




Adult Day Program Directors' Experiences Managing the COVID-19 Pandemic

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Article

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Résumé

Les programmes de jour pour adultes (PJA) offrent aux personnes âgées vivant avec des maladies chroniques et à leurs aidants des services récréatifs supervisés dans la communauté. Durant la pandémie, la plupart des PJA ont maintenu une certaine offre de programmes et de services, laissant aux directeurs de PJA la responsabilité de faire face aux complexités de la pandémie de COVID-19. Cette étude a exploré comment les directeurs de TAD ont géré et vécu la pandémie de COVID-19. Au total, 18 entrevues semi-structurées ont été réalisées avec des directeurs d'une grande région sanitaire en Ontario. L'analyse thématique a permis de dégager quatre thèmes qui représentent comment les participants : a) ont réagi à la pandémie en adaptant leurs services ; b) ont géré leur réponse à la pandémie au sein de systèmes et d'organisations, mais aussi entre eux, ainsi que les relations avec les clients et les aidants ; c) se sont sentis personnellement pendant la pandémie ; et d) ont acquis de nouvelles connaissances sur leurs clients grâce à la pandémie, ainsi que sur l'importance des PJA dans le système de santé. Les résultats mettent en évidence des lacunes et des opportunités préexistantes et émergentes dans la prestation de PJA pour les clients et les aidants, ainsi que pour les fournisseurs de services et les directeurs.

Abstract

Adult day programs (ADPs) provide community-based supervised recreational services to older adults living with chronic conditions and their caregivers. Most ADPs continued operating during the pandemic, tasking directors with the responsibility of managing the complexities of the coronavirus disease (COVID-19) pandemic. This study explored how ADP directors managed and experienced the COVID-19 pandemic. Semi-structured interviews were conducted with 18 ADP directors from a large health care region in Ontario. Thematic analysis resulted in four themes that detailed how participants: 1) responded to the pandemic with adapted services; 2) navigated the pandemic responses within systems and organizations, and with each other, clients, and caregivers; 3) felt personally during the pandemic; and 4) gained new insights on their clients and the importance of ADPs in the health care system due to the pandemic. Findings highlight pre-existing and emerging gaps and opportunities within ADP service provision for clients and caregivers, as well as service providers and directors.

Introduction

The novel coronavirus disease (COVID-19) pandemic has profoundly impacted the delivery of healthcare, including community health and support services. Canadian federal and provincial governments enforced several public health and safety measure mandates to control the spread of the COVID-19 virus (Government of Canada, 2020; Ontario Ministry of Health, 2020). For example, the Ontario Ministries of Health and Long-Term Care (LTC) communicated multiple directives to hospital and LTC settings on the screening of staff and patients/residents, environmental cleaning, and managing outbreaks (Ontario Chief Medical Officer of Health, 2020). Other aspects of these directives included decisions about health care access, operation, and a delineation of which workers and services were considered “essential” or “non-essential” during different waves of the pandemic in Ontario (Ogbogu & Hardcastle, 2021). However, such guidelines and their communication were not always clear, consistent, or comprehensive, and the implementation of directives was not always straightforward (Siu, Kristof, Elston, Hafid, & Mather, 2020). These gaps left some leaders of health care service organizations to navigate the ever-changing conditions of the pandemic with minimal direction or support (Donnelly & Keller, 2021).

Organizations that provide community health and support services were only sometimes explicitly included within health care mandates and directives. When these organizations were

considered, services and workers were often deemed non-essential due to the high demand and low supply of personal protective equipment and staff across the health care system, which resulted in these limited resources being redirected to increase hospital capacities and to help mitigate the LTC crisis (Lefebvre *et al.*, 2020; Marrocco, Coke, & Kitts, 2021). This resource redistribution influenced the ability of many community health and support service organizations to remain open. Additionally, other government-mandated public health measures factored into the operation of government-funded organizations during the pandemic. Different regions of Ontario experienced lockdown and reopening at different times for different reasons based on a variety of public health metrics, such as the number of active COVID-19 cases and the extent of community-spread virus transmission. As a result, some leaders of community health and support service organizations halted their services altogether, while others continued operating with significant disruptions (Lefebvre *et al.*, 2020; Sadarangani, Zhong, Vora, & Missaelides, 2021) as services typically fluctuated between open and closed over time (Nielsen, 2021). The location, size, and status as, or affiliation with, a larger organization also impacted the capacity of these organizations to deliver services (Sadarangani *et al.*, 2021). For example, physical distancing requirements placed limits on the number of clients and staff permitted in a facility at the same time. Organizations with large physical infrastructure were able to serve clients on site and still adhere to physical distancing protocols.

Adult day programs (ADPs) were among the community health and support service organizations impacted by the uncertainties of the pandemic, brought on by unclear and inconsistent communication of directives and significant service disruptions (Sadarangani *et al.*, 2021). Some ADPs are nested within larger organizations, while others are stand-alone organizations (Ellen, Demaio, Lange, & Wilson, 2017). ADPs primarily serve older adults through health and wellness programming in a supervised group setting (Ellen *et al.*, 2017; Ontario Community Support Association, 1999). The services offered by ADPs are wide ranging, including social and recreational programs, cognitively stimulating activities, mobility and physical health exercises, and personal care supports for clients (Fields, Anderson, & Dabelko-Schoeny, 2014). Clients who attend ADPs may have a variety of chronic conditions, including living with dementia and the effects of stroke (Anderson, Dabelko-Schoeny, & Johnson, 2013). Client groups served can depend on the type of ADP. For example, integrated or blended ADPs provide services to a variety of client groups, and specialized ADPs focus on one client group, such as dementia or acquired brain injury (Dabelko-Schoeny & King, 2010). ADPs also assist unpaid caregivers and provide opportunities for respite care (Government of Ontario, 2021a). ADP services are provided by trained staff with a variety of professional backgrounds, including recreational therapists, personal support workers, and nurses (Dabelko-Schoeny & King, 2010).

The importance of ADP services for some older people and their caregivers has been highlighted and heightened by the pandemic due to the disproportionate impact of the COVID-19 virus and the resulting government mandates and directives for older adults (Flett & Heisel, 2020; Flint, Bingham, & Iaboni, 2020; Meisner *et al.*, 2020; Verity *et al.*, 2020). Approximately four-fifths of older adults reported a significant decrease in their overall well-being due to COVID-19 restrictions (De Pue *et al.*, 2021). Because of stay-at-home directives, many community-dwelling older people were placed at an increased risk of social isolation, which can result in loneliness and other mental health concerns such as anxiety and

depression (Armitage & Nellums, 2020; Sepúlveda-Loyola *et al.*, 2020). Research demonstrates that approximately two-fifths of older adults experienced such a significant decline in their social interactions following COVID-19 social and physical distancing measures that they met the criteria used to classify social isolation (Kotwal *et al.*, 2021). Physical health and functional decline were also shown to be negatively impacted by stay-at-home COVID-19 measures, through reduced participation in physical movement and activity (Visser, Schaap, & Wijnhoven, 2020), which corresponds with past research on the relationship between social isolation and physical health (e.g., poor cardiovascular and cognitive health outcomes) (Courtin & Knapp, 2017). Further, unpaid caregivers were more likely to experience greater demands and role strain due to increased levels of at-home care provision in the absence of out-of-home ADP respite services (Greenberg, Wallick, & Brown, 2020). Therefore, by accommodating for the closure or reduced supports available from community health and support service organizations, unpaid caregivers have been placed at a higher risk of experiencing caregiver stress, burden, and burn-out (Greenberg *et al.*, 2020).

During the pandemic, many ADPs continued to provide some degree of supports and services to clients and caregivers, within the constraints of directives on typical service delivery, while also handling sudden changes to service provision due to the evolving circumstances of the COVID-19 pandemic. For example, many ADPs began offering services virtually (Mildon, 2020). There are challenges associated with offering services online, such as privacy issues or virtual platforms that may be difficult to use for providers and clients (Jnr, Nweke, & Al-Sharafi, 2020). It is also possible that the quality of online services may not be as high as that of in-person services, as some conversations and activities may be more difficult to implement online, and emotional, sensory, and social experiences may be more challenging, or impossible, to develop and maintain over time (Aughterson, McKinlay, Fancourt, & Burton, 2021). However, because it was not possible to deliver services in-person during the pandemic, rather than not offering services, some organizations developed and offered virtual services to their clients and their caregivers to help address the social isolation inadvertently created by stay-at-home measures (Whitehead & Torossian, 2021).

The task of navigating through these organizational and service delivery changes mainly fell on the leadership of ADPs, namely, ADP directors. Although studies specific to ADP directors are sparse, research on community health and support services more broadly demonstrates that directors play a critical role in the overall success of an organization as they are required to be accountable for multiple responsibilities and have a vast skill set (McCann & Kowalski, 2015). For example, ADPs have a limited budget with funding coming from various sources. Therefore, directors must engage in financial management to ensure that available funding is acquired and spent efficiently to ensure the sustainability of the organization and services (McCann & Kowalski, 2015). Directors are also responsible for building and maintaining community partnerships, as well as facilitating collaboration with other organizations with the aim to better serve clients (Teixeira-Poit, Napier, Carr, Williams, & Pulliam, 2020). Therefore, ADP directors were essential stakeholders for their organizational pursuits during the pandemic.

Considering the complexity of the director role, it is conceivable that ADP directors experience psychosocial stress when attempting to manage their many professional responsibilities, both before and during the pandemic. For example, working remotely during the

pandemic is noted to have a profound impact on mental and physical health, resulting in individuals being more likely to experience symptoms of strain and burn-out (Aldossari & Chaudhry, 2020). Further, individuals working from home in managerial positions have highlighted a lack of separation between the home and workplace, which contributes to their working outside of expected hours and being in constant communication with team members (Hayes, Priestley, Ishmakhametov, & Ray, 2020). Those continuing to work in-person, particularly in health care settings, have also experienced negative impacts on their health and wellness. In addition to being at greater risk for burn-out as highlighted previously, concerns exist in terms of placing themselves and others at risk for COVID-19 infection (Aughterson et al., 2021), which has significant implications for individuals responsible for the operation of organizations and the implementation of safety measures during the pandemic (Jones, Comerford, Curry, & Holubiec, 2020; Mildon, 2020).

To date, there is only one study focused on ADP director experiences during the pandemic in the United States (Sadarangani et al., 2021) and two more that discuss ADPs through case studies of larger organizations that offer ADP services in Canada (Jones et al., 2020; Mildon, 2020). Sadarangani et al. (2021) focused on ADP client and caregiver experiences of the pandemic gathered from ADP director perspectives, as well as the resources needed for community-level resilience during the pandemic. Mildon (2020) also focused on the experiences of others (i.e., clients, caregivers, and frontline staff), while leadership perspectives were framed in terms of the organizational responses to the pandemic, and Jones et al. (2020) focused on the Victorian Order of Nurses' operation and navigation of the pandemic. Overall, the personal experiences of ADP directors are missing from these studies. This study sought to fill this gap, while answering the call for research that uses qualitative methods to understand the varied experiences of the pandemic (Meisner et al., 2020; Teti, Schatz, & Liebenberg, 2020). As such, this study explored how ADP directors both managed their professional responsibilities and experienced their personal feelings and insights during the COVID-19 pandemic – that is, how ADP directors operated their ADPs during the pandemic according to their professional roles and how they personally experienced their occupational duties within the pandemic context.

Methods

Methodological Approach

To report on relevant components of this study, the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) were used. This guideline was cross-referenced with the standards for reporting qualitative research (SRQR) (O'Brien, Harris, Beckman, Reed, & Cook, 2014). In terms of the research methodology, qualitative description with hues of phenomenology was used for this study (Sandelowski, 2000). The qualitative description methodology aims to provide a thorough summary of a phenomenon or event through the reporting of a rich, straight description of that phenomenon or event using first-person accounts (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000; Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Permitted by the qualitative description approach, this study incorporated phenomenological hues in its methodology as the research objective was to attend to moments of experience related to the COVID-19 pandemic, but the analysis of these

experiences, while still interpretive, remained as low interference as possible (Neergaard et al., 2009; Sandelowski, 2000, 2010; Wojnar & Swanson, 2007). The qualitative description approach is consistent with practical or applied health services research (Chafe, 2017; Neergaard et al., 2009; Sandelowski, 2000, 2010). This study received approval from York University's Office of Research Ethics (Protocol #: e2020-354) and was authorized within ADP organizations as required.

Setting, Participants, and Recruitment

This study took place in a large health care region of Ontario comprising multiple sub-regions. According to 2016 census data, this region overall represents approximately 30% of the provincial population. Approximately 50% of residents live in urban centres, whereas 20% live in rural areas, and about 30% are ages 65 years and greater. In terms of COVID-19 government-mandated restrictions for this setting, all areas within this region were under lockdown with maximum measures to help slow the spread of the virus (i.e., grey zone) (Government of Ontario, 2021b) at least once for at least 2 weeks at a time (Government of Ontario, 2020). Restrictions included the standard 2-meter physical distancing from people who reside outside one's household, wearing a mask in indoor public spaces, and avoiding non-essential travel, which were supplemented by additional restrictions. For example, during lockdown, it was illegal to gather indoors with anyone who did not live in one's household, recreational facilities were shut down with few exceptions (e.g., childcare), and all personal care services were closed (Government of Ontario, 2020). To maintain the anonymity of the region and study participants, further details on the study setting cannot be provided.

A total of 18 ADP directors participated in this study. To be eligible to participate, individuals had to be a current director of an ADP funded by the Ontario Ministry of Health within the health care region. Purposeful and snowball sampling techniques were used to recruit participants within each sub-region by drawing on the professional networks of the researchers and participants, respectively. This process involved sending potential participants an invitation to participate via e-mail that included a brief study description. Individuals indicated their interest via e-mail or phone. At that time, their eligibility for the study was confirmed and, if met, an interview was scheduled. Recruitment and interviews occurred between December 4, 2020, and February 19, 2021, a time frame that included a province-wide, grey-zone lockdown (Government of Ontario, 2020).

In terms of participant characteristics, most participants were female, white, and ranged in age between 37 and 60 years. Participants' work experience with community health and support services, which included but was not limited to ADPs, ranged between 9 and 30 years. Regarding the characteristics of the ADPs participants directed, 16 participants directed ADPs nested within larger organizations that provide a package of services beyond ADP, six of which also provided LTC services. Two participants directed stand-alone ADPs, such that their organizations provide ADP services only. The number of ADP locations that participants were responsible for ranged from one to eight. Most participants directed dementia-specific ADPs, but some also directed integrated programs (i.e., mix of client conditions). Before the pandemic, the number of clients served per day ranged from approximately 10 to 100 across different ADP locations. Most participants directed ADPs according to a mixed model (i.e., dual consideration of medical and social needs and interests). Each sub-region of the

broader health region was represented by a minimum of two and a maximum of eight participants.

Data Collection

Seventeen interviews were conducted virtually in a password-protected Zoom meeting, whereas one was conducted via phone. A semi-structured interview guide was used to ensure that the primary research questions were discussed specifically while allowing for the use of off-script probing questions on unanticipated relevant topics. The guide contained a variety of questions, which included asking ADP directors to describe their experiences managing ADPs before and during the pandemic in terms of key services being offered. The guide was pilot-tested with five frontline staff of an ADP prior to starting data collection to ensure that the content and organization of questions were appropriate and invited answers relevant to the research questions. Discussions pertaining to COVID-19 were used for the current study. With additional consent, interviews were audio-recorded for subsequent verbatim transcription to facilitate data analysis. Recordings and transcripts were not returned to participants; however, participants were invited to reflect on the discussion and to be in contact if they wanted to make any additions or subtractions.

Data Analysis

Qualitative content analysis was used to analyze the transcribed interview data. This analytical process involved the examination and interpretation of textual data to identify and report on themes (Assarroudi, Heshmati Nabavi, Armat, Ebadi, & Vaismoradi, 2018). This type of analysis is consistent with the qualitative description methodology used as it is a low inference form of analysis that allowed researchers to stay close to participants' experiences (Elo & Kyngäs, 2008; Sandelowski, 2010). The conventional approach of content analysis was used over other methods as it allowed for themes to be more inductively constructed to align with qualitative description methodology that involves phenomenological hues (Hsieh & Shannon, 2005; Sandelowski, 2000).

The data were analyzed according to the established four-step process of qualitative content analysis, as outlined by Erlingsson and Brysiewicz (2017), that was complemented by the coding procedures detailed by Saldaña (2013). Firstly, data familiarity was acquired through listening multiple times to the audio-recorded interviews prior to transcription. Transcripts were then read through carefully, and initial notes were taken to generate an overall sense of the data. Secondly, descriptive codes, in the form of short meaning units, were generated from and within the transcripts. These codes condensed the transcript text in ways that kept intact the central meaning of the data. Thirdly, codes and code categories, in the form of code clusters, were refined (i.e., recoded) and developed (i.e., recategorized) as needed to establish a coding scheme. This step facilitated code comparisons within and across transcripts as well as the construction and reconstruction of categories. Fourthly, to describe the collective experiences of participants, themes were identified from the coding and categorization process and through analytical reflection. This analytical process was supplemented by strategies to enhance trustworthiness, as recommended by Elo et al. (2014). For example, consistent with content analysis methods, one researcher (the first author) was primarily responsible for analyzing transcripts (Elo et al., 2014; Kyngäs, Kääriäinen, & Elo, 2020); however, this approach was augmented by regular research team meetings to discuss and reach

consensus on codes as meaning units, representativeness of codes within categories, and the identification and description of themes from codes and categories.

Results

Four themes were identified to describe how ADP directors professionally managed and personally experienced the COVID-19 pandemic and resulting government mandates and directives. The first theme, *Flying By the Seat of Our Pants*, describes how participants responded to the pandemic with adapted services. The second theme, *Can You Give Us Direction?* captures how directors navigated pandemic responses within systems and organizations and with each other, clients, and caregivers. The third theme, *Fish Out of Water but Doing Our Best*, represents how participants felt personally during the pandemic. The final theme, *Pause and Redefine*, shares how participants gained new insights on ADP clients and caregivers, as well as the important role of ADPs in the health care system, which were brought to light due to the pandemic. Consistent with qualitative description and qualitative content analysis reporting, direct quotations from participants, while not exhaustive, are integrated throughout the findings in the language used by participants to provide evidence for the themes presented. Participant quotations are referenced using pseudonyms.

Adapted Service Responses to the Pandemic: *Flying By the Seat of Our Pants*

The first theme describes *what* actions participants took in their response to COVID-19 in terms of the resulting delays and changes to ADP service delivery. All participants noted that the onset of the pandemic resulted in many rapid modifications of services. This sudden shift to providing pandemic-safe services was described as chaotic and occurring "on a dime" (Diana). All participants acknowledged that typical in-person services were "significantly reduced" (Mike) and that some usual meal and personal care services (e.g., foot care) were stopped. Many participants continued to provide in-person services during the pandemic, to some extent, often after a period of closure. As Kerry shared, "We shut down and because we were so careful with our reopening it was three months that we didn't see some people." When offered, in-person services aligned with the ways that ADP services were delivered before COVID-19, but now with enhanced public health and safety measures.

While in-person services were being changed, a suite of new services was "very quickly" (Diana) developed and implemented out of recognition that "things need to be done differently now" (Mike). These new services were often described as creative and educational. Participants recognized therapeutic recreation staff as integral to supplying these innovative programs. For example, Leah described her therapeutic recreation staff as "best suited" for the "outside the box" programming offered during the pandemic because "that's what they went to school for. They've got those resources and connections." Part of this innovation was adapting programs as tools to educate clients and caregivers about the new services offered, as well as about the pandemic, such as "IPAC [Infection Prevention and Control] measures and reminders" (Louise). Examples of new services included regular wellness checks over the phone, care packages and activity kits delivered to clients' homes, pandemic-specific information resources, porch visits and outdoor activities, and in-home or mobile recreation. The

evolution of these new and modified services demonstrated participants' awareness of the interests and needs of clients and caregivers as the pandemic evolved. To guide these services, participants created new policies and procedures.

Most participants delivered this new suite of services concurrently with modified pre-existing services, using this simultaneous strategy to achieve pre-pandemic attendance frequency of their clients. Leah acknowledged the following hypothetical scenario: "Let's say 'Helen' used to come five days a week, but, now, because of our reduced numbers, we can only accommodate Helen one day a week. But we can still accommodate Helen those other four days, only virtually." Through new services, participants discussed that, in some cases, clients were receiving a higher frequency of services than before the pandemic, despite the decrease of in-person services. As Kerry said, "Some of our clients are getting more recreation now than they did when they were attending physically. Some people are joining every day of the week, multiple times a day, when before they only came once or twice a week." In addition to directing the adaptation of existing services, the creation of new services, and the coordination of synchronized service delivery, some participants were also involved with pandemic response teams at a systems level. For example, Margaret shared that she was "a member of the incident management group which is the planning group for long term care outbreaks, as well as vaccination planning." The overall collective experience of participants during the pandemic was described as "flying by the seat of our pants to keep our programs going and our clients engaged" (Melody). As can be seen throughout this theme, while services were modified quickly, these changes were made with consideration of the interests and needs of clients and caregivers.

Navigating the Pandemic Context: *Can You Give Us Direction?*

The second theme captures *how* participants strategized their actions and responses to the COVID-19 pandemic while navigating various contexts encountered during the pandemic. Most notable, participants navigated service delivery without ADP-specific pandemic guidelines and without an explicit acknowledgement that ADPs offer essential services. In recognition that it would be easier to navigate the pandemic with ADP-specific guidelines, some participants contacted the Ministry of Health for guidance. As Leah described, "Numerous people asked the ministry, 'Can you give us direction? What should we do?'... and nobody's getting that direction." In the absence of this information, participants relied on services and sectors that did have guidelines, including public health units, child day-care, LTC, and provincial and federal governments. Kendra summarized, "There isn't really day program guidelines anywhere. It's not like childcare or long-term care. We're kind of in the middle there with no strict guidelines that have been developed." However, using such guidelines, at times, was difficult due to the affiliations of some ADPs. ADPs' organizational status and location within certain public health unit oversight resulted in differences of ADP reopening status and service delivery, even within the same health care sub-region.

The widespread shortage of frontline staff during the pandemic further complicated participants' directorial roles as they were forced to find new ways to provide services with limited staff in unconventional circumstances. Mike described "scrambling to support clients without having to close my program because I don't have enough staff to run it that day." The shortage of human resources was not limited to paid staff, as participants shared that their volunteer base was restricted for a variety of reasons,

including age. Participants directing ADPs affiliated with LTC and hospitals also had to navigate the redeployment of staff to their umbrella organizations. Sometimes this redeployment included themselves, as Sandra shared "being reassigned at the assessment centre." Redeployment, as well as staff time off and/or lay-offs and remote conditions, often resulted in changes to participants' typical duties, such as supervision and staff education. For example, Mike discussed "managing the staff remotely" and Kendra described providing education on "self care and wellness" because of the pandemic.

Participants experienced significant constraints during the pandemic; however, some had access to a variety of resources to help navigate it. Participants nested within larger organizations typically had greater access to resources. As Kendra recounted, when negotiating client fees for services during the pandemic, "I hear a lot of other day programs' monthly fees for activities. We've been able to offer that all for free and continued to service them." Melody described access to LTC resources as critical to their work in the pandemic, specifically the quality of housekeeping provided to them. Similarly, Kerry, whose ADP is attached to an LTC facility, described, "Day programs that are attached to long-term care, not just us, they've been able to get swabbed biweekly.... It shouldn't just be the ADPs attached to a long-term care home. Why can't all these other adult day programs that are stand-alones?" This frustration arose from participants who recognized the disparities in access to pandemic resources between ADPs affiliated with LTC and other ADPs. Disparities were discovered by participants through discussions and collaboration among ADP directors during this time.

Participants described ADP director collaborations within and across sub-regions as vital to negotiating these different and evolving circumstances of the pandemic and the lack of ADP guidelines. Melody acknowledged that, "Network wise, locally, it's so valuable to be connected to other day partners... to bounce different ideas off of, to talk about some of the pressures, system changes. Those are really good pieces to have that really make a difference." Some ideas shared among directors included strategies on how to cohort and ethically prioritize clients, ramp up or down services, and manage infection control mandates. For some participants, these connections were established prior to the pandemic. However, for others, the pandemic encouraged forging stronger collaboration. Leah described, "Before the pandemic, I think we got together once a year. When you met with everybody... you didn't feel comfortable Now, when you're meeting twice a month... you're seeing each other on Zoom, you're feeling comfortable." Participants recognized these connections were successful at the grassroots level.

Funding was another area that participants described to be of great importance. Typically limited resources, due to pre-pandemic funding decreases or stagnation, were addressed by an increase in funding opportunities from various sources, including Ontario's Ministry of Health. Pandemic relief wages, one-time funding, and grants supported participants' ability to "stay open" (Lucy) by enhancing participants' ability to demonstrate that they valued staff who were strained and constrained; meet infection protection and control requirements; and create and implement new services to meet the specific needs of their ADP's clients and caregivers.

While these funding opportunities supported participants at the time, participants were very concerned about when these supports might end and the impact that would bring. Pandemic relief wages for frontline staff were a particular focus. The potential removal of these wages was described as a "slap in the face for those that are

putting themselves at risk” (Diana) and as something “that’s going to sting ... because the amount of work is still the same” (Mike). Participants did not foresee wages improving for ADP frontline staff, partly due to wage increases happening “across the board ... that means that the pay scale for other organizations is still continuing to climb if you’re in long-term care and hospitals” (Louise). This wage disparity was described as something that will “seriously hinder adult day program service providers” (Lydia) in the future.

As participants navigated returning to in-person services while continuing new services, they also had to consider the changing circumstances of clients and caregivers. For example, some clients’ conditions had declined beyond the scope of ADPs while they were closed to in-person services. Louise described seeing “the functionality of the clients decline. As time went on, they weren’t able to come to the adult day program.” At the same time, some clients and caregivers chose not to access services due to COVID-19 fears, or they chose to wait until they could be cohorted with friends. Other access barriers included low familiarity or desire to use virtual services, health conditions that limited the suitability of new services, and costs associated with virtual devices and the Internet. Participants also acknowledged the changing roles of caregivers during the pandemic that sometimes limited the relevance of new services. For example, some caregivers working from home chose to forgo ADP services and others had to prioritize meeting basic needs. As Mike described, “Oftentimes caregivers decided, ‘am I going to encourage them to do a therapeutic colouring sheet or am I going to try and get them to eat today?’ They had to kind of pick and choose their fights and day programming was usually on the losing end of that.” Participants navigated these conditions by respecting client and caregiver wishes but offering to stay connected, typically through regular wellness phone calls.

Personal Experiences During the Pandemic: *Fish Out of Water But Doing Our Best*

Findings within the third theme capture how participants felt, personally, during their response and navigation of ADPs due to the COVID-19 pandemic. Participants described an overall feeling of uncertainty. As Diana shared, “There’s days I go, ‘what am I doing?’” Participants discussed feelings of uncertainty, particularly with the decision-making required of their roles. For example, Natalie stated that she felt “like I was a fish out of water for a while there” when discussing the lack of ADP-specific guidelines. In these scenarios, participants were encouraged by others to “go with your gut” (Kerry). However, following their professional judgement was not always straightforward. For some, efforts to follow through on their decisions were described as a battle that participants were “fighting” (Lucy) to keep programs open even if such efforts created personal discomfort. Lucy described such a conflict when using child day-care guidelines to reopen their ADP:

There was a part of myself that was a little disappointed in myself for doing that. But that was the only way I could get open, was to compare ourselves to daycares. But I kept thinking in my mind, ‘but we are not a daycare, we’re not a daycare.’ But I did use that myself to get this program opened as part of my argument.

There was also a degree of resentment for having to make these decisions knowing that some other sectors did not need to. Although some participants associated with larger organizations were not tasked with making decisions, they still faced the uncertainty of not knowing what decisions their superiors would

make, when, why, and how the implementation of these decisions should happen.

The outcomes of these decisions, including consequent changes to service delivery and participants’ roles, resulted in participants feeling removed from others and their typical work. As Diana described, “My staff are all talking to our people and doing all the visits, and I said, ‘I’m the isolated one, actually.’ I don’t leave this room for 12 hours a day.” Elizabeth felt removed from typical “work challenges” experienced before the pandemic; “I kind of miss those times because they’re just so interesting to work through. ‘What can we do to keep that person engaged and keep them here and to support this family?’” Participants also felt disheartened when reflecting on how they had no choice but to adapt to these changes in their work and were reminiscent of typical ADP operations. As Lauren shared:

It’s a little bit discouraging now because we had a really good thing going. Now it just feels like, you know, the winds been knocked out.... We’ve moved backwards, we’re going to have to start from scratch and kind of start to build up again. So that’s a little disappointing at this point in time, where we were gaining so much momentum. Now, all of a sudden, oh god, it’s just all torn down, and we’ve got to start again.

Feelings brought on by changes to service delivery and duties manifested as grief or a sense of loss, for some participants. For example, Elizabeth elaborated on feeling “a little bit, I don’t know, not sad, but just how we haven’t been able to do the work that we need to do this year.” Participants also grieved the impacts of these changes for clients and caregivers. As Kerry said, “I can’t believe how some of our clients look now. It’s just heartbreaking.”

Feelings centred on participants’ professional lives permeated their personal experiences and lives during the pandemic as well, as participants “were always on.” For example, Diana shared, “I was always on call with our staff because that’s how it is when you’re ‘it,’ right? When your phone’s ringing at 10 at night, your husband looks at you and goes, ‘Can you turn that off?’” Further, Kerry stated that “the amount of brain power and the e-mail is through the roof. I’ve never had so much e-mail.... I’ve hit a couple walls over the last few months.... I don’t sleep well. I’m constantly dreaming of work. I dream about Zoom all the time.” This stress impacted the typical temperament of some participants. As Natalie described, “It’s been a tough go. I try really hard to be an optimistic person and find the silver lining in everything, but it’s been tough. It’s definitely been tough.” While these personal experiences were largely bleak, participants also described feeling galvanized by their work. As Natalie shared, “I truly believe in the services that we provide. I truly believe in the impact that it has on people.” These feelings were couched in pride and a firm belief that participants were collectively “doing our best” (Diana) in uncertain times.

New Insights Inspired by the Pandemic: *Pause and Redefine*

The fourth theme describes the new insights that participants gained from the pandemic due to the conditions that encouraged moments “to pause and redefine” (Tessa). More specifically, participants acquired new insights on the abilities and interests of clients and caregivers, opportunities for ADPs to meet these abilities and interests, and what ADPs can do within, and for, the broader health care system. For example, pertaining to clients and caregivers, the provision of virtual services to a typically older population resulted in many participants having “eye opening”

(Kerry) experiences of becoming aware of ageist and ableist assumptions. As Teresa described, “We’re finding that people are a lot more tech savvy than you think.” Tessa also shared how virtual spaces were an unexpected site for meaningful connection during the pandemic and why she did not expect this:

People chatting on Zoom with each other. They’re laughing, they’re too close to the screen, and jokes about, ‘Oh, can you see my facial hair?’ Some of the hilarious things that are happening that we would have never guessed would happen. So, again, to me, that’s just a bit ageist in itself, that we didn’t think that they would be able to do that.... We can break out of that.

Participants also shared their insights on how they think the changes to services during the pandemic could influence ADP services in the future. As Lydia described, “I’m really feeling like we have completely different insight now. The horizon, it feels kind of blown apart.” The pandemic sparked, “thinking about changing service delivery completely” (Lydia) in ways that many participants described they wanted to in the past, but never did. For example, seizing the opportunity to implement a mobile ADP service that provided recreational programs for clients in their homes.

Participants were also aware that these service modifications and changes would not be temporary and, therefore, require forward thinking. A notable amount of attention was paid to the future of virtual services as a strategy to address some of the new and pre-existing challenges that participants face. Virtual services were described as beneficial for a number of reasons: to address the lower number of clients attending in-person services in the future due to COVID-19 restrictions; to transition clients through ADPs as their needs change; to continue to provide recreation to clients with care needs too high or complex for ADPs; to gradually onboard clients who are initially reluctant to attend ADPs; to support clients on in-person ADP waitlists; to support inclement weather days; and to meet future generations’ familiarity with virtual tools. As an example, Kerry speculated, “Our early-stage people probably are going to use more of the virtual supports and it’ll allow people who are mid to later stage to actually come on site because we’re not going to be able to have that many people a day again.”

Although participants noted that virtual services were necessary and, for the most part, accepted by many clients as the new mode of connecting with frontline staff and other clients, many participants held the perspective that in-person services are necessary and need to remain. When in-person services were re-offered post-lockdown, clients were described as “thrilled to be back” (Kerry). Kendra also acknowledged that, while virtual services have been important, they are “not exactly what the families want. What our service was always, was a place for you to bring them and know they’re safe for the whole day.” New insights for service delivery also included for whom the ADP services are designed. Participants reflected on the ADPs’ primary populations, clients and caregivers, and shared a new understanding that ADPs support both equally. As Kerry discussed:

I think that’s one of the things I’ve learned the most with the day program through the pandemic. That day programs are often advertised as respite for caregivers. Absolutely. They really are. But the benefit that therapeutic recreation, that meaningful engagement, that socialization, those relationships. That is so huge for people with dementia.

In addition to personal and service delivery insights, participants reflected on how the collaboration across sub-regions, sectors, and

services required during the pandemic changed people’s perspectives of ADPs and the potential for systems level change in the future. For example, Margaret stated that the recognition of ADPs has “improved substantially because of COVID because we’ve had to all come together. We haven’t had a choice to do the work. It’s being further recognized that, yes, we can contribute. Yes, our staff do have talent. We’re starting to be invited into different planning groups.” This awareness starkly contrasted participants’ experiences of the limited recognition that ADP services received before the pandemic. As Leah shared, “Nobody realized the impact that coming out on a regular basis has. Doing our exercises, having those healthy meals, how that was affecting loved ones. Nobody realized that until now.” These insights sparked optimism that, “Maybe this time around, when we start rebuilding up, we’ve got new ideas and we could really sell ourselves, as valuable contributors” (Lauren).

Discussion

This study explored how ADP directors both managed and experienced the COVID-19 pandemic. Findings demonstrate that participants quickly responded with new services and a retention of in-person services when and where possible. To do so, they navigated various challenges, while also accessing and creating some opportunities. Participants also described their feelings associated with their professional roles during this time, and how these experiences influenced them as people, including their well-being and personal lives. Finally, through managing and experiencing the pandemic, participants manifested new insights and a deeper appreciation for the competencies and interests of ADP clients and caregivers, the ability of ADPs to serve these groups, and the value of ADPs within the broader health care system. Overall, their professional management *and* personal experiences of the pandemic were nested within and affected by varying aspects of larger systems and organizations, as well as their connections with each other, staff, clients and caregivers, and themselves as individuals. Findings are discussed below in terms of these nested levels, pertaining to participants’ system, organizational, and personal contexts.

The importance of controlling the transmission of COVID-19, while ensuring continued access to health care and support services, resulted in systems-level decisions regarding the status of various services as “essential” or “non-essential” (Dawson, Ashcroft, Lorenz-Dant, & Comas-Herrera, 2020) and subsequent guidelines and resources to support those deemed as essential. Participants’ experiences with the ambiguity of their ADPs’ essential status and lack of guidelines and pandemic resources in Ontario are consistent with ADP director experiences from other areas of North America (Jones et al., 2020; Sadarangani et al., 2021). While not speculated on directly by participants, others have commented on how the lack of attention and resources allocated to ADPs during the pandemic may be a result of the long-established privileging of acute medical services over community health and support services (Lefebvre et al., 2020; Milton, 2020). The historical devaluing of older people and services to support them may also be contributing to the lower prioritization of ADPs during the pandemic as governments scrambled to address LTC and did not provide guidelines for ADPs (Marrocco et al., 2021; Ontario Human Rights Commission, 2001).

The disparities manifested from a sustained focus on biomedical health services and on younger populations created a ripple effect throughout the health care system. To illustrate, the initial

attention on hospitals informed by past pandemics, in isolation from other health and community support services, contributed to the LTC crisis (Marrocco *et al.*, 2021). When efforts and attention were forcefully turned to LTC, services suffered further along the prevention end of the health care continuum. For example, the redeployment of ADP staff inadvertently narrowed the already limited health care workforce available to provide vital community supports (Dawson *et al.*, 2020; Foley & Luz, 2020; Lefebvre *et al.*, 2020). Research has yet to fully document client deconditioning and caregiver stress, burden, or burn-out that resulted from the closure and restriction of ADP in-person health and wellness services during the pandemic. There is a need for the health care system to be more balanced in its attention to the spectrum of health services across different settings and across all ages to prevent future crises.

Participants also acknowledged the value of relief wages received from the Ontario Ministry of Health for all health care professionals, including frontline ADP staff. Although deserved, equal payments do not address established income inequalities between health care professionals working in LTC and hospitals compared to those working in home and community care. A continued lack of funding for ADPs will only serve to maintain or increase the gap in access to resources that are necessary to serve clients and caregivers during and after the pandemic (Ontario Community Support Association, 2021).

Findings situated at the organizational level demonstrated how connections within and outside of ADPs should continue to be supported to begin to address broader disparities. Relationships with Local Health Integration Networks were vital for participants in terms of communicating about and receiving one-time pandemic relief funding. Connections with other organizations at pandemic planning tables, such as hospitals and congregate care settings, were also described as creating positive changes to service delivery and collective perceptions of the value that ADPs contribute to health care systems. The current findings support the need for greater levels of advocacy for community services during the pandemic, as identified by other studies (Halcomb *et al.*, 2020; Lefebvre *et al.*, 2020; Sadarangani *et al.*, 2021). The recent transformation from Local Health Integration Networks to Ontario Health and Ontario Health Teams may eventually address disparities; however, evolving healthcare into an integrated system that equally values community support services will require action on the part of all sectors and organizations involved. Services and organizations that recognized the value of ADPs during the pandemic need to sustain these insights.

In contrast, the different organizational or affiliate status of ADPs introduced variability in how participants managed and experienced the pandemic in terms of access to resources and control in decision making. The influence of such organizational status on the operation of ADPs is something recognized both before (Ellen *et al.*, 2017) and during the pandemic (Jones *et al.*, 2020; Mildon, 2020; Sadarangani *et al.*, 2021). The mixed experiences related to organizational status suggest that this is an area that should be explored further to discern whether there is an optimal organizational status for the operation of ADPs. Future research with ADP stakeholders should also provide organizational status as part of the study context to ensure that this important and differentiating aspect of ADPs is fully understood.

To overcome the differences and disparities in organizational status to maintain a level of similarity in ADP operations, participants described grassroots collaboration with other ADP directors as valuable. This is akin to Lefebvre *et al.*'s (2020) findings of nurse

leaders coming together across their different home and community care organizations to unite their efforts and bring awareness to their services and clients. In addition to the benefits of collaboration with ADP organizations through these networks, an increased level of comfort was developed between participants. This finding extends the results of research conducted with frontline workers during the pandemic (Fernandez *et al.*, 2020) to include a director stakeholder group. Collaborations among participants should be supported into the future as it may positively influence the collective operation of ADPs.

Despite the disruption of the continuum of care brought on by the pandemic, as well as the system and organizational complexities discussed previously, participants managed to provide services at the personal level, specifically to clients and caregivers. Participants' implementation of new ADP services (e.g., care packages and activity kits, in-home recreation, and virtual and phone services) is consistent with other ADP and community-based organizations' pandemic responses (Danilovich *et al.*, 2020; Kordova & Keisari, 2020; Lightfoot & Moone, 2020; Mildon, 2020). Many participants described virtual services as places of joy for some clients, and participants were interested in the use of virtual modes of delivery following the pandemic as a potential strategy to help increase the frequency of client and caregiver access to services for those who are able and want to use virtual services. As with participants, virtual services have received particular attention in the literature. The satisfaction with new virtual services to increase access of ADP services during the pandemic aligns with the findings of Cohen-Mansfield, Muff, Meschiany, and Lev-Ari (2021), Danilovich *et al.* (2020), and Gallo and Wilber (2021) whose research touched upon virtual community services for older people.

Virtual services were described as an important tool to engage with clients and caregivers during the pandemic. However, participants also emphasized that in-person services need to continue to ensure that services remain accessible and at a required level of support to best serve their clients and caregivers. Barriers that prevented clients and caregivers from accessing virtual and telephone services are consistent with Portacolone *et al.*'s (2021) findings related to the constraints some people living with cognitive impairment experience and Danilovich *et al.*'s (2020) results pertaining to the constraint of low socioeconomic status. Coughlin (2020) and Giebel, Pulford, Cooper, Shenton, and Cannon (2021) acknowledge the need for equity and awareness of client support requirements when redesigning and implementing services. The continued demand for in-person services is particularly highlighted by participants' accounts of client deconditioning and caregivers taking on more role responsibilities during ADP facility closures. Although just beginning to be documented in community health and support services literature (Portacolone *et al.*, 2021), the impacts of ADP closures on clients and caregivers who typically access in-person services should be followed up with first-person research. Such research could be used to substantiate the "essential status" claim of ADP services made by directors (Sadarangani *et al.*, 2021). New and modified services adapted during the pandemic, particularly virtual services, should also be evaluated for their ability to meet the interests and support requirements of clients and caregivers, as well as the typical purposes and desired outcomes of ADP services identified prior to the pandemic. These evaluations should prioritize and be based on client and caregiver accounts of their experiences of ADP services during the pandemic.

The observed interest and involvement of clients and caregivers in the adapted in-person and virtual services resulted in

participants acquiring new insights into the operation of ADPs. Participants' new understandings regarding the abilities of clients to use and enjoy virtual services are consistent with Danilovich et al.'s (2020) findings of the shifting assumptions of staff related to clients' competence and interest in accessing virtual services. These findings support Meisner and Levy's (2016) call for future ageism and age stereotyping research within health care systems and settings. Participants' willingness to "break out" of age stereotypes that limited past services and to re-envision services according to the changes introduced by the pandemic is consistent with ADPs originating out of and evolving with community needs (Fields et al., 2014).

An understanding that ADPs serve both clients and caregivers is long-established and aligns with the generally accepted purposes of ADPs to provide support and respite opportunities for unpaid caregivers, as well as to preserve functioning of clients (Anderson et al., 2013; Gaugler, 2014; Ontario Community Support Association, 1999). Participants clarified that meeting the wants and needs of caregivers and clients is equally valuable to the overall purpose of ADPs. The explicit recognition of an ADP population, people living with dementia, suggests that the type of ADP (e.g., dementia-specific, integrated) may be important to how the purposes of ADPs are valued and achieved. The influence of ADP type on how ADPs meet their purposes and implementation of ADP services should be explored further.

The pandemic brought on many potential opportunities for ADP directors in terms of ADP operation and services and the positioning of ADPs within the health care system. These opportunities engendered feelings of pride and optimism among participants. This finding coincides with Mildon (2020) that noted feelings of satisfaction for the quick service responses during the pandemic. However, sustaining ADPs during the pandemic also produced feelings of uncertainty, conflict, discomfort, disappointment, stress, strain, isolation, and, at times, grief. Participants mourned their typical work as well as in-person ADP services provided prior to the pandemic that were not able to continue or continue to the same extent during the pandemic. This grief, a deep sense of loss, is noted to be a common collective experience during the pandemic as people's sense of normalcy was dismantled (Berinato, 2020). Grief was also experienced by participants due to how some clients deconditioned as a result from, at least partially, the closure of ADPs and the inability to sustain clients and caregivers in usual and expected ways. Grief from witnessing client experiences of the pandemic is supported by research with frontline medical and clinical staff during the pandemic (Eftekhar Ardebili et al., 2020). Participants' understanding of the conditions of clients and caregivers from before and during the pandemic speaks to the relationships they build while in their higher-systems level positions that, although professional, influence them personally.

The pandemic also added new and more constant duties to the historically challenging roles of participants and of community support service directors more broadly (Teixeira-Poit et al., 2020), which intruded on their personal time and lives. These increased responsibilities occurred amidst messaging that their client and caregiver populations were especially susceptible to the effects of the novel coronavirus (Meisner et al., 2020). The nonstop responsibilities to their organizations, the provision of services, and clients, caregivers, and staff are consistent with other research into frontline personnel pandemic experiences (Aquila et al., 2020; McGilton et al., 2021). This study complements and extends the literature to include the impact that these seemingly purely professional experiences have on their personal lives. Although the

research question framed professional experiences (i.e., managing) as separate from personal experiences, the findings demonstrate that these experiences are linked inextricably. Findings regarding ADP directors' *personal* experiences and how these experiences are intimately intertwined with *professional* roles expand upon the ADP-specific pandemic literature specifically that has focused on community and organizational levels only (Jones et al., 2020; Mildon, 2020; Sadarangani et al., 2021). There is no one at a higher level to support directors' health and well-being when needed like there is with staff, clients, and caregivers. Resources to support directors in their professional roles, and the spillover effects into their personal lives, should be created in consultation with ADP directors and made accessible.

Limitations

There are limitations of this study to consider. Participants were from only one health care region of Ontario. Findings may not represent or transfer to the other four health care regions in Ontario or to other provinces and territories across Canada. Also, these 18 participants represent only a portion of the total number of ADP directors in this region, and participants were not equally distributed across sub-regions. It is possible that ADP directors who participated in this study managed and experienced the pandemic differently than those in the region and sub-regions who did not participate. Additionally, participants were directors of ADPs that are funded by the Ontario Ministry of Health. Therefore, findings do not represent ADPs that are funded through other means, such as other ministries or private models. Further, recruitment and data collection ended in February, so findings only pertain to the first year of the pandemic. Finally, participants provided an indirect representation of staff, clients, and caregivers through their observations as directors. As such, these accounts may not fully represent the perspectives or experiences of these groups. Future research can examine these limitations as the pandemic continues.

Conclusion

This study described how ADP directors responded, navigated, felt, and gained insight as they managed and experienced the pandemic. As demonstrated, the findings of this research have implications at different levels of the health care sector, including systems, organizations, and people, who include ADP clients, caregivers, staff, and directors. The closure or significant interruption of ADPs, and community health and support services more broadly, disrupted the continuum of healthcare during the pandemic, thereby creating a gap in essential services for many individuals. As such, policy makers and others who hold decision-making authority within health and healthcare need to acknowledge that ADP organizations, services, and workers are indeed essential and to include the community health and support services sector intentionally and consistently in pandemic mandates and directives in the future. There is no guarantee that the progress, potentials, and opportunities described by participants will be achieved if the established value laden hierarchy within the continuum of services in the health care system continues. There is a demonstrated need for mutually beneficial collaborations within and across health and health care sectors and the need for collective action. ADP directors, in their leadership roles, are important stakeholders and future key informants of the revisioning of health care services and

supports both during and after the pandemic. To effectively engage in these prospective efforts, ADP directors require greater supports and resources provided to them as professionals and as people.

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