Long-Term Care COVID-19 Commission Meeting

Accreditation Canada
on Monday, February 8, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 8th day of February, 2021, 9:30 a.m. to 10:43 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

Leslee Thompson, CEO, HSO & Accreditation Canada;
Asmita Gillani, Executive Director, Canadian Accreditation, HSO & Accreditation Canada;
Erin Bonokoski, Director of Communications and Public Affairs, HSO & Accreditation Canada;

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat;

Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat;
Max Libman, Counsel;
John Callaghan, Counsel, Gowling WLG;
Lynn Mahoney, Counsel, Gowling WLG.

ALSO PRESENT:

Carissa Stabbler, Stenographer/Transcriptionist

-- Upon commencing at 9:30 am.

LEAD COMMISSIONER FRANK MARROCCO: Thank you for coming. The three Commissioners are here: Dr. Jack Kitts you know, Ms. Thompson, and Commissioner Angela Coke, and myself.

We do have, as you know, a transcript, and we will post it within -- in the next couple of days.

So beyond that, we will -- if you don't mind, if questions occur to us, we'll just interrupt and ask the questions rather than waiting until you're finished and then trying to go back, if that's okay with you. It seems to work well from our end.

And with that, we're ready to go when you're ready to go.

LESLEE THOMPSON: Well, thank you very much. We are delighted to be here and want to thank you for your work and also acknowledge the tremendously difficult time that we are in with lives lost and the real imperative kind of more than we've ever seen to improve quality and safety in long-term care and for our seniors.

And we're pleased to be here today to

talk with you about some of the ways in which our experience in long-term care may contribute to your review and inform your recommendations.

My name is Leslee Thompson, and I am the CEO of Health Standards Organization & Accreditation Canada. I'm a nurse by profession. I've been working directly in the health care field for almost 40 years, including time as a hospital CEO leading a major organization turnaround of a hospital with serious quality and financial issues and have been with Accreditation Canada for the past five years.

Asmita Gillani is with me for this presentation today. Asmita?

ASMITA GILLANI: Hello, Commissioners, and it's also a real privilege to be with you today. I also want to really acknowledge the lives lost and the tremendous admiration that we have for all the frontline workers and you, Commissioners, for engaging in this very, very challenging work. We hope that we will be able to contribute in some small measure.

I am Asmita Gillani. I am -- my background is health care executive. My roots are in virology and labs, so I'm very familiar with

infectious disease. I was in the reference lab before it moved to Winnipeg.

I was also a hospital CEO during the SARS outbreak, and our hospital, York Central, which is now Mackenzie Health was in quarantine, so I have real-life experience of SARS.

And then I went on to Kenya to become the CEO of the Aga Khan University Hospital in Nairobi, and I was overseeing five countries in -- hospitals in five countries, and we were dealing with Ebola there. So I'm somewhat familiar with infectious disease and their spread.

And more recently, I joined Accreditation Canada to revamp our programs and give it new momentum.

And I'll turn it over to Leslee to get it going. Thank you.

LESLEE THOMPSON: Thank you. So I wanted to just stage set and then review the framework of the presentation with you.

To stage set about Accreditation Canada and HSO, we're both -- both organizations are independent, meaning they're nongovernment, they're not-for-profit, and internationally recognized, trusted source of National Standards and

high-quality third-party assessments for over 60 years.

We are the only -- HSO is the only officially recognized Standards Development Organization officially designated by Standards Council of Canada as an SDO that focuses exclusively on health and social services. And that means we can set National Standards and call them officially National Standards.

AC is -- we are the largest, most comprehensive accreditation body in Canada. Listed here are some of the -- the breadth of clients. Every hospital and health region across Canada is enrolled in our program.

Most long-term care hospitals are -- in Canada are enrolled in our program, including all public LTC homes outside of Ontario. There's a mix inside Ontario.

Some of our clients are actual provincial governments. So the Government of Quebec, as an example, is our client, and Ontario Government is the client for all the lab accreditation that -- and proficiency testing program that we run.

The Federal Government is also a client

for specific areas, private and public providers. There's a mix across all parts of the health care ecosystem, as well as post-secondary institutions. We accredit education programs for 17 health professions including paramedics, lab techs, et cetera.

So when you look at by the numbers just in terms of reach, over 15,000 locations use the programs, 38 countries. We train and keep continued status for 900 peer surveyors. 400 experts are involved in scientific advisory committees, very active.

And 100 published standards, 1,000 leading practices that are all kind of available for clients, and a variety of programs of which accreditation is one of the external assessment programs, but it's by far our largest and most high-profile.

Just as an acknowledgement also that we have to go undergo rigorous external accreditation requirements in order to operate. Not anybody can accredit, and we have to meet the requirements of these four organizations: SCC, ISQua, APAC, and ILAC. Lots of good acronyms. But those are -- those kind of establish that credibility base to

start.

So we thought that with that just brief overview of kind of the bit of who we are and what we do, the next slide is our proposed outline for today.

Just starting also with a bit of what Accreditation is and isn't, our experience in long-term care across Canada and Ontario to leverage learnings, the program that has been in place for assessing and accrediting long-term care homes today and has been in for the number of years, some of the observations from assessments pre- and during COVID.

Give you a review of the new program that's starting in long-term care for 2021 that has really been built as a result of needing to update based on some of the learnings and realities that we're experiencing now, and our recommendations for improving quality infrastructure going forward.

And with that, Commissioner, shall we proceed?

LEAD COMMISSIONER FRANK MARROCCO: Yeah, I think so.

LESLEE THOMPSON: Okay. Thank you. So just as a background with standards, inspections,

and accreditation, they are all part of -- integral parts to any quality infrastructure.

And just as a level set, there's lots of people who say they develop standards, but the kind of official mechanisms are through consensus of experts, consistent agreed-upon evidence-based criteria and guidelines.

They can be mandatory or voluntary. They're distinct again from acts, regulations, and codes, which can be referenced a lot in those legal instruments.

Only an SDO that -- in Canada can issue National Standards of Canada, and those standards go to a regular update and review process.

Inspections, by contrast, are instruments of government, as you well know, and they focus on compliance with regulation and codes, whereas accreditation bodies are independent of government, and they're typically not-for-profit. They can -- programs can vary in scope, rigor, and cost.

Some develop their own standards versus an SDO process. Ours goes through SDO process and sometimes requirements -- sometimes there are requirements by governments or other bodies that

say you have to have -- use only approved accreditation bodies.

There's -- in Canada and in Ontario specifically, the AC programs all require compliance with laws and regulations as minimum thresholds. So the accreditation program builds on those and focuses on overall quality, management, and improvement.

And we're going to take you through the specifics of the Accreditation Canada program so you can see exactly what's in there and how that has been undertaken in long-term care homes to date.

And, you know, there's lots of reports and research, evaluations, and feedback that consistently identify accreditation as part of the -- as part of any quality infrastructure.

And there's correlation between accreditation and quality culture, but there's no one-to-one direct relationship between -- in a complex adaptive system by saying this one thing influenced this one indicator.

And so I just wanted to paint that reality and acknowledge preventable harm unfortunately still happens in every hospital and

health setting, but accreditation is one of those vehicles to help clients keep quality and safety at the forefront, constantly improve and demonstrate progress, and helps hardwire it into daily operations.

There's lots of evidence to show that strong quality cultures and systems help organizations prepare for and adapt to crisis situations, and many top performers use multiple vehicles for quality improvement including accreditation. So that's just the general story in context.

Let's look at Accreditation Canada specifically. So we accredit -- and in long-term care. We accredit 1,482 homes across Canada. Most accreditation is mandatory in -- it shouldn't say 10." It should say -- I think there's -- in many of the jurisdictions for -- or actually, for all publicly operated long-term care and -- except in Ontario.

And in Quebec, the 2018 government was awarded -- awarded us a 10-year contract. We accredit all health care authorities and their long-term care homes.

The program has been tailored to them.

They receive provincial reports, and we customize a program for seniors and long-term care for them that will be started in 2021.

And then we outlined here B.C. and -- did I skip -- oh, sorry, I skipped slide 5. Let me just go back there for one second. I apologize.

That also accreditation for the current status in Ontario, before I do long-term care, every hospital undergoes accreditation every four years. The Royal College requires all teaching hospitals to be accredited.

There are hospitals -- long-term care beds within hospitals that are accredited, and the AC reports are property of the hospital. There's no posting requirements, and there is no direct government involvement in Ontario, although the AG report in 2019 when they pulled the results of safety culture surveys and recommended that government review the hospital reports, identify areas where people aren't meeting standards and safety practices and had that oversight of the reports. But to date, there's been no specific uptake on that.

In Ontario, just by -- just showing us the precedent, every lab, public and private,

undergoes accreditation by IQMH, which is now part of Accreditation Canada.

And in that situation, lab management and proficiency testing is mandatory. The program is funded by the Ministry of Health, and results can and do lead to suspension of licenses for specific tests and labs as a whole.

When it comes to accreditation in long-term care, it's done by two Ministry-approved accreditation bodies: Accreditation Canada and CARF, which is a U.S.-based firm.

The Ministry does provide incentive for homes to undergo accreditation as part of the long-term care funding formula, but each home makes its own decision.

There's no accountability back to the Ministry, no transparency with reports, and we often don't do province-specific reports for large cross-country private chains. And there are 16 percent of homes in Ontario who choose not to undergo accreditation.

LEAD COMMISSIONER FRANK MARROCCO: If I could, I'm just trying to understand if you -- it was ever explained why it would be voluntary.

LESLEE THOMPSON: It -- there's been no

decision by government in Ontario for long-term care or even hospitals that it is mandatory.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

LESLEE THOMPSON: Unlike other provinces.

KATE MCGRANN: Quick question before you proceed to the next slide: When you're talking about long-term care accreditation in Ontario, you've got a point here that says that there's no accountability back to the Ministry and no transparency with reports.

Is it the case that Accreditation Canada does not share its reports with the Ministry?

LESLEE THOMPSON: No. The hospitals or the homes are our clients. They are the ones in Ontario that pay the fee to Accreditation Canada to be part of their program, and there is no -- those reports are theirs.

In situations where -- like Quebec, the reports all go to the government, and then we do trending analysis and province-wide reporting for them.

KATE MCGRANN: Okay. And then for

organizations who choose to seek accreditation with you, do they have any obligation to you to report back on findings from Ministry inspections of their homes?

LESLEE THOMPSON: Not specifically on the Ministry inspections, but we do look at -- there's about 30 percent of our criteria that overlap with Ministry inspection elements.

And if through our process there are identified gaps that are identified during that accreditation process and will show you the current state, then they -- then that information is considered in the accreditation process.

KATE MCGRANN: Okay. Just so that it's clear in the transcript, it's the case, then, that government inspections and any findings flowing from government inspections are not considered in the accreditation process that your organization runs?

LESLEE THOMPSON: They would be considered, but they are not -- it would be if the home gave it to us.

KATE MCGRANN: Okay. And are they required to give it to you?

LESLEE THOMPSON: They are not required

to give it to us. They are encouraged. We don't have that teeth of the program right now.

LEAD COMMISSIONER FRANK MARROCCO: Were there ever any conversations with the Ontario government that you're aware of about making accreditation mandatory?

The reason I ask is, you know, there's a shortage of long-term care beds in Ontario, 38,000 bed shortage, so it's one thing if there's a surplus of beds, then people could choose to go to a place that's accredited as opposed to a home that's not accredited.

But if there's a shortage of beds, then you have no -- if you need to be in a long-term care facility, you have no choice, and therefore, accreditation becomes a kind of way of ensuring that there's quality of care for people who have no choice but to go into the homes.

LESLEE THOMPSON: Correct.

LEAD COMMISSIONER FRANK MARROCCO: Has there been any -- has this issue come up?

LESLEE THOMPSON: Most recently, as we will describe, where we did send reports to the Ministry of Long-Term Care, given COVID situation, when accreditation status of a couple of homes was

suspended, that notice prompted Ministry discussions around the development of province-wide programming and the option of mandatory accreditation.

LEAD COMMISSIONER FRANK MARROCCO: Discussions?

LESLEE THOMPSON: Discussions -- a proposal was requested, and extensive discussions have followed, but no decision, to our knowledge, has been made.

LEAD COMMISSIONER FRANK MARROCCO: Okay. There's been no shortage of discussions in what we've heard.

LESLEE THOMPSON: Mm-hm.

LEAD COMMISSIONER FRANK MARROCCO: Sorry, go ahead, Ms. Thompson.

LESLEE THOMPSON: No problem. So the other -- just the piece for Ontario is each -- while each home make its decision, there are -- there is a funding formula, as you know, for long-term care, and there is an incentive fund.

There's incentive payment there for people who do choose to be accredited, but there's no accountability loop-back and no follow-up of what that really was, the extent and et cetera.

So if I go to the next --

ASMITA GILLANI: To add, we have to notify Ministry if homes are accredited when they're accredited, so then they can access the fund. They need a nod from us.

So that's why when -- during COVID when we suspended some homes, we had to notify the Ministry that they were suspended. And that spurred a whole lot of discussions, very detailed proposal with costing, everything.

Suffice to say that the Ministry got caught in several crisis management, and so I think the will was there, but I think there was just too much happening with that.

LESLEE THOMPSON: Okay. So the gist of this slide just shows the variety of approaches to long-term care across the country. And if I go -- I spoke previously about Quebec as an example, and we accredit all publicly funded homes outside of Ontario.

Again, Ontario has a mixed approach. And of note is that 42 homes are run by hospitals, and those are assessed by us as part of the hospital accreditation process.

And we spoke on the requirement of --

there's no kind of follow-up or public reporting of reports in Ontario.

LEAD COMMISSIONER FRANK MARROCCO: So with respect to the 60 percent of the homes that are not accredited, in addition to not wanting to be accredited, they have chosen to give up whatever financial incentive the province is offering for accreditation on top of that?

LESLEE THOMPSON: That would be our understanding, yes.

ASMITA GILLANI: Yeah, I think --

LEAD COMMISSIONER FRANK MARROCCO: That strikes me as alarming, actually, that rather than be accredited, you would choose to give up money.

ASMITA GILLANI: I think, if I may, Commissioner, the financial incentive works out better for larger chains and -- because it's per bed, and it's per bed day. It's 36 cents per -- so that the pot is about 10 and a half million or so.

I think the big chains take full advantage of it, but everybody will go for the cheapest, and we're not the cheapest.

And so I think that it's also difficult to do accreditation. You have to be really pretty conscious. And we'll get into that later. So some

of the smaller homes, it's difficult for them.

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah, can I just ask a question on the previous slide, Leslee?

LESLEE THOMPSON: Yeah.

COMMISSIONER JACK KITTS: The private chains with cross-Canada presence are reviewed as whole, so no Ontario-specific reports, can you tell us more about that accreditation?

LESLEE THOMPSON: So that would be an example of Extendicare or -- Asmita, give me an example.

LEAD COMMISSIONER FRANK MARROCCO: Chartwell?

LESLEE THOMPSON: Yeah.

ASMITA GILLANI: Chartwell, Sienna, and we do Extendicare, yes, and they have Canada-wide presence. So, you know, we do 80 percent sampling and visit those homes.

We don't have the funding to go and visit every home in the chain every year. That was one of the proposals that we had put to the Ministry because the incentive fund would more than cover it.

LESLEE THOMPSON: The issue is, Jack, that the -- or Commissioner Kitts, that Extendicare is the client, or these are -- the big chain is the client, not the individual homes.

COMMISSIONER JACK KITTS: But you would have to make the assumption that an individual home in Manitoba and another in Alberta would also be the same in Ontario or another province?

LESLEE THOMPSON: We look at them -- sample them across the country, and we also -- we have the data, which we are going to share with you.

We've included there Ontario homes in the pool of the data we're going to show you for trending of results, but the -- and in a provincial report, you could break out those homes, but right now, overall, the national chain is the client.

COMMISSIONER JACK KITTS: Okay. So you're going to talk more about the inspection process --

LESLEE THOMPSON: Yes.

COMMISSIONER JACK KITTS: -- later on? Okay. Thank you.

LESLEE THOMPSON: Yeah. So let's go to -- let's go to that.

And, Asmita, if you could do, like, a brief overview of how it works currently and want to make sure that we show you -- we've got time for the observations and the trending analysis that we've done across all the homes.

ASMITA GILLANI: Sure. I think, Commissioner Kitts, you may be aware of our program. We have a set of standards specifically for long-term care.

We have the IPAC, the med management, leadership and governance, and then delivery of care model, which includes the resident experience and person-centered care and the delivery of care. Sorry, med management is twice.

Each standard has a set of criteria, and some of the criteria that are really related to safety and ethics are deemed and they're tagged digitally as high priority.

And then there is the self-assessment. We start with the self-assessment that the organization does a look-see on themselves, and they -- this is in preparation for the survey visit. So they see the gaps against our standards.

The standards, everything is available to the home, to the organization through a client

portal. They can access it any time. It has all kinds of resources on how to achieve the standard, on what references we use, and all those things.

And then the on-site survey is conducted by peer experts. These are practitioners in the field. They generally come from other provinces or, you know, other areas.

They include hospital leadership as well. Most of them are, you know, the C-suite as well as some clinical champions as well as physicians, et cetera.

And then we have these, what we call, required organizational practices, which are an absolute must-have to pass an accreditation. There's a certain algorithm that we go through.

And then the priority processes are ways that the surveyors use to identify, you know, how they will judge. So it's not just a checklist. They actually have to go through a tracer methodology, which means they have to go all the way from governance, leadership.

They follow the chain all the way to the frontline. They talk to residents. They talk to staff. They see if what is documented is actually valid. So there's a real deep dive in the

tracer methodology.

And then we have a ton of -- well, we have four requirements of them having to fill out surveys that they do during their prep time, and that is the staff work/life experience, the patient safety culture.

So staff judge, you know, what they feel is missing or strong or not. It's all anonymous. And then the patient experience survey as well.

And then we have a governance functioning tool, which means, you know, we get a sense of how much focus the board pays on quality and human resources and all those things and how it is -- we have tracers in governance as well to see if what is said actually translates to the front-lines.

And then the results are all collated in a portal. It's a different portal that the surveyors use. They do the assessment. Those results go to another body called the Accreditation Decision Committee that is at arm's length from us.

And they then go over all the evidence. They deliver it. They do follow-ups. They'll write back and say, "Well, this is unmet here.

What is -- you know, what is your plan?" They give them certain time to fulfill, and if they don't, then they don't get accredited.

We generally take a stance of nonpunitive because our interest, our social mission is to encourage people to elevate their quality, not to beat them down. It's how can we support you to get to that endpoint?

So sometimes, you know, the three-month time period sometimes will take six months, so we negotiate. And sometimes we just say, "Sorry, you're not meeting it." End of story.

In the past four, five years maybe, we've not given accreditation to about three or four long-term care homes.

And then we have a suspension policy. If we find from third-party sources that there's been egregious violation of our standards or noncompliance, then we can lift their status.

KATE MCGRANN: A couple of questions -- sorry, Commissioner Kitts, please go ahead.

COMMISSIONER JACK KITTS: Just with the standards, you're aware that the long-term care homes have inspections periodically by the Ministry of Long-Term Care, by Ministry of Labour, and

sometimes by Public Health or Food and Safety.

ASMITA GILLANI: Yes.

COMMISSIONER JACK KITTS: Are those parts of the documents that you would study when you're going in for an accreditation? Are the standards --

LESLEE THOMPSON: Yeah, about 30 percent of the criteria are overlap and would be looked at for sure. And then the other reports are available, especially we would -- they would ask whether there had been any major -- the surveyors would ask if there have been any major issues or gaps identified in previous reports, but it is not a -- we don't review every aspect of those reports now.

In the new program, which we will also describe, there's actually a capability to attest to some of the criteria, so to reduce the burden of duplication and to have organizations identify where there have been gaps in other reports and how they are addressing those as part of their overall quality improvement plan.

So we've taken steps to tighten up the alignment for an overall quality improvement approach better than it's been before.

ASMITA GILLANI: Yeah, we do take into consideration in Ontario the old HQO, you know, falls prevention, what they measure, and we look at those because we have specific processes around those outcomes.

But they're not necessarily all integrated. That's our future that we are looking to integrate the CIHI, the HQO, the interRAI. There are a number of indicators that are collected.

But we do look at minutes of board meetings or leadership meetings, so if there's inspection flags in there, we look at resident council minutes and those kinds of things. So it does give us a sense of, you know, what is the home's culture.

But most surveyors tell us that they learn so much when they're on the ground.

COMMISSIONER JACK KITTS: Okay. And just one more question: Some of the big chains, there's the owner, the license owner is a company who hires a company like Extendicare to manage.

Do you survey both the owners and the board or, like, how do you sort that one out in terms of governance?

LESLEE THOMPSON: Governance with those big chains is complicated, and we are often not provided with information, the same kind of level of governance detail that we would expect in a hospital when it's those more complex governance structures.

COMMISSIONER JACK KITTS: Okay. The last question is do you survey these every four years like hospitals, or what is the --

LESLEE THOMPSON: That's the current program, yes. The new program, it will be a continuous program with touch points each and every year including unannounced surveys.

COMMISSIONER JACK KITTS: Thank you.

KATE MCGRANN: Couple of other questions before we move on. You had mentioned that over the last couple of years, I think, three or four homes had not achieved accreditation.

Just to help us put that in context, is that in Ontario, or is that across Canada?

ASMITA GILLANI: In Ontario. I'm speaking now just in Ontario.

KATE MCGRANN: Okay. And about how many homes would have achieved accreditation at the same time? I'm trying to understand how many homes

didn't manage to get it in context.

ASMITA GILLANI: I would say that we do about 50 or so a year because of the four-year cycle. So it's about -- you know, 50 homes are seen every year and accredited or not or, you know, they have follow-ups.

KATE MCGRANN: Okay. Do homes lose their incentive funding if their accreditation is suspended?

ASMITA GILLANI: Yes. I mean, they might have negotiations with the Ministry particularly on COVID, but no. But technically, yes, they do.

LEAD COMMISSIONER FRANK MARROCCO: Do you have a process that people have to go -- that you go through when you're suspending, or do you just suspend?

ASMITA GILLANI: No, no, there's a whole process --

LESLEE THOMPSON: Very detailed process.

ASMITA GILLANI: Very, yeah, detailed process, and we actually go back on-site, and we do what we call a supplementary survey. And I think that it's been -- that's been quite challenging in

the COVID period.

LEAD COMMISSIONER FRANK MARROCCO: How long does the suspension process take to play itself out?

ASMITA GILLANI: Well, it depends also on the readiness of the home to say, "Okay, we fixed these," you know, so it -- I mean, they can stay, you know, permanently suspended and eventually lose their status altogether, but they do get, you know, time periods.

So we touch base with them right away and say, "Okay, these are the standards that are noncompliant. What is your time frame? We would like to come in and see what is the state of affairs, and then we can judge what effort it will take for you to do these."

Sometimes they agree, sometimes they do a written submission, but we are always insistent that we absolutely need to go in and check things out, you know, what we did.

LEAD COMMISSIONER FRANK MARROCCO: Are they suspended, and then is the process about lifting the suspension --

ASMITA GILLANI: Yes.

LEAD COMMISSIONER FRANK MARROCCO: --

or is the process directed towards imposing the suspension?

ASMITA GILLANI: So it is with the notion that if they work towards, you know, meeting these standards, then we would lift the suspension. Does that answer your question?

LEAD COMMISSIONER FRANK MARROCCO: So is there some sort of an agreement reached that they're going to work towards remedying whatever it is --

ASMITA GILLANI: Correct.

LEAD COMMISSIONER FRANK MARROCCO: -- and that immediately result -- immediately upon an agreement being entered into, the suspension is lifted?

ASMITA GILLANI: No, no, no.

LESLEE THOMPSON: No, no, the suspension is not lifted until the evidence is provided and the supplementary survey is conducted. So they are suspended through that time frame.

So there's a bit of an incentive for some that you want to get it through -- they want to do it quickly, and they want to move through quickly.

And for some of the homes that have

multiple sites, in addition to looking at that particular home, we also sample a few of the other homes in that -- from that operator as part of the suspension process.

ASMITA GILLANI: We just needed to make sure that other homes under the control of that operator were not experiencing the same issues, but they just didn't get captured by, you know, external reviewers like CAF or somebody.

Have we answered your question, Commissioner?

LEAD COMMISSIONER FRANK MARROCCO: Yes, for now, yes.

LESLEE THOMPSON: We'd be happy to provide a, you know, copy of the policy and process that's used if that would be helpful.

LEAD COMMISSIONER FRANK MARROCCO: Thank you.

LESLEE THOMPSON: One of the things that we've done is look at the -- kind of what are some of the trends if you step back and look at all long-term care homes across the country, over the past couple of years the main findings from their reports.

And one of the things that stands out

is actually Ontario data -- sorry, Ontario data is not -- there's no significant difference between the findings of Ontario and findings of other provinces.

So these are some of the highlights of things that over the past few years kind of has been -- the most frequent unmet criteria are typically around infection prevention and control and within that, hand hygiene practices, monitoring environmental cleanliness, lack of IPC education, resources, and training. That's often one of the top areas that people struggle with.

Leadership, overall leadership, compliance with leadership standards is overall weak in long-term care, especially compared to hospitals, especially in the privately run chain homes where there's often a lack of clarity on the ultimate accountability that we were just talking about with an on-site management, outsourced management, and the owner. And, you know, it's clear on-site leadership matters and qualified on-site leadership matters.

In medication management, there's frequent unmet criteria on the very specific requirements and the standards and criteria for

double identification for high alerts, "do not use" dose designations, documentation, and involvement of patients and families, which is critical in med management and especially in long-term care.

Resident and family engagement. There's been a lot of movement in that in the hospital and health system sector, not as much in long-term care, as reflected in the standards that people have not been able to meet those criteria in really meaningful ways. Same with our people-centered care criteria, which is peppered through the entire program.

There are duplication, as you know, of -- with the criteria of some inspection protocols. And ours -- the nature and the review of the process is quite different, so it's hard to compare exactly criteria to criteria, but they're just acknowledging that that duplication does occur.

And ours is more of a carrot approach than a stick approach, but you need a bit of both in order to have your overall model.

And the trends arising from accreditation reports can provide that valuable insight, gaps, trending, and benchmarking reports,

but only certain governments or health authorities commission those.

So depending on what the client wants and if there is no government client, then those are not provided. But they can provide early warning signals --

LEAD COMMISSIONER FRANK MARROCCO: When you say "the client," how do you define the client?

LESLEE THOMPSON: The one who pays Accreditation Canada for access to the program and for the delivery of the programs and services that we offer.

LEAD COMMISSIONER FRANK MARROCCO: So when there's a Ministry -- when part of the financial -- part of the money that the home receives is connected to accreditation, who do you view as paying you the money? The home or the government?

LESLEE THOMPSON: In the current model, it's been clear that the client is the individual home. They happen to get that money from the government, but government has never set up the expectation of any relationship with accreditation bodies.

LEAD COMMISSIONER FRANK MARROCCO:

Okay.

COMMISSIONER ANGELA COKE: Sorry, can I just clarify one thing?

LESLEE THOMPSON: Yes.

COMMISSIONER ANGELA COKE: For some other jurisdictions, though, is the Ministry the client?

LESLEE THOMPSON: Yes. The example of Quebec is or for Alberta Health Services, the Alberta Health Services, which is a regional authority, is in all the homes that are part of their system. Because they are an integrated system, all fall under the contract that we have with Alberta Health Services for accreditation.

COMMISSIONER ANGELA COKE: Okay. So they would get the reports and be well aware of how those homes are doing. Thank you.

LESLEE THOMPSON: Depending on the jurisdiction, the authority or the government, we work with them to have reports that meet their needs.

So Quebec wants to look at, you know, seniors across the whole continuum of care. You'd produce a report that relates to that and others, but it depends on what that relationship is.

ASMITA GILLANI: I mean, B.C., for instance, right now they want us to come and do a look-see on just their infection prevention and control and how they manage COVID. So they want an external review of, you know, potential gaps, et cetera. So they commission these specific studies.

LESLEE THOMPSON: This is an example of looking at just the -- we can work with data in a whole variety of ways. This is just an example of the patient safety culture survey.

This was what the AG in Ontario drew on the results of the safety culture tool in one of the most recent reports on hospital safety.

And this just shows you, again, this was -- LTC was included in these results, and it just shows the example of the view of staff, which is why it's so important to get their voices directly, not just looking at papers and talking to the administrators or the board about what they feel is happening related to quality. And this is another important dimension of looking at what needs to be improved overall.

And, you know, in -- what's striking with this is the high number of people, of staff

that feel reporting a safety issue can cause them problems with their job, and they are worried about declaring. And this is a concern to us and something that we're working on with our programs.

KATE MCGRANN: And what dates was that survey --

LEAD COMMISSIONER FRANK MARROCCO: Can you just go back to the --

LESLEE THOMPSON: Hmm?

KATE MCGRANN: What dates was that survey current of?

LESLEE THOMPSON: These were over -- these 260,000 staff sample is over three years. I believe this report was -- this data is from about 2015 to 2019.

ASMITA GILLANI: 2019, yeah. 2019.

LEAD COMMISSIONER FRANK MARROCCO: Before you leave this slide, at the very bottom, and just so I understand it, this represents 260,000 staff across Canada that you surveyed?

ASMITA GILLANI: Right.

LESLEE THOMPSON: That completed the survey instruments in the accreditation process, yes.

LEAD COMMISSIONER FRANK MARROCCO: And

it says at the last one, the fourth category:

"Please give your organization an overall grade on patient."

LESLEE THOMPSON: It should say "patient safety." And so every home that would be going through accreditation, the staff would be giving their -- or hospitals, their staff give an overall rating on patient safety.

And what this slide shows is that 55 percent in Ontario -- 55 percent is the rating. It's the overall grade of patient safety that the staff have given the hospitals in long-term care settings.

LEAD COMMISSIONER FRANK MARROCCO: So what does the 55 percent mean?

LESLEE THOMPSON: It means that people are saying -- this is a pooling of the data that says that 260,000 staff that were surveyed said that in Ontario, our rating for patient safety is about 55 percent, is what it turned out to be.

LEAD COMMISSIONER FRANK MARROCCO: And that's the lowest across Canada?

LESLEE THOMPSON: It's lower than the rest of Canada.

LEAD COMMISSIONER FRANK MARROCCO:

Yeah, that makes it the lowest.

LESLEE THOMPSON: Well, there may be others -- there may be others, but that's the -- I'm just pulling the Ontario-specific data.

LEAD COMMISSIONER FRANK MARROCCO: All right. And where you have on this "N=112,058," does that mean that the 55 percent, the grade 55 percent, is a grade extracted from the 112,000?

LESLEE THOMPSON: Yes, that's what -- from those staff what they rated Ontario, yes.

LEAD COMMISSIONER FRANK MARROCCO: Right. Right. Because somebody working in another province wouldn't be able to --

LESLEE THOMPSON: Exactly.

LEAD COMMISSIONER FRANK MARROCCO: -- right, fill that in.

LESLEE THOMPSON: Exactly.

LEAD COMMISSIONER FRANK MARROCCO: All right. Okay.

LESLEE THOMPSON: So looking at COVID, there were some key insights from -- of what happened during COVID that we wanted to share about what we did and then what are some of the other actions that are underway.

We, during COVID, halted all on-site

surveys for a seven-month period, and then where feasible -- and that was across Canada, and surveys started in October where feasible, and there have been some that have been done in Ontario.

We've mentioned already that when the CAF report was published, we then went and reviewed the status of homes for policy, decided that there was enough evidence for four homes that were not upholding the standard, so their accreditation status was suspended. They had to go -- supplementary surveys, and the Ministry was notified.

There was a release of all the relevant standards. Knowing that there's a real mix of uptake of accreditation and a variety of programs out there, we decided to release all Accreditation Canada relevant standards and toolkits at no fee for all long-term care homes during the COVID period, offered webinars, ongoing client support.

It was really clear to us that, you know, lots of guidance and requirements of everybody jumping in to help, so sometimes we took more of a backseat too, just letting people know we were here, but there were others that were being asked to take a more forceful front role.

We did notice that when hospitals took over the long-term care homes, that they brought speed, scale, and deep experience in kind of key areas of IPC, quality and crisis management.

And of note is they've already been using AC standards for a long time, sometimes so imbedded that you don't actually say, "Oh, this is an AC standard." It's hardwired into your processes and your ways of working.

But many of them did draw on the IPC standards to set up their rapid, you know, COVID boards in the hospitals.

And we are absolutely -- agree with the importance of better connection and relationships with hospitals and long-term care as needed on a systematic basis, and we saw consequences of that when that doesn't happen.

And then also during COVID, we undertook a rapid review with outside experts of all Public Health guidelines, COVID lessons learned, and then standards were updated and guidance updated for organizations on IPC and emergency preparedness.

And there's some examples here of criteria that have been added related to inventory

and supply chain of PPE, gowning protocols, environmental factors, and other related issues.

And so now our Long-Term Care Assessment Tool, the 2020 edition, includes these updated standards. And this is kind of part of what we do is making sure that we're bringing the most relevant guidance to organizations for them to follow.

KATE MCGRANN: A couple of questions on that slide just before you move on. I understand that the organization halted on-site surveys in March and then didn't conduct any for the seven-month period due to the pandemic.

What feeds of information did you have available to you to allow you to assess eligibility for ongoing accreditation during that period of time?

ASMITA GILLANI: The first and foremost was travel restrictions. Certain provinces -- is that your question?

KATE MCGRANN: No. I'll give you an example to try to help clarify because I don't think I did a great job with that question.

You spoke to responding to the Canadian Armed Forces report by suspending the accreditation

of four homes. You're not doing your own on-the-ground surveys during this seven-month period, so what information is available to you to help assess whether the homes that you have accredited should be permitted --

ASMITA GILLANI: Oh, for those homes -- for those homes that we suspended, we absolutely went in again.

LESLEE THOMPSON: But the source of information that led to that decision was the CAF report which we deemed to be a credible publicly posted report that -- with the seriousness of examples that were brought there through that credible mechanism, we actually -- you know, done by the Canadian Military, we actually accredit the Canadian Military Health Services that -- that was what we relied on.

We don't rely on -- we don't go in after a newspaper headline or informal reports. They need to be in between surveys, a really public egregious departure with good evidence that leads to going in there.

Again, in the new program with continuous, you're in there every year because this is obviously one of the shortcomings of an

every-four-year cycle.

KATE MCGRANN: In the current program, how often are you doing on-site surveys in the homes that you've accredited?

LESLEE THOMPSON: Once every four years.

KATE MCGRANN: Are those surveys announced?

LESLEE THOMPSON: They are announced in the current program. There will be a combination of both in the new.

KATE MCGRANN: Other than the four homes mentioned in the Canadian Armed Forces report, did you suspend the accreditation of any other homes in Ontario since --

LESLEE THOMPSON: No.

KATE MCGRANN: -- the pandemic has been declared?

LESLEE THOMPSON: No, we have not.

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Kitts?

COMMISSIONER JACK KITTS: Just a question about your last sentence:

"LTC Assessment Tool 2020 Edition now includes updated

standards."

Can you give us an idea of how many standards there are and which ones you've updated?

LESLEE THOMPSON: Yeah, so we focused on the update -- so I can show you exactly here what the -- so the program is under transition right now.

In the new program in the 2020 edition, the Long-Term Care Assessment Tool, there are six chapters that combine a variety of standards into the assessment tool and focused on governance and leadership, infection prevention and control, delivery of care, medication management, emergency disaster management, and resident experience.

And there are 200 criteria kind of within those as well as what Asmita was talking about with some required practices, priority processes, et cetera, are identified.

But those are the areas -- infection prevention and control, emergency disaster management are two of the areas and resident experience that have been updated specifically since COVID.

COMMISSIONER JACK KITTS: Are those criteria standards? Is there 200 standards or

is --

LESLEE THOMPSON: No, they're kind of criteria within the standard. So you have the standard, and then there's multiple criteria that are set as -- that the -- to be specific about what that standard is about, and they're assessed on criteria.

ASMITA GILLANI: Each standard has a set of criteria. Some are required organizational practice criteria. Some are deemed high priority, and then, you know, some are tagged as, you know, attestable -- and we can go into that later -- so that they can be done virtually. And then there are those criteria that absolutely require an on-site visit.

So the whole thing is digitally tagged, the program, to give guidance. Like, you can do a lot of the documentation review virtually kind of thing.

And then, you know, the standard -- the criteria from these existing -- these updated standards have been pulled out that are completely relevant to long-term care sector.

COMMISSIONER JACK KITTS: When the Federal Government speaks about creating standards

for long-term care homes in Canada, is that you and is that this?

LESLEE THOMPSON: Well, I think you will hear from the Federal Government shortly on their plan for how those -- how that national long-term care standard will be developed. And you could expect they will rely on standards development organizations like HSO to provide a leadership role.

COMMISSIONER JACK KITTS: Are you able to share the standards that exist now with us?

LESLEE THOMPSON: Yes.

ASMITA GILLANI: Yes.

LESLEE THOMPSON: We can share the Long-Term Care Assessment Tool with you.

COMMISSIONER JACK KITTS: Okay. Thank you.

ASMITA GILLANI: It's not something we can post, though; right?

LESLEE THOMPSON: It's okay. We can share with you our -- we are not for profit but we are not for loss, so we will provide the Commission with the copy of the tool.

If the Ontario Government so chooses to kind of roll out the program overall and have

everyone have complete transparent access, that changes the situation.

COMMISSIONER JACK KITTS: Okay. So, Kate, will you follow up and make sure we do the right thing?

KATE MCGRANN: Yeah.

COMMISSIONER JACK KITTS: Okay.

LESLEE THOMPSON: And then this slide just shows the migration to the new program, which is moving from -- we are actually phasing out every four-year survey cycles in all sectors including hospitals and health systems over the course of the next couple of years.

And the Qmentum Long-Term Care Accreditation Program is ready for clients as of June 2021 based on the tool, and then there's this continuous approach.

There's updated survey instruments. They're streamlined. Dr. Ross Baker and others have been involved in updating our tools that will be used.

There will be unannounced and virtual surveys, new methods to ensure reducing duplication, thresholds that have to be met every year, benchmarking and trending data all on kind of

a platform that allows for people to continuously improve and self-assess and share data across as well as a significant amount of training, education, and resources.

So that program is being implemented. These are some of the key highlights, and most of them I've already mentioned.

And should a province -- and this would be discussions that we would have. Should a province want more on-site visits, more of something, deeper customized look at particular areas like IPC or other areas, that's all possible in setting it up, depending on the approach to the program.

The real value comes when you pool multiple settings in order to generate the insights that can be actionable at a local level as well as at a provincial and even national level.

This just shows the cycle, that it's an ongoing -- there's an ongoing phase of activities that are part of the program.

In summary, we wanted to highlight some things that we see are kind of right in front of you as opportunities to leverage programs that currently exist, don't have to reinvent the wheel

for things and to show some examples of where AC programs can be leveraged to achieve goals for higher quality, safety, and resident experience in Ontario.

We've spoken about the proven track record and the role that we play but often in the background. It's not always out front for everyone.

When common approaches to accreditation are used on a province-wide basis, there's opportunities to increase standardization. And you know well from quality improvement experience that standardization is vital to a safe culture. It can provide more robust reporting and analysis.

Every hospital already undergoes accreditation with AC, and the approach can easily be extended and connected to long-term care across the province.

And then you've got common language, common protocols, common policies, the clinical oversight. We've got clinical governance standards, et cetera. All of that can be there. There's a much broader pool of standards that can support the overall programming and work.

The report has a richness of data

that's available for trending early warning signals and so forth that is available if asked for.

And the survey instruments really focus on issues that -- metrics that matter, a lot around resident safety culture, staff work/life, governance functioning.

And, again, it can be tracked in a variety of ways and, with support, can improve the -- kind of the number of people completing those surveys can -- the more that that's increased, the better the data.

There's also -- we have Leading Practices. Those were from the Canadian Quality Commission that had the Leading Practices library. Accreditation Canada assumed responsibility for those and building them, and they're available. And people can contribute case studies, and it's a way to provide access to improvements to people.

We recognize really that the empowerment, coaching, and support of staff is essential over the long term. There's been a lot of attention on staffing levels, hours of care.

While we agree that those are critical to address, really we need to look at the overall supports for staff. And there's lots of programs

again that currently exist: Education, training, even certification for frontline staff on quality improvement. And those programs exist and are used in other jurisdictions.

On an immediate basis, knowing you're also looking at short-term, there's education and training that can be immediately provided through a vast network of peer surveyors and trainers in areas of IPAC, emergency disaster management, et cetera.

Our surveyor training in these areas is expensive, and it can be leveraged in a variety of ways, and then it's consistent. One of the observations now is there's a lot of individual interventions, and there are opportunities to leverage what already exists.

And then the use of data can certainly be enhanced for evidence-informed improvements and decreasing the burden of inspections and criteria and protocols with the mechanisms that we have now. With the digital platforms, you can reduce some of that duplication and burden on homes, which is a positive.

And finally, just some other kind of recommendations for your consideration and

observations from our kind of experience in Ontario and elsewhere that, you know, we certainly agree that every long-term care home should have a formal partnership with local hospitals and then the EMS, Public Health, transport and ideally as part of kind of an integrated system but, at the very least, with hospitals as key. And we see lots of examples of the value of that integrated system approach in other jurisdictions.

That consistent use of language of standards and the language of processes across health settings that increase -- just like within a hospital, if you had a different quality standard in every -- you know, in OR, from the emerg, from somewhere, you know, an inpatient unit, you all had different ways to talk about infection prevention and control, that creates problems in your -- and risk for quality and safety.

Same across settings and really needing to raise all votes including leadership for quality, which is absolutely essential. And having skilled leadership on-site we agree with.

Our hope is that you will really also minimize one-off solutions, one-off, time-limited solutions. They can be important for a focused

effort, but really if you want to strengthen quality infrastructure for improvement over the long term, need to take a broader approach and look further than pumping out kind of individual interventions.

You know, we also believe that there's, you know, opportunity to make sure that you do provide immediate access to recognized education and training, and for staff, ensure those investments for staff are sustained over the long term so that they are supported to improve quality.

We believe that all kind of the three legs of the quality infrastructure stool, if you will, of licensing, inspection protocols, and accreditation -- when those are mandatory and mutually reenforcing, multiple reports, World Bank, looking at ISO, multiple international reports that look at national jurisdictions, all three are required for having a strong, robust quality infrastructure.

And so we believe that accreditation is definitely a part of that and would ask you to consider that as well as making, you know, any reports and postings of accreditation results and findings, if they are mandatory, especially making

those reports transparent and publicly available and then encouraging Ontario to contribute to the development and adoption of National Standards when that call will be coming very shortly.

COMMISSIONER JACK KITTS: Just a quick question, Leslee. We've spoken about this before, but there was a time when hospitals were ramping up to standards indicators, targets, metrics, and we've heard that long-term care is highly regulated with hundreds of regulations, standards, metrics, indicators to the point of chaos in terms of which one is more important than the other.

And I'm intrigued by your slide where you have the six focus areas for long-term care that you're going to be rolling out. I don't know what slide it was.

LESLEE THOMPSON: Yeah, 13.

COMMISSIONER JACK KITTS: I mean, in an effort to get away from indicator chaos, these six look like very pragmatic things, that if you were to evaluate them, you could get a pretty good idea, maybe the 80-20 rule, of how well a home is functioning --

LESLEE THOMPSON: Absolutely.

COMMISSIONER JACK KITTS: -- and you

don't have hundreds of other things.

The only thing I would suggest is where you have resident experience, resident and staff experience would be, to me --

LESLEE THOMPSON: That's what it should say. That's what it -- yeah.

COMMISSIONER JACK KITTS: So to me, everybody could remember that, and basically if all of these things are in order, you've got a pretty good chance that the home is well run and safer and better quality than now.

Is there any thought to saying these are the vital few or create the vital few so it's not overwhelming?

LESLEE THOMPSON: I would say that these would absolutely be that vital few, and within there, there are specific criteria that have been identified as these are the absolute must-haves and these are the priority processes that need to be assessed as well so that you've got that full picture.

I think that sometimes -- and every province is a little bit different with how much they throw into their provincial regulations and inspections, and so there is an opportunity to

streamline those, to pull some of the focus back on some of those to not duplicate.

The key is you've got to make sure -- if you didn't have any accreditation, you'd need to pile up more on the regulations and the government-run oversight.

In a situation where you've got the opportunity for both, you can also have government rely on an independent third-party assessment of these other elements and not do all the work themselves against detail, more and more kind of criteria each time you turn around.

COMMISSIONER JACK KITTS: Sounds good. Thank you.

LEAD COMMISSIONER FRANK MARROCCO: Well, I think that completes the questioning. Ms. McGrann, do you have any further -- any questions you want to ask?

I think the Commissioners -- we've probably asked all the questions that occur to us, so thank you very much to both of you for the presentation.

You know, the issue has occurred to us that some of these homes somehow did get under the radar, and so the accreditation process is a matter

of interest in terms of what we're thinking about.

So thank you for the presentation. It's extremely helpful, and it will be a help to us.

LESLEE THOMPSON: And we will send you the follow-up material and perhaps some other -- yes, we will send you that.

LEAD COMMISSIONER FRANK MARROCCO: Yeah, and if there's something that you think we should see, if you forward it to Ms. McGrann, I'm sure she'll make sure that we see it.

LESLEE THOMPSON: That would be good, including the call-to-action from a number of other -- like, CMA, CNA, and others that are asking for in their recent reports that, you know, there be a requirement for long-term care services across the continuum to be accredited.

So there's multiple voices that are supporting this, and we are pleased to have the opportunity to provide you with kind of our detailed approach that would enable those kind of recommendations to be implemented.

LEAD COMMISSIONER FRANK MARROCCO: Yeah, you shouldn't feel inhibited in any regard. If you think there's something we need to see that

for some reason wasn't mentioned, just send it to Ms. McGrann, and she'll make sure we see it.

ASMITA GILLANI: Thank you very much. I think the only parting words I would say that the -- you know, the standards are really good, robust, and very specific that give you the scaffolding.

I think the review process, the assessment is also a very key part. It's very different from inspection, and that's why it gets you to a very detailed view from staff perspective, from resident/family perspective.

So I think we like to call it our secret sauce, you know, our tracer methodology, et cetera, which is really something we pay a lot of attention to.

And these surveyors are not paid. I mean, we give them per diem when they're on survey. And the one thing is that -- the only reason is every four years is if we had the right support and right mandate from Ministry, we could go in much more frequently.

Our surveyors are very committed. They've been undergoing very specific training with experts. So I think that's an untapped resource

that we're sitting on, and it will be very easy to unleash that network. They're keen, they're ready, and they're experienced and skilled.

So those would be my parting words.

LEAD COMMISSIONER FRANK MARROCCO: Well, thank you.

KATE MCGRANN: A question coming from that actually: When you say that they're not paid but they're paid a per diem, can you just explain what you mean by that?

ASMITA GILLANI: They're paid a per diem when they are on survey to cover costs and, you know, because they go -- over the weekend, they review the documents, et cetera.

These are, you know, physicians, nurses that have other day jobs as well, and they take time off. And we actually insist that we have some current and some retired because then they are encouraged with the practice of what's happening.

And they also run webinars of communities of practice where, you know, a certain problem gets, you know, discussed by a few homes together, so we are able to do a lot more.

Our stance has always been -- our investment is to improve quality, not to beat them

down. You need a stick -- if we had the government stick, we could do that as well, so...

LEAD COMMISSIONER FRANK MARROCCO: So in order to unleash that, you need the support of the Ministry of Long-Term Care in order to bring that about?

LESLEE THOMPSON: We need, yeah, the support, the funding of the program, and the support --

ASMITA GILLANI: And the mandate.

LESLEE THOMPSON: -- that puts that mandate forward. Encourages people to know that government is there to support quality improvement for the long term, not just to come and send their own people or their own inspectors in to check every so often on the technical requirements.

LEAD COMMISSIONER FRANK MARROCCO: Okay. Thank you for that.

LESLEE THOMPSON: Thank you. All the best.

LEAD COMMISSIONER FRANK MARROCCO: Thank you.

COMMISSIONER JACK KITTS: Thanks, Leslee. Bye-bye.

ASMITA GILLANI: Good luck. Bye-bye.

LESLEE THOMPSON: Bye for now.

-- Adjourned at 10:43 a.m.

REPORTER'S CERTIFICATE

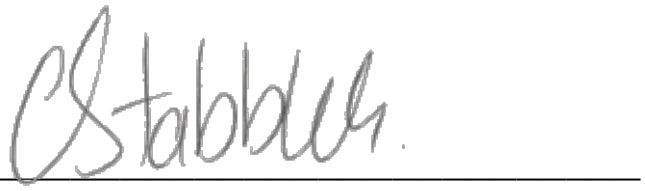
I, CARISSA STABBLER, Registered Professional Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 8th day of February 2021.



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C L A R I F I C A T I O N S

Page 20, line 4: "16 percent" not "60 percent"

Page 20, line 21: "many might just go" not "everybody will go"

Page 20, lines 23-25: Should be clarified to read "There has to be a strong focus and dedication to quality and sometimes, especially for smaller homes, it is difficult. Our new program, and we will get into that later, will help them achieve these."

Page 21, line 24: "covers it" not "would more than cover it"

Page 25, line 2: Strike "ton of"

Page 25, line 4: "survey instruments" not "surveys"

C L A R I F I C A T I O N S

(Continued)

Page 25, line 24: "the accreditation award" not "it"

Page 26, line 7: Strike "not to beat them down"

Page 30, lines 10-12: Should be clarified to read "We are unable speak to Ministry conversations, but technically, [...]"

Page 38, lines 1-7: Should be clarified to read "In BC, for instance, a Health Authority wanted us to review how they managed COVID and whether there were gaps - so specific studies can be commissioned."

Page 40, line 12: "and" not "in"

Page 43, line 12: "wards" not "boards"

C L A R I F I C A T I O N S

(Continued)

Page 53, line 13: "safety" not "safe"

Page 54, line 12: "expansive" not "expensive"

Page 55, line 20: "voices" not "votes"

Page 62, line 25: Strike "not to beat them down"