Impact and Insights:

COVID-19 and Alberta's Community Disability Services Sector

October 30, 2020

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Research and analysis: Elizabeth Schweighardt

Authors: Elizabeth Schweighardt, Nilima Sonpal-Valias, and Andrea Hesse

About ACDS

The Alberta Council of Disability Services (ACDS) is a non-profit association of community-based service providers supporting individuals with developmental disabilities.

Vision: People with disabilities live full lives as citizens supported by a vibrant network of services in their communities.

Mission: ACDS is the collective voice of our members, advancing excellence and best practices, advocating for effective public policy, and championing professional disability services.

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1 Introduction

On March 17, 2020, Alberta declared a public health emergency in the face of the global COVID-19 pandemic. Like many industries, the Community Disability Services (CDS) sector demonstrated agility by responding rapidly and creatively to unforeseen challenges. Service providers developed new ways to continue supporting individuals while adhering to safety protocols, and intensified collaboration by sharing expertise and leveraging resources to address emerging issues. This was supported by the government's increased communication activities and temporarily increased funding flexibility. Were it not for the pressures of the pandemic, some of these actions might never have occurred or would have taken longer and had less impact.

In contrast to these positive outcomes, the pandemic exacerbated some chronic problems in the CDS sector: overlap between the Persons with Developmental Disabilities (PDD) program and Alberta Health Services (AHS) created confusion in implementing public health orders; the sector's characteristic low wages amplified retention issues; service providers with already-thin organizational capacities were stretched to their limits; and, in some cases, underlying relationships between PDD program staff and contracted agencies tended to tint perceptions of decisions and actions by either party.

This paper synthesizes how service providers in the CDS sector were impacted during the first six months since the public health emergency was declared. It also summarizes the insights gleaned from those experiences. The intent is to document emerging learnings, including promising new practices to retain and build upon, and highlight the chronic issues that must be addressed for the sector to be effective and sustainable in a challenging post-pandemic social and economic reality.

Data sources

The information in this document is based on what we heard from early March to end of September 2020 through our participation in:

- The Service Provider Partnership Committee (SPPC) co-chaired by ACDS and Alberta Community and Social Services (CSS)
- SPPC's working groups, which duplicate SPPC's co-chaired, equal representation model
- Biweekly meetings hosted by CSS Assistant Deputy Ministers (ADMs) and regional PDD leaders, with regional service providers
- Regional service provider councils and any sub-groups or task forces they formed to address program-specific challenges
- Individual conversations and inquiries from ACDS member organizations

Data sources number well into the hundreds. They include meeting/video-conference minutes and notes from collaborative tables; copies of emails sent by agencies or networks to their peers or to government; pulse-check surveys conducted by regional councils; and, emails or notes of conversations with service providers and government officers.

2 Disjoint Between AHS and PDD

The most significant impacts on community disability services arose due to the lack of clear boundaries between PDD and AHS/Public Health. When public health orders began to be released in Alberta beginning on March 16, 2020, organizations struggled to understand if, and to what extent, the requirements applied to them. AHS' lack of understanding of the PDD program, and the lack of CDS sector-specific information and guidelines, created undue stress and burden on service providers already at their limits of trying to provide safe and meaningful supports.

Essential vs. non-essential services

On March 27, Alberta's Chief Medical Officer of Health (CMOH) issued Order 07-2020, which prohibited, among other things, the indoor gathering of groups in excess of 15 people and the provision of 'non-essential health services' and 'personal services'.[1] The health order was not sufficiently clear how the restriction applied to the scope and variety of services offered by CDS sector organizations. Thus, service providers were initially left confused and had to use their own judgement about which of their programs were essential, and whether administrative staff supporting frontline workers could be considered essential under the health order.

On several occasions during the SPPC meetings and the biweekly regional meetings with ADMs, CSS verbally advised that day programs[2] were considered non-essential and should be closed or modified to virtual or individual programs. However, the information on the government website was less clear as it referenced services to individuals in their homes, thereby causing further confusion. On April 6, ACDS was able to confirm with CSS that '*all* disability service workers that provide direct service to Albertans with disabilities and organizational supports needed to facilitate this work' were captured under Alberta's 'essential services' designation; this clarified the status of non-frontline staff, however the status of day programs remained murky for some time.[3]

The lack of clarity about what aspects of the CDS sector is deemed 'essential' has also played out in the uncertainty over whether CDS sector workers are eligible for any of the $3 billion pledged in early May by the Government of Canada to increase the wages of low-income essential workers,[4] a decision that ultimately rests with the Alberta government.

Designated or licensed vs. non-licensed residential site

Beginning in late March, a series of public health orders were issued to update the operational and outbreak standards of various healthcare and continuing care facilities. The updates included changes to screening and reporting protocols, resident activity restrictions, cleaning and distancing protocols, visitor limitations, restrictions to movement of staff across facilities, and – as public spaces began opening up – screening and isolation protocols for residents leaving and subsequently

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[1] Alberta Health. March 27, 2020. Record of Decision – CMOH Order 07-2020.

[2] These are non-residential programs that support individuals with activities during the daytime; many are delivered at specific facilities with several participants present.

[3] ACDS. 2020. April 6 COVID-19 Update. Calgary, AB.

[4] CBC News. May 7, 2020. "Ottawa, provinces and territories reach $4B deal to boost essential workers' pay."

returning to the site. The orders were issued frequently and rapidly as the pandemic situation shifted, more evidence became available, or issues arose that had to be addressed.

More often than not, each order was complex with information that was often challenging for service providers outside the healthcare system to interpret and implement into operations. Service providers had to spend considerable time understanding the guidelines and subsequently translating them into concrete procedures in line with their own policies and practices for their staff to follow.

One of the biggest challenges, however, was to decipher to what extent and under what conditions each order applied to a particular service or site due to the licensing framework applicable to PDD homes and facilities:

- Homes or facilities within PDD service delivery where four or more residents live are required to be licensed under the *Supportive Living Accommodation and Licensing Act* (SLALA). These homes are "licensed" but not "designated".
- Some AHS continuing care facilities for supportive living are licensed under the same standards and are also defined as "designated".
- Homes within PDD service delivery where three or fewer individuals live and homes that are private residences are not required to be licensed at all under SLALA.

Prior to the pandemic, ACDS had flagged as problematic both the discrepancies of these requirements as well as the administratively cumbersome and often contradictory nature of these accommodation standards to the CET Accreditation standards.[5] However, the limitations and inconsistencies of these requirements became extremely problematic as mandatory public health orders were issued based on licensing regimes. The full extent of most orders only applied to designated supportive living facilities that were contracted by AHS and those that were licensed under SLALA.

- Facilities licensed under SLALA but not contracted by AHS were required to update their operational and outbreak standards, and were only required to implement additional restrictions (e.g., limit the movement of staff) in case of a COVID-19 outbreak at the facility.
- Supportive living sites and homes with three or fewer residents, which are not licensed under SLALA, were not *required* to follow Order 07-2020, but were *strongly recommended* to implement the guidelines and follow the outbreak reporting protocols when possible.

While the legal line between 'required' and 'strongly recommended' may be clear, it is quite fuzzy in terms of moral or ethical responsibility especially during a pandemic. Moreover, erring on the side of caution by following public health orders even when not required to do so, has considerable implications (e.g., potential staff shortage).

To complicate matters further, many CDS service providers have a combination of licensed and non-licensed facilities; a few also operate AHS designated sites. This meant there were different legal regulations for different homes run by a single organization. ACDS fielded many questions regarding which category a home fell under, resulting in the release of a flowchart detailing regulatory

[5] ACDS Creating Excellence Together (CET) Accreditation sets the benchmark standards in Alberta for supports to adults with developmental disabilities.

requirements and recommendations for different types of living facilities.[6] If the health orders had been written with the CDS sector in mind, these confusions would have been greatly minimized.

Access to PPE and supplies

AHS' lack of understanding of PDD services was further demonstrated in how it determined access to PPE. CMOH Order 10-2020, issued on April 10, mandated continuous masking when providing direct care in designated or licensed residential facilities, and recommended it in non-licensed sites. This directive escalated service providers' need for PPE. With ACDS' advocacy and support from PDD, service providers were able to procure the supplies from the Provincial Operations Centre (POC) or through AHS.

However, many organizations did not receive enough PPE to fully equip their staff. This is because AHS' formula for calculating PPE was based on the number of beds in a facility, and assumptions of care levels typical in a long-term care facility. These assumptions do not take into consideration the diverse support needs of individuals in the PDD delivery system: an individual with high or ultra-complex needs, for example, typically has significantly more support staff than an individual in long term care, and potentially more care requirements where PPE need to be used.

In addition, following this order, masks were initially dispatched only to "licensed" homes leaving significant gaps and uncertainties for services that operated both licensed and non-licensed homes under the same organization. These agencies, thus, had to scramble to put in orders for their non-licensed homes. For a short time, PDD regional offices helped to coordinate PPE orders and delivery from AHS to service providers until AHS had a better understanding of the sector's needs and supplies were stabilized. Despite these interventions, a survey of Edmonton service providers in July showed that 45% of organizations felt that lack or delay of PPE was challenging service delivery,[7] and many organizations had to augment the supply from AHS by seeking out other sources.

Insights

Boundary barriers: Due to AHS' lack of understanding of the disability sector, complex public health requirements caused confusion, and the burden of protocol applicability and implementation was placed on service providers. Though ACDS attempted to assist with interpretation, earlier and clear guidance from CSS and AHS/CMOH would have expedited organizational decision-making and minimized the sense of disorder across the sector.

Inefficient system overlaps: Issues arising from the overlap between PDD services and AHS were not unique to the COVID-19 crisis; the urgency of the pandemic, however, sharpened the sting of existing issues or created unnecessary new hurdles. ACDS has already noted, for example, that the existence of a 'parallel system' – where PDD resorts to creating supports for individuals that should otherwise be provided through existing programs such as AHS – creates financial inefficiencies as well as gaps if one system believes the other is covering off responsibilities.[8]

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[6] ACDS. 2020. Alberta CMOH Order 10-2020: Clarification. Calgary, AB.

[7] Edmonton Region Council of Service Providers. July 2020. *COVID-19 Pandemic Survey*.

[8] ACDS. 2019. *Moving Forward: ACDS Vision and Framework for Impact*. Calgary, AB.

The parallel system also has implications for frontline workers in the CDS sector. They need to learn to become pseudo-healthcare workers by attending to individuals' health-related needs when these supports would be provided by Health, and learn to navigate a very complex and highly regulated system.[9] On top of keeping up with the demands of their core work, these expectations are neither realistic nor sustainable. As was demonstrated during the last few months, most disability service providers were unaccustomed to the strict protocols demanded by the public health orders. Learning to interpret and accommodate orders written for the healthcare field was a stressful addition to many agencies' service demands and models.

Intentional cross-systems solutions: Clarifying AHS' overlap with PDD is a critical step in delineating PDD's scope and capacity. Determining which program possesses overriding authority, liability and costs in cases of system conflict are integral to developing sustainability and efficiency. In addition, sector-specific, or at least sector-sensitive, guidance in future public health orders as well as a better understanding of disability service models and approaches will significantly reduce the ongoing stress and burden on the disability sector should the pandemic crisis persist.

3 Service Delivery and Operational Changes

Like all organizations, disability service providers had to rapidly modify or in some cases cease part of their operations in response to the public health orders or guidelines. There was no uniformity in responses: what services were provided, how they were delivered, and what organizations did to support their workers with the transitions depended on a combination of factors including the individuals supported, the organization's range of programs, PDD's flexibility, and organizational agility and capacity. Several innovative practices were implemented, many with the use of technological solutions, that will likely be retained even after the pandemic ends.

Residential supports

Residential and community access (day program) supports were the earliest and most impacted service areas. As public health orders mandated restrictions or closure of educational settings,[10] public recreational and entertainment facilities,[11] businesses, and retail services,[12] residential programs had to respond to a rapid escalation of demands to support individuals now unable to participate in their communities for employment, leisure or social activities.

To adhere to physical distancing and visitor restrictions[13] while trying to provide opportunities for individuals to maintain social connections, staff implemented measures such as supporting visit through the window or in side-by-side cars, or delivering communicative technology to families.[14] Recognizing the negative impact that visitor restrictions were having on residents' quality of life,

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[9] ACDS. 2019. Developing a Comprehensive Human Resources Strategy for the Community Disability Services Sector: Discussion Paper. Calgary, AB.

[10] Alberta Health. March 16, 2020. Record of Decision – CMOH Order 01-2020.

[11] Alberta Health. March 17, 2020. Record of Decision – CMOH Order 02-2020.

[12] Alberta Health. March 27, 2020. Record of Decision – CMOH Order 7-2020.

[13] Alberta Health. March 22, 2020. Record of Decision – CMOH Order 03-2020.

[14] Alberta Disability Workers Association. 2020. "Your Stories."

public health orders later allowed outdoor visits and expanded the definition of 'essential visitors', however, significant limits still remained.[15] In July, 55% of Edmonton service providers indicated that visitor restrictions in group homes continued to impact service delivery.[16]

The pandemic also impacted overnight stays of individuals at the homes of their families. On the one hand, families were reluctant to invite individuals because of a health order in May requiring that any person away from a designated or licensed site for over 24 hours would have to isolate for 14 days upon returning.[17] Many non-licensed sites also implemented this measure although they were not required to. Residential staff, who were working at full tilt, were further stretched without the temporary relief obtained when individuals occasionally stayed overnight with families.

On the other hand, some families – either of their own choice or in response to requests by over-stretched organizations – chose to take individuals to stay at family homes until residential supports could stabilize. This led to several individuals and families choosing to keep the individual at the family home rather than having them return to their own home, even after the 14-day isolation period was relaxed in late-September.[18] An unintended consequence of this was that the affected service providers were, in reality, not providing contracted services to those individuals even though staffing hours were high to support the individuals who were in the homes. Additionally, residential funding is typically based on the number of individuals who live at the site. With some individuals now staying with their families and reluctant to return to their own home, we heard from several agencies that PDD pressured them to fill the resulting vacancy within 90 days or lose funding. This created a difficult situation for organizations trying to maintain their staffing and service model.

Community access supports and day programs

Unlike residential programs that were stretched to the limits at the onset of the pandemic, almost all community access and day programs had to cease operations at least temporarily until they could determine if they could put in place measures to meet public health guidelines. Some organizations pivoted rapidly to change how supports were delivered, typically by using technology to provide virtual supports to individuals forced to stay at home, or providing materials and equipment to residential staff or families so that individuals could continue their programs and routines at home. A few organizations with large facilities rearranged their spaces so that on-site programs could continue with physical distancing. Many agencies, however, had little choice but to suspend operations and redeploy or temporarily layoff staff, either because they were unable to implement alternative service approaches that met health measures or because individuals were unable or unwilling to participate.

In the weeks prior to the announcement in mid-June of Phase 2 of Alberta's reopening strategy, the ongoing confusion regarding the essential status of day programs led to significant advocacy by some organizations and ACDS for clear sector-specific guidelines for reopening. As well, ACDS and some service providers, most notably Chrysalis, advocated for safe reopening to respond to the growing mental health and isolation concerns of individuals who had lost community access and day

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[15] Alberta Health. April 28, 2020. Record of Decision – CMOH Order 14-2020.

[16] Edmonton Region Council of Service Providers. July 2020. *COVID-19 Pandemic Survey*.

[17] Alberta Health. May 25, 2020. Appendix A to Record of Decision – CMOH Order 23-2020.

[18] Alberta Health. September 23, 2020. Record of Decision – CMOH Order 32-2020.

programs. In addition to advocacy, in the absence of sector-specific guidelines, Chrysalis developed a proposal for CSS for safe reopening of day programs, while ACDS published a decision-making and planning tool on May 21 to assist day programs to develop their own reopening strategies. ACDS' tool was based on public health guidelines in place at that time for residential services and other sectors.

On June 8, CSS released a guidance document for reopening day programs. Once Phase 2 of Alberta's reopening strategy was announced in mid-June, most community access programs that had temporarily closed began offering modified programs while respecting health orders. For all agencies, physical distancing and enhanced cleaning protocols significantly increased the workloads of frontline staff. Several agencies had to implement higher, and in many cases one-to-one, staffing ratios to ensure individuals adhered to these strict and unfamiliar new protocols.

Though high staffing ratios allowed individuals to resume meaningful daily social and leisure activities and provided residential staff reprieve, organizations were concerned that these service models would not be supported by PDD. In July, 45% of Edmonton service providers reported that funding for one-to-one staffing in day programs was a priority issue, and that without it, more individuals would be forced to remain at home and add to the cost of residential programs.

While most day programs have opened since June, many are not operating at full capacity. In July, 82% of Edmonton service providers identified public health restrictions as the top issue impacting community access programs.[19] Many individuals or their families are still reluctant for individuals to be in spaces where physical distancing is not easy. Concerns about the risk of viral transmission in public transit have also kept individuals away from day programs. Many agencies, thus, have chosen to expand their services for current attendees rather than returning to pre-pandemic group sizes. Organizations have also tried other ways to bring individuals to their day programs, such as making multiple trips each with fewer individuals in agency vehicles, and incentivizing staff to transport individuals one-on-one in their own vehicles by reimbursing them for car insurance. These options have increased agency costs, and again, they are unsure if they will be reimbursed by the funder.

Unanticipated expenses and shifts in service demands

Community-based services to adults with developmental disabilities receive, on average, 86% of each organization's operational revenues from PDD. The remaining revenues, for the sector as a whole, come from sources such as social enterprises, fundraising, donations and grants.[20] As many social enterprises were forced to close their doors and fundraising events were suspended due to pandemic restrictions, PDD funding became very critical to service providers. For organizations without other revenue sources and a higher (or complete) reliance on PDD, the implications were even more dire.

Beginning in March, as public health orders started rolling out in rapid succession, agencies began incurring significant unbudgeted costs, including: overtime for residential staff, sick leave for quarantined or ill workers, PPE costs (until PPE became readily available at no cost to service providers from AHS), extra staff time to implement health orders, and wage top-ups to incentivise employees to continue working during the pandemic and in outbreak sites. Constricted by contracts

[19] Edmonton Region Council of Service Providers. July 2020. *COVID-19 Pandemic Survey*.

[20] ACDS. 2020. *ACDS 2019 Workforce Survey*. Calgary, AB.

with rigid service codes, service providers advocated via ACDS and regional councils for CSS to address these concerns.

Recognizing that agencies needed immediate flexibility to shift their staffing resources and address increased costs, CSS ADMs communicated to service providers on March 20 that PDD staff would work with agencies "to manage, adjust or move services as required to ensure client and staff safety" within existing funding allocations. In addition, agencies were asked to track unanticipated pandemic-related costs.[21] The expectation was that CSS would explore options for how the additional costs might get addressed at a future time.

On April 28, following a consultation with SPPC's Contract Management Working Group (established in late 2019 to collaboratively address contract issues), CSS released a revised invoicing process for agencies to identify pandemic-related costs separate from their approved funding allocation. If the additional expenses were within the agency's monthly approved amount (no additional funding required) payments would be processed as usual; for expenses exceeding the monthly allocation, the regional PDD staff would follow up and a payment decision would be made within three to five business days. The revised process maintained adherence to the contractual agreement which already allowed: (i) agencies to make limited reallocations within their budgets without new approval required (Clause 6.11), and (ii) temporary adjustment to a service model due to an extraordinary circumstance, with the approval and at the discretion of PDD (Clause 6.10).[22]

The revised process was not without its glitches, and issues varied across regions. Though CSS' senior leaders were comfortable with the flexibility given the evolving impact on agency operations, PDD staff in some regions were less clear about their scope of authority in this newly-vague environment. As late as June, invoicing processes implemented in April were being clarified regarding the acceptable level of detail and timelines for validation. A few outstanding issues were still being ironed out in October through the Contract Management Working Group. The revised process was complicated and confusing because it existed alongside other financial practices and monitoring processes that had been put in place to address pre-pandemic PDD budget pressures.[23]

Overall, progress in the funding relationship was made by allowing the flexibility that technically, if not in actual practice, already existed in service agreements. It allowed service providers to adapt to the evolving demands of the pandemic, and to adjust supports and staffing models to focus on individual well-being rather than be scripted by service codes.

Increased use of technology

In addition to agency-level considerations of what programs to continue operating and how to deploy finite staffing and financial resources during the pandemic, the most common way in which organizations have adapted is by using technology – a change made even by those previously averse

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[21] Alberta Community and Social Services. March 20, 2020. Letter from Office of the Assistant Deputy Minister to Disability Services Providers.

[22] Alberta Community and Social Services. April 28, 2020. PDD Service Provider Contracts – Invoicing Process. Letter from Thomas (Tom) Sutton to Service Providers.; Government of Alberta. April 28, 2020. 2020 Persons with Developmental Disabilities (PDD) Contract Template Questions and Answers.

[23] These practices and processes included focusing services on individuals with "critical and urgent" needs, tracking expenditures and reviewing service provision capacity in contracts.

to technology. These solutions were intended to maintain service delivery to individuals as well as to support staff and connect with other organizations.

Phone and video supports replaced in-person meetings. Instructional videos were used to teach individuals and families how to make and wear reusable masks. Videos demonstrating new physical layouts and procedures prepared individuals for the unfamiliar sights and practices awaiting them in adapted facilities. Organizations mass communicated with families and staff through live or pre-recorded virtual town halls or private Facebook groups which they could access at their own convenience. Online portals were created for a various purposes including: to disseminate pandemic information, make available tools and resources such as employee hazard assessments and procedural handbooks for staff returning to work, or collect staffing availability information.

In a survey of Calgary service providers, most agencies listed increased use of technology as one of two most common changes their organization would retain as a result of COVID-19.[24]

Opportunity for capacity building

Instead of temporarily laying off staff in programs that were suspended due to COVID-19, many organizations used the time to reinforce staff training. Some organizations permanently transferred their training processes to online mechanisms, others added mandatory training such as WHMIS and COVID protocols.[25] Agencies also used program closures or reductions as opportunities to increase their organizational capacity and prepare for a similar crisis or a second wave of business closures. Staff were redeployed towards projects such as developing pandemic or business continuity plans and communicable illness policies. Others used the time to strengthen their practices.

Insights

Service innovations: Many organizations managed to reposition their services to continue supporting individuals throughout the first six months of the pandemic. The ability to restructure program delivery gave organizations the opportunity to explore new, or previously overlooked, service models and approaches. While some program changes will be eliminated when pandemic precautions are no longer necessary, other newly discovered practices will continue to be utilized if organizations believe they are more efficient or effective. Organizations should be supported to evaluate these promising practices; successful practices should be refined and eventually amplified by sharing the learnings and encouraging their duplication in other organizations.

Organizational expertise and capacity: The pandemic demonstrated the deep expertise in many agencies, particularly those with long experience or those large enough to have skills in diverse program areas. Some smaller organizations, too, demonstrated their agility to respond, most likely because of flatter structures and decision-makers more closely connected to frontline work.

However, several agencies also struggled in the pandemic's fluid and uncertain conditions. These organizations seemed less likely to have the financial reserves, staffing breadth, or leadership

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[24] Community Rehabilitation Service Provider Council of Calgary. July 2020. *Calgary Service Provider COVID Response and Planning Survey*.

[25] Community Rehabilitation Service Provider Council of Calgary. July 2020. *Calgary Service Provider COVID Response and Planning Survey*.

capacity to adapt to rapidly changing guidelines, manage unexpected expenses, and restructure at the speed required in a crisis situation. Despite these challenges, many of these agencies play a necessary role in in the landscape of supports for individuals with disabilities.

As a sector, we need to explore how to strengthen organizational capacities in agencies that make valuable contributions but may need some extra support to forge though crises. Inter-agency program collaborations, partnerships, and mergers should be explored as potential solutions to strengthen the resiliency of the disability services sector as a whole.

Contract flexibility: The pandemic necessitated increased flexibility with less unnecessary oversight or perceived "micromanagement" of changes to individual funding and agency contracts. Most agencies rose to the challenge and showed that both PDD and individuals benefit when organizations can organize and adapt their supports to meet changing individual (vs. rigid contract) needs. Some agencies, however, appeared shell-shocked by PDD's permission to structure supports as they saw fit; agencies had not seen this level of flexibility before, and they doubted both PDD's sincerity and their own ability to make sound decisions.

The sector stands to benefit greatly if the flexibility necessitated during the pandemic continues after the crisis. This change can succeed if it is accompanied by a clear framework of outcomes and quality assurance standards, i.e., well-defined "goal posts" delineating where flexibility ends and accountability begins. Such a framework could consist of: a fixed contract amount for clear expectations; service codes used only as tools to build the budget (not as line items for accountability); flexible invoicing as long as it does not exceed total contracted amount; and service provider ability to respond to individuals' changing needs without having to get approvals for supports that are within program criteria. This frameworks and its goals posts, furthermore, need to be clear not only for service providers, but also for PDD staff responsible for contract compliance.[26]

4 Heightened Communication and Collaboration

Communication and collaboration activities were significantly increased during the pandemic. Primary means included working within existing mechanisms such as SPPC and regional service provider councils both as communication conduits as well as sites for discussing issues and crafting potential solutions. In addition, CSS ADMs hosted new biweekly videoconferences with regional service providers, and ADM John Stinson and ACDS CEO Andrea Hesse had daily briefings until about the end of June. CSS also developed Q&A posts to clarify emerging questions or directions. Regional councils created task forces and sub-groups to collaboratively address program-specific challenges by sharing expertise and resources. Outside of these formal structures, informal, ad hoc communication and collaboration between individual agencies also increased.

SPPC: Facilitating rapid provincial-level responses

SPPC is a formal, co-chaired mechanism for collaboration between CSS and ACDS to support improvements to the delivery of PDD-funded programs and services. It originated in ACDS' negotiations with CSS from 2018 to 2019 for a formal structure to collaboratively identify and

[26] COVID Learnings Working Group. July 29, 2020. Report of lessons learned. Email by Tom Sutton on behalf of the COVID Learnings Working Group to SPPC.

address issues, and to provide feedback from service provider perspectives on proposed changes. Since its formation in late 2019, SPPC had already established itself as a valuable table. Once the pandemic hit, its role escalated significantly.

At the start of the public health emergency, SPPC began meeting weekly to identify emerging issues and develop iterative solutions to the rapidly evolving crisis. Initially, CSS communicated with service providers only though SPCC or ACDS, which created confusion about the division of communication roles and responsibilities between ACDS and CSS, as well as anxiety for agencies that needed clear directions straight from CSS to the complex requirements flowing down from public health orders.

Upon ACDS stressing for the need for direct communication between CSS and service providers, starting March 27 CSS ADMs began hosting videoconferences every two weeks with each region's service provider council. The presence of CSS ADMs and regional PDD directors at these meetings allowed organizations to directly communicate their questions, concerns and requests. In late April, CSS began releasing a weekly Q&A targeting prevalent concerns and need for information in Alberta's disability sector. The biweekly videoconferences continued until the end of the public emergency in mid-June; the Q&As were released until questions were no longer being submitted to CSS, with the last one to date being released in mid-July. Both the videoconferences and the Q&As helped ease service providers' need for information and assured clarity of expectations for all sides.

SPPC's Contract Management Working Group (established in December 2019 to improve the contract template for 2020/21 and then to identify future opportunities for strengthening the contract framework) was tasked in late March to act in an advisory role for a revised invoicing process to address pandemic expenses. As of the time of writing in October 2020, the group was ironing out some ongoing invoicing issues.

In mid-June, as the crisis response began to plateau and Phase 2 of Alberta's reopening was announced, SPPC recommenced pre-pandemic conversations related to requesting PDD for more program data to help plan for service demands and address program sustainability challenges. Historically, limited PDD data has been available from the government, making it almost impossible for service providers to plan services or provide feedback on policy improvements. In response to persistent advocacy by ACDS and the sector, in December 2019, senior CSS staff presented SPPC, and subsequently service provides and families, information on PDD caseload, waitlists, and funding pressures. ACDS provided a written response to questions by CSS related to addressing current pressures.[27] In September 2020, the government released more PDD program data, updating the figures to June 2020 and providing new breakdowns by region and service delivery models.

While resuming pre-pandemic priorities in mid-June, SPPC also created a new COVID Learnings Working Group to provide a high-level summary of learnings from the pandemic's first four months of impact on the sector. A month later, the group provided SPCC with recommendations to support governance, flexibility, communication, and service innovation. With respect to the role of SPPC during the pandemic, the group noted that:[28]

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[27] ACDS. January 2020. *Achieving Sustainability: Recommendations from ACDS for Addressing Challenges in the PDD Program*. Calgary, AB.

[28] COVID Learnings Working Group. July 29, 2020. Report of lessons learned. Email by Tom Sutton on behalf of the COVID Learnings Working Group to SPPC.

> *Having the formal, provincial-level structure of the Partnership Committee in place prior to the pandemic made information and issue-sharing and rapid response easier, faster and more consistent ….*

Since the end of summer, while emerging issues related to the pandemic remain on SPPC's agenda, service providers and CSS feel more comfortable with the processes in place. The focus has shifted from crisis response, to returning to quality service provision amid the backdrop of growing waitlists and intensifying program sustainability pressures that are unlikely to ease in the foreseeable future. SPPC's role will likely ramp up again as these latter conversations begin taking centre stage.

Regional service provider councils: Catalyzing local efforts

Regional service provider councils were essential partners in the crisis response. In a survey by the Calgary regional council about member experiences between March and May, service providers said two of the "most helpful" sources of information were directly calling a peer agency and regional SP council meetings.[29]

The biweekly conversations with CSS ADMs were rapidly implemented as regional councils could easily reach out to their members to inform them of these sessions, and share ongoing information coming down from CSS. Regional council chairs voiced collective concerns at the videoconferences, gathered any local information needed by CSS to help address service delivery, and proposed solutions in response to operational issues that needed to be addressed at the local level by PDD regional offices.

Regional councils were also sites for sharing expertise and resources. The extent to which they were able to support their members, and the range of activities they undertook, varied depending on their capacity; larger regional councils such as Calgary and Edmonton were, not surprisingly, far more active than the councils in the other regions, in large part because the large urban centres also have larger organizations with more depth and breadth. When appropriate, information about what issues other regions were facing, the activities they were undertaking, or the resources or solutions they were developing, were shared by ACDS at the regional meetings so they could connect with each other for further information or assistance if needed.

Starting with the declaration of the public emergency in mid-March, most regional councils increased their meeting frequencies, hosted professional information sessions such as seminars with human resources and employment law consultants, and assembled inventories of resources to help members with service delivery. Larger councils established program-specific task forces to share expertise and work on residential and day program challenges separately. These task forces were vital, especially in the absence of messaging or reopening guidelines for the CDS sector from the government. Edmonton's day program group, for example, shared staged relaunch plans drafted by some member agencies and created detailed lists of conditions necessary for reopening. The collaborative work of these task forces helped create consistency, eliminated wasted duplicative efforts, and eased pressure off agencies with less capacity.

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[29] Community Rehabilitation Service Provider Council of Calgary. July 2020. *Calgary Service Provider COVID Response and Planning Survey*.

A particularly notable point of collaboration was the effort to retain experienced staff within the sector. While many day programs were forced to close, residential programs faced an increased demand for staff to support individuals unable to be out in the community. The Edmonton regional council developed a staff-sharing agreement which enabled agencies to temporarily share their (primarily day program) staff who might otherwise have been laid off, to work for an under-staffed organization; this work was subsequently adopted and built on by the Calgary regional council. Both regions also created their own databases where agencies could post if they needed staff (or had staff they could release) with particular areas of expertise, so that job sharing or recruitment could occur more efficiently. By supporting these activities, especially in a sector that has historically struggled with high turnover and competed to recruit qualified staff, agencies demonstrated their commitment to providing high-quality services to individuals and to the survival of the sector as a whole.

Regional councils also played a role in advocacy during the pandemic. In addition to their important participation at the biweekly videoconferences with CSS ADMs, the regional councils often helped coordinate letters signed by multiple agencies campaigning for PPE, emergency phone resources, inclusion in provincial messaging around 'essential services', loosening contract restrictions, isolation requirements, public transportation, and health order clarifications.

Inter-agency communication: Sharing practical expertise

In addition to communicating and collaborating at mechanisms such as SPPC, regional councils, or videoconferences with CSS, agencies directly contacted various authorities for guidance and each other to learn from their peers' experiences or share expertise.

In the initial period of the pandemic, service providers needed rapid information in order to take quick and decisive action. Gaps in communication from Public Health/AHS and CSS often caused confusion. This led to organizations contacting AHS directly with specific questions and proceeding to share the answers they received at regional council meetings or through email. Organizations also directly contacted other agencies often to discuss solutions on topics such as the application of specific legislations or regulations, practical ways to ensure safety of staff and individuals, and what to do when an outbreak occurred at a facility. Agencies also helped each other out to procure bulk orders of PPE, share information on their supply sources, and as mentioned in the previous section, to share staffing resources.

The pandemic caused a significant increase in the level of direct collaboration between agencies. The capacity of each agency to contribute varied. Larger organizations had more capacity to contribute and often were the ones who took the lead on task forces. Quite paradoxically, though, some highly self-sufficient large organizations *reduced* their participation at the regional councils; perhaps they were focused on crisis response management within their own agencies and did not need help from their peers or the distraction of engaging in numerous meetings.

Insights

Formal structures: Rapid response and frequent, ongoing problem-solving were possible because formal structures such as SPPC and regional councils existed and could immediately mobilize at the beginning of the pandemic when the need for clear communication and decisive action was imperative. These structures, together with the essential biweekly videoconferences with CSS ADMs,

became sites for information sharing, issue identification and management, and advocacy. Pandemic response would no doubt have occurred in the CDS sector without these mechanisms in place, as it did in others; their existence, however, provided provincial as well as local level connectivity that was organized and efficient.

Trust through open communication: The pandemic's uncertain and high-risk environment demands that decision-makers—both CSS and service providers—base their action on trusted communication, i.e., that they receive the right information from the right sources at the right time. Frequent, regular and open communication between CSS ADMs with sector leaders at the biweekly videoconferences, and daily briefings between ADM Stinson and ACDS CEO, kept all parties in the loop of emerging issues, and helped service providers prepare for potential developments or responses from government. Most importantly, these forums facilitated collaborative problem solution and helped to build trust.

However, since these communication mechanisms have ceased as the need for them dissipated, some service providers are feeling that their regional PDD staff have, in many instances, reverted back to providing conflicting messages and requesting information inconsistent with contract obligations. While it is unreasonable to expect senior government officers to directly engage with contracted services as frequently as they did, the past few months have shown the benefits of direct communication. The ongoing budget and pandemic management challenges are likely creating environments within PDD regional offices that exacerbate these issues. It is hoped that new processes currently being implemented to increase consistency across regions, and the reconvening of SPPC's Contract Management Working Group to address issues and ensure clear consistent communication, will help address these issues.

Access to data: Sharing PDD program data is one of many steps required towards sector transparency. PDD's commitment to making new and updated data available on the government's open data portal every quarter is a new and welcome direction. So far, however, CSS has controlled what data is shared. A more effective approach would be to collaborate with service providers, through a SPPC working group for example, to develop a comprehensive data strategy that includes not only current caseload, waitlist and program expense information, but also: demographic projections to ascertain future needs, identify service and cost overlaps with other programs, geospatially map service demands and gaps, and run models of different scenarios to assist in developing a system design to address program sustainability challenges.

5 Human Resource Issues

In general, across all sectors, the pandemic has impacted female workers more negatively than male workers. Women are more likely to: shoulder the burden of childcare due to school and daycare closures; stay at home to support children in homeschooling or online schooling; and, provide care for sick or quarantined family members. They are also more likely to be in lower paying jobs, and if receiving the Canada Emergency Response Benefit (CERB), less motivated to speed-up their return to work after temporary unemployment.[30]

[30] Royal Bank of Canada Economics. July 16, 2020. "Pandemic Threatens Decades of Women's Labour Force Gains."

In the CDS sector, with a turnover rate of 26%, where 73% of workers are women and the average hourly wage is $21.27/hr,[31] the pandemic has exacerbated long-standing recruitment and retention challenges. Managers had to confront the troubling prospect of permanent loss in the CDS workforce as day programs closed and staff had to be permanently or temporarily laid off. At the same time, single site restrictions, quarantining requirements, low wages, demanding work, and workers' fears of contracting COVID-19 became significant obstacles for organizations juggling staffing resources to provide consistent and high-quality services.

Managing contrasting service demands

To address the change in staffing needs as day programs closed and demand for residential supports increased, CSS permitted agencies to alter program delivery models and shift staff within existing budgets to where they were most needed. Organizations with both residential and day programs or outreach services were able to redeploy staff to areas that needed extra help with individuals unable to access community supports, or that had lost staff due to school closures, sickness or self-quarantining. Some programs, such as complex healthcare homes, required even more support to manage public health protocols and had to facilitate a high amount of overtime.

Service providers that could not shift employees internally to another position were forced to layoff surplus workers, either permanently or temporarily, or choose to share staff with agencies that needed them. Although staff sharing agreements and databases (noted earlier in the discussion of collaboration) facilitated some continued provision of supports and staff retention in the sector, the practical application of this strategy was dampened by a public health order announced in April recommending or restricting staff to working in a single care facility.[32]

These temporary collaborative efforts occurred in a sector where recruitment is a perennial issue, and where organizations compete for a limited workforce; it remains to be seen if these strategies result in the shift of workers from less to more attractive workplaces and what implications that has for inter-agency relationships.

Single site staffing restrictions

The public health order restricting staff to working in a single care facility,[33] created multiple challenges for organizations. While the order only applied to designated and licenced sites during an outbreak, CSS highly recommended that all residential providers follow the order if possible. This discretionary allowance for non-licensed sites, and lack of clarity between designated and non-designated licensed sites, created confusion and an uneven landscape of organizational responses. Many residential service organizations operate a variety of sites, and several chose to implement the single site restriction across all their sites. Though this provided consistency, these organizations had to address more restrictive staffing challenges than was legally necessary. Other organizations, that were not required to follow the single site staffing restriction, allowed their staff to work at multiple sites within their own organizations or with other similarly regulated agencies. Yet other agencies,

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[31] ACDS. 2020. *ACDS 2019 Workforce Survey*. Calgary, AB.

[32] Alberta Health. April 10, 2020. Record of Decision – CMOH Order 10-2020.

[33] Alberta Health. April 10, 2020. Record of Decision – CMOH Order 10-2020.

that were unable to modify their staffing models to facilitate single site work, implemented other measures to mitigate viral spread such as limiting the number of employees working per site.

The single site restriction also impacted workers. About 40% of CDS sector employees work part-time or casual hours, and due to low wages, a high percentage of workers have multiple jobs in the sector as well as in higher-paying AHS-operated sites.[34] Employees working multiple jobs in organizations mandated by the single site restriction were forced to choose which site (or employer) to work for. Though the sector did not lose as many employees to AHS as originally feared, some organizations with a high percentage of employees also working for AHS were disproportionately affected. The loss to AHS was not as severe as expected largely because workers weighed the risk of working in long-term care sites which were among the first to report high numbers of outbreaks; the perceived relative safety of disability service organizations made them more attractive during the pandemic despite lower wages.

Regardless of whether workers had to choose between disability services or AHS sites, the single site restriction had ramifications on all frontline employees who worked at multiple locations to support themselves. Employees who lost wages by being forced to work in only one position, as well as employees in organizations that offered only reduced hours during the pandemic, were placed in difficult financial situations at a time when providing quality care to vulnerable Albertans was integral to provincial recovery. As one employer stated:[35]

> *Lack of wage increase for staff working in this sector has decreased morale and made them feel like they aren't essential workers when in fact they are doing a very important job. Related to this, restricting some of them to one work site without a raise has caused a huge problem in the ability of these staff to financially make ends meet which makes some of them wonder how long they can keep doing this work.*

Over time, some organizations have relaxed their restrictions in non-mandated locations in order to serve individuals in the way they believe is most effective, while others continue to apply stricter requirements than mandated. A survey of Edmonton service providers in July found that 59% of agencies were comfortable following public health orders for the foreseeable future, while 41% were seeing a negative impact on their ability to deliver services.[36]

Sick leave and vacation entitlements

Inadequate allowances for paid sick time and accumulating vacation balances are problems facing all employers as the pandemic continues. Some service providers modified their sick day, leave of absence, or wellness policies to allow employees the ability to borrow time from the next fiscal year, or to carry forward portions of accumulated vacation balances within allowances permitted by employment standards regulations.

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[34] ACDS. 2020. *ACDS 2019 Workforce Survey*. Calgary, AB. The most recent statistics indicate that 27% of workers in the CDS sector work in more than one position with the same employer; the proportion who work multiple jobs across organizations is not known but is estimated to be high. During the pandemic, one organization reported learning that they had several employees working 80 to 100 hours per week at multiple jobs.

[35] Edmonton Region Council of Service Providers. July 2020. *COVID-19 Pandemic Survey*.

[36] Edmonton Region Council of Service Providers. July 2020. *COVID-19 Pandemic Survey*.

Federal and provincial governments have also amended regulations or increased benefits to help address some of these challenges. In March, the Alberta government amended the *Employment Standards Code* to include the COVID-19 Leave Regulation, which provides two weeks of unpaid, job-protected leave to employees who have to self-isolate or self-quarantine due to COVID-19, for as many times as needed during the year.[37] The regulation extends job protection for employees who need to take leave for childcare or to care for ill or quarantined family members. In addition, the federal government recently announced the Canada Recovery Sickness Benefit to allow all working Canadians access to paid sick leave while self-quarantining for 2 weeks.[38]

While these measures will provide some relief to employers and workers, service providers are still left with the daunting task of managing staffing resources in frontline services especially as the pandemic continues, the spread of the virus in schools and communities increases, and the threat of a potential second wave looms.

The chronic problem of low wages

Low wages and demanding work have long been a barrier to recruitment and retention in the CDS sector. The pandemic has simply brought the wage issue into sharper focus through factors such as: single site restrictions, the added workload of implementing pandemic-related safety protocols to already demanding jobs, the stress of working in frontline jobs where the threat of viral transmission are higher, and employees' fear of working in outbreak sites.

Many employers have advocated for the need to raise wages to incentivize workers to remain in the sector during the pandemic, though fewer have had the capacity to actually do so without external assistance. CSS was clear that organizations had the ability to flexibly allocate resources within their contract allocation as long as services were being delivered. Some organizations were able to redirect funds from closed programs or rely on revenues from social enterprises (although these have also been negatively impacted by the closures).

Low wages have contributed to a loss of workers to CERB. For some employees, the federal benefits were comparable to their regular wages, or at least high enough (along with other pandemic considerations such as childcare) to disincentivize them from returning to work. Some service providers attempted to get employees back working for under $1,000 a month so they could remain eligible for CERB, but many chose to stay at home for the time being. When CERB transitioned to employment insurance (EI) in October, the federal government made changes to EI so that all beneficiaries receive a minimum of $500 per week, rather than just 55% of previous earnings as was the practice in the past.[39] While these changes are good for workers who have lost their job, they pose unanticipated recruitment and retention challenges for organizations.

To recognize the job done by essential workers, in early May, the federal government announced $3 billion to be distributed in a cost share agreement with the provinces and territories contributing an additional $1 billion to increase the wages of low income essential workers.[40] The provinces and

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[37] Government of Alberta. COVID-19 Leave.

[38] Canada Employment and Social Development. August 28, 2020. "Supporting Canadians through the next phase of the economy re-opening: Increased access to EI and recovery benefits."

[39] Government of Canada. September 29, 2020. "Employment Insurance – COVID-19."

[40] CBC News. May 7, 2020. "Ottawa, provinces and territories reach $4B deal to boost essential workers' pay."

territorial governments are to determine who qualifies under this agreement. While the payment to Alberta is still under negotiations with the federal government,[41] other provinces that have successfully accessed this funding (Ontario, British Columbia, Manitoba and Nova Scotia) have all provided varying levels of wage top-ups to disability service workers.[42] It remains unclear, though, whether Alberta will also include disability service workers under this federal transfer.[43]

Following the federal announcement, ACDS provided CSS Minister Sawhney information and data on staff retention and wages in the sector, as well as a formal statement advocating for wage top-ups. The chronic issue of low wages has also prompted the Alberta Disability Workers Association (ADWA) to spearhead a letter writing campaign requesting that the Alberta Government provide wage top-ups for disability support workers.[44]

Insights

Vulnerabilities of a low-paying, female-dominated sector: Recruitment and retention issues in the CDS sector are chronic and stem from a persistent history of low wages. The pandemic—with its disproportionately negative impact on women who bear primary care responsibilities—has created an additional layer of challenges for a sector in which women constitute almost three-quarters of the workforce, and where most of the work must occur on site. This combination of factors poses to significantly exacerbate the human resources issues in the sector, especially against the backdrop of the province's current economic crisis. Service providers and government funders will need creative solutions to address program sustainability challenges while protecting one of Alberta's most vulnerable populations from loss of workers.

6 Mental Health Impacts

> *The mental health consequences of COVID-19 can be described as the "fourth wave" of the pandemic, and are projected to result in the greatest and most enduring health footprint.*[45]

Several sources of recent research are reporting the negative impact of the pandemic on Canadians. These include anxieties related to job loss, economic uncertainty, physical distancing, housing and food insecurity, and demands related to childcare or school closures. While all Canadians are impacted to some degree, 48% of individuals with a disability, 59% of those with a pre-existing mental health condition, and 44% of people living in poverty are experiencing more pronounced

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[41] CBC News. September 1, 2020. "Federal top-up pay for Alberta essential workers remains in limbo."

[42] Government of Ontario. April 25, 2020. *Backgrounder: Pandemic Pay Provides Support for Frontline Workers Fighting COVID-19;* Government of British Columbia. August 17, 2020. "B.C. COVID-19 Temporary Pandemic Pay."; Government of Manitoba. 2020. "Manitoba Risk Recognition Program Eligible Organizations and Positions."; CBC News. July 9, 2020. "Thousands of health workers, others, ineligible for 'essential workers' bonus."

[43] CBC News. May 7, 2020. "Ottawa, provinces and territories reach $4B deal to boost essential workers' pay."

[44] ADWA. 2020. "Letter Campaign: Let's Get Those Wages Up!"

[45] Jenkins, Emily, Anne Gadermann and Corey McAuliffe. July 31, 2020. "New Research: Mental Health Impact of Coronavirus Pandemic Hits Marginalized Groups Hardest."

deterioration in mental health since the onset of the pandemic.[46] Individuals with developmental disabilities intersect completely, or at the very least a lot, with each of these demographics.

Several organizations in our sector reported the negative effects of the pandemic on the individuals they support. Distancing measures were particularly challenging for many individuals. One organization, for example, reported an elevated amount of destruction of property due to increased frustration and aggravation caused by quarantine. Organizations had to make quick decisions to ensure individuals could physically distance where possible. Several organizations collaborated to provide unutilized service locations to those in dire need of additional space.

Some health orders, such as more stringent self-isolation for vulnerable people, are at odds with the spirit and intent of individualised supports and self-determination. There is also a disjoint between health regulations, created without the CDS sector in mind, that have resulted in confusing and inconsistent situations. For example, visitation restrictions in residential settings limit access by families, yet, individuals living in these settings are free to access a day program. Families and individuals alike are finding these discrepancies difficult to come to terms with.

The mental impact on workers cannot be overstated either. As noted in the previous section, most workers are women and average wages in the sector are low. The differential impact of the pandemic on them is likely to have significant spillover effects on the sector that relies on this workforce.

Insights

Profound mental health consequences: As we remain preoccupied with the current state of the pandemic as a potential second wave approaches, we cannot lose sight of what might be the most profound consequences of the global pandemic on marginalized populations such as individuals with disabilities and a large part of the workforce that supports them. At present, we have little more than ad hoc information on the immediate mental health impacts of the pandemic; this is an area that needs research investment. Policy solutions will have to heed the intersectionality of impacts through strategies that address poverty, food security, affordable housing, accessible transportation and equitable access to quality healthcare.

[46] Jenkins, Emily, Anne Gadermann and Corey McAuliffe. July 31, 2020. "New Research: Mental Health Impact of Coronavirus Pandemic Hits Marginalized Groups Hardest."

7 Conclusion: Sector Recovery and Growth

The immense pressure of adapting to the COVID-19 pandemic forced all stakeholders in the CDS sector to work creatively and collaboratively to maintain quality supports to Albertans with disabilities. The first six months also revealed and sharpened several long-standing problems in the sector and the PDD program. Emerging from this experience are critical learnings for the action required to support the recovery and growth of this important sector in Alberta's social fabric.

The Recovery and Growth of the CDS Sector Requires:

Government supports for civil society organizations: Federal and provincial governments have reduced regulatory obligations and implemented numerous initiatives and cost-saving measures to support private sector employers to withstand and recover from the economic impacts of the pandemic. Civil society organizations typically get overlooked in these programs and policies. Automatically including nonprofits, charities and social enterprises in such government initiatives will accelerate both economic and social recovery.

Purposeful cross-system design and understanding: Both pandemic planning and general public policy have often failed to consider implications for individuals with disabilities and the services that support them. As the pandemic continues, it is essential that AHS and other programs and systems that intersect with PDD understand its mandate, scope, and service delivery model, and examine the implications of their policies on PDD services and individuals.

Due to its individualised focus, the PDD program has grown incrementally over time to develop niche areas of support to respond to emerging needs; its current scope extends well beyond the intention of the original design, and in some costly ways, duplicates roles and responsibilities of other programs. A thorough review of these overlaps and a thoughtful system redesign will result in a more focused, effective and sustainable program of supports for individuals with disabilities.

Contract flexibility and trust: When contractual practices were eased to allow organizational flexibility, service providers developed innovative solutions to continue providing quality supports and demonstrated their competency to act in the best interest of vulnerable Albertans. Trusting organizations to allocate approved resources based on their expertise and evolving circumstances permits service providers to generate solutions rather than wait for instructions. A clear framework with well-defined expectations for outcomes and quality assurance standards will free up service providers and compliance officers to focus their reporting and contract management efforts to activities that make a difference.

Communication and collaboration: Increased communication and cooperation at all levels have been integral to the sector's pandemic response and will remain important for recovery. Formal structures of collaboration between government and service providers (such as SPPC) facilitate effective and timely information sharing, collaborative problem solving, and trust building. There must be ongoing commitment to SPPC and similar mechanisms, and support for community disability service leaders to meaningfully participate.

In addition, a forum for direct communication (e.g., a regularly scheduled "town hall") between senior CSS officers and service providers about upcoming issues or trends and government's program and policy considerations, will enable service providers to understand government's decision-making and provide their perspective to help develop sound policy, while being an important foundation to strengthen relationships with the funder.

Transparency: Clarity from government about program usage, costs, and projections, is a necessary step towards making sound policy and service delivery decisions. A comprehensive data strategy, leveraging service provider experience at the frontlines, will enhance transparency and facilitate informed and collaborative decision-making and policy development.

Strong, adaptive organizations: Many organizations have altered their practices and operations to continue providing care during the pandemic. Supporting innovation, evaluating adaptations, and encouraging adoption of successful changes will invigorate practices and accelerate recovery. Adaptive capacity, however, is not equally distributed across all organizations. Organizations with limited resources or comfort for innovation and adaptation might make it through a time-limited crisis, but are likely to need significant life support if the pandemic lingers.

Supporting the sector to recover and grow requires a two-pronged approach.

1. **Ongoing investment in organizational capacity.** Funders target their funding to frontline services, yet expect organizations to somehow have administrative resources and leadership sophistication to navigate uncertainty. Funding frontline supports without investing in organizational capacity simply delays, and does not prevent, the possibility of eventual failure. Funding frontline supports and simultaneously investing in organizational capacity will boost the resiliency of the sector.
2. **Critical assessment of organizational viability.** Organizational boards and leaders must honestly assess whether their agencies have the capacity and the culture to successfully navigate rapid change and uncertainty. If not, they must fulfil their fiduciary responsibilities to mitigate the risk of failure. Strategies to consider may include trimming service delivery to a particular expertise niche, collaborating with other agencies to address time-limited program or capacity gaps, establishing formal long-term partnerships, restructuring to merge with a similar (or complementary) organization to strengthen (or expand) program reach, and even considering the option to dissolve the organization to shift service delivery to another, more viable, organization in the best interest of the individuals needing supports.

Workforce stabilization and development: The pandemic has made the disability sector even less attractive than before. Before we can talk about sector recovery, immediate steps are needed to first stabilize the workforce. These include: wage top-ups, reimbursements for costs arising from back-filling the increasing gaps left by extended sick leaves and self-isolation requirements, and incentivizing employees with additional hazard pay to work in sites with COVID-19 cases.

Following workforce stabilization, longer-term responses will need to include: foundational training and professional development for frontline and managerial positions, leadership training, well-defined job profiles for generalist and specialist positions, thoughtfully designed career ladders, and post-secondary programs to develop the next generation of workers. In 2019, ACDS had begun working with its members to develop a comprehensive human resource strategy. [47] It is hoped that as we move through 2021, the current pandemic crisis and the planned program review for PDD will be complete, and allow this work to recommence with a new perspective. A committed, qualified and well-compensated workforce is essential to support the recovery of the sector and its capacity to tackle future challenges.

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[47] ACDS. 2019. Developing a Comprehensive Human Resources Strategy for the Community Disability Services Sector: Discussion Paper. Calgary, AB.