Long-Term Care COVID-19 Commission Meeting

Marsh Canada
on Friday, February 5, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 5th day of February, 2021, 3:30 p.m. to 4:34 p.m.

BEFORE:

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

PRESENTERS:

Sarah Robson, President and CEO of Marsh Canada
Greg Fisk, Managing Director and Public Entity Practice Manager, Marsh Canada
Trevor Mapplebeck, Managing Director, National Marsh Advisory Leader, Marsh Canada
Shani Briffa, Assistant General Counsel and Chief Compliance Officer, Marsh Canada
Kimberley Brouse, Senior Vice President, Healthcare and Life Sciences Unit Leader, Marsh Canada
Cristina Scenna, Senior Vice President, Business Development Lead, Marsh Advisory, Marsh Canada
Jennifer Johnson, National Financial Services Leader, PwC Canada
Angela Ma, Partner, Healthcare Operations, PwC Canada
Keegan Iles, Partner, Insurance Consulting, PwC Canada

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Angeline Hawthorn, Senior Policy Analyst, Long-Term Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 3:30 p.m.

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

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

LEAD COMMISSIONER FRANK MARROCCO:

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

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

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

Commission today on this Friday afternoon.

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

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

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

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

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

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

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

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

Cristina?

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

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

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

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

As a result, they often provide dated

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

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

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

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

Long-term care owners and operators are

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

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

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

Greg?

GREG FISK: Thank you, Cristina.

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

KIMBERLEY BROUSE: Thank you, Greg.

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

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

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: Okay. Is that the kind

of premiums we're talking about in that range?

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

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

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

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

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

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

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

LYNN MAHONEY: Okay.

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

LYNN MAHONEY: Okay.

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

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

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

JENNIFER JOHNSON: Okay. Thank you.

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

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

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

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

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

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

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

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

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

JENNIFER JOHNSON: Of course.

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

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

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

LYNN MAHONEY: Sorry. Standards, I mean.

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

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

JENNIFER JOHNSON: That is our understanding.

LYNN MAHONEY: Okay.

JENNIFER JOHNSON: Okay.

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

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

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

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

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

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

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

LYNN MAHONEY: Okay.

JENNIFER JOHNSON: And the

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

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

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

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

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

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

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

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

Another control example would be

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

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

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

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

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

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

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

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

LYNN MAHONEY: Okay, awesome. Thank you.

JENNIFER JOHNSON: Excellent. Okay.

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

Angela, can you speak to a little bit

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

ANGELA MA: Yes. Next slide, please.

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: Okay.

ANGELA MA: Finally, on the top right --

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

ANGELA MA: Yes. Please go.

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

ANGELA MA: Frontline staff.

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

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

Do I have that right?

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

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

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

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

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

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

quality in the sector.

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

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

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

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

ANGELA MA: Yes, yes.

LYNN MAHONEY: Okay.

ANGELA MA: Extended age care.

LYNN MAHONEY: Okay.

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

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

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

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

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

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

ANGELA MA: Yeah.

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

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

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

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

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

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

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

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

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

ANGELA MA: Yeah.

LYNN MAHONEY: -- that's going into it.

What I'm asking, though, is the aggregators of the data, is it just a flow-through of information, or are they able to -- is there some input on their parts? Is there some way of

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

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

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

LYNN MAHONEY: Yeah.

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

LYNN MAHONEY: Right.

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

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

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

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

ANGELA MA: Yeah. Yes, indeed.

LYNN MAHONEY: Okay.

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

LYNN MAHONEY: Mm-hm.

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

LYNN MAHONEY: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO:

Yeah.

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

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

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

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

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

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

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

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

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

Not sure if others have any views on that.

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

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

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

operating if you don't comply. Okay.

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

LEAD COMMISSIONER FRANK MARROCCO: Okay, thanks.

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

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

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

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

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

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO: Yeah, okay. All right.

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

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

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

LYNN MAHONEY: Okay.

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

LYNN MAHONEY: Yeah.

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

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

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

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

ANGELA MA: Mm-hm.

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

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

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

LYNN MAHONEY: Yeah.

ANGELA MA: -- do play a critical role.

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

ANGELA MA: Yeah.

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

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

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

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

COMMISSIONER JACK KITTS: Can I just

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

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: No.

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

ANGELA MA: Yes.

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

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

ANGELA MA: Yes.

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

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

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

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

JENNIFER JOHNSON: And maybe just to

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

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

COMMISSIONER ANGELA COKE: Thank you.

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

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

LEAD COMMISSIONER FRANK MARROCCO:

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

Let me say on behalf of all of us that

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

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

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

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

COMMISSIONER ANGELA COKE: Yeah.

COMMISSIONER JACK KITTS: Yeah.

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

LYNN MAHONEY: Yes.

SARAH ROBSON: And so happy to continue that engagement.

LYNN MAHONEY: Thank you.

LEAD COMMISSIONER FRANK MARROCCO: Thank you.

ANGELA MA: Yeah. Thank you for having us.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you.

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

SHANI BRIFFA: My pleasure.

-- Adjourned at 4:34 p.m.

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.

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

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"

WORD INDEX