Long-Term Care Facility Access (LTCFA) Policy Workgroup Meeting
August 22, 2023
Auto-Generated Transcript

SLIDE 15

MARK BECKLEY | CDA
... to revise recommendations. As we discuss each recommendation in the next section we will articulate how feedback provided by the workgroup was integrated and reflected in each round of updates, and how the recommendations were refined.

We will then ask workgroup members to provide specific edits that would be needed for them to support the recommendation. And I think this point is really critical, we really hope to send forward to the legislature areas of alignment recommendations and key areas of disagreement, but we really hope that by the end of today we will have some recommendations that hopefully everyone can support, that will assist the legislature and possibly developing additional legislation. So, I really encourage all of you to speak up, to speak candidly and honestly, and you know, at the same time will continue to maintain a respectful atmosphere among all stakeholder groups. But unless we really know the pain or pressure points are and where there might be area of compromise it'll be hard to really develop really strong recommendations for the legislature.

So, as we continue in the course of this discussion we will be seeking edits from you via a Poll Everywhere function that we will be posting indicating where the group may be comfortable with proposed edits. And acknowledging that this is our last meeting, like I say, we may be prompting some of you for, to really highlight your area of disagreement or discomfort we may be calling on you directly, but please feel free, like I say to provide your input either verbally or through the chat function. And with that I will turn it over to Juliette.

2:01

SLIDE 16

JULIETTE MULLIN | MANATT
All right, thank you so much Mark and Brandie. And with that we're going to move into our first policy and practice recommendation section. Just before we do that I do want to do one final reminder to folks to please update your name in Zoom. It's going to make it a lot easier when we get to raising our hands and calling on people so I can see folks names. If you joined as a panelist your name is currently policy workgroup panelist and so if you can go in and click rename and put your actual name in there that would be very helpful. All right we can go to the next slide

2:36

SLIDE 17

So, a couple things that are woven throughout the recommendations that we want to highlight before we dive in. The first is we want to really emphasize that all of what we're about to talk about today reflects recommendations for long-term care visitation during states of emergency in which a local or state order may curtail visitation due to a legitimate public health or safety risk. So, we're really emphasizing this particular element and the fact that it's going to be woven through everything today, because we've gotten this feedback from a number of you all about being really specific about the scenario that we're talking about. This is not a generic set of recommendations for what should happen in any emergency, or in any circumstance, it is it is specifically about this circumstance. So, we have endeavored to be very specific in the language on each slide that is what we were are referring to, if I sometimes use the term state of emergency generally just to move through conversation, I am referring to this context and this type of state of emergency.

And just another reminder for folks that we are talking about visitation and long-term care facilities defined as follows on this slide they include Skilled Nursing Facilities, Intermediate Care Facilities, Adult Residential Facilities and Residential Care Facilities for The Elderly. And so, we're highlighting that as we get later into the conversation we want to think about some of the unique differences between them and how we make sure we account for those in the recommendation. Next slide please.

4:09

SLIDE 18

All right, so with that we're going to dive into recommendation A. We're hoping to move through this one fairly quickly because we've spent a lot of time in this workgroup on this recommendation, and this is related to who can visit during an emergency. So, if we go to the next slide.

4:30

SLIDE 19

So, as Mark noted recommendations have evolved over time. On this recommendation we have done three different versions of this recommendation. I'm going to summarize briefly how this recommendation has evolved and what the core feedback you all have provided over the course of the past few meetings and via surveys have been at a high level.

So, between version one which we discussed in meeting three and version two, you all provided feedback both in meeting three and via a follow up comment opportunity about ways that you wanted to see version one change. So, between version one and version two, here are some of the core areas of feedback that we endeavored to weave into the recommendation.

The first was that version one needed to further develop and distinguish between visitor types. And as a result, additional categories were developed for version two that reflect the range of visitors who may visit during an emergency and really distinctly call out the different categories without blend them together.

The second core area that we received feedback on in version one was the workgroup provided feedback to simplify the language on how to designate a visitor. So that was reflected in version two.

And then the last piece we'll call out is based on the feedback on version one there was kind of a range in the workgroup on whether to use the term visitor or support person to describe the individual with designated access. So, if we go to the next slide

5:58

SLIDE 20

We sent out a version two update to you all via email between meeting three and this meeting today. And you all provided additional feedback on version two that we have used to again update the recommendations for version three that we're going to talk about today.

Two major areas of feedback that we received, the first is we really received strong feedback on version two, that the term resident designated visitor that was used in version two did not adequately reflect the role of the designated individual in supporting that resident's wellbeing and participating in that resident's care. And so, we received strong feedback on version two to change the use of the term to resident designated support person.

The second major area of feedback on version two is we did have workgroup members express concern about the operational challenges associated with having any kind of prescriptive format or process that facilities would be required to follow to designate visitors and track those designations. And this was specifically acknowledging that the recommendation specifically said there would be no limit on the number of people you could designate, and with that in mind it would therefore be hard to track an unlimited number of designees. And so, if we go to the next slide

7:28

SLIDE 21

We have updated proposal A. And so you are now looking at proposed version three of recommendation A.

So, the key areas that changed between version two and version three are all in orange, so you can really see what the difference has been and how we incorporated feedback. There are really two big areas that I'll spotlight. The first is we did update the language from resident designated visitor to resident designated support person, and that edit has been carried throughout all of the recommendations. We also added a very specific clause saying that this recommendation is not intended to require a specific type of process for tracking designation. What it's intended to do is

emphasize resident choice. So, the core element here is that the resident is the individual that determines who can visit them, for that category A of visitor.

So, I'm going to give people just 30 seconds to read through this. All right I think that's given folks a moment to read. If we could go to the next slide. I'm just going to kind of illustrate how we'd like to facilitate this conversation and then we'll go to the line.

9:04

SLIDE 22

So, what we're hoping to do today is really focus in on areas that the workgroup really strongly feels need to be edited prior to finalizing this report. So, what we're going to encourage people to do is, if you have minor wordsmiths, we're going to encourage people to drop those in the chat, so that we can really focus in on where we have really sticky points that we need to address as a workgroup, and we need to kind of do some quick alignment on in the workgroup.

So, what we'll do is, we're asking people to raise their hand and provide a specific edit to version three of this recommendation. So, we're asking people to come with a suggested specific change, and then we'll have a brief conversation about that change and then we may invite folks to actually give us a pulse check on whether they would like to see that edit incorporated, and whether they'd be comfortable with seeing that edit potentially incorporated into the final report, or not. So, with that framing in mind let's just go back to the recommendation slide so that we can all see it on the screen while we're talking.

10:17

SLIDE 21

Thank you and I see we have folks that have raised their hand so I'm going to go to the top of the line we have Catherine Blakemore, Catherine.

10:27

CATHERINE BLAKEMORE
So, thank you. I appreciate the change in the terminology. I wonder if there is room for saying what a support person is. I didn't have a definition. I thought what you said you know how you defined it Juliette was fine, but because it's not a term that's used now, I think it opens up for interpretation of what that might be. I think people understand visitor could be anyone, but I think support person will have different meanings to different people, different facilities, and it, unless we use a broad definition like you just gave it will make it hard for consistency across the state.

11:18

JULIETTE MULLIN | MANATT
I think we have some language from past iterations as we got to this recommendation, that we can weave into kind of define more clearly in the report what that would look like. Thank you. Appreciate that comment. All right. Heather.

11:38

HEATHER HARRISON | CALA
Hi thanks. Appreciate all of the clarifications and additions to this section. My question is with the four that's been added. If there, if there are unlimited, and we support this concept obviously 100% ensuring ongoing visitation, even in a state of emergency as a top priority for the Assisted Living providers that we represent. Just want to be sure the operationalizing it is as smooth and barrier-free as possible.

The concern that we have is if since residents have this choice which is exactly what we all want, they can change their, they have the right to be visited by whoever they want when they when that needs to happen, but how does the provider track all that when it is it's an unlimited number and it can change at any time. I mean whoever shows up can visit the resident we don't have to maintain a running list. If I have 80 residents all the people they want to come see them, tracking that, if they can change being changed at any time almost seems like a barrier without a purpose, it's just more hurdles people have to go through, and the provider has to go through, When the point is residents can see who they want. Or am I

misinterpreting this or is there another way people are seeing how this would work in practice?

13:12

JULIETTE MULLIN | MANATT
So, I think, the core, I think, your point is completely heard I think the core concept is, in having some way to know who to let in the front door basically. That doesn't necessarily, there's not a specific process that this recommendation is intended to recommend for tracking that, but to indicate that if a resident has said to the facility. I want Heather to be able to visit me, that the facility is going to let Heather in the door. Whether that looks like a designation happening in the moment or a designation that's tracked, this recommendation is kind of silent on. Does that help answer your question, or give you a thought on a way you might suggest editing this?

13:54

HEATHER HARRISON | CALA
I will think about ways to edit it. I'm, it just gets challenging in real time, somebody shows up they're not on the list, but the resident can designate them at any time. It just becomes a kind of hurdle, more hurdles as opposed to letting people come in and visit their loved ones. Then we have to have a check, you know are you on the list, you're not on the list, go make a phone call you can get on the list instead of just letting, do people have access to visitors? Or is it, are we setting up unnecessary restrictions on visitors, I guess, it's another way to look at it.

14:36

JULIETTE MULLIN | MANATT
Yeah and, I think the, so I'm actually going to read Melody's comment right now. The list would only be needed during a lockdown, not for general operations. So, I do think maybe the important context is what's above, that this only applies in a situation where an order has been placed limiting visitation in any way, that there then is a process for tracking who is it allow in the door because they've been designated. This doesn't apply in like a situation where there's not an order limiting the situation.

HEATHER HARRISON | CALA
So, there is a limit on visitors. This is, this is contemplating some kind of limit.

15:12

JULIETTE MULLIN | MANATT
This is contemplating a scenario where there is a state of emergency in which there has been a local or state order that in some way curtails visitation. This would indicate that residents have the right to designate individuals and the right to see at least one of them at a time, even in a situation where there's a limitation.

15:37

HEATHER HARRISON | CALA
Okay, so it's number two then. That the facilities may not limit the number of individuals, but the state might be limiting the number of individuals. Is that the issue?

15:46

JULIETTE MULLIN | MANATT
Potentially in this scenario yes. This recommendation is saying that a local or state order should not curtail to, it must at least meet the minimum where a resident can have at least at least one person at a time.

16:02

HEATHER HARRISON | CALA
Okay, I got it and I wanted to also respond to Nancy's comment. We do not, absolutely do not, see our residents as an inconvenience, we're trying to make this as convenient as possible for our residents, so that they can continue to have a free flow of visitors during you know these difficult times.

16:22

JULIETTE MULLIN | MANATT
Appreciate that comment Heather. And I think this really gets to the concept of when there is curtailed visitation how does the facility know who to let in the door.

HEATHER HARRISON | CALA
Got it, thank you.

JULIETTE MULLIN | MANATT
And I'm glad we had this conversation. I think that helped clarify some of it. But if you want to pause and think about maybe an additional edit to clarify that we'll welcome that. When it comes to you yeah, great, thank you. All right, I see Beth has raised your hand

16:50

BETH MUSZYNSKI | CALVET VETERANS HOMES
Hi thank you. I'm with CalVet, the California Department of Veterans Affairs and we run the veterans homes throughout the state of California which are skilled nursing and assisted living facilities for veterans and some spouses. My question is kind of along the same lines, part of it was answered by that earlier conversation, so thank you very much to you all and to the representative from CALA. But there's maybe another part of it that I just want to clarify. And I know we went over some of this in the prior meetings so I'm sorry for any repetition, but I just want to make it clear, make sure it's clear in my mind, so yes, when so, in our facilities during the height of the pandemic we did outdoor visitation, even long before we were able to bring back indoor visit, normal visitation, in rooms and things, we had outdoor visitation with setups, with, you know, a barrier and chairs and whatnot. And then we also did tablets a lot, you know, for Facetime and things like that, and so that was one way that we were able to keep people in touch.

So when it comes to this though, if there is for example, a local county public health, you know, directive that we need to strictly curtail certain kind of gatherings and activities and things like that, is this something, and I, and I fully support the concept here, so I just want to make sure that it's clear, is this something that could then be applied, I mean either as it was suggested just now, to some extent, this would be able to override in a way for lack of better terms, that directive. Not override it, but we added in, factored in, as we manage that and comply with that but, so I guess my question is if we do get something that's clear-cut from the county, for example, how do we balance these? And then, is outdoor visitation maybe a way that we would balance this? I'm just trying to think operationally, if we have this recommendation, then let's say it goes somewhere, you know, with legislation or whatever, and then we also have a county directive, how do we, how do we, I fully support this, but how do we balance that operationally?

18:55

JULIETTE MULLIN | MANATT
Yeah, I really appreciate that question. So, we're going to have kind of whole recommendation that focuses on what visitation looks like, and with acknowledgement for that point Beth, of their may be situations where visitation parameters vary somewhat in different states of emergency. And so, we'll look at that as we get a little bit further. I think what's core here, and I know we have some folks that may have some comments on this in line as well, but what's core here is, the idea here is that the local or state order itself would acknowledge that this visitation can continue.

BETH MUSZYNSKI | CALVET VETERANS HOMES
Okay good. That that's what I assumed, and I just want to make sure. Because as we're, as we're achieving all these different things we'd have to be able to combine them. Okay.

JULIETTE MULLIN | MANATT
Right, the intent is not to create contradictory.

BETH MUSZYNSKI | CALVET VETERANS HOMES
Right, and the intent on our part is to allow you know visitation and these you know perpetuating, these very important ongoing relationships between residents and family and friends and things as much as we can. So, I appreciate the thought that went into this recommendation.

JULIETTE MULLIN | MANATT
Thank you Beth, appreciate that. All right Anissa I see you've raised your hand.

20:08

ANISSA DAVIS | CCLHO
Hi, thank you. I'm Anissa Davis. I'm the president of the California Conference of Local Health Officers, and I just wanted to provide feedback. We also are very much in support in concept of the resident designated support people, we feel like they are very instrumental in the health and well-being of residents and long-term care facilities. The issue is that we have to be able to have the tools that we need to address the situation that presents itself. And so, it's really difficult to have any kind of limitations placed on that ability. Like it's just really difficult to say that there's not ever

going to be a situation in the future that's significant public health risk or safety risk where we may, for the benefit of the entire facility, have to limit visitation more than what's stated here. And so, by having these restrictions placed, it's really limiting our ability to respond to a public health emergency adequately in a long-term care facility. So, we ..

21:28

JULIETTE MULLIN | MANATT
Oh, go ahead please finish.

ANISSA DAVIS | CCLHO
I was going to say so we agree with the importance, and we don't feel that there should be a curtailing of state and local orders.

JULIETTE MULLIN | MANATT
And can I just ask a follow up there so in our, it's recommendations C and D when we get to them, they have kind of clauses in them that acknowledge what you're speaking to Anissa, which is we can't anticipate every situation today in this moment, and so in those situations there is a process through which the state can establish transparent public collaborative recommendations in a timely and fast way. And so that that is acknowledged in recommendations C and D in terms of defining the safety protocols and the parameters for visitation. Knowing that those elements are there in C and D is there something this, that would need editing in your mind? Acknowledging that there is those provisions coming up in in C and D.

ANISSA DAVIS | CCLHO
Right. So, C and D, it felt a little different, it felt like you've made a decision and now we're going to do something after that. Whereas this is something that's saying when you're making the decision there's some parameters on the decision. So, to me this is about making the decision and I think we need to be able to have all the tools that we need and there's just no way that we can be able to say that there's never going to be a time when we may need to limit visitation more than what's right here in this this recommendation A.

JULIETTE MULLIN | MANATT
And is the specific, so just acknowledging that this says subject to the safety protocols and visiting parameters in this framework, so it is subject to

establishing the safety protocols and the visitation parameters later. Essentially what this recommendation would say is that there needs to be some way to say a resident can talk to their loved one, and can interact with their loved one, understanding that there may be some scenarios that we'll talk about in C and D where it might be outdoors for a period of time or something like that but at a baseline there has to be some way for that contact to happen. I'm just trying to understand if there's something here versus later on that we want to kind of lift up to edit.

ANISSA DAVIS | CCLHO
So, it's really it's looking at the curtailing. So, it's, I think the important part is as we're looking at what visitation is, there are people who are providing very necessary care and so they should be considered as, you know, what we've decided here is this term, and so that needs to be factored in when we're making our decisions. But the part that, it's the curtailing, the saying that you cannot curtail this for the following types in under any circumstances. So, whether you know maybe there's somebody asked me to give some examples it's very difficult because I don't think any of us could have given a the COVID example, you know, the all the factors that went into that emergency there were so many different ones. But say there is an Ebola outbreak and so that is going to look really different than say a smallpox outbreak, or maybe there's a new type of flu there's that type of outbreak, so I think that, you know it's just we don't know what we don't know, and so I think we need to have the tools in order to make the decisions that need to get made in this timely manner in order to protect the facility as a whole.

JULIETTE MULLIN | MANATT
Okay that, that's helpful, thanks Anissa. So, it sounds like one of the areas that's troubling for you is actually the use of the term, like not curtail, because that's very, that's a very broad term. Okay, thank you, appreciate that. Colleen I see you have your hand raised.

26:05

COLLEEN CHAWLA | CHEAC
Yes, thank you very much. And I want to support and concur with everything that Dr. Davis just represented. I'm from the California Health Executives Association of California and completely support this recommendation with the exception of the added phrase at the end of the intro. For all the reasons that Dr. Davis just said, so my recommendation on

this specific language would be that the newly added phrase at the beginning of the recommendation be eliminated.

And to your question Juliette about the recommendations C and D and how those would factor in. Some elements of those recommendations really require immediate response to come up with some alternatives or plans, and it's very hard, as Dr. Davis said, to really know in the moment where there, whether there's going to be the ability to come together within 14 days and do these things, so it's very hard to predict. And by legislating or trying to legislate something that that curtails our ability to be as responsive as possible, while taking these principles and very important factors in mind, really, it makes it hard to know that we can be as responsive and protective of Public Health in any emergency in the future.

JULIETTE MULLIN | MANATT
Thank you for that comment I appreciate that, and we will get into that much more deeply when we get to C and D. So, appreciate that comment. I think what I'm hearing from both you and Anissa is kind of a core edit in your mind that would need to be made here in order to be able to support or be comfortable with this recommendation. And I think you just said it pretty explicitly Colleen, is to remove the term that says local and state order orders not curtail, and instead perhaps clarify it with something like, that they not prohibit long-term care visitation. Acknowledging that there may be some parameters that get mentioned later, but that the core of it is that, what this what this recommendation is intended to put forward is that orders shouldn't prohibit and entirely prevent visitation understanding there may be some parameters.

COLLEEN CHAWLA | CHEAC
I would say that that language still sounds like it limits the orders in a way that that doesn't allow the health officer flexibility, and the Health Department's flexibility to respond to any emergency. I would say something more like that, to the greatest extent possible allow for visitors in these in, with these parameters.

JULIETTE MULLIN | MANATT
Okay. All right. Let's go to the next in line. Thank you Colleen, appreciate it. George.

29:19

GEORGE KUTNERIAN | 6 BEDS
Hi, thank you. So, one thing I wanted to get clarification, I think I understand this, but just to clarify, is when we say unlimited number of people who are designated as RDSPs, that's just the list itself. It's not saying that you know an essentially an unlimited number of people can visit like simultaneously. So, I don't know if that's worthwhile to clarify at all, or if that if that is giving anybody heartburn, if it's not, if that's not a source of confusion then fine. I don't want to add anything further to it but could be worthwhile to just kind of clarify that a little bit, so that there's no confusion. That we're not talking about like an unlimited number of people coming at the same time to visit someone because they're all designated as RDSPs, it's just that their the list of people can be unlimited.

JULIETTE MULLIN | MANATT
Yeah, appreciate that clarification. And I think definitely if that's an area that's causing any of the concern for folks invite them to weigh in on that as well. Maitely you raised your hand, and you have a related comment according to your chat so perfect timing.

30:31

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
Yeah, George, thank for the runway on that. So relatedly, in regard to A (iii), so there, the language is a little bit unclear in regard to what we mean by, when there is a necessity to limit the number of residents as needed support persons in the facility. Are we talking about per resident in that clause? Or are we talking about per facility? Because that is, you know wildly different. We don't, we, there aren't actually enough of us to overrun a facility, it's very unrealistic. But I wanted to make sure it's clear in the language.

JULIETTE MULLIN | MANATT
It is certainly intended to mean per resident. And we will add that if it is not already explicitly in there. I know it's gone through a couple iterations, so it may have gotten a little deemphasized. So, per resident is a key clarification. Thank you. Melody you raised your hand.

31:41

MELODY TAYLOR STARK | CHOSEN FAMILY

Hi. Thank you. Yes, a couple things to note. And first thing just as a side note, Mark when you, when Mark opened up and, you know thanking everyone for being here and it's for me anyway, it's been a privilege to be able to be on the on the panel and speak up. And I, you know truly believe in this to the point I'm not getting paid to be here. And that isn't a comment on others, but I take time off, someone has to actually cover my work for me who also believes in this project for me, and I know there's others on the call in the same situation.

Anyway, having said that I wanted to address a little bit regarding the topic of tools. And also, that, you know, we're still focusing a lot on COVID and one thing that I had to mention, yesterday I was on the CalCTM call on, in infection prevention and my friend, her name was Dr. Lily Hong, I think from DPH was on, and there was a lot regarding RSV and other things. So many times we relate back to COVID and what happened in the past and what we're doing is preparing for what we might be looking at, hopefully not, but very soon. And as another side note, I would recommend people going on to the CalCTM site and taking a look at that video because being a non-medical person I learned a tremendous amount from it.

Anyway, regarding tools, I was involved, or participated in a very interesting situation this past weekend. Friday right after work I happen to have checked Facebook and among one of the caregiver groups I belong to, someone in Waymart Pennsylvania, eastern Pennsylvania, said I got an email this afternoon that my mom's nursing home went on lockdown because they have a couple of COVID cases. And so, we exchanged back and forth, got some information, before the weekend was over, and of course a lot of times changes aren't going to happen over the weekend because of who's in place. Across the country calls were made from various states to the ombudsman in Pennsylvania, to the ombudsman's supervisor in Pennsylvania. I was on the call with one of the supervisors at 6:00 here, which meant 6 till 7 7:30, so over 10:00 on their time. People reported in different states across the country to the department of DPH in Pennsylvania. Calls were made to the facility, I know like in most places the facility staff were you know very nice very great to work with, and on Saturday morning I spoke with the DON, and we talked about the CMS regs and what was going on. And she said because a lot of times when

we're having this conversation we're looking at the designated support persons we're looking at the residents and so forth and we certainly want to encompass and acknowledge the facilities themselves, and there's a lot of challenges that go on with that. So, as we were talking she said well what happened is we had some cases and we wanted to implement people wearing PPE coming in, and people were refusing, so we just completely shut down. And I said, I understand that challenge that you had and so forth, and I said but while we're talking on it I want to encourage you to get involved in advocacy for laws and policies and protocols because those policies and protocols would state that anyone coming in has to use the same PPE as staff.

So that's something in their toolbox that they can stand on like right now, they don't have a law in place in Pennsylvania. And so, they just had to say hey we're locking our doors. Where had there been a law they would have that tool to stand on to say you can come in, no says right here you can't if you're not willing to use PPE. So, you know that that just became, you know really apparent of how much this means to everyone who's involved to the entire treatment, to the entire support of the resident, as well as all of us, not only support persons, but the paid support, the facilities, you know that it means to everyone. And I also thought you know right now we're going to be recommending to legislature and what legislature is going to do with all this information, I hope, that something comes up very, very quickly because between the conversation over the weekend, oh by the way the facility opened up first thing yesterday morning. So, you know in between all that it became apparent of the tools that are needed the things that we're putting in place with this workgroup and if an outbreak and a lockdown happens again, and we don't have anything in place, first of all yeah the residents and the families aren't going to want to deal with it. Do the facilities want to deal with it? Does DPH want to deal with it? Ombudsman? I recall talking to Meray Painter who's you know national with ombudsman and talking about how many calls they were getting from staff, from residents, and how much pressure was on their staff. So, if we can expedite getting laws in place, should something happen again with COVID, seeing an uptick on that. Should something happen with RSV. Does DPH want all those reports, the calls the media attention, and not just calling out DPH, but staff went through a lot with that I know they did. So, in addition to what the families went through I don't think those in the regulatory agencies and industry want to go through it either.

So, I know I’m getting on very much of a soapbox but I, with the outcome of this and today being our last meeting, if there's any way possible of getting legislature to get systems in place ASAP, I think we all need that, every single person on this call and everyone that we represent. Thank you.

38:03

JULIETTE MULLIN | MANATT
Thank you melody really appreciate that. Catherine I see you've raised your hand.

38:09

CATHERINE BLAKEMORE
I just wanted to do a little reminder about why we're here. The point of this, I believe, is to position the resident designated support person in the same position as staff who work in the facility. So just like we wouldn't curtail staff from going into a facility, a support person is in the same position, and we shouldn't curtail them. So, I think curtail is the correct word because what we're trying to achieve is something different than what happened in COVID, when in fact there were state orders that curtailed visitation. And so, if we want to actually do what this group was charged with, I think we should leave it the same. I think we should make clear that these people are positioned, that support people are positioned the same as staff, and yes of course they have to use the same tools, they should have priority for those tools, for PPE and for vaccines, and whatever else is available.

And then my final note is, I hope we aren't in these discussions suggesting that using Facetime is the same, or that it achieves the same purpose for some residents, such as my mom who lived in a long-term care facility. She was not because of her disability able to use facetime it actually created more confusion more upset, defeated the purpose of any attempt to visit her, because she 90 years old, had dementia and couldn't understand what was even trying to be used as a tool to help her communicate. So, thank you.

JULIETTE MULLIN | MANATT
Thank you Catherine, I appreciate that. Anissa, you've raised your hand. So, we'll take that comment and then I think if we can we'll start to move on to the subsequent recommendations, because those details may actually help create more clarity on this one. Anissa.

40:10

ANISSA DAVIS | CCLHO
Thank you I was just going to you know follow up on the last comment, that maybe that's what this should say. Is that the recommendation is that these resident designated support care people should be treated as staff. Because there could be times when some staff could be you know part of an order where there might have to be some kind of curtailing. It might say something like do Telehealth if you can, or only you know the medical director can come in, or we're gonna not do this other type of thing right now. So, I think that that might more point to what it is you're trying to do and not curtail the decision-making that health officers need. Thanks.

41:00

JULIETTE MULLIN | MANATT
Anissa, Catherine, I really appreciate that comment. I would actually love some workgroup feedback on that one. So, the proposal on the table, kind of based on this conversation we just had, which was really productive I thought, was to come to a concept of instead of stating that orders do not curtail visitation for the following visitor types, the recommendation would actually be to adjust the language here to create an equivalency between the access level of a resident designated support person and long-term care facility staff. So, if we go to the next slide.

41:44

SLIDE 22

We're actually going to ask people to respond to that. So, in the chat workgroup members are going, Caroline just dropped a Poll Everywhere survey into the chat.

41:47

SURVEY SLIDE

And we'd love, because we're in our last meeting and we're trying to really be as definitive as we can with some of these, some of these changes. We'd love to have people's initial reaction to that proposed edit, which would establish equivalency in the access level of a resident designated support person and a long-term care facility staff member. And we would

edit the statement to reflect that. So please go to the link that Caroline just dropped in the chat and react to that. We'll give it a moment here and I will try to be silent for a moment.

43:55

I'm going to give it about 30 more seconds if you need more time than that please just let me know in the chat.

44:30

All right. Based on these responses we've got a very clear indication from the workgroup that we could move forward with this recommendation and the final report, if we edit it to reflect specifically that we are tying access for resident designated support people to the same level of access as staff.

So, I just first of all want to thank everyone for that extremely productive conversation that brought us here, and really appreciate everyone's iteration and conversation to help us get to a recommendation that we can all jointly support, because that's really big and that's the whole purpose of this workgroup coming together. With that, and I do see, the ask when we do the follow-up surveys like this to drop the language in the chat that we're recommending we can do that for the next one.

45:28

SLIDE 24

Okay. All right and with that we're going to open for a moment to public comments. Would love to hear from folks that have joined us today before we move into a conversation on recommendation B, to hear any questions or comments or reactions to the conversation so far. And let me go over and we have Teresa has raised her hand. And you should be able to unmute yourself at this time Teresa.

45:54

TERESA PALMER
Can you hear me? I'm concerned that it'd be direct care staff, the same, it's got to be the same access as direct care staff.

46:08

JULIETTE MULLIN | MANATT
Got it. Okay, thank you appreciate that comment. Thank you Teresa. Great. Any other comments from folks that have joined us from the public today? All right. With that we will go into recommendation B.

46:35

SLIDE 25/26

JULIETTE MULLIN | MANATT
All right so we did do a little bit of a reorder of the recommendations just for the flow of conversation. This next one is actually one we have not yet discussed in a meeting. It kind of came out of meeting three, as a potential need, and we added it to the survey that we did between meetings.

So, we did send a preliminary recommendation that is intended to ensure access to emergency supplies for long-term care facility visitors, including support people. And just to, one note, there I'm going to pause there for a second, when we use the term visitors broadly, we're referring to any individual in the list that we looked at beforehand. So that includes ombudsman, that includes any individuals that are not employed by the facility or living in the facility that come in. Of which resident designated support person is a category. So, as we look at some of the parameters that we'll talk about they're intended to apply to both the broader category of visitors, as well as resident designated support people specifically, and we call out when if there's ever a situation where we're distinguishing one from the other, when it comes to parameters of visitation.

So, we provided an initial recommendation that would recommend prioritizing access to emergency supplies for long-term care facility visitors, including support people. We received a first round of feedback from the workgroup on that via survey. So, there was some, just general confusion about why we may be in a situation of limited supply and so we've endeavored to be a little bit more clear about when this recommendation would apply in the next slide. Some workgroup members noted that there may be times of extremely limited supply and just expressed concern about anything in the recommendation deprioritizing staff. And then some workgroup members indicated that there should be a requirement specifically for the supplies to be made available to visitor, for visitors use.

So not just that it be globally prioritized but that that then trickle its way down to the actual visitor. So, if we go to the next slide.

48:44

SLIDE 27

The proposed recommendation here does a couple things to address these pieces of feedback. So, the first is we clarify that this recommendation is specifically applicable in a situation in which emergency supplies are limited across the board, and in which state, county, and local authorities are involved in supply distribution. So, this is very specifically speaking to a scenario like one that did happen in COVID, and one that could happen in a future emergency, where there's a type of PPE, or a type of emergency supply, vaccination for example, that is being distributed, or in which the state, local, or county authorities are involved in the distribution of that supply. In those scenarios, this recommendation is one where the workgroup recommends that long-term care facility visitors, including support people, be considered among the top priority populations for any emergency supplies required to adhere to long-term care facility safety protocols.

So just to thread an example through, if a specific type of mask is required of all people for entering a facility, this recommendation would state that visitors should be among the priority populations to access that type of mask, for example. Here we indicate, when we say emergency supplies examples include, but are not limited to, PPE, vaccination, testing equipment, that kind of thing. We did add the clause that the facilities shall provide emergency supplies to visitors, including support people, to the extent that those supplies have been made available to the facility by county or local authorities. And then we did explicitly note that nothing in this recommendation would deprioritize or inhibit access to supplies for staff.

So, I am going to open this up for conversation and again we'll use kind of the same process here, so what we're asking people to do here is really indicate I have an edit to this that I would like this group to consider, or I have a particular issue with this recommendation that is a really significant sticky point that I would like this group to consider. George I see you've raised your hand so let's start there.

51:11

GEORGE KUTNERIAN | 6 BEDS
Thank you. Would it be possible to, so looking at I'm looking at (b), so facility shall provide emergency supplies to visitors including RDSPs to the extent that those supplies have been made available to the facility by state or local entities. Can we further clarify that this is also assuming that those supplies are actually available at the time of visitation is happening. Because the state or county can distribute supplies and then at some point they could be exhausted. So, at some point they were given supplies but then they're gone. So, if they're gone and they're not available for anybody then you know they may not be available at that time. I don't know if there's a way we can just kind of maybe make that a little more clear.

52:00

JULIETTE MULLIN | MANATT
Great. I think we can incorporate that. I'll, that seems like a relatively small but important clarification. I, what I'm going to do, we won't take that to a full check for folks, but if anyone has an objection to that edit, please let us know in the chat, and then we can talk that through. Thank you, appreciate that George. Mark you raised your hand.

52:25

MARK BECKLEY | CDA
Yeah, I was just wondering how the equivalency standard that we set in the last recommendation kind of coincides with this. So, it seems if we're putting resident designated support persons at the same level as staff at facilities, that they would have equal access to things like supplies and equipment. And just want to see if that's the direction we're headed. If we are, then I think that would argue in favor of, you know, and I know that facilities don't like the idea of creating list of like designated visitors, but, you know the smaller the population, right, the more accessible things supplies, like PPE or vaccinations would be. So, if that's the direction we're headed I would probably recommend, you know, designating like, limiting the number of, you know, called out designated support persons so that folks would have quick access to supplies, otherwise, if you just open it up to everybody that's basically the general population right, and it might be hard to make visitors a priority population.

53:37

JULIETTE MULLIN | MANATT
Great thank you for that comment Mark. I'm going to invite, we'll kind of do like we did for the first recommendation, we'll invite folks to react to that, and then we'll pause and see if there's a particular edit we want to work on together. So, I see Ken you have your hand raised next either for a comment unrelated to this or reacting to Mark's comment.

53:57

KEN DAROSA | SCDD
It's an additional comment, and it's one that may come up a little bit later, but, you know during COVID a lot of people demonstrated the ability to be resourceful, and maybe this is a little too in the weeds, but is it reasonable to articulate something here that says if someone who is part, you know, an RDSP, if they themselves have the necessary PPE that meets the facility standard, and they're able to provide it for themselves, you know, would, that should allow them to visit as structured, and I don't mean to be critical, but as structured it kind of puts all the onus on the facility, but if people have their own and they're meeting the standard of the of the facility, that, I just, I think some recognition of that might be important so that the facility can't fall back and say no we don't have it you know you can't be here or we're curtailing. That's my only comment.

54:57

JULIETTE MULLIN | MANATT
Thank you Ken, appreciate that point. We do actually tackle that a little bit more explicitly in recommendation C and say that but hear you that this as a standalone recommendation may create some confusion there. So, we can either add, kind of in the opening to the recommendation or in the recommendation itself that cross reference to recommendation C. Appreciate that. Nancy you've raised your hand

55:22

NANCY STEVENS | RESIDENT
Hi. Thanks so much Juliette. I know we're just at the very beginning of this we have a long way to go, so I'll make this as brief as possible. I'm just wondering if there's a way to consider maybe having PPE fall under the

same like stocking. I don't know if there's a specific stocking guideline for e-kits, but I think that PPE should have the same sort of guidelines as how an e-kit is stocked.

And also, I just wanted to make a quick comment, we had an abundance of PPE here, but there were two facilities who were less than 20 miles away who had nothing for a long amount of time, and so we were able to provide them with the PPE that they needed, and more, because at that time there were no visitors coming in. But anyway, they ended up with an abundance, so once visitation started up again people were able to still wear PPE at all of the neighboring facilities, including ours, and the two that didn't have any to begin with thanks.

56:40

JULIETTE MULLIN | MANATT
Thank you Nancy, I appreciate that comment. I don't see anyone else with their hand, oh Karen you've raised your hand. Oh sorry, we'll come to you in just a moment Karen, in the public. I do want to tackle a question head on in the chat first. So, I do see Anissa you've reacted to Mark's comment, I do just want to lift up the comment again for consideration. So, I'll just reflect it back again now that we've gone through our list of folks that had their hand raised. So, Mark raised the question that if we are establishing equivalency and access between a resident designated support person and staff and here we are also recommending that resident designated support people be among the groups prioritized for access to PPE, might there be an advantage in being more specific about the number and the process for listing designees so that they can then get that priority. Invite people to weigh in on that one. Oh, I we don't want to go to a survey on this one just yet, thank you. Would like some comments on that. Anissa you've raised your hand.

58:05

ANISSA DAVIS | CCLHO
Yeah, I was just gonna say the comment that I put in the chat, I didn't know if that's what you were looking for. But I do support what Mark is saying. I think that depending on what the situation is again and what kind of PPE is necessary that there may need to be limits on the numbers. And the comment that I in the chat was that it could be a fairness issue, if you have limited supplies and then you have really large groups of people for one

resident and the really small group for another resident that that could impact who is getting this essential care in the facility.

58:45

JULIETTE MULLIN | MANATT
Thanks Anissa, appreciate that. Curious if folks have any reaction to that. Beth, you've raised your hand.

59:05

BETH MUSZYNSKI | CALVET VETERANS HOMES
Yes, let me turn on my camera. Thank you. I just thought of something. So, with regard specifically to the vaccination part of it, and I'm sorry if this was brought up earlier and I missed it, so, I was just looking at the list, and I know those are just examples and I understand that, but a question is with the vaccine, so for example, COVID when we had vaccines, you know were coming out and they were being available for different groups and etc. then of course there were requirements and expectations associated with vaccinations. We had clinics in a lot of our locations, some locations, I'm trying to think we might have had one location that actually had the vaccine on site but for, maybe, I'm trying to remember, but, because there was a time when we looked at that, but we had to also look at storage and stuff Basically what we did was bring in clinics, we partnered with Walgreens or whomever, and we had clinics on site. So, my initial thought with regard to PPE, testing, vaccines, and things like that is that, within reason, I do think that having them available to visitors is a good recommendation. I mean we did do that ourselves especially with PPE, we still are actually, they're right there at the front door. But with the vaccine of course that was limited to the days that we had arranged for them to come on site, and so there wasn't a limitation, in our experience in the agreement with those companies, there wasn't a limitation on amount, so presumably yes, we could have made it available to additional people on site, but it was only on certain days. So, I just thought I would throw that in there as something that maybe would be considered that it's availability of these things, or scheduling of shipments or scheduling of whatever, that would make these things available versus less available.

1:00:51

JULIETTE MULLIN | MANATT
Yeah, appreciate that Beth. I think part of what we endeavored to do with this recommend is speak to prioritization rather than the specific mechanisms through which one would be prioritized acknowledging that different types of supplies have different, as you said, in some cases it'll be scheduling, in some cases it'll be actual supplies, things like that. Thanks, appreciate that. Karen you raised your hand.

1:00:12

KAREN JONES | CLTCOA
Yeah, I just wanted to kind of bring a reminder back that we have an awful lot, of I think it's easy to think visitor even if we're using the RDSP definition, is extra and not necessary. I know that's what this whole conversation's about is that they're necessary, but it really want to make sure we're reminding that a lot of these visitors are doing actual physical care. They're feeding people who cannot feed themselves, and the staff do not have enough time to really take the time that's necessary. And so, we were seeing weight loss during the COVID pandemic because the family member who had been there every day three and four times a day to give food, couldn't get in, and was watching staff not be able to spend the time and kind of rushing through and taking away the food because there was a little pause, like okay they're done. Well, they weren't done they just couldn't keep going and they were tired and needed a break. And I don't, I also, I know it's not part the recommendation but I want to make sure we never get to a point where we're sort of putting a priority on people doing physical care, because the mental care is also important that psychosocial side of it is so important for so many people. But I'm just really worried that we're going to get to a point where these recommendations may get changed a bit and we're going to be back to PPE is only for the fit, the staff who work there. These visitors are not extra they are they are completely essential. And we lost a lot of people during COVID that we didn't need to lose because they just didn't have access to the folks that they needed.

1:02:49

JULIETTE MULLIN | MANATT
Thank you Karen. I really appreciate that. And can I just ask you a follow up on that? Does the kind of place we landed for recommendation A help advance that in your minds creating that equivalency of access?

KAREN JONES | CLTCOA
It does. I really I do like that one quite a bit. Thank you.

JULIETTE MULLIN | MANATT
Great. Appreciate that, thank you. Mark you've raised your hand.

1:03:07

MARK BECKLEY | CDA
Yeah I just want to respond to a comment that Karen had in the chat regarding facilities purchasing the PPE or incurring that as a cost. I don't think that'd be the intention during COVID at least, a lot of those are state purchases or they were provided by federal government. So yeah, I mean this would be something that as the state or the federal government acquires these resources then the resident designated support persons would be a priority population equivalent to a staff person.

JULIETTE MULLIN | MANATT
Thanks Mark, I appreciate that clarification. So there has been a conversation put on the table about you know helping to ensure prioritization and access, helping to really make sure prioritization of access in the facility, access to PPE, by having more specific lists of individuals, totally at the resident discretion, who they are saying they want to visit them in a state of emergency in which there is a public health risk.

I would love to get a sense from the group if there would be some comfort with having a designation to say, for example, a resident can designate three people at any given point in time, I'm putting the number out there but I'm going to ask people to give me a number in a moment, at any point in time to be a resident designated support person. They can change their support people when changes happen in their life, that is that is natural and normal, but would there be comfort with saying that there is a number that people can designate? And if we can go to the next slide.

1:04:58

SLIDE 28 / SURVEY

Let's actually go ahead and do a quick poll on that one to see how comfortable people would be with adding an element that would potentially say there is a number of individuals that can be designated as a resident designated support person. And we will I will drop that in the chat as well as folks are considering that.

Okay seeing kind of a variety of stances here. All right. I'm wondering if anyone who has indicated that they would prefer not to make this edit and add this in, would be willing to kind of share some thoughts on what their position is here, and why they would not advise this addition. Karen you've raised your hand.

1:06:52

KAREN JONES | CLTCOA

So, as an Ombudsman I spend a lot of my time sort of dealing with family issues, and you get a lot of families that have factions, or you get family who comes in, you know, once in a while they're sharing the duty of doing care. So, I see not a lot of people coming in at once but a need for residents to have access to more than one or two people for a variety of reasons. And it would be a, particularly for the folks who have families who don't get along with each other. it would be a real shame if one side of that faction got access to Mom or Dad or the person in the facility, and the other side simply couldn't because all the spots have been used for visitation for that person. I would maybe say, and I don't like any visitation limitations to be honest, but, you know, it could be if they have more than say two people designated then they would have maybe a limit on a number on the day. But I can tell you how much struggles the facilities had when people had to figure out who got to visit that day. I got a lot of calls from facilities when that was happening because the family person A was there, and family person B also wanted to visit, and they couldn't be in the same room together, and then who gets to decide that? Is it the facility staff? We need them doing care, not trying to figure out family issues. So, I think if you're limiting how many people, it's going to cause its own problems, and some people who really need to be able to visit with their loved one aren't going to be able to do that.

JULIETTE MULLIN | MANATT
Thank you Karen, appreciate that. Catherine, I see you've raised your hand as well

1:08:31

CATHERINE BLAKEMORE
I will just add to what I thought were Karen's good points, of the need for support is individual, right, depending on the significance of the support needs. If you're primarily even just talking about feeding or assistance with toileting or changing, those kinds of things that's going to depend on the individual, and one person or two people may not be able given everything else that's going on in their life to be the two designated support people. So, it just seems as though you create more challenges by putting an arbitrary number on that may not meet the needs of that individual and may not appropriately accommodate the significance of their disability.

1:09:21

JULIETTE MULLIN | MANATT
Thank you Catherine, appreciate that. Eric, you raised your hand.

1:09:26

ERIC CARLSON | JUSTICE IN AGING
Yeah I'd agree with what Karen and Catherine just said, and maybe ask a, make an observation rather. That it seemed to me in following the conversation that this suggested edit came a little bit out of left field, it wasn't clear what the point of it is. If it's dealing with the shortage of supplies, this doesn't necessarily address the problem and prioritize things appropriately. And so maybe I'd ask that, if you could respond in just a couple of senses if that's possible what's the point of this because to me at least it's not obvious how we move to this suggestion from the conversation that we were having.

1:10:15

JULIETTE MULLIN | MANATT
Well, I see Mark has raised his hand so I'm wondering Mark if you want to chime in on that.

MARK BECKLEY | CDA
Yeah, I'm happy to clarify. So, at the beginning of the pandemic we know that PPE and vaccinations were in very short supply. So that being the case and hospitals, facility staff were prioritized, we trying to create this equivalency standard with visitors, which is good, but if you have a spare supply and you only have X amount of vaccine and PPE to go round, who do you pick and choose, just that to if you can. Like say there's, you know, 50,000, whatever, people, who are you know visitors and there's not enough supply to accommodate all of them, then what do you do?

1:11:07

ERIC CARLSON | JUSTICE IN AGING
Yeah, my response is it seems like a blunt instrument. It's a, for us not knowing the circumstances setting a limit like that seems not, as other people pointed out, not responsive to people's individual familial situations, their personal situations, and not necessarily the right prioritization as to the, as to whatever overall limits there may be in any case. So, it risks a little bit going back to the problem that we're trying to address, right, that the people are just told no sorry about that we can't do anything for you because there's a guidance from several levels above us and there's nothing we can do about it.

1:12:06

JULIETTE MULLIN | MANATT
Thank you Eric and Mark, appreciate your comments. Catherine you have your hand raised.

1:12:13

CATHERINE BLAKEMORE
So, I guess the question is whether particularly for PPE, that even would address the problem. Because if I come as an individual every single day I'm going to get PPE, unless you're suggesting that I just reuse it. And so is it any different if I go seven days a week, versus I go three days a week and my brother goes four days a week, right. It seems to me kind of the same amount of PPE absent the vaccine discussion. So, I'm, I really am struggling to see how saying there's a limit on visitors is solving a mask, you know, other kinds of shortage things.

1:13:01

JULIETTE MULLIN | MANATT
Thank you Catherine. George you have your hand raised.

1:13:05

GEORGE KUTNERIAN | 6 BEDS
Thanks. I would say, my suggestion would be, instead of maybe focusing on the visit, the number of you know RDSPs per person, the group maybe we focus more directly just on the PPE issue itself. For example, I don't know what the solution is exactly but we're talking about on one hand for example the vaccinations. You know when we did have visitors coming in during COVID, you know the facilities didn't arrange for the family members to get vaccinated, they were getting those vaccinations on their own and then coming in. So, and I'm not saying what, I don't know what the solution is, but I what it sounds like is we should focus then on the PPE because that seems to be the problem and not focus on changing the visitor aspect of it to try to solve the PPE issue.

1:14:06

JULIETTE MULLIN | MANATT
Thank you George, appreciate it. Mark.

1:14:11

MARK BECKLEY | CDA
Yeah, and this is a great discussion and I'm hoping to get towards a solution here. So, what I'm hearing is folks aren't comfortable with setting a number of visitors, and I appreciate that or naming individuals. If we focus it on PPE, so given what supply and demand of PPE looks like at given any given time. There will be a certain amount of PPE say available at facilities for RDSPs and I'm not exactly sure how that gets prioritized like first come first serve, whoever gets their first gets access to you know to their loved ones. I, so I mean, and this might be getting to with weeds, I'm just trying to think practically when you have a time of scarcity, and we know that at the outset of COVID we definitely have scarcity in terms of PPE and the vaccine, and the vaccine is another issue and I'll let you know Public Health colleagues speak to those issues you know, whether you allow people in facilities who are unvaccinated or not. But I'm just trying to address some

practical considerations here, because I'd hate to put something forward in legislation and then have it collapse in terms of in practical terms when you know, if there's this not enough go around and there's not a prioritization in place, you know what happens to RDSPs at that point.

1:15:38

JULIETTE MULLIN | MANATT
Thank you Mark, I appreciate that comment. It does make me wonder if we think about a provision in this recommendation that notes that in a situation of extremely limited supply there would be some process for further prioritizing access, rather than necessarily revisiting the RDSP designation generally. Maybe that's a way to approach that. And I see Anissa has her hand raised, so, Anissa.

1:16:09

ANISSA DAVIS | CCLHO
Yeah, I was thinking something similar to what you just said, like, I understand not wanting to have a limit on the number, so say somebody has 10 that they've listed, but if you don't have enough vaccinations for instance, which there was like a finite limited number, then it, I feel like there should be something in here that signifies that just because there's that many on the list doesn't mean that all of those people necessarily are going to have access to PPE. Like they'll be prioritized, but it's it just might not be possible. And if somebody has 10 on their list and another person has two on their list, like how do you balance all of that? Like that to me is the issue.

1:16:59

JULIETTE MULLIN | MANATT
Appreciate that Anissa. And I think that's something we can add to your or Marks point, something we can add into this element on prioritizing PPE, that doesn't necessarily change the RDSP designation itself. And I just saw a hand that was raised go down. So, I'm going to imagine we've maybe addressed the comment.

I do know that we are running a little behind time and it sounds like folks are generally okay with this recommendation. And can we go back to it for a moment. I just want to emphasize what it is again because I feel we

talked a lot about maybe there needing to be a need to prioritize, but I do want to emphasize that what this recommendation at its core does is it provides a recommendation to state, county, and local authorities that resident designated support people and other types of visitors that we identified in recommendation A, like the Ombudsman, should be among the priority populations for supplies. I just want to emphasize that, that is kind of the core part of what this recommendation is doing. And it is stating that at the state and county and local level that they should be considered among those priority populations. And I, I'm hearing general agreement for that, I didn't hear anyone say no let's not consider them among priority populations. So, it seems like we can continue forward and then add a little bit of context around what happens around extremely limited supply, when there needs to be deeper prioritization from the day-to-day of how things are rolling out. Okay, with that I'm going to go to public comment for this section before we move into recommendation C. And so, I do see that we have Karen has raised her hand, and Karen you should be allowed to unmute yourself.

1:19:06

SLIDE 30

KAREN KLINK
Okay am I unmuted? Can you hear me?

JULIETTE MULLIN | MANATT
Yes we can hear you.

KAREN KLINK
So, what I want to point out and I don't know how it fits in here and how to be addressed. But during this time of testing and PPE etc. assisted livings in RCFEs were not treated the same as skilled nurses, skilled nursing facilities. We did not have, as visitors or essential caregivers or whatever you want to call us, did not have the same access to PPE and testing. The California Department of Health along with where I live in Los Angeles said at a certain time that they supplied PPE and tests to skilled nursing facilities for a long period of time they were supplied, when they could get it. And we did not get that, we did not have that, so we did we're not considered the same. I think that should be addressed. I was in contact with many people that when they went to visit their loved ones in a skilled nursing facility they got PPE. They got tested before they got, and that was supplied by I don't

know California Department of Health or CMS, because they're federally funded. Assisted living I would go, and they would they had PPE they had tests, but they didn't have to give it to us. They would say no we don't have to supply you, because the Department of Health, I mean the California Department of Social Services had no such guideline or rule. So, I would argue that if this, if this what we're trying to propose includes assisted livings and RCFEs that it should all be the same and if it's being supplied then it should be supplied for everyone.

1:21:02

JULIETTE MULLIN | MANATT
Thank you Karen, appreciate that comment about the distinction between the facilities themselves as well. Thank you for that. Next we have Teresa, and I will, you should be able to unmute yourself at this time Teresa.

1:21:20

TERESA PALMER
Hi, I agree with Karen that DSS has to be the same as CDPH in terms of prioritization. I also think you should get rid of (d) the paragraph with compassionate care because that's where all the problems are. And I do think that if RDSPs are encouraged to select among themselves with the resident's help who shouldn't visit that's the highly individualized way of limiting RDSPs, and it should not come from above. A nursing administrator should not be able to select who can visit and who can't. The resident and the RDSP knows what the, what they supply that the patient would not otherwise get. And it's very important that we maintain the equity between RDSPs and staff, and it's not stated strongly enough. Supplying us sufficient PPE for RDSPs should be part of the cost of doing business, whether the government covers it, or the individual facilities cover it. If there's really equity between staff and RDSPs that is part of the cost of doing business. Thank you.

1:22:44

JULIETTE MULLIN | MANATT
Thank you Teresa, and I appreciate you raising that point on compassionate care, we're actually going to have a more full conversation about compassionate care a little later in our meeting today and can and can come back to this recommendation as we do that. All right with that I'm

going to take us into our next recommendation because we're running a bit behind and hoping to get through everything today.

1:23:09

SLIDE 31

So, our next recommendation addresses the safety protocols that visitors including RDSPs must follow when visiting a long-term care facility. So, this is a recommendation that has been circulated a couple times to the group already. We've done three different versions of it, we'll talk about the third version today, but I do want to provide a bit of context and history on how we got to this recommendation.

We looked at the first version of this recommendation in meeting number three, and folks also provided some offline written comments about it as well in a follow-up comment, in a follow-up survey. A lot of the feedback that we got from the workgroup is summarized here on this recommendation. So, the, one of the pieces that we heard from you all is that really most of it really dealt with what to do in a non-standard situation. So, this recommendation, as folks may recall, establishes a standard for visitation protocols, and then identifies a process through which anything that's not standard would have to be developed.

The first piece of feedback we got on that non-standard process would be that that should always be set at the state level, never the county and facility level. So, if there's ever a scenario that would call for something unique that we maybe can't anticipate in a state of emergency, that that would be applicable statewide.

The second is that the initial recommendation to convene a stakeholder group within 30 days was considered far too long, and it was really unclear what would happen during that 30-day window. So, we endeavored to be much more clear about what would happen in that window of time, and we've reduced the window of time to 14 days. We also got feedback from the workgroup that visitors including RDSPs may want to follow more stringent safety protocol, such as for example using a higher quality mask than those followed by staff. All of these were incorporated into the version number two. If we go to the next slide.

1:25:02

SLIDE 32

Which was circulated via survey to the work group a couple weeks ago. The feedback in the survey is summarized here. So, we did hear some concern about the feasibility of state departments convening a stakeholder group in a public meeting during a really acute phase and of an emergency. So, we'll talk about that today. We also heard some concern expressed about what happened during that 14-day window. And so, what we heard kind of two different types of concern. There was first of all concern that no visitation would occur during that window of time, and then on kind of the other side of it there was also concern that public health officials would not be able to implement any safety protocols or safety protocols known to be effective during that time. So, we endeavored to be much more clear in the recommendations about what happens in that 14-day window. And then we also got some disagreement on what would constitute or what is meant by the term legitimate external factor, so we did remove that language and update it in the recommendation. So, if we go to the next slide.

1:26:03

SLIDE 33

This is the proposed update to recommendation C. So, I'll highlight the core changes which again are or are in orange, and then I'll give folks a moment to read it as well.

So, the first piece is we really highlight what is the scenario that we're talking about here. In a scenario where safety protocols may, where long-term care facilities may be asked to implement safety protocols that are different from those of staff. So as a standard this recommendation says that long-term care facilities should implement the same safety protocols for visitors and staff.

It does identify that there may be unique circumstances of a state of emergency that may impact long-term care facility visitors' ability to follow the exact same protocol as staff. In those circumstances, state departments must issue visitor specific protocols that would allow some form of visitation. So, I want to highlight that edit to really emphasize that at no point does this recommendation say you can have no visitation. It says that state departments have to issue visitor specific protocols. When they

do so within 14 days of issuing those protocols they have to bring together a representative group of stakeholders in a public meeting to discuss those protocols, get feedback on those protocols.

We list out what some external factors could be here, that impact the ability to follow the same protocols as staff. And we've really emphasized a couple core points here. One really big one is that nothing in this recommendation prohibits state departments from responding in a timely manner to legitimate public health or safety risk. It does however require consultation with stakeholders within 14 days of issuing any orders that establish visitor specific protocols.

The next is that nothing in this protocol would allow a full stop visitation for any period of time. So, I have now read through most of this, and I see Catherine you have your hand raised, so Catherine.

1:28:17

CATHERINE BLAKEMORE
Thank you. I think I guess a question because it says allow some form of visitation, and we just finished maybe in a two prior sections ago saying that visitation could be by Facetime or using technology. So, if that's not what's anticipated I think it's important to clarify that. Because what happened during COVID is people would say you're allowed a visit because you can Facetime with your loved one, even though that might not meet their needs. Or you can do a window visit, even though that might not meet their need, and so I'm a little concerned that some form of visitation is too broad to accommodate what I thought you were saying, which is visitation, meaning you get to go into the facility with maybe some different kinds of PPE or something, not that we're now going backwards and saying it can be a window visit for example.

1:29:17

JULIETTE MULLIN | MANATT
Okay appreciate that question Catherine. Let's take a couple more comments and then we can maybe come up with some language. I unfortunately don't know the name, but someone has raised their hand as long-term care facility policy work group panelist, if you've raised your hand.

1:29:34

NANCY STEVENS | RESIDENT
I'm so sorry I forgot to rename myself when I got disconnected and logged back in, my apologies. This is Nancy Stevens, I'm a resident in long-term care, and I've been here for five years. And I think that these things should have been work worked out by now. We lost so many people and I think that resident designate support people should have top tier priority, the same as, you know, the same as staff or government officials or outside health agencies, those types of things, because no one was there to protect us. The last go around, I know this is not just about last go around at all and try not to focus on the last go around, but it's really hard when I lost 80% of my neighbors, who I grew to love very much. And I think that also 14 days is just far too long to convene a public meeting with stakeholders and representatives and government officials, mostly. I think that 14 days is far too long and we should be much more a priority if the decision can be made so quickly to not, or to, if a decision can be made that a situation has arised that it's so, such an emergency that, that they have to figure out how to get resident designate support people in, or if they're going to restrict their limit due to emergency, due to an emergency situation. If they can come up with that as quickly, I think that this particular proposal, or this piece of legislation, or this policy, should be an absolute priority.

1:31:43

JULIETTE MULLIN | MANATT
Thank you Nancy, appreciate that very much. Thank you. Karen, I see you have your hand raised.

1:31:50

KAREN JONES | CLTCOA
Hi, yeah so I kind of feel like we're writing that policy that's what this is isn't it. So maybe we kind look at rewriting this, and that if another visitor restriction is considered, either all these things that we're recommending become the new policy for visitation during a restricted time, or public health officials have five days to convene a workgroup if they want something else, besides what we're all working so hard to create. I mean we're writing it now, you don't know that it needs to be different than what we're writing right now. It just makes sense to say use this when you're

creating those differences or those limitations, or you only really get five days to figure it out, because to convene a public workgroup, as you guys well know is not the easiest thing to do. And trying to come up with this process that you guys have done such a great job with is not easy to do, so why not just use what we're working on so hard.

1:32:57

JULIETTE MULLIN | MANATT
And when you say what we're working on so hard, does that point to A in this essentially or

KAREN JONES | CLTCOA
So far it's A and B. I'm just wondering if C just needs to be rewritten a little bit, just to say use what we've done.

1:33:17

JULIETTE MULLIN | MANATT
Thank you Karen, appreciate that comment. Anissa you've raised your hand.

1:33:22

ANISSA DAVIS | CCLHO
Yes, thank you. So yeah I want to try to get clarity on this. So, we're saying that we've designated RDSPs that we are going to treat as staff, so this particular instance is if we need to limit other visitation, right. So, it's not it's not that group, it's

JULIETTE MULLIN | MANATT
Well, no, so actually, and maybe this is going to answer our whole question for us, because when this was written A did not create that equivalency between resident designated support person and staff. So now that we have established that we're comfortable moving forward with that, having resident designated support person have equivalent access to the facility as staff, I guess maybe it's a question to this workgroup is are we then comfortable with what is, I realize we should have numbered these a little differently recommendation C part (a), without having part (b), that's maybe the question to your point Anissa. Because perhaps if we're creating that equivalency at the beginning I think the question to the group then is what,

where might we need (b), C (b). We shouldn't have used all letters, I'm a little lost, but carry on.

So here referring to if the state for any reason determines the unique nature or conditions of the state of emergency may impact visitors ability to follow the same safety protocols as staff. We have established earlier on that there, we are comfortable establishing equivalency between resident designated support people and staff. Are we then comfortable just saying visitors should not be subject to the same protocols, or sorry, long-term care facilities should implement the same safety protocols for visitors as staff, in like, in light of that and just leaving it there.

ANISSA DAVIS | CCLHO
I mean, there might be times when visitors absent RDSPs are limited.

JULIETTE MULLIN | MANATT
So here we're talking about visitors, the capital V visitor, is defined as RDSPs okay. And then healthcare and social service staff not employed by the facility, and then the third category is visitors that have a statutory right to access facility such as ombudsman, patient advocate, surveyors that type of category.

ANISSA DAVIS | CCLHO
Okay. I think it would be good to call that out. I think it would be very difficult to convene a stakeholder meeting in the midst of an emergency, while you're making emergency recommendations. So, I think if we are able to not have to do that would be best.

JULIETTE MULLIN | MANATT
Okay, and would you then be comfortable saying based on the visitor categories we've defined, we could just say they follow the same protocol as a staff. Can we go back to those categories, can we just look at recommendation A again, to look at who we mean by visitors. Apologies if we give people a little vertigo, here we go.

1:36:46

SLIDE 21

So, this is who we mean by visitors. We mean resident designated support people. We mean individual who have access to enter long-term care facilities through legal, statutory, regulatory, or similar authorities. And then

we mean individuals who provide in-person services to residents such as healthcare workers, hospice providers, paid caregivers, not employed by the facility.

ANISSA DAVIS | CCLHO
And then what we're saying for all of them is again

JULIETTE MULLIN | MANATT
We're saying, the so the question is would we be comfortable saying all of these individuals have the same access as staff and have to follow the same protocols of staff.

ANISSA DAVIS | CCLHO
I feel like in concept yes. I mean I think you know you never know what you're going to have to do for an emergency, but I feel like in concept.

1:38:00

JULIETTE MULLIN | MANATT
Okay, We'll mull that, if you have additional thoughts we can come back to it. I do see Jack has his hand raised. Jack. Can we go back to recommendation C please, while we're doing that. Oh, maybe Jack no longer has a comment. I will go to Colleen then.

1:38:24

SLIDE 33

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS (very hard to hear)
No, I got it, I got. I'm sorry. My thoughts are, and I to put it in the chat that less is more here, because I don't know if C clouds the issue. If there is already equity between, because we're just giving, oh I'm sorry, we're just giving them another opportunity, we're giving another opportunity to stall the process of letting visitors in by putting this. Because the whole assumption that I'm working from is that we are, this comes into play because of emergency, so therefore we already established equity and maybe because we established equity earlier or we didn't have that before it makes the unnecessary in general. Because the whole point of this is that we are creating really established that this only comes into play for legislation that emergency. I'm a little bit confused to having had the earlier discussions about the equity so that's ...

1:39:40

JULIETTE MULLIN | MANATT
Appreciate that comment Jack, and this was definitely written without having had that foundation. So, this likely needs some editing now that we have that foundation, so appreciate that comment. Colleen you've raised your hand as well.

1:39:53

COLLEEN CHAWLA | CHEAC
Yes, thank you. I see it as the equity conversation was about access, and so you're trying to carry that equity principle over to safety protocols as well. And I think that I could support having a single phrase that says something about staff and visitors would follow, would have the same access and safety protocol, would follow the same access and safety protocols.

JULIETTE MULLIN | MANATT
Great, thank you Colleen. Blanca, you've raised your hand.

1:40:40

BLANCA CASTRO | OSLTCO
Can you hear me? So, just wanted to lift up a couple of things. This has been, I wanted also just to thank, really appreciate hearing from public health and the executive associations because this is an important conversation to have. And one of the things I wanted to highlight is, I, what I'm, with the recommendation C or excuse me, yes, the recommendation C the safety protocols even during COVID it was very, it was imperative, and it currently is imperative that all visitors and surveyors, ombudsman and everyone follow the same protocols as staff.

And so, the other thing I wanted to just highlight is during COVID we had regular meetings at the state, with our regulatory partners and other partners with health and human services, and those were the times where we could really identify where the challenges were, what was going on. And so, I would encourage us to stick to, or ensure that there is some sort of this public facing meeting that would include key members of the different organizations that, what we're suggesting, that they already convene, even now, that they be part of the emergency management system, the OES at

the local level. And not wait until an emergency, but have those protocols in place now, so that when an emergency happens there's already a forum and a group of individuals who are ready and prepared to address any of the issues that need to be addressed. So, I don't know necessarily about the 14 calendar days. I think we do need to at least for purposes of the statute have some specific time upon which they should be meeting. But I've, we found that extremely helpful at the state level and it also helped us to determine where the hotpots were, and where, what we needed to do in terms of prioritizing PPE.

1:43:32

JULIETTE MULLIN | MANATT
Thank you Blanca. I definitely appreciate that. It sounds like I just want to make sure I'm capturing this right that would be essentially a recommendation to keep in the report somewhere a recommendation to have public transparent cross department, cross entity meetings, it's just not tied to this necessarily. Got it that's really helpful, thank you. Okay. Eric I see you've raised your hand.

1:44:01

ERIC CARLSON | JUSTICE IN AGING
Yeah. I'm gonna ask a question again. I think that my thought would be that this is ambiguous as to what's intended. If you just look at the language, arguably it means that the state would be loosening the protocols for visitors in it in in order to make sure there's visitation, given a shortage of PPE or vaccination. That's I think arguably reads like, that my sense from the conversation that something different is intending, is intended, that really, that suggest that we wouldn't be modifying the protocols as much as we would be modifying folks' right to have access to the facility. So that's my question. What's the intent here in this provision just putting the language aside for a second?

1:44:58

JULIETTE MULLIN | MANATT
Well, I do think now that we have established earlier on that the workgroup is comfortable establishing equity in access. And it sounds like equity and safety protocols between staff and residents, we may not need this provision. The intent of this provision was to, the kind of example that we

were thinking of in our head as we drafted this, was the example where vaccines are rolling out and maybe there's a 3-week window where not all visitors have vaccination yet, and so maybe staff is increasingly going to be required to be vaccinated, or there's going to be some type of vaccine requirement that can't be enforced for residents. And so, an alternate way to be able to enter the facility is made available to residents. That was the example we were gaming through. But I think what we're hearing now is comfort with saying that the protocols themselves can have parity and should be written for consideration both on the staff side and resident side of, you know, a vaccine rolling out for instance, and having multiple options for safety protocols for both staff and residents during that time.

1:46:14

ERIC CARLSON | JUSTICE IN AGING
Yeah, I think that when you read it now, just, I think, I'm maybe repeating what you just said to a certain extent. It's contrary to what we've discussed for the last hour saying that there should be general equivalence between the two populations. And then I'd suggest that if we, regardless were to go through with some language like, this that it'd be clear that this is meant to be of assistance to visitors, designate support person as opposed to an authorization to restrict their access to the facility. But again, I go back to your original point which is that maybe you don't need this if treated equivalent then what's the point of suggesting what you do when they're, when they're not equivalent.

JULIETTE MULLIN | MANATT
Exactly. yeah and I think we'll do a pulse check in just a moment, but I see that George has his hand raised so I want to give George a moment to provide his comments before we do that.

1:47:15

GEORGE KUTNERIAN | 6 BEDS
Hi, so I just, going off this, piggy backing off this conversation was legitimately actually confused then. Because I was under the impression that this part (b) was a mechanism to be more stringent or tighten up visitation for the designated person. So, I think other people probably shared that confusion as well, based on the conversation we've been having for a while now. So, I think either that this language has to get either clarified or I think to some people's point, and I actually agree with it if we're

you know putting the designated support persons on parity with staff, and we're also making them a prioritized group in terms of access to PPE etc. then this might not even be necessary.

1:48:13

JULIETTE MULLIN | MANATT
Thank you George, appreciate it. I think we're hearing pretty clearly from the workgroup that we may not need what is section (b) of this recommendation. So, I would like to take that to do a brief pulse check with people to make sure that reflects how people are feeling. If we go ahead and open up a new pulse check survey.

1:48:38

Would love for people to react and we'll drop in the chat, my colleague Caroline will just drop in the chat what we're asking people to react to, which is would you be comfortable moving forward without part (b) of that recommendation. Which is to say saying that staff and visitors follow the same protocols.

1:49:31

Colleen is raising a point that I'll just lift up and articulate about whether recommendation C is even needed if we've established parity and access at the beginning. We may merge the two in the final version to your point.

1:49:50

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS (very hard to hear)
I'm sorry are we still discussing this point (b) to keep point as stated?

JULIETTE MULLIN | MANATT
The question is are we comfortable removing section (b) from this recommendation. So, this recommendation simply says visitors and staff follow the same protocols.

Thank you. No, I apologize we didn't think about this when we use multiple lettering systems and it's very confusing as I'm saying it out loud.

1:50:50

All right. I'm seeing the numbers get pretty stable, so I think most folks have voted. Apologies, I shouldn't actually refer, this is a pulse check statement and we'll be incorporating everything into our recommendation document. Okay. And most people have indicated their level of support for this, and it sounds like we can move forward with making this update to the recommendation.

I want to thank everyone so much for how truly collaborative the last hour and a half, I'm losing track of time a little bit here. Two and a half hours have been this is this has gone very well. We've actually made up a fair amount of time in the last recommendation because we were able to kind of work through some of the conversation by establishing that, that parity principle in recommendation A. So, we're going to go ahead and take a 20-minute break at this moment in time. It is currently 2:35, so we will come back at, or sorry it's not 2:35, it's 2:38. So we will go ahead and come back at 2:58. And we'll, I'll come back and kind of guide people to come back to their computers at that time. So, thank you everyone. Please take a 20-minute break and we'll see you back in 20 minutes. Finish your snack, wherever you've walked off to, and please come back to your screen so that we can continue our conversation today.

1:52:36

All right I'm going to do a little bit of a recap of our conversation to date and then we'll dive into the next recommendation. So, we've talked through three core recommendations, and made just tremendous progress as a group, and a really collaborative discussion. And I just want to thank everyone for the conversation that we've had so far and hoping we can carry forward this progress in our last couple hours here.

Our first recommendation we talked through looked at the designation of visitors, and a really key point of alignment in the workgroup coming out of that first recommendation, is that we would make an edit to the recommendation to state that resident designated support people have equivalent access to a long-term care facility as staff. So that concept of parity was established in recommendation A and was a really critical edit made to this work group that we're now carrying through in recommendations as we move forward.

In recommendation B the workgroup aligned around a recommendation to state that in any situation where state, county, or local authorities are directing and prioritizing emergency supplies in a state of any kind of strict limitation of supply, that long-term care facility res, sorry long-term care facility visitors, be considered a priority group to receive those supplies.

And then finally in recommendation C we discussed safety protocols where we really pulled through the concept of parity that we established in that first recommendation and aligned on a substantial edit to recommendation C, to simply state that long-term care facility visitors including resident designated support people must follow the same safety protocol as long-term care facility staff.

So those are our first three sets of recommendations. We've had a really great conversation to align on those three recommendations today. We're going to move into recommendation B, or sorry D. I am losing track of letters and numbers. I apologize recommendation D.

1:54:55

SLIDE 39

And so, in recommendation D this is where we talk a little bit about any parameters to visitation, that may need to be considered in a state of emergency where visitation is being curtailed, or impacted, in any way by that state of emergency. So, we've already established that a resident designated support person has access to enter the facility akin to staff, and that they have to follow the same safety protocols as staff.

Now we're going to talk about any additional parameters that may be permissible for visitation. So, we've talked through a couple iterations of this with the workgroup. In version one a big piece of feedback we got was to be really clear that when we talk about visitation we are talking about in person visitation as the standard.

We also talked through, again we had a similar process in recommendation D as the one we just talked about, which was this ability, this process through which the state departments might establish a set of additional parameters to visitation, and what it would look like for them to do that. So, the recommendation from the workgroup is that if we were going to have that type of process it had to be at the state level, and that the work and that, the state departments would need to convene a stakeholder group

much sooner than 30 days. So again, there was a recommendation to reduce to 14 days here.

So, we're going to take a look at all of that and think through how our alignment on parity maybe impacts anything in this recommendation if at all. If we go to the next slide.

1:56:37

SLIDE 40

We circulated an updated version of this to the workgroup, version two. I'm not going to spend too long summarizing the feedback because I think we'll just talk through a lot of it in a moment. But some of the key pieces here, again, was concern with what happens in that 14-day window where the state is required to, where the state is convening a stakeholder workgroup. And there's kind of, again, here, there was concern that it would impede the ability to take effective safety measures to protect residents. And there was also a concern that it would functionally lead to a situation where there was no visitation during that period of time. So, if we go to the next slide.

1:57:22

SLIDE 41

I'm taking us through quickly because I think we'll have a good conversation here and build on where we've been. So, this, again, this recommendation talks about parameters. So, we've established already in our recommendations that resident designated support people can visit on par with staff, following, they can access the facility on par with staff and they can, they must follow the same safety protocols.

Here we're looking at a couple, additional considerations that may be unique to visitors compared to staff. So, one might be the locations in which they can be within the facility. The recommendation here is that we have a set of standards that are generally used for all of these parameters, and then in any situation where those parameters may not work at the state level, that state departments would establish specific parameters for that pandemic in consultation with a representative stakeholder group.

The standards would state first that a long-term care facility visitor must be able to see residents in person in a location that is accessible for the

resident and visitor as a standard. Generally, this should occur in a resident's room, although steps should be taken to ensure privacy in the case of a shared room.

The second is that hours of visitation must be daily. And then this was an edit made based on kind of rounds of feedback we got from folks to say that it must be at least as expansive as those required of a long-term care facility outside of a state of emergency. Those requirements may vary by facility type. And so, this acknowledges that there is a current set of requirements around hours of visitation, and those would still apply in a state of emergency.

All right. So, I'm going to pause here, and see if, oh I I've lost my participant panel, sorry excuse me, this is what happens when we go on break, I lose my line. There we go, okay. So, I'm going to pause here and see if there are any immediate edits or recommended changes to this set of parameters. So, this establishes baseline parameters that should be used in a state of emergency and says, if for whatever reason this is not a possible set of parameters in a state of emergency, you have to convene a stakeholder group to have a conversation about the parameters you are using. Anissa, so you raised your hand.

2:00:10

ANISSA DAVIS | CCLHO
So, like the other recommendation, I think convening a stakeholder group before you make decisions or right after you make decisions, I think could be really difficult. It might be really unfeasible. And then as far as A(i) here, that the location, let's see, that it should occur in a resident room. That may be challenged by the nature of the emergency. So, I do feel like in general that should be the goal, but it could be that there's public health issues going on for the facility that may preclude that or preclude like the amount of people that might be able to congregate in the room or what have you.

2:01:02

JULIETTE MULLIN | MANATT
Appreciate that Anissa. I think part of what we were endeavoring to do with this second part of the recommendation was acknowledge that those situations may happen, and set a way in which we could address those. But, hearing you that a, that there are challenges around that kind of rapid

standing up of a workgroup in a time of pandemic or other state of emergency. I'm going to come back to this one in a bit but definitely welcome any specific suggestions on a different way to approach that. Jack I see you've raised your hand

2:01:40

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS

The, so the intent of this was, if we, if we ran into a situation where there was a need to limit visitation, right. So, in simplest logic we say, okay you can limit it for up to 14 days. What I'm not seeing in this, and I think that what's where I'm kind of concerned about 14 days, is, what happens if you can't reasonable or unreasonable, what happens if you can't convene something in 14 days, and you can't get a resolution within 14 days. I just don't want to put out the, you know, we don't want to have legislation that doesn't anticipate, you can't promise something that you cannot for sure deliver.

And what if you can't deliver it? What's the recourse? That that's kind of my concern because, one, you've already, you have you've already been established the authority to somewhat limit it for a short period of time, you tried to put in a safety net so that something's happening during the short period of time, but the reality may be nothing gets decided with in that window. Do we need more language, or do we need less language? I, me, you know, here where we go again, I know we talked about arbitrary numbers for the PPEs and .. You know, what is 14 calendar days versus 14 business days? So, I'm just thinking. I don't know if you decide first, I flip it on its head, you have to decide first that you're going to limit it, before you limit it and then take 14 days to decide whether your decision is, when you want to equal. But in the meantime, we've already created equity, so somebody's got to be going into the facilities that we, the staff are going in there and if we're making the visitors equal to the staff then as long as the staff are going in there why can't the visitors continue to go in as usual, during the emergency, until something has been established that's been thought out. Because this is the other way around. You're going to allow all the staff to come in or keep coming in as they usually do, and then take 14 days to decide how you're going to limit everybody else, while you're still limiting everybody else. I don't know if that helps, I'm thinking out loud actually sorry but that's kind of what I'm trying to do.

2:04:51

JULIETTE MULLIN | MANATT
Yeah, so I think maybe I can offer an example of what this might look like, what this might apply to for example and maybe we can pull that thread through. So, a potential example, probably should have thought of one ahead of time, so I'm going to do one on the spot here. Is that you may have a scenario where the, you know the airborne nature of a virus and the demonstrated effectiveness of PPE for that particular virus suggests visitation should happen in separate rooms. So, like in the particular example of a shared room for residents you may have a situation in a pandemic where you say visitation really shouldn't happen in a shared room, it should happen when the roommate is not there. As we don't necessarily want to set that as the standard that you always have to have it without the roommate there, but there may be a situation where the state Department's Public Health officials are really advising that in this particular pandemic there should be really strong measures taken to make sure that the roommate is not in the room, or if the roommate can't leave the room that the visitation happens in a place outside the room where the roommate isn't going to be there, for example. In that particular case if that's non-standard, it doesn't prevent the fact that visitation has to happen, but there may be a parameter that is unique to that state of emergency, and this would be the process through which that parameter would be set. That my example was not great just now, I'm I see Karen's raise her hand maybe she'll have a better example. But that that is that is what this is intended for it's not to prevent visitation or to say it can't happen it's to potentially say there might be a unique parameter in this pandemic that is needed and what would be the process for that parameter. Does that help at all Jack or not really?

2:06:53

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS
No, I think, it's I mean, I think I think as long as it doesn't, because again, the more I thought about it, the whole, that was a very pivotal point, when you equate the visitor capital V, the RDSPs, with the staff, it kind of makes you think about all these other question is a little bit different. Because then the staff wouldn't necessarily be able to be congregating around somebody with you know they have to wear a special respiratory equipment for

somebody air, so that's kind of where I'm thinking but, yeah, no you're you you're right I mean your example was, got us close.

JULIETTE MULLIN | MANATT
Thanks Jack I appreciate your comment, and definitely hear your point about pulling that parity thread through and where does it take us. We'll go next in the line and see what Karen thinks. Karen.

2:07:54

KAREN JONES | CLTCOA
I'll just fix the whole world. So, I just wanted to remind that you know a lot of the folks who needed those in room visits during the pandemic, had a roommate who couldn't leave or wouldn't leave. And that means that that person couldn't have a visit if the resident also couldn't leave the room. So, anyone who was bedbound or was incredibly hard to get out of bed was really missing their visitors more than, or their person, more so than even the residents who could get out and go to those common visiting rooms. And it's really important to me that we do not let you know the location be the thing that stops someone from getting a visit. Because I can tell you from an ombudsman perspective roommate issues are huge, you know do they want the TV on or not, do they want the light on or not, and do they want to leave to allow their the room to allow a roommate they may or may not like to have a visitor, they're not doing it. And so that roommate's now making the decision of whether or not there be a visitor and again really unfair because folks who are bedbound need the most assistance from their family, or from their visitors. So, I really highly recommend not putting a limit on letting people have in-room visits even during an emergency.

The other thing that kind of occurred to me suddenly was maybe we should think about when we're looking at this we've talked about limited PPE, there's a lot of staff in care facilities who do not give any care. And maybe that's a place we can save PPE. Is have them work somewhere where they don't need PPE, away from the facility, you know billing folks they, they're not doing any care, a lot of admin folks, records folks don't need to be physically in the building using PPE. So that may be an option for using PPE for those designated visitors.

JULIETTE MULLIN | MANATT
Thank you Karen. Nancy you've raised your hand.

2:10:02

NANCY STEVENS | RESIDENT
I just think that if we're looking at resident designated support people having the same access as the staff, the staff are going in with the residents still in their rooms if there's two in the room or three in the room or however many it may be. I just think that you know having the restriction there, having any restrictions there goes against what we have already decided on as a group. That will have the that resident designated support people while have the same access to their loved ones. And so yeah that's all.

JULIETTE MULLIN | MANATT
Thank you Nancy, appreciate that. Tony.

2:11:01

TONY CHICOTEL | CANHR
Yeah, hi, how's it going. Just want to speak a little bit in support of the idea of the 14-day stakeholder requirement, stakeholder group requirement. I've said a couple different times in these meetings that I think it's really important if we're going to have limits, any limits to what would be normal visitation and access that there be some process that's sort of, that we all agree is a fair and quick process to get to the best decision in a very short period of time. And really what I'm think, when I read this requirement I'm seeing like finally a step to, not just for like good policy, but responsible policymaking, to include the voices of the people that your policies are impacting the most. And this is something that was really dropped during, you know, the first six months to a year of COVID visitation restrictions is public health officers did not reach out to residents, they did not reach out to advocates, ombudsmen, and get their input, and I think the policies really suffered as a result of that. And felt really and felt less fair and less deliberate as a result. I think 14 days is an eminently reasonable time, maybe too long of a time for the policy makers to just seek the input of the people their policies are impacting. This, that's what, and that's what I see this this function here is to just get responsible input for your decision making.

2:12:46

JULIETTE MULLIN | MANATT
Thank you Tony, appreciate that comment. We've heard some questions about this recommendation, I have not heard, or some kind of general comments around how it fits into the broader framework we've talked about. I'm wondering if anyone has any particular edits they want to recommend to this at this stage. Anissa.

2:13:44

ANISSA DAVIS | CCLHO
I don't really have an edit, I'm just not, I don't know how feasible it's going to be. And I understand this pandemic was very long, and there were a lot of moving pieces. So, I don't know that if we would have been able, if the state was able to do a 14-day stakeholder meeting, how applicable that might have been, like two more weeks down the line, or a month or three or four months, once the vaccines got here and things like that, like there were always you know so many different things. So, I don't really have an edit, I just feel that it's going to be a heavy lift to have the state every time they need to make a decision to have to convene. I feel like it's like when we have to rapidly deal with these other emergencies which are more, are shorter I do understand that, but you kind of have to take the information you have and make a decision and kind of go from there, and so I do feel like it's difficult to do it to convene all these things.

2:15:07

JULIETTE MULLIN | MANATT
I think maybe one important well, clarification and I'll ask if this helps. Is the, this would only trigger the 14-day need, like that timeline, if for whatever reason, the state wanted to issue an order saying that the parameters that are listed here around seeing them in person, and around visitation being daily an equivalent in time frame is what it currently is. They would only, that 14-day clock would only start, if for whatever reason the state said one of those two things could have been true, for the resident designated support people that we've identified who are already following the same safety protocols as staff. Jack I see you've raised your hand as well.

2:16:09

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS
Yeah I think that it's. The way it's written now is I think I agree that that with a previous comment that nice to have the input. I can also see how practically there are maybe some challenges because you have to decide which stakeholders and how broad. I think where I'm struggling with is how broad, that the policy may apply to such a broad area, that there may be some differences between even stakeholders. So, there's that the practice. And then I guess the last part of it is that, you know, it's I just don't want anybody to think that just because there's input that it always affects the outcome. And that's all this is saying, is that you'll get some input from some group of people within a certain time period. So really there's no guarantee that any of that input will drive a different proceeding. I think that that's where the, maybe some disappointment. But that's the reality we need so that's just kind of where my thoughts are. But yeah as it stands it makes sense, if that if something has to be really out of the norm that everybody becomes transparent as to why there's some sort of stakeholder group that can provide some input I think that's what this is saying.

2:18:09

JULIETTE MULLIN | MANATT
Yeah it is really intended to focus on the transparency, the collaborative nature that you're getting input, that is the focus of this one, yes. Maybe part of the question for folks to consider is to just take a look at those two standard parameters that are listed here. And do we foresee a situation where those, establish, having established already parity and being able to enter the facility, and parity in being able to do safety protocols, you know do we need to define these parameters for long-term care facility visitors acknowledging that we've established that parity, and are there any situations in which we would foresee with that parity in mind these parameters might not always be possible. Karen you've raised your hand. Maybe not to answer the question I've just asked but that's fine.

2:19:14

KAREN JONES | CLTCOA
Yeah, well maybe it's close. But I think, you know, I think Jack had a really good point that you know input doesn't mean policy is going to be exactly what we want, and I think that's a good reminder also. But I think either

there's a requirement that the plan, and I think Nancy pointed this out also, is created ahead of time with some minor room for adjustments so that we already know, if, you know flesh eating bacteria breaks out in a bad way, or RSV, or whatever is going around there's already a visitation plan in place to protect residents, folks, staff, the visitors, the public, so we've done it in advance. Or we make it hard to destroy people's, so, you know, civil rights that normally takes a judge and a hearing and lots of attorneys to do. You, most of us cannot, and I know it's normally a public health ability, but you shouldn't easily be able to take away people's civil rights. So, let's keep it hard if there's going to be this taking away of rights even though it's for their own good, that's very paternalistic, and we don't want that to be a simple process. So, I would prefer not to have any limitations, but if we have to have something let let's make it work right.

2:20:38

JULIETTE MULLIN | MANATT
And Karen, just to clarify then do would this achieve that in your mind?

KAREN JONES | CLTCOA
I think it would make people who can make easy decisions think harder about making the easy decisions. It is so easy to say, we just won't allow visitors. It is so easy to say, I've never met these people but I'm going to make these decisions for them. And not think about all that they are and that their humanity is being affected. So, I think this is a better option, but personally I'd rather we have a plan ahead of time that is kind of bot off. We, we're doing a lot of that here, but let's make the actual plan. It's not that hard, and it's so much easier to make a plan when you're not in a crisis. And be the part of the legislation, you know, whatever the bill is going to be let's make it part of the legislation so that the plan is already in place, with just again, minor changes, is it transported by air, is it out and about because of touch. You know PPE kind of covers all that stuff and some of the PPE really sucks, like face shields oh my goodness, but still better than getting COVID. So, I think we could do it this group is working really well but if we can't come up with a plan as part of the legislation then let's have a hearing so people who make those decisions have to hear from the people being affected by it.

2:22:06

JULIETTE MULLIN | MANATT
Thank you Karen. Eric.

ERIC CARLSON | JUSTICE IN AGING
I suggest that the current language may be a bit ambiguous. In (a) there's a discussion of standard parameters and under that it talks about where the visitation occurs and the hours of visitation. And if you go down to (b)(iii) it says nothing in this recommendation would allow a full stop. But arguably if parameters just mean location and hours, that's the only thing that could be changed here. But there's a, but because the word parameters itself just out of the dictionary is broader than that, (b) seems to just open up everything potentially, and I don't know our conversation here may be contemplating that it would be broader than that, and the limiting parameters could be setting all sorts of limitations, that maybe would go beyond, where do you meet people, in what are the hours in which you can access the facility. So, I think it would help to have some real clarity there. If we're talking about location and hours then we should say location and hours rather than talking than tossing around the word, unless we define parameters as explicitly including only those two things, but absent that there should be some clarity here otherwise it just throws the door wide open and maybe in a way that we're not intending.

2:23:51

JULIETTE MULLIN | MANATT
Thanks for that comment Eric. I think as written it was certainly intended to speak to hours and location. If folks feel there are other things that should include please let us know, but if not we I think we can make that refinement. Nancy you raise your hand.

2:24:09

NANCY STEVENS | RESIDENT
I put it in the comments, but I think this is really important so I'm going to state it as well. I was wondering if we can change the words should, like for example this should occur in a resident's room, if we can change the word should to shall, to make it more definitive and make it more of like a policy statement, or something to actually abide by.

2:24:39

JULIETTE MULLIN | MANATT
Okay. Thanks. I think the one thing I just that came to mind as you were saying that to me, is we wouldn't want it to limit visitation to the residents room, right. So, yes we might need to add a couple additional words there but tracking that statement definitely. Thank you Nancy.

So, I'm hearing generally that people are okay, and please raise your hand if what I'm saying you don't necessarily agree with. People are okay with this general framework of saying these are the standard rules, per se, for location and hours of visitation. If we're in a situation where we want to recommend, where state departments want to implement different hours or different locations of visitation because of a legitimate public health risk, they would be required to convene a public group to discuss those parameters and take input from a variety of stakeholder groups to have that collaborative policy decision-making that we were talking about earlier. Colleen, I see you've raised your hand.

2:26:34

COLLEEN CHAWLA | CHEAC
Yes, are you talking about in advance of implementing any changes?

JULIETTE MULLIN | MANATT
In this particular situation we're saying, what's stated here is that it would have to be within 14 days of implementing the changes. So, it doesn't prevent timely response to a legitimate fast-moving issue, but it does require consultation very quickly with stakeholders.

COLLEEN CHAWLA | CHEAC
So, I agree with Dr. Davis earlier that that putting this requirement in the middle of everything else that's going on, especially if we've already talked about parity, I'm not sure. You know, it's hard to predict what the, what the emergency is going to be. But it would be, I don't think that I can support that as written.

2:27:26

JULIETTE MULLIN | MANATT
Okay, thank you for that Colleen. I see Cassie you've raised your hand as well.

2:27:32

CASSIE DUNHAM | CDPH
Yeah, hi this is Cassie Dunham from CDPH, and I just want to first qualify my statements that, I can, I can weigh in from the Center for Health Care Quality perspective but certainly cannot be presenting the department as a whole, because we have a number of other centers that in a in a major public health emergency or even in a small public health emergency that affects limited groups of individuals, the response and the involved parties may be different, and those centers certainly would weigh in from a different perspective. Logistically coordinating I think a stakeholder meeting, I'm certainly you know from the CHCQ perspective not opposed to something like that, but the logistics of bringing it all together and collecting input and trying to do that under the pressures, as I think Colleen and Anissa alluded to, may present its own challenges.

And then the other thing that I would just encourage folks to be thinking about that in situations like this where there's you know a need to make an emergent decision, sometimes there is a need for flexibility in the sense that we need to be planning also for the things that we would never expect to happen, right. My experience has been that what I can predict are typically not the circumstances that we face, it's the things that we didn't think about. So, with that lens you know being mindful that there may be limits on what we can accommodate under an emergency situation where critical decisions have to be made, you know life-saving decisions in a at a moment's notice. So, you know our full, you know, intent of participating in this group is certainly to respect the rights of folks and make sure that the visitation is not taken away. We know that it had severe impacts, but I would also just say that let's avoid thinking of things in the in the perspective of either comparing them to COVID because it's you know COVID is we've managed through that now expect what we're not going to expect in circumstances being very different in another emergency, and then how do we facilitate decision making around that. But yeah, I personally from the CHCQ perspective I think logistically pulling off a 14-day stakeholder meeting would just be difficult, not necessarily impossible.

2:30:16

JULIETTE MULLIN | MANATT
Thank you, I appreciate that. Catherine.

CATHERINE BLAKEMORE
I just note that it says consultation with stakeholders. I don't think there's anything that says it has to be a meeting. And having a process by which if you're going to restrict something beyond what we understand to be the standards, why would you not in a 14-day period want to consult with stakeholders. I guess, I'm just, I'm confused by the assumption it's a meeting, I'm confused about why you couldn't come up with some creative ways to get stakeholder comments, and hear the perspectives of people that, or their representatives that might be affected by that decision.

JULIETTE MULLIN | MANATT
Thank you Catherine. Maitely.

2:31:18

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I guess I'm just confused. Are we talking about all visitors right now, not RDSPs. Because I, earlier in the session we established that we all liked the concept of RDSPs being treated, you know, given equal access as staff, with equal you know infection control protocols in place. So can you explain is this just general everyone visitation other than RDSPs.

JULIETTE MULLIN | MANATT
So, this, this, as written would apply to RDSPs. It was written before we aligned on that recommendation though that we would consider our RDSPs as having equal access to staff. So, it is certainly a question for this work group to answer is, do we need this all of this recommendation if we've established that parody.

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
Yeah, thanks.

2:32:12

JULIETTE MULLIN | MANATT
George.

GEORGE KUTNERIAN | 6 BEDS
Thanks. Yeah, I was just going to actually say the same essentially the same thing. If we're pulling through the threat of RDSPs being on parity with staff, then I don't know why we, why we need this. Why we need at least (b). I mean if (a) we want to clarify you know hours have to be the

same as they would otherwise be, you know I could see that (a) maybe is needed I'm not sure we need (b) though. Just my two cents.

JULIETTE MULLIN | MANATT
No, I appreciate that George. I think I think that is a question for the workgroup is if we've established this concept of parity, do we need one or either or any part of this recommendation, if we've already established that that parity earlier. Catherine.

2:33:14

CATHERINE BLAKEMORE
I guess the question for me is to the, in, do the entities that were concerned about getting stakeholder input in 14 days think that if we just leave it with parity, then that means there can't be any changes. Because the conversation has in both discussions said well what about Ebola or what about these other things, and I guess it leaves me wondering whether DPH or someone else believes that, fine get rid of (b), but we still have our other authority, and we could do this, and we don't need to consult with anybody. So that's the risk to me, like it's great to say there's parity and we can all agree with that, but then does that really mean there's parity and there won't be changes.

JULIETTE MULLIN | MANATT
Thank you Cathleen. Maitely.

2:34:11

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
My comment applied to (a) and (b). Because (a), if staff is going in at any hour that they're needed, and you know, that's any hour of the 24/7 week, right. And they also are giving, providing services in the privacy of the rooms, then why is this even a question now? Even section (a).

JULIETTE MULLIN | MANATT
Thank you Maitely. George.

2:34:51

GEORGE KUTNERIAN | 6 BEDS
Yeah, I would just say facilities do have, are legally allowed to have visitation hours. So just because staff is there 24/7 that's not always the

case with, for, I come from RCFE world so I can only speak in the RCFE world, but we are allowed to have established visitation hours and they are not necessarily 24 hours. So just want to put that out there.

JULIETTE MULLIN | MANATT
Thank you George. Nancy.

2:35:25

NANCY STEVENS | RESIDENT
I think that this policy makes that distinction between regular visitors or normal visitors to resident designated support people to have a different type of access. So, it's not, I don't think this would fall under, you know facilities ability or right to have visitation hours per se. I think this this whole policy is intended to make sure that there's a different category of people who can enter, not regular visitors. And then I also think that this is really unnecessary because it does leave too many loopholes for contradictions of previously stated policies or recommendations.

2:36:21

JULIETTE MULLIN | MANATT
Thank you Nancy. I think just one clarification on this one before we go to the next comment. When we used the term capital V visitors, that is intended to encompass resident designated support people. So just want to be clear on that that as written right now this would say visitation hours could, like can adhere to the exist in state of visitation hours for those individuals essentially.

2:36:52

NANCY STEVENS | RESIDENT
Can I make one more quick comment. My video is disabled, so I'm not able to smile or wave at you all. But I just wanted to say that, oh thanks, yeah I just wanted to say that, oh I lost my train of thought for a second. Go back to my, I think I might have put it in the chat, I know that the chat has gone over, but yeah. Oh, if staff have to care for a resident outside, like if there's a need, like a health need for a resident to be outside to be able to receive care from their nurses or nurse aids, then that should be the only time that a resident should be forced to either choose to have a resident designate support person in, or to go outside and have their RDSPs.

JULIETTE MULLIN | MANATT
Thank you Nancy. Maitely.

2:38:06

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I just wanted to thank George because he makes a very good point, people residing in long-term care skilled facilities, they have 24/7 rights to visitation with people that they choose, their representatives, their family, people close to them. RCFEs have, are living in the ice ages where we did not have such rights for people, and it makes very little sense. And this is a very important comment we need to make and also potentially fix right now, by ensuring that inequity is squashed.

JULIETTE MULLIN | MANATT
Thank you Maitely. Jack.

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS
Yeah I'm just back to the just kind of, just want to reiterate the point. Just to help us move forward. That as its stated now I don't see it as really restricting anybody's ability to visit, because of the parity, if you were to take it all out you'd still have the parity. I think part (a) establishes to me that there's a minimum standard that must always be met. But again because of the parity if staff is there then the RDSPs can be there.

I don't know what (b) is, I don't know what would be a legitimate operational safety consideration that wouldn't apply also to staff, right. So, it would have to apply to everybody, with or without, (b) so I think yeah, I agree that it's not clear to find what kind of input or how they could get it, but I think that this meeting is indicative of how transformational the pandemic was and that a Zoom meeting like this can be convened relatively quickly. We're not asking people to get in their cars and drive up to a conference room. I don't know, I just, I think this is one of those things that if in my mind if you left it as is, or took it out, I don't think it is, it's not, it doesn't affect the overall policy. I'm just, I'm just still focused on the fact that I think that was a game changer, the equity thing. If staff are going to be in there and an authority comes in and says, well we're going to change some of these visitation issues regarding the room where and hours, I don't know how it applies to the RDSP. It definitely applies to somebody that is a lowercase visitor but not to the RDSP or the staff.

2:41:20

JULIETTE MULLIN | MANATT
Thank you Jack, I appreciate that. I think we're hearing, I, so I'm going to reflect back a few things. I think we, I have heard a few people comment that there is value in having a process for collaborative policy conversation. I think Blanca made that point when we were talking about the past recommendation as well. It doesn't have to be tied to what we're talking about here, it can be a broader recommendation of this workgroup that, in states like, in situations like this stakeholders should be talking to each other about visitation policies, and it should there should be ongoing collaborative policy conversations. So, I'm hearing support for that, and to keep that in broader recommendations, not necessarily tied to this ability to create non-standard policy. Just a recommendation around ongoing collaboration.

I think the core question then become here, I think one of the core ones I'm actually hearing get raised up a little bit here is about this question of hours. I will say we did survey folks around what hours of visitation people recommended and there was a very wide divide in the group. The recommendation was to say that at least in a state of pandemic you cannot restrict beyond what is currently available in a non-state of pandemic, or non-state of emergency.

I'm hearing some recommendations to potentially leverage these recommendations to be more expansive than that, but I'm not necessarily seeing, I think maybe I'll pose that and see if folks have any reactions to that, or any additional comments they want to make to that. On the hours of visitation and potentially providing a recommendation on what they would be that is different than what is the current state outside of a state of recommendation, a state of emergency. Maitely.

2:43:51

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I just want to share that during a COVID outbreak my mom had CDIF, and people were not going inside, they didn't have the booties and the other contact precautions available immediately. I ended up finding it on Amazon, and I lived in her room for about three weeks, almost non-stop, 24/7. And so, hours to me are a moot point and also a potential restriction that could harm someone. I'm really fortunate that I was in a place where I had some

leverage, if I did not, like the majority of people, I don't know what would have happened to my mother. Because no one was going in there to change her and I don't know if you know about CDIF, but it's constantly coming out, there's a very acidic diarrhea constantly coming out, it creates a major risk to the skin, and infection, and dehydration, and just on and on and on. And if they're not going in or just staying with her, consistently through that time there is no, I don't know how she would have made it through. So, I'm just telling you that there are situations that we have to consider that do not, that could be very harmful to a resident if we try to restrict to certain hours or locations.

2:45:14

JULIETTE MULLIN | MANATT
Understood and appreciate that Maitely. Mark, I see you've raised your hand.

MARK BECKLEY | CDA
But yeah, I mean I think for the purpose of this workgroup, if we're saying that the resident support persons have, you know, the same hours as they would standard, that would seem to be within the group. I hear you know questions or concerns about RCFEs being on priority with say skilled nursing facilities and other facility types, that's beyond the scope of this workgroup, so that would be a separate discussion with other, you know, other groups of stakeholders. So, I don't, you know, I don't think that's within this group to really discuss. But I think as written if we talk about just standard visitation hours and having parity with the staff, I mean, just like what the current standard is, I think we're fine,

2:46:19

JULIETTE MULLIN | MANATT
Thank you Mark. So that would be moving forward with the first part of this, but not the second part of this. And then noting in the report that there was a discussion about this for consideration, around the hours but acknowledging that it's what, from what I just heard you said not necessarily in the scope of this workgroup, to put forward recommendations for visitation outside of states of emergency, is that right? Okay, appreciate that Mark. And I will, I do just want to note, I know Mark went over this at the beginning but there will be the final report on this. We'll

have areas where we can elaborate on questions like this, and so, that the areas that don't necessarily end up being words put into a recommendation can still be addressed and noted in the report as well. Any additional comments on this? So, I am tracking, this would be keeping (a) and, like keeping the first part of this recommendation and removing the second part of this recommendation. Ellen you raised your hand.

2:47:49

ELLEN SCHMEDING | CALIFORNIA COMMISSION ON AGING (CCOA)
Yeah, I would just say that there's an advantage to having clarity in (b) around the 14-day workgroup that's coming together, so unless this detail makes it somewhere else, I would recommend keeping it in, somewhere.

JULIETTE MULLIN | MANATT
You mean the general recommendation around having a workgroup that

ELLEN SCHMEDING | CALIFORNIA COMMISSION ON AGING (CCOA)
Who is in it, you know, there's quite a bit of specificity as to who's in the group, why they're coming together, so maybe it's a standalone recommendation about that group. I don't think we're saying that that group doesn't need to meet because the two are equivalent staff and visitors.

2:48:27

JULIETTE MULLIN | MANATT
Got it. Thank you Ellen. And so that would be a recommend, still having a recommendation that is separate from this one, around ongoing collaboration in a state of emergency with some specificity that's included here. Great. I think with that we can go into the next recommendation. We can go to the next slide please. Thank you.

SLIDE 44

2:49:01

And before we go to that next recommendation, I am just going to take a moment to open to public comments, around any public comments around the conversation we just had on hours and location of visitation. Teresa let me, you should be able to unmute yourself.

2:49:22

TERESA PALMER
Yeah anything that has 14 days in it, at the expense of visitation is dangerous, and should be jettisoned. And so, I think (b) in this recommendation should just be abolished. I agree with Tony Chicotel that there, you want to have some kind of due process, but not at the expense of equity and visitation. Thank you.

JULIETTE MULLIN | MANATT
Thanks Teresa. And just to clarify the consensus was to remove the second part of that recommendation. Just to make sure everyone's tracking that piece too. All right, I'm referring to it a second part of the recommendation because there's so much lettering that it becomes confusing. This moves us into recommendation E.

SLIDE 46

2:50:10

So, this is actually a recommendation that was included in initial versions of these recommendations around having a specific recommendation that expands visitation parameters in the case of compassionate care. So, we've made a few iterations on this, one was to really elaborate on the situations that this would encompass including to really emphasize that this is not a facility determination. However, we have had kind of a recurring theme of people not really being certain if we wanted to have this recommendation, and we wanted to have a compassionate care recommendation in the recommendations of this workgroup. So, if we go to the next slide

SLIDE 47

2:50:56

From version two to version three, we again, got some questions about whether or not we needed this recommendation, and some feedback from some workgroup members to remove it. We also got some feedback on some refinements to a recommendation on compassionate care, were the group to decide to keep it. If we could go to the next slide

SLIDE 48

2:51:15

The actual recommendation for compassionate care is listed here. I think the core thing I'm just going to highlight that this would do, if the workgroup were to put this forward, is essentially this recommendation recommends that visiting parameters which is specifically to say the number of simultaneous visitors, which we've talked about, be expanded to enable compassionate care, as well as visiting hours. So, we talked about the fact that there is the ability to say, you know, in a state of emergency, a public health order could say that a facility can limit an individual resident to one visitor at a time, for instance. This recommendation might say for example in a state of compassionate care you can't limit to one visitor at a time or give a higher number or something to that effect. So that's sort of what this would do if we were to decide to move forward with it. But I think the gate question for this workgroup is going to be do, does, or does this workgroup want to put forward a recommendation related to compassionate care? Melody, I see that you've raised your hand so let's start with you.

2:52:26

MELODY TAYLOR STARK | CHOSEN FAMILY

Yeah, I'm just wondering, and I put in chat, I think I've we've talked about this a little bit before, it just seems extraneous to put at this point, particularly because we've got it covered in recommendation A, and then throughout the entire document of, even, you know professional outside caregivers and so forth so, I don't think this section is at all needed it just is it's redundant.

JULIETTE MULLIN | MANATT

Thank you Melody. Karen I see you've raised your hand.

2:53:07

KAREN JONES | CLTCOA

So, the only reason I would say keep this, is if we think there's a risk that any other recommendations will not be carried forward. So, if we're going to lose anything else as the process goes through with the bill, or with, you know, eventual plans or whatever this turns into, we need to keep this. But if we think the other stuff is solid, like if we're not going to lose those things and our recommendations are really going to stand and become the new

requirement in California, then this is extra we don't need it. But we need it, we may need it as backup in case we lose the rest of what we've all discussed today. I've done a lot of legislation and sometimes you spend hours in meetings like this and then suddenly it's all different.

JULIETTE MULLIN | MANATT
Thank you Karen. Catherine.

2:53:55

CATHERINE BLAKEMORE
I think I was persuaded by your points, Juliette, about the flexibility to have more than one visitor at a time, or some additional flexibility for someone who's at the end of their life, by way of example. And so, I think at least the principle in particular I think is like important to acknowledge that even in a state of emergency if you're saying only one visitor at a time, that there may be circumstances where that's not going to work for someone who is in these circumstances.

JULIETTE MULLIN | MANATT
Thank you Katherine. Maitely.

2:54:40

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I agree that we should keep a clause that has this intention, because earlier we did potentially limit our RDSPs per resident right. And so, if there is a great need that you know, that this calls upon, I think this would be a solution to that problem if it was during a time that they were restricted in number. But I do recommend even though there is a CMS definition for compassionate care, an established definition, the, everyone has adopted the connotation, and I think it would be a Herculean effort to re-educate everyone on what compassionate care, was, would have truly entailed. So, I think that there does need to be sort of a more clarifying terminology. The connotation it has completely eclipsed the definition

JULIETTE MULLIN | MANATT
Yeah I understand that thank you. Nancy.

2:55:54

NANCY STEVENS | RESIDENT
I can't remember what recommendation it was in, it'll take me a moment to find it, but I'll put that in the chat. But I was wondering if we could put maybe the term compassionate care under where like staff, administrators, public health officials would be able to have access to have compassionate care visitors on that list, so that RDSPs can have the same access using that type of language in that area of the recommendations, so that we don't have to try and define compassionate care later on.

JULIETTE MULLIN | MANATT
Do you mean to just move, in the, in the recommendation that defines visitors, to move the definition of a compassionate care visitor there.

NANCY STEVENS | RESIDENT
Yes, but also list the word compassionate care underneath where it says, like it towards the beginning where it says, that resident designated support persons will have the same access as staff, and public health officials, ombudsman, on that type of list. I don't remember if we kept that in or not, but I think that compassionate care should be listed on that so that there's no having to, you know, make a distinction between who is a compassionate caregiver and who is a resident designated support person because it's the same to me anyway.

JULIETTE MULLIN | MANATT
Got it. Okay. Thank you Nancy.

Any others who, I'd be curious if there's other folks that want to chime in on potentially not including a compassionate care recommendation. Ken.

KEN DAROSA | SCDD
Well, since you asked it, actually my feelings are quite the opposite. I think this should remain. It's intended to highlight an extraordinary circumstance. And I think Catherine Blakemore made it made a similar point along these lines, that if we're not calling it out, I guess I'm worried that it would get lost in terms of standard visit protocols. And I think it's, this is, I mean let's be honest about what we're talking about here, and I do respect the point that some of the RDSPs are going to be the same people, but, you know, for many of you have been there at you know a parent or you know or a child's passing and you know it's a much different dynamic there's a lot of people

coming forward that you know are going to take their last opportunity. So, at the risk of stating the obvious, you know, this is an extraordinary circumstance and I think it's really something that that should be called out. Also echoing Karen Jones' point that you know there's always the risk of something getting diluted, and I think you know this was put in for a reason when we started, I think everyone was kind of behind it and I think it's still a valid point to articulate so thanks.

JULIETTE MULLIN | MANATT
Thank you Ken. Eric you raised your hand.

ERIC CARLSON | JUSTICE IN AGING
Yeah, I'm a bit on, the, I'm not sure where my vote is or where my pulse is on this. I think but I recognize, I just want to point out, that I do recognize the argument that it's redundant a bit and in any case I think it would benefit from some clarity in, when you get to this point where compassionate care exception is warranted, because otherwise it feels a little bit like a wild card that opens up the system to some limitations that we have seen to prohibit a couple recommendations previous. So, it does, it doesn't seem consistent. I think if you track it, if you're trying to do a flowchart and say okay, when is visitation for the designated support person's absolutely guaranteed in this circumstance, but when is this exception that, that the compassionate care becomes relevant. It's unclear to me how that flowchart sets up, and so that's why I don't think it's, that's why I think there's, it feels like there's an inconsistency between this and what we've done previously which is seemed to have tried to lock down people's ability to visit, no matter what. And so that would be my comment.

I, I'm not voting or saying exactly what my position would be at this point, but my suggestion would be that if we were to keep it we'd want to, and I know this this is hard at this stage of the game, but we'd want to have more clarity on that kind of flowchart issue about when would be going down this route, and when would this route not be necessary because of course under A, B, and C above, people just have a right to designate visitors who have a right for in to, and they have a right to accept in person visitation from those folks.

3:02:08

JULIETTE MULLIN | MANATT
Yeah, so I think just to clarify on I think two, the main thing I would say for this recommendation, if it stands, is, it does not change at all the right to resident designated support people in everyday moments. So that is the baseline. What we have acknowledged kind of in the leadup to this is there are potentially two limitations that may happen with a resident designated support person. The first is it may be permissible if needed in a state of emergency to say that you can limit the number of simultaneous resident designated support people to one. That doesn't at all change the number you can have over the course of a day, it's just the simultaneous that you have at the same moment in time.

The second restriction we've identified is that current law does allow for some types of visitation hours outside of a state of emergency, regardless of a state of emergency. And while these recommendations are staying there should be no additional restrictions on hours in a state of emergency, that is still a general parameter. What this recommendation is saying is that we would go above we would, we would have more permissible access than limiting it to one simultaneous visitor, or potentially having limits to hours of visitation in a in a situation like this. It does not change the level of access that you would normally have. Jack you've raised your hand.

3:03:42

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS
I was just going to say basically the same. I think the whole point was to expand, actually, the options to visit and beyond we could even make it even stronger is the change that should be expanded, to must be expanded to a compassionate care. But I thought, I thought the intent of this was to expand the reasons for having visitation. And you could argue without lacking a designated visitor with a capital V, that you could argue this would be an opportunity for somebody that wasn't designated originally to come if a resident had some of conditions that were applying here. Yeah I thought it was just to expand.

JULIETTE MULLIN | MANATT
Yeah, that's right. Mark, I see you've raised your hand.

3:04:43

MARK BECKLEY | CDA
Yeah, in addition to the two factors that you describe, I would add a third one which is, if there is a limitation in you know PPE, vaccines, those types of resources, that compassionate care visitors may, you know, get a higher priority, you know, given the condition of the loved one. So that might be another reason for including this.

3:05:07

JULIETTE MULLIN | MANATT
Thank you Mark. Any additional comment before we move into our last recommendation? All right. I think with that it sounds like there may be a little bit of word smithing and language changes, but that the general recommendation to say that those few restrictions, that we identified that may occur for a resident designated support person, would be expanded, or lifted in a case of compassionate care. With that let's go to the next slide.

3:06:03

SLIDE 51

And we will pause again here for our public comment before we move into our last recommendation. And Teresa, I see you've raised your hand, and you should be able to mute yourself.

3:06:15

TERESA PALMER
Yeah, I think it's the compassionate care idea was so misused and abused, and my own mother was actually discriminated against because she wasn't quote unquote sick enough unquote to need compassionate care, and actually, at the time she was, but the place was too understaffed for anyone to notice that she had stopped eating. I think what we have to do is jettison the limit on one visitor at a time. There has to be a generous exceptions to that. And individualized exceptions to that. And then we don't need compassionate care. Because the only thing that compassionate care makes a difference on is time of visitation and number of visits. And so, if there are individualized exceptions to that we don't need compassionate care, which is misunderstood and misused. And people, you know, nursing homes were waiting till people were at death's door to let anyone in with

this excuse. It was horrible, and who wants to go through that again. Thanks a lot.

3:07:33

JULIETTE MULLIN | MANATT
Thank you Teresa. All right.

SLIDE 52/53

I think with that it takes us into our last recommendation which is a recommendation around a process for appeals and grievances. In any situation where the resident designated support person's ability to visit a facility, or the other types of visitors that we've identified is not honored. I'll acknowledge the first time we, sorry, the first time we walked through recommendations we did not have the recommendation yet, we didn't get there. But we did circulate an initial version of a recommendation around this in the survey, so our version two of recommendations did include a recommendation around this. At a high level I think one of the biggest areas of feedback that we got on the initial recommendation was to really emphasize the need for much more clarity on the time frames and the process for appeals and grievances. So, if we go to the next slide.

3:08:44

SLIDE 54

Let's just talk about the proposal before us and have a conversation. So, there's two sections to this. The first has to do with clear communication of policies. And the first section in that clear communication of policies speaks to clearly posting for that state licensing agencies would clearly post on their website the current policies for visitation and long-term care facilities, including required visitor safety protocols and any parameter that has been established via this framework. So, I am just going to acknowledge right now, via all the verbal edits we've done today, we've eliminated that process for establishing visitor specific protocols and parameters. So, we will make that edit here to reflect that here. I think that the comparable edit would then just be to say they need to clearly post on their website current policies for, you know, both staff and visitor safety protocols and parameters for visitation and long-term care facilities. And those would be one and the same.

The next is a note that facilities must then clearly post those policies visible locations within the facility. And then the last is a call out that all of that communication must be, must meet state accessibility standards, be written in plain language, and be available in threshold languages. So that has to do with the communication of these policies so that residents really have the information they need to say, this is what I have access to.

The second part of this speaks to the implementation of those policies. And this is the, a provision to really help ensure that they are implemented equitably, and that resident visitors support people have the access to a grievance and appeals process that can address a situation where they may not have access to facility, even though policies suggest they should. So here what we have suggested, acknowledging that this workgroup isn't necessarily going to sit down and write the extremely detailed ... of exactly the ins and outs of a complaint process, where it would go on the website, etc. the recommendation here is that the workgroup act, that the legislature actually direct the state licensing agency to develop a detailed process for grievances and appeals, and that those processes be released as a proposal for public comment prior to finalizing them.

So that detailed work of determining exactly what an appeals process would look like for this, and whether it would build on an existing process or provide a net new process, would be developed by the state licensing agencies. That process has to include two core things that we call out here.

So, the first is it should include a method for a resident's loved one to appeal a situation in which a resident did not identify them as an RDSP, or a situation in which there is no representative able to make these designations.

The second core thing it needs to include is a method for rapidly responding to a situation in which a resident designated support person was not able to visit a resident in accordance with the policies posted on the state licensing agency's website.

So, I’m going open this up. Oh, and I skipped over it, but the policies also have to include specific timelines for responding to grievances and appeals. I'm going to open this one up, we have never discussed this recommendation in a meeting, so I’m going to open it up for initial comments from folks before we start to talk about specific edits. Catherine.

3:12:34

CATHERINE BLAKEMORE
So, just a clarifying question for me, are these intended to be regulations, or policies in some other form? I think there's kind of pros and cons to both, regulations take, you know, we could be in the midst of a pandemic before a regulation would get approved, which means it wouldn't be all that useful. And so, I guess I'm just trying to understand what form people are envisioning these taking.

JULIETTE MULLIN | MANATT
I think we did not specify in drafting these, so I think we'll open it up to the workgroup to weigh in on that question. Do you have an initial, it sounds like your initial suggestion is not take regulation the form of.

CATHERINE BLAKEMORE
I mean I guess there's a mechanism by which you can, I'd be interested, and I don't really have a recommendation, but you know, in some other circumstances there's a mechanism by which a department can do a directive until regulations are developed with a timeline for developing regulations. I think that has worked okay, particularly if there's an opportunity for comment before the directive becomes effective. I just think, yeah, so anyway, I think there's pros and cons and regulations take a really long time, like years.

3:13:52

JULIETTE MULLIN | MANATT
Thank you Catherine. Other comments or edits to this one? Maitely.

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I'm sorry I don't have an exact edit or comment exactly, but I would really love to hear public health authorities response to this. Especially in, in respect to how they would ensure that this information, because they would ultimately be behind the enforcement of this, and you know, all that. And if I recall correctly, actually it's right in front of me, on page two of the Assembly Appropriations Analysis on AB 2546, the date being May 11, 2022, on page two there is a fiscal effect in the analysis, and that refers, at that point we did not get the CDPH potential cost analysis, but it looks like, this is what the fiscal effect says: Estimated ongoing general funding costs in the range of $2 million to$ 2.5 million to CDSS for approximately 15 field

staff positions to provide ongoing complaint investigation enforcement of the new requirement. Additional one-time costs likely in the low hundreds of thousands of dollars to convene a workgroup, develop best practices, and develop regulations and provide a legislative report. I just wanted to bring this up, and this is why I would like to hear public health's response to that. For a $2.5 million annual ongoing price tag, what in here, where does this, how are we going to address that, and is that real that number. Thank you.

3:16:02

JULIETTE MULLIN | MANATT
Thank you Maitely.

CASSIE DUNHAM | CDPH
Oh, I'll respond to that. Maitely, what you just read off sounds like it was the estimate, fiscal estimate from Department of Social Services, not CDPH. So public health can't speak to the fiscal assessment or the fiscal estimate for that projection. I will say that there would be, need to be consideration if you're setting a different standard from the typical complaint process. And if this were to be, create a significant number of additional complaints, or significant additional process, then there would typically be resources that would be needed in order to respond, and to respond within a certain time frame. So, I'll defer to our social services folks if they want to speak to the fiscal question

3:17:00

CLAIR RAMSEY | CDSS
This is Claire. I'm sorry, I realized my name isn't listed as CDSS. I can't speak to the individual like numbers right at this meeting, but you're welcome to send that back to me. But, just to what Cassie said and agree, yeah, so we we'll just have increased workload if we're receiving additional complaints. So, we are generally asked if we do have to take on additional workload like what is the resource needs to meet that additional workload. So that would be what's included, and then if there were ongoing workgroup or other obligations those are additional workloads for staff. So happy to take a look at the fiscal estimate you're looking at and see whether or not it still connects in, you know, I'm not sure what it was linked to, so I can't speak to whether it's accurate based on what you guys are talking about right now. But I see that you dropped it in I'll take a look. But

again, it seems like it's related just to a former proposal, so wouldn't be necessarily accurate for what you guys are discussing today. Thanks.

JULIETTE MULLIN | MANATT
Thank you both, appreciate it. Tony, I see you've raised your hand.

3:18:13

TONY CHICOTEL | CANHR
Thanks. I think maybe during the pandemic I might have filed more appeals and grievances about visitation policies on anybody in the state. And might just to share my experience was that generally, and most of them were nursing homes, the DPH complaint process, the typical DPH complaint process, in my opinion worked. And we didn't need anything special, some of these cases I did elevate things high, you know, beyond the district offices to get something done quickly. But in and I can't remember a case where I didn't get what I thought was a timely response. And policies, illegal policies were amended usually within days of me having filed a complaint. So, take that for what it is worth, that's just my experience.

And then just one quibble on section (a) subsection (b), about facilities posting their policies. There's a little bit of irony here, if you can't get into the facility, that's the problem. How are you going to see the policy when it's inside the building? So, you know, I guess broaden the requirement to, you know, sending it to email addresses or mailing addresses if the facility has them and posting them to a website if the facility has a website, which a lot of facilities did during the pandemic.

3:19:40

JULIETTE MULLIN | MANATT
Yeah appreciate that Tony. And I will say, and in practice the policies that would get post, based on everything we've talked about today, the policies that would get posted at the facilities would be the same one on the licensing agency websites. Because we've established that they would be the same now. Might help a little bit there but.

TONY CHICOTEL | CANHR
Yeah I totally get that, but there may be some, real like tiny nuances like, this is the person you call to let know that you're going to visit, or this is how we would prefer, you know, announce yourself, those kinds of things.

3:20:14

JULIETTE MULLIN | MANATT
Yeah. Appreciate that. Yeah Thank you for that clarification. Catherine.

3:20:20

CATHERINE BLAKEMORE
So, I guess one solution to like, I, you know, we're not going to figure out I recognize, that kind of what form are these going to be in, but there should be a timeline by which the state licensing agencies are going to complete this work, right. And so, I would encourage that we say within six months or I, really, I'm making up a number, but it feels like there needs to be a timeline, and something that it'd be interesting to hear from player, or others about sort of what's realistic. And then the process will include specific timelines for responding to grievances and complaint grievances and appeals. I think there should be some expedited process, so like go back to our compassionate care discussion, where a facility decides that no you can't have more visitors than what this restricted number is, like, and the person's going to die, so some expedited method within that appeals and grievance process for sort of responding to emergency. So, Tony's great because he knows how to get a quick response from somebody higher in the state, that is not most people's life and how they can influence how timely a decision is, so I just think sort of an exception for extraordinary circumstances would be helpful too

3:21:47

JULIETTE MULLIN | MANATT
Great. Thank you Catherine. Heather.

HEATHER HARRISON | CALA
Hi, thanks, I just wanted to follow up on the comment about facilities posting the information that they get from the state, what their policy is. I think the focus should be on communicating it to residents and families. There are a number of different ways providers did that well during the pandemic and then just even on a regular basis. Sometimes it can be challenging to make changes to websites especially if there is a major state of emergency. So just a caution, the ability of individual providers to make website changes quickly can be impacted during this time. But the focus is

making sure that residents and families, the resident designated support persons know what the policies are.

3:22:49

JULIETTE MULLIN | MANATT
Thank you Heather, appreciate that. Jack.

3:22:49

JACK LIGHT | CA CAREGIVER RESOURCE CENTERS
When we put this in there I just understood this to be almost canned, a canned statement, that anytime you create new legislation and create a new burden that you have to enforce it somehow. And there should be always, there's always a grievance process. So, I don't know I mean I, can you put something forth like a new law like this and not include some sort of grievance process? I mean isn't it just part and parcel of anything like this where you're going to stipulate that they, that there are certain rights that we are maintaining for people, and if those rights are taken away, there's, it's going to have to be some sort of process. It just comes with, it comes at a cost. I understand that, but you know we're functioning at a $30 billion deficit right, tapped into the rainy-day funds this year. You know $2 million is a rounding error. I mean, I just think, I just want to get us away from the idea that that money has anything to do with. Do we want to make good policy? We'll let Department of Finance figure out the cost, but again, I just thought that this, you do you have to have this language, or does it just happen automatically anyways? Because they, don't residents have a right and their families have a right to some grievance process anyways.

3:24:35

JULIETTE MULLIN | MANATT
Thank you for that point Jack. I think folks should let me know if they feel otherwise, but I think folks are generally aligned around including a grievance and appeals process on this one. The question may be if there's additional elements that folks want to make sure we add in here, or any edits around what the process will be for establishing that.

I'll just summarize a couple things. One piece that I'll highlight is we did stay silent here in whether it has to develop a new process or revise an existing process. That would be something for the licensing agency to put forward. Whether it would be an existing process that's modified in X, Y,

and Z way that creates a new category and it goes through that process, or it would need to be a net new. And that may help address some of the questions that we got around what the cost might look like, because you can imagine those are very different scenarios on that front. And then there is this element around putting forward, putting it forward for public comment so that there is the ability to weigh in on the timelines etc. that are included in that in that process. Nancy I see you've raised your hand.

3:25:46

NANCY STEVENS | RESIDENT
Hi yes under (a), (b) and (c), I'm just wondering if it's possible to add, you know how like elected officials Governors even the President, Health and Human Services and CMS they were all on television talking about, you know, certain guidelines or regulations or policies that were implemented in the last state of emergency. And I was wondering if there's any way to add like the letter (d) in there to add that elected officials, like state and federal elected officials can also, like, make note of this policy during states of emergencies. I don't know. Are they notified? There was a lot of panic from inside, you know a lot of residents were watching the news not knowing what's going on, not knowing when they would ever see or receive help from their RDSP. So, I don't know if there's any way to put that in there that it should also be the policy should also be included in like

JULIETTE MULLIN | MANATT
Communicated by state officials. Yeah, got it. Okay, Thanks. Any additional edits. Maitely.

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
I just want to clarify what I said earlier. This is a very important section, and I just don't think in 26 minutes it will be properly addressed. Because I think the root cause is the rounding error. Because you know, and I mean the root cause of, I think, sorry it's not the root cause, it's the root of these decisions do come from collaboration on a sort of like a more extensive level, you know, because it does include a lot of complicated things like money, and resources and implementation. And I don't know, I just that's what I meant. I didn't mean to say that it wasn't important because it is absolutely important. I just think that I'm stuck in in 25 minutes to even consider how I can contribute. I'm sorry.

3:28:38

JULIETTE MULLIN | MANATT
No, I appreciate that point Maitely. And I certainly understood your comment that way, which was not to say to not have an appeals grievance process but that the question of the how and that the cost was important in what would end up happening. I think part of what we're endeavoring to do, and welcome your comments or other folks comments, is to really say, to your point, it's not something that this workgroup is going to be able to sort out in 25 minutes. And it does require some pretty detailed, like operational development of an appeals process that really best sits in the agencies that would implement them. So, the recommendation here is actually to include in the law that, well, that the recommendation to the legislature would be to recommend that the legislature require them to put together an appeals process and gather comments on it.

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
In that case can I add that the family caregivers and the resident stakeholders and advocates should be a part of that conversation as well. Thank you.

Juliette you're on mute.

JULIETTE MULLIN | MANATT
Yeah I've just been talking to myself. Thank you. I was just saying we will clarify what's meant by public comment and speak to the collaboration element on getting input from stakeholders. Any additional comment on this one? All right, so I'm just going to summarize on this one.

We are certainly acknowledging the importance of having an appeals process and a grievance process and establishing that the recommendation to the legislature that the state licensing agencies for long-term care facilities put together a proposal for how that appeals process would work. That that proposal would include timelines, that would include a process for appealing a situation in which someone was not designated as a support person and felt that they should be, and that it would include a process for rapidly responding to a situation in which a support person is not able to visit a resident in accordance with the policies

we've discussed in this forum. That process, that proposal would be posted, made available for public comment and opportunities would be provided for a representative group of stakeholders, we'll pull from other language we've used there, to weigh in and provide input and collaborate with the state licensing agency on that process. We'll also make the refinement in the communications around the policies to also note that

You're on mute again Juliette

JULIETTE MULLIN | MANATT
I don't know why that keeps happening, sorry. We would also include a, we would also edit the communication of policy section to note that the policies must, they, facilities must post them within the facility and then must also have proactive methods for communicating them to loved ones and families of residents in their facility as well.

And finally, I'll just note there was also the recommendation to establish a time frame in which these, the proposal around the grievances and appeals would be developed and issued. Mercedes, I see you've raised your hand.

3:32:57

MERCEDES VEGA
I yes sorry, it was right before you started speaking. Oh, I was just gonna say, yeah, a lot of us added some feedback that I think you know it's very useful and so I was just wondering if you guys will look at that once or download that and take that into consideration. A lot of it is you know, I did share some of my experiences. And I also wanted to add that I know like to me it seems like we think of the worst-case scenarios when it comes to visitors, like the potential threat, right, so for us who've experienced, also the worst-case scenarios of facility administrators being extremely restrictive, you know, I have those experiences and I'm coming from that place, and you know that's why I decided today to share that. Because those things do happen. So, if we're going to look at how we, you know, family members can post, can you know probably be very threatening you know during a public health emergency, we need to also look at the other threats that came with that. So, it's not that I'm not, I don't have a bias against facilities at all, but I did go through my experience, and I wish I

hadn't. I wish you know the people who are in a position of power to make decisions wouldn't have been, would have handled things differently, but these are the reality, so yeah. So again, I didn't have a chance to share it out loud or voice it, but I did add a lot on the chat, so I hope you guys take that into account thanks.

3:34:47

JULIETTE MULLIN | MANATT
Thank you Mercedes we definitely appreciate that, and we do store every chat and read it. It's also posted on the website for anyone else that would like to read it. But that's been a really invaluable source for us throughout this process to read the transcripts of these conversations after the fact as well as the chat. So please keep it coming in the chat. Todd, you raised your hand.

3:35:08

TODD HIGGINS | DISABILITY RIGHTS CALIFORNIA
Yeah, I just had a thought around the 14-day, kind of get, getting comment and convening a meeting or work group what do folks think of the idea of naming a standing committee of community interested, community groups, many of them who are on this call, to, in the policy to say these are the initial people that we're going to go to begin that process of getting this group together.

3:35:45

JULIETTE MULLIN | MANATT
Appreciate that comment. I will just make one clarification, that based on the revisions made today verbally throughout the session, we have struck having that like 14-day requirement, because we have struck the concept that non-standard protocols and parameters can be established, because we set that parity. But, we did speak to having a regular process absent that 14-day trigger, having a regular process for ongoing collaboration. So definitely hearing your recommendation that that not be established when the emergency starts, but rather perhaps is a standing group called upon when needed. Is that what I'm hearing? Great.

I know we're coming up near the end of our session, so I'll invite folks to chime in in the chat. I'm already seeing some agreement there, so, that I think that makes great sense. Melody you raised your hand.

MELODY TAYLOR STARK | CHOSEN FAMILY
Yeah, I just wanted to tap into what Todd was just saying and I know that some of it was connected to the 14-day topic and so forth. But we've also had some broader conversations in here, that after this meeting happens there's some further work that needs to be done that would involve a broad spectrum of voices and perhaps that work, you know, developing some of the, whatever the legislature is going to be doing, adjusting some of the policies regarding grievances and so forth, that perhaps this roster can be resourced for some of those pieces of the work, as well. So that's kind of what I was taking too from what Todd was saying, I'm not quite sure if that was it, but I you know just think see we've already been part of the conversation, we're already we are invested in what in what's going on, so that may be a suggestion to utilize this group for resources for those further conversations. Thank you.

3:37:53

JULIETTE MULLIN | MANATT
Thank you both Melody and Todd for that comment. I'm seeing some agreement in the chat with that, so appreciate that. And Maitely you raised your hand.

MAITELY WEISMANN | RCFE FAMILY CAREGIVER
Yeah, I also appreciated Todd's idea because, Juliette, I might have missed it when you were reading the recommendations that you just compiled from today, but I didn't hear where the resident and family caregiver stakeholders would have direct input into those grievance policies before they're published for public comment.

3:38:30

JULIETTE MULLIN | MANATT
Got it. Yes, I did not make that distinction about before public comment, so I'll add that in. All right, I think with that we will go to our last opportunity for public comment for this forum, realized we were just talking about a different type of public comment. If we could go to our last public comment slide

3:39:02

SLIDE 51

All right. And Teresa, oh no, apologies Teresa, Karen is the first person in my line. So, Karen. I will provide you the opportunity to speak, you should be able to unmute yourself.

KAREN KLINK

Hi, okay obviously these are just my thoughts and I put them down before we discussed all this, so, I originally help work on the original Bill AB 2546 The Essential Caregivers Act. That bill was a decent bill in itself, it was supported strongly in the two committees that passed through, and there was no real financial burden attached to it. Then it got to the appropriation committee and all of a sudden $2.5 million to enforce and regulate. We didn't expect that. My recollection is it was the CDSS, CCLD that said that they didn't have the, they didn't have the funding to police this essential caregivers coalition. You know, part of the problem, I believe is that they didn't have funding to take care of what they needed to in the first place, and we've had that issue we' discussed, that there has been problems with you know time takes for complaints and grievances and appeals. I believe that there were entities that just wanted to kill the bill, and that certainly did it. They never had to justify why it would cost that much money, they just said it. I'm pretty sure that's not true. There are not that many people that are essential caregivers or resident designated support people. We're not coming out in mass numbers and lining up at the doors of long-term facilities to cause a financial burden. I don't believe, I hope that this time this can be thought out in a more rational manner.

Okay, secondly, since I'm not going to be able to speak again, I want to be able to speak to the fact that I am, that I am my mother's voice. My mom has dementia, she is in long-term care facility. I am her voice, I am her ears and her eyes and I'm essential. I am not a visitor, I would note that in all times other than a public health emergency I am allowed to visit my mom at a facility at all times especially when she wants me. That is part of resident rights because a public health emergency overrides resident rights something I would argue, but that's that is for another time. We need a law in place till residents have access to a designated person or persons for their emotional, physical, and psychosocial support. Before the pandemic. And to this day there have been problems in long-term care that became worst during the pandemic. There were violations, deficiencies, short

staffing, neglect, and abuse. Facilities staff administrators, LA County Department of Health, California Department of Health, CDSS and CCLD and CMS were remiss and doing their job. Yes I understand it's for a variety of reasons, but that is why this law is necessary we can help, not hinder

Lastly I'll say that I will not be locked out of my mother's facility whether there's a law or not. Thank you for letting me say my piece.

3:42:14

JULIETTE MULLIN | MANATT
Thank you Karen, we appreciate you sharing that. Teresa you should be able to unmute yourself.

TERESA PALMER
Yeah, my experience with the previously, very well-written, AB 2546 was that it was subverted under the aegis of the cost by CDSS and CDPH. And this should not be allowed to happen again. And I recommend that there be another session of this workgroup. This has been a very positive experience for me, and I am someone that has absolutely no trust in this process, due to what I and my mother went through in COVID. And I think it'd be a really good idea to have another session of this workgroup to really tighten things up. And that will limit the possibility of subversion of the legislation that we need to see. Thank you.

3:43:20

JULIETTE MULLIN | MANATT
Thank you Teresa. And I see Nancy you've raised your hand, if you'd like to provide a final comment for the workgroup today before we begin to wrap up.

NANCY STEVENS | RESIDENT
Yeah, sort of to just repeat what Teresa said just now, I just want to say that I'm really thankful and so grateful and so are so many other residents, about like maybe 35 that I talked to, just this past weekend. They're so grateful that, that a resident is allowed and invited and listen to, heard and acknowledged, on something as, with great importance like this. So just thank you, and yeah keep helping us. Thanks.

3:44:12

JULIETTE MULLIN | MANATT
Thank you Nancy. Melody.

MELODY TAYLOR STARK | CHOSEN FAMILY
Hi, I know we're going to be wrapping up soon and just a couple of little side things, because this is what I do. For anyone you know who's on the call and so forth and, Karen this would be a great thing for family councils and so forth, but I'm putting a link in chat this is National but, LA county has a project called Project First Line. Anyone can register for it and it, and it is education on infection control. So, you know just kind of good things to have in someone's pocket, maybe something that can be helpful for the resident designated support persons.

The other thing, it is another link and Nancy was mentioning earlier about residents not being informed that maybe sometimes there was communication to the families, but the families couldn't communicate with resent, what was going on. And back in, when COVID started there was a group on Roosevelt Island in New York in a 500-bed facility and there were about 200 of them there, and when New York was looking for places to put COVID patients they were watching the news one night to find out that their facility that no one was there, and their facility was being brought back online to bring in COVID patients. And their story is, well, I'm looking for a great word for it, Maitely you probably can, but I've gotten to know some of the individuals through some Zoom meetings, and so forth, and PBS is doing a special, did a documentary on it called fire through Dry Grass and it's coming out in October, so a little message for that. But I think it's something that everyone on this call would be interested in in viewing.

And you know reflecting on Nancy's sentiment I'm really, you know, been thankful for this this group and the process and hopefully as Terry said there'll be further conversation and just I'm sure as you're wrapping up you'll probably address this, but what like kind of the what happens next what happens when the information goes to legislature, and then does, it do we all just go our separate ways and forget we did all this work or what happens. So, I share it and Juliette appreciate your, the way that you facilitated the meetings and so forth.

3:46:55

JULIETTE MULLIN | MANATT
Thank you Melody. Thank you everyone for what was a really, I think, extremely productive, really collaborative conversation today. I'm going to hand it over to Brandie to provide us with some next steps and start our close out. Brandie.

3:47:11

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BRANDIE DEVALL | CDA
Thank you. And again, thank you to everyone, and especially to Juliette for navigating these meetings with so much grace and professionalism. You really did a wonderful job.

So following today's meeting CDA and Manatt teams will review additional feedback received by the workgroup and from the members of the public. As a reminder the final recommendations report will summarize the discussion and the joint recommendations of this workgroup. That report will be submitted to the fiscal and appropriate policy committees of the legislature. Members of this workgroup will be provided a copy of the final report. If there are recommendations that your organization wishes to provide, but on which this workgroup did not reach consensus, workgroup members will have an opportunity to submit a letter, or a position paper on behalf of their organizations for inclusion as an attachment to the report. And as always, materials will be listed on the Long-Term Care Facility Access Policy Workgroup webpage, which this team will drop into the chat now.

I thank you again for participating in this important work, and before we conclude we would like to have a word from our Director, Susan DeMarois.

3:48:42

SUSAN DEMAROIS | CDA
Thank you very much Brandie, and hello everyone. It's been a pleasure to join you for the tail end of this fourth and final meeting. I just wanted to take a minute to thank every single workgroup member, all who are present today, and if anybody's missing, for your, the hours that you've given to this effort for your respectful debate and your collaboration, your diverse

perspectives, and you know the expertise and experience that you've all shared, especially our resident members and our family members, thank you very much for your contributions to this workgroup, and to the report that will be developed, as, from your work.

I also wanted to thank of course our legislative partners, and the Governor who made this possible, that we could convene this group and focus on this topic over the past six months. I want to especially thank the CDA team for their leadership Brandie, Mark Beckley, our Long-Term Care Ombudsman Blanca Castro, and all of our colleagues across government, Public Health, Department of Social Services, Department of Health Care Services who've made this a priority to participate.

And then today I was able to hear public comment, but for all members of the public who've commented over the, all four meetings and who will follow up with comments after today's meeting, I want to thank you for your ongoing engagement and your participation in these conversations. And I'll just uplift Brandie's thanks for Juliette and the Manatt team they've been terrific partners, and this is where I'm especially grateful to the legislature and the Governor for providing the resources to facilitate such a forum, in such a professional way so that we can all move forward and move to recommendations that we can all make good use of. So, my thanks to all of you, every one of you, and especially you Brandie. I'll turn it back to you.

3:50:57

SLIDE 60

BRANDIE DEVALL | CDA
Okay. Well thank you. Questions or comments, email us. Someone will drop that into the chat and that's it everybody, have a great evening, much appreciated, bye.