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SUBMISSION TO CONTINUING CARE LEGISLATION REVIEW 2021

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ABOUT ACDS

ACDS is a not-for-profit network of 140 community disability sector organizations located in all regions of the province, representing 85% of agencies funded by the PDD program.

Since our origin in 1973 as the Alberta Association of Rehabilitation Centres, we have been regarded as a trusted and respected partner, collaborating with the Government of Alberta and community allies to strengthen services and develop supportive policies to benefit Albertans with developmental disabilities and the Community Disability Services (CDS) sector as a whole.

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

Our Mission To be the collective voice of our members, advancing excellence and best practices, advocating for effective public policy, and championing professional disability services

Our Members ACDS members employ 15,000 people to support over 11,000 Albertans with developmental disabilities, including individuals with autism, FASD, dual diagnosis, complex behaviours, brain injury, and individuals who are medically fragile. Supports are provided to adults with developmental disabilities, 73% support individuals 65 years and older (73%), youth 16 – 18 years old (43%), and children (36%).

Over 70% of our members operate overnight staffed residences 66% operate supported living accommodations, 55% manage independent support homes, and 42% provide in-home respite services. These organizations are directly impacted by the continuing care legislative framework and any changes to its scope and requirements.

ABOUT THIS SUBMISSION

Our input to this review is based on:

- Deep knowledge of the CDS sector, from ongoing membership consultations, and participation in provincial and regional forums, committees, and networks
- Research on the impact of COVID-19 on CDS service providers (attached), which identifies challenges caused by the differential applicability of orders and regulations to different continuing care settings
- Targeted input solicited from a small group of members with extensive experience operating residential sites covered by the legislative framework within the scope of this review; members have provided examples of operational issues and challenges, and valuable suggestions for improvements

ACDS POSITION AND RECOMMENDATIONS

Our Position Vibrant communities thrive when all citizens feel safe, healthy, connected, and valued. Supportive community living homes, funded by the Persons with Developmental Disabilities Program (PDD), are foundational components in the physical, mental, emotional, and social wellbeing of many citizens with disabilities. Supports in these homes must be guided by principles of dignity and choice, and assessed by standards and practices that respect the right to personal freedoms, self-determination, and independence in one's own home.

Recommendations

Remove the unintended negative consequences of the licensing requirements and standards under the *Supportive Living Accommodation Licensing Act 2010* (SLALA) for PDD-funded community living homes by:

1. **Exempting all PDD-funded community living homes from SLALA's licensing requirement, with the exception of accommodations where the number of residents far exceeds those typical in personal homes such that the setting resembles a facility-based care site**
   i. Exempt all PDD-funded community living homes from the licensing requirement under SLALA, except those that resemble larger, facility-based care settings rather than personal homes
   ii. Increase the minimum number of residents before licensing is required from the current minimum of 4 residents to a much higher number to be determined in consultation with service providers and families

   AND

2. **Developing a new set of standards appropriate for community-based service delivery to apply to all PDD-funded community living homes instead of the current Supportive Living Accommodation Standards 2010**
   i. Develop new set of simplified core accommodation standards that are appropriate for and applied to *all* PDD-funded community living homes (regardless of number of residents), based on principles and practices supporting dignity, and the right to personal freedoms, self-determination, and independence
   ii. Reserve a small set of more rigorous standards and accountability expectations for PDD-funded community living homes that resemble larger, facility-based care settings

The same recommendations have been made by ACDS in our advocacy to Community and Social Services as the Ministry responsible for PDD, and the Ministry likely responsible for the proposed new PDD-specific standards.

Rationale

Currently, SLALA's application and requirements result in the following issues that are unintended negative consequences for residents or operators of PDD-funded community living homes:

- **Restrictions to personal freedoms and right to self-determination of persons with disabilities living in PDD-funded community living homes shared by a few people,** due to application of regulations and standards more suited to large care facilities
- **Inconsistent standards,** where PDD-funded community living homes with 4 or more residents are subject to regulations and monitoring to the same extent as large facilities with significantly more residents, while homes with 3 or fewer residents have no controls under SLALA
- **Unreasonable amount of red tape and expectations for a community-based delivery model**, creating administrative inefficiencies and impacting quality service delivery
- **Curtailment of the capacity and sustainability of the PDD program**, by dissuading service providers from operating homes for 4 or more residents which would be more efficient were it not for the regulatory burden created by SLALA for these homes. This also impacts the housing choices available for individuals.

ORGANIZATIONAL RESPONSE TO CONTINUING CARE REVIEW QUESTIONS

1. ISSUE(S):

Please describe an issue that should be addressed through continuing care legislation. (If you have identified more than one issue, please answer questions 1.1 and 1.2 for each issue.)

<table>
<tr><td colspan="2">NOTE: The issues described and the solutions provided in this section reflect the formal position of ACDS.
This position is compiled from input specifically solicited for this review from ACDS members with extensive experience operating residential sites covered by the legislative framework within the scope of this review. While respecting our members’ confidentiality, we kindly acknowledge and thank them for their valuable perspectives, concrete examples, and thoughtful suggestions for solutions.</td></tr>
<tr><td>ISSUE 1</td><td>Restrictions to personal freedoms and right to self-determination of persons with disabilities living in PDD-funded community living homes shared by a few people, due to application of regulations and standards more suited to large care facilities.
Supports for people with disabilities in community living homes must be guided by principles of dignity and choice, and assessed by standards and practices that respect the right to personal freedoms, self-determination, and independence in one’s own home.
Many Alberta families live in homes with more than 3 people; many roommates share a home with more than 3 people. Just as these homes do not require a license, nor should homes shared by more than 3 people with disabilities be subject to a licensing process to ensure quality of care; on the contrary, the licensing requirement – which is currently drafted in terms more appropriate for large, congregate care settings – creates an institutional environment in what should be a person’s home. The 2016 repeal of safety standards is a clear example of inappropriate requirements that are better suited for facilities than individual homes.
We do, however, support regulatory oversight for community living homes that resemble larger, facility-based care settings. However, the cut-off for the number of residents when a home becomes a facility should be much larger than 3, and is best determined in collaboration with service providers and families of individuals living in these settings.</td></tr>
<tr><td>1-1.1</td><td>Is this issue a result of a barrier or obstacle caused by the current Continuing Care Legislation? If so, please identify the relevant legislation (Act, Regulation, and Section).</td></tr>
<tr><td></td><td><i>Supportive Living Accommodation Licensing Act 2010</i> (SLALA): S.2(1)(a)</td></tr>
<tr><td>1-1.2</td><td>In what ways do you think the issue(s) could be addressed? How could legislation address this issue?</td></tr>
<tr><td></td><td>(i) Exempt all PDD-funded community living homes from the licensing requirement under SLALA, except those that resemble larger, facility-based care settings rather than personal homes
AND
(ii) Increase the minimum number of residents before licensing is required from the current minimum of 4 residents to a much higher number to be determined in consultation with service providers and families</td></tr>
<tr><td>ISSUE 2</td><td>Inconsistent standards, with PDD-funded community living homes of 4 or more residents subject to regulations and monitoring to the same extent as large facilities with significantly more residents, and homes with 3 or fewer residents having no controls under SLALA.
On the one hand, the current licensing and standards regime creates inequities between homes that differ very little in all aspects other than a small number of residents. On the other hand, there is broad-brush application of standards across all licensed accommodations despite</td></tr>
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	significant differences in these sites; 4-person homes do not operate in the same way, nor should they have the same regulations, as facilities with far more residents. The wide discrepancy hard-wired into the current SLALA framework results in practices and monitoring regime that are irrational and unpractical, costly and time-consuming, and not in the best interests of people with disabilities living either in small homes or in large facilities. Instead of being supportive, the legislative framework forces operators to create work-arounds such as, for instance, leasing a home with 4 or more residents in the names of the residents than the operator in order to exempt the site from SLALA.
2-1.1	Is this issue a result of a barrier or obstacle caused by the current Continuing Care Legislation? If so, please identify the relevant legislation (Act, Regulation, and Section).
	Supportive Living Accommodation Licensing Act 2010 (SLALA): S.2(1)(a); S.2(1)(b) Supportive Living Accommodation Licensing Regulation 2010: S.7. Supportive Living Accommodation Standards 2010
2-1.2	In what ways do you think the issue(s) could be addressed? How could legislation address this issue?
	(i) Develop new set of simplified core accommodation standards that are appropriate for, and consistently applied across, all PDD-funded community living homes (regardless of number of residents), based on principles and practices supporting dignity, and respect for the right to personal freedoms, self-determination, and independence AND (ii) Reserve a small set of more rigorous standards and accountability expectations for PDD-funded community living homes that resemble larger, facility-based care settings where the number of residents far exceed those typical in personal homes
ISSUE 3	**Unreasonable amount of red tape and expectations for a community-based delivery model, creating administrative inefficiencies and impacting quality service delivery.** Administrative inefficiencies and red tape burdens due to SLALA include, but are not limited to: • Multiple types of inspections, often with conflicting expectations and guidance on a single issue (e.g., water temperature guidance from AHS, SLALA standards, accreditation, Alberta Buildings Code, etc.) • Immediate reporting of non-compliance even for minor issues rectifiable within 24hrs • No recognition of prior history of successful compliance despite having multi-year licences • Over-emphasis on operational policy statements rather than actual practice on site • Requirements to post inspection results in visible areas of the home, creating an "institutional" feel in a private home
3-1.1	Is this issue a result of a barrier or obstacle caused by the current Continuing Care Legislation? If so, please identify the relevant legislation (Act, Regulation, and Section).
	Supportive Living Accommodation Licensing Act 2010 (SLALA): S.2(1)(a); S.2(1)(b) Supportive Living Accommodation Licensing Regulation 2010: S.7. Supportive Living Accommodation Standards 2010 *Resident and Family Councils Act 2017* (RFCA)
3-1.2	In what ways do you think the issue(s) could be addressed? How could legislation address this issue?
	See overarching recommendations 1-1.2 and 2-1.2 above, PLUS • Streamline inspection process by having one inspector assigned per agency, • Ensure all inspectors (health, licensing, etc.) have a clear understanding of community-delivery models and a consistent set of expectations • Exempt PDD licensed non-designated supportive living homes from RFCA

ISSUE 4	**Curtailment of the capacity and sustainability of the PDD program, by dissuading service providers from operating homes for 4 or more residents which would be more efficient were it not for the regulatory burden created by SLALA for these homes. This also impacts the housing choices available for individuals.** It is significantly more cost effective to operate and fund 4-person homes than homes with fewer people. However, SLALA's licensing requirement discourages operators from providing this option, thus creating a cost as well as a supply issue for a program that needs to both save costs and increase delivery capacity. In addition, this barrier limits choice and ability for people with disabilities to obtain housing. In some regions. for example, service providers are experiencing that, as PDD seeks to save service-delivery costs, it is more likely to encourage funded individuals to move miles away from familiar places to communities with larger shared-model homes. Removing the barriers to operate homes for 4 or more residents would enable PDD funding to be used more efficiently, create capacity in a system with a long wait list, and provide more choice for individuals, especially in rural communities.
4-1.1	Is this issue a result of a barrier or obstacle caused by the current Continuing Care Legislation? If so, please identify the relevant legislation (Act, Regulation, and Section).
	Supportive Living Accommodation Licensing Act 2010 (SLALA): S.2(1)(a)
4-1.2	In what ways do you think the issue(s) could be addressed? How could legislation address this issue?
	See overarching recommendation 1-1.2 above

2. GUIDING QUESTIONS

Please feel free to respond to any of the following questions, or check not applicable if you do not have input to provide. These questions address topics pertinent to the legislative framework and your consideration of these topics will be helpful in developing the framework. *Please note that this list is not meant to be comprehensive or limiting, but rather provide some examples of the type of topics to consider*.

NOTE: The suggestions provided in this section represent the perspectives of ACDS members. They do not necessarily reflect the formal position of ACDS, which is articulated in the recommendations in Section 1. Members' perspectives are presented to demonstrate the diversity of issues, points of view, and creative solutions that may be possible for legislative improvements.

Many responses below are shared verbatim from input provided specifically for this review by ACDS members with extensive experience operating residential sites covered by the legislative framework within the scope of this review. While respecting their confidentiality, we kindly acknowledge and thank them for their valuable perspectives, concrete examples, and creative suggestions for solutions.

2.1	**How can legislation support the quality of life of clients/residents?** • For example, are there minimum expectations with respect to supporting quality of life (such as those expected for supporting quality of care and safety)? • For example, are there current requirements or ways of doing things that negatively impact clients'/residents' quality of life?
	• Residences with a small number of inhabitants should be recognised and treated as private home environments, with standards to ensure quality service while allowing people to live with personal freedom and dignity. The cut-off before more rigorous standards and monitoring become required should be much higher than the current minimum of 4 residents to a number more reflective of a facility-based care setting.

	• The current standards under SLALA are not appropriate for community-based service delivery for people with disabilities. All PDD-funded community living homes should be required to follow a new set of standards created specifically for this model of service delivery and guided by its values and principles of dignity, choice, and inclusion. In addition, homes that resemble large facilities should have a sub-set of more rigorous standards to ensure safety and accountability. These standards should be developed in collaboration with service providers and PDD, and PDD (not AHS or SLALA) should likely have the responsibility for monitoring. • Legislation can make provision to acknowledge that how service delivery models are provided will vary depending on the type and scope of the supportive living accommodation, and allow service providers the flexibility to design personalised responses to meet the health and safety needs of individuals during situations (such as a pandemic) where health restrictions do not take into account the diversity of supported living accommodations. • Individuals need to be at the center of their care and supports. Legislated standards should require that service providers implement practices that include individuals (and/or legal guardians) to understand the care needs and have the final say in what care approaches, treatments, and accommodations are appropriate for their needs. Supports should not only be implemented to achieve individual’s health outcomes but also to respond to their psychological and emotional needs.
2.2	**How can legislation support integration of existing levels of facility-based continuing care (i.e., designated supportive living and long-term care)?** • For example, how could legislation enable operators to support couples with different health needs to stay together?
	• Make provision for variety of rooming options: single room, double room for shared (non-partner) accommodation, or double room for partnered couples • In order to move up into a DSL or LTC site, the individual needs to be assessed as needing a higher level of support and funded based on this assessment. If the individual’ partner is not also assessed at the same level, the funding model does not allow them to stay together. Create legislation that allows couples to stay together even if only one individual needs a higher level of care. The number of situations to which this applies is probably low compared to the caseload as a whole, and should make little difference in the overall costs, while creating significant savings due to the emotional supports and well-being resulting in the couples that are allowed this arrangement. • Allow organizations to offer private pay beds that are affordable to the average individual to subsidise the partial costs for couples.
2.3	**How could legislation refer to family and friend caregivers and their contributions?** • For example, should legislation recognize caregivers as part of the care team? • For example, should legislation address support for caregivers?
	• Caregivers provide connection, friendship, and love; these are important to good mental health. Family and friends who provide caregiving support, could be acknowledged as volunteers and allowed to access the training and supports provided to other volunteers. • If an individual feels that family or friends are an integral part of their support network , then legislation should consider them as part of the individual’s care team. • Family and friends play an essential role in keeping individuals in their own homes as long as possible before professional supports become necessary. However, caregiver burnout is a serious concern. Information on legislations and programs about respite, financial assistance, etc., should be expanded and taught to all caregivers so they are knowledgeable. Education should not only inform individuals but their natural supports as well.

2.4	**What could be incorporated into legislation to reflect a flexible approach to staffing to meet client/resident assessed needs while ensuring appropriate minimum requirements?** • For example, what should we consider when designing a flexible approach to staffing that enables residents to remain in place as their needs evolve?
	• Legislative provision for family or friends to provide assessed needs, within set parameters for the health and safety of the people providing those supports. • Legislative provision for service providers to support and maintain family and friend as essential supports. The same safety requirements for staff can be provided to family members to enable them to safely access a site. • Legislative provision for sites across the care continuum to access designated funding (set hours) that could be used outside the normal funding to assist individuals when supports change. Criteria could be created to guide who can access it, how to access it, and the criteria for when to access it to ensure appropriate usage. It could be made available immediately for a short period of time while the individual's level of care assessments are being completed.
2.5	**How can legislation provide the public with assurance that the appropriate amount and type of staff is available to meet client/resident needs without being overly restrictive or prescriptive?** • For example, what kind of public reporting and accountability mechanisms should we consider to promote public confidence and transparency regarding staffing levels? • For example, how could the legislation focus more on client outcomes?
	• At present, we can view Health Quality Council reports of facility surveys. Public reporting could be made available to view raw data submissions of care underway at any facility. • Publicly-available information on staff and resident ratios should be mandatory, while maintaining privacy of residents. • Performance metrics detailing the appropriate ratio of designated support staff to individuals based on needs and required levels of support categories. • Service providers should be required to consult with and/or obtain consent from guardians or agents prior to medications changes being made. Plans should be supplied to guardians/agents detailing any restraints or restrictions used to support health and safety, and that may limit autonomy. Rationale should be provided for reasons, and accompanied by a plan to reduce the restrictive procedures where possible. Provision should be made to enable service providers to provide additional training in areas such as PPE and mental health first-aid. • Public reporting on staffing levels show accountability. They may include: how many shifts go un-filled, how that corresponds with negative outcomes, etc. For reportable incidents, abuse, or serious concerns, staffing levels should be included and indicated to determine if there is potential correlation.
2.6	**How could the legislative framework support consistent, person-centred, team-based care?** • For example, how can legislation facilitate client and resident access to the most appropriate providers to meet their care needs, without being overly prescriptive/restrictive? • For example, how can legislation facilitate more consistency for residents in who provides their care from day to day?
	• While the care needs for an individual are determined by respective health professionals and actioned by practitioners at the facility, individuals and guardians (if applicable) should be supported to make informed decisions in the best interest of the individual. The information presented should demonstrate options, associated benefits, and any potential consequences or risks of the choices made.

	• Provision for a spectrum of support options to be available. Legislative framework could make provision for person-centered planning that includes the person receiving support, as well as families, advocates, agents and the care team. • Streamline care streams and make these easily accessible and easy to understand by creating simple processes for individuals to follow. GP could work on care maps with individuals, outlining step-by-step what they need to do to get the care they require. This should travel with them like their goals of care so that all members of the team are on the same page and working to support the individuals in their journey.
2.7	**How could the legislative framework support positive work environments/conditions for staff?** • For example, how could legislation enable a collaborative care team? • For example, how could legislation support person-centred leadership?
	• Provision for service providers to provide evidence of on-going staff training. • Support to implement a multi-disciplinary support model in staffing teams. • Provision for staff advisory board, working in collaboration with home/facility managers.
2.8	**How could palliative and end-of-life care be incorporated into the legislative framework?** • For example, incorporating oversight for hospice care; establishing minimum volunteer qualifications, etc.
	• Creating a reporting standard with more emphasis on demonstrating individual quality of life in addition to comfort care. • In a supportive living site, licensed staff may not work on site; provision for service providers to access professional supports, incorporated into the framework. • Recognition that end of life care is its own unique type of care, while linked into the overall quality of life. Supporting access to this type of care should be a priority for all providers operating under this legislation
2.9	**Should legislation address and/or support client autonomy and choice to purchase private services and, if so, should it provide consumer protection for those private services?** • For example, how could legislation support or protect clients and residents with cognitive limitations to exercise choice in purchasing services safely? • For example, should legislation ensure that privately purchased services meet minimum standards for quality? • For example, should legislation cover client-directed care that allow clients/families to receive funding directly to hire a care provider of their choice?
	• Yes, where there is legislation to establish minimum care expectations and practice. Should individuals and families/guardians augment and purchase services, legislation should be in place to ensure these services are reporting transparently how they are contributing to the person centre plan. Legislation should support, not prohibit, but also hold the private service accountable to reporting on their activities related to the individual. • Provision for recognition that guardians/agents have decision making authorities, and should be involved when choosing services. Resident's voice and choice should also be respected, with safeguards to ensure that agents/guardians make choices in the resident's best interest. • Services that are provided privately should meet minimum standards for quality of care and training requirements to ensure the health, safety and mental health of both individuals and the staff who support them. These requirements should be stated in legislation, and include public accountability and reporting expectations and mechanisms. Individuals should have the ability to access these services if they choose to, and should be supported to do so.

	• Funding should be made available to families to purchase supports. This may help keep individuals in their own homes longer and open up more spaces in the health care sector. This might be a beneficial addition to home care services or substitute depending on the situation.
2.10	**What should be in legislation regarding client/resident co-payments (for those who can afford it) to contribute to the cost of various services or supports (such as equipment and supplies, homemaking, or personal care)?** • For example, what services or supports (if any) should be subject to client/resident co-payments and what services should always be provided at no cost to clients? • For example, if client co-payment contributions are expected for certain services or supports in home care, should these co-payment expectations also be applied consistently to residents in facility-based care? • For example, should accommodation charges paid by residents in long-term care and designated supportive living include a fee designated for capital (e.g. building repairs/renovations/replacement).
	• No. Like K-12 education, services and supports under this legislative framework should be consistent for all Albertans, those who have and those who don't. Legislation should ensure there is never a co- payment model in place. • With oversight mechanisms in place, the availability of privately purchased services would expand the scope of options in the continuum of care, and would increase personal choice on whether to access public or private support based on one's preference and capacity. • No. Personal care and homemaking supports should always be provided at no-cost – this should be a basic minimum standard. Any damage caused willfully could have a specified fee for repair or replacement. • Co-payment contributions should be based on need and consistent among the care continuum. If a service while at home is only 50% covered (e.g., foot care) then it should only be covered 50% in LTC. However, if the individual is deemed to need the service for health reasons (e.g., diabetic neuropathy) then it should be fully covered. Diagnosis and treatment plans should play a role in what is covered and what isn't, and the same standards of measurement should be used across the continuum of care. • There should be an accommodation charge to individuals for capital expenditures as these are typically huge financial costs when they occur, however, they are almost always necessary for the health and safety of residents and staff. Perhaps residents' financial supports should be evaluated to include this.
2.11	**How should legislation address operators that are not compliant with legislation?** • For example, what is an appropriate suite of penalties (suspension of contract, official administrator in place, fines, closure, etc.)? • For example, what factors should determine which penalty applies (time in non-compliance, failure to rectify non-compliance, dependent on what is not being complied with, etc.)?
	• Legislation should ensure consistent operation and reporting from all operators. In cases of non-compliance, the consequence should be reflective of the frequency, duration, and severity of non-compliance. Legislation should have a low threshold for non-compliance in items that threaten safety, with a penalty that escalates up to and including closure of an operator facility. • Incidences of non-compliances should be continuously evaluated to determine overall compliance levels, and the latter should be made available publicly. • Legislation should outline a progression of penalties that are dependent on the situation. The type of penalty should consider: the time in non-compliance; magnitude of non-compliance; type of factors needed to remedy; what steps could have been taken; if/what steps actually

	were taken; number of non-compliances in the last 3 – 5 years; reporting of people who had received care; level of risk to individuals or staff; the outcome or adverse effect. The penalty could range from notice of penalty, to public posting, to fines, replacement of administrator, suspension of contract, to closure of the building. Consistent non-compliance with legislation could result in 1-year licenses, for a period of three years, until consistency is demonstrated.
2.12	**How could legislation enable exemptions (temporary or otherwise) to certain requirements/ provisions and what would the parameters be?** • For example: ○ provision conflicts with service delivery model/staffing approach/specialized care; ○ provision cannot be met due to external factors (e.g. lack of availability of staff in remote areas; pandemic; inability to replace equipment in a timely manner); ○ provision interferes with quality of life or care of residents (e.g. people living with cognitive impairment); and/or, ○ provision disrupts operational requirements.
	• The pandemic is proof that legislation needs to allow for discretion for leaders of facilities related to requirements or provisions, particularly when the safety of an individual may be at risk. However, this would not be a “get out of jail free” card. To apply for an exemption, there would need to be some type of application process, a timely adjudication and a time limit for the duration of the exception. After the time limit is over, operators could be required to provide a report on the exemption to allow for a post-mortem assessment. • Legislation should reflect that supportive living is delivered in a variety of service delivery models, and should provide for exemptions based on: type of accommodation (single-unit home vs. 75-bed facility); individual needs (cognitive impairment vs. other considerations); and service delivery model. For example, requirement for a sprinkler system in a 75-bed facility may be reasonable, but may not be appropriate in a 4-person home which is based on the principle of supporting people to live in the same type of home as others in their neighborhood or community. In this case, the exemption should take into consideration what other homes would normally have upon inspection, i.e., wiring in good repair, windows that support egress, fire extinguishers, plan for exiting, etc. • Temporary exceptions should be allowed if the operator can show the steps taken to address the concern in a timely timeline that outlines when it will be addressed. Exceptions should only be considered if it is not causing immediate harm or risk to the clients/staff. Health and safety of the residents should always be the first priority.
2.13	**How could legislation address requirements for compliance and monitoring and public reporting?** • For example, how could legislation address effective and efficient mechanisms to ensure compliance with minimum expectations? • For example, what information should legislation require be publicly reported and by whom?
	• Reduce the redundancy of multiple departments requiring the same reporting. For example: water temperature recording is required in Accommodation Standards, Alberta Health Inspections, Accreditation metrics – where applicable, Alberta Building Codes. Designating one oversight body to assume the responsibility for monitoring and public reporting on that measurement would be more effective, reduce redundancy, and create efficiency as the service provider would clearly understand what is being measured, and have greater confidence that the oversight body has the authority to understand and establish the expectations for that area. Monitoring and public reporting to demonstrate compliance should also include the highlights of success and any commendations to the service provider. • There is no incentive for operators to maintain 3-year licenses, as inspections processes are almost identical for inspections required for a one-year license. More effective monitoring would be achieved if a true 3-year license was awarded when compliance was demonstrated.

	Alternatively, create a 2-year license, with a 6-month re-inspection mandatory for operators who do not achieve 2 years; if the 6- month inspection demonstrates remediation, then a 2-year license can be provided, and if not, then the appropriate level of response can be applied. • Legislation should mandate a mechanism to monitor health and safety in homes that are not licensed.
2.14	**How could legislation facilitate responses to future pandemics?** • For example, should legislation enable/enact site level leadership requirements for some or all situations? • For example, should legislation enable exemptions due to extraordinary circumstances?
	• Legislation should provide for application of exemptions/variances in extraordinary situations, with the provision that all types/models of support have the equipment and training for all staff to be safe at work. • Legislation should indicate level of response based on emerging situation in health care. For example: level 1 – enhance all cleaning (what that entails), prepare comfort training (how many individuals should be trained on this) etc. • Exceptions should be noted, as in the end, health and safety should be the priority.

3. ORGANIZATIONAL DOCUMENTS ATTACHED TO THIS SUBMISSION

If you are attaching previous documentation pertinent to continuing care legislation to this submission, please list the document title(s) and number of pages included below.

ACDS. Oct 2020. *Impact and Insights. COVID-19 and Alberta's Community Disability Services Sector. Executive Summary.* (8 pages)