

Long-Term Care COVID-19 Commission Meeting

Marsh Canada
on Friday, February 5, 2021



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held Virtually via Zoom, with all participants
15	attending remotely, on the 5th day of February,
16	2021, 3:30 p.m. to 4:34 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

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9 Sarah Robson, President and CEO of Marsh Canada

10 Greg Fisk, Managing Director and Public Entity

11 Practice Manager, Marsh Canada

12 Trevor Mapplebeck, Managing Director, National

13 Marsh Advisory Leader, Marsh Canada

14 Shani Briffa, Assistant General Counsel and Chief

15 Compliance Officer, Marsh Canada

16 Kimberley Brouse, Senior Vice President, Healthcare

17 and Life Sciences Unit Leader, Marsh Canada

18 Cristina Scenna, Senior Vice President, Business

19 Development Lead, Marsh Advisory, Marsh Canada

20 Jennifer Johnson, National Financial Services

21 Leader, PwC Canada

22 Angela Ma, Partner, Healthcare Operations, PwC

23 Canada

24 Keegan Iles, Partner, Insurance Consulting, PwC

25 Canada

1 PARTICIPANTS:

- 2
- 3 Alison Drummond, Assistant Deputy Minister,
4 Long-Term Care Commission Secretariat
- 5 John Callaghan, Counsel, Long-Term Care Commission
6 Secretariat
- 7 Derek Lett, Policy Director, Long-Term Care
8 Commission Secretariat
- 9 Lynn Mahoney, Counsel, Long-Term Care Commission
10 Secretariat
- 11 Angeline Hawthorn, Senior Policy Analyst, Long-Term
12 Commission Secretariat
- 13 Angela Walwyn, Senior Policy Analyst, Long-Term
14 Commission Secretariat

15

16 ALSO PRESENT:

- 17
- 18 Olivia Arnaud, Stenographer/Transcriptionist
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1 -- Upon commencing at 3:30 p.m.

2
3 LYNN MAHONEY: This is a group that is
4 here, Commissioner, in response to some of the
5 questions that arose subsequent to Marsh's original
6 appearance before you with respect to issues
7 related to insurability of the long-term care
8 sectors and also with respect to the necessity for
9 a more thorough and robust auditing inspection
10 process relating to these long-term care homes that
11 may impact their insurability.

12 So with that, Commissioner Marrocco,
13 this is the group from Marsh and PwC, who are here
14 to help you with those issues.

15 LEAD COMMISSIONER FRANK MARROCCO:

16 Well, thank you all, and thanks for
17 coming back, at least some of you. Nice to see you
18 again, Ms. Briffa. And you know the drill, so I
19 don't think I'll waste any time on a Friday
20 afternoon.

21 Go ahead. When you're ready, we're
22 ready.

23 SARAH ROBSON: All right. Well, thank
24 you very much, and good afternoon. And thank you
25 once again for the opportunity to speak to the

1 Commission today on this Friday afternoon.

2 As was referenced, since our last
3 meeting on November 3rd, we have been responding to
4 the council, to the Commission's various follow-up
5 inquiries regarding audits and inspections, risk
6 mitigation, and operational excellence in the
7 healthcare and long-term care sectors.

8 We're pleased to have the opportunity
9 to present our views on proactive and ongoing
10 quality management to drive better quality care and
11 how it may assist in improving the insurability of
12 the long-term care sector.

13 Joining me today are my colleagues,
14 whom you met at the November meeting: Greg Fisk,
15 managing director and healthcare practice leader
16 for Marsh; Trevor Mapplebeck, managing director and
17 national leader of our Marsh advisory team; and
18 Shani Briffa, who's known to you, our assistant
19 general counsel and chief compliance officer for
20 Marsh Canada. And Shani's also responsible for
21 government relations and is our key liaison with
22 insurance industry bodies.

23 We've also added two additional
24 colleagues today, Kim Brouse, a senior vice
25 president in our healthcare and life sciences

1 practice, who specializes in placing coverage for
2 our healthcare clients and, in particular, the
3 long-term care sector; as well as Cristina Scenna,
4 national business development lead in our advisory
5 practice, who has a background in risk assurance
6 broadly and management consulting in the public
7 sector healthcare space.

8 Additionally, we've been collaborating
9 with PwC, who consult to the healthcare sector.
10 Joining us today from PwC are Angela Ma, a PwC
11 consulting partner with a focus on operational
12 improvements in healthcare. Angela works with
13 different clients to help them in their operations
14 to improve quality and efficiency.

15 Jennifer Johnson is also a partner,
16 specializing in governance, risk, and controls.
17 She previously led PwC's risk services practice
18 across Canada and primarily focuses in the
19 insurance industry now; and Keegan Iles, another
20 consulting partner, who leads PwC's insurance
21 practice nationally with experience in the U.S.,
22 U.K., and Canada.

23 I'll now turn it over to
24 Cristina Scenna, who will set the stage for our
25 discussion this afternoon.

1 Cristina?

2 CRISTINA SCENNA: Thank you, Sarah.
3 Thank you, Sarah.

4 Marsh has leveraged our network of
5 professionals to respond to the Commission's
6 questions regarding inspection and audit experience
7 in the long-term care sector. Through
8 collaboration between Marsh and PwC, it was clear
9 that a holistic approach including clinical audit
10 and assurance and insurance expertise would be
11 required.

12 The coordinated insights and expertise
13 of all these professionals is necessary to identify
14 solutions that will improve risk mitigation,
15 achieve operational excellence, rebuild confidence
16 and insurability in the sector, attract capital,
17 and improve quality care for residents.

18 This input is also required to address
19 the complementary but sometimes distinct
20 stakeholder focuses; for example, though minimum
21 audits and inspections may serve a purpose in
22 measuring organizations against imposed
23 Public Health standards, they typically are both
24 backward-looking and infrequent.

25 As a result, they often provide dated

1 insights, which has implications on enforcement.
2 That level of audit and inspection likely will not
3 be sufficient to attract insurance capacity for the
4 sector. Furthermore, without reform, the existing
5 capacity will continue to contract.

6 Insurance markets overall are
7 underperforming, which is causing a market-wide
8 shrink in capacity and an increased conservative
9 risk appetite. Periodic compliance reviews against
10 minimum regulatory requirements will not
11 sufficiently address the insurance markets' risk
12 appetite.

13 The key stakeholder groups in the
14 long-term care sector may have varying perspectives
15 on risk and risk tolerance. When developing new or
16 improved standards, the sector will need to
17 consider all key stakeholder requirements in order
18 to close the gap in risk acceptance and effectively
19 meet objectives of each group.

20 Government is looking to meet
21 increasing demands for services without compromise.
22 The Public Health objective is to ensure public
23 well-being. Insurers require risk management
24 practices that align with risk appetite.

25 Long-term care owners and operators are

1 striving to deliver quality care, meet the needs of
2 the public, and comply with existing and new
3 healthcare policies and guidelines, while residents
4 and families need to receive quality care.

5 Today, PwC and Marsh will jointly
6 provide context on the sector's contracting
7 insurance market, the key drivers, and how a
8 culture of ongoing quality improvement and
9 empowerment can address the needs of all key
10 stakeholders.

11 I will now hand it over to Greg Fisk,
12 who will provide an overview of the current
13 insurance market.

14 Greg?

15 GREG FISK: Thank you, Cristina.

16 Although our last presentation to the
17 Commission was only three months ago, there has
18 been some fairly significant activity in both the
19 long-term care and insurance sectors in Ontario,
20 and I wanted to provide you with an update on
21 current market conditions as we start 2021.

22 Since our discussion in November, we've
23 faced a new second wave of the pandemic, new and
24 more infectious strains of COVID, vaccine rollout
25 and delays, and pending legal decisions from claims

1 arising from COVID. These factors have not
2 improved the position for Ontario's long-term care
3 insurers.

4 As a result, owners and operators will
5 continue to face significant challenges with
6 respect to their insurance. Property premiums are
7 projected to increase between 10 and 40 percent due
8 to a combination of factors, including global
9 market conditions and a particular focus on the
10 quality of long-term care homes in Ontario. Loss
11 of business due to an outbreak is now excluded, and
12 long-term care homes may need to accept increased
13 deductibles or lower amounts of insurance to manage
14 premium costs.

15 Insurers have taken a hard line on
16 general and professional liability insurance as
17 well. Reliability insurance market for long-term
18 care has always been quite limited and is now
19 closed, as key insurers have stopped accepting new
20 business. Liability for claims arising out of
21 COVID is now essentially uninsurable. Long-term
22 care homes are expected to face increased liability
23 premiums of between 30 and 60 percent.

24 Insurers have also increased their
25 underwriting scrutiny. Homes where there have been

1 multiple outbreaks and poor inspection reports may
2 be subject to higher increases or even non-renewal
3 from insurers. We continue to see market
4 contraction in the sector for directors and
5 officers liability as well, as insurers exit this
6 business class altogether.

7 The terms currently being offered to
8 long-term care homes are very restrictive, with no
9 coverage for COVID claims, higher deductibles, and
10 lower limits. In addition, premiums are expected
11 to rise by 30 percent or more.

12 I'd like to point out that these market
13 changes have a compounding impact for owners and
14 operators in the long-term care sector. As we
15 approach the one-year anniversary of the pandemic
16 in Canada, many homes will soon begin their second
17 insurance renewal cycle under these conditions,
18 and, on average, we project that by the end of
19 2021, their insurance costs will have increased by
20 50 to 75 percent since 2019 with less coverage.

21 Next slide, please.

22 Bill 218 is seen as a positive step
23 forward by insurers, but it does not improve
24 conditions at this point. Insurers continue to
25 defend claims in the midst of new outbreaks, and

1 until there is more clarity around the application
2 of the immunity, increasing losses arising from
3 defence costs will continue to restrict the market.

4 As anticipated, insurers were no longer
5 able to transfer the contagious disease risk to
6 reinsurers during the January 1st reinsurance
7 renewals. In addition, higher reinsurance costs
8 will be passed to long-term care owners and
9 operators in the form of increased premiums.

10 Unfortunately, the insurance market
11 outlook for 2021 does not look good. Property
12 insurance premiums will remain high due to global
13 losses in 2020 and the systemic risk issues
14 associated with an aging long-term care
15 infrastructure.

16 Liability insurance for contagious
17 disease risk will remain extremely limited due to
18 the second wave, uncertainty around immunity
19 legislation, vaccination, and a skeptical outlook
20 for the future of pandemic risk.

21 However, work continues, and I remain
22 hopeful. We are working with all of the key
23 stakeholders necessary to drive a number of
24 solutions forward, but it will take time. Although
25 slow now, the distribution of vaccines will improve

1 and provide us with greater clarity by the end of
2 the year. In the meantime, owners and operators
3 will continue to face significant challenges at a
4 time when the sector is at its most vulnerable.

5 With that, I'll pass it over to my
6 colleague, Kim Brouse, who leads the healthcare
7 team in Toronto.

8 KIMBERLEY BROUSE: Thank you, Greg.

9 We've outlined the changes to the
10 insurance markets specifically affecting the
11 long-term care industry, but what is the practical
12 impact on individual homes and larger operators?

13 There will continue to be significant
14 financial impact due to increasing premiums and the
15 retention of more risk with higher deductibles; for
16 example, if the annual insurance cost for an
17 individual facility was \$20,000 in 2019, it would
18 have increased to approximately \$25,000 in 2020,
19 and with the proposed increases for 2021 will
20 escalate to somewhere between 32,000 and \$40,000.

21 The worst-case scenario could result in
22 a doubling of the premium within a two-year period.
23 The percentage impact to larger operators will be
24 the same, though with much larger dollar
25 difference.

1 Insurers have essentially frozen their
2 long-term care accounts and are not accepting new
3 business, which means there is no longer market
4 competition, and operators have no choice but to
5 remain with their incumbent insurers. This also
6 means that the new operators cannot obtain
7 insurance coverage for new builds or residences
8 that are required. Insurers are accepting
9 additional locations for existing insurance but
10 have restrictions in certain territories such as
11 Québec and B.C.

12 The application of the contagious
13 disease exclusion by most insurers also affects
14 coverage for vaccine administration and COVID
15 testing because these are not insured. The
16 responsibility for vaccine-related activities
17 belongs to each home, and yet there is no insurance
18 remedy for the resulting legal liability.

19 Further, potential liabilities retained
20 by the long-term care operators and to officers and
21 directors of the organization has affected their
22 ability to attract and retain independent board
23 members.

24 Finally, the increased retention of
25 risk due to the contagious disease exclusion and

1 higher deductibles may lead to the contravention of
2 lender agreements, leaving operators in breach of
3 their debt covenants. This is also expected to
4 impact the ability of operators to obtain financing
5 for renovation of older residences and new
6 developments.

7 With that, I welcome Jennifer Johnson
8 of Pw- --

9 LYNN MAHONEY: Kim, could I just ask
10 you just to clarify, and I think you did give us
11 some risk, but could you just repeat for me, if you
12 can, what the premiums were, how much they have
13 increased?

14 KIMBERLEY BROUSE: So last year, we
15 would have expected about a 20 percent increase.
16 You know, that's an average increase across the
17 board. In the figures that I provided -- that I've
18 just provided would have contemplated a 30 to
19 60 percent increase. So that means in the
20 worst-case scenario, it would result in a two-year
21 period of about a doubling of premiums.

22 So if we started off at 20,000, for
23 instance, in 2019, by the end of 2020, you could
24 see somewhere between 32,000 and 40,000.

25 LYNN MAHONEY: Okay. Is that the kind

1 of premiums we're talking about in that range?

2 KIMBERLEY BROUSE: That dollar figure,
3 it -- the dollar figure ranges quite a bit. That
4 would be probably for a mid-sized -- maybe two or
5 three homes in a portfolio. It could be -- you
6 know, it could be smaller for a single operator but
7 much, much larger for a larger operator.

8 LYNN MAHONEY: Okay. So if you could
9 just give us sort of the ranges of what the
10 premiums are. So for a home that has -- like, for
11 an operator that runs three homes, it would be in
12 the range of...?

13 KIMBERLEY BROUSE: So this would be the
14 range for about two or three homes. For one home,
15 it might be -- you know, their total spend might be
16 15 to 20,000, and then for, you know, for mid-sized
17 operators that have multiple locations but not, you
18 know, the giant ones, their overall premium spend
19 could be up to about -- you know, if we're talking
20 about liability and property, for instance, and
21 cyber, it could be up to a million dollars.

22 And then for the very large operators,
23 it would be in excess of two million dollars.

24 LYNN MAHONEY: Okay. And so the
25 increase, could you tell me again? So for one of

1 the mid-range, you're saying that their premiums
2 could increase from, sort of...

3 KIMBERLEY BROUSE: Yeah. So say,
4 20,000 to 30 or 40,000.

5 LYNN MAHONEY: Okay.

6 KIMBERLEY BROUSE: And the percentage
7 increase will be expected to be the same for small
8 or large operators.

9 LYNN MAHONEY: Okay.

10 KIMBERLEY BROUSE: Of course, the
11 dollar differences would be different.

12 LYNN MAHONEY: Right. And you've given
13 us an indication of what they are, so thank you for
14 that. Okay.

15 KIMBERLEY BROUSE: Sorry, over to
16 Jennifer Johnson at PwC.

17 JENNIFER JOHNSON: Okay. Thank you.

18 So as the Marsh team has indicated,
19 enhancing and setting a strong governance, risk,
20 and compliance focus, commonly called GRC, is a key
21 consideration in the insurability of the LTC homes.

22 A strong focus on GRC typically starts
23 with a holistic risk assessment of the risks that
24 are facing the LTC homes. The individual risks, as
25 well as how they're evaluated, can and will evolve

1 over time; for example, an LTC would be looking at
2 risks including ongoing training, communication of
3 expectations, controls around active management and
4 supervision, ongoing performance reviews,
5 definition and clarity of roles and responsibility,
6 measures of quality of care, plans to handle
7 infectious disease and/or pandemic breakouts as
8 well as scenario testing in both of those cases,
9 controls and risks around follow-ups on complaints,
10 as well as many others.

11 With an understanding of the higher
12 impact risks, you have a path to set a clear and
13 consistent set of standards in risk mitigation
14 steps that can either enhance upon what exists
15 today or newly designed and implemented, depending
16 on where the gaps may exist. Inherent, though, in
17 this is the need for clear communication and
18 training throughout the organizations around these
19 expectations and repercussions if or when
20 expectations are not met.

21 A level of monitoring during the
22 implementation of new standards may be desired and
23 is a common best practice to help ensure the
24 consistency in both the adoption and the
25 application of these new standards; i.e., giving

1 yourselves comfort that, in fact, these new
2 standards are understood, and, as you look from one
3 home to the next, they're being adopted in a fairly
4 consistent manner.

5 One example we've seen and understood
6 is that a number of changes have been made to the
7 IPAC over the last year, sometimes even a number of
8 changes in a given day. But it is unclear if
9 leadership at the homes as well as caregivers
10 across the LTC homes fully and consistently
11 understand these changes in expectations, therefore
12 giving rise to non-compliance.

13 Once we have a clear set of
14 understanding the risks, the higher-impact risks,
15 setting some standards and risk mitigations around
16 that, and helping to get that communicated out to
17 the LTC homes, the next question naturally becomes
18 ways to get a level of ongoing assurance that those
19 standards and controls are actually being adhered
20 to in practice.

21 LYNN MAHONEY: Sorry, can I just ask a
22 question?

23 JENNIFER JOHNSON: Of course.

24 LYNN MAHONEY: You say the IPAC
25 practices have changed over the last year. Is that

1 your understanding that they've changed or that
2 they just haven't been adhered to, and now someone
3 is monitoring the -- because I'm not aware that
4 IPAC practices have changed. They're probably just
5 now being monitored and enforced.

6 JENNIFER JOHNSON: Our understanding is
7 that there were [indecipherable] --

8 LYNN MAHONEY: Sorry. Standards, I
9 mean.

10 JENNIFER JOHNSON: Yeah, our
11 understanding was that changes had been made during
12 the year.

13 LYNN MAHONEY: To the standards? To
14 the IPAC standards?

15 JENNIFER JOHNSON: That is our
16 understanding.

17 LYNN MAHONEY: Okay.

18 JENNIFER JOHNSON: Okay.

19 LEAD COMMISSIONER FRANK MARROCCO: When
20 you say changes, who's making the changes? The
21 owners? Or who do you understand to be driving the
22 change?

23 JENNIFER JOHNSON: Ang, maybe you want
24 to comment on that, as you work more closely with
25 the homes.

1 ANGELA MA: Yeah. Sometimes those
2 changes are assessed out of, you know, new risks
3 being identified or understanding of disease
4 pathogens. Some of those changes -- or guidelines,
5 rather -- were, let's say, as a result of union
6 intervention as well. So some of those have taken
7 place over the past year.

8 LYNN MAHONEY: Are you saying these
9 came from the Ministry of Long-Term Care, these
10 standards to I...?

11 ANGELA MA: Some of those changes are
12 actually initiated by the Ministry of Labour around
13 kind of health and safety procedure for the
14 caregivers in the home; for instance, PPE patrols
15 as one of those examples.

16 LYNN MAHONEY: Right. So I don't know
17 that this -- but maybe if that's what you're
18 finding is that the standards have changed, I think
19 it's just the adherence to the standards and the
20 spotlight on it. But you're saying that you think
21 that there's been some change in the standard?

22 ANGELA MA: Different PPE protocols,
23 for instance, have evolved.

24 LYNN MAHONEY: Okay.

25 JENNIFER JOHNSON: And the

1 understanding is that's really created some
2 confusion as you look across not only within a
3 given home but across homes.

4 And so when we step back and we think
5 about going back to a strong risk management
6 framework, over the last several years, I'd say
7 that thinking around how and where one places the
8 emphasis on risk management has been evolving.

9 Thinking now focuses on placing the
10 primary responsibility for managing risk on the
11 first line of defence. In an LTC, this means those
12 that are providing care to the residents. Enabling
13 the frontline care providers to understand risks,
14 to have a level of risk consciousness, if you will,
15 the importance of managing those risks, following
16 the proper risk mitigation protocols, it helps to
17 reduce the risk of non-compliance during day-to-day
18 activities. In essence, this means that everyone
19 is a risk manager.

20 With an emphasis on managing risk at
21 the front level, consideration can be given to
22 leveraging proactive, key risk indicators on a near
23 real-time basis by capturing data as and where care
24 is being given. This concept we'll expand upon in
25 a few minutes, but it helps to empower the

1 frontline. It also creates an environment of
2 transparency where the data captured around these
3 key risk indicators can be analyzed and provide
4 kind of an early warning signal to potential
5 concerns that may be arising.

6 It can also do two other things. It
7 can provide a basis for continuous improvement
8 programs and a basis upon which to perform ongoing
9 monitoring not only within a home but across the
10 homes in Ontario if the results were to be
11 aggregated and analyzed at such a level.

12 Now, it's important to empower the
13 frontline caregivers, but it's also important that
14 the LTC home leadership, such as a quality of care
15 leader, has strong monitoring practices in place.

16 Some ideas around this could include a
17 daily review of the aggregate real-time indicators
18 at that facility; actively monitoring complaints
19 and building response or action plans accordingly;
20 holding meetings with staff to reinforce training
21 messages, as it's not enough to train folks once,
22 but they need ongoing reminders and continuous
23 training to ensure that their duties are executed
24 properly.

25 Another control example would be

1 periodic scenario testing of infectious disease or
2 pandemic plans or other procedures that are not
3 routinely executed to ensure that folks know what
4 to do, when, and if needed.

5 However, even with empowering the
6 frontline as well as the local management to focus
7 on and transparently report their activities in
8 near real-time, periodic monitoring or compliance
9 audits are still really important.

10 Independent and objective periodic
11 reviews or audits have a key role to play to bring
12 that independent assessment of compliance. We
13 would suggest that the scope of compliance
14 assessments should not be static; i.e., it's not a
15 set list of questions. It's not a check-the-box
16 exercise. There should be a level of fluidity.

17 And the focus areas of periodic
18 compliance assessments should be informed by a
19 number of things, including known issues; trends
20 noted from the near real-time key risk indicators;
21 key risks stemming from the risk assessment or
22 other known changes in the industry or operations
23 that might give rise to compliance concerns.

24 Consideration as well around
25 enforcement is a key element in a compliance

1 program; for example, the key risk indicators, that
2 early warning signal, that could be used and it
3 continues to improve [indecipherable] program
4 model. It is really important to think about it
5 that way in order to ensure that the caregivers are
6 accurate and complete in the information and the
7 integrity of that information that they enter in on
8 a day-to-day basis as they execute their
9 responsibilities.

10 LYNN MAHONEY: Jenn, are you going to
11 give us what these key risk indicators are that
12 you're suggesting?

13 JENNIFER JOHNSON: We are going to talk
14 about a few, yes.

15 LYNN MAHONEY: Okay, awesome. Thank
16 you.

17 JENNIFER JOHNSON: Excellent. Okay.

18 On periodic assessment results, those
19 may be the tool that you use to determine when and
20 if penalties or ramifications should be applied,
21 but inherent with that might also be a remediation
22 period. So again, clarity around that would be
23 important and in agreement, obviously, by all
24 parties.

25 Angela, can you speak to a little bit

1 of the benefits as well as some of the tools and
2 real-time assessments that we've seen out there?

3 ANGELA MA: Yes. Next slide, please.

4 So building on Jenn's point -- building
5 on Jenn's point on the approach to focus on the
6 first line of defence, i.e., enabling the frontline
7 caregivers, I'll talk a little bit more about some
8 of the benefits this approach will bring.

9 I'm going to go counterclockwise on
10 this slide, starting with quality care.

11 The first and most obvious benefit is
12 an increase in quality of care, primarily because
13 caregivers will have easier access to the most
14 up-to-date guidelines, relevant practice
15 guidelines, and also management will be able to
16 customize specific guidelines to perhaps different
17 units, different facility, different worker groups,
18 especially in an environment sometimes that
19 guidelines may evolve as the situations evolve, as
20 well as staffing, full-time consistent staffing may
21 continue to be a little bit of a challenge for this
22 sector.

23 Moving to the bottom left, to
24 strengthen our first line of defence, empowering
25 our frontline is critical, as they are the ones who

1 have the best, most firsthand knowledge of the
2 operating environment. Enabling them with most
3 up-to-date guidelines, the tool to track and
4 identify areas that require attention and
5 improvement would empower them to address these
6 concerns.

7 These can also serve, as Jenn said, as
8 early indicators to inform more detailed periodic
9 compliance assessments, although there is, indeed,
10 a fine balance to ensure that this mechanism does
11 not cause punitive actions and therefore discourage
12 the frontline staff in adopting the practice.

13 On the bottom right, one of the
14 greatest benefits of more frequent reviews and
15 audits is the timeliness and transparency of
16 information. That would not only support
17 continuous quality improvement on a daily basis
18 instead of more reactively on a quarterly or annual
19 basis; this near real-time information will also
20 help stakeholders observe trends and perhaps
21 uncover more underlying issues more rapidly.

22 LYNN MAHONEY: What are your
23 suggestions, and do you address it later as well,
24 as to who's going to do these audits and
25 inspections?

1 ANGELA MA: Yes, we'll talk a little
2 bit about who.

3 LYNN MAHONEY: Okay.

4 ANGELA MA: Finally, on the top
5 right --

6 LYNN MAHONEY: Sorry, Dr. Kitts has a
7 question.

8 ANGELA MA: Yes. Please go.

9 COMMISSIONER JACK KITTS: I just want
10 to see if I have this right, as it pertains to
11 long-term care. So I think what you've said is you
12 have to set the standards and make sure that the
13 standards are understood by everybody in the home,
14 and then you'd set targets, and then you -- the
15 first line of defence for meeting the quality,
16 safety standards, the first would be the frontline
17 staff and management in the home, onsite
18 management. Second --

19 ANGELA MA: Frontline staff.

20 COMMISSIONER JACK KITTS: Second line
21 would be the IPAC specialist, the quality control
22 specialist. That'd be the second line.

23 And then the inspections would be the
24 long-term care home inspectors, which would be sort
25 of the compliance or third line of defence.

1 Do I have that right?

2 ANGELA MA: Yes, as you go to the
3 second and frontline of defence, we would see a
4 more independent body to conduct some of those
5 reviews.

6 COMMISSIONER JACK KITTS: Okay. Thank
7 you.

8 ANGELA MA: Yeah. So finally back on
9 this slide on the top right, rebuilding trust, we
10 believe, amongst the stakeholders is going to be
11 very important for this sector. Transparency and
12 timely sharing of information, we believe, will be
13 one of the very important tools to achieve that
14 goal.

15 And that may include helping families
16 and residents regain confidence in the quality of
17 long-term care homes and allow regulators -- as
18 some of the external stakeholders you just
19 described, Dr. Kitts -- to leverage information,
20 timely access to information such that they can
21 monitor more closely care and quality across not
22 only one facility but benchmarks, as Jenn said,
23 against facilities across the board.

24 On the next slide on a little bit of
25 who and how, I've talked a lot about the frontline

1 already. As you pointed out, Dr. Kitts, how does
2 that link then to the multi-layer of quality and
3 risk management approach?

4 We believe, starting on the right-hand
5 side of this slide, more frequent inspections
6 conducted by frontline staff will allow for reviews
7 that are more customized, more unit-specific. That
8 may be further informed by indicators from the
9 specific unit or the specific homes to track and
10 pay attention, close attention to quality metrics
11 to identify any emerging challenges as well as to
12 guide very regular proactive action planning.

13 As you gradually move to the left-hand
14 side of this slide, this can be complemented and
15 needs to be complemented with approach that are
16 less frequent review by more independent and
17 external inspectors and stakeholders such that
18 their reviews, their comprehensive reviews can be
19 further customized and informed by emerging trends
20 that we see through the more regular frontline
21 reviews that are conducted.

22 Over time, the richness of the data
23 that will be built up through this system will
24 provide an option for more transparent sharing of
25 information and therefore drive accountability of

1 quality in the sector.

2 Moving on to the next slide to show you
3 an example of how and the tool on how to do it,
4 these tools don't require a significant technology
5 investment. These are solutions that already exist
6 in the marketplace; in fact, are commonly adopted
7 in some global jurisdictions, such as the U.K.,
8 Australia, South Africa. These are solutions that
9 are mobile-based and can be used directly in the
10 home. Further --

11 LYNN MAHONEY: Are they being used in
12 long-term care homes elsewhere?

13 ANGELA MA: In the U.K., Australia, and
14 South Africa are some of the example jurisdictions
15 that this practice is adopted.

16 LYNN MAHONEY: Okay. But I didn't know
17 if that was specific to the long-term care sector,
18 but it is?

19 ANGELA MA: Yes, yes.

20 LYNN MAHONEY: Okay.

21 ANGELA MA: Extended age care.

22 LYNN MAHONEY: Okay.

23 ANGELA MA: Frontline staff are able to
24 answer survey-style questionnaire and can also
25 upload photo evidence and descriptions to identify

1 improvement areas. Key findings can be flagged to
2 management; for example, quality of care leader to
3 follow up on actions as well as ensure corrective
4 actions are done on a timely basis.

5 And because all this data can be stored
6 in a centralized location, managers and other
7 external stakeholders can get a quick snapshot of
8 each unit and clearly point to areas that require
9 attention.

10 LYNN MAHONEY: So, Angela, are these
11 being used in these other jurisdictions so that
12 frontline workers in these homes are sending this
13 data to government? Or is it just going to the
14 owners or the operators of the homes? Or is it
15 going out to external stakeholders, such as
16 governments?

17 ANGELA MA: In some cases, they are
18 shared with families, for instance, and they are,
19 in some cases, shared with external inspectors to
20 inform trending of quality indicators.

21 LYNN MAHONEY: Who shares them? So
22 does the information go to the owner, and the owner
23 filters them somehow and then shares it with
24 families and government, or does it --

25 ANGELA MA: Yeah.

1 LYNN MAHONEY: -- go directly from
2 frontline right out to government and families?

3 ANGELA MA: Usually there's a
4 governance structure set up to filter and select
5 information that are most relevant for different
6 stakeholders and shared on a less-frequent basis
7 rather than on a daily basis as the frontline uses
8 it to track information.

9 LYNN MAHONEY: And have there been
10 issues with the integrity of the information
11 shared, given the fact that it's going through the
12 owners/operators of the homes, out to families and
13 government?

14 ANGELA MA: So usually more aggregate
15 data is shared externally rather than very
16 specific, you know, audit by audit or inspection by
17 inspection. So usually it's the trend and the
18 aggregation of information that's shared
19 externally.

20 LYNN MAHONEY: And I guess my question
21 is, can people have faith in it? Is it skewed
22 somehow? Like, in terms of transparency and for
23 the public to know what's going on in long-term
24 care homes and for governments, the regulators to
25 know what's going on in long-term care homes, there

1 has to be some confidence in the data, and that's
2 what I'm asking about.

3 ANGELA MA: Yeah, for sure. And
4 because it is shared on an aggregate and trending
5 level, any individual opportunity for improvement
6 is not shared on a real-time basis. There are
7 opportunities for frontline as well as the
8 facilities to correct, so therefore, it doesn't
9 necessarily discourage capturing of information.

10 And that's actually a very critical
11 point to double-click on to make sure that
12 information is captured in a trusted way and only
13 aggregate information is shared so that there's no
14 discouragement of capturing of accurate information
15 on the frontline.

16 LYNN MAHONEY: Yeah. So I hear that in
17 terms of being able to -- what you're saying is not
18 necessarily being able to -- the sort of the
19 one-off information --

20 ANGELA MA: Yeah.

21 LYNN MAHONEY: -- that's going into it.
22 What I'm asking, though, is the
23 aggregators of the data, is it just a flow-through
24 of information, or are they able to -- is there
25 some input on their parts? Is there some way of

1 altering the data so that what goes out is not
2 necessarily a reflection of what goes in?

3 JENNIFER JOHNSON: Angela, maybe I can
4 jump in here.

5 I think certainly what we've seen as
6 the best practice would be to lock that down, Lynn,
7 so there's no ability to intentionally or
8 unintentionally alter that data and skew --

9 LYNN MAHONEY: Yeah.

10 JENNIFER JOHNSON: -- or interrupt or
11 affect that transparency. I think it's also an
12 important point when you think about those
13 independent and objective inspections. They would
14 also be looking for this --

15 LYNN MAHONEY: Right.

16 JENNIFER JOHNSON: -- right, to make
17 sure there's continuity there and that, in fact, we
18 have integrity around the results that are getting
19 aggregated on a more real-time basis.

20 And obviously, you know, anyone found
21 to be editing or changing that, that would be
22 subject to significant ramifications.

23 LYNN MAHONEY: Okay. And I just wanted
24 to know what your experience is in these other
25 jurisdictions. Have these tools been beneficial in

1 relaying an accurate picture of what's going on in
2 these homes?

3 ANGELA MA: Yeah. Yes, indeed.

4 LYNN MAHONEY: Okay.

5 ANGELA MA: Yeah, and as I talked a
6 little bit about the trending information, really,
7 these trending data that gets built up over time in
8 a system like this really then inform regulators,
9 insurers, others who are part of this ecosystem to
10 do their deep-dive reviews and focus their
11 attention on specific areas in addition to more
12 general comprehensive review such that those
13 efforts can be more focused.

14 LYNN MAHONEY: Mm-hm.

15 ANGELA MA: Again, the trending will
16 also help uncover any underlying issues that may be
17 preventing, perhaps, more optimal level of quality
18 of performance in these facilities.

19 LYNN MAHONEY: Yeah.

20 ANGELA MA: With that, I'll pass it
21 back to Trevor, to Marsh.

22 TREVOR MAPPLEBECK: Apologies. I was
23 on mute there. Thanks very much, Angela.

24 So creating a culture of continuous
25 improvement and enabling and empowering frontline

1 staff such that everyone feels they have a role in
2 managing risk will certainly result in a
3 much-improved result for residents, staff, owners,
4 and operators. Enhanced risk management, more
5 rigorous and more frequent inspections, and
6 improved quality and frequency of audits ensures
7 that the diversities of key stakeholders will be
8 better met.

9 The overarching objective of enhancing
10 the quality and consistency of operational
11 standards in risk management needs to address the
12 needs of the full spectrum of key stakeholders,
13 including Public Health, government, owners and
14 operators, and insurers, of course with a focus on
15 residents and their families.

16 These stakeholders must all have input
17 in the development of improved risk inspections,
18 risk management, and the associated audit
19 framework. Understanding the current state of risk
20 management and governance will enable the creation
21 of a consistent approach, leveraging existing good
22 practices within Canada and globally and building
23 upon its foundation.

24 The establishment of enhanced and more
25 transparent risk inspections as well as audit and

1 enforcement is required in order to rebuild trust
2 across the spectrum of stakeholders, including
3 insurers. Transparency of information and near
4 real-time information, as has been referenced, will
5 certainly enhance the level of trust in the sector.

6 In the absence of a disciplined
7 approach and ensuring that insurers have input in
8 the approach could leave the insurance market not
9 actually being available for the sector.

10 These enhancements will also enable the
11 ability to review metrics that are meaningful to
12 regulators, insurers, staff, and owner/operators.

13 Ensuring that these stakeholders have
14 input into the development of improved risk
15 management standards will provide greater adoption
16 and buy-in. Creating a risk-aware culture means
17 that all staff are risk managers, as Jenn had
18 alluded to. Empowering frontline staff to spot
19 ongoing issues, share best practice, trigger
20 actions, and see issues through to completion will
21 certainly drive improved quality and patient
22 safety.

23 Some key elements of an effective risk
24 inspection and management standard will include
25 such areas as an up-to-date IPAC policy with

1 appropriate training, and training is not a
2 one-and-done event; rather, training needs to take
3 place prior to any employee or contractor beginning
4 work and must be conducted on a regular basis.
5 Standards and associated training need to capture
6 information as quickly as science and government
7 guidance presents the changes.

8 Additional areas of risk management
9 improvement can include but certainly are not
10 limited to IPAC for visitors; safe admission
11 protocols; access to testing for staff and
12 residents; pre-workplace entry screening; effective
13 use of PPE, including don and doff procedures,
14 along with an appropriate supply; protocols for
15 employees who are sick at work; staffing ratios and
16 clear outline of roles and responsibilities;
17 shielding and physical distancing and contact
18 reduction measures, including segregation of work
19 spaces to the extent that's possible; contact
20 tracing; workplace sanitization plans;
21 post-infection return-to-work policies and
22 training; emergency action plan procedures;
23 communication and engagement plans; and ultimately,
24 an effective safety culture with no repercussions
25 for raising concerns.

1 Creating consistent risk assessment and
2 management will greatly reduce concerns over a lack
3 of training, monitoring, and enforcement. As
4 Angela addressed, developing a near real-time
5 information environment will improve the timeliness
6 and transparency of risk information, which will
7 ultimately enable, in an instant, an
8 organization-wide view of self-inspection and
9 management as well as quality assurance, the
10 facilitation of real-time communication of
11 identified risk from the frontline, and it will
12 also facilitate remote communication of the latest
13 guidance to the frontline team, leveraging near
14 real-time data.

15 Additionally, it certainly creates a
16 much more streamlined and simplified reporting,
17 freeing capacity for staff to effect positive
18 change.

19 Angela earlier walked us through the
20 framework for more frequent audits, leveraging both
21 internal and external resources with both regular
22 and ad hoc audits performed, delivering a more
23 consistent approach that can be tailored to match
24 operators' needs based on size and certainly scale
25 of services delivered.

1 The results of improved timeliness of
2 information also enables operators to capture data
3 to support more objective and nimble
4 decision-making around risk mitigation. Mitigating
5 risk where it is caused will be a key factor in
6 improving operational efficiency and quality care.

7 There must also be ramifications
8 associated with non-adherence to the standards,
9 including, perhaps, loss of the license to operate.
10 History may suggest that this ability has not
11 necessarily been utilized, perhaps due to some
12 possible impact on capacity. This does not suggest
13 shutdown due to non-compliance; rather, removal of
14 an operator and transition to and replacement with
15 another operator.

16 LEAD COMMISSIONER FRANK MARROCCO:

17 Yeah.

18 TREVOR MAPPLEBECK: Certainly, the last
19 thing we don't want to see is a loss of capacity in
20 the sector that is already capacity-constrained.

21 Now, operating in a more real-time
22 environment, we develop objective data which can
23 drive improved underwriting criteria for insurers
24 and differentiating risk for underwriting purposes.
25 This enhanced trust should lead to improved

1 insurability, either attracting new insurer capital
2 or providing greater comfort to insurers currently
3 writing in this sector. It can also support the
4 evaluation of alternative methods of risk finance.

5 Cristina, if you can just move on to
6 the next slide, please?

7 LEAD COMMISSIONER FRANK MARROCCO: Just
8 before you do that, I can understand how the
9 insurer can put pressure on the owner seeking
10 insurance or the operator seeking insurance to
11 comply with this -- or to engage with this reform.

12 From your perspective, do you have a
13 thought on what we could do, what we could
14 recommend to government that would be consistent
15 and encourage this kind of reform?

16 TREVOR MAPPLEBECK: Well, I'll kick
17 off, and maybe some others have a view on that as
18 well. I think, you know, you could certainly tie
19 it into the funding model that -- the public sector
20 funds that are being made available are driven and
21 generated through, I'll call it, compliance or
22 scoring relative to enhanced risk inspection and
23 management standards.

24 We've certainly seen that across other
25 industries. Maybe not necessarily through

1 government funding, but as you benchmark one
2 facility to another or one owner and -- sorry, one
3 operator to another, seeing who kind of leads the
4 way, if you will, in terms of risk improvement and
5 operational effectiveness.

6 Not sure if others have any views on
7 that.

8 ANGELA MA: Perhaps a brief addition to
9 that: Government, as the licensor of the sector,
10 can encourage this type of practice to ensure risks
11 are properly monitored and managed on an ongoing
12 basis. This could become the system of controls we
13 described before; let's say, as an example, could
14 be become part of, you know, how licenses are
15 evaluated going forward.

16 GREG FISK: Yeah, I can just add that I
17 think insurers are evaluating the future level of
18 their involvement as external stakeholders as it
19 respects risk management, and their hope and
20 expectation is that government will take a more
21 active role in risk management in the sector.

22 LEAD COMMISSIONER FRANK MARROCCO: So
23 it's part of the conditions of getting the license
24 and create a risk that you can be replaced by
25 another operator who receives the money for

1 operating if you don't comply. Okay.

2 TREVOR MAPPLEBECK: Yeah, that's
3 certainly one lever. Yeah.

4 LEAD COMMISSIONER FRANK MARROCCO:
5 Okay, thanks.

6 TREVOR MAPPLEBECK: So we're just going
7 to quickly pivot to looking at funding options for
8 pandemic risk. Beyond traditional insurance, the
9 sector should also be exploring alternative ways to
10 finance infectious disease risks specifically.

11 These alternatives can include the
12 creation of a risk pool owned by and managed by the
13 sector with insurance industry support, to the
14 other extreme of a full governmental backstop.

15 The interdependent nature of pandemic
16 risk really does necessitate close cooperation by
17 the public and private sectors and managing its
18 impacts and restoring confidence in the workings of
19 markets, economies, and ultimately society at
20 large.

21 The key to building a more proactive
22 and agile response to the next pandemic will be an
23 insurance and risk management partnership that
24 helps to close coverage gaps and ultimately
25 incentivizes pandemic risk preparedness and

1 mitigation efforts, which ultimately will, in turn,
2 facilitate access to capital from lenders and
3 equity markets. Reducing the financial exposure
4 due to this risk will certainly improve confidence
5 in the capital markets, as Kim had alluded to
6 earlier in this discussion.

7 It will also limit the tail risk of
8 insurers, meaning this type of systemic exposure
9 will be shared across stakeholders. The insurance
10 market, candidly, is not sufficiently capitalized
11 to withstand the magnitude of loss of a global or
12 national pandemic. It will also create greater
13 certainty for regulators, owners, operators, and
14 employees.

15 So with that, we'd like to now open it
16 up for any questions perhaps we've not addressed
17 thus far or a clarification of any of the points
18 we've discussed.

19 LEAD COMMISSIONER FRANK MARROCCO: Do
20 you have a sense of why it's in the state that it's
21 in? You know, if we all sat around and talked
22 about this for about an hour, we would come up,
23 probably, with the idea that we need compliance
24 mechanism; we need monitoring; we need real-time
25 data.

1 Do you have any sense of why we find
2 ourselves in the state that we're in? Not that I'm
3 trying to suggest it's your responsibility -- it
4 isn't -- but I'd just be curious whether you have a
5 view. Okay.

6 GREG FISK: I mean, I'll just quickly
7 comment. I think, you know, even as part of this
8 exercise in coming before the Commission and
9 answering the question, it became evident that
10 there was a gap in terms of expertise from the
11 insurance community, that this work wasn't being
12 done by insurers.

13 And, you know, I don't know -- that's
14 one area you feel that maybe if more could have
15 been done on the clinical risk side, but insurers
16 did not have this expertise or these requirements
17 in place.

18 LEAD COMMISSIONER FRANK MARROCCO:

19 Yeah, okay. All right.

20 LYNN MAHONEY: Can I ask you, and it
21 goes back to questions that I asked earlier and I
22 may have missed it, but the specific questions I
23 was asking about were these metrics, these key
24 indicators that you were going to sort of suggest
25 that they be measured against or that be looked at.

1 And secondly, who is going to do these
2 audits and inspections?

3 ANGELA MA: Maybe I'll start with risk
4 indicators as examples. Some of the common ones we
5 know out of jurisdiction track on these types of
6 systems are things like adherence to guidelines,
7 staffing levels, cleanliness of facilities, whether
8 residents are cared for during certain time
9 interval, or some of the metrics are tracked right
10 in the tool that we shared with you.

11 LYNN MAHONEY: Okay.

12 ANGELA MA: As it relates to who,
13 generally, there are, as we talked a lot about
14 today, the frontline caretakers, head nurse, or the
15 quality of care leader in the home --

16 LYNN MAHONEY: Yeah.

17 ANGELA MA: -- management of the
18 facilities or the owners, and then kind of go
19 upstream. There are general regulators who are
20 doing independent reviews on an ongoing basis, and
21 then there might be also accreditation-type agency
22 as well.

23 LYNN MAHONEY: Okay. So in terms of --
24 and I think some of you have specific experience in
25 the long-term care sector or knowledge of it, but

1 what this Commission has heard is the inspections
2 were not taking place specifically with respect to
3 IPAC, and the reasons that the inspectors were
4 going into the home were varied. So we have that.

5 So we have that knowledge of what the
6 state of that inspection process is.

7 ANGELA MA: Mm-hm.

8 LYNN MAHONEY: I don't think we're
9 suggesting that the homes are going to inspect
10 themselves. I don't know that that's an audit
11 standard that I would be satisfied with.

12 So who can do these inspections? Who
13 should do these inspections?

14 ANGELA MA: I think the homes should
15 not be inspecting themselves in isolation, but as
16 we talked a little bit about the system of
17 controls, we believe the homes, i.e., the
18 frontline, the first line of defence --

19 LYNN MAHONEY: Yeah.

20 ANGELA MA: -- do play a critical role.

21 LYNN MAHONEY: Yeah. So if we're
22 talking about given what we know about and the
23 inspections that were done by the Ministry of
24 Long-Term Care and inspections that were done by
25 the Ministry of Labour --

1 ANGELA MA: Yeah.

2 LYNN MAHONEY: -- and maybe some
3 Public Health inspections, given what this
4 Commission has heard, and I assume it's one of the
5 reasons that there's some issues in terms of
6 insurance issues right now, who should be doing
7 these inspections? What organization should be
8 going in and doing these inspections, given what we
9 know about -- or what should happen to these
10 inspection groups that are supposed to be doing it?

11 Like, what suggestions do you have, and
12 what thoughts do you have on that?

13 ANGELA MA: So we've not done a
14 complete review of all the audit systems and
15 inspection systems that are in place. But we would
16 say, if I follow leading practices in risk
17 management, starting with the frontline, gradually
18 involving stakeholder groups that are doing these
19 reviews in a coordinated way, leveraging more
20 real-time observations of the facilities will help
21 focus some of those inspection efforts.

22 I think a more coordinated approach
23 around, you know, all aspects of the homes'
24 operations will be beneficial.

25 COMMISSIONER JACK KITTS: Can I just

1 follow up on that? I think Commissioner Marrocco,
2 I think he asked the question "how did we get
3 here?" What you're telling us makes a lot of
4 sense, but it starts, I think, with a culture of
5 commitment to continuous improvement.

6 And I think that we're finding that
7 that culture, for the most part -- I wouldn't paint
8 them all with the same brush -- wasn't really
9 existing. And to get that culture, I think what
10 you're saying is that there is no one body going to
11 create that; that the first line in mitigating the
12 risk to these residents has got to be the frontline
13 staff and the onsite management because if they're
14 not every day looking for that quality improvement,
15 it's not likely an inspector coming once every so
16 often is going to change that.

17 The second line is also lacking, and I
18 think the second line in your model -- is the IPAC
19 specialist the person responsible for quality of
20 care? And so the second line is an internal
21 assessment, or, if you want, assessment so that the
22 first two lines, and just for the -- I guess for
23 the compliance, the third line would be the
24 regulators who come in to make sure you're meeting
25 the regulations and the inspectors of

1 Public Health -- or sorry, long-term care home
2 inspectors and the Ministry of Labour inspectors
3 and Public Health inspectors.

4 So they're now external verification
5 that the internal system is working. And to make
6 sure that that's all wrapped up, you're saying you
7 need to have understood standards or metrics of the
8 performance you're supposed to achieve and then be
9 transparent in what the results are.

10 JENNIFER JOHNSON: I think that's very
11 well summarized, and I think when you talk about
12 the external inspections, be it through various
13 regulatory and government bodies, we have the three
14 that have been mentioned here today, and as we've
15 heard and I think your own report has indicated,
16 you know, those three have different objectives,
17 but they can't have overlap in trends that they're
18 seeing.

19 And so if you're going -- you know, you
20 could streamline theoretically and go to one
21 inspection body that has a more robust mandate;
22 that's one option. You could keep with having
23 multiple bodies with different mandates and
24 different scopes of mandates, but I think inherent
25 in that is a need to ensure there's a level of

1 collaboration and that output or results from one
2 can be considered as you plan for other types of
3 reviews.

4 Again, or the other option is to
5 simplify with a broader inspection by a single
6 body. There's probably pluses and minuses to
7 both -- we've not gone into detail on that -- but
8 otherwise, your summary is very spot-on.

9 And I think it really reads back to
10 that concept of the first line of defence. Those
11 caregivers really need to understand what quality
12 care means. They need to be well-trained. They
13 need to be clear on what the standards are that
14 they need to operate by day in and day out, and
15 there needs to be a level of consciousness, right,
16 a culture of managing risk, of understanding why
17 these things are so important, such that they will
18 adhere to it and that they'll also be transparent
19 in completing a tool like the last set that Ang
20 shared.

21 Otherwise, you do run the risk that
22 they don't feel trust in the system and they will
23 not put in accurate information, and we won't get
24 further ahead, which is certainly not the
25 objective.

1 LYNN MAHONEY: No.

2 LEAD COMMISSIONER FRANK MARROCCO:

3 Certainly, you know, we've met with
4 staff, and we've done it on a quasi-confidential
5 basis, not identified in the transcript and so on.
6 And one of the things that struck me was how
7 committed they actually are to the care of the
8 people that they're looking after. It's a bit of a
9 vocation, and it's difficult work, like, physically
10 difficult.

11 ANGELA MA: Yes.

12 LEAD COMMISSIONER FRANK MARROCCO: You
13 know, it's messy, and you don't get paid a lot, and
14 so you're getting a certain type of person.

15 I think in terms of them being a source
16 of information, they're probably mentally in a
17 state where they would serve that purpose. I think
18 if they didn't think there would be reprisals, I
19 think they would report. And to some extent, the
20 safety of the employees and the safety of the
21 residents is the same thing.

22 ANGELA MA: Yes.

23 LEAD COMMISSIONER FRANK MARROCCO: In
24 any event, I think the staff, you could work with
25 the staff.

1 COMMISSIONER ANGELA COKE: I'd just
2 like to ask a question about -- or your thoughts on
3 the role of accreditation bodies and how you can
4 rely on their processes or the outcomes that
5 they're able to come up with in terms of their
6 accreditation process.

7 ANGELA MA: Maybe I'll start, and
8 others can chime in. I will, you know, go back,
9 rely back on we really need a system of
10 stakeholders that are well-coordinated, that are
11 reviewing testing against a common set of standards
12 that are comprehensive, that are current and
13 reflective of emerging risks, and in some cases,
14 may be specific to certain environments that they
15 are looking at; different types of facilities,
16 design of facilities as examples of factors that
17 may impact the types of reviews and where the focus
18 should be placed on this type of review.

19 I think accreditation agencies are one
20 of the external stakeholders that can service that
21 independent body to be part of the system. But the
22 system itself, between the different stakeholders,
23 need to be coordinated to achieve the outcome we're
24 speaking a little bit about today.

25 JENNIFER JOHNSON: And maybe just to

1 expand on that point, Ang, I think inherent in that
2 is that the accreditation is based on what is
3 considered the right set of standards, right, and
4 that certainly has probably been evolving here.

5 And so that would require a little bit
6 of a closer look, but again, it goes back to that
7 coordination of the system and then the
8 accreditation body can probably [inaudible].

9 COMMISSIONER ANGELA COKE: Thank you.

10 LEAD COMMISSIONER FRANK MARROCCO: It
11 doesn't seem unreasonable to me, anyway, that the
12 insurers participated in an accreditation body
13 because you'd be reasonably confident that they're
14 going to be -- there's going to be some -- it's in
15 their interest to have integrity in the
16 accreditation system. I'm not sure what state the
17 accreditation system is in as we sit here, but
18 that's another question.

19 LYNN MAHONEY: We're going to hear
20 about that next week.

21 LEAD COMMISSIONER FRANK MARROCCO:

22 Well, I think we don't have any further
23 questions, assuming you've completed what you're
24 going to say.

25 Let me say on behalf of all of us that

1 we really do appreciate this. We all have a sense
2 that you don't all get together and put a
3 presentation together like this at no cost because
4 you've got nothing else to do.

5 We very much understand that this was
6 an imposition, and thank you for accepting that
7 burden because it does help clarify some of our
8 thinking around inspections, which, as you could
9 tell from our interim report, we already think is
10 something we should pay attention to.

11 This gives us a perspective that I
12 don't think we'd otherwise have if you hadn't taken
13 the time to do this. So thank you again.

14 And at the rates you're charging us,
15 thank you for that too.

16 COMMISSIONER ANGELA COKE: Yeah.

17 COMMISSIONER JACK KITTS: Yeah.

18 SARAH ROBSON: Thank you. And if there
19 are any further questions or follow-ups, then we'd
20 be happy to engage and respond accordingly. I
21 think before, we worked through Shani.

22 LYNN MAHONEY: Yes.

23 SARAH ROBSON: And so happy to continue
24 that engagement.

25 LYNN MAHONEY: Thank you.

1 LEAD COMMISSIONER FRANK MARROCCO:

2 Thank you.

3 ANGELA MA: Yeah. Thank you for having

4 us.

5 COMMISSIONER ANGELA COKE: Thank you.

6 COMMISSIONER JACK KITTS: Thank you.

7 LYNN MAHONEY: And thank you, Shani,
8 for everything that you did to coordinate this.

9 SHANI BRIFFA: My pleasure.

10

11 -- Adjourned at 4:34 p.m.

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REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified
Shorthand 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 5th day of February, 2021.



NEESONS, A VERITEXT COMPANY

PER: OLIVIA ARNAUD, CSR

CHARTERED SHORTHAND REPORTER

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Page 10, line 17: "The liability" not
"Reliability"

Page 14, line 8: "acquired" not "required"

Page 29, line 3: "third line" not "frontline"

Page 31, line 21: "aged care" not "age care"

Page 37, line 7: "diverse needs" not
"diversities"

Page 41, line 19: "we want to see" not
"we don't want to see"

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