and any social, recreational and other related services to meet the psychosocial needs of the residents of the facility; and
- accommodation and meals.

Adult residential care, as it was delivered prior to its removal from VIP services, most closely resembled the type of care that would be offered under the assisted living approach to care, the subject of this review.

Respite Care

VAC recognizes the demanding nature of caregiving and the toll it can take on family members who look after and support Veterans. The VIP provides funding to eligible Veterans for respite care to ensure that family members have the opportunity to rest and recover from caregiving duties. While all provinces provide some form of respite care through their home care programs, each program differs in the type and level of services offered. VAC will supplement these respite programs in cases where they are not, or perhaps minimally,

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[16] As of February 12, 2014 there is only one living grandfathered client from the Adult Residential Care Program.
[17] Veterans Health Care Regulations, SOR/90-594, Sec 2 definitions. See also Annex B of this report

subsidized by the provinces.

Long-Term Care Program

Any Veteran who requires intermediate or chronic care and meets the eligibility requirements may receive a financial contribution towards the cost of that care from VAC. Veterans are expected to cover the cost of the accommodation and meals on a co-payment basis, subject to their ability to pay. Veterans who are receiving care because of a condition for which they are receiving a VAC disability pension or award, or for Veteran and civilian pensioners who are seriously disabled (i.e. they have a disability assessed at 78 percent or more) the full cost of long-term care is paid by VAC.

VAC will provide funding to eligible Veterans for accommodation and meals. Each province sets accommodation and meal fees for residents of long-term care facilities, also known as resident fees or co-payment. VAC establishes a maximum amount that Veterans must contribute to pay for long-term care that is equal to or lower than the lowest of all the provincial rates. Funding will be provided for the difference between the provincially set rates and the maximum standard contribution payable by the Veteran. As previously mentioned, in instances where care is required for a service-related disability or if the Veteran is seriously disabled, the full fee charged by the facility is covered by VAC. For other Veterans, household income and income exemptions are considered in calculating how much the Veteran is required to contribute. The maximum monthly amount that a Veteran may have to contribute is $925.15 (as of January 1, 2014).

Financial support is provided in three types of settings:

- Community beds in community facilities with other beds that provide nursing home care to eligible Veterans as well as other provincial residents;
- Contract beds in community facilities that have beds designated for priority access for eligible Veterans (Priority Access Beds – PAB's); and
- Departmental beds located at Ste. Anne's Hospital.[18]

[18] Veterans Ombudsman, *Veterans Long-Term Care Needs: A Review of the Support Provided by Veterans Affairs Canada Through its Long-Term Care Program,* May 2013.

Analysis of Data

Assisted Living: the Benefit

This review of assisted living options for seniors has shown that the concept of assisted living is still evolving on the Canadian landscape, evidenced by the wide range of assisted living models that were examined in both the publicly and privately-funded sectors. Although assisted living has been around for many years in the United States, there are encouraging signs that provincial health authorities are turning their attention to this shelter/care option for seniors. With the exception of the territories, every province in Canada provides some level of subsidized assisted living, even if it only subsidizes the health care support services that are part of a client's approved health care plan.

There is no doubt that keeping a senior out of a long-term care facility and in the community or in his or her own home is a more cost effective way of managing the health care issues that are specific to aging seniors, as long as their health status allows it. With the cost of long-term care continuing to increase at an alarming rate, many provincial health authorities are beginning to experiment with assisted living as a viable and cost effective shelter/care alternative.

Assisted Living: A Philosophy of Shelter/Care rather than a Model

As mentioned earlier in the review, one of the challenges of examining assisted living is coming up with a universally accepted definition of the concept, and then placing that concept on the shelter/care continuum. Because so many iterations and models of assisted living can be found in both the public and privately-funded arenas, perhaps it would be better to think of assisted living as a shelter/care philosophy or approach, rather than a specific model of shelter/care. Not only would it make it easier for government and health authorities to establish standards for the delivery of assisted living, it would facilitate the decision making process for seniors knowing they are buying into a service philosophy or approach rather than a specific level of housing combined with a package of support services. It would also remove the necessity of placing assisted living somewhere on the shelter/care continuum, reducing the confusion around the concept that currently exists.

What the Provinces are doing

It is encouraging to see that provincial health ministries are, for the most part, managing these programs by downloading the responsibility to local or regional health authorities. It is also encouraging to see that the local authorities are partnering with community health agencies and private interests to deliver assisted living to seniors who can benefit from this type of support.

Regional health authorities all seem to be determining eligibility using widely accepted health care needs assessment instruments. This consistent approach to assessing health needs, priority and overall eligibility

lends credibility and fairness to the process and enables seniors to have confidence that they are being given fair and equitable consideration when it comes to their health care needs. Wait list management criteria do seem to differ however, but priority generally seems to be given to the seniors who are in the most urgent need.[19]

The High Cost of Assisted Living for Low-Income Seniors

While many regional health authorities are united in their approach to determining eligibility, they are far from consistent on the way they determine the client's share of the co-pay contribution when applicable. We have seen a wide variance across the country in the approaches to subsidized assisted living and financial assistance for clients as well as some confusion in where the subsidies should come. Some subsidies that are available to clients are only available from federal assistance programs or from provincial income subsidy programs or other financial assistance programs sponsored by ministries or departments unrelated to the public health sector. These differing approaches to subsidies and financial assistance do raise questions about how financial policy directions affect seniors' shelter/care and their ability to pay for at least part of the cost.

As we have noted, certain jurisdictions subsidize long-term care and home care but do not subsidize assisted living – others subsidize all three care options. When assisted living is subsidized, generally accommodation costs are solely the responsibility of the resident, with health support services paid for, in whole or in part, by regional health authorities. This enables seniors and Veterans with adequate means to choose the level of accommodation they want (rather than what they might minimally need) but still have access to subsidized support services provided according to an approved health care plan created in partnership with the health authority. This approach empowers the senior to maintain their individuality and independence by participating in the decisions about their health care and shelter, with the health authority preserving a level of social responsibility for the well-being of seniors, stewardship of the subsidy levels and oversight of the process.

The difficulty of accessing assisted living becomes more evident as the income level of seniors (and Veterans) decreases and their choices of accommodation become more limited. Where assisted living subsidies are available, most often they are based on income and means tests. Quite often, the application processes for subsidized assisted living are complex and the quantity of information clients must provide for their income test can be overwhelming for seniors who have no one to assist them, or who do not understand why they have to provide so much detail. A more simple and straightforward income test process would go a long way to removing the high levels of stress and potential embarrassment that clients experience when they have to disclose their personal financial situations.

The income test process does, however, satisfy the requirement to determine income levels before approving subsidies, but the income and means tests used across the country vary widely in how gross/net income is

[19] Wait list management criteria can vary widely from region to region, however medical urgency, client safety, availability in a given geographical area and vacancy are all factors that can be taken into consideration.

calculated, and the extent to which income figures are used to calculate subsidies. As previously mentioned, the types of income that are included and excluded in income calculations also differ across the country. For instance, some provinces include Veterans' benefits in the calculation while others exclude them. Further to this, certain provinces require clients to use or dispose of personal assets, investments and savings to pay for care before any subsidies are approved. This can be problematic when significant assets such as family homes or farms are at stake or when other family members occupy real property.

As each province assesses eligibility for subsidies differently, there may be a perception that seniors in one province receive a greater subsidy compared to a similarly situated senior in another province. This is an important observation because VAC provides supplemental funding to eligible Veterans for long-term care and must ensure that all benefit recipients from coast-to-coast are treated in a fair and equitable manner.

Payers of Last Resort

Also challenging for VAC is the fact that two provinces, Nova Scotia and Prince Edward Island, take the position that they are "insurers (payers) of last resort". If a resident of either province has access to funding from sources other than the provincial health care plan, such as worker's compensation benefits, insurance claim settlements, court decisions or VAC benefits, they must seek payment from those sources first. This is problematic for VAC, as Veterans' benefits must be used to pay for accommodations and services first, before any funding is forthcoming from the province. Residents who have no access to any other source of benefits or income are eligible for coverage under their provincial plans without such preconditions.

It is not surprising to see the wide range of approaches to financing or subsidizing assisted living among the provinces. Clearly each province and region faces its own economic reality and decisions about if and how assisted living is financed depending on the individual situations. We are already seeing that in Ontario (where budget deficits are at record levels), there seems to be a much greater emphasis on providing care in the home (the Ontario Assisted Living Services for High Risk Seniors Program) than paying for accommodation and support in a publicly or privately-owned facility. In December 2012, the Ontario government announced health initiatives aimed at keeping seniors in their homes longer by providing enhanced health support services, which includes more visits from doctors and registered nurses. Included in the initiatives are generous tax credits for home adaptations and ramp construction designed to make the home safer and encourage seniors to remain in their homes in spite of their physical challenges.[20]

The Ontario approach to shelter/care may be a reflection of the higher cost of facility-based assisted living versus home care, enriched or traditional. This sentiment could make its way into other jurisdictions in the future, if the Ontario program is found to achieve the desired health care outcomes in a cost-effective manner.

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[20] Ontario Government, Ministry of Health and Long-Term Care, Archived News Release, *Keeping Ontarians Healthier at Home – McGuinty Government Providing More Access To Community Health Care,* http://news.ontario.ca/mohltc/en/2012/12/keeping-ontarians-healthier-at-home-2.html.

It could even lead health authorities to re-examine their practices and move away from subsidized facility-based care for seniors.

Abundance of Choice for Some

Although allusion was made to the wide variety of shelter/care options in both the publicly and privately-funded sectors, the abundance of options can only be seen as a positive for seniors. With many different housing and care options to choose from, finding a suitable assisted living option should be relatively easy, assuming that the client lives in a densely populated urban environment and that demand for this type of housing is low. Unfortunately, for those living in rural areas, the choices are not so plentiful. If a rural client is searching for an assisted living option, the likelihood of finding such accommodation in a rural setting is relatively low.

On a more positive note, programs such as Manitoba and Nova Scotia's "self-managed care" offer seniors an innovative way of managing their own care with financial support from regional health authorities. Seniors who qualify receive an hourly rate to hire, train and manage their own health care professionals from their home, subject to a contractual and reporting agreement with the regional health authority. Although seniors must be competent and willing to manage their own affairs, this program ensures that seniors are given the opportunity to actively participate in the execution of their health care plan, reinforcing their independence and fulfilling their desire to remain in their own homes.

Cost Benefit Analysis – Assisted Living vs. Long-Term Care

This review has examined the concept of assisted living as an appropriate and affordable shelter/care alternative for Veterans who, because of failing health or frailty, can no longer safely reside in their own homes but do not require the intensive medical supervision afforded by long-term care facilities.

Veterans who require in-home health and support services can request funding through VAC's Veterans Independence Program or VIP. Through the Long-term Care Program or LTC, VAC also provides financial assistance to eligible Veterans, who by virtue of declining health and need for intense medical supervision, require chronic or intermediate care.

Provincially Funded Long-Term Care

For eligible Veterans who require long-term care (i.e. chronic or intermediate care), VAC provides financial support towards the high cost of long-term care as well as benefits that complement those provided by provincial health authorities.[21]

Because provincially subsidized long-term care is comprised of a medical component and an accommodation

[21] Veterans Ombudsman, *Veterans Long-Term Care Needs: A Review of the Support Provided by Veterans Affairs Canada Through its Long-Term Care Program,* May 2013.

(or room and board) component, the costs of long-term care are paid for on a co-payment basis, shared between the client and the provincial health authority. Normally the client is responsible for the accommodation portion while the province picks up the costs of the required medical care and support. Should the client not be able to afford the co-payment, subsidies are available for asset and income-qualified individuals.

In most provinces, provincial health authorities establish the co-payment rates based on a complex funding formula and agreements with service providers on how they can access funding that has been allocated for long-term care. In addition to the revenue they receive from the client's co-payment that covers room and board, these formulas tend to limit the amounts that service providers can charge back to the province for the approved and subsidized services they provide to clients, thereby providing legislative control over how the funding is distributed. These funded services usually include nursing and personal care, support services, a food allowance and certain salaries. All other optional services that are requested by clients and do not meet the funding criteria are the sole responsibility of the client.

The standard of accommodation provided, the extent of the medical support required and type of program support services needed by the client all impact the overall cost of providing long-term care on a per patient basis, as do the provincial funding formulas in use across the country. Because of these factors, it is challenging to estimate with a high degree of certainty the actual cost to the provinces of providing subsidized long-term care. It is clear, however, that because of the higher degree of medical supervision generally required by long-term care clients, the cost of providing such services is likely to be proportionately higher to the provinces than it would be in an assisted living facility, one that provides a significantly lower level of nursing and medical support and a more independent lifestyle. On the other hand, the standard of accommodation in basic level subsidized long-term care is generally found to be somewhat lower than private-pay facilities, given that clients who can afford to pay for long-term care on their own tend to request more space and additional amenities. Clearly, residents have the option of upgrading their level of accommodation, but do so at a higher per diem cost.

Residents of long-term care facilities, whether client-paid or subsidized, are minimally housed in a hospital-type room, given three meals a day, obtain assistance with the ADL and receive an appropriate level of nursing and medical care as well as adequate program support given their assessed medical conditions.

In the Province of Ontario for example, the maximum regulated co-payment rates for long-term care are set at the following July 2013 levels:[22]

Type of accommodation	Daily rate	Monthly co-payment cost
Basic	$56.14	$1707.59

[22] http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx

Type of accommodation	Daily rate	Monthly co-payment cost
Semi-private	$66.14	$2011.76
Private	$77.64	$2,361.55

According to an Ontario Ministry of Health and Long-term Care news release dated May 30 2012, the government provides $152.94 per day in funding for a long-term care bed, for a total annual funding envelope of $55,823.10.[23] Ontario funding levels for 2013 were not available for this report. Using the 2012 figures and including the annual 2013 co-payment rate of $28,338.60, it would appear the combined publicly-funded and co-paid cost of occupying a private long-term care bed in the province of Ontario is approximately $84,161.70 per year. The cost for basic long-term care accommodation (ward level) comes in at approximately $76,314.20 per year, also using the 2013 co-payment rates. As mentioned previously, should the client not be able to afford the co-payment rates because of low personal income or asset levels, the cost of subsidizing the client's co-payment would be added to the above annual cost, although the funds would likely come from a different provincial budget envelope.

Under VAC's Long-term Care Program, for the calendar year 2013, the maximum amount payable for chronic care in a community facility other than in a contract bed is $239.10 per day, or $87,271.50 annually.[24]

Home Care and the Veterans Independence Program

As previously mentioned, eligible Veterans whose medical conditions require them to seek assistance with ADL can access funding for home care services and support through the Veterans Independence program. There are a number of funded services available to Veterans including:

- housekeeping
- grounds maintenance
- health and support services
- personal care
- access to nutrition
- home adaptations
- ambulatory health care
- transportation
- intermediate care in community facilities

The funding for these services is subject to maximum payable rates under the *Veterans Health Care Regulations*. The maximum amount payable for home care services, which includes up to the allowable

[23] http://news.ontario.ca/mohltc/en/2012/05/ontario-protecting-quality-in-long-term-care-homes.html
[24] Veterans Affairs Canada, *Veterans Health Care Regulations, SOR 90-594,* sec. 23(1)

maximum amounts for ground maintenance services, personal care services as well as the total amounts for housekeeping services, access to nutrition and health and support services, is $10,170.04 annually for 2013.

Grounds maintenance, ambulatory health care services, transportation services and home adaptations are limited annually to $1,419.18, $1,182.66, $1,419.18 and $5,819.08 respectively for 2013. As previously mentioned, intermediate care services most closely resemble the type of services available in assisted living facilities, are funded up to $142.49 per client per day ($4,334.07 per month) or $52,008.85 annually under the VIP.[25]

The advantages of supporting a Veteran's desire to safely remain in his or her home are clearly stated in this report and in the program objectives of the VIP. There also appears to be no dispute about the merits of supporting home care programs from a cost effectiveness perspective, as they provide necessary medical services and supports for aging Veterans at a very reasonable price point. When home care is appropriate from a medical standpoint, it has the added benefit of delaying and sometimes avoiding the necessity of admitting Veterans to chronic care where wait lists are common and the costs of care are the highest.

Assisted Living: Cost-Effective Alternative

Unfortunately, when the health status of a Veteran changes to the point where they can no longer safely remain at home, home care support can fall short of what is required to address the ever-increasing health care concerns that can arise, such as the need for on-site medical supervision and monitoring.

We have seen that assisted living can bridge that gap by ensuring that eligible Veterans have a safe environment in which to live, necessary supports with their ADL and appropriate medical care and supervision. From a financial perspective, assisted living also presents an opportunity for VAC to realize significant savings over what has traditionally been the answer to caring for Veterans who can no longer remain safely at home – long-term care. It is also interesting to note that VAC already funds intermediate care under the VIP to a maximum of $142.49 per client per day ($4,334.07/month) or $52,008.85 annually.[26]

At a relatively inexpensive cost average of about $3,400 per month nationally for basic heavy care accommodation[27], assisted living is cost-effective when compared to the medically unnecessary alternative of placing certain Veterans in long-term care, as long as their health permits or condition demands. When consideration is given to the fact that provincially subsidized home care services can also be made available to eligible residents of assisted living facilities in most provinces, the need for VAC to pay for home care services is diminished. The exception exists for Nova Scotia and P.E.I. however, who consider themselves "payers of last resort", and would normally require VAC to pay for all support services provided in long-term care. Particularly in the case of Nova Scotia and P.E.I., where VAC is expected to cover the entire cost of long-term care, assisted living represents significant potential savings over long-term care. By comparison, in Ontario, the

[25] Veterans Affairs Canada, *Veterans Health Care Regulations, SOR 90-594*, sec 20(1)
[26] Ibid.
[27] Canada Mortgage and Housing Corporation, *CMHC Seniors Housing Report – 2012*

savings are in the order of $25-30,000 per year when comparing the cost of assisted living to more expensive long-term care. When one considers that VAC will provide long-term care funding of $239.10 per day or $87,271.50 annually (as of January 2013)[28] for chronic care in a community bed and that the VIP is already spending in the order of 57 million dollar for FY 2011-2012 on intermediate care, the potential for significant savings is enormous.

Final Note on Seniors Accessing Information about Assisted Living

While conducting this review, locating relevant and up-to-date information was quite challenging at times. As this was open-source research, most of the subsidized assisted living information was found online, with specific attention paid to websites belonging to the federal government, provincial governments, ministries of health, local or regional health authorities and private retirement living websites.

With a few exceptions, finding relevant subsidized assisted living information on government websites was difficult. Much of the information that was obtained on subsidized assisted living was found on successive searches of related and unrelated websites, because there were few centralized information sources that spoke to the issues that concern seniors the most: eligibility, accessibility, cost and the processes for securing subsidies or financial assistance. Greater effort needs to go into making this information easily accessible and understandable, given the large number of seniors who will, no doubt, require it in the very near future.

[28] Veterans Affairs Canada, *Veterans Health Care Regulations, SOR 90-594,* sec. 23(1)

Annex A: Other Examples of Provincially Funded Assisted Living Options

A.1 Independent Living BC (British Columbia)

The government of British Columbia is one of the leaders in providing assisted living options to seniors and disabled adults. Since 2002, BC Housing has offered the Independent Living BC Program which offers both assisted living and supportive housing options for individuals who require assistance with their activities of daily living (ADL). Through Housing Matters BC, the province of British Columbia has created more than 4,300 affordable assisted living apartments for seniors and people with disabilities.

Assisted living in the province of British Columbia offers housing, hospitality and personal care services to clients who can live independently and make decisions on their own but require a supportive environment due to physical and functional health challenges.

Accommodations can range from a unit in a high-rise apartment complex to a unit within a private residence. They vary from a single room in size to private self-contained apartments. Services included in this model are:

- a private housing unit with a lockable door;
- personal care services (which may include assistance with ADL such as bathing, grooming, dressing and mobility or tasks delegated by a health care professional);
- two meals a day, one of which is the main meal;
- access to basic activities such as games, music and crafts;
- weekly housekeeping;
- laundering of towels and linen;
- access to laundry equipment for personal laundry;
- heating or cooling as necessary to maintain the safety of basic comfort level of the residence; and
- 24-hour emergency response system.

Eligibility:

In order to be considered for BC Housing subsidized assisted living, the client must first meet the general eligibility requirements for home and community care services. The client must:

- be a Canadian citizen (or have permanent resident status, or have been issued a temporary resident permit by the federal Minister of Immigration);
- have been a resident of British Columbia for at least three months; and
- be 19 years of age or older.

In addition to the general requirements for eligibility, there are specific requirements for assisted living. The client must:

- require both hospitality services and personal care services;
- be able to make decision on their own behalf that will allow them to function safely in an assisted living residence, or have a spouse who is going to be living with them and is willing and able to make decisions on the client's behalf;
- be at significant risk by remaining in the current living environment; and
- agree to pay the assessed client rate and any additional optional charges for services, programs or supplies that are not included as a benefit but are offered by the service provider.[29]

Once the eligibility requirements are met, the client must contact the Home and Community Care office at the local regional health authority to request a health needs assessment. During the assessment, the client's health history and current health issues will be reviewed along with their relative ability to cope with their general health situation. Contact may be made with the client's current health care professionals to better understand their health history and the medications that they may be taking. They will also be asked about how they manage their ADL and what supports they have access to including family and social supports, friendships, churches or other groups to which they belong. Finally, they will be asked to provide income information in order to undergo a means test. Once the assessment is completed, the client will understand exactly what their health care needs are, what assisted living services they are eligible for and what they will be required to pay.

Accessibility:

Once the client has been approved for assisted living, they will be offered a residence in their community if one is available. If not, they will be placed on a waiting list that is based on priority. Client needs, existing supports, availability and urgency will be used to determine the priority for a given client. Those with the greatest urgency receive access to services first; this ensures consistency in the way subsidized assisted living is granted to all prospective clients.

Cost:

Clients must pay a monthly rate that is based on 70 percent of their after-tax income, subject to a minimum and maximum rate. If the client is living with a spouse, the combined after-tax income is used to calculate the 70 percent co-pay. The minimum monthly rate for assisted living services is $880.10. The minimum rate for a couple living together is $1,418.90 per month.[30]

The maximum monthly rate for a client receiving assisted living services is based on a combination of the market rent for housing and hospitality services for the given geographic area as well as the actual cost of personal care services.

If the client cannot afford to pay the minimum rate, they can apply for assistance in the form of a Temporary Rate Reduction Due To Hardship.

[29] Government of British Columbia, Home and Community Care website

[30] Ibid.

A.2 British Columbia Housing's Senior Supportive Housing Program

BC Housing's Senior's Supportive Housing Program provides specially modified rental homes in selected buildings to low-income seniors who need assistance with ADL in order to continue living independently and stay in their homes longer. It involves the retrofitting and upgrading of existing seniors' housing and offers an inclusive package of support services. The upgrades to the units include:

- accessibility improvements (showers instead of bathtubs, grab bars for showers and toilets, handrails in hallways)
- fire and safety (lighting enhancements for exits/entrances and corridors, sprinklers and in-suite smoke detectors)

The Province of British Columbia funds this initiative. BC Housing oversees the program and directly manages some of the buildings. Non-profit operators manage others.
The package of support services include:

- one main meal per day
- 24-hour emergency response
- weekly light housekeeping
- weekly laundering of towels and linens
- social and recreational activities[31]

Eligibility:

The Seniors Supportive Housing Program is primarily for low-income seniors. Applicants must meet the following requirement.

General requirements:

- be 55 years of age or older;
- reside in British Columbia;
- be Canadian citizens not under sponsorship; and
- have a household income that does not exceed a certain limit according to the region in which they reside (driven by the cost of the rental market for the given region).

Specific to Seniors Supportive Housing:

- be able to manage their own lifestyles including reacting properly in an emergency situation;
- not be a risk to themselves or others;
- require a modified physical environment and support services to assist them to "age in place"; and

[31] Government of British Columbia, BC Housing website, Seniors Supportive Housing, http://www.bchousing.org/Options/Supportive_Housing/SSH/SSH

- not require a permanent level of support that exceeds the services available through Seniors Supportive Housing.[32]

Clients then apply to the Housing Registry so that their application is considered for available units managed by BC Housing and a number of non-profit and co-operative housing providers that use the database. The application form requires that applicants disclose their financial situation to determine eligibility, subject to income and asset ceilings.

Applicants are strongly urged to apply to non-Registry properties in order to improve their chances of securing supportive housing.

Accessibility:

Availability is driven by demand, occupancy and the facility's ability to meets the care needs of the applicants.

Cost:

Subject to the income and asset tests, seniors pay 50 percent of the gross household income for their housing, and this amount includes the package of support services. Of the 50 percent, 30 percent is allocated to accommodation and 20 percent to support services. Where the total cost of support services exceeds 20 percent of gross household income, BC Housing will provide a subsidy directly to the housing provider to cover the difference.[33]

Note:

There is no indication that VAC benefits would be excluded from the income and assets test that seniors must undergo to determine eligibility. Because of the strict income and asset limits established for low-income housing, this option may be difficult for some Veterans to access depending on their assets, VAC disability pensions and/or awards, and other sources of income.

A.3 Nova Scotia

Nova Scotia delivers subsidized senior housing and care through the Continuing Care Branch of the Department of Health and Wellness (provincial ministry). Seniors can access assisted living in two ways – through a community-based option or in a residential care facility.

One of two community-based options is known as a community residence. A community residence is a Department of Health and Wellness approved family home in which accommodation and minimal supervision is provided for three or less seniors who are not immediate family members of the operator. The intent of this

[32] Ibid, Seniors Supportive Housing Program (FAQ) QAs_SSH_Public_Final (2).doc. 23-10-2007 .
[33] Government of British Columbia, BC Housing website, Seniors Supportive Housing, http://www.bchousing.org/Options/Supportive_Housing/SSH/SSH (FAQ) QAs_SSH_Public_Final (2).doc 23-10-2007

type of housing is to assist the resident in the development of self-care skills. The other option is known as a small option home where support and supervision is provided to three or less seniors, but in a rented or purchased unit. Trained staff is available on site at all times. It is also intended for the development of self-care skills.

Residential Care Facilities are also licensed by the Department of Health and Wellness pursuant to the *Homes for Special Care Act*[34] and *Homes for Special Care Regulations*.[35] They provide supervisory care and personal care in a residential setting for four or more persons.

These assisted living options are designed primarily for persons who have decreased physical or mental abilities and who require supervision or assistance with the ADL and the provision of psycho-social needs through social and recreational activities.

Eligibility:

Generally, in order to qualify for subsidized housing and care, an applicant must:

- be 18 years of age or older;
- be a resident of Nova Scotia;
- be lawfully entitled to be or remain in Canada; and
- meet the eligibility requirements of the Nova Scotia Health Insurance Plan.[36]

If one or more of the following conditions are present, the applicant may be deemed ineligible:

- Require the services of a Registered Nurse (ongoing professional nursing assessment and care);
- Cannot ambulate on their own (with or without the assistance of a cane, wheelchair or walker);
- Do not have the physical or cognitive ability to evacuate independently in the event of an emergency;
- Require more than 1.5 hours of one-on-one care per day for supervision or assistance with ADL;
- Are consistently confused or an elopement risk; or
- Require complete assistance with ADL due to confusion or physical impairment.[37]

If an applicant meets the eligibility requirements, they must undergo a functional assessment using the Minimum Data Set - Home Care instrument. This process examines a person's functional, health and social situation and helps the continuing care coordinator recommend the most appropriate, cost effective and least intrusive health care plan and housing/care option.

[34] Government of Nova Scotia, Homes for Special Care Act
[35] Government of Nova Scotia, *Homes for Special Care Regulations*
[36] Government of Nova Scotia, Department of Health and Wellness, Continuing Care Branch, *Service Eligibility Policy*, Sec 4.0, General Eligibility
[37] Government of Nova Scotia, Department of Health and Wellness, Continuing Care Branch, *Service Eligibility Policy*, Sec 5.5.2.1, Residential Care Facilities and Community-Based Options

Accessibility:

Assuming there is space available in the recommended housing/care option, the continuing care coordinator informs the Placement Coordination office of the client's specific care needs and personal preferences. Where the two conflict for the choice of a suitable facility, the client's care needs must be met first.

Cost:

Along with Prince Edward Island, Nova Scotia considers itself an "insurer of last resort for the payment of health care costs and accommodation costs". In other words, the full per diem rate for residential care facilities or community-based options is charged to individuals who are the responsibility of VAC. Residents who are not affiliated with VAC are only responsible for accommodation costs.

Clients can apply for a reduction in their accommodation costs but must undergo an income test to do so. Generally, if 85 percent of their income is greater than the standard accommodation costs, they will not be eligible for a reduction.

The standard accommodation charges to the client for subsidized assisted living effective November 1st 2012 are:

- Residential Care Facilities - $61.50 per day
- Community-based options - $50.50 per day

For comparison purposes, the cost to the client for long-term care facilities in Nova Scotia is $102.50 per day.[38]

A.4 Nova Scotia Additional Option: Self-Managed Care

Nova Scotia also offers "Self-Managed Care" as an alternative to facility based assisted living. Under the "Self-Managed Care" program, seniors can apply to the Department of Health and Wellness for funding to directly employ care providers for the purpose of meeting their approved health care service needs in their own homes. Clients assume full responsibility for the coordination, hiring, training and management of the funded services. This step enables them to enhance their participation in the community by actively participating in the development of their care planning and directly arranging and administering their own support services.

As previously mentioned, clients are expected to hire and manage their care providers on their own. Funding is available for services such as personal care and housekeeping. Registered professional health services such as nursing are provided and paid for directly by the Continuing Care Program in accordance with the clients approved health care plan.

[38] Government of Nova Scotia, Department of Health and Wellness, Continuing Care Branch, *Resident Charge Policy*, sec 4.3.3, Standard Accommodation Charge

Conditions of the funding are governed by a contract between the Department of Health and Wellness and eligible clients. Self-Managed Care is intended to promote individual initiative, self-reliance, self-sufficiency and responsibility.

Eligibility:

In order to qualify for the program, the client must be able to fully participate in decisions, make arrangements regarding his or her own care and have the competency to enter into a contractual agreement.

Funding available:

Under the program, individuals may be able to access funding up to a monthly ceiling of $3,780.29 (or $18.36/hour).[39]

A.5 Ontario

In Ontario, Community Care Access Centers are the focal point for the delivery of subsidized assisted living services. Under the auspices of a Local Health Integration Network, the Community Care Access Centers partner with local community health agencies to ensure that their clients receive consistent quality care across the geographical areas they serve.

Assisted living services in Ontario vary according to need, but consist essentially of attendant services, personal care, essential homemaking and an emergency response system. The stated aims of the program are:

> "to promote wellness and improve the health of clients by providing a level of services that enables them, despite their illnesses or conditions, to live in the community with a high degree of independence, and to be integrated into community life as much as possible. It enables the individual to remain independent, and prevents or delays institutionalization".[40]

Senior residents of Ontario have two assisted living options that are available to them, assuming they meet the eligibility requirements.

Assisted Living Services for High Risk Seniors

Assisted Living Services for High Risk Seniors is a program designed to assist frail or cognitively impaired seniors who do not need 24-hour nursing care and can reside at home with support, but whose care requirements cannot be met solely on a scheduled visitation basis. This program provides a combination of personal support and homemaking services, security checks or reassurance services, and care coordination,

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[39] Government of Nova Scotia, Department of Seniors, *Positive Aging – 2012 Directory*, Self-Managed Care, p. 111

[40] Government of Ontario, Ministry of Health and Long-term Care, *Assisted Living Services for High-Risk Seniors,* http://www.health.gov.on.ca/en/public/programs/ltc/13_housing.aspx

around the clock, on a scheduled and as-needed basis.

Services are provided to clusters of clients in their own homes within a geographic service area designated by the Local Health Integration Network as a “hub”, or to clusters of clients in apartment buildings. Clustering of clients is believed to provide an efficient and effective mean to provide long-term care that helps to keep people independent and prevents or delays institutionalization. Staff providing services operate from a central location in the “hub”, which allows them to get to a client quickly in the event of an emergency or the need for an unscheduled visit.

This model of assisted living more closely resembles home care but provides enhanced or enriched home care services in order to meet the needs of higher care requirement clients, thus enabling them to remain in their homes, and thereby delaying admission to a long-term care facility.

Assisted Living in Supportive Housing (Congregate Assisted Living model)

Local Health Integration Networks also provide assisted living services in supportive housing for seniors who have cognitive or physical limitations, persons who have a physical disability, an acquired brain injury, or are living with HIV/AIDS, and do not require 24-hour nursing care, but whose care requirements cannot be met solely on a scheduled visitation basis. Clients lease their accommodations from a specially designed building or within a cluster of adapted apartments within an ordinary apartment building. This model of housing and care can also include shared houses or self-contained apartments. The buildings are usually owned and operated by not-for-profit corporations such as municipal governments, housing cooperatives, or non-profit groups including faith groups, seniors' organizations, service clubs, cultural groups, and service providers. In most cases, the rent charged is based on ability to pay, or the market level rent is subsidized.

Staff members are present in the building 24 hours a day and are available to help residents on a scheduled basis, or as required. This program provides a combination of personal support and homemaking services, security checks or reassurance services, and care coordination. A corporation or person who is not the service provider normally manages the accommodation aspect. The support services provided are normally part of the client’s approved health care plan while the housing arrangements are documented in the lease with the property holder and are paid for by the client.

Eligibility:

Applicants must apply through their local Community Care Access Center and undergo a health care needs assessment by a case manager (using the Resident Assessment Instrument – Home Care assessment instrument). In order to be eligible for subsidized home care and the type of services described in “Assisted Living Services for High Risk Seniors” and “Assisted Living in Supportive Housing”, each one of the support services that are subsidized by the Community Care Access Center (professional services, personal support workers, homemaking and child care) have their own eligibility requirements. All clients must, at a minimum, be enrolled in the Ontario Health Insurance Plan (OHIP).

Accessibility:

Once the health care needs assessment is completed and a health care plan is approved, and there is no availability, the client will be placed on a waiting list for the required services. Wait lists are prioritized according to:

- the client's condition;
- the client's available support system;
- the availability of other community resources; and
- the Community Care Access Center's prioritization system.

Wait lists can exist for any or all of the support services that the Community Care Access Center delivers. Lengths of wait times depend on the availability of resources and services and the demand volume.

Cost:

For "Assisted Living Services for High-Risk Seniors" clients taking advantage of this enhanced home care model, because the support services are delivered in the client's home, the client is responsible for all the usual costs associated with owning or renting their own homes. All support services that are contained in the approved health care plan prepared by the Community Care Access Center case manager are funded by the Local Health Integration Network and the Ministry of Health and Long-term Care. There is no additional cost for this type of "enriched" home care as compared to the more conventional model with a lower level of support.

For Assisted Living Services for High-Risk Seniors living in a congregate setting, rental costs vary according to the current rental market in the area for non-profit housing. However, rents usually range from $600 to $1,500 depending on the location. Rent subsidies up to 30 percent of household gross income are available in some areas. All support services that are contained in the approved health care plan prepared by the Community Care Access Center case manager are funded by the Local Health Integration Network and the Ministry of Health and Long-term Care.

A.6 Alberta Health Services

In the province of Alberta, government health authorities provide subsidized "designated supportive living" with two different levels of support. The term "designated supportive living" simply means that assisted living is provided in partnership with Alberta Health Care services and a housing provider through a contractual arrangement.

Designated supportive living – level 4 – denotes the highest level of support that was found in this review, falling just short of long-term care. This high-care level of support is intended for clients who have complex medical needs that are predictable and safely managed by on site professional nursing (Licensed Practical Nurses) under the direction of the Home Care case manager (a registered nurse or R.N.). They may require

chronic disease management or could be living with mild to moderate dementia for example. They may require one or more types of assistance with activities of daily living (ADL) such as:

- assistance to eat, including tube-feeding
- mechanical lift or two-person transfers
- assistance with medication or its administration
- total assistance with mobility or getting around
- total assistance with the management of bowel or bladder control

Designated supportive living – level 3 – denotes a slightly lower level of support than level 4 and is intended for a client who can no longer safely reside at home. Admission to a facility with this level of support depends entirely on the client's health needs as assessed by the case manager. This type of care is delivered by Health Care Aides exclusively, but they can refer to on-call R.N.'s for assistance. It is intended for a client who is medically and physically stable or may be living with a disability. They could be diagnosed with a mental health issue or mild dementia with no known risk of wandering. They can normally move around on their own, but might require the assistance of one other person for short periods of time. They are likely to be experiencing higher care needs that cannot be scheduled and are capable of using a call system to get help. Level 3 would not be appropriate if the client needs assistance with any of the ADL mentioned in level 4.[41]

Eligibility:

In order to qualify for designated supportive living, clients must be residents of Alberta, must have an Alberta health care number or have applied for a health care number. They must undergo a health care needs assessment administered by their Home Care case manager (a R.N.) and be recommended for designated assisted living. Designated assisted living is also an option that is available for couples that require this type of support, but obviously the fees for shelter and care will increase.

Designated supportive living would not be appropriate for someone who is believed to be a risk to themselves or others, or requires 24-hour per day unscheduled assessments by a R.N. or a doctor.[42]

Accessibility:

When an individual is assessed and approved for designated assisted living, she/he is put on a wait list. The length of time on the wait list depends on the vacancy factors in the service area, how many people are already on the wait list, the priority of an individual's case and availability of space in the program.

Cost:

The cost of room and board, which ranges from $1,650 to $3,000 per month, is the sole responsibility of the client. The subsidy provided by Alberta Health Services applies wholly to the health care services that are part

[41] Government of Alberta, Alberta Health Services website, (PDF) The Right Care in the Right Place – designated Supportive Living Level 3 and Level 4 http://www.albertahealthservices.ca/3880.asp
[42] Government of Alberta, Alberta Health Services website, http://www.albertahealthservices.ca/4484.asp

of the approved health care plan prepared by a client's Home Care case manager. Any additional services outside of the health care plan are billable to the client. Medication and assistance with certain instrumental activities of daily living (IADL) are provided on a co-pay basis. Should the client not be able to afford their portion of the cost, low income seniors can apply to the Alberta Seniors Benefit program or the Assured Income for the Severely Disabled program for assistance. Income or means tests are used to determine the benefit level to which a senior would be entitled.[43]

A.7 Manitoba

In the province of Manitoba, the publicly-funded assisted living model is known as supportive housing for seniors. Between personal care homes (the equivalent of Special Care Homes or nursing homes in Saskatchewan – see below) and independent living on the scale of assistance, supportive housing is designed for people (primarily seniors) who need 24-hour support and supervision. It is the right choice for people who require assistance managing with physical limitations, or ongoing health conditions such as dementia. Supportive housing provides residents with assistance with ADL when required, such as bathing, dressing and medication reminders. "Resident Companions" who know and support the residents and their families are on site 24 hours per day.

Supportive housing services are made up of three components: rent, services and supports. The client is responsible for the rent and services while the Manitoba Regional Health Authorities are responsible for the support aspect.

Eligibility:

Clients wishing to be admitted to supportive housing in Manitoba must undergo a health needs assessment administered by their regional health authority. Usually a home care case coordinator will review the assessment and determine whether the client meets the threshold for this model of assisted living. Failing that, home care or nursing home care (long-term care personal care homes) could be suggested.

Accessibility:

Once the client is referred to supportive housing, he or she can apply directly to the supportive housing facility of their choice. Accessibility depends on the occupancy status for the given home and the ability of the home to meet the care needs of the client. There are no formal wait lists administered by the regional health authorities.

Cost:

The total cost for rent and services at a supportive housing facility are market-driven but can range from $1,000 to $2,500. The cost for support is paid for by the regional health authorities and is managed in the same manner as home care, as if the client still resided in his private residence.

[43] Government of Alberta, Alberta Health Services website, (PDF) The Right Care in the Right Place – designated Supportive Living Level 3 and Level 4 http://www.albertahealthservices.ca/3880.asp

There is no indication that there would be any additional financial support available for clients requiring this type of housing/care and not being able to afford it. However, if the client is referred to a long-term care personal care home (nursing home) with a higher level of care, the cost of the personal care home is shared on a co-pay basis between the provincial health authority and the client. In that case, the client undergoes a complex means test that determines his/her share of the co-pay arrangement.[44]

A.8 New Brunswick

The province of New Brunswick appears to employ a hybrid system of home care, "special care homes" and "nursing homes", to provide subsidized assisted living services to seniors who need support with their ADL and IADL. All three levels of subsidized care are managed by the New Brunswick long-term care system.

The long-term care system is broken down into three components: in-home services, special care homes and nursing homes. In-home services and special care home services are delivered through the eight regional offices in the province. Nursing homes are under the direction of the Nursing Home Services branch, with actual nursing home services provided by licensed nursing homes.

There are four levels of care for clients that can be admitted into approved residential facilities:

Level 1: Clients are generally mobile but require the availability of supervision on a 24-hour basis related to their personal care. Services are usually delivered in a Special Care Home.

Level 2: Clients may require some assistance or supervision with mobility and require more individualized assistance or supervision on a 24-hour basis with personal care and their ADL. Services are usually delivered in a Special Care Home.

Level 3: Clients have a medically stable physical or mental health condition or functional limitation and require assistance and supervision on a 24-hour basis. These clients need a great deal of assistance with personal care and often require medical attention. Services are usually delivered in a Nursing Home.

Level 4: Clients have difficulties with cognition and/or behavior requiring supervision and care on a 24-hour basis. Clients may display aggressive behavior toward self and/or others. Most often they need maximum assistance with their personal care and ADL. Often they also require medical care. Services are usually delivered in a Nursing Home.

In-home services generally consist of support by non-professional resources of ADL such as dressing, bathing and grooming, assistance with housekeeping tasks such as cleaning, laundry and meal preparation and respite care. These services are provided through third-party contracts with home support agencies.

[44] Government of Manitoba, Department of Health, *Personal Care Services – A Guide to Services and Charges in Manitoba* (rate year 1-8-2012/31-07-2013)

Special Care Homes are intended for clients who require supervision and assistance with ADL because of limitations that preclude them from safely remaining in their homes, but they do not require high levels of care or supervision (generally level 1 and 2 care needs clients). Some Special Care Homes offer enhanced services to seniors with dementia or physical frailty who require help with many ADL and IADL. Special Care Homes are privately owned and operated on a for-profit basis.

Nursing Homes provide service to clients whose primary need is nursing care (those patients who meet the criteria set out in level 3 and 4 care needs). Nursing Homes are generally not-for-profit organizations that are privately owned and operated by a volunteer board of directors.

Eligibility:

In general terms, clients are eligible for subsidized care if they are:

- 19 years of age or older;
- a citizen or permanent resident of Canada;
- a resident of New Brunswick; and
- for admission to nursing homes, assessed as needing a nursing home level of care (levels 3 or 4).

The regional offices of Family and Community Health Services manage the assessment process. There are eight such offices throughout the province. Assessments are conducted to determine a client's health care needs and can help the client transition to a residential facility.

Accessibility:

Once a client is assessed for health care needs and approved for placement, the Department of Social Development will forward the client's name to all nursing homes within 100 kilometers of the client's municipality. When the homes have a vacancy, they must select potential residents from the approved client list. Spouses can be admitted but the client must make such a request to the Department of Social Development. Clients are allowed one refusal but if they refuse a second option, they are removed from the client list. No information was found for accessibility to Special Care Homes.

Cost:

None of the services available under long-term care are covered under provincial Medicare. A client's family is expected to pay the full cost of care if they can afford it. Effective July 1, 2012, the maximum amount to be paid by nursing home residents is $101 per day. This daily cost covers room and board services. The average monthly payment would be approximately $3072. The rate will be increased to $107 per day in April 2013 and to $113 per day in April 2014. The Department of Social Development covers the cost of nursing and rehabilitation services for residents in Nursing Homes.

Because Special Care Homes are privately operated for profit, the rates for these residences vary from facility to facility.

For those who cannot afford the cost of services, the province employs a "Standard Family Contribution Policy" that sets out the income limits for subsidy eligibility. The Standard Family Contribution Policy was introduced in April 1997 and is designed to ensure that those who are able to contribute their fair share will do so by contributing at least a nominal amount to the cost of their services, unless their income is at or below set income limits.[45]

New Brunswick is one of the provinces that specifically exclude certain types of Veterans Affairs Canada benefits in the calculation of net income for subsidy eligibility.

In the case of Veterans, effective April 1, 2008, the Veteran's Disability Pension Survivor's Benefit is exempt from consideration as income when completing a financial assessment for all long-term care services. When the Veteran is living at home, the VAC disability pension, including the additional sum paid to the disability pensioner on behalf of a spouse/common-law partner, is not included when calculating the client contribution for his/her spouse in a residential facility.

Effective May 1, 2009, the Veteran's disability pension (including the additional sum paid to the disability pensioner on behalf of a spouse/common-law partner) is not considered as income if VAC has determined that the Veteran's requirement for long-term care is linked to the service related injury for which he/she is pensioned.[46]

A.9 Newfoundland and Labrador

The Newfoundland Department of Health and Community Services offers two levels of subsidized care for its seniors – nursing homes and personal care homes. The publicly-funded nursing homes provide onsite professional health and nursing services while privately-owned and operated personal care homes provide residents with assistance for their personal care and ADL. Clients of personal care homes can also take advantage of visits from the regional health authority's health professionals.

Eligibility:

The regional health authorities in Newfoundland/Labrador are responsible for the administration of a health care needs assessment for clients requesting subsidized assisted living. The assessment process helps to determine a client's overall eligibility for long-term care services. During the assessment process, clients can apply for provincial subsidies to help defray the costs of personal care homes. An income and asset test is also administered in order to determine the extent of the subsidy, if any, to which the client might be entitled.

The co-pay amount assigned to the client is scaled to annual income. For the majority of clients in the $28,000-$150,000 of annual income, the co-pay would be approximately 15 percent of net income (see the income test

[45] Government of New Brunswick, Department of Social Development, *Standard Family Contribution Policy*, May 2009
[46] Ibid.

for full details – 2009 figures).[47]

Accessibility:

In the reviewed literature, there was no information available on accessibility. However, it is clear that personal care homes are privately owned and therefore vacancy at individual facilities is the prime consideration for accessibility, followed by suitability to the client's care needs and ability to pay, net of provincial subsidies.

Cost:

Due to the privately-owned nature of personal care homes, costs are market driven. However, net cost to the client is a function of their income and asset levels combined with eligibility for provincial subsidies.

A.10 Prince Edward Island

The Prince Edward Island government provides three levels of care for seniors: Home Care, Community Care Facilities and Nursing Homes. Certain facilities have both Nursing Home beds and licensed Community Care beds and are designated as "dual facilities".

Community Care Facilities most closely fit the assisted living model and reside in the gap between home care and long-term care nursing homes. They are privately owned or co-operative establishments that are licensed by the provincial government to house five or more residents and provide services such as housekeeping, meal preparation and assistance with grooming and hygiene (all ADL). Twenty-four hour per day nursing is not provided, differentiating this model of care from the more intensive levels of support provided by nursing homes.

Eligibility:

The Eligibility requirements for funded beds in Community Care Facilities are the same as the requirements for Nursing Homes. To be eligible for a licensed Community Care bed in a dual facility, a client must be a resident of Prince Edward Island and:

- hold Canadian citizenship or be a landed immigrant (a non-Canadian who has established residence in Canada and who holds a visa entitling permanent residence in Canada);
- be ordinarily present for six months or more in Prince Edward Island; and
- hold a valid Provincial Health Card for PEI.[48]

[47] Government of Newfoundland and Labrador, *Income Based Financial Assessment Policy Manual for the Home Support and Special Assistance Programs*, September 2011

[48] Government of Prince Edward Island, Health PEI, *Long-Term Care in Nursing Homes in PEI*, Criteria for Nursing Home Admission, p.2

An individual's care needs will be evaluated by their Home Care office using a standard health assessment review instrument. The assessment is used to determine the type of care required by the client in order to maintain their basic daily health care requirements.

Accessibility:

If the health care assessment indicates that the most suitable housing/care option is a community care facility, because they are privately owned or co-operatives, the client can apply to the facility of their choice.

Cost:

The client is expected to pay for their care to the extent they can. If they cannot pay the entire amount, the province can subsidize the care under the *Social Assistance Act*.[49] In order to apply for a subsidy, the client will have to undergo an income test to determine their ability to contribute on a co-pay basis. All assets that can be converted to cash must be disposed of in order to pay for care. The only exception is the client's home, but it must be occupied by a family member who lived there before the application for admission was made. If no family member occupies the home, it must be sold at fair market value and the proceeds used to pay for care.

Note:

Prince Edward Island Department of Health is a payer of last resort for health care and accommodation costs for residents of nursing homes (manors and private nursing homes). Residents who are eligible for cost of care funding from other sources are expected to look to those sources before funding is provided by the Department of Health.

These sources include, but are not limited to:

- VAC
- Workers Compensation
- Court judgments
- Federal Government Acts
- Medical/Health Insurance[50]

A.11 Quebec

The publicly-funded model of assisted living in Quebec is known as an "intermediate resource" (*ressource intermédiaire* in French). It is appropriately named, as it is a housing/care option that lies between independent living with home care support and long-term care.

An intermediate resource is a residential environment adapted to the needs of people with decreased

[49] Government of Prince Edward Island, *Social Assistance Act*
[50] Government of Prince Edward Island, Department of Health, *Long-Term Care in Nursing Homes in PEI*, Fact Sheet

independence or who need assistance of up to three hours per day with their ADL. This type of residential accommodation can be used as a temporary measure to help a senior transition back to their own homes after a crisis or a stay in hospital or can be a more permanent solution when the senior's home is no longer a safe option. All subsidized intermediate resources are affiliated with the public health and social service network (CSSS – Centre de Santé et Services Sociaux – the local or regional health authority).

Generally, an intermediate resource is a privately-run facility under contract with the local Public Health and Social Service Center (CSSS) to provide housing and care. As such, the residents are responsible for the cost of room, board and hospitality services while the CSSS assumes the cost of the support. Amongst the services included in the client's portion of the co-pay arrangement are:

- room and board services such as meal preparation, housekeeping, climate control;
- products and services for personal hygiene; and
- all other equipment required for therapeutic purposes.[51]

Eligibility:

Clients are usually referred to a specific intermediate resource as a result of a health needs assessment by the local or regional Health and Social Services Center. There is no age requirement to be admitted to an intermediate resource, however a person's age does influence the share of the co-pay arrangement that must be assumed by the client, as does the anticipated length of stay (over or under two years).

Accessibility:

Accessibility is driven by demand and the occupancy of the individual intermediate resource. However, intermediate resources as a model of assisted living are not common across the province. Where they do exist, they are often used as a transitional model of housing rather than a more permanent solution to a senior's intermediate shelter/care need.

Cost:

The client is responsible for a maximum monthly contribution of $1,132.80, a rate set by the Quebec Health Insurance Plan (RAMQ – Régie de l'Assurance Médicale du Québec). That amount can be adjusted pursuant to an income test administered by the provincial insurance plan. If the intermediate resource has a contractual agreement with the local Health and Social Services Center, all services required by the client's approved health care plan are covered, but the client is still responsible for the room and board portion.[52]

A.12 Saskatchewan

[51] Government of Quebec website, City of Montreal Health Department portal, http://www.santemontreal.qc.ca/en/where-to-go/residential-resources/#c2928
[52] Government of Quebec, Régie de l'assurance maladie du Quebec, http://www.ramq.gouv.qc.ca/en/citizens/aid-programs/Pages/accomodation-in-intermediate-resource.aspx

In the province of Saskatchewan, there is generally no public funding available for an assisted living model of housing/care. In a 2010 report to the Saskatchewan Minister of Health entitled *Focus on the Future: Long-term Care Initiative* by Laura Ross, Legislative Secretary to the Minister, public consultations urged the government to enact legislation that would subsidize personal care homes for seniors when there is an assessed need for assisted living.

> "The Ministry of Health and the Ministry of Social Services regularly hear from individuals and organizations respecting the difficulties that low-income individuals, mostly seniors, are having in affording personal care homes when their needs cannot be sustained with home care or their needs are not great enough to access a publicly subsidized special-care home. This issue is continuing to grow, as there are increasing pressures on special-care homes and home care.
>
> A subsidy is needed for residents of personal care homes with an assessed care and income need. There was almost unanimous agreement at all consultations that there is a 'gap' in the continuum of care. This sentiment was also echoed in the *Patient First Review*. While all other care options have some form of subsidy for the individual based on need (home care, social housing and special-care) the fee for personal care homes is paid for fully by the resident. Many individuals and interest groups pointed out the significant difficulties that low-income individuals, most times seniors, have in affording personal care homes. This is especially difficult for those individuals whose needs cannot be sustained with home care (e.g. persons with early stage dementia) yet their needs are not great enough to access a publicly subsidized special-care home. Many seniors need intermediate, transitional support, such as a personal care home, yet this option is often unaffordable."[53]

Personal care homes are privately-owned and operated facilities that are regulated and inspected by the Saskatchewan Ministry of Health. Because they are privately run, the assisted living services offered vary from one home to another.

Eligibility:

As the provincial health authority does not subsidize these homes and there is little involvement with the regional health authorities, there are no collective eligibility requirements. Clients apply to the home of their choice and are assessed based on their individual health needs and the ability of the home to provide the required support.

Accessibility:

Access to subsidized assisted living in Saskatchewan is accomplished by applying directly to the personal care home of one's choice. Availability is driven by demand, occupancy and the facility's ability to meets the care needs of the applicants.

Cost:

[53] Government of Saskatchewan, Ministry of Health, Laura Ross, MLA, *Focus on the Future: Long-term Care Initiative – A Report to the Honorable Don McMorris, Minister of Health* (April 2012), 7

As personal care homes do not receive subsidies from the provincial health authority, the cost for this model of assisted living is market-driven. However, low-income seniors who cannot afford to pay the full cost of personal care homes can apply to the Ministry of Social Services for an income-tested benefit known as the "Personal Care Home Benefit".

To qualify for the benefit, a client must be:

- 65 years of age or older;
- be a resident of Saskatchewan;
- live in a Saskatchewan licensed personal care home;
- receive an Old Age Security pension; and
- have a monthly income below specified levels.

The amount of the benefit depends on the income level and marital status. The amount of the supplement will be the difference between a threshold of $1,800 less the applicant's monthly income. Income is calculated as the total of current benefits and the previous year's personal income as determined by the Canada Revenue Agency. It does not appear from the legislation that VAC benefits are included as income in the calculation.[54]

A.13 Yukon, Northwest Territories, Nunavut

There is limited information available from open sources on the availability of publicly-funded assisted living services in the Yukon, Northwest Territories or Nunavut. Where assisted living services are available, they appear to be client paid. Long-term care appears to be provincially funded.

The Continuing Care Branch of the Yukon Government offers residential, home care and regional therapy services to its citizens. The Residential Care Program is affiliated with three facilities in the Yukon: *Copper Ridge Place*, *McCauley Lodge* in Whitehorse and *McDonald Lodge* in Dawson City. No specific information was found on the extent to which these facilities were subsidized by the government, if at all.

The Department of Health and Social Services for the Northwest Territories does provide subsidized home care services and long-term care. There was no information located on assisted living services.

In Nunavut, both home care and long-term care are fully funded by the territorial government. There is no indication of any type of funded assisted living services available in Nunavut.

[54] Government of Saskatchewan, *Personal Home Care Benefit Regulations*, Chapter S-8, Regulation 10, as amended by Saskatchewan Regulations 29/2013

Annex B: Definitions of Health Need Types

Source: *Veterans Health Care Regulations*, SOR/90-594. Sec 2 definitions

Type I Health Need - means the need of a person for personal care and supervision on a continuing basis, where the person is ambulant or independently mobile but has decreased physical or mental faculties.

Type II Health Need - means the need of a person for personal care on a continuing basis under the supervision of a health professional, where the person has a functional disability, has reached the apparent limit of recovery and has little need for diagnostic or therapeutic services.

Type III Health Need - means the need of a person for personal care and for diagnostic, nursing and therapeutic services provided by a health professional on a continuing basis, where the person is chronically ill or has a functional disability and the acute phase of the illness or disability has ended, whether or not the status of the illness or disability is unstable.