Gaps in Facility Care for East Asian Cultural Groups in Selected GVRD Communities: A Geographic Information Systems and Focus Group Report

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EXECUTIVE SUMMARY

This Highlight Report provides findings on patterns of residential care (RC) and assisted living (AL) utilization in Burnaby, Coquitlam, Port Coquitlam, Port Moody, Richmond, Surrey, Vancouver, and White Rock among persons of East Asian (EA) (defined as Chinese, Japanese, Korean, and Filipino) and non-EA ethnic backgrounds. South Asians were not included in this ethnic grouping due to different cultural service needs.

The findings in this report are based on GIS (geographic information system) analyses of census data coupled with data on RC and AL facilities from several sources, including the Office of the Seniors Advocate of BC, the Assisted Living Registry, Health Authorities, and a survey covering 95% of all 111 publically funded facilities (66 RC and 45 AL) for seniors in the catchment area. These data are supplemented with thematic analyses drawn from four focus groups.

This report shows that about one-quarter of older persons in the municipalities of Burnaby, Coquitlam, Port Coquitlam, Port Moody, Richmond, Surrey, Vancouver, and White Rock are EA, and that this ethnic older population has been growing rapidly. There is also a gap in available RC and AL beds for EAs. Occupancy rates are calculated based on the number of residents per capita, expressed as a percentage. Among adults aged 65+ years, the EA bed occupancy rate is 3.5% compared to 3.9% for the non-EAs population. This difference is greater for the population aged 75+ years, where the bed occupancy rate for EAs is 7.9% compared to 9.4% for non-EAs.

Although the EA population of older people are concentrated in areas where there are more RC and AL facilities (compared with non-EAs), EAs have lower occupancy rates in their local neighbourhoods, and are more likely to have to relocate beyond their local neighbourhood.

Approximately 28% of EA residents of RC and AL facilities do not live in facilities that offer culturally tailored programs, suggesting a service gap in programs tailored to EAs. Furthermore, a smaller percentage of EA residents in RC and AL facilities are within 2 km of a facility providing culturally tailored programs compared to non-EAs. This suggests a need for new culturally relevant facilities or additions to current ones that are located in areas with high concentrations of EAs.

The GIS mapping also clearly shows that, despite high concentrations of older EA residents in Richmond, South Burnaby, and the TriCities, there are very low beds per capita in RC or AL facilities with EA cultural programs.

Overall, this report identifies important gaps in RC, AL, and culturally relevant programs targeting older EAs living in the targeted communities with high concentrations of EAs. This conclusion is reinforced by the strong preference for RC and AL housing that provides culturally relevant services and programs.

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BACKGROUND

In the past decade, the highest numbers of immigrants to Metro Vancouver have come from China, South Asia, and the Philippines[1] with immigrants from Mainland China comprising the largest newcomer group to the region.[2] A recent scoping review of literature conducted for S.U.C.C.E.S.S. by Simon Fraser University's Gerontology Research Centre (GRC) establishes a significant lack in residential and continuing care environments, programs, and services tailored to the needs of East Asians living in Burnaby, Coquitlam, Port Coquitlam, Port Moody, Richmond, Surrey, Vancouver, and White Rock (S.U.C.C.E.S.S.-GRC, 2016). This is the result of a dramatic increase in East Asian seniors in these areas, especially East Vancouver and Richmond, coupled with a structural lag in the development of care facilities, supported housing, and programs developed specifically for older persons of East Asian ethic background. Nevertheless, East Asian seniors living in urban areas are similar to their non-East Asian counterparts in both the need and desire for supportive housing and residential care.

In addition, a new study from the BC Senior Advocates Office[3] reported that, although the number of adults aged 85+ years has increased by 21% since 2012, the number of residential care beds has only increased 3.5% during this time. In addition, the wait times for residential care increased in three health authorities, including the Fraser Health Authority.

In order to effect change in the long-term and continuing care policies, programs and services supported and delivered by the provincial government and Local Health Authorities, there is an urgent need for a strong evidence base establishing potential gaps in the supply and demand for culturally sensitive care and support for elderly East Asian populations. This knowledge will help organizations understand the availability of programs and services in specific communities, aid in their ability to identify gaps and barriers to serve, and to improve service delivery to address the needs of these diverse populations.

This report aims to fill this knowledge gap by providing results from a geographical information systems (GIS) mapping and analysis, which was conducted to estimate the need for residential care (RC) and assisted living (AL) and to depict areas where supply-demand gaps are most prominent, based on analyses of patterns for East Asian (EA) and non-East Asian (non-EA) older populations in the targeted communities. This is complemented by qualitative findings from a series of focus groups.

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[1] City of Vancouver, Social Policy Division (2010). Seniors in Vancouver. Available: http://vancouver.ca/files/cov/Seniors-Backgrounder.pdf

[2] United Way of the Lower Mainland (2008). Moving towards age-friendly communities: Lower mainland/sea to sky seniors and seniors' services. Available: http://www.uwlm.ca/wp-content/uploads/2015/07/Lower-Mainland-Sea-to-Sky-Seniors-Services.pdf

[3] Office of the Seniors Advocate. (2016). *Monitoring Seniors' Services*. Available: https://www.seniorsadvocatebc.ca/osa-reports/report-monitoring-seniors-services-2016/

GIS METHODS

Data Collection

A scan of residential care (RC) and assisted living (AL) facilities located in Burnaby, Coquitlam, Port Coquitlam, Port Moody, Richmond, Surrey, Vancouver, and White Rock was conducted using the Office of the Seniors Advocate British Columbia Residential Care Facilities Quick Facts Directory (2016)[4] and the BC Assisted Living Registrar.[5] This scan generated a list of 67 RC and 46 AL facilities. One RC and one AL facility each were excluded from the sample as these facilities reported catering to a resident population under age 65. Thus, 66 RC and 45 AL facilities were eligible for data collection.

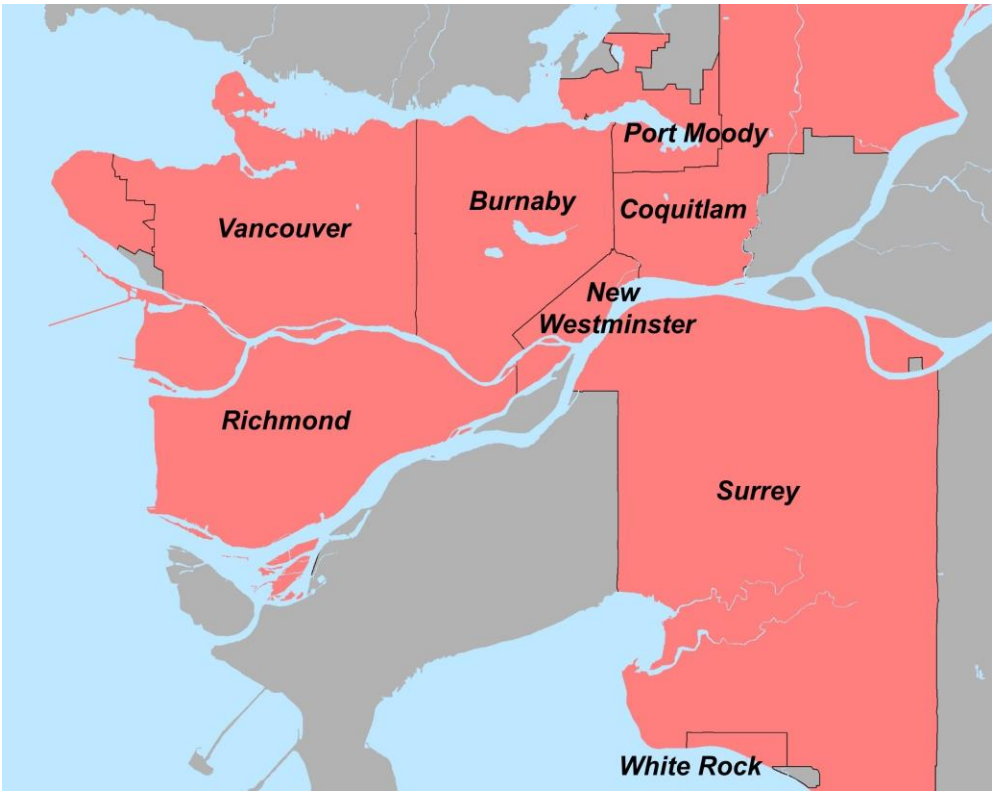
An introductory email letter was sent to facilities in which an email address was available; when email responses were not provided, follow-up phone calls were made. Responses were not provided by 3 RC and 2 AL facilities; and 1 AL facility refused participation. Our final sample included 63 RC and 42 AL facilities; a response rate of approximately 95%.

Internet searches generated data on the number of public, private, and total beds available for each facility. Additionally, information on accreditation status, resident room configuration, and non-English languages spoken by staff was collected for RC facilities. Email and telephone surveys asked representatives from the facilities to estimate the number of East Asian (EA) residents living in their facility and to describe any services or programs tailored to residents of EA descent. The estimated number of residents with EA descent was based on surname or current knowledge of the ethnic background of residents.

All facilities were mapped across the study area using GIS. Maps highlight each facility by the number of beds, percentage of EA residents, and whether or not they offer culturally tailored programs. To assess whether a facility offered culturally tailored programs, we asked respondents what programs were offered in their RC and AL facilities for EA residents. We then probed on this question based on our knowledge of common programs in the region. The most common EA programs included: EA foods served on a regular basis; EA physical activity programs, such as Tai Chi or others conducted in Mandarin or Cantonese; EA leisure activities such as Mahjong or singing programs in Mandarin or Cantonese; and religious services in in Mandarin or Cantonese. Responses were dichotomized as yes or no (i.e., facilities either did or did not offer culturally tailored programs) by a senior researcher for standardization, following team discussion.

[4] Office of the Seniors Advocate British Columbia Residential Care Facilities Quick Facts Directory (2016). Available: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/05/BC-Residential-Care-Quick-Facts-Directory-May-2016.pdf

[5] BC Assisted Living Registrar. (2016). Available: http://www.health.gov.bc.ca/assisted/locator/index.php/displaycommunity/index



Map of Study Area

Population Data

Population data were acquired from Statistics Canada for the census year 2011, for every census tract in the study area. (Census tracts are areas with a population between 2,500 and 8,000 persons, typically the size of a small neighbourhood.) Populations were categorised by age and mother tongue. Individuals with a mother tongue from Korea, Japan, China, or the Philippines were categorised as EA. All other individuals were categorised as non-EA. Note that non-EA includes all other ethnicities, not only Caucasian/European.

Annual age-specific mortality rates for British Columbia (also from Statistics Canada) were then used to estimate the 2016 populations in each census tract, for each age and EA/non-EA study population. These population groups were mapped across the study area to highlight concentrations of EA and non-EA seniors.

Regional Analysis

Occupancy rates were calculated as the proportion of the population currently residing in a facility represented the number of beds per 1,000 population. These rates are converted into percentages in the tables and in the text. Four occupancy rates were separately calculated as the percentage of the population aged 65+ and 75+ years, and for both EA and non-EA groups. These rates were calculated for the entire study region to identify overall patterns of occupancy. Given that most residents of residential care and assisted

living facilities are 75+, the occupancy rates using the 75+ population in the calculation are more accurate than using occupancy rates based on all seniors aged 65+. Comparisons between EA and non-EA groups are equally affected by this bias.

Local Analyses

To identify neighbourhood-scale patterns in occupancy rates and to highlight geographical gaps in service availability, we conducted a local analysis of occupancy rates. Geographical information systems were used to calculate the population residing within 2 km of a facility (termed local). Two kilometres was selected as the radius, since this distance has been used in other studies to approximate an average neighbourhood in a study area.

Local Access

The percentage of each study population that resides within 2 km of a facility was calculated as a measure of potential access to local facilities. For EA populations, we also calculated this for facilities with culturally specific programs and services.

Beds per Local Capita

Bed occupancy rates were calculated for the local populations within 2 km, calculated separately for each age group (65+ and 75+, regardless of ethnicity). The beds per local capita were then mapped to identify geographical concentrations and gaps in care. We also calculated the number of beds in facilities with culturally specific programs and services per 1,000 EA capita (aged 65+ and 75+). Again, these rates are converted into percentages in the tables and report.

Local Occupancy

The occupancy rates per 1,000 local capita provides a measure of service utilization for EA and non-EA populations. These ratios were calculated as the number of EA residents in a facility per 1,000 EA persons residing with 2 km of a facility, and also converted into a percentage in the tables. Additionally, we calculated the local culturally specific occupancy rates as the number of EA residents in facilities with culturally specific programming per 1,000 EA capita within 2 km converted into a percentage. These ratios were mapped to identify gaps in EA occupancy and availability of EA programs and services.

GIS FINDINGS

Demographic Profile of EA Older Populations and Residents in Facilities

Approximately 25% of the population aged 65+ years (72,181), and 26% of the population aged 75+ years (31,784) is East Asian (speaks an EA language as their mother tongue) (Table 1). EA residents of both age groups are widely dispersed throughout the region, although there are more significant concentrations of EA residents in the City of Richmond and City of Vancouver (Figures 1 and 2).

Table 1. EA and non-EA Population in the Study Area

	East Asian (N, %)	**Non-East Asian (N, %)**
Age 65+	72,181 (25%)	214,030 (75%)
Age 75+	31,784 (26%)	31,784 (74%)

Figure 1. The Number of EA Persons Aged 65+ by Census Tract

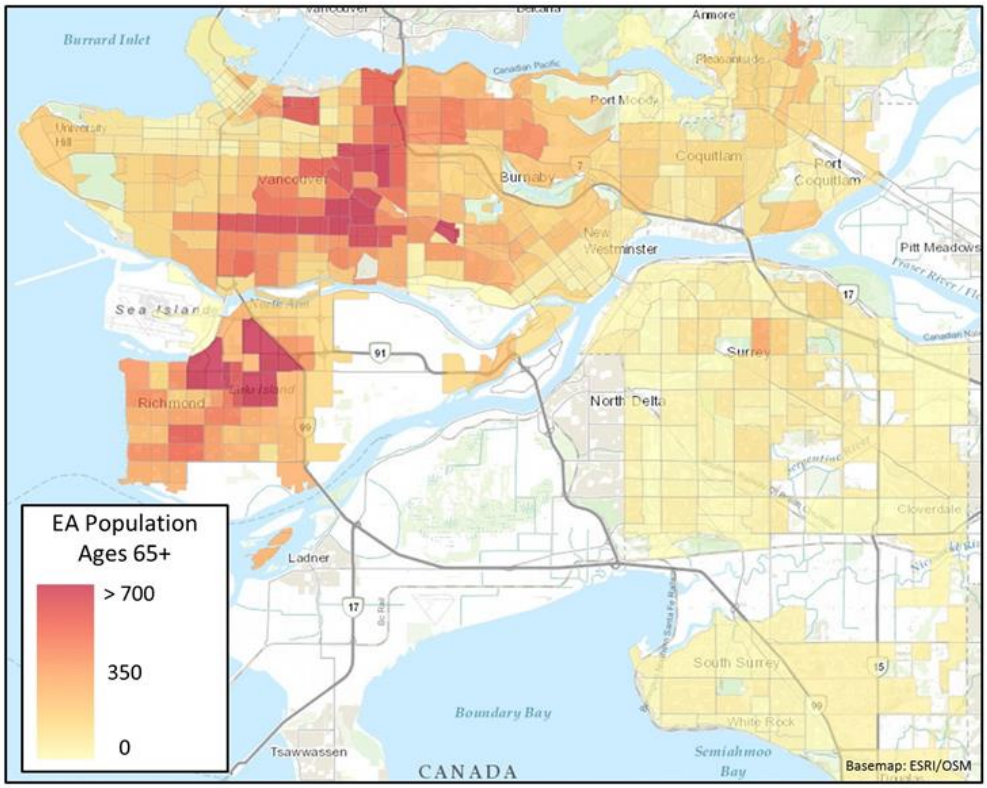
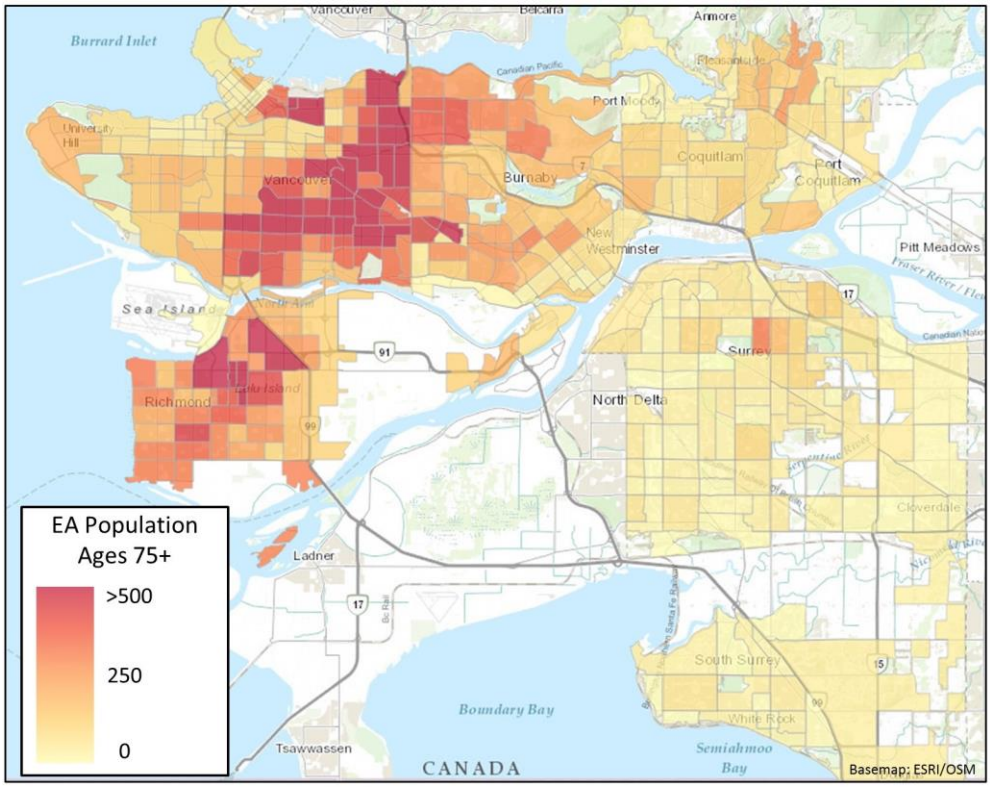


Figure 2. The Number of EA Persons Aged 75+ by Census Tract



We identified 66 RC and 45 AL facilities housing 2,491 AL beds and 8,352 RC beds (Table 2). Just under one-quarter of residents living in both facility types are of EA descent using the 65+ population (23% of RC residents; 24% of AL residents). Thus, EA residents represent a significant proportion of persons living in RC and AL facilities in these communities.

Table 2. Number of Facilities, Beds, and non-EA and EA Residents, 65+

	Facilities (N)	**Beds** (N)	**Non-EA Residents** (N, %)	**EA Residents, 65+±** (N, %)
Residential Care	66	8,352	1,905 (77%)	1,922 (23%)
Assisted Living	45	2,491	6,430 (76%)	586 (24%)
Total	111	10,843	8,335 (77%)	2,508 (23%)

±Note: Data on the number of EA residents were provided by 63 RC and 42 AL facilities (95%). This may slightly affect the calculations, depending on the ratios of ethnic group residents in the non-reporting facilities.

Bed Occupancy Rates for EAs and non-EAs

We turn now to occupancy rates by EA and non-EA persons to examine potential gaps in services. The EA population has a lower combined RC and AL bed occupancy rate than the non-EA population (Table 3). For adults aged 65+ years, the EA bed occupancy rate is 3.5% compared to 3.9% for the non-EAs. This difference is greater for the population aged 75+ years, where the bed occupancy rate for EAs is 7.9% compared to 9.4% for non-EAs for both types of facilities; and 6.0% compared to 7.3% for residential care. Comparing the percentage point differentials, non-EAs show a 19% higher occupancy rate compared to EAs for both types of facilities, and a 22% higher rate for residential care. This indicates a service gap for EAs, assuming equal need.

Table 3. Bed Occupancy Rates for EAs and non-EAs, 65+ and 75+

	EA, 65+	Non-EA, 65+	EA, 75+	Non-EA, 75+
Residential Care	2.7%	3.0%	6.0%	7.3%
Assisted Living	0.8%	0.9%	1.8%	2.2%
Total	3.5%	3.9%	7.9%	9.4%

Local Access

It is useful to examine proximity to facilities, given differential concentrations of ethnic older populations in these communities. Approximately 88% of EAs aged 75+ years live within 2 km of either an RC or AL facility compared to 79% of non-EAs aged 75+ years (Table 4). A similar trend is observed when examining only RC facilities: 82% of EAs aged 75+ years compared to about 71% of non-EAs, lives within 2 km. This shows that the EA population of older people are concentrated in areas where there are more facilities compared with non-EAs.

Table 4. Percentage of the Population Living within 2 km of RC or AL Facilities, 65+ and 75+

	EA Population, 65+	Non-EA Population, 65+	EA Population, 75+	Non-EA Population, 75+
Residential Care	79.6%	68.0%	82.0%	70.5%
Assisted Living	61.7%	54.8%	63.8%	57.7%
Total	85.5%	76.7%	87.8%	79.3%

Local RC and AL Occupancy Rates of EA and non-EA persons

Although EA populations appear to have better access to local facilities (within the 2 km radius), their rates of occupancy per capita for local facilities are significantly lower compared to the non-EA population (Table 5). For RC beds, individuals on the waiting list are placed based on availability and appropriateness rather than proximity; however, for AL units, individuals may choose a facility but this is also based on availability.

For both RC and AL facilities, 7.4% (74 in 1,000) of EAs aged 75+ years live in a local facility within 2 km compared to 11.9% (119 in 1,000) of non-EAs aged 75+ years. This difference is particularly notable for RC facilities, where only 7.4% EAs are in a local RC facility compared to 10.3% of non-EAs who reside in a local RC facility. Thus, despite better local access to facilities, EAs have lower occupancy rates in their local neighbourhoods, and are more likely to have to relocate beyond their local neighbourhood. This may be the result of the highly clustered EA population in areas of the study region, which cannot be accommodated with the existing facilities. Furthermore, this service gap may be related to the availability of culturally tailored programs linked to particular facilities, as examined in the following section.

Table 5. Local RC and AL Occupancy Rates for EA and non-EA Persons, 65+ and 75+

	EA occupants per capita, 65+	**Non-EA occupants per capita, 65+**	**EA occupants per capita, 75+**	**Non-EA occupants per capita, 75+**
Residential Care	3.3%	4.4%	7.4%	10.3%
Assisted Living	1.3%	1.6%	2.9%	3.7%
Total	3.3%	5.1%	7.4%	11.9%

East Asian Culturally Tailored Programs

Of the 111 RC and AL facilities, 36% (40) reported offering programs culturally tailored to their EA residents. These include physical activity and leisure activities, as well as regular EA food availability. This was more common in RC than AL facilities, where 42% of RC facilities reported offering regular activities and programs tailored to East Asian resident preferences compared to only 27% of AL facilities (Table 6; Figures 3 & 4).

In RC and AL facilities reporting no culturally tailored programs, EA residents made up 28% of the residents. In RC and AL facilities reporting culturally tailored programming, EA residents comprised 71% of the residents. It is not known what percentage of EA residents not living in facilities providing culturally tailored EA programs want them; however, it is likely a significant proportion of the 28% not receiving such services desire or require them.

Table 6. Facilities, Beds, and Residents in Facilities with EA Cultural Programs

	Facilities with EA Programs± (N, %)	**Beds in Facilities with EA programs±** (N, %)	**EA Residents in Facilities with EA programs±** (N, %)	**EA Residents in Facilities without EA programs±** (N, %)
Residential Care	28 (42%)	3,359 (40%)	1,453 (76%)	469 (24%)
Assisted Living	12 (27%)	677 (27%)	344 (59%)	242 (41%)
Total	40 (36%)	4,036 (37%)	1,797 (72%)	711 (28%)

±Note: Data on the number of EA residents and programs were provided by 63 RC and 42 AL facilities. This may slightly affect the calculations, depending on the ratios of ethnic group residents in the non-reporting facilities.

Figure 3. Number of Beds per Facility and EA Cultural Programs

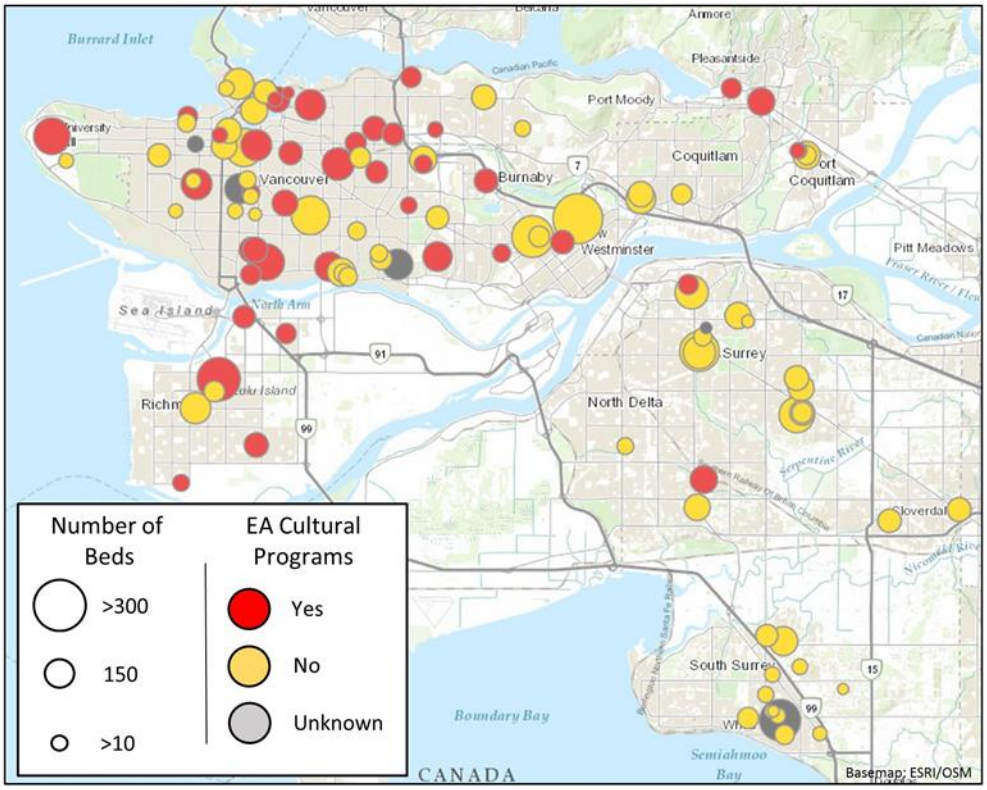
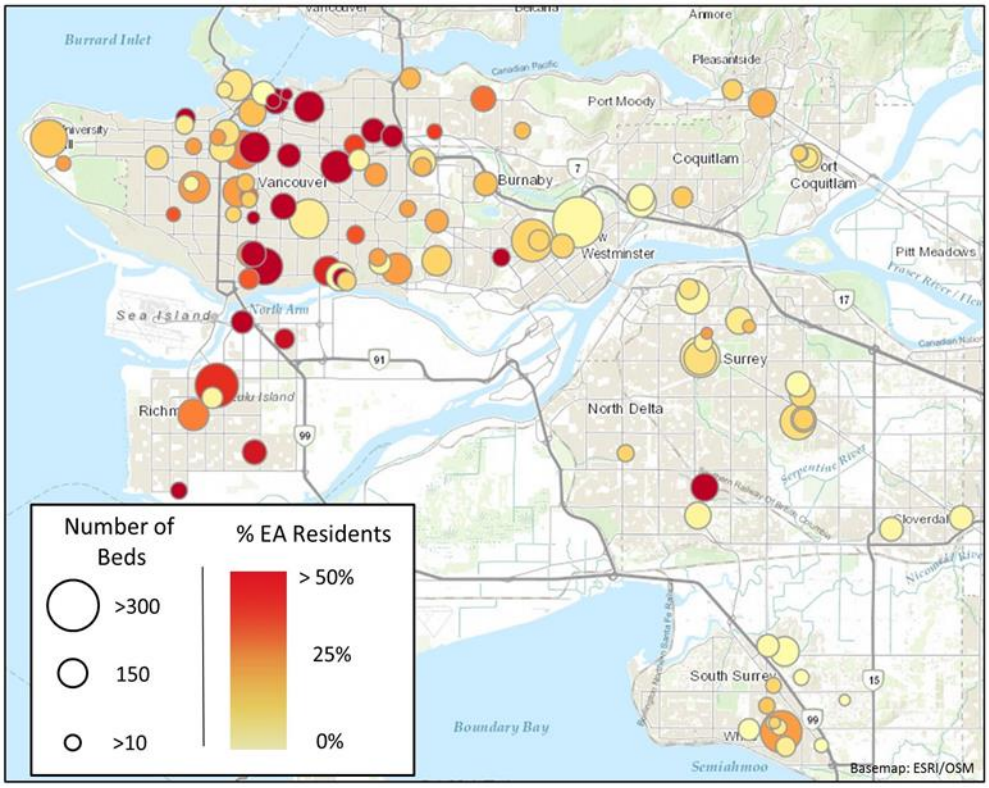


Figure 4. Proportion of EA Resident Population per Facility with Cultural Programs



Access to Facilities with EA Programs

While a larger proportion of the EA population aged 65+ and 75+ live within 2 km of a facility compared to the non-EA population (shown above), it is useful to examine the proportion living within a 2 km proximity to those facilities with EA tailored programs (Table 7). About 67% of EAs aged 75+ live within 2 km of a RC facility and 34% within 2 km of an AL facility offering EA programs compared to 71% and 58%, respectively, for non-EAs. Even though older EAs are more concentrated in particular areas, a slightly smaller percentage are within 2 km of a facility providing EA tailored programs compared to non-EAs. This indicates a need for new culturally relevant facilities or additions to current ones located in these high concentration areas.

Table 7. Percentage of the Population Living within 2 km of a Facility with EA Programs

	EA Population, 65+	Non-EA Population, 65+	EA Population, 75+	Non-EA Population, 75+
Residential Care	63.4%	68.0%	67.1%	70.5%
Assisted Living	31.4%	54.8%	33.5%	57.7%
Total	72.7%	76.7%	76.1%	79.3%

Occupancy Rates in Facilities with EA Programs

The EA population has significantly lower occupancy rates in facilities with EA cultural programs, relative to the non-EA population (Table 8). For the population aged 75+ years, the EA occupancy rate in local (within 2 km) facilities with EA programs is 5.6% for RC and 1.7% for AL compared to 10.3% and 3.7% respectively for non-EAs. This indicates that there is a significant service gap for EAs living in either RC or AL.

In order to examine the local occupancy rates by region, we compare access to local beds per capita for all RC and AL for the total population of persons 65+ and 75+ (Figures 5 & 6), with the local beds per capita for only RC and AL with EA cultural programs for the population of EAs aged 65+ and 75+ (Figures 7 & 8). Note that in Figures 5 and 6, darker areas denote census tracts with a high number of beds per capita within a 2 km radius; whereas for Figures 7 and 8, darker areas denote census tracks where there are low beds in RC and AL with EA cultural programs per capita for EA residents. . Also, in Figures 7 and 8, census tracts with less than 50 EA residents are shown in grey to denote very small numbers for meaningful estimation of service gaps. These Figures indicate that, despite high concentrations of older EA residents in Richmond, South Burnaby, and the TriCities, there are very low beds per capita in RC or AL with EA cultural programs.

Table 8. Local Occupancy Rates for EA and non-EA persons in Culturally Appropriate Facilities

	EA occupants per capita, 65+	**Non-EA occupants per capita, 65+**	**EA occupants per capita, 75+**	**Non-EA occupants per capita, 75+**
Residential Care	2.5%	4.4%	5.6%	10.3%
Assisted Living	8.0%	1.6%	1.7%	3.7%
Total	2.9%	5.1%	6.4%	11.9%

Figure 5. Local Beds per Capita, Aged 65+ years

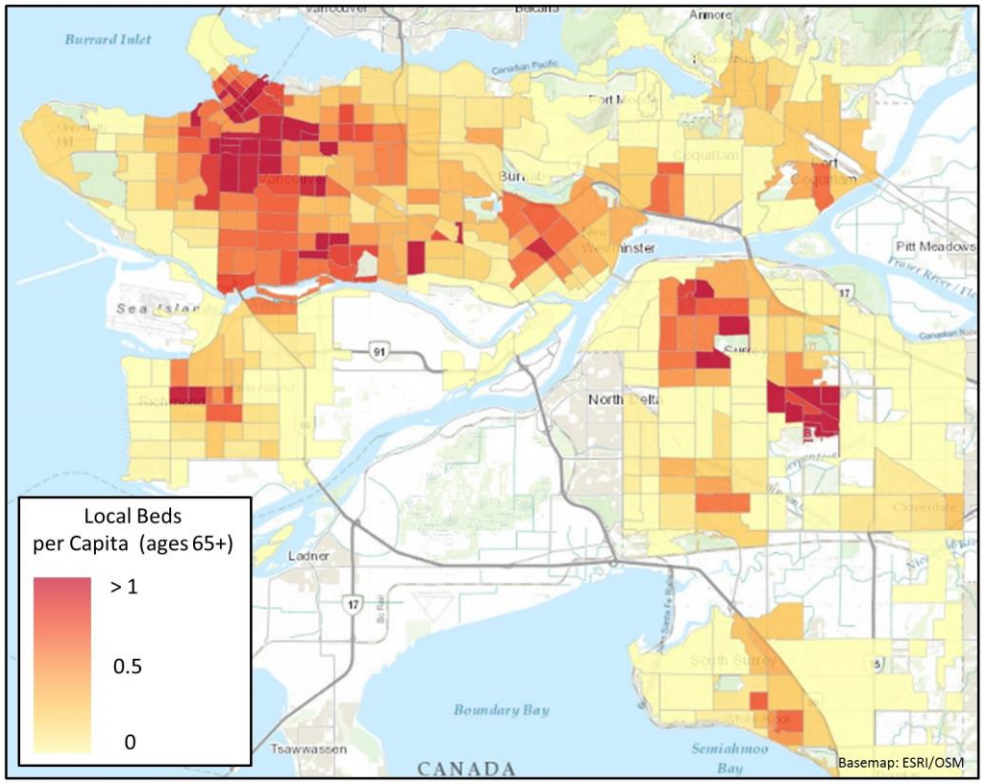


Figure 6. Local Beds per Capita, Aged 75+ years

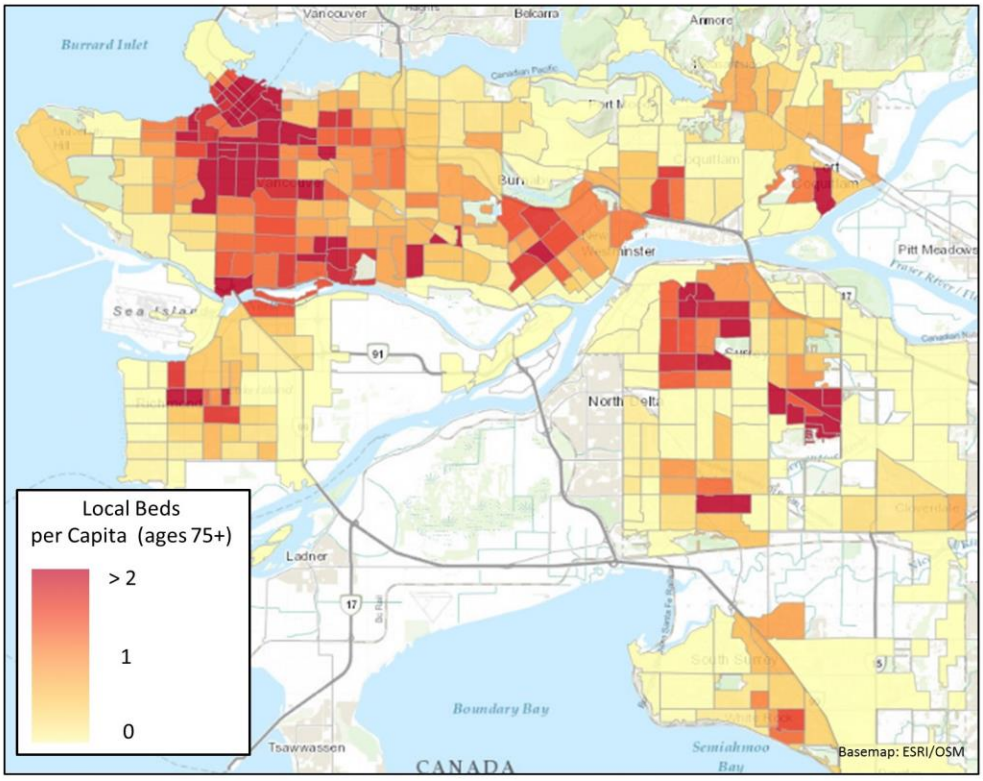


Figure 7. Local EA Occupancy Rates in Facilities with EA Programs, per EA Capita, Aged 65+ years

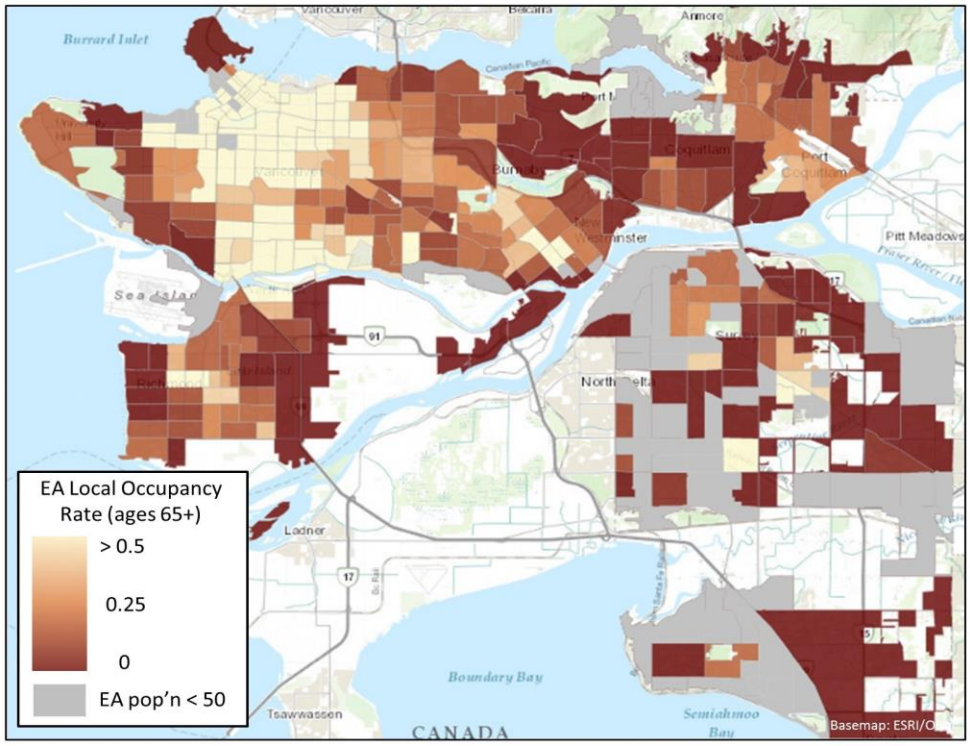
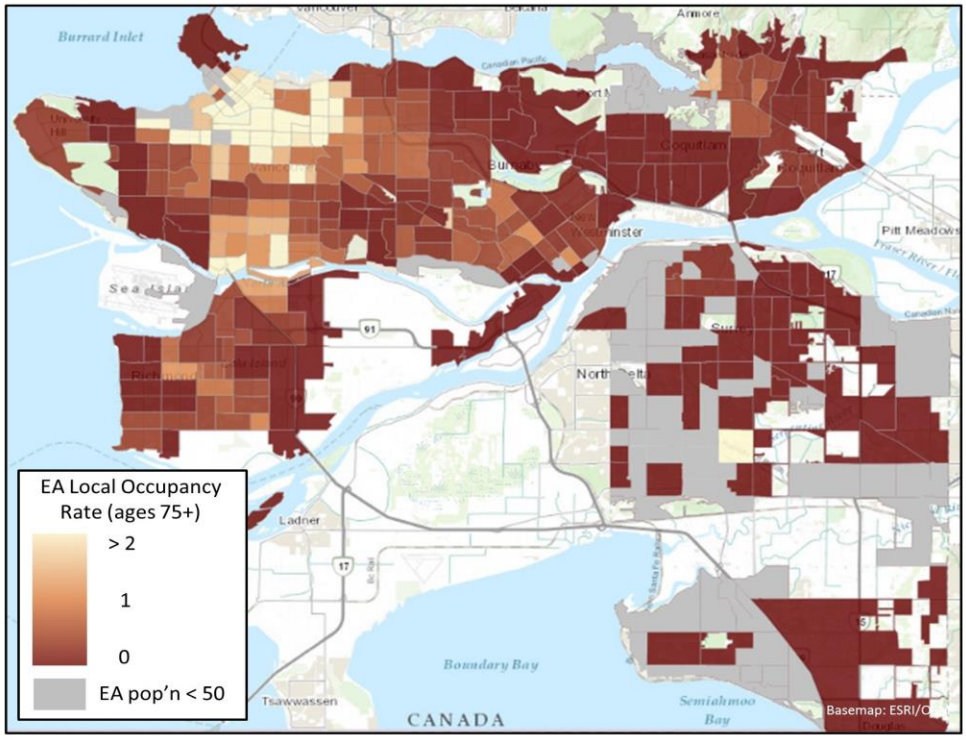


Figure 8. Local EA Occupancy Rates in Facilities with EA Programs, per EA Capita, Aged 75+ years



FOCUS GROUP METHODS

Four focus groups were conducted in Cantonese with a total of 52 older adults, including 40 women and 12 men (77% and 23%, respectively), aged 60 years and older. Approximately half of all focus group participants were fluent in both Cantonese and Mandarin; and the majority had little or no English-speaking skills. These characteristics were deemed representative of the target groups. The four focus groups were comprised of participants with the following characteristics.

1. Adult Day Care (ADC) participants: Focus group 1 (lasting 53 minutes) was conducted with a group of 13 older adults (8 women; 5 men) who lived in the community and attended a S.U.C.C.E.S.S.-run ADC once per week. This ADC is only available to Vancouver residents; and there is a significant waitlist. Most participants lived in close proximity to S.U.C.C.E.S.S. (Chinatown area) and a few lived in East Vancouver.

2. Assisted-Living (AL) participants: Focus group 2 (lasting 66 minutes) was conducted with a group of 11 older adults (8 women; 3 men) who were residents of a S.U.C.C.E.S.S.-run AL facility in Chinatown. The majority of participants had lived at the residence for a few years. Participants felt privileged and happy to have secured a place that they could call home at the AL residence because there were so few AL accommodations suitable for older Chinese people.

3. Community living participants: Focus group 3 (lasting 65 minutes) was conducted with a group of 9 older adults (7 women; 2 men) who lived independently in the community.

4. Community living participants: Focus group 4 (lasting 55 minutes) was conducted with a group of 19 older adults (17 women; 2 men) who lived independently in the community. Since it was deemed 'unlucky' to speak about future outcomes for older Chinese people, many participants did not want to talk about subjects such as senior housing.

Focus group participants were asked to discuss culturally sensitive care, programs, and services that exist for East Asian cultural groups in Metro Vancouver and to identify the needs and demand for specific programs and services. Efforts were made to not lead participants in a particular direction, but rather, to allow them to express their preferences, attitudes, and ideas about the topic areas. Sample questions included: "*What culturally sensitive care, programs, and/or services do you use?*" and "*What is one Chinese service that is most important to you; and what is one service you think is missing?*" All focus groups were audio recorded and translated into English and thematically analyzed. Notably, as participants were recruited by S.U.C.C.E.S.S. staff and from S.U.C.C.E.S.S. programs, the services offered by S.U.C.C.E.S.S. were well-known.

FOCUS GROUP FINDINGS

Across the four focus groups, the primary topics discussed by participants included residential care and assisted living; adult day care services; community-based information services; and community-based language and interpretation services.

Residential Care and Assisted Living

In discussions regarding supported living environments for seniors, there was some difficulty in differentiating between what participants were referring to when they wanted a higher level of care and supported housing, as there is not a Chinese term that distinguishes between RC and AL; both are translated as 'a place for seniors'. Nevertheless, there was consensus that supported housing options for seniors were needed across the continuum of care that could cater to Chinese seniors.

ADC participants reported a need to better understand their housing options. One participant stated,

> *"We aren't at the age for going into an old folk's home yet, but we really want to know what sort of criteria will allow us to get in. When we go in, we also want to know what amenities are available there. It's difficult because we just don't know. So it would be nice to have an organization or service catered to those people who want to consider RC."*

Not only was there a need expressed for more information about senior housing, but also about whether such housing catered to Chinese residents:

> *"We like Chinese meals. If I had to eat Western meals every day I would starve! Sometimes they serve cold meals. I just can't eat cold foods."*

Having more supported housing options that cater to the preferences of Chinese seniors was seen as a need:

> *"To be honest, the City of Vancouver needs more Chinese-speaking services. The nursing homes. Because the Chinese nursing home has a Chinese way of doing things, the culture, will give us a peace of mind. I mean for instance, we can live in a English nursing home, but because we are so culturally different that we would feel like we'll never be at home. If we're in a Chinese nursing home, it'll feel like we're always with home, with friends."*

Community living participants agreed:

> *"It would be great if the government can do something like increase the number of Chinese-speaking facilities in the community, because you know, us Chinese don't really like living in English-speaking facilities. We'll grow old someday too. It's going to be in demand."*

> *"When I'm speaking of my ideal I'm referring to the nurses and caregivers being able to speak our language. If they speak English I wouldn't understand what they're saying."*

> *"I could live in an English nursing home but I will prefer it if I lived in a Chinese-speaking one instead. I mean firstly, I would never be able to understand English staff 100% if they spoke English. Secondly, they'll serve English meals all the time and that won't do. We need to eat rice every day."*

ADC participants reported limited availability of Chinese RC and AL facilities and the long wait times to be admitted. One ADC participant stated, *"I think I can speak for everyone that we're all concerned about the lack of nursing homes. We're worried that we would not be able to get into one."* Another community living participant confirmed this:

> *"There are some older adults that do not have the ability to live by themselves. They can't even do basic necessities such as going outside and buying (lifting) groceries. Due to certain circumstances they may not have any children who will be able to take care of them. But because all these Chinese nursing homes are full they have to go and wait for another one. Sometimes to a place they don't like. The process to get into a nursing home is difficult too. You have to have a doctor's recommendation, a hospital's recommendation, then you have to go through Fraser Health and pass the 10 or so questions they ask you. And if you don't pass them all you won't be able to get in. What are those who failed supposed to do? It's very sad really."*

Most participants seemed to know about the AL and RC facilities run by S.U.C.C.E.S.S., but noted the high demand and long wait times. One AL participant reported waiting 3 years before being offered a home in the S.U.C.C.E.S.S. AL residence where she currently lives. Other AL participants were in agreement; one individual reported that her husband died while they were on the AL waitlist. While waiting to move into the AL residence, AL participants reported being referred to the neighbouring ADC or being provided with home care services, including a Chinese-speaking care aide, who assisted with bathing and housekeeping.

There was some indication that community living and ADC participants disliked the idea of aging-in-place, preferring to know they could move to supported housing when they are not longer able to live at home. Community living participants agreed that they would prefer to not live alone when they are older because no one would know whether they had fallen or died in their homes. In agreement, one ADC participant stated:

> *"We're currently living in our own homes right now. But we don't know what our health might be like in the future. If one day you can't even lift of cup of water by yourself what would you do? Plus your family members can't monitor you 24/7. At nursing homes they'll be able to do that. For us, that's a safer alternative than living by yourself."*

ADC participants did not believe that they would rely on their children or family to provide care for them in their homes in the community as it was not always feasible or appropriate, and participants would want formal care from "professionals". One ADC participant stated: "*At our age, we're in our 80s, 90s, even our kids at home are in their 60s. If their health isn't that good they might need to consider nursing homes themselves!"* Community living participants agreed:

"We need more AL. In 20 years we'll be really old and will need to be taken care of. Even though we have children, they have their own lives. Therefore we're practically just little lonely seniors once we're old. If there are AL facilities with nurses that can help us when we need it—helping us get around, helping us bathe—that would be great. But it has to be in Chinese, they have to be able to speak in Chinese."

"I currently live by myself right now. All my children are not in Vancouver. When I grow old they wouldn't be able to help me out. I just don't know what to do. I'm hoping that I'll be able to enter an AL. I'll still be able to do what I want but when I'm in trouble or need of assistance, I feel safe knowing that there's a qualified nurse nearby."

In support of this, a community living participant commented on her father's current situation and the difficulty in getting him into AL:

"My father is nearing 90 and lives by himself in his home. He can still manage on his own for now. But recently he had a pacemaker put in and we're getting worried about his health. We aren't requesting a lot, we just wanted my dad to be admitted to an AL facility. But for the past 2 years we've already requested 3 times to admit my dad. All 3 times we were rejected because my father is too healthy (capable) to qualify. So how can I, being 65 years old right now, even consider moving into AL when my father's who's 90, can't? This issue can be resolved if there were more AL in the area."

One AL participant reported the desire for living in an AL residence closer to her family, but having limited options because too few staff spoke Chinese:

"My daughter lives in Burnaby so it takes her a hour drive to get here. There is a nursing home that's close by to her house. It would be great if they employed some Chinese-speaking staff there. That way I wouldn't mind being with English staff and residents."

AL participants discussed needing more Chinese-speaking care aids and nurses in facilities so that Chinese- and English-speaking residents can live together. One AL participant suggested that culturally tailored Chinese AL facilities could lead to segregation and that what is needed is the integration of people, beliefs, values, and practices. And further, that if AL facilities would adjust to creating an environment where all people could participate and feel that their culture was valued and appreciated, there would be less urgency to develop more culturally tailored Chinese AL facilities.

Adult Day Care Services and Community Centres

One focus group was conducted with participants of a S.U.C.C.E.S.S. ADC, which was reported to be the only Chinese ADC in Vancouver. Participants expressed that this was a great program and they would like to see this model replicated and offered elsewhere throughout Greater Vancouver. Limited availability of ADC services in the region was emphasized by the majority of participants; and exemplified by the long waitlist. Currently, the S.U.C.C.E.S.S. ADC program was reported to be 'at capacity' and as such more funding was required to create similar ADC programs. One participant suggested that she

chose to forego vacations because she would lose her place on the list and would have to go back on the ADC waitlist: "*I don't even dare ask the coordinator if I can go on vacation because I fear that if I go and leave ADC, my spot will be taken by another person.*" Another participant agreed:

> *"The only thing I don't agree on is how little Chinese ADC there are around here. I mean, I can only come here once a week, and it's only for a few hours. Additionally, if I go on vacation for 2 or 3 months and I come back, my spot here will be taken and I may have to wait for 2 or 3 months to get back into ADC."*

Community living participants commented on the undesirability of the neighbourhood in which S.U.C.C.E.S.S. was located and the sense of feeling unsafe when going there. Thus, there was a preference among some to participate in activities at their local community centres, though there were limitations to these centres, such as the inability to accommodate high numbers of Chinese-speaking seniors. One community living participant stated:

> *"Oh we do everything [at the community centre]; for a low cost. We play Mahjong, do dancing. But the facility is so small; and there's hardly any space to admit more people… there's also a lack of Chinese-speaking people at the community centres. The majority of people who serve us are English-speaking. That's fine for the most part but sometimes we want to know new programs or other information that's offered, but we can't convey it to the staff. We also don't understand what they try to say to us as well."*

Though there are various community centres throughout the lower Mainland, some participants preferred S.U.C.C.E.S.S. services because of the variety of programs offered in Chinese that are of interest. As one community living participant stated, the programs offered by S.U.C.C.E.S.S. are more comprehensive:

> *"Even though I live close to a community centre, in comparison to S.U.C.C.E.S.S., they only offer one type of service or program. In S.U.C.C.E.S.S. I can enrol in different programs and if I want to ask for the news or have a concern, they can arrange a room for me and listen to my problems. At the community centre, you enrol in one program and that's it; you start at this time and leave at this time. The services that they provide are just not as comprehensive."*

Community-Based Information Services

ADC participants indicated that when they require information and resources, their first 'go-to' was S.U.C.C.E.S.S. Many reported that the S.U.C.C.E.S.S. ADC provided community news/information, offered health seminars, and provided Chinese meals. ADC participants reported relying on their children or family members to complete paperwork or to visit a family doctor, though children/grandchildren were reported to be limited on time because of school, work, and other responsibilities. ADC participants wanted a coordinated Chinese information system that could provide information on different services.

> *"If there's a Chinese organization that would help us when we want something that would be great. You ask if we know any services but we just don't know. We only know of S.U.C.C.E.S.S."*

Community living participants reported a need for an integrated communication and information system in multiple languages to inform seniors on housing options and other social services. One community living participant suggested that S.U.C.C.E.S.S. collaborate with the local Chinese radio station once or twice a week to broadcast current news or programs for older adults, and also have available a number to call for assistance (i.e., a Chinese equivalent of the yellow pages for seniors). At present, community living participants rely on friends at community centres for information, but for those who do not attend community centres or have few friends, a single telephone number to call for information and assistance was identified as an important resource:

> *"Most older adults can't speak English so it'll be beneficial if there was a number available that they're able to call and ask for anything. Such as applying for pension, asking for legal advice, etc."*

Another community living participant reported that most urgent news or information that was broadcasted was not available in Chinese, making it difficult for people to know about emergencies (e.g., information on an earthquake was not available on Chinese radio stations until later in the evening).

Community-Based Language and Interpretation Services

Both community living and ADC participants indicated that they would like to see more English language courses available at low or no cost. As one community living participant stated, *"It would be nice if there are more English classes available for us so we can integrate into society. Free though, not those classes that cost $10-$20*." AL participants discussed wanting more interpretation services because of their lack of English-speaking skills. One AL participant stated:

> "*When we come here [to Canada] at an old age, it's harder for us to learn or be in contact with English-speaking people. We'll be able to learn English if we come in contact, but we rarely have to. Even if we learned English if we don't use it, we'll lose it. I don't even remember the English we've learned when I enrolled in citizenship class!"*

S.U.C.C.E.S.S. was the only organization known to one community living participant that offered English classes:

> *"S.U.C.C.E.S.S. is the only organization I know that offers English classes and other things we can enrol and participate. The area where I live doesn't offer these things in Chinese."*

As well, S.U.C.C.E.S.S. was praised by community living participants for having a bilingual system in place, which allowed participants to read information in Chinese and learn English at the same time. According to one AL participant, the inability to speak English influenced participants' experiences with primary health care, particularly interactions with medical professionals in hospital settings:

> *"Our English skills are not up to par, so we cannot communicate well. Therefore it would be nice if we can have someone who would be able to interpret for us. Especially when we have to go to the hospital. The thing that I'm most reluctant to do in Canada is to go to the hospital. Everything is great here, it's just that I don't know how to speak English."*

Community living participants agreed, noting a need for interpreters:

> *"I wish for more people who can help us interpret when we go to the hospital so I don't have to rely on my daughter all the time. I mean, when she's out traveling I'm stuck with all these English words. I have to rely on my dictionary to help me decipher the words when my daughter isn't around."*
>
> *"It's so hard to go to the hospital sometimes. It's better at the 'Chinese hospital' (there are a high number of Chinese-speaking staff at Mount St. Joseph Hospital) because you get Chinese nurses or doctors on shift depending on the time you go to the hospital. In other places you have to arrange for a translator and go by their times to make an appointment. And when the doctors speak to you, you just don't understand what they're saying. It makes us anxious."*

HIGHLIGHTS & CONCLUSIONS

- Approximately one-quarter of older persons in the municipalities of Burnaby, Coquitlam, Port Coquitlam, Port Moody, Richmond, Surrey, Vancouver, and White Rock are East Asian (EA).

- The EA population aged 65+ years has grown significantly in recent years.

- There are 66 residential care (RC) facilities (8,352 beds) and 45 assisted living (AL) facilities (2,491 units) in these communities.

- EA older adults aged 65+ years comprise 23% of residents living in RC and 24% of residents living in AL, slightly below the proportion of EAs in the regional population.

- For adults aged 65+ years, the EA bed occupancy rate is 3.5% compared to 3.9% for the non-EAs population. This difference is greater for the population aged 75+ years, where the bed occupancy rate for EAs is 7.9% compared to 9.4% for non-EAs. This indicates a service gap for EAs, assuming equal need.

- The EA population of older people is concentrated in areas where there are more RC and AL facilities compared with non-EAs.

- Despite better local access to facilities, EAs have lower occupancy rates in their local neighbourhoods, and are more likely to have to relocate farther for care.

- In RC and AL facilities reporting no culturally tailored programs, EA residents made up 28% of the residents. It is likely that a significant proportion of the 28% not receiving such services desire or require them.

- About 67% of EAs aged 75+ years live within 2 km of a RC facility and 34% within 2 km of an AL facility offering EA cultural programs compared to 71% and 58%, respectively, for non-EAs. Though older EAs are concentrated in particular areas, a slightly smaller percentage live within 2 km of a facility providing culturally tailored programs compared to non-EAs. This indicates a need for new culturally relevant facilities or additions to current ones in areas with high concentrations of EAs.

- For the population aged 75+ years, the EA occupancy rate in local (within 2 km) facilities with EA cultural programs is 5.6% for RC and 1.7% for AL compared to 10.3% and 3.7%, respectively, for non-EAs. This indicates that there is a significant service gap for EAs living in either RC or AL facilities in these communities.

- Despite high concentrations of EAs in Richmond, South Burnaby, and the TriCities, there are very few beds per EA capita in facilities with EA cultural programs.
- There was consensus among focus group participants that more supportive housing and care facilities targeting EA seniors are needed across the continuum of care.

Since housing and care options that cater to EA seniors are limited, it is in high demand, with long waitlists.

- Focus group participants reported needing more EA-speaking care aids and nurses in facilities so that EA- and English-speaking residents can live together.

- There was some indication from focus group participants that aging-in-place may not be desired for all seniors of advanced ages. Participants reported preferring to know that they could move to supported housing when they are no longer able to live at home.

- Focus group participants reported limited availability of ADC services in the region as exemplified by the long waitlists.

- Focus group participants reported participating in activities at their local community centres; however, there were limitations to these centres, such as the inability to accommodate high numbers of EA-speaking seniors.

- Focus group participants wanted an easily accessible information and communication system that could inform seniors about different services and emergencies.

- Focus group participants indicated that they would like to see more English language courses available at low or no cost.

- The inability to speak English among many EA seniors influenced interactions with primary health care providers, particularly those with medical professionals in hospital settings.

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