Long-Term Care Facility Access Policy Workgroup
Meeting #2
May 30, 2023

SLIDE 2

0:00:08

Hedy Lim, CDA: Hello, and welcome to meeting two of the California Long-Term Care Facility Access Policy Workgroup. My name is Hedy Lim, with the California Department of Aging, and I'll be kicking off this meeting today.

Throughout the meeting my team will be in the background answering any Zoom technical questions. If you experience any difficulties during the session, please type your question into the Q & A, which is located on the Zoom panel at the bottom of your screen. The chat panel is also available for comments and feedback. We'll provide additional information on that shortly.

During today's event, live Closed Captioning will be available in 11 languages. We are also joined by an American Sign Language interpreter who will be providing live translation throughout today's meeting.

SLIDE 3

The LTCFA Policy Workgroup’s purpose: We are commissioned by the California Legislature, the Long-Term Care Facility Access Policy Workgroup will develop recommendations for policies and practices regarding access and visitation to long-term care facilities during states of emergency, with consideration for the impact that restricted access has on mental health of residents, families, and friends and on the physical health and safety of residents.

SLIDE 4

CDA is committed to ensuring an open, transparent, and accessible process. All workgroup meetings will be held publicly and are subject to the Bagley-Keene Open Meeting Act.

All meetings and deliberations of this workgroup will be made available to the public, and members of the public will have an opportunity to provide comments at every meeting.

Meeting information, agendas, and materials from past meetings will be available on the following web page. We can post that web page into the chat if we need to.

SLIDE 5

For Workgroup Members: Verbal comments. Workgroup members may raise their hand in the Reactions feature of Zoom to enter the line for a verbal comment for question.

At multiple points throughout the meeting, CDA will take comments or questions from the workgroup members in line and members can unmute themselves.

For Written Comments: Workgroup members may submit their comments and questions throughout the meeting using the Zoom Chat. Workgroup members should send their comments to everyone. There's a little drop down for it. All comments will be recorded and reviewed by CDA staff.

SLIDE 6

For Members of the Public: Verbal comments. CDA will take public comments at designated times during the meeting, and as indicated in the meeting agenda.

Workgroup members may raise their hand in the Reactions feature of Zoom or press Star 9 on their phone to dial pad to enter the line for verbal comments or questions.

For Written Comments. Members of the public may submit their comments and questions throughout the meeting, using the Zoom Q & A. All comments will be recorded and reviewed by CDA staff.

SLIDE 7

So, we'll start with a welcome roll call and background, continue on to a summary of meeting number one, learnings from research and lived experience, following with actionable principles for LTCF visitation, and closing with public comment and closing and next steps.

0:04:29

Brandie Devall: Thank you, I will take it over from here. Thank you. My name is Brandie Devall and welcome to the Long-Term Care Facility Access Workgroup meeting number two. As Hedy noted, this is the second of four meetings of this workgroup, which means that the meeting today will take us halfway through our work together. We've been reminded of the workgroups purpose. We've looked at the agenda and I'd like to start by recapping some background on the workgroups task, including our scope and plan for each of the workgroups four meetings.

Then we will share key learnings gathered from the research and lived experiences shared by residents and their loved ones during meeting number one.

The bulk of today's discussion will be on actionable principles for visitation.

We will take comments throughout the discussion today. And we will also have a dedicated comments period for the public, and this will happen at the end of our meeting.

I would now like to introduce my colleagues, who will be presenting throughout our meeting today.

SLIDE 8

First, we have Mark Beckley, Chief Deputy Director at CDA. And, we have Juliette Mullen, Senior Manager for Manatt Health.

SLIDE 9

On this slide is a full list of organizations, and their representatives participating in the workgroup. On our website we have posted a list of all the representatives and their biographies. A member of our team will drop that link in the chat now, you can go there and check out all the Bios. This

document will include the workgroup bios that were already submitted to CDA. If you haven't done that, it's not too late. Please send us your bio, and we will add it to this document.

SLIDE 10

At this time, I would like to invite the workgroup members to make use of the chat. Just introduce yourselves, let us know you're here. Maybe drop your name, title, and the organization that you're from.

Oh, great. Great welcome, Eric, Jason, Melody. They're coming in fast now. Thank you so much for that. So please continue to introduce yourselves.

I'm going to move on to the next slide while you all do that.

SLIDE 11

So, before we, we review the scope and plan for workgroup meetings. It is important to remind ourselves of what this workgroup has been tasked to do.

This workgroup has been tasked with bringing together diverse perspectives from across the state and building on learning from the COVID-19 Public Health Emergency. The Long-Term Care Facility Access Workgroup will develop recommendations for access and visitation policies for future states of emergency.

“The California Department of Aging shall submit the recommendations of the workgroup to the fiscal and appropriate policy committees of the Legislature.”

SLIDE 12

As far as the scope overview, in developing recommendations, the Workgroup members will evaluate the impact of restricted access on the mental health of residents, families, and friends and on the physical health and safety of residents, and consider a range of the following:

So, visitors, and we have some examples there, friends, family, chosen family, and the list of examples goes on. Long-term care facilities, including

SNFs and ICFs, ARFs, and those are also listed there, by example. And then types of emergencies, pandemics, and more natural disasters, bioterrorism, things like that. Take just a second to read that.

SLIDE 13

Okay, as a reminder the Long-Term Care Facility Access Workgroup will engage in a total of four meetings, and the meetings will build upon each other. In meeting one we focused on research, the lived experience of workgroup members and the public, and existing state policies on long-term care facility access and visitation during the COVID-19 Public Health Emergency. Building on those learnings, today's meeting will focus on identifying actionable principles for visitation and future emergencies. During meetings three and four we will identify specific policy and practice recommendations for future emergencies for each actionable principle.

SLIDE 14

The meeting objective of today's discussion is to identify actionable principles for long-term care facility visitation in future states of emergency. We will do that by recapping the learning from meeting one, and identifying actionable principles related to the following:

First, how to achieve a balance of visitation rights and public health protections. How to ensure visitation rights and public health protections are implemented equitably, and finally, how to address regional variation to ensure equitable implementation of visitation rights and public health protections.

Now I will turn it over to Mark Beckley, who will be discussing the learnings from meeting one.

SLIDE 15

0:11:43

Mark Beckley: Right? Thank you so much. Brandie and thank you all for attending today's meeting two of the Long-Term Care Facilities Access Workgroup. We really appreciate your active participation on this workgroup. Before launching into the learnings from meeting one, I'd like to

take some time to thank all of you for your engagement up until this point. I'd like to particularly thank those speakers in the last meeting who shared with us their experiences on visiting or attempting to visit loved ones in long-term care facilities during the COVID pandemic. We do recognize that these, many of these topics, including those raised today, can be very personal in nature and are not always easy to discuss.

In today's meeting there will be a variety of views shared from the public health perspective and options that California may want to consider regarding visitation during natural and public health emergencies.

Today, we want to continue to have an active and healthy conversation on this topic and continue to do so in respect for a more productive manner.

I also want to note that State Department representatives will be mainly in listening mode to actively listen to the perspectives of the stakeholders on this workgroup and from the public, but they may weigh in from time to time to provide additional background or additional information on this topic.

Next slide.

SLIDE 16

Okay, so with that in mind, we'll begin by reminding everyone of the key topics discussed during meeting one which was held on March 13th. And these focused on research on long-term care facility visitation and access policies, the lived experience of long-term care visitation, and a preliminary overview of long-term care facility visitation policies in the United States.

A reminder, again, that the summary of, and links to research articles and the State statutes that were referenced in the last meeting can be accessed on the workgroup website. So please, feel free to refer to those to refresh yourselves or to find additional information on this topic.

Okay. Next slide

SLIDE 17

From our discussion in meeting one, four key themes emerged.

One, family friends, chosen family and other individuals, including those not employed by long-term care facilities provide care and support for residents that is essential for their health and well-being.

Two, that it is difficult to understand visitation guidance and rights given all the different agencies and departments involved in establishing visitation policies.

Three, that implementation and enforcement of visitation guidance was inconsistent, fostering disparities and access to visitation.

And finally, challenges with facility infrastructure, staff shortages and limited staff training exacerbated a pre-existing digital divide for long-term care facility residents.

The following slides will outline the specific learnings from the research and the lived experiences shared with the workgroup to illustrate how these key themes impact visitation.

And if you have any additional thoughts or takeaways from meeting one, please feel free to drop those either in the Q & A, or the chat as I walk through them today.

Okay, next slide

SLIDE 18

So as previously stated, the first theme was that family friends, chosen family, and other individuals provide care and support for residents that is essential for their health and well-being.

I won't read through this entire slide, but I will highlight a few key findings.

One, that social contact is essential in preventing resident’s social isolation and loneliness, and we recognize that several workgroup members shared how their loved ones experience serious declines in physical and mental health during periods of restricted visitation.

Two, research underscores the contributions of family and friends who provide frontline care when they visit residents of long-term care facilities.

And finally, visitors who did not work for long-term care facilities have an important role in identifying issues with resident health and well-being and advocating for care for their loved ones as we heard from several workgroup members in the last meeting

Next slide.

SLIDE 19

The second learning from the workgroup members and members of the public was how difficult it was for most stakeholders, including residents and loved ones, to understand visitation guidance and rights given all of the different agencies and departments involved in establishing visitation policy.

And although many different levels of government agencies provide guidance and established regulations related to long-term care facility visitation, there is no single source of information for members of the public to understand the current guidance and rules governing long-term care facility access and visitation rights for their specific long-term care facility.

And finally, facilities do not consistently provide clear and publicly accessible information about the facility's policies governing visitation access. And we do understand that during the COVID pandemic there were sometimes frequent changes to state and local policies, but we are trying to figure out a way to get the information from the facilities on a consistent and a clear basis.

Okay, next slide.

SLIDE 20

For the third learning, a related but distinct challenge to the previous learning is that implementation and enforcement of visitation guidance was inconsistent, fostering disparities and access to visitation.

Some workgroup members provided examples of situations where facilities did not appear to it, to adhere to existing guidance from the state.

And then some workgroup members also provided examples of situations where they were unsuccessful raising issues with facility's adherents to guidance.

Next slide.

SLIDE 21

And the last theme that was identified is that challenges with facility infrastructure, staffing shortages and limited staff training exacerbated a pre-existing digital divide.

Several workgroup members expressed challenges with using technology to communicate with their loved ones during restricted visit, visitations, such as facilities that did not have sufficient technology to support tele-visits between residents and loved ones. Facilities that had staffing constraints that may have contributed to a lack of support for residents in using virtual visit technologies. And finally, facilities that did not have staff with knowledge or training to assist residents with tele-visits.

So that's a summary of the key themes and learnings from the last meeting. I'll now turn it over to Juliette, who will give us, who will present the discussion on actual principles for long-term care facility visitation.

00:19:02.570

Juliette Mullin | Manatt: Great. Thank you so much, Mark. We could go to the next slide.

SLIDE 22

So as Mark noted, and Brandie previewed at the top of our meeting today, our focus today is going to be really outlining actionable principles for long-term care visitation. Mark just reviewed all of the core takeaways brought, well, many of the core, you know not all, and so we invite folks to chime in in the chat if there are other big takeaways from your perspective. But Mark just reviewed kind of core takeaways from our discussion of the research and the lived experience and the existing state policies. And this is really our foundational conversation around the learnings that we can build upon. Today what we're going to do is really build on those learnings and start to

map out what this workgroup recommends that the State of California do going forward in future states of emergencies.

So, if we could go to the next slide.

SLIDE 23

And so, in thinking about kind of the entire goal of today's conversation, we're really focused on this concept of how might we achieve balance in visitation policies? And so, there's really one, the core way that we are thinking about this across the workgroup is really thinking about how we balance preserving individual rights to physical/mental health support, advocacy, and autonomy. And these are all really core themes and important issues that we heard raised from the workgroup. And then how do we balance that kind of on the other end of the scale with the protecting public health, and make sure that we're achieving balance across those two concepts. So, we're really going to be very focused today and talking through how we do that.

You'll see kind of on the bottom of this visual we are going to spend the, the kind of back half of our conversation today, or the end of our discussion today, focused on once we figure out, once we talk through how we want to achieve that balance, talking through how we ensure that that balance is equitably implemented, and that both visitation rights and public health protections are equitably implemented, and then how we address any regional factors that might impact rights and public health protections. But for the first core section of our conversation we'll be focused up here in the top in achieving that balance. We'll start on the left hand side of this diagram and look at how we might preserve individual rights to physical mental health support advocacy and autonomy, and then we'll go into public health protection. So, if we go to the next slide.

SLIDE 24

So as, as we've kind of already teed up and in a number of ways our discussion objective today is actionable principles. We're going to start with visitation rights, then go into public health safety. We'll talk through equitable implementation, and then we'll discuss regional factors and implementation.

Go to the next slide.

SLIDE 25

So, discussion one. So here we're going to really dive into how might we preserve individual rights to physical mental health, advocacy, and autonomy. And talk through different strategies and ways in which we might ensure that we're protecting that right.

SLIDE 26

As with every section we're going to talk through today, we're going to start by defining the issue. What are we making sure we solve? For what are we making sure we prevent? What are the situations that we're concerned about, that we want to make sure that we're putting forward recommendations to address.

With this first section, we actually spent a lot of time in our first workgroup meeting defining this issue. And so what we've done here is we've taken a first pass at summarizing the issue as we heard it from the research as we heard it from the lived experience, as we heard it from all the different members of the workgroup that shared their very personal stories and experiences with visitation and what happened when it was restricted.

So here we've identified kind of 4 major ways in which we heard from this workgroup issues when facility access is restricted.

The first, and we've listed these out A, B, C, D so folks can kind of chime in on them in the chat by easily referencing the letter.

The first is that loved ones are not able to provide important care, social connection, and advocacy for long-term care facility residents which can worsen mental and physical health. So, Mark spoke to that quite a bit. We heard a lot about this from the workgroup. When we, when we talked about it in March. This concept of, of not being able to really meet the, the mental and physical health needs of your loved ones, and and, and be there for them to provide advocacy and important care.

A second major thing we heard from the workgroup is that residents are not able to be with their loved ones specifically during moments of crisis, and

that might include end-of-life, it might include transitions between facilities, for example, it might include loss of a loved one, so experiencing grief. It might include situations where the resident is experiencing kind of really severe eating and drinking issues and may not be eating and drinking, or moments of acute need for, for mental health support.

So that was a, a very big area where we heard kind of a really big issue arising when you restrict access to a facility. For C we, we heard folks talk about the importance of participating in off-site events. So, so, being able not just to have people come on site to see you if you're a resident, but also be able to go off-site and participate in the life of your family and loved ones and be able to do things, for example like attend funerals, birthdays, weddings, those, those can be things that are impacted when access to, to, to a facility is restricted.

And then the, the final core one, we really pulled out from the conversation in March, is that residents are not able to receive services that are not provided by long-term care facility staff when facility access is restricted. And that can include things like health care needs that that cannot be provided by the facility or care management or social services, and it can also see, it could also be situations like getting, you know haircuts or dentist visits things like that.

So, I'm gonna pause here, and I'm actually gonna invite folks to chime in on this list because we'd really like to make sure that we have a good definition of the issues that we're endeavoring to address with these recommendations before we start to talk about what we want to recommend. And this is not a mutually exclusive list this is not pick one, this may be all of them, but would love to hear from folks. I think, first of all, which of these issues really come out to them? And the answer can be all four, that's fine, I just saw that answer in the chat, in fact. And then we also want to understand if this is missing anything really important. So, I'm gonna open it up to folks in the chat to chime in, and then I'm going to invite members of the workgroup to raise their hand and, and share their thoughts verbally here.

And I'm looking at the chat. I'll just chime in a little bit on what I'm seeing. And actually, I'll read the first one, and then I see she has her hand raised

and we'll go, we'll go there. Nancy Stevens is pointing out, “I wish there was a 1, 2 and 3 listed under advocacy”. So, we'd love to hear, hear more on that, and I see you have your hand raised Nancy.

Okay, please feel free to unmute yourself and share your thoughts.

00:26:42.630

Nancy Stevens Resident: Yeah, so certainly under advocacy for instance, in, in my, my personal situation, I was told I was not allowed to record or take photographs of things like someone else's feces being put next to my bed, where my feet stepped down so that I couldn't get out of bed. So just as an example.

I do wish that there were a 1, 2, and 3 under advocacy so that it can be more detailed.

00:27:16.460

Juliette Mullin | Manatt: Yeah. And so, I'm hearing you say, there's, there's a concept of it's not just like, can you be in the building? It's also what can you do when you're in the building. Yeah.

Around the advocacy piece. That's great. Thank you.

Other folks have additions here, or want to chime in and add, like another layer to what what's on this slide?

00:27:44.390

Todd Higgins Disability Rights California: This is, this is Todd Higgins for Disability Rights California. I apologize, I couldn't find my raise hand function. But I, I think also, one thing that I saw was also residents being a lot, unable to go home for family visits and then return to the facility, and I think that became a, an issue. So, it's, it's you know it, it's, it's not technically a visitation to the facility issue, but it, it is a, an issue that I think kind of falls into this category, if, if folks agree with that.

Juliette Mullin | Manatt: And this is just to be, I want to make sure I heard that right, this is a thing people were not able to do that during ...

Todd Higgins Disability Rights California: Correct, correct, not, not allowed to, to leave for, for, for family visits, and then return to the facility.

00:28:35.730

Juliette Mullin | Manatt: Yep. And, Karen, I see you raise your hand.

00:28:38.050

Karen Jones, CLTCOA: I, I just want to clarify. So, I definitely think all four of these need to be included. But, one thing that needs to at least be a subset of this is what happens when a resident, you know, is able to do those things, and possibly you know, well with COVID, you know, maybe, be exposed to COVID, and then coming back into the facility, and, you know, possibly creating a harm. So, a, I'm not against people going out, I mean, actually, I'm very, very for it, or having access to everybody but we do need to talk about how that, you know affects everyone. And as Todd kind of alluded to the quarantine issues, you know it, it almost became a punishment to residents who did exercise any of their rights to leave during COVID. That then they, you know, for a while it was like 2 to 3 weeks of quarantine if they if they wanted to go out once. And that, you know, there was even a time when you know the folks on dialysis were concerned, and they were kind of being punished for being on dialysis, so that needs to be addressed in the policy.

00:29:41.800

Juliette Mullin | Manatt: Thank you for that. And I think maybe that takes us into our next set of slides. I'm hearing generally in the chat a lot of alignment with what's on this slide, and these core issues being really important issues, we want to make sure that we're addressing in recommendations. I'm seeing some recommendations to add and emphasize notes like on the first one, that also providing communication support, in addition to social connection, advocacy and care is big piece there. So, I think all, all of this is, is great, and I think I'm hearing, both in the comments and in the chat specifically on C, not limiting C to something that's a funeral, or a wedding or a birthday. But I see when one person in the chat, noting that just being able to get out and get fresh air and then being able to visit family as well.

So, I think it, it sounds like this is, you know, gathering, this is capturing the major issues, and then we're kind of we, we're emphasizing and adding some dimensions to these issues. But I think with that in mind we may be able to move to the next piece, which you were starting to speak to Karen, which is, how do you actually define these things. And how do you make sure you do these things safely? And you think about, and all the implications and the parameters behind it.

SLIDE 27

So, what we've done on the next four slides is we've taken each of these four issues, and we've sort of broken out, you know, let's understand the issue a little bit more deeply, and, and would love to hear folks' kind of additional thoughts on, on ways to understand this issue.

And then what we've done is we've pulled out how other, either other states have approached this or some options we may have heard from the workgroup in the first meeting, and just list it out, some ways that, that this workgroup could recommend to the State of California to address this issue.

So, for this, and we'll just have a conversation on each. So, for this first issue, which is the issue of ensuring that you have access to the facility so that loved ones and chosen family and family can provide care, social connection, advocacy, I'm going to add communication support that we just heard, it to residents in the facility.

So, one of the core ways that states have ensured this right and built in this right is through this concept that we talked about in meeting one of the essential caregiver or essential support person or support person different states call it different things, but it's functionally a concept where an individual resident in the facility or, or one of their representatives, can designate an individual who will have access to the facility and be able to provide that care, social connection, communication support, and advocacy.

Generally speaking, the essential caregiver is defined as an individual who provides in-person visits that are necessary for the physical, emotional, and social well-being of the resident or patient. That individual is generally

selected by the resident or their representatives. And I will note, and actually, this is just in line with what I just saw got dropped in the chat. Some laws specify specifically that though the term may be caregiver there's no requirement that the person deliver, you know, front line care to, to meet that criteria.

So, I'm going to pause here for a moment, and I would actually love to hear from the workgroup. I, I think now we're starting to try to get into what do we specifically want to recommend? And so, this would be one option for how the workgroup might address this issue specifically of making sure that residents have access to the care, social connection, communication support, and advocacy they need, would be to a to, to recommend a similar policy where residents can designate someone who will or multiple people who will have access to them in the facility.

I'm gonna open it up for feedback and whether this is an approach that this, this workgroup would recommend for California.

So, I'm seeing I'm just gonna read out what I'm seeing. Oh, actually, I, I see some hands raised. So, we'll go there first. Ellen, I see you have your hand raised.

00:34:02.300

Ellen Schmeding, CCoA: Thank you. I, you know one of the challenges I have with this is the different types of disasters that we're looking at, and I think different elements will apply, depending upon whether it is a pandemic versus something wrong with the infrastructure of the building. So, I think that's just one of the struggles I have when I look at this is in, in a something's wrong with the building, of course you want the essential person to be able to come in, and I think that person is extremely important.

But during a pandemic it, such as what we went through, it was difficult to make exclusions when we were in the midst of a real crisis. So, I, you know, I just, I don't know how to tease that out, but I think it, it would be different requirements depending upon the issue at hand, the disaster.

00:34:56.969

Juliette Mullin | Manatt: That's a great point, and I thank you for raising that, Ellen, because we are, we are really endeavoring to think about a broad, broad range of public health, not even necessarily public health, of states of emergency that could include a fire, for instance, or a fire emergency in a county, and so, we, we want to think that through. Part, part of that I think we'll get to a little bit when we dive into options for making sure that we have the tools in place for protecting public health and protecting the public. But thank you for raising that, cause it is a, it does make these decision points complicated. We're not thinking this is not a particular recommendation for COVID-19 in 2022, this is a recommendation for the future and a future state of emergency that's not necessarily defined in this moment.

Thanks for raising that. Nancy. I see you've raised your hand.

00:35:52.890

Nancy Stevens Resident: Yeah, thank you, thanks Juliette. I think something that's missing here is spiritual well-being. So having a connection to one's congregation or faith-based group is important as well.

00:36:17.950

Juliette Mullin | Manatt: That's great. Thank you for that addition.

And I see Karen in the chat has commented about a recommendation, and I want to make sure I'm understanding this correctly, Karen. That if you have a situation where there is an essential caregiver designation and that's the only person that can come in to see the person, to see the resident that that be time bound. Am I getting that correctly, Karen?

00:36:57.000

Karen Jones, CLTCOA: Yeah. So, my point is, I don't, I don't think there should only be one person designated. But if the crisis is so bad that there has to be some limitations, and you can't have all of your support people that they would be time-limited, very short, time-limited. And that could be one person. But after that time period is over, then you should be able to have access to all of your support people, or a significantly higher number.

Not, not one person for 3 years, or whatever that might be that, that's horrifically not, that's not, it's better, but it's not much better than having one.

00:37:35.510

Juliette Mullin | Manatt: That's really helpful. Thank you, Karen.

Maitely, I see you, you raised your hand.

00:37:43.910

Maitely Weismann, Essential Caregivers Coalition: Yes, hi, thank you. I'm trying to wrap my head around that suggestion. So, during normal times, when, when we're not in a pandemic that, that locked us down for 2 years, you're saying that, so during normal times residents have rights to their family members and friends, and it's up to them. During a pandemic like what we are still sort of experiencing where it may last for more than 30 days or more than a year, and lockdowns are just recurring. You're saying that they have to alternate people, or they have to open it up to other people. My question is, is that because some people only have one person? So, it's you know, I wouldn't want it to be confused for the ability to stop those visits, you know, or, or even maybe in a situation where it is unsafe to let the whole family in at that stage, to, you know, invite the entire family, and I'm trying to understand exactly what the parameters of that of that suggestion.

00:38:56.230

Karen Jones, CLTCOA: So, to clarify my, my point is, I don't think we should make people pick and choose their loved ones who can come and visit, and if they must pick and choose, it should be only for a short time, and then it gets opened up again. I had so many clients during COVID that had to decide between their adult daughter, who was, you know, a really good advocate for them or their husband to 50 years, and they can only have one for some period of time, even though we didn't have this law in California.

And, and, it, it wasn't fair to the resident to have to make that choice, or to the family to say, well, sorry, you, you know you guys cannot be here. So if there must be a limit, for some reason it should be very limited time, and it should not extend past some basic amount of time, and, and I continue to have issues with saying, if PPE will protect the residents, you know, from the staff, why would it not, and, and there's multiple staff in those buildings every day, why wouldn't it protect them from multiple family members? It, it doesn't make scientific sense.

00:39:56.900

Maitely Weismann, Essential Caregivers Coalition: Thank you. Yeah, agreed.

00:40:01.510

Juliette Mullin | Manatt: Nancy. I see you raised your hand.

00:40:07.140

Nancy Stevens Resident: Yes, I, I agree with all of these things. And, speaking for my neighbors, and other residents throughout the State of California, I, I do hope that, that all these suggestions will be taken into to strong consideration.

Juliette Mullin | Manatt: Thank you.

Nancy Stevens Resident: You're welcome. I just say that because I'm, I'm the only resident on the, the member group. So, thanks.

00:40:34.250

Juliette Mullin | Manatt: And we appreciate you very much, taking the time to participate and share that. Thank you.

I'm trying. I'm looking through the chat as I'm tracking.

So, I'm hear, I'm seeing in the chat some general alignment that if you're limiting significantly to a very small number of essential caregivers, there should be some time boundedness in that limitation. So, it's if a, an emergency lasts 3 years as a hypothetical scenario, emergency lasts 3

years, we would not want to recommend that it would be okay to have only one person able to access the resident over a 3-year window. So, it may be a recommendation that either says that the number needs to be higher beyond a certain amount of time, and you can only limit to one person for a brief window. Something to that effect.

Great. And I think I've seen a lot in the chat about you know, fundamentally, being in a mindset of how might we enable visitation, and understanding that there are situations where there are public health considerations. How do we create some, some crisp definition and time boundedness around that, so that we are ensuring that we are enabling visitation. I'm seeing kind of a few different types of comments, reflecting that in the chat.

Catherine, I see you raised your hand.

00:42:19.870

Catherine Blakemore: Thank you. I, I guess I just want to loop back about the notion of limiting the number of what you're calling caregivers, and it's not intuitive to me about why we would start with a rule that would say, it's okay to limit the number as opposed to people designate people.

And if there was going to be some change, there has to be something specific that happened that would result in a need to limit the numbers because of, if, as is said in the chat, there's PPE being used, and it's the same the same requirements that staff have given the number of staff that come in and out of facilities. It's, it's a little difficult to understand why a resident could only have one caregiver from, that was a family member, as opposed to two. And so, I, I, I'm not comfortable starting from a place that says it's okay to limit the number of, of individuals. Thank you.

00:43:17.600

Juliette Mullin | Manatt: Thank you for that comment.

I, I'm going to open that up to the workgroup and, and see what folks think about that.

Karen. I see you raise your hand.

00:43:58.960

Karen Jones, CLTCOA: I just want to say I, I also agree. I think if we could have recommendations that start with don't limit, protect, you know, using whatever methods are available that would probably be the best way to do it, and then if, if protections must be put in place, that exceed that, then we would start looking at these limitations that still protect their rights, but, but no limitation should be in there. If there's a way to, if, if staff can be in those facilities, families can be in those facilities. It, it just doesn't make sense otherwise.

00:44:38.940

Juliette Mullin | Manatt: And I'm apologizing, I don't know how to say your first name. Leza. Okay, Leza.

Leza Coleman CCoA: There you go. I, I, I feel very strongly that there shouldn't be a limit, these are not criminals, these are people that have, that are in these homes, and they should be given the rights that those of us that are in homes. We, we, we, we start to really tread into this world of being very paternalistic, and what's in their best interest, instead of asking them what is their expressed wish?

There were too many residents that would have rather died nine months earlier, having got COVID, but having held their hands of their loved ones. And I think many of us on this still have some post-traumatic stress of, of, of having those phone calls where we're trying to keep people safe when maybe it isn't my job to, to be everybody's you know. I, I, I don't think I am instilled with the right to say what is in their best interest. I, I'm trying to advocate for them. Using common sense.

And so, if it is safe enough for the residents, if it is safe enough for staff to be in there, then I feel like it has to be safe enough for family members. Cause I think in some ways the family members took more precautions, and were more careful than some of the staff, not all staff, certain, lots of staff were very, very diligent and lots of, I, I do not want to be in any way discouraging on the staff, they did amazing jobs. But as it was mentioned in the comments many staff work in multiple facilities. And we watched

COVID going, crossing over. We don't have many family members that have family in multiple facilities. Thank you.

00:46:37.220

Juliette Mullin | Manatt: Thank you.

Jack. You your next in line.

00:46:46.490

Jack Light, Providence St. Jude Medical Ctr: Yes. just, just really echoing something in the chat. I, I think, you know I agree with the, the patients should be able to identify as, as many family members or support people that they choose to. And I'm hoping that we're you know in agreement with that, and we're just talking about some of the more practical concerns in terms of limiting how many people you can have in there at any one time. So, I'm all for people having a list of one to a list of a dozen.

But for all intents and purposes, is it practical to have a dozen people come in at once? So, I'm, I'm just kind of echoing something that's already been put in the chat and really offering nothing new. Just kind of want to redirect in that way. And just say, I, I, I, don't think the, the limitation issue, it's on two levels, and, and I don't think we're, I think we're all kind of in agreement that patients should be able to, to have some latitude and naming the number of people that they choose to be essential providers.

00:47:53.150

Juliette Mullin | Manatt: That's a really helpful distinction, not limiting who you can name, you could have a very broad list. But thinking about, like the logistic, you can have X number at a time for operational reasons, safety reasons, etc. I want to note before I go to the next in line, I am seeing some comments about compassionate care. Our next slide and our next topic will be diving into the compassionate care right issue, and we'll kind of look at that as a particular set of issues as well in just a moment. So, I just wanted to flag that for, for folks in the chat that are starting to talk about that. Jayleen.

00:48:25.940

Jayleen Richards, Solano Public Health, CHEAC member: Hi, my comments were going to be very much in line with Jack Lights comments, but just a, providing those options especially during a public health emergency that you can respond appropriately. Some facilities have people sharing rooms, and they're too crowded if all caregivers are in the room. So just thinking that kind of thing through during the particular emergency. Thank you.

00:48:57.420

Juliette Mullin | Manatt: Thank you for that.

Karen. You've raised your hand.

00:49:00.770

Karen Jones, CLTCOA: I just wanted to also respond. And I don't think necessarily we're saying that, you know 12 or 15 or 30 people should visit at once, we're just saying that, you know, you shouldn't have to pick between your kids and your husband or your niece who came into town and hasn't otherwise been able to see you, but certainly it can be limited to how many people are physically present at a time. It just needs to be more than just only your daughter for 3 years, or only your whoever for 3 years.

00:49:30.130

Juliette Mullin | Manatt: So, I'm hearing some consensus around being able to. First of all, I, I just want to, and, and folks, if what I'm about to say is totally not in line with how you're thinking about this, please drop this in the chat, cause I want to make sure I'm summarizing what I'm hearing so far. I'm hearing a lot of consensus around having a recommendation for California to adopt a essential caregiver, the Port Person approach. We can decide which of those terms we think is appropriate. In which residents could name potentially as many people as they want to that list.

We'll talk in a moment about, perhaps, what types of precaution those people agree to take, but name whoever they want to that list. And then we'd essentially be saying, you know, in a state of emergency, a facility can, for example, limit the location of the visit. I saw some comments in the

chat about shared rooms, for example, so that there might be some ability for, for sites to say it should happen in one location or the other. Or perhaps the number who are there at one particular time. But not to say, you can only have one person for a year. It can be rotating people coming in and out, and that there's a, you can enumerate a broad list of people who could come.

I see a few hands raised. This is great, Nancy.

00:50:52.930

Nancy Stevens Resident: Yes, I agree with everything you just said Juliette. Thank you so much for, for making due mention of that. I also wanted to go back a second, and, and just also mentioned that my essential caregivers who were allowed to come in under compassionate care at one point were also here to, to make sure to gently remind staff to wear their PPE, because every single day during the pandemic I had staff inside my room, caring for me as well as for my roommate at that time who were not donning PPE at all. And I actually had push back from some senior management personnel as well who refused to wear their PPE. So.

00:51:41.990

Juliette Mullin | Manatt: Thank you for raising that Nancy that really important advocacy and raising issues for the resident like that. It's very critical.

Blanca.

00:51:55.280

Blanca Castro State LTC Ombudsman: Hi, So California always is the one that does things a little different. So, I appreciate that we're looking at other state laws, but I, I do feel that we need to create one for California specific. So, I was glad to hear there was a recommendation or an acknowledgment that there's people who need translators, somebody that understands their language. I just wanted to underscore that I, I hear a lot of, of the stakeholders and work panel members talking about, thanks for summarizing what we, we heard. So, I agree with everything you pointed

out and also just underscore that during the pandemic, and even today we continue to see a shortage of staff in facilities, and many family members and our givers were, were handling some of the tasks that that staff would ordinarily handle. And so, I think that it's just something we should include in our recommendations, or acknowledging that that they do play a very significant role as well. Thank you.

00:53:16.240

Juliette Mullin | Manatt: Thank you, Blanca.

Karen.

00:53:21.790

Karen Jones, CLTCOA: I, I wanted to address the where part of that. I had a lot of clients who couldn't leave their room and their family, couldn't use, so that because they couldn't leave their room for various health reasons, the family, if there was a visiting area, it, it, it wouldn't work, and you know, especially when we have places in California where winter is really awful you wouldn't want to have an outside visit at that point in time, so we need to make sure that the where is also addressed in the recommendations, because that that can be a hugely limiting factor in. I'll tell you, I had one, I think I may mentioned this before one client, I mean several, but you know two residents, neither one of them particularly mobile in the same room, and, and neither, well, one of the residents who didn't want to leave the room also didn't want visits in the room, and his family didn't want visits in the room, because COVID was scary, and it still is, but that limited when the wife could visit her husband, who also had mobility issues and was hard for him to leave the room because it was really rare that he could be out of the room enough at the same time she could visit. And so, we can't let roommates stop visits, but we have to figure out a way to do a recommendation that honors their wishes too. But you can't be, if you can leave the room but you choose not to that, you can stop a visit. And, and that was a big issue, and a lot of the guidance was that, you know, if there was another roommate in the room, you couldn't have the visit in the room, and, and that, that was kind of unfair, if you had a more open family you could visit, but if you didn't, you couldn't. And, and again that it's not a very

fair way to make the decision about whether you can see your loved one or not.

00:55:01.670

Juliette Mullin | Manatt: Thank you for raising that.

Todd. I see you have your hand raised.

00:55:08.850

Todd Higgins Disability Rights California: Oh, yes, can you hear me? So, I, I just wanted to address the, the, a concern with the word essential caregiver. I think when you put the word essential with it, it, it, you know it, leaves it up to a subjective interpretation, you know, and, and as far as you know, what you know, anyway, I, I think I would prefer to see just that, you know, that the word essential being dropped from the policy, because again, I think it just opens it up to some, you know, more subjective interpretation or, or limited, limiting what essential means to, to a person.

00:55:45.160

Juliette Mullin | Manatt: I appreciate that comment and I do want to preview for folks in our third meeting. What we'll do is we'll take these principles, this general alignment we have on what we want to recommend for this workgroup, and then we'll start to finesse, what are we going to call it? What are, you know, where we have particular parameters that we're putting in place or recommending for anything, what are exactly do those look like? So, I want, I encourage everyone to, to think about that one specifically, if you have thoughts now on what the language is that would be appropriate for this, I certainly welcome that. But we'll definitely make sure we spend some time on that Todd in our in our next conversation, because that's an important one.

Great. Leza.

00:56:27.490

Leza Coleman CCoA: Thank you. I, I am very cautious about the, the notion of these visits having to occur in certain places, because we've

already discussed that loved ones can be providing essential services. So, if we've now decided that I can only meet with my mom in this area, does that mean I rub my mother's back in this now public area. But if she wants me to, you know, undo her bra, because her shoulders are really hurting her. I, I think we are going to be in conflict if we're saying this that there are certain areas of the building that are okay for visits if we've already acknowledged that loved ones are providing essential services. So, I think we're going to get ourselves into conflict there and then I'm going to go back - PPE is safe for staff, PPE is safe for families. Thank you.

00:57:23.150

Juliette Mullin | Manatt: Thank you.

We have a hand raise. I don't, the person's just named long-term care facility access numbers, I'm not sure who it is, but if you would like to take yourself off mute.

They drop their hand.

Okay? So, I think on this piece, we have some pretty good alignment with this group and encourage people to drop in the chat If anything I’m about to say you don't agree with. That we are recommending some kind of approach to, to be named that would mirror the concept of being able to designate individuals who can come visit you in the facility, and that to the extent that, that, that there would not necessarily be a limit to the number of individuals you can name, there may be considerations in an emergency for the number who can be on site at a given time. But that you could theoretically name 12 loved ones and they could come visit you if there was a simultaneous visitor limitation on a rotating basis, something to that effect.

All right.

I'm seeing general agreement with that. I'm seeing a lot of comments about the public health protections, that we would recommend in terms of PPE and things like that. And we're going to come to that a little bit later in our conversation today, but I think you know, we are at the one-hour mark, and we have our first core principle that we want to recommend moving

forward, which is to move forward with this general approach. And we'll, we'll spend some more time defining that later in today's conversation, and then, in our subsequent conversations as well.

So, our, we have our first big principle aligned upon with this workgroup, which is great. Let's go to our next slide.

SLIDE 28

So now we wanted to take some time, and I alluded, as folks were talking about this in the chat, that we would take a moment to talk specifically about the issue of compassionate care as a potentially distinct thing that we want to put some recommendations forward around, from not, moments that would not be considered moments of crisis, for example. And so, what this might look like and has looked like in certain states is that in a in a moment that is appropriate for compassionate care situations and those can be defined very broadly based on the state, it can include transitions, grief, end-of-life a lot of other situations.

In those particular moments when compassionate care is needed to have an elevated right to or a, a, a distinct right to visitation during that time, because it is a moment of crisis.

So especially in the context of the conversation we just had about kind of like what we would recommend is more baseline visitation would love to invite this group to speak to what are situations in which California may recommend a different set of rights or visitation in a situation of compassionate care.

So, I see we have a couple of hands raised. The first hand raised does not have a name it's long-term care facility access member, but if you know who you are and you know you have your hand raised I invite you to take yourself off mute.

01:01:02.130

Liz Fuller: Liz Fuller, I'm not sure why I'm named this. But I, I just I ask that I think that I am in, I'm supportive of everything that everyone has said, but I don't think it's all that different than what, some of what was in a bill

previously, and so I what I'd love for us to kind of consider is what is our dream, and then what would be our line in the sand. And that helps in what the recommendations are that's not to say that the recommendations aren't the dream and the hope as we move forward. But what would be reasonable, in moving through the legislature?

Because what was, what was thought to be reasonable is a lot of what is discussed here, in fact, even greater, but wasn't moved through the legislature. And so, I would hate for us to only have the recommendations that are kind of the dream, but not having discussed what our line in the sand is, because, we may have to ultimately build off that line as we, as we move forward.

01:02:16.850

Juliette Mullin | Manatt: Thank you for that comment, Liz.

Perhaps before we move into a robust conversation about compassionate care, we can go back to essential care giver for a moment. I think we've heard from folks what we want to recommend to Liz's point as the dream and what, what we'd, what this workgroup would recommend, but would love to hear from folks about, as she said, the line in the sand when it comes to an approach for essential care givers, oh, go ahead.

01:02:48.400

SLIDE 27

Liz Fuller: I'm sorry. You know, we can also consider that if you did put a number to how many you know, we call them resident designated support person(s), you know plural, can be plural, that those could be changed by the residents at any time. The same way that you can in family councils, you know that is the person that you designate, but that can change at any given time. And that would then allow for that person that in the current state it needs to be my daughter, because maybe my husband isn't, isn't well or can be both, so that if one person is not available, the other can also be reached or accessible, but also where, where are we with making those changes, because if a resident is designating who they want as their people of choice, they should be allowed to change them as well, and I

understand that those people would still have to follow the same guidelines, but can be changed and designated by the residents, you know new people it at their choosing.

Maybe not necessarily keep us in that it can be one, it can be two, but in saying if it is two, or if there is a certain number that we agree upon, but that could be changed by the resident at any point.

01:03:59.650

Juliette Mullin | Manatt:

Karen, I see you have raised your hand. Did you want to comment on that?

01:04:21.260

Karen Jones, CLTCOA: I do, and I appreciate Liz's like kind of dream that we want, and, and I'm a firm believer in having meetings with no barriers initially. So, I would have to say, we don't need to change anything if we have our dream, which is, don't mess with residents rights. You know residents have the right, it's already in law, state, and federal. So, let's just not limit it, and you know, talk about what protections their visitors can use, you know, in a public health emergency. But, but that would be the first line is that we want, we just want to use what's already in the law, you know, just like we can't go speeding down the freeway at 150 miles an hour during non-public emergencies, you shouldn't lose your right to do things because of a change in a public health emergency.

You know, we can't throw out all the laws just because there's a public health issue. I, I know we need to protect people, I, I get that, but, but if we're going with our dream, let's just not, not limit visitors. We can ask them to wear their PPE and do their testing, and whatever, if we have to, or whatever it might be. But let's just not limit them at all.

01:05:24.480

Juliette Mullin | Manatt: I'm curious, Karen, if you have a reaction to the thought around the line in the stand, though, like, what do we consider in a in a totally unforeseen emergency. We don't know what it is, we don't know

how serious it is. What is the baseline thing that we want to make sure must happen in that situation.

01:05:43.060

Karen Jones, CLTCOA: If I was, if I got to write this policy, I would say, give us 30 days to do some figuring out, you know. COVID became such a political hotbed that we almost didn't know from any direction what to listen to and, and I don't want this to sound like it's gonna sound, I'm, I'm not trying to disparage, you know, local public health but the local public health in my area had really never set foot in a care facility, they didn't know what they were regulating during this when it came to visitors and, and so it, it cost them nothing to say, nobody can go in. It cost them nothing to say, you know, only staff. You know, in our area, in most of the facilities if you have COVID and you're in the isolation area, in my area they said, you can't have a shower because it will aerosolize it. In other areas it doesn't happen that way, so we have a lot of opinion, and we all know that's just a problem that's happened with COVID. But it, it, let's give it 30 days, you know, and then let's maybe re-look at it. But let's not give people 3 years or 2 years of losing all their rights because of, because of what kind of roof is over their head.

01:06:58.390

Juliette Mullin | Manatt: Thank you, Karen.

Anyone else want to kind of chime in on this concept of the line in the sand, or the, the bare minimum situation we think would have to happen, understanding that we don't know what emergency it's going to be. It could be a fire emergency; it could be public health emergency. There could be operational considerations. What is it that a long-term care facility would be told, you have to at minimum make sure this happens.

Leza.

01:07:35.650

Leza Coleman CCoA: I'm in agreement with, with Karen on this one. I don't think we need a law. We already have the law, we need to ensure that

facilities are following the law, and that families have ongoing rights to visit with their loved ones. I think if we do want to make a law, the law is that local public health has to be in communication with the advocates, that know those buildings. That, and, and that could be if it's a fire, if it's a you know, a, a, an active shooter. It, it could be a flood, it could be a, a communicable disease. I, I don't think we need to expect that local public health officers know everything, but if we mandated that they had to be in communication with the entity that that knows that information best, that we give that guidance and let those experts work it out. That would be my hopeful line and sand.

01:08:40.109

Juliette Mullin | Manatt: So rather in, in kind of that framework, rather than setting minimum for the state, it would be saying, any parameters you set have to be developed in X way, so like in partnership with.

01:08:54.010

Leza Coleman CCoA: Yes, and that we, we, before the emergency occurs, we identify who are the experts that should be in communication with other groups. I know for the Long-Term Care Ombudsman programs, for those Ombudsman programs that were housed within the county they were, they had a, a, a easier time coordinating and working with the local public health officers, because those are often also based in the counties. So, during a, a pandemic is not the time when you're going to craft new relationships. So, for those programs that already had established relationships, it, it went a bit better. So that would be what I would say, is our proposed law, that you've got to talk to the experts, who and whoever those experts are. So, if it's a fire, I would assume that local public health should be in communication with the fire department, as opposed to us trying to create arbitrary this many people, this time of day, this part of the building.

Thank you.

01:10:00.170

Juliette Mullin | Manatt: Thank you. Tony. I see you've raised your hand.

01:10:05.450

Tony Chicotel: Yeah. Hi. I don't expect this will be the last time I talk today, but I wanted to say first of all, thank you to the Department for setting this up in such an organized way. And, and you too Julia, really appreciate the way this has been formatted. Appreciate all the comments for sure. What Leza is getting at is something that I've been thinking about a lot lately is as, as someone who had a hand in writing AB 2546, the substantive piece matters about protecting these rights or trying to find the right balance between public health concerns and, and resident rights concerns, resident quality of life concerns. The other piece is process. We don't, I don't think we have anything in 2546 about process, and I think that's what Leza is getting at is, and I think maybe that we would want an approach that addresses both things there, there would be some requirement for consultation on the part of people who would restrict visitation in some way to consult with the people affected by that, or the people who speak, and the people affected by that that would be nice, and then also some so like a consultation piece, and maybe a review piece to have that reviewed by some other store, source, maybe a statewide agency or something like that. I, I do have a number of thoughts about the process, I don't want to take us too far in that direction at this point, but I, I think we should at some point think about what processes would be protective of making sure that we get this as close to right as we possibly can.

01:11:37.130

Juliette Mullin | Manatt: Thank you, Tony.

Jack, you've raised your hand.

01:11:42.570

Jack Light, Providence St. Jude Medical Ctr: Yeah, thank you, Tony, because he kind of teed up my comments. I think process is important, and then also naming, and a, some adjudicating body that, that convenes and meets immediately once a, some sort of disaster has been declared. And then the only other piece I would add to that, aside from process is timeliness, there needs to be some time standards there, and it, it's you know, care delayed is care denied.

So therefore, I think, if we are going to draw parameters or lines in the sand that we put some timeliness standards in there, and I can just talk about, you know my experience as a mental health professional and getting involved in, in psychiatric holds and things like that - there is a process. It is adjudicated along the way, and there are timeliness standards.

So therefore, I think that any legislation we put forth, create, you know, an adjudicating body, and that whatever process that we have has timeliness standards. So, we're not in a position where it's a, a care delayed kind of care denied scenario.

01:13:07.330

Juliette Mullin | Manatt: Thank you for that Jack.

Ellen, I see you raise your hand.

01:13:16.510

Ellen Schmeding, CCoA: One thing I just wanted to mention having worked in a couple of different facilities during the pandemic is that the facility administrator was often the person that was able to make decisions when there were gray areas. And I go back to Leza, one of Leza's comments about the relationship with the Ombudsman, with other advocates, with the facilities, working with the organizations that represent them, and really having those relationships cemented before they're needed.

So, because it's, it's the facility directors license that hangs on the wall, and they ultimately are responsible for what happens there. But they need to hear from many others that have a point of view that needs to be considered.

01:14:05.000

Juliette Mullin | Manatt: Thank you, Ellen. Nancy.

01:14:09.760

Nancy Stevens Resident: Hi, thanks Ellen and Jack for those comments. I, I want to speak just a little bit on what Jack had mentioned or have brought

to light actually, us residents, we're, we're still trying our best to recover and some don't know a way out from the tragedy and traumas that came from being kept away from our essential caregivers. So, we're still recovering. We're in the recovery process still. And the more time that goes by the less likely we'll be able to continue to recover from those traumas, of sort of being forsaken, or felt forsaken.

01:15:02.750

Juliette Mullin | Manatt: So, I'm gonna kind of edit my summary from this section. And just before we move into to compassionate care or we move back into compassionate care, to, to say I think, like coming back to like the core principles we think are important. I'm hearing, you know, we shouldn't, whatever process we have for determining how many people, or how many, who you can designate as a visitor should allow you to designate a wide range of people. I heard a couple options for that, I heard people saying, just let people designate as many people as they want and then perhaps you can say, you know, due to operational safety reasons you can limit the number who are in the room at one particular moment in time, but allow as many designation as you want. Another option, for that was to limit the number of designations, but to allow residents to change those designations as often as they want.

Those are kind of two core ways that we could approach what I heard as a core principle of not forcing residents to pick and choose between loved ones, and to be in a situation where there's certain loved ones they can never see, because they can't make that designation, was one principal I heard. Another big one that I heard was thinking through the process through which any parameters on visitation get set, acknowledging that a future emergency may not be predictable.

Us sitting in this virtual room today may not be able to, to name what that emergency would be and what it would look like. So perhaps, as we think about what are permissible parameters to visitation, or what, how do we set parameters thinking about the process for setting them, rather than sitting down right now and saying it should be A, B, C and D, because we don't know what that emergency is, but perhaps saying they have to be set in X, Y and Z way to ensure that that fundamental right is achieved.

Nancy, you've raised your hand.

01:17:06.170

Nancy Stevens Resident: I just want to read off what I put in the chat so no one misses this. I can't choose for someone else to be my mom. No one else can give me the kind of safety feeling, compassion, love that a mom can give, you know, my clergy person can't be my mom, and vice versa. So, I just want to make that.

01:17:32.650

Juliette Mullin | Manatt: Thanks, Nancy. I think that, that really underscores the, the piece around, not forcing people to pick one or only one. Yes. Great.

Okay.

We're gonna talk a lot more, in probably about 20 minutes, about different parameters, and how, how we might recommend to set parameters for safety, for public health protections be set. But I, I think we have some really good alignment that we want to recommend, from an essential caregiver approach. We'll spend a lot more time talking about the parameters around that in our next meeting.

SLIDE 28

Let’s talk a little bit about compassionate care. But we're really trying to do today is getting a full kind of list of the areas that this group wants to recommend. And then we can talk through more exactly what the specifics of each recommendation will look like.

And so, this next section really gets into compassionate care, and whether there are any particular recommendations that this workgroup wants to put forward that are unique to a compassionate care situation. And reflecting on a lot of what we heard from the workgroup about the, the limitations of what the practice of compassionate care has looked like during restricted visitation, that sometimes there were severe time limits, or certain numbers of people could, be available, could participate in a compassionate care visit. Would love to open it up to this group and just hear from you all,

where you see some needs for a particular recommendation to address the issue of not being able to be with a resident during a moment of crisis.

And, Nancy, I see you have your hand raised, I'm not sure if that's a new hand raise, or from your comment you just made just now, either, either way, if you would like to speak, please do so.

No, okay. Karen.

01:19:58.310

Karen Jones, CLTCOA: I know it's hard because we're a big state. But consistency would be really helpful. You know, if you're in one county, you get these kind of requirements and ability to visit, and you're in a different county, it's a different one. We really do need statewide consistency. I, I know that, like, okay, so this county is having a neuro outbreak or whatever outbreak in that county is not so, that would be different. But, but when it goes past a certain timeframe at some point we need to be a little bit more consistent about it, and it could be the consistency is, if you have this rate of whatever it's, you know, it's this, this visitation plan. But consistency would be really nice. There was, again, a lot of opinion and a lot of personal choices about what to do with these things, and I know it was more than that. But it, it, it was just so random, even in areas with very similar COVID situation. So, we need consistency.

01:20:55.540

Juliette Mullin | Manatt: Thank you, Karen.

Nancy, I see you raised your hand.

01:21:02.000

Nancy Stevens Resident: Yes, to Piggyback off what Karen just said. I was told by, by our administrator and other folks in management that it was impossible. They specifically use the word impossible to keep up with all of the, the changing guidance policies. Which is another reason why this this law is so important. If that word impossible was used, we witnessed how, how, following the, the ever-changing guidance just was, was affecting the negative, the residents negatively on a on a harmful basis.

That's all.

01:21:50.980

Juliette Mullin | Manatt: Thank you. That's great. Well, that's helpful. The, I think we are going to spend a little bit of time later on our conversation today for folks, just so you're tracking, talking a little bit about the communication of policies, on the implementation of policies once we sort of get a canvas of what we want to recommend.

Maitely.

01:22:14.750

Maitely Weismann, Essential Caregivers Coalition: Hi! So compassionate care became such a subjective term. You know, people would decide whether someone needed it and that's what made it so inconsistent across the board the, it, it had a very broad or very narrow definition depending on which part of the pandemic you're in and, if you have a resident designated support person, you have someone in there who has eyes on the person who knows them very well, we are usually the ones who see the changes in our loved one before caregivers who are paid because they have so many other people to take care of, and during the pandemic they were very limited in terms of their staff numbers and their, the pressure on them, it was very difficult, and so, having an individual resident designated support person for residents who are able to have one, because they have someone, they'll at least be, have eyes on them that can say, look, I know this person, and they need, they need compassionate care. And the way that I understood compassionate care was, you know, if someone, if you have a resident designated support person, you have your, you have social support. You have a lot of the issues that you know, like when people were crying at one point they were, they were able to get compassionate care. They didn't all the time, but they, technically it was written that they could but, but end-of-life can't be, oh, she's on her last day, or she might be on her last day, because nobody really knows, except, I, I don't even know who knows. I can’t tell you, but nobody really knows when that last breath will be taken. And so, for, for compassionate care to be timed it was very unfair. But I can tell you that if you have a resident designated support

person in there, they can tell you when they should see their family and have more access to everyone who needs to be with them at end-of-life, if we're talking end-of-life specifically.

01:24:21.350

Juliette Mullin | Manatt: That's helpful, thank you. And so, I think that gets a little bit to how we define and how we identify the need for a compassionate care visit, and not necessarily leaving that entirely up to the facility, but having to your point Maitely, the opportunity for the resident designated support person to actually identify those scenarios and lift them up too.

I'm seeing some questions about like, why would we need to consider compassionate care? Well, I mean, first of all, it's going to be the, you know, this decision and consensus of this workgroup whether to lift up a particular compassionate care, recommendation. So, if the workgroup does not, think one needs to be put forward, that's kind of the decision of this workgroup. I think the, the piece I will raise is thinking about the, the line in the sand situation, which is acknowledging that in certain states of emergencies there may be certain types of restrictions that are set for public protection, and you know we will, we'll spend some more time in a minute talking about what those might be. If you're in a situation where there's limitation on, for example, the number of simultaneous essential caregivers who can be in a space with someone. Does this workgroup want to make a recommendation that the number of simultaneous visitors in a compassionate care situation should look different, for example, that that would be, or that where the compassionate care recommendation would come in.

Any additional thoughts from folks about a compassionate care recommendation?

Leza.

01:26:39.060

Leza Coleman CCoA: I, I feel like this one is one of those slippery slopes. If we carve this in, it gives, it gives a reason why you couldn't be allowed in. So only if you had these special words, and you know how to say this

person, I, I need this person because they are my compassionate care, you know, person. It, it, it becomes a carve out for why so and so can't come in.

And if we get to, well, it's only end-of-life, I think, my most traumatizing COVID call was they won't let me in to see my mom unless I agree to pull the plug and take her off life support, because then she will be, in fact, dying. I, that's just, that's just an unfathomable thing, and I don't want us to ever go back to that world, so I would just assume not, and I would just assume that we have the right to visit with people, and that we do our best to enforce a way that makes sense safely for the residents and for the operation of the facility.

01:27:55.320

Juliette Mullin | Manatt: Thank you for that comment.

George.

01:27:59.860

George Kutnerian - 6Beds, Inc.: Hi, thank you. I think, for, for compassionate care it depends on, what's afforded for that relative to, let's say, like a base recommendation. So, if the base recommendations are, there's a lot of latitude, and you don't necessarily need to distinguish compassionate care cause the base recommendation is, is satisfactory, then you may not need to distinguish, but, but you know that, that really depends, though, on what the base recommendations are. I mean, I was hearing earlier in discussion that essentially, you know, pretty much allow all visitation as long as the visitors are doing the same things that the staff are doing. So, if that's the case then what's the distinguishment for, for a compassionate care situation? So, it just really depends on a relative basis what that involves. If that makes sense.

01:28:54.660

Juliette Mullin | Manatt: That makes perfect sense, I'm, I'm hearing that we essentially just need to define further what are the public health protections?

01:29:02.460

George Kutnerian - 6Beds, Inc.: You may not need to distinguish if there's so much latitude in just, on a general basis, then what's the point? But if but if there's not, less latitude on the general recommendations, then you may need to do some more distinguishing for, for compassionate care. So, it just depends.

01:29:21.880

Juliette Mullin | Manatt: Appreciate that, thank you.

Nancy, I see you have your hand raised.

01:29:28.850

Nancy Stevens Resident: I want to apologize if I'm taking up anyone else's time to be able to speak, I, I seem to be chiming in quite a lot on this issue. But I, the definitions of, of both are sort of in, in my own personal experience, and from what I've witnessed here in my facility. There's, and looking at all of the, the numbers of people who have died, not due to having COVID directly, you know, failure to thrive to me, it's all end-of-life, it's all end-of-life visits or potentially saving people from being at that point. You know, you speak of, everyone speaks of this fine line, but there's also a fine line between having that essential caregiver come in and end-of-life, and I can talk about personal, my own personal story if anyone wants to connect. But there's, there's a need for, for definition, but as it stands now, it's one and the same for me.

01:30:42.110

Juliette Mullin | Manatt: Thank you for sharing that, and please do not apologize for speaking up. You are experiencing this, you are a resident living in a long-term care facility, and your input is extremely valuable for this workgroup.

Melody, I see you have your hand raised.

01:30:57.200

Melody Taylor Stark: Hi, thank you. Yeah, just a, a couple of, of notes and, and kind of underscoring what a couple of, others have said about just the,

the knowledge of the loved one by, by our chosen family member. I, I remember being on a very, on a landline, very bad landline call with my husband, and I'm the one who detected he had pneumonia, not the staff who were working with him directly.

So, I think, you know there, there's that viewpoint. And then also, when we're talking about compassionate care, if we're looking at policies and procedures that are going to cover visitation no matter what the person's status is, doesn't that already include compassionate care?

So, you know, when, are we, you know, looking at it at another category, that's not really another category, because it's already encompassed in the main content of the subject matter that we're discussing.

And, and then, third, there's, you know, when it's compassionate care when it's not compassionate care, and I don't see the slide up, and I think it's maybe the next slide down asks the question. I'm sorry I'm looking at another monitor right now, under what circumstances do you feel that the, that essential caregiving and compassionate care can be enabled, and kind of counter with that of what circumstances do we feel that essential caregiving and compassionate care can be disabled? Shouldn't they always be enabled?

01:32:38.360

Juliette Mullin | Manatt: So, I appreciate you raising that slide Melody, cause I, I wonder if we actually go there next in our conversation. Apologies, I, I have a cold, I'm losing my voice a little bit. But yeah, I, I, I, I think that's a great call, Melody, that it really, and, and to George's point earlier as well, it's sort of all depends how we define some of the parameters, and, and how we define the essential caregiver than what additional elements we need to consider.

SLIDE 29

So perhaps we go there, and we can, and then we can come back to this conversation. Perhaps we may not have time today, but in a future conversation we come back to looking at these additional considerations around rights to see if we feel there's additional specific recommendations

to be made there based on where we land in the public health protections parameter section.

SLIDE 30 & 31

So, I'm going to take us there now. We have about an hour left in our discussion, and what we really want to talk about in this section is understanding, I think we're, we're, we're coming to, to this with a mindset of enabling visitation, that we've talked about for the past hour and, and some, and we want to talk a little bit about what are the measures that we also need to consider in terms of protecting public health. And I know this is an area that is so, it's not easy to talk about. It's kind, it's very complex, and so really encourage folks to, to come, especially for the next few minutes, with a mindset of putting things on the table, of what is it that we do need to be able to protect public health, that we can consider and make sure we weave into visitation from a really productive standpoint.

So, we go to the next slide.

SLIDE 32

We have a few questions we want to invite folks to weigh in on here, and, and, we're gonna again, we're gonna come back to our additional categories of visitations to talk about, but I think it'll be helpful to do a little bit more conversation here first. So, we really want to invite the group to put, you know, with a public health lens for a moment, to really think through some of the public health considerations for visitation policies.

I don't, a, a few core questions we have listed on this slide. I'm, I'm going to read them, as well so folks kind of think through their comments here.

The first is, you know, we really want to think through how do we strike a balance that would give public health professionals flexibility to address unexpected situations during a state of emergency.

And, here I really want to remind folks of comments made by a few different people in the workgroup that we are not making policy recommendations for COVID-19 in April of 2022, we are making policy recommendations for states of emergencies unknown to us in the future.

A couple kind of additional questions to think about. Under what circumstances do you feel that essential caregiving and compassionate care can be enabled, and what circumstances might they potentially be impacted? Thinking about the range of public health emergencies we might face.

And, then this last question is one that's been raised by a few different folks to really dig into this idea of are there specific situations in which staff and residents might need to follow different safety protocols to protect public health? Or might we be able to set a standard that, as long as there's parity there, we can move forward with types of visitations.

So, we want to encourage a really productive and focused conversation, and on these questions to really identify what are the public health protections that we need to think about for this workgroup?

Tony, I see you have your hands raised. We'll go to you first. But I also know we have some folks from our, our, public health professionals on the workgroup who are also prepared to speak to this, so I'll ask them to, to speak to this as well in a moment.

Tony.

01:36:33.160

Tony Chicotel: Yeah, thanks, two points. First of all, going back to, I think with Slide 23 we had the scale, and there was a, a balance there between resident rights and public health. Just, and I understand why you do it that way, I mean, those are the big considerations we're, we're worried about, and we're just trying to simplify it to a PowerPoint slide. But, one thing that I think we've overlooked a lot is that they're not always antagonistic with one another, that, that, having access to visitation in many ways improves public health, that at least the health of the, the people being visited, and in some cases the visitors as well. So, there, I don't see them as necessarily two sides of that scale all the time, but I understand why it was set up that way, but just wanted to raise that point.

And then the other issue is, I've had a hard time coming up with a scenario, and I would really appreciate maybe some input from public health officials

or other public safety representatives of a scenario where a resident designated support person could be treated differently from a staff person that I, I just have a hard time figuring out a way where the, that designated support person is going to provide less in terms of quality of care and quality of life to that person than the average staff person.

01:38:00.010

Juliette Mullin | Manatt: Thank you, Tony, for that question.

I know, I see we have Nancy, who's raised her hand, so we'll go to Nancy next.

01:38:08.360

Nancy Stevens Resident: Thanks Tony, thanks Juliette. Also, I wanted to talk about the, the shortage of staffing, not just in the nursing homes, but also in public health departments, and also in the Ombudsman departments. There's a shortage of staff in all of those places, and having a central caregiver to come in and sort of assist with those roles as well would be very, very helpful, extremely helpful, it's to the detriment of, of our health and well-being. And then to that third bullet point there, do you see situations where staff and visitors might need to follow different safety protocols to protect public health. Perhaps just not going from room to room.

01:39:00.670

Juliette Mullin | Manatt: Thank you, Nancy.

01:39:02.260

Nancy Stevens Resident: You bet.

01:39:09.440

Juliette Mullin | Manatt: Makes sense. All right, I want to open up, I know we have a few public health folks. I see Jayleen's raised her hand so I will go there.

01:39:18.760

Jayleen Richards, Solano Public Health, CHEAC member: Hi, Jayleen Richards, with Solano Public Health, and I'm also representative of County Health Executives Association of California. And thank you for having this call and allowing time for us to share. You know, I've mentioned on this call, probably, and, and past calls that public health officials need to have their flexibility and their toolbox during a given, an emergency, and what we found with COVID-19 is that it was a very unusual emergency, and there wasn't a lot known about it. When there's a, emergencies in other emergencies, like fires, neurovirus, tuberculosis, there is a pretty good playbook on how to respond to that emergency. But COVID-19 was very unusual, and health officers needed to have the powers and the tools to respond to it in a, at a given time. The minimal necessary restrictions need to be used during a given, during a given emergency and clear communication about the emergency needs to be provided to the public, to the family members, to the caregivers and others.

And, and, and I agree with what a lot has been said about how, why this action is being taken, how it impacts visitation possibly, and what's the timetable that is needed. And when will it be reassessed should be part of that clear communication.

One thing Solano worked very, very closely with our long-term care facilities here in our county. We have an infection prevention team, and we are not demobilizing it, we're going to keep that team running, and, and we think that can help long-term care facilities now and in the future in responding to emergencies.

One thing that we want to keep going is having a video for family members on how to visit their loved ones safely, especially during an emergency. Teaching long-term care facilities about zoning, within a facility. Having a red zone for those who are experiencing the disease, a green zone for those who are okay, in a, a yellow zone for those who may be in that, if the situation that we kept on having during COVID. And some zones would require full PPE.

We talked a lot about compassionate care and visiting and just visiting in general, and I think we've learned a lot from this past emergency and that we can move forward, that there could be electronic visitation, time limited

visitation if needed. Education about PPE, how to use it, how to have a successful visit with it. And the last thing I wanted to talk about, oh, different protocols for say that for employees versus visitors.

There again, if there is an unknown disease, there might need to be different protocols in some instances, and, and I know that during COVID, health care workers, for example, could get the vaccine very, very early, but the general public couldn't. So, you wouldn't want to not have visitors because they didn't have their vaccine per se. But there could be different rules for different folks based on a situation. That's all I have to say, and I'm sure I'll add in more later. Thank you.

01:43:52.720

Juliette Mullin | Manatt: Thank you. We really appreciate you raising all of those pieces and, and sharing the kind of core elements from a public health perspective that that are critical here.

Katherine, you've raised your hand.

01:44:03.630

Catherine Blakemore: Thanks so much Juliette. I, so I, I guess I thought those comments brought to light. I, I appreciated your earlier comments about we're not designing a policy for 2020, but yet whatever we're doing is influenced by that, for the reasons that Jayleen said, which is, it was something new and different. So, I, I still think, sort of understanding what we live through during that period of time, and what we might be able to do different and better is really an important part of that. So, if you, if you thought about you know, what Jayleen was saying, which was, maybe there have to be limitations, I think we have to still start from the place, that there are consequences for people if they're not allowed visitors that we did not fully take into account, and maybe didn't appreciate, and that that we can't end back up ever again in a place where people did not have a visitor for a year or sometimes longer. And so, if there is something so extreme and there's no way to protect people, it has to be more time limited, with a careful, thorough ongoing review, so that we're not jeopardizing people's health in other ways. So, I, I, I think it, I think the past foretells sometimes what the future is, and we have to learn from that, or we're gonna end up

making the same mistakes that we made, made the last time. So, thank you.

01:45:38.740

Juliette Mullin | Manatt: Comments very well taken, and certainly why, we spent a lot of time talking about COVID-19 at our first meeting. I think what one thing I'll just raise before we go to the next person who's raised their hand, to your point Catherine, is learning from COVID, knowing that it can last a long time, knowing it can be unexpected, to Jayleen's point, you know, what are our, as Liz Fuller was saying earlier in the meeting, line in the sand.

It needs to at least be this, and this is how you determine any kind of parameters. So that we are coming from a, a place of a stronger baseline next in, in any future situation, and we know what it at minimum, even in a really unexpected situation, needs to be informed by COVID.

Nancy, you raised your hand.

01:46:27.720

Nancy Stevens Resident: You took most of the words out of my mouth, Juliette. Stay out of my head, that's my personal space. This is not about taking away the toolboxes from public health officials at all, by any means. We greatly, greatly appreciate and have a need for public health departments, whether it be a federal, state or local. You know again, like the like, Juliette, and, and the prior speaker just spoke on, this we need to, we need a start. And there's a lot of survivors guilt, that my neighbors and I talk about openly on a regular basis to heal because we didn't speak about this specific issue sooner as we watch body bags go by us every day.

Thanks for listening.

01:47:25.950

Juliette Mullin | Manatt: Thank you for sharing Nancy.

Ellen. Do you have your hand raised?

01:47:31.530

Ellen Schmeding, CCoA: Yes, I, I just wanted to mention that I thought that public health, I'm from San Diego, and I believe they worked extremely hard. We had tremendous communication and long-term care workgroup that was specific to issues coming up in facilities. I think the most important thing that I take away is the communication. One of the big challenges was trying to figure out what you were operating under, what AFL, what PIN, what the, you know, where were you getting your direction, was it current, were you doing what it was that public health was requiring at the time.

So, towards the future, I would just say, to try to, to improve that, to figure out who is on first, and who is providing the instructions so that at every level people know what it is that is of that moment. I know it's really hard, COVID, looking back at COVID it, it was like being in a crisis unit or a M.A.S.H. unit. But I think aspirationally trying to figure out, yes, the state public health has jurisdiction, no, the local public health has jurisdiction, here is the most recent guidance that you need to pay attention to and how it impacts residents and others.

01:48:53.530

Juliette Mullin | Manatt: Thank you. Ellen.

Karen, you raise your hand.

01:48:57.690

Karen Jones, CLTCOA: Yeah. So, you know, again, going back to the toolbox. And I really appreciate Jayleen being willing to be on here and help out with you know, how do we find whatever kind of balance we can find? Because, you know, we don't want people sick, we didn't want people going out in those bags, but you know we also wanted access, and that that's a hard razor to ride, but, we have to be cautious with those toolboxes that we're giving out, because there was a lot of freedoms that were lost, and we all we all understand the why’s behind most of it. But, for instance, in one area, paid Ombudsman could go into facilities, but volunteers were told by local public health that they couldn't go in. And I absolutely guarantee there is no difference with COVID whether we get a paycheck or not.

And so that was hard to hear that that was even a requirement. But the other thing that we've heard about was, you know, pre pandemic, pre COVID, you know, our Ombudsman office, and I know several others, we're part of helping counties write the standard operating procedures, the SOPs for how to handle pandemic, flu, or how to handle a fire, an earthquake, or whatever, and then, being told when the emergency hit that they'd thrown the entire playbook out, it was gone. Then we were starting all fresh, and every protection that was put in, every plan was out the window, we were starting all new. We need to make sure whatever recommendations and whatever becomes eventual policy that that we can't just toss it all out, you know obviously you got to revise it for the incident, but you can't just throw out everything and then lose all those relationships, and you know, attendance at meetings and being part of the plan, part of the, you know, at the at the table, and you, we can have people we kept out of facility simply because of their paycheck status, it, that that makes no scientific sense, and it's not a toy, it's not a toolbox that anyone should be allowed to, to wield. There's plenty of things that needed to happen, but that one just didn't make sense. And, and, I don't want Jayleen or anyone else to, to defend those choices, that's not what today is about, I just want to point out when we're giving out tools that affect people's lives and their freedoms and, and their ability to see their loved ones, we have to be very careful with that, what power we're giving out.

01:51:16.190

Juliette Mullin | Manatt: Thank you, Karen. Jayleen, and I know you have your hand raised, and I know Anissa Davis is also prepared to speak a little bit. Let's go to Jayleen since you had your hand raised first.

01:51:27.790

Jayleen Richards, Solano Public Health, CHEAC member: Anissa could go first and then I'll go.

01:51:30.960

Juliette Mullin | Manatt: Okay, sure. Anissa would you like to?

01:51:35.000

A Davis, CCLHO: Hi. Yes, thank you. A lot of these things have already been said. But I'll just, you know little bit of repetition. Hi, I'm Anissa Davis. I'm the City Health Officer for the City of Long Beach, and also the President of the California Conference of Local Health Officers or CCLHO, and I just wanted to thank the group for this opportunity to share some comment.

The, California's Local Health Officers are physicians that are appointed either by the County Board of Supervisors or by the City Council, in the cases of the three city health jurisdictions which are Berkeley, Pasadena and Long Beach. And we're actually required by California Health and Safety Code, that's what you know empowers us and gives us our authority, and requires us to take actions as necessary to prevent the spread of disease, in any setting within our jurisdiction. So, whether that's workplaces or schools, shelters, special events, and long-term care facilities and acute care hospitals. And a lot of the times these actions are often, you know, put forth in the form of health officers orders. We do take multiple variables into consideration. And I think when we're working to prevent and control the spread of disease and protect our community and, and so sometimes that can affect, you know, the consistency between different jurisdictions, because we're responding to the makeup of our own jurisdiction, and what things are looking like in our jurisdiction, and it is also, can affect, sometimes depending on what's going on, the type of recommendations that you make within a particular facility, you know, to address kind of when would something be different for a resident versus a staff versus a visitor or a support person.

It could be like during the beginning of the pandemic, we didn't have enough PPE, and then there's, there's certain requirements in order to wear certain types of PPE like N95 mask, so it's just an example of things that we take into consideration. As well as the risk of the disease in a particular population. How prevalent the disease is in the community, how it's spread, what kind of protective measures, measures are in place and available, and then the risk of severe outcomes in certain population.

I just want to reiterate with Jayleen said that our orders are, you know, we are bound to use the least restrictive practices, and we are subject, all of our orders are subject to due process, and they can be challenged in court.

We must operate consistent with the United States and California Constitutions, and in case law, precedent has really provided the onus that these orders should be really narrowly tailored, and use the least restrictive, reasonable means of preventing disease.

And so just, you know, also reiterating that we need to retain our flexible authority, we don't know what the next disaster could be. It could be communicable disease that's spread by air or touch, it could be a radiological disaster, it could be a chemical spill, and so, you know, having the greatest flexibility also with the constitutional and legal constraints that are in place is really important. As we, you know, move forward. Thank you.

01:55:25.250

Juliette Mullin | Manatt: Thank you for those comments.

I see, next we have Nancy, who's raised her hand, and then we have Cassie with CDPH, so, Nancy.

01:55:37.720

Nancy Stevens Resident: Just really quick. I didn't realize how dummy proof this needed to be, if there's you know the, the buildings crumbling down, and firefighters are in the building and doing all that stuff. I don't believe that essential caregivers would want to run in to do firefighters job. Also, I do believe that this is a constitutional issue. And then my next point is that I think that there's a lot of credentialism going into these thoughts and, maybe questions, maybe not the questions, but, you don't need a, you don't need a degree to see that someone needs TLC of any kind. So that's all.

01:56:30.090

Juliette Mullin | Manatt: Thank you, Nancy. Cassie, if you, you raised your hand.

01:56:33.410

Cassie Dunham- CDPH: Yeah, Hi, Cassie Dunham. I'm Deputy Director at Center for Health Care Quality with CDPH, and I've been, been very

intently listening, and just waiting to, you know, really consume what everybody else's thoughts are. Broadly, I want to just say that we, that any time that there's a consideration for suspending visitation, it is certainly a very sensitive issue, one that we don't take lightly.

I don't think anybody in the, the period where visitation was suspended at, could anticipate how long that was going to transpire. And I think certainly, looking back, there's, you know obvious lessons, learned that we can take away and, and put into place from the center and department perspective.

But I do just want to echo some of the comments that Anissa made that we can't necessarily forecast specific nuances that might come with the future emergency, and so, having the flexibility to be as nimble as possible to mitigate any risk to resident safety in those moments is, is really imperative, and we, we were working very closely with local public health officers and trying to do the least restrictions possible throughout the pandemic. And I think that that's certainly what we would want to take forward and continue, and to try to be the least restrictive in anything, solutions that we might put into place. So, I'm really happy to be part of this conversation today and, and learning about the different perspectives and the sensitivities that we need to be mindful of going forward, and I think that this group will come up with some really great solutions and recommendations for us to take into future consideration. So, thank you for the opportunity to join today.

01:58:24.320

Juliette Mullin | Manatt: Thank you for joining us Cassie and for your comments.

Melody.

01:58:30.330

Melody Taylor Stark: Thank you, Cassie, for, for your comments and the input, it's really important to hear that feedback. And, as we're on topic of, of, you know, least restrictive, and so forth, so many times the facilities, in and of themselves were saying, you know, we don't have to go by what DPH is, is telling us, or CMH is telling us, we can kind of make up our own rules. And it, it also, while we are on the topic of least restrictive, and

moving forward and, you know, I, I like that term of Cassie, or the concept of what we're going to be doing future forward, because one of the, when I'm hearing least restrictive, that if, you know, and it makes us wonder what least restrictive being the legal standard, why was the most restrictive used in practice. And I think in agreement with the comment that you made at the end Cassie, to what can be prevented from that happening in the future. And just wanted to put that thought out there. Thank you.

01:59:50.260

Juliette Mullin | Manatt: Thank you for that comment, Melody.

We have a hand raised. I, long-term care facility access member, so I can't see your name, but if you know who you are, please take yourself off mute to comment.

02:00:09.810

Claire Ramsey: Yeah, Juliette. Sorry. Hi, I'm Claire Ramsey, Chief Deputy Director of the Department of Social Services. Just want to also join in the conversation that's happening, and really have been in listening mode, as Mark mentioned at the beginning. I think it's been really valuable, as Cassie also said, for the departments to be able to be part of this workgroup, and to really sit and listen to all the different perspectives that are coming forward, and for us to really think deeply both about lessons learned, which I know a lot of us have talked about kind of what's going forward and also what it looks like to operationalize all these pieces, given that there is, it is such a dynamic environment.

So I hope people appreciate that the departments really are trying to listen and think through what all these different component parts would mean in practice, given that the scope of what we're talking about is so broad, and, you know, appreciate that, you know, we have this very specific set of circumstances that happen in COVID, which could, hopefully, will never repeat themselves in our lifetime, but you know, people may be again thinking about the things that go along with communicable diseases, around PPE, and you know how many visitors at a room and a time, those type of things. But also us when we do think about things that might be more natural disasters, or, you know, an earthquake, a fire, where really

there are significant reasons that people wouldn't, maybe we would say here on this call in the calmness, oh, nobody is going to go into a building when there's a fire, but just making sure that we're thinking through the fact that, like, maybe somebody would think they need to do that. And so just making sure we're being thoughtful about like the what if there and that we both are really protecting residents, rights to visitation, and also thinking through, sometimes people may not be acting how we might all be thinking, 50 of us might be thinking on a call today when it's calm. So, so, just, just acknowledging that as well. Thank you.

02:02:18.670

Juliette Mullin | Manatt: Thank you. Appreciate those comments.

Leza, I see you've raised your hand.

02:02:25.080

Leza Coleman CCoA: I want to start off by saying thank you to the public health officers that are on this call, and to, to really hear my intent with this. Because I don't mean to attack any of you, because the fact that you're on this call, makes you different than many of your peers. I, I don't know that I'm as big a fan of local control, because I think what that felt like from, from an outside advocacy perspective was that was 58 different kings and queens that got to make rules for their local areas. But those laws were being enforced by the licensing agency, which was really just two right, Community Care Licensing, or the, the, the California Department of Public Health. And so those surveyors and, and, and analysts that were in the facilities, I think that local control and the 58 different rules that could be applied wasn't as helpful during an emergency. So, I'm going to go back to what I was saying at the very beginning about the need for local public health to be in communication with the experts and those experts already know what the rules and the laws are, and maybe that would have helped to, to, to have promoted the least restrictive, instead of what many of us saw as being the most restrictive out of fear. So again, I'm saying this, not as any kind of an attack on those that are representing agencies here today. Because you're here. Right? You want to be a part of this

conversation. I, I wish we could have brought a few of those other folks to this call.

02:04:16.250

Juliette Mullin | Manatt: Thank you for those comments. Karen.

02:04:22.170

Karen Jones, CLTCOA: Sorry my phone was ringing. I wanted to kind of, I know we're nearing the end of this, so it's probably a little late for this, but we, we were just talking about, you know, fires and people running in or out or buildings or not, and we have had situations where it was families and neighbors who did go into those buildings to get people out. So, I think what we're talking about here is an infectious disease type, public health emergency. We're not talking a fire or an earthquake, because in those situations we do need those families to come and help out a lot of times, even in an evacuation. The facilities, you know, with our current staffing ratios in every facility, there's never going to be enough staff to help really, truly evacuate people safely. So, there are going to be families and friends who show up and neighbors to help. It's really the infectious public diseases where the public health is going to have time, CDPH is going to have time, CCL will have time to write visitor restrictions or not to write public health policy about it, that you know, if, if we get a Sonoma area level fire where it blows through on 60 mile an hour winds, no one sitting down to write a policy about visits That may come eventually, perhaps, but I doubt it. It's really a public health emergency where someone else can get sick because of a choice somebody else makes.

And so, I think we need to maybe look at limiting it to not those immediate public health like the smoke, is bad and we're all going to have a lung problem, which did kinda happen here and everywhere else, when we had big fires. But it it's not those, that's not where we're going to see these limitations, because we've had those forever. We've had earthquakes, we've had, you know all that. It's COVID brought this out, and now we've got to deal with what we do the next time there's an infectious problem.

02:06:07.910

Juliette Mullin | Manatt: Thank you, Karen, for those comments. Anissa. I see you've raised your hand.

02:06:12.480

A Davis, CCLHO: Yes, thank you. I just wanted to respond. And just, you know, appreciate other folks feedback and, and that, you know I, I, I just want to echo that, yes, there was a lot of confusion on the different levels of you know, locus of control, and so I think that, that was, I could see how that bread a lot of confusion, but there were a lot of things that were outside of the local Public Health Department's control. And I think that was confusing to like a lot of things were coming from federal, and then the state was interpreting, and, and then, you know, locals could, could work within that, and I appreciate the, so I just want to say that I, I, I could see that that causes a lot of confusion. I think, for everybody involved, it was causing a lot of confusion that would, there was a lot of different areas of people making rules.

And then I also just wanted to say that, the, you know, we were trying, and I, I, you know, to speak for the local health officers, I know that we weren't always there like we've said that there were lessons learned, and I just want to say that we, we were trying to be the least restrictive. I understand, like, looking at it from like this, your resident or this other, you know, situation or perspective, that it looks like the, the most restrictive, however, we were trying to be the least restrictive within all of the variables and things that were happening. And then all of the unknowns. So, I know that it, it may not have been implemented that way or come off that way, but that was really our, our intention, because we realized that caregivers, you know, support staff, family members are just a very vital part of residents health, just like they are in all of community, social supports are important in all of the community. So, you know, I just wanted to put that out there. Thanks.

02:08:42.350

Juliette Mullin | Manatt: Thank you for those comments.

I'd love it if we could go to the next slide and maybe start moving us into, and I know we're not going to have a full conversation about this today, but would love to tee up this conversation for our next meeting.

SLIDE 33

So, one of the things that was talked about very early on in our conversation today, and I think we, all the, the group really aligned behind the concept of ensuring that residents can name anyone that they would like to be able to see them, to be someone who can see them, understanding that there may be operational considerations for having 20 people in the room at one time.

So, what are some of the baselines that we would want to set, or that we would want to recommend in this workgroup to ensure that people are getting access to the people that they love in a way that is, that respects their, their personal right and their, promotes their personal health and well-being to be able to have access to their loved ones.

What we've done here is, we've listed out a few different ways that States have thought about this, and I know, I think Blanca noted earlier in the conversation today, California doesn't always do things exactly the way other states do. But we can learn from these ways and think about them.

There's a few different approaches that other states have taken to say something might be happening in terms of a communicable disease, in this, in the community, something might be happening in terms of an emergency in the community, and this is how you might allow for certain types of public health protections that could have an impact on visitation.

So, in the first cut, and we, we've categorized them a little bit here for the sake of conversation.

In the first category, there is a, a general approach of saying, you know, we, we established some, some baseline visitation rights, so, this concept of being able to have access to an essential caregiver and, and a facility or a state can say, or a county can say, those caregivers have to follow certain types of safety protocols. And so that can be grounded to the policies that by an organization like the CDC, or CMS, or a Public Health Commissioner.

It can be tied to the protocols that are established for staff. That's one that's been, been stated a lot. What that might look like is saying you can have, you can name 20 people to come, visit you, and they can visit you as long as they follow the same safety protocols as staff, or they follow the same for safety protocols as those set by CDC or CMS.

That's one bucket that we might consider. And if folks want to start reacting to, to things, they think sound like a good approach for California would welcome those in the chat.

In the middle category, we have allowing facilities to set permissible parameters for visitations, if needed, to protect public health. And so, in some situations states have set very specific parameters, they have said, you know, states, facilities are allowed, and we talked about this earlier, are allowed to limit the number of simultaneous visitors, but then some states have said, but it can't be lower than the number. X.

They have, some states have said facilities could limit the hours of visitation for operational reasons, but it can't be less than X amount of hours, or it can't be less than some visitation hours on the weekend, or, or whatever that might look like. And, and in some situation states have said, you know, we can limit visitation to, to certain locations, and we, we heard some feedback on that earlier today about some, some drawbacks of that approach.

There are some states that have, and all of these state policies are available on the, the Long-Term Care Facility Access Policy website, if you want to go in and read more about them. If with our particular areas we're interested in exploring more and learning more about how different states do it, we can pull those forward in our next meeting.

There are states that have established kind of a, a reasonable standard. So, essentially, in their policies, they say that long-term care, so any limitations to visitation rights must be the least restrictive and in some scenarios facilities have to provide the, the public health reason for a specific limitation.

And then on the, in the last column, here you can see there is an approach of establishing a process where facilities can request time bound lockdowns to protect public health.

And so, this this essentially says, and, and I think other folks have mentioned this concept of a time boundedness, if there is a situation you can't anticipate, it can't continue forever. If you, there's a serious limitation on visitation setting a limit on how long that can happen for in some states have done that.

I see Melody, your note about, and you know we can use a combination of these measures, these are just different approaches leveraged by different states, and welcome any reactions or, or, or thoughts around any of these.

I see Melody put in a comment in the chat about looking at the original version of the language in the Resident Designated Support Act, that is included in the summary that Caroline just dropped in the chat. If folks want to look at that.

And I'm opening it up at this point for any thoughts. I'll just, I'm losing my voice a little bit. Any thoughts on the approaches that we might consider? Or, and it, it does not have to be just what's limited to this slide here, this is just to get people thinking, if any of these are approaches we want to explore further in our upcoming meeting, or if there are any additional thoughts on how to think about, you know, allowing for an unexpected public health situation, and thinking through what might be some ways in which we put guardrails and rules around how we think about visitation impacts for public health protections.

Seeing a lot of alignment around A. Karen, you've raised your hand.

02:15:43.730

Karen Jones, CLTCOA: Yeah, I, I put in my comments that you know I definitely prefer A with a requirement. But, more importantly, I definitely prefer no limits for visitors. If staff can go in, then visitors should be able to go in, maybe not as many as we had like at the beginning or before COVID, but every resident should have an access to a visitor, and if there's enough PPE for staff, there should be at least one or two pieces of PPE for

those visitors. So that would be, you know, the, the line in the sand. I would, that'd be my preference. But if we have to do something, and we do, then A would probably be it. But I don't think we should let, let facilities individually decide to limit visitation, that, some facilities that's going to be a big problem, and there'll be more limits than we need, and they don't always tell residents what their rights are when it comes to visitation. So, we can't really count on them to say, well, we'd like this, but you could, we, you know, you can do all these things, they, they never, that doesn't happen too often.

02:16:40.360

Juliette Mullin | Manatt: Well, let me perhaps restate the concept of letting facilities allow limitations, to actually, are there ways that we want to think about putting recommendations on the bare minimum that facilities have to allow. So, it's not necessarily establishing rules that you can limit X, Y, and Z, it's actually to say you at minimum have to provide this.

02:17:01.889

Karen Jones, CLTCOA: Well, a lot of people know my frustration with guidance that has come out during COVID, and really, anytime, you know when you get guidance from, you know, whoever CDPH, CCL, CDMS.

There's a lot of shoulds, and coulds, and may, and I hate those words because they're permissive. And, and people are gonna do whatever's easiest for them within those words. So, if you say permit facilities, they're going to say, well, I'm permitted to not, I'm permitted to limit instead of saying, you must. And so, we have to watch what words we use.

02:17:41.219

Juliette Mullin | Manatt: Thank you, Karen, that's helpful.

So, it might be thinking that instead of saying, you can limit simultaneous visitors, but you have to allow at least two at once. The policy recommendation there might actually just be, that must allow two at once.

02:17:52.690

Karen Jones, CLTCOA: Yeah, I don't, at least, I mean, I, I don't have an issue with having, saying only one person per, per, per resident at a time, except in certain circumstances like, you know, end-of-life. At least they still have a visitor, and it doesn't have to be the same visitor each time. And that gives that little bit more, you know, public health emergency where things are spreading it, it helps spread people out, and you know all the stuff we learn to do with public, you know, with COVID.

So, I don't mean they have to have two people. They just need to have access to more than one visitor, but it still be singly each time.

02:18:30.740

Juliette Mullin | Manatt: Yeah. Thank you. I appreciate that. I'm seeing a lot of echoing of Tony's comments in the chat. Tony, I, I wonder if you'd be willing to just share those verbally.

02:18:41.830

Tony Chicotel: Sure, it was just expressing big misgivings about the idea of facilities being able to restrict visitation ad hoc, or as they see fit. What my experience during the first two years of COVID was that there were many nursing homes that just proved to be totally inhospitable to the idea of visitation, even when they were being ordered to allow visitation to some extent. That was not my experience with assisted living where I thought there were significant efforts made from the provider point of view to try to expand visitation. But nursing homes it was, it was a whole nother story. And I think if there, if they've got discretion, a lot of, not all, but a lot of facilities would use that in violation of the spirit of what we're talking about here today.

02:19:37.780

Juliette Mullin | Manatt: Thank you for that comment, Tony. I, we have a few hands raised. I'm going to take a few of them, and then I do want to acknowledge we have a few folks that have joined us today who are not from, not part of the workgroup who are joining as members of the public.

If you have any comments you want to share, please feel free to raise your hand at this time, and we will go to comments from the public in, in just a moment.

Nancy, you've raised your hand.

02:20:02.250

Nancy Stevens Resident: I know we've got a lot of people so I'll make this quick. It's sort of an unspoken belief that visitors or family members, or essential caregivers, essentially are going to come in and cause trouble. They bring grief, and they bring additional workloads, things like that. So please, please, folks, take that into consideration. And it's my experience that facilities will use, the, the, their, their ability if given so, the right to shutter down, so to speak. We just recently had a, a long-term, a new admission for a long-term care resident here, and because we were short staffed on all three stations, very short staffed on all three stations, the nursing home administrator decided to say, well, this person may have come into contact with COVID at some point, without any proof whatsoever, and they were able to shut our facility into lockdown. We were told to stay in our rooms, stay in our beds don't come out, no visitors allowed because they were short staffed. And one person could possibly have come into contact with COVID outside. That's all.

02:21:28.220

Juliette Mullin | Manatt: Thank you, Nancy.

Derek.

02:21:33.860

Darrick Lam: I think, as a former owner/operator of skilled nursing, assisted living, we lived through the first two years with a lot of inconsistencies in terms of how different states agencies, asked, you know, asked us to look at this specific issue. So, my key, my point is to make sure that it has to be carefully developed. And there's consistency among all the state agencies and overseeing this process. Thank you.

02:22:07.990

Juliette Mullin | Manatt: Thank you, Derek. George.

02:22:15.410

George Kutnerian - 6Beds, Inc.: Thank you. To kind of ease some people's angst, speaking as someone who represents, at least the smaller facilities, certainly we don't represent all the facilities. But, our members, I don't think, want the burden of establishing these parameters.

So, you know, I know there's a lot of support more for A and that's probably where we're at, I think, echoing some of the, the, the, just, comments. Now, I think the biggest issue for our members was just the, you know, some of the inconsistencies and the guidance, the lack of parity with, between visitors and staff. The fact that residents could go outside the facility and pretty much do most of what they want, and then come back in, but they couldn't have visitors in the facility.

So, a lot of just confusing guidance, conflicting guidance sometimes, and also rapidly evolving guidance. And so, I think that was, you know, some of the issues from the facility perspective. But certainly, you know, I could speak for a lot of our, our members, the smaller facilities when I say that, you know, I don't think we want to be the ones setting the parameters. But we do, you know, and you know, part of the problem with that, too, is you know, one of the principles of the group is parity. So, if you have different parameters set by facilities then you can have a lot of inconsistency across the board which is difficult to manage in its own right. So that's I'll say about that.

02:23:48.550

Juliette Mullin | Manatt: Thank you, George

Heather.

02:23:52.730

Heather Harrison: Hi. Thanks. I don't, I'm not going to repeat everything that's been said in this last section. But, you know, I agree with these comments that assistant living communities worked really hard to maintain and to achieve visitation. Under B, I kind, I think when I first read this I

interpreted it, it differently, than maybe others, when they first saw it. I didn't see it as, as the facilities creating, you know, their own emergency plans.

But instead, based on the experience we just all lived through the last few years, it was how we're going to manage and implement the instructions we've gotten from the various, you know government entities that were putting out the guidance. If we have to screen people at the door, observe visits to make sure that there's 6-feet apart, and people where masks, you know, there are all these other things you had to do in order to have a visit, you had to check vaccine status, you had to train people how to put on PPEs, that those things had to be managed in order to be in compliance. So, I just wanted to mention that, and also some, respond to something that came up in the chat a little bit earlier, and even one of the bullets here that, about requiring facilities to establish or follow the least restrictive. What the, the rule was, and still is, facilities are required to follow the most restrictive. So, when state, local, and federal guidance differed, there would, there was any conflict, facilities had to follow the most restrictive, even if it was in the where, we're in the in the unwinding phase, and you know some level of experts had lessened the rules. If your specific rule hadn't yet, you know, caught up, you still had to follow the most restrictive. So that felt bad for everybody. Okay, that just did feel wrong.

02:25:49.460

SLIDES 34 – 41 WERE SKIPPED

SLIDE 42

Juliette Mullin | Manatt: Thank you, Heather. Thanks.

You know we're coming to the end of our time. I do want to turn to our folks who've joined us, who are not part of the workgroup that have joined us from the public. And just see if there's any comments from folks who have not, who joined us today before we wrap up.

Teresa, you raised your hand.

I think someone on the CDA Comms team is going to help you come off of mute.

02:26:23.990

Teresa Palmer: Hi. Can you hear me?

Juliette Mullin | Manatt: Yes, we can hear you.

Teresa Palmer: Yeah. I've been typing my comments into Q&A all along. So, I, I won't use up any more of your time. I've, I've participated by typing my comments into Q& A. Thank you.

02:26:41.180

Juliette Mullin | Manatt: I appreciate that, Theresa.

And both, I'll, I'll also just note that both for the Q&A and the chat we do, we review those after the call as well. So, all of that we will be looking for all of that.

02:26:52.120

Teresa Palmer: I wanted to say I'm a retired nursing home physician, and I also, my mother died, it, I took her out of the nursing home to die. But it, it was a nightmare. Reassuring her at the end of her life that we had not abandoned her. It was horrible. And I still have basically PTSD, from that. Thank you.

02:27:15.590

Juliette Mullin | Manatt: Thank you for joining us today and thank you for that comment.

I think with that, this is going to bring us to the end of our conversation today. I just want to summarize a few, a few core things before we move on. So, I, I heard from today a few core principles we can move forward and then begin to define much more deeply in our next meeting. The first was really some very strong alignment that we want to ensure that members are able to designate individuals who can visit them, and that that designation process does not force them to have a very small number of people who can visit for a very extended period of time. So, we want to

think about the number. We want to think about the choice. We want to think about the time period for that, for that element of it.

SLIDE 43

What I also heard is, we need to spend some additional time thinking through what are some of the baseline requirements, of, of what a facility, every facility would have to do. And so, we're not leaving it up to the facilities to determine, but what every facility has to at least allow. And that way facilities are not setting individual policies around things that are undefined and, and not specified, but rather we are, we are kind of setting up a baseline. So, I want to encourage folks to think about that between now and our next meeting.

And then I think the last, and we we'll have a whole conversation around that our next meeting, and then I think our, our last piece will be, once we've talked through what it looks like to define that residents' designated support person rights, what it looks like to set some core minimums, and processes around things like safety protocols.

We'll then also kind of have a conversation about whether we might consider any additional considerations for things like compassionate care, offsite visitation, and services that might not be accounted for in the, in the other two categories as we address this.

So that will be the focus of our next conversation. with that, if you go to the next slide.

SLIDE 44

And I think, Brandie, I'm handing it back to you to prepare us for meeting three. Is that right, Brandie?

02:29:35.780

Brandie Devall: Yes, so thank you all for coming. For the next meeting, meeting three, we want you to know it will be on Wednesday, July 12th, at 12:30. CDA will circulate the agenda at least 10 days in advance, and we will do our best to get the materials out five days before that meeting.

We encourage you all to review the materials prior to the meeting and consult with other people in your organizations as needed. The materials will be listed on the CDA website, which somebody from the team will drop into the chat.

I also want to let you all know that we will post the chat transcripts and video recording from this meeting on the website as soon as we can.

And I just want to thank you all again for participating in this important work and sharing your thoughts and experiences.

We look forward to continued collaboration with all of you on the Long-Term Care Facility Access Policy Workgroup over the next few months.

If you have questions, you can email LTCFAPolicyWorkgroup@Aging.Ca.Gov, which we can also drop into the chat.

And again, just to thank you and enjoy the rest of your afternoon.

Goodbye.