Long-Term Care Facility Access (LTCFA) Policy Workgroup Meeting

July 12, 2023 | Transcript

SLIDE 9

BRANDIE DEVALL| CDA: ..... Juliette Mullin, Senior Manager from Manatt Health.

SLIDE 10-11

0:05

On this slide is a full list of organizations and their representatives participating in this workgroup. As a reminder we have posted a list of all the representatives and their biographies on the CDA website. A member of our team will drop that link in the chat shortly. We have included workgroup member bios that were submitted to CDA, in the document that you will see.

At this time I'd like to invite representatives from these organizations who are here for today's meeting to introduce themselves in the chat. Please drop us a little note letting us know that you are here. Give us your name, your title, and the organization that you are representing today.

Great. Thank you. Wow folks are saying hello and getting warmed up, there we go.

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1:29

I'm going to talk about the workgroup's task. So, before we review the scope and plan for workgroup meetings, let's take a minute to remind ourselves of what it is that we are tasked to do. This workgroup is tasked with bringing together diverse perspectives from across the state and building on learnings from the COVID-19 public health emergency. The LTCFA Workgroup will develop recommendations for access and visitation policies for future states of emergency. Next slide please.

SLIDE 13

2:17

As a reminder this workgroup continues to evaluate the impact of restricted access on the mental health of residents, families, and friends, and on the physical health and safety of residents.

SLIDE 14

2:41

To recap the Long-Term Care Facility Access Workgroup will engage in a total of four meetings and they will build on each other. In the last meeting the workgroup discussed key elements that the workgroup's recommendations should contain. We call these key elements Actionable Principles on which the workgroup's recommendations will be founded. Since the last meeting the group provided written feedback on the draft set of Principles which we will discuss today. Most of today's meeting, as well as meeting four, will be dedicated to identifying specific policy and practice recommendations for future emergencies based on the Actionable Principles.

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3:31

This slide outlines the plan for today. Today we will identify policy and practice recommendations for future emergencies. We will summarize the work, we will provide a summary of submitted workgroup feedback on draft principles and develop policy and practice recommendations that establish the following: a process for residents to designate visitors; standards for safety protocols, visiting parameters, and compassionate care visits; and the process for establishing any protocols and parameters to address situations where standards may not apply. And with that I will turn it over to Mark Beckley

SLIDE 16

4:10

MARK BECKLEY | CDA: HI am Mark Beckley, Chief Deputy Director for the California Department of Aging. I will be walking you through workgroup feedback that we received on the visitation principles that were sent out via survey to all of you. But before I do that work, that walk through, I'd really like to thank all the residents, family members, state department representatives, advocates stakeholders that have participated in the workgroups and provided your feedback, your input, your personal experiences and insights into, into the work of this Workgroup. Your participation, your input has been invaluable, and I'm just really happy to see the high level of engagement that's within the meetings, but also that we saw through the survey feedback. We had approximately 19 stakeholders respond to the survey, which is close to the majority of our workgroup. So, thank you so much for those of you who did complete the survey, your input was so needed and so valuable.

And I also really want to emphasize again, Brandie had stated this is the last of two, or the second of two meetings that we have left. So, please you know, as you listen to the discussion today, participate on those points that you're in strongly in favor of, so those principles where you really want to emphasize and you think are really critical to support, as well as those areas concern. And I, you know, I kind of reached out to our advocates as well as our public health partners, if there's something you're not comfortable with, if there's a wording change, if there's a tweak or provision you want to make for those for principles, please speak up and speak up now because this time is valuable, only two Workgroup meetings left. And it's really our charge to come up with principles and perspectives and recommendations that we can then submit and report to the legislature, and even if we see a great sort of like consensus, majority support for certain principles, we also want to, you know, capture any dissenting opinions or views in our report as well. So please, do actively participate and speak up, it's really important.

SLIDE 17

6:45

So going into the principles themselves, what I want to start off with is really talking about the process that Manatt and CDA use to develop the principles. So, what we did is, we went through the previous meeting transcripts, comments that were submitted, questions that were asked from

the workgroup members, and from the members of the public in order to formulate these Principles. In all we've captured 7 actionable principles that are related to long-term care facility access and visitation, and we developed these into areas of alignment from the workgroup members. These draft principles were then sent, as I mentioned, through a survey to workgroup members for their feedback. And what we were looking for is, we did provide some open field comment, comments, where you could provide feedback, ask questions, but by and large the questions really asked you to rank your agreement in alignment with the principles on a scale of one to five. One being were you just disagree, and you do not support a principal, to five, where you are in complete agreement with the principal. We also provided an option of three where you might have just been neutral.

We reviewed all the input that was provided on the survey, and really, you know, summarized that survey and that feedback on the slides that you're about to see. In general, I'll say that there was really strong agreement in alignment with the principles and you'll see that, at least from the workgroup members that responded to the survey. So, it's nice to see that there is general alignment and agreement with the principles that were defined.

In the discussion today we have provided some edits to the principles, based on feedback that we received from the workgroup members through the survey. We're going to walk through the feedback, and the edits pretty briefly today, we only have two and a half hours for this workgroup meeting, and we really want to reserve the majority of the time from hearing from you, so I'm just going to give sort of like a broad review of the principles. But I do want to acknowledge that, based on the feedback that we hear from you today, that we will continue to refine these Principles and send them back to the workgroup for further review

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9:15

So, slide 18, next slide. I'm not going to read the entirety of the principles, but I do want to highlight the main components of the first principle, which is long-term care facility visitors are essential to a long-term care resident’s well-being and that the workgroup members do think that they should be

considered to be a critical component of resident’s care. We kind of entertained the idea of saying that they're a critical portion of the resident's care team, but we really didn't want to confuse that with the care teams within facilities that are comprised of professional staff, so we just said that they were critical component of a residents care. So, as you can see from this slide there was overwhelming agreement on this principle and like I said we'll continue to refine the language and I believe that this principle actually had the greatest number of respondents.

SLIDE 19

10:19

Okay moving on to the next slide. So, these are Actionable Principles 2 and 3. And again as you can see from the histogram results there was very strong agreement on both of these principles. I’ll paraphrase Principle 2, which recommends that California establish a framework that gives long-term care facilities clear standards on how to enable visitation during a state of emergency.

Principle 3 basically articulates that proposed framework would include residents’ access to timely appeals and grievances process to address situations where visitation standards were not adhered to. So, if a visitor was denied, and they felt that they were denied unfairly, this, this grievance process would be available to them.

I think the comments also emphasize that in developing these standards and this appeals and grievances process that it's very critical to involve public health offices, our State Long-Term Care Ombudsman, long-term care facilities as well as licensing agencies. Next slide.

SLIDE 20

11:29

So, Principles 4 and 5 and again as you can see a strong agreement and alignment with both of these principles. Principle 4 states that proposed framework would establish that residents could see a wide range of visitors during a state of emergency, subject to any parameters that were set forth in Principles 5 and 7, which we'll discuss in a moment.

I'll flag a language modification that was made to this principle, we, we've been kind of using the word “right” and I think it's really important to put the term “right” in proper context. So “right” in terms of how we're defining in this workgroup to date really is that residents should have the ability to have visitors and visitations, even during a state of emergency. What we really want to distinguish this from is a legal definition of “right”, that is something that is, say, set in statute, or set in a constitution. And so, we're not using any definition of the term “right”. However, if any workgroup members feel strongly that there should be something that's codified as a formal “right” for residents, you know, that concern might be, you know, put forward as a recommendation. But in terms of this workgroup, we're not going to attempt to create a legal definition of “right,” we just don't think that we've got, you know, the right people or the expertise to, to really, go down that path. But that is something that legislature could absolutely entertain.

In Principle 5 we saw alignment for the workgroup for these recommendations that visitors must adhere to the same safety protocols as long-term care facility staff, although acknowledging that external factors such as, but not limited to supply issues, could contribute to some variation. And of course, we saw that during the COVID pandemic where, you know, the general public did not have access to things like PPE or vaccinations, maybe as quickly as a long-term care of facility staff did. And then in this survey we saw feedback and questions that, you know, we'll spend more time talking about later today in this presentation. Okay, next slide.

SLIDE 21

14:04

So Actionable Principle 5(b), this principle has been adjusted slightly based on workgroup member feedback that voiced concern that, that (1), not including residents and families directly in this process, and (2) permitting different safety protocols as a result of staffing levels. The proposed principle has been revised to specifically point out the inclusion of residents and family representatives, to work alongside public health officers, long-term care facility operators, resident advocates, to collaborate on safety protocol, protocols for a long-term care facilities visitors during a state of emergency. In the detailed recommendations that support this principle, the workgroup may want to define which and how external factors may impact safety protocols for residents.

SLIDE 22

15:05

Okay that's fine. Okay, Principles 6(a) and 7. So here workgroup members again were in complete alignment with both Principle 6(a) and 7. 6(a) states that visitation parameters to account for operational and safety considerations, such as, but not limited to hours of visitation and number of simultaneous visitors, must not reasonably inhibit a resident's ability to receive a wide range of visitors and must be transparently communicated to the public. I think this is something that you know we've heard from residents and family members that there was pretty significant variants among facilities in terms of either visitation hours or the number of visitors that could be entertained in a facility at a given time.

Principal 7 states that when compassionate care is needed and acknowledged, the importance of visitors during these moments of crisis, the proposed framework would provide guidance to long-term care facilities on enhanced steps to mitigate operational and safety considerations and enable timely access to visitors. So what this really speaks to is if there are issues such as supply chain issues, that you know, facilities should to the extent possible extend you know, accommodations such as if they have excess PPE for instance, that could be extended to compassionate care visitors they should do so, and you know we might also look at, like in a public health emergency, if there's an ability for compassionate care visitors to receive vaccinations say in a higher priority.

And again, we saw feedback and questions about the details behind these principles and again that will be the purpose of the today's discussion is to delve deeper into your questions and concerns and also further refine and define these principles. Okay, next slide.

SLIDE 23

17:14

So, slide 23, this speaks to Actionable Principle 6(b), this is the last principle we will review. This is similar to principle 5(b), this principle has been revised again based on what group member feedback that voice a concern with A) not including residents and families directly in the process and B) not having a period of time where a resident designated support

persons are not able to access the resident. Taking these concerns into consideration a proposed edit has been proposed to again, directly include residents and family members among the parties that would work with public health officers, facility operators, and resident advocates to collaborate on parameters that would enable visitation. And again, we'll talk about the feedback that we receive from workgroup members as part of the survey process in our discussions. Right next slide.

SLIDE 24

18:22

And then, you know, finally I just want to acknowledge that there was additional feedback that was provided from workgroup members on all these principles. I won't read through this chart, but I do encourage you if you haven't been able to do so already, to review the comments. We really appreciate the comments that we received and the time that people took, the thought that they put into producing these comments. We're really going to, and we have to the extent that we, you know, could, use a lot of your comments to help provide, refine, the language of the principles, or the content of the principles. And again, during today's workgroup discussion please speak up if there's something that you haven't thought about yet, that you haven't captured through the survey process, we really want to hear your comments verbally in the discussion today. And with that I'm going to turn it over to Juliette.

SLIDE 25

19:29

JULIETTE MULLIN | Manatt: Wonderful thank you Mark. So, with that we are looking forward to transitioning into a conversation about policy and practice recommendation. I'm going to walk through some framing first. We do find that you know, I know we've been doing quite a bit of framing at the top of this call today, but it's helpful to get a kind of sense of the overall arc of what we're going to talk about, so that we can then focus in on specific areas because I think you know we found in past conversations it can be hard to talk about one isolated element of these recommendations without having the broader context of what they all look like. So, if we go to the next slide please.

SLIDE 26

20:07

So, the focus of today's conversation is really going to be developing this recommended framework that Mark just spoke to, and really using Principles 4 through 7 to develop that framework. And so, we're really going to be focused there today. I saw a lot of comments in the chat about, you know, things we need to add more definition to, what do we mean by compassionate care? What do we mean by timely? That is the entire focus of today's conversation. I will flag, there is a very important principle around the appeals and grievance process that we want to spend a lot of time on in this workgroup. We are proposing having that be the focus of meeting number 4, our next meeting.

So today what we're going to do is we're really going to focus on defining and workshopping as a group some recommendations around what the framework looks like at a baseline. And then in our next meeting we'll focus much more on the process around appeals and grievances for residents and loved ones when things might not be working the way that the framework is recommending that they need to work. So, if we go to the next slide.

SLIDE 27

21:23

So, the conversation today is going to be split into three parts. We're going to start first by discussing a recommendation for the process for residents designating visitors. So, this is really getting to the ‘who’ can be a visitor in this framework. The second component here is we're going to look at those standards that we alluded to in the principles. So, in the principles, you know, this workgroup gave a lot of great feedback and aligned around this concept of establishing some standards so that it's not completely variable from long-term care facility to long-term care facility, and we're not, it's not open to interpretation what the base, what the baseline standards should be. So, we'll talk about standards and that'll be in three parts. We'll have a conversation about standards related to safety protocols, standards related to visiting, visiting parameters, and then standards relating to compassionate care specifically. And then our last section for today is going to be recommendations on process for developing any protocols or

parameters in situations where standards may not apply. So that's that 5(a) and 6(a) scenarios we'll build those out into actual recommendations. Next slide please.

SLIDE 28

22:37

So, I want a caveat, I know folks just got these materials not that long ago and are probably just beginning to, to digest all of it and thinking through you know positions and ideas for this. What this deck recommends and the, what this deck represents, and the following draft recommendations are, is, these are really developed based on those Actionable Principles and based on feedback and discussion of those principles. So as with the Actionable Principles we really went back and looked at the totality of the workgroup conversations to date, all of the written comments, and chat comments submitted, all of the research and put together strawman recommendations for us to begin to workshop together. These are by no means final, and the intent to really talk them through today and to workshop them. So next slide.

SLIDE 29

23:36

So, we're gonna, as I noted, it'll be in three parts, our conversation. I'm just going to talk about the high-level elements of the framework, and then we're going to dive in. So, the first element around a process for designating visitors at a high level, the strawman recommendation here, outlines that in a state of emergency a long-term care facility resident, or their designated decision maker if they are unable to decide for themselves, can designate any individual as a resident designated visitor who has access to the facility for in-person visits subject to the protocols and parameters in this framework. So, we're really going to spend some time defining the designation process and we're going to spend about 30 minutes there. Next slide.

SLIDE 30

24:20

Once we are done with that conversation, our longest section of today is going to be standards for visitation. This will be in three core parts, and I'm just going to go through at a very high level what the recommendations are, and just note that we're going to talk about all of the definitions and specifics in a moment.

So, the first piece is around safety protocols and the straw model that we'll be discussing today starts from a baseline of saying as a standard, during a state of emergency facilities may not impose different protocols for staff and visitors. So, we'll do a lot more definition there.

The second piece is saying as a standard, during a state of emergency visiting parameters may reasonably, sorry, must reasonably allow resident designated visitors to conduct in-person visits with the resident and, must at least meet minimum standards for number of permitted simultaneous visitors, visiting hours, and locations of visitation. So, if people are commenting in the chat the definitions behind all of those are going to matter a lot and so we'll talk about that.

And then the third section of this part of the conversation is going to be about compassionate care. And so, we'll be looking at in particular scenarios of compassionate care as a standard during a state of emergency. We'll start from a baseline recommendation to workshop, that visiting parameters including the number of simultaneous visitors, visiting hours and locations of visitations should be expanded to enable compassionate care. We will define compassionate care and then we will define minimum standards. Next slide please.

SLIDE 31

26:00

And our final section is going to be defining that process that we spoke to around what happens when standards may not apply. And so, we will talk about a process through which various stakeholders will be brought together to establish protocols in situations where the standards can't, may not be able to apply. When it comes to safety protocols we'll start from a baseline recommendation to workshop that says in situations where visitors may need to follow unique safety protocols to account for external factors such, as but not limited to supply issues for an extended period of time, safety protocols for visitors must be determined at the county/city, or state

level not the facility level. And so, we'll talk about what is an extended period of time, what does that mean? And we'll talk about the definition of the actual process for defining protocols. And then we'll do the same thing for visitation parameters that are not safety protocols. I've just talked a lot I'm looking forward to getting into the discussion now let's go to the next slide.

SLIDE 32

27:09

So, section one we are going to talk about the process for designating a visitor. Our goal here is to not spend more than 30 minutes in this section, and you're actually going to see these time cues throughout. What we're going to do to leverage, really the strength and the power of this group's expertise, and, and you know advocacy, is we're going to time box some of these conversations, and then leverage a polling tool to be able to gauge alignment and keep moving the conversation, because as you've just seen we're trying to get through a lot today. Next slide.

SLIDE 33

27:46

So, in scope for this conversation is how individuals are selected to be long-term care facility visitors, and which individuals can be selected. We're not yet going to talk about safety protocols. Our visiting parameters that'll be in the next section. Next slide.

SLIDE 34

28:03

All right. We get to our first straw model recommendation. So, acknowledging that I know folks are probably still digesting some of the materials. I actually will take a moment to kind of walk through this, and then we're just going to open it up to 15 minutes of conversation, once we get to the 15-minute mark we're going to invite people to, to give an indication of their level of support for this recommendation. And then we'll continue some conversation if the workgroup feels like there needs to be a lot more workshopping here.

So, I'm going to read through this and just again acknowledge this is the starting point we're looking for people to react. It's a lot, we think it'll be a lot more helpful, it'll be really helpful to have something to base this off of, so I'll just read a couple points of this and then I see we already have some hands raised.

The core topline item here is that in a state of emergency the workgroup recommends that a long-term care facility resident can designate any individual as a resident designated visitor who has access to the facility for in-person visits subject to the safety protocols and visiting parameters in this framework. So, we're not going to talk about those safety protocols and visiting parameters just yet, but we're we are acknowledging that that's a note here. We are going to have a long conversation about those in a moment though.

Here we indicate who resident, resident designated visitors may include, but we do note that it's not limited to that and certainly welcome input and additions and edits to this list. We do note that if a resident is unable to speak for themselves that there would be a process for ensuring that a resident designated visitor can be named, or multiple designated visitors can be named. And then we note here at the bottom that as a standard, facilities may not limit the number of individuals who may be designated as resident designated visitors, but they may require visitors to follow safety protocols as a condition of in-person access, and visitation may be subject to operational and safety parameters such as a limitation on the number of simultaneous visitors.

So, I see we already have a couple hands raised, and I'm just going to go straight there. So, the first in line we have Karen.

30:19

KAREN JONES | CLTCOA: Hi, thanks Juliette. So, two points, one on the first bullet point is - Ombudsman probably shouldn't be included there, we have our own access to facilities and the residents don't need to designate us, and we wouldn't want to be in the way of a family or other visitor for them.

And then, the second bullet point of - if the resident isn't able to speak for them then they, then certain people could designate for them. I think I speak for a lot of Ombudsmen that, that can be a real nightmare, when the

designated person doesn't get along with other family member they might leave out people that the resident would otherwise want. And in California in particular, really, the healthcare agent isn't able to make visitor decisions. The only people who can is the resident, or if a judge gives visitation control powers to a conservator of the person, and that's even documented in court records, it's documented in court forms.

I don't know how to solve this for those residents except maybe a grievance procedure can be added, so that if somebody isn't designated they would be able to find out they haven't been designated, and then have a way of grieving it, you know, where would they go to figure out who could kind of resolve that so they can get added to the list, when you know maybe it's one sister who doesn't like the other sister and won't let her be the designated person, even though mom or dad or whoever might have always wanted them present. So that probably needs more fleshing out and it's going to take a little bit of work.

31:57

JULIETTE MULLIN | Manatt: Yep, so, and that would kind of look like a process where rather than there being a process to make sure, you know, everyone has a resident designated visitor, it's more about making sure that individuals who are raising their hand and saying we want to be a resident designated visitor, we think we should be a resident designated visitor for this person, and there's no process, what do we do? Like having a process for that. Okay. Right. Thank you.

And I think next we have, oh it is Long-Term Care Facility Policy Worker Panelists, it's someone that didn't update their name. Looking at the icon.

32:41

JASON SULLIVAN-HALPERN | LTCOA: Can you hear me okay?

JULIETTE MULLIN | Manatt: Yes we can hear you.

JASON SULLIVAN-HALPERN | LTCOA: Hi, this is Jason Sullivan Halpern from the Long-Term Care Ombudsman Association. Just following up on, on what Karen said there, definitely agree with those recommendations, and I would just add to that that, I think Ombudsman and like state survey staff would be on sort of the same level, like it doesn't make sense to me

that a facility would be able to use a state of emergency as a way to turn away regulators or something, if they were needing to access the facility for monitoring. And I think Ombudsman fall into that sort of category too, because we, the Ombudsmen, you know, have some State authority to access facility, visitor, residents whenever they want really. So, I think there should be like a special category for that because I definitely agree with Karen that by framing it as like the resident needs to designate these visitors, I, there's definitely some visitors they don't need to, to designate. Thank you.

33:41

JULIETTE MULLIN | Manatt: Thank you that's helpful. So that might look like saying, there's resident designated visitors, that's what's, this is what that process looks like for designating them, and then there's other types of visitors, Ombudsman, State surveyors, that may be subject to the same parameters and safety protocols listed here that are not resident designated. That's really...

JASON SULLIVAN-HALPERN | LTCOA: Yeah, I would add law enforcement.

JULIETTE MULLIN | Manatt: Exactly. Got it great. All right, next I see Catherine.

34:09

CATHERINE BLAKEMORE: Hello everyone. Thank you. Just one small clarifying question in the bolded (A) it says "any individual" which might be viewed by some is singular, and I don't think that's what intent, is intended, so maybe adding an 's' in parentheses after that so it's clear throughout, because you use visitors plural in other places.

But I actually wanted to speak to the second bullet that individuals "unable to speak for themselves," California has a supported decision-making statute that allows someone to help that person figure out what they might want to say, and I think that's an important concept to weave into this discussion. I think saying things like, the resident is unable to speak for themselves, I think that's actually not a very clear legal standard of what does that mean, right. So, I feel like it's our collective job to help people, like even people who lack capacity to make a medical decision, I believe in

many cases will have an opinion about who do they want to see, and the question really would be how do we help them articulate who they want to have, is, on their list of visitors right. So, I'm not suggesting we go to a legal standard I just think that requires as others have said some additional work. Thank you.

35:37

JULIETTE MULLIN | Manatt: Thank you Catherine, appreciate that. And I think we're seeing a couple comments to that effect as well in the chat. So we will, I think, I'm hearing a general agreement that there needs to be a way to ensure that someone who might again, acknowledging that that's not a particularly legally enforceable statement, cannot speak for themselves, there needs to be some way to support them and making sure they can have visitors, and that may be a combination of supporting people who are raising their hand and saying I would like to be a visitor of this person, and having a process for them, as well as a process, as you just noted Catherine, to support the kind of help, support residents and identifying members if it's something they need help with doing. So, we're tracking both of those pieces around that clause, and we can do more workshopping there. Let me go back to, I keep losing, so sorry one second, coming back to my list, Melody you're next to my list.

36:41

MELODY TAYLOR STARK: Hi, hi, and this may have been talked about or alluded to before so I'm I'm sorry for any duplication of comment, but in the first bullet point where it's talking about resident designated visitors, but then it goes on to include a list that the resident may, like, they may not designate a health care worker, and outside health care practitioner, etc. that's on the list, and, and as I'm also looking at some of the other language that says wide range of visitors just wanting to make sure that the language is stated such we're not backing ourselves into a corner, of resident designated visitor and, you know, you have to you have an outside health care practitioner coming in but they're not on the resident designated visitor list. So perhaps there needs to be some language that's a distinction between the resident designated visitors, and those who I think Karen and some of the other Ombudsman talked about it before, you know, we should just you know have access as well without necessarily having a specific designation by the resident, that makes sense?

38:03

JULIETTE MULLIN | Manatt: Yeah, that makes sense. Thank you Melody. Next we have Ellen.

38:10

ELLEN SCHMEDING | CCoA: Yes, hi just have a couple comments. One of them is that I think the resident, we should state somehow that they can designate ongoing, they may designate somebody today, tomorrow they designate someone else. It's got to be a fluid process not a one-time process, so I'm not sure that's completely clear. The other comment, and I don't have an answer to it, is just, how many people, I think that is a real challenge during an emergency, is how many people are on site at a particular facility. So, in some way shape or form figure out how to, how to discuss the number of people that can come at any given time.

38:50

JULIETTE MULLIN | Manatt: Yeah absolutely. I appreciate that comment Ellen. I think in a couple slides, once we kind of align on this piece, we'll talk about, you know, so you maybe have five family members, what does it look like at any given point in time in the facility, and what does, what is a standard for simultaneous visitation. Yeah it's a great call, thank you. Tony.

39:14

TONY CHICOTEL | CANHR: Hey good afternoon thanks for putting, all this together really appreciate it. Sort of in this vein of how language is so important, a couple things, I know we may be using the term “state of emergency” is sort of shorthand for a larger process where visitation rights are specifically disrupted, but I think, and maybe it was addressed in a prior slide, but I think at some point there should be a discussion of what we mean by “state of emergency.” Because just a general declaration of state of emergency doesn’t, wouldn't impact nursing home visitation or long-term care facility visitation. Normally it would require a specific inclusion of a limitation of visitation, an extraordinary kind of, specificity, so I don't want people to get the wrong idea that any state of emergency we can suddenly, we have things that happen with visitation that wouldn't normally happen.

Another thing is the term “visitor,” we, and with AB2546 we were very deliberate to not use the term “visitor,” and so we used “support person” because we felt visitors sort of minimized what the support people bring to the table. So that's a word that I'm having a little trouble with using. I get it, and we want to be broad here, but visitation I think minimizes what, what we're getting at.

And then the third thing and last thing, I promise, that I want to talk about on this slide is the, in the bullet points that the term “designated decision maker” a lot of, I think the majority of residents probably have, who have decision makers who aren't making their own decisions, don't have a designated decision maker, they haven't done a healthcare directive or a designation, an oral designation of a surrogate through the probate code process. It's usually a default kind of thing, a family member steps up they haven't been designated they just sort of take the reins, and now there's a new default surrogacy process under state law went into effect on January 1. So, I'm, I'm a little worried about the term “designated” when you're talking decision maker. We usually use is the term you know “resident representative” and even though it's not very well defined legally, it's, I think more inclusive to the reality of what, how surrogate decision making happens in these facilities.

41:53

JULIETTE MULLIN | Manatt: Yeah, tracking that. Thank you Tony. All right, I see Eric.

42:01

ERIC CARLSON: Yeah I'm just gonna follow up on what Tony just said agreeing that designated decision maker doesn't mean anything, or may, you know, suggests too much because there is no such thing. And it's, it's a problem right, does, this, I'm sure everyone on this call knows the difficulty here just like Tony said, most people don't have formal, you know, there's no not someone with formal legal authority. And in practice the system runs to a certain extent, well, or sometimes not so well, some informal understandings of who's gonna step up and oftentimes it's a, there's just some implicit understanding of someone's adult child for example, is gonna, gonna participate. So I just needs to be some clarity there, and maybe, I'm, I'm not, you know, I don't necessarily want to be held to this

because I'm still, we're still obviously thinking these things through but maybe there could be some acceptance of some informality, because, you know, trying to come up with a formal designee and even the bullet point right below that convening the Ombudsmen and the other stakeholders, that's a lot of process and a lot of time and a lot of difficulty. and I can imagine in these situations it might get in the way of allowing someone to, to visit so, I, there's some, there's some significant issues there, and, it may be again, I'm not sure I want to be held to it, but maybe there should be less process rather than more and some acceptance of some informal understandings as opposed to nailing everything down with, with, with maybe undo process, because we're, you know, we're talking about allowing someone to walk in the front door and say hi we're not giving someone's authority to make medical decisions, to make financial decisions it's, it's a, the risk is less there and there maybe should be less process because of that.

JULIETTE MULLIN | Manatt: Thank you Eric, I think that's really helpful.

I'm gonna summarize, kind of the core elements of feedback that I'm hearing, and how we may want to continue to workshop this, and then we're actually just going to pause and we're going to ask people to kind of tell us their level of agreement with being able to kind of move forward with this general concept, assuming, understanding that we're going to continue to evolve it based on the feedback that we got. But I'll just summarize my core takeaways here.

So, I'm hearing a lot of feedback on this concept of what is included within a resident designated visitor and looking at specifically kind of actually having different categories around a resident designated visitor versus State and Long-term care Ombudsman, state surveyors, that kind of category of individual that would have access to the facility that's not employed by the facility. And then another category around healthcare providers, service providers that are not employed by the facility and their access, and acknowledging those are distinct categories that are not necessarily resident designated visitors. So that's one area of feedback I'm hearing and an area for us to workshop a little bit more. I'm going to recommend, you know, after the meeting we'll do a little bit more iterating and what we'll share at the end of the conversation today, is, we're going to do multiple rounds of iterating on these and getting more feedback from

you all based on the conversation today. So, we'll take that that note and that comment and look to incorporate that.

And then I'm also hearing a lot of feedback around this process, what it looks like, that that middle section and kind of thinking through how we ensure that people have access to a visitor without developing too much process here that may be unclear or onerous. That's one element that I'm hearing.

I'm also hearing the recommendation, kind of at the top of this section, that there may be a way to actually build this element in or ensure some of this through the appeals and grievance approach rather than necessarily building out a whole process that we have to have for designation in these situations.

So those are kind of two major areas I'm hearing. We'll kind of go back through the transcript after the call and workshop this a little bit further based on those two major areas of feedback. With that I'm going to take us to the next slide.

SLIDE 35

46:45

JULIETTE MULLIN | Manatt: So, we're going to try to use technology and I'd say try because I feel like it never quite works how you need it to work when you most need it to work, but, we have a poll everywhere tool. Folks who are members of the workgroup should have received a link that you can access at this time. And I'm also going to ask, thank you, one of my colleagues just dropped that link in the chat for workgroup members. I'm going to ask members of the workgroup to go ahead and go into that survey, and indicate kind of based on where we are, based on the recommendation we looked at, and the two areas we just aligned on workshopping a little bit further, are you, what's your level of comfort and your level of support with where we're landing around this first recommendation. And so exactly like in the survey that you all did we're asking you to say between a one and five how you're feeling about this or where you stand rather, right now on this recommendation. One is I disagree and cannot support, five as I completely agree. I do just want to acknowledge this is not a vote of the workgroup, we're going to continue to workshop, this is a facilitation tool to see, you know, if we're comfortable

with where we're landing right now and can move on to the next section. So, with that I think on our next slide we'll be able to see how people are voting.

SLIDE 36

48:26

Okay oh yes, and someone just chatted, noted in the chat, I'll also, I'm also tracking that area to workshop, which is being a little bit more crisp when we say state of emergency, about it being a state of emergency that impacts visitation and developing some more language there.

Okay, I'm seeing some general alignment acknowledging that we do have a two and a three, so what I will say is I think we've got enough to kind of keep moving into the next section, acknowledging we're going to send this back around for another round of iteration and feedback for the group. And we will move into the next section.

SLIDE 37

49:19

Before we move into the next section, I do want to pause, and before we start talking about standards for visitation I do want to open to members of the public that have joined today, we just thought, we just got a pulse check on where our workgroup members are, and are gauging that they're comfortable moving into the next section, acknowledging we're going to keep workshopping a little bit more, but moving into the next section. If there are members of the public who would like to give any comments around the recommendation we just looked at, at this time we're going to open that up. So, I've got my eye on the list to see if we have any hands raised, and Theresa I see you have your hand raised. And I'm going to ask the Manatt, actually I can do it. So, Teresa you should be able to unmute yourself.

50:11

TERESA PALMER: Can you hear me now?

JULIETTE MULLIN | Manatt: Yes we can hear you.

<u>TERESA PALMER</u>: Yeah I think it's really really important that any limitation on the number, the designation of the visitors, the number of visits, the number of people that can visit, and the time they can visit, be highly individualized and not arbitrary. And this is one of the things we saw where there were just sort of arbitrary limitations that, it has to be, each decision about that has to be individualized to the, to the resident. And, and it cannot be left to the industry or the nursing home administration who will act for their own convenience as we saw during, during the pandemic. Thank you.

51:05

<u>JULIETTE MULLIN | Manatt</u>: Thank you Teresa, appreciate that comment. All right, I think with that we can move into the next section.

SLIDE 38

51:20

So, we've just talked about a kind of baseline that we're beginning with, that residents can designate anyone to visit them, but we also acknowledge that, you know, those to, in order to have in-person access to the facility there, the visitor would agree and would have to adhere to safety protocols, we're going to talk about those safety protocols. And then we're going to talk about parameters in terms of the number of visitors and the time of visitation and elements like that. But let's start with safety protocols, so if we could go to the next slide.

SLIDE 39

So here we're going to focus first on safety protocols. Next slide

SLIDE 40

52:04

And I want to acknowledge that we're talking here about the standard, we will talk a little bit later about what happens in a situation we can't anticipate. So, if there, we're acknowledging that we can't predict everything into the future, and so we will talk after we're done is like setting an essential set of standards for this. We will talk afterwards about the process if standards may not be able to apply and what happens and how

are those developed, so just want to acknowledge that before we talk about standards.

So, this first recommendation is about safety protocols. At a high level it states that as a standard during a state of emergency the workgroup recommends that facilities may not impose different safety protocols for staff and resident designated visitors. Safety protocols include conditions for an individual to enter the facility, which may include requirements for testing, vaccination, isolation quarantine, personal protective equipment, or others, this is not intended to be all-encompassing, it's intended to be illustrative.

And we are acknowledging that there may be situations in which external factors to the facility may create variation between the safety protocols that may reasonably be allowed by staff versus residents. So, an example, for example, but I’ll just suggest and put out there is one for example that happened in COVID where vaccines were rolled out in waves. And so, staff in the facility may have had access to vaccination prior to the visitors. This is acknowledging that there may be situations like that where access is a little bit different and that may just impact the ability to, to follow the same protocols.

What we're acknowledging here is that if a situation like that persists for an extended period of time, which we are setting kind of an initial proposal that extended period of time is more than 30 days, counties, cities, or the state should follow the process recommendation established in recommendation (C) for establishing visitor specific safety protocols that allow resident designated visitors to visit residents. We're going to talk about that process a little bit later, but we just want to acknowledge that if there's ever a situation where for whatever reason the safety, the ability to follow a safety protocol looks different for staff or residents, if that persists for more than 30 days then we're going to this process of establishing protocols in a, with, with a number of different stakeholders, and we'll talk about what that looks like.

I'm gonna pause here and take comments and questions, and Maitely, I see you've raised your hand.

54:56

MAITELY WEISMANN: Hi, yes, in regard to, to situations like that, in relation to the specific example you gave, vaccines, so in our experience, at least in my experience, a lot of the staff members, there were very few staff members because a lot of people had quit, passed on due to the virus, or they were afraid to get the vaccine, so they were not getting them in the numbers that we wanted. And so family members were invited, you know, sort of proactively in, in case we could get in, and I was getting in so Immediately signed up and, and my husband as well so that you know we could be a team and I just think that's going to happen again. Like if we if we're in a situation where we're the support people, you know my mom can't wait 30 days for support, you know, she would, she would not have anyone feeding her or giving her beverages, she's full support right. And when staff was, was minimized she didn't have anyone coming into her room, they just did not, they put food outside, she's quadriplegic. So, I'm just saying that this, I agree with, with the statement that this has to be highly person-centered and also these sorts of resources should be used for the family support people, because they are literally filling in for staff, not that we want to be unpaid caregivers but when an emergency strikes and we are needed we are at the door ready to go. So, I just wanted to make sure that's clear and referenced and considered, please. Thank you

56:53

JULIETTE MULLIN | Manatt: So, can I just ask a follow-up to you on that, would that maybe look like adding an element around recommendations about like prioritization and investments related to supplies and things like that?

MAITELY WEISMANN: Yeah, I see that definitely being necessary for people who are coming in and providing support.

JULIETTE MULLIN | Manatt: Great, thank you. Thank you. And I keep moving away from my list here, Eric.

57:16

ERIC CARLSON: Thanks. I want to comment on the last bullet point here. I think there's some ambiguity in how it's written currently, it seems like a statement of fact, 'residents may not have access to PPE at the same levels as staff,' and I assume it's meant to be a statement of what should happen. I, there's a further ambiguity because, I am, I guess it's implicit

here that the facility would supply PPE. Is, is that the understanding? Or I think it needs to be clear because that's obviously, you know, I think a lot of what we're thinking about it, access in the COVID context relates to, to PPE, and to the discussion of restricted access. So, I think there needs to be some clarity here. If, if it's the intend to, to state that the facility has to require that for people, you know, under whatever circumstances, then I think it it should be explicit here. And it should be clear what the, what the priority is because I think that last bullet point doesn't do it it raises the issue, but it's, it's not clear as to how that's supposed to play out.

58:37

JULIETTE MULLIN | Manatt: Yeah, I will, I will just say I don't, there was not an intention around the recommendation for whether a facility would provide or pay for PPE because we didn't, you know, going through all the transcripts and what was shared in the past we, we didn't gather that from past workgroup conversations, but welcome your thoughts on that.

ERIC CARLSON: Well, I mean as a practical matter that's a lot to require from, from somebody's daughter, next door neighbor, that they come in equipped the same way a healthcare worker would be equipped. it's too easy, I can imagine, for the facility just to say oops sorry you're, you, you don't have it right, you can't come in. So, again a lot, so much this conversation is based on a COVID type of scenario, because that's what we're coming out of, but you can see how that would play out if, if the expectation is that people would have to provide it themselves, and that they would have to meet the facility's standards upon entering the front door of the facility, you can imagine a tremendous percentage of people being turned away.

59:49

JULIETTE MULLIN | Manatt: Thank you Eric. I see Melody is next with her hand raised.

59:54

MELODY TAYLOR STARK: Hi, just kind of wanted to interject this thought. It might be a little bit premature to another segment of the conversation, but regarding PPE, and one of the things that, you know, saying hey, you know, caregiver who wants to get in using the, we'll use the same PPE as as staff,

and I'm not sure how this can be worded or expressed and so forth, but, I just wanted to put an example out there of a situation that I ran into where I was required to use the same PPE or PPE that was required by the health care facility and, and, I think it created a little bit of a conundrum for me. One of my chosen family members was in the hospital for about a week, and on a side note I was only allowed to visit her at the nursing home for 30 minutes, one day per week, but I was able to visit her at the hospital every single day. However, regarding the PPE, I'd have to park my car, check out a brand new, you know, high quality N95 mask, and I walked into the entrance of the hospital, and staff said, you have to throw that out. And because of the standards that were in place I had to throw out this really good safe high quality N95 and replaced it with a mask that I could get at the dollar store. So, I think while there was, you know, part of, you know, using the same PPE as staff that this was also a situation where it was detrimental and not as, as effective. Not quite sure how this would frame all in there but just wanted to put that that thought out, so.

1:01:51

JULIETTE MULLIN | Manatt: Thank you Melody, appreciate that. Jack, I see you have your hand raised.

1:01:59

JACK LIGHT: Yeah, no, in my, I'll just be really brief, I just wanted to echo the comment, I almost felt I was beat, beat to the punch there on that second bullet. I think just, who's, there is some imply, something implied there that the facility is required to provide the PPE, and I, or whatever else may be needed, so I think that, that is a good point of clarification, so that it becomes more implicit as a, as was previously spoken to. So just wanted to echo those thoughts. Thank you.

1:02:39

JULIETTE MULLIN | Manatt: Thank you. Mark I see you have your hand raised.

1:02:46

MARK BECKLEY | CDA: Yeah, I was just going to say on the, getting an echo here, is there something we can do about that? Yeah on the point of

view here and vaccinations I know that, you know, there's obviously very high demand at the onset of the pandemic and you know March the orders that were being put in place, and you know, health care facilities were requiring facilities to receive PPE and vaccinations, and I don't know if it's a question of it becoming a like facility responsibility, or this is something that states should consider in terms of like prioritizing who is eligible to receive PPE or vaccines during a situation like we had. So just an alternative to consider, because I would imagine that facilities, but you know, be challenged to determine how much PPE and vaccines they need just for their own care staff, but then also have to kind of like include visitors in that order as well on visitors they incorporate. So just something to think about whether this is more facility issue, or just like a larger sake question about prioritizing which populations are in already ordered to receive things like PPE and vaccines.

1:04:09

JULIETTE MULLIN | Manatt: Thank you for that comment Mark. Catherine do you raise your hand?

1:04:15

CATHERINE BLAKEMORE: Just echoing what Mark was saying, I think there are some elements where it really is a State policy, not a, not an individual facility policy, vaccinations being one of them. I mean the place we ended up in California was prioritizing for it by way of example, in home support services workers, many family members fall within that category, and I think sort of the notion of an equivalent of somebody who's providing direct support whether that's, you know, physical support or other kinds of support, should fall within that category, but I think particularly in, in a pandemic setting that those decisions were being made by the State, they weren't being made on the county level, they weren't being made by facilities, and so I think the policy should reflect kind of the important State role in helping with kind of the PPE vaccination kinds of, of requirements, and, and the ability to get to get that out. The only other comment I have is I will say that, and I think this came up very early I'm sorry I don't remember who made the comment, was that 30 days is a really long period of time for individuals who are receiving direct support. I mean, a person with dementia, such as my mother, 30 days could could feel like a lifetime without having that connection, and the amount of deterioration that doesn't

come back is not insignificant. So, I think like I can appreciate the desire for a clear benchmark, but I don't know that I think 30 days is the right one for every, every circumstance.

1:06:04

JULIETTE MULLIN | Manatt: Yeah definitely appreciate that comment Catherine. And maybe a clarification here that we can expand upon is 30 days was not necessarily intended here to indicate that there could be no visitation for 30 days, it was acknowledging that there could be maybe separate sets of safety protocols, but completely hear your point and welcome other suggestions from folks on that in the chat or folks want to raise their hand. Karen.

1:06:33

KAREN JONES: So, along those lines, I'd recommend 14 days. If we're going to talk about stopping visitors, 14 days max at the beginning of a pandemic, we know how incredibly chaotic it is and nobody really knows anything, but after 14 days we should, we should start looking at a better protocol than just saying you got 30 days to make decisions that people won't have access to their loved ones. I'd almost go seven days, but that gets hard to do in a, you know, even a flu outbreak. The other thing is the last bullet point about PPE. I know that's just an example, but we need to make sure we're clarifying who decides it's a restricted access. We had some facilities throughout the pandemic, and even today, that had lots of PPE, maybe not the beginning but as time went on, we had others that didn't have a lot of PPE. And, and a facility can make their own PPE challenge, or just, just access issues. So, we, I think we need to clarify the restricted access to PPE needs to be determined by someone other than individual facilities. It needs to be a statewide restriction not, not a individual area.

1:07:42

JULIETTE MULLIN | Manatt: Tracking that. Thank you Karen. We have one last comment from Maitely, and then we'll pause, summarize the feedback, and get a gauge of whether folks feel comfortable to move on based on the feedback shared to date. Maitely.

1:08:00

<u>MAITELY WEISMANN</u>: Hi. I just want to quickly weigh in on the time period, just put it out there, so if, if someone doesn't eat or drink for two or three days, that's probably two or three days too many, right. So, I'd like, for like I said earlier person centered, a person-centered approach to this you know, knowing this the person's needs and also the facility you know during, during a, an emergency is going to already be strapped for support, so I'm just putting it out there that, that even a week is too too long for, for some people. Thank you.

1:08:38

<u>JULIETTE MULLIN | Manatt</u>: Thank you. Yeah completely tracking that. Nancy.

1:08:46

<u>NANCY STEVENS | Resident</u>: Hi, thanks Juliette. Maitely thank you. Sorry I'm, I'm unable to be on video because of a skin condition. I can't put anything on it so I just wanted to say thanks Maitely, I was just about to say something very very similar, almost like a challenge to anyone who thinks that 14 days, or 30 days, would be feasible or allowable to go that length of time without eating or drinking or bathing or toileting, and see if it's doable, you know, because it's it's really not, it's really not. Any bit of nourishment that one person can get might be lifesaving for them on any given day. So that's all. And I'd like to see the word essential in there somewhere, I put that in the chat. Thanks for letting me talk.

1:09:55

<u>JULIETTE MULLIN | Manatt</u>: Thank you so much for sharing Nancy. Mark I see you have your hand raised.

1:10:00

<u>MARK BECKLEY | CDA</u>: Yeah this one, that possible suggestion which would be to maybe for a public health colleague to talk about how resources like the vaccines, do you go through a prioritization protocol in the system. I know that there's Federal recommendations that are made by you know, groups of health experts and then there's that's typically the state committee, so I think what we're really talking about here is possibly

prioritizing visitors as a priority population, and so it might be helpful just for folks to see that process and maybe that's something Public Health could provide to us.

1:10:51

CASSIE DUNHAM | CDPH, CHCQ: Mark, I'm not sure if you were referring to CDPH Public Health or local public health. I see that Chelsea and I are both on today we're not in that kind of process flow of prioritization for things like PPE or vaccination, so can't really speak to that process. But you know, perhaps we could get somebody that could weigh in on that in a future conversation or just you know via email or something.

MARK BECKLEY | CDA: I have vague recollections, my recollection from the beginning of the pandemic that federal recommendations had priority regulations and that there was like a flow that went into States and then States came up with their own sort of like

CASSIE DUNHAM | CDPH, CHCQ: The, yeah but out, totally outside of Center for Health Care Quality, and I would hate to misrepresent what their process was.

MARK BECKLEY | CDA: See if our local CDPH or if one of our local public health, you know experts, has, has that process, yeah.

1:11:48

ANISSA DAVIS: This is Anissa Davis, the City Health Officer for the City of Long Beach. Okay we are, thank you I was trying to figure out how to start my video. And so I think, just to kind of go over what I remember of the process, I think it was really hampered by the fact that, the fact that there was such low amounts of PPE so I think that made things very, like maybe not standard, like I think we have the usual way that we would do things if you had a supply, and then there was the way that this ended up going because there were such big gaps, and what was needed, like having you know needed to be tested for N95s versus just needing some surgical mask, so there's just a lot of things that went into this particular event, but in general, so there's, when there's scarcity the, in general for things it does start with the feds, so they, especially if they're the ones that are supplying, and I think that was kind of a an issue too because there was a federal stockpile and we had some state stockpiles, we had some local stockpiles

and then a lot of people were doing things on the private market and trying to buy, and that was, was complicated because we were trying to have the feds buy everything, and if you remember that they weren't doing that at the beginning and so then you had all the states competing against each other, so I feel like you know we could definitely get kind of what the process is, but I feel like there were so many different variables in this particular activation that I don't know how much it would inform what we would do for the next one, if that makes any sense,

CASSIE DUNHAM | CDPH, CHCQ: I would agree with Anissa. I think just overall speaking to our experience with COVID, it was so atypical of any other kind of situation that we've dealt with. It'd be, I think we would need exercise caution to kind of use that as a model, but certainly is a point of reference in the context of visitation, if, if you know per your recommendation Mark we explore kind of how that rolled out but, it's certainly a unique experience in this case because it was so widespread.

MARK BECKLEY | CDA: And I would just want that to be acknowledged before we put forward recommendations. I mean I hate to put a time frame and statute that feasibly could not be met, so I think there'd just be, must be parameters that as soon as sufficient PPE or vaccines become available, because I do remember that particularly with vaccination process once you've had certain quantities of vaccines available there were priority populations, kind of like, in an order that relative to receive a vaccine at different points in time.

JULIETTE MULLIN | Manatt: Thank you for that discussion. I think one of one of the pro, one of the ways we might be able to move forward on that piece is we're, I think we're hearing from the group and I'm just going to start summarizing the feedback on, on this, recommendation here. Hearing from the group that we need to add into this some kind of recommendation around state level investment, prioritization, policy relating to getting supplies and and having supplies be available to visitors. So, so I think maybe the suggestion would be, we'll take that back and we'll we'll workshop something, and then circulate it back to the workgroup for additional workshopping and feedback and iteration.

But that's one big one that we're hearing that, that state recommendation or state level, not facility level, recommendation around supplies that, that

enables safety protocols and that would enable visitors to do the same and follow the same safety protocols as staff.

I'm also hearing some concern with the language and the examples, and I think you know one thing we can do is we can just take out the examples like those who are intended for illustration for this group. But that's certainly a way we can, we can adjust that.

And then a lot of feedback around 30 days. So, we're hearing a couple a couple different, a couple different elements around 30 days, you know, either setting a different number or defining that significantly differently in terms of what it, what it means for the situation to persist.

And then also hearing from a number of folks the particular situ, like in particular situations of distress and crisis if someone's not eating someone's not sleeping someone's not drinking acknowledging that you can't just lock down visitation in those situations, and perhaps we can explore that a little bit more and add some definition in the compassionate care section that might help us with with that element as well.

So those are the big elements of feedback that I'm hearing and and really great conversation, thank you everyone. With that if we could go to the next slide.

SLIDE 41

1:17:12

And, and I have my eye on the chat, it's very active it's a little hard to do both the verbal and the chat so we will go through it again afterwards and, but if I missed anything please indicate that.

So, as we did in the last one we're going to ask everyone to just tell us how they're feeling about where we're landing. Again, this is not a vote this is not an affirmation that exactly what was on that slide is what we want to move forward with, it's really indicating a level of support for the combination of the straw model recommendation and the areas we just discussed to workshop. So, acknowledging that we'll do that workshopping, are folks comfortable with moving on do they have agreement, is there anyone that would like us to actually stop and keep discussing this before we move on to the next one, because they feel we have not captured

critical feedback on this recommendation. Moving to the next slide we'll start to take a look at how folks are feeling.

SLIDE 42

1:18:02

Seeing some general comfort with the direction of this, the feedback we've gotten to date, and that we can move into the next section.

All right. With that we'll just take a moment to see if there's anyone who's joined us from the public today who would like to add any comments on this particular recommendation, and I see Teresa you've raised your hand.

1:18:43

TERESA PALMER: Yeah. 30, if you're really going to treat, especially essential resident designated support people the same as staff, you need to do that, period. And I would just get rid of any exceptions, this is why people died, and the nursing home staff did not admit their shortcomings, did not notice that people were dying, and this is too dangerous to make any exceptions, that's too dangerous. thank you,

1:19:25

JULIETTE MULLIN | Manatt: thank you for your comments Teresa. Karen, I see you've raised your hand. let me allow you to unmute yourself, you should be able to unmute yourself

1:19:39

KAREN KLINK: I guess I just wanted to say, obviously I think everybody here understands how necessary this is to have to try to get a bill that might be able to go through, or to put some principles that would be able to be passed here in California. I just want to reiterate how important it was because I did go through a process last year for myself, to, since there was a term ‘essential support person’ or a ‘dental care person’ in, you know, in like the California Department of Health and in Los Angeles there was a term, but they didn't have a process, there was no process to go through. So I went out to the California Department of Health the LA Department of Health, my mom's in an assisted living so I went to the Department of Social Services, I went to the Ombudsman, I went to the state

Ombudsman, I went to all sorts of people to go to find out how do I become an essential support person, how do I become a designated person my mother is deteriorating, I can't get in to see her she's, you know, she's losing weight, she's depressed she's this, and there was no process everybody said sorry, that's not my job, you know, we don't have a process for this, so I just want to point out how important this is because there was no process.

And finally, I found a person at the L.A County Department of Health a medical director that said you know, you know, I'm deciding that you should be one because, because your mother has a cognitive impairment and you're, you're the, you’re the designated support person. And she wrote me a letter and I was able to go in. So, the point is, is I think a person should be a designated support person if, you know, if I say so, or my mother says so, and that should be that the main, the main definition. And I found someone that was, you know, that had the guts to say that, that that should be the case. It was clear that my mother needed someone because she she was, you know, she was failing because she didn't have the support she needed and, and I was able to go right in at that time. And, and you know, and yes, I did I, did take risk and yes, I did get COVID, but I was willing to take the risk. It was informed consent on my part, and I think people should be able to make that decision.

SLIDE 44

1:22:09

JULIETTE MULLIN | Manatt: Thank you Karen for your comments. All right I think that leads us into our next section.

So, this is now workshop, and as you can see this is complicated because the font size has gotten much smaller. This is now workshopping a recommendation about parameters beyond safety protocols like vaccination, PPE, etc. that we just talked about that may exist around visitation during a state of emergency. So again, want to kind of reframe for people that this came from this principle that the workgroup provided feedback on, that the workgroup did not want to leave it to individual long-term care facilities to determine what the standards should be in their facility, because we see a lot of variation in what the standards were and so here we're, we've put together a straw model recommendation based on

some of what we've heard from the workgroup to date, around what some standards might look like. So, I’ll just go through these and then same same as we did last time we'll take on it.

So, the high-level framing here is that during, as a standard during a state of emergency the workgroup recommends that visiting parameters must reasonably allow, we'll talk about what that means, resident designated visitors to conduct in-person visits with the resident and must at least meet minimum standards on the number of permitted simultaneous visitors, visiting hours, and locations of visitation. So, I will say this is a kind of a two-part recommendation and it's important because those go together.

So, the first principle and it's the overarching principle across all of this is that to reasonably allow visitation, parameters must account for, and we welcome additional elements to include here, the mobility, accessibility, translation needs, employment hours, travel, and other reasonable determinants of visitation for individual resident and visitor. So, this is I think we've heard a few comments about this being a person-centered approach. This is kind of a draft statement that reflects that concept, that says, you know, the hours of visitation that work for one person may not be the same as the ones that work for another, and we we need to acknowledge that in the in the recommendation. So that's that first element, and that first component of the rule.

Then we note subject to the condition above. So subject to allowing, reasonably allowing visitation based on individual parameters to visitation, long-term care facilities may establish visiting parameters due to a reasonable public health or safety risk as follows. So here we've, we've outlined a preliminary step for this workgroup to workshop a preliminary set of minimum parameters relating to all of the core things we've been talking about and welcome iteration, editions from the workgroup on this. So, the first is that long-term care facilities may limit simultaneous resident designated visitors due to a reasonable public health or safety risk but must allow at least one at any given time. So that's one.

Two, long-term care visitors may limit visits to specific locations within the facility, but those locations must reasonably allow visitation as defined above. So, this is in part intended to acknowledge some of the feedback we heard in earlier sessions that for example, you could, in a situation where two residents share a room, if one isn't mobile requiring them to be in a

different location for visitation, in that particular scenario may not be feasible, so acknowledging that.

And then the third piece here long-term care facilities may limit the hours of visitation, but those hours must include weekend and evening options, and must reasonably allow visitation as defined above.

Finally, we note that all facilities must post their visitation policies on their website in a manner that is accessible for resident and resident designated visitors. Policies must include details on any parameters to visitation and policies must be up to date.

With that I'm going to invite folks to provide feedback on any of these proposed parameters or approaches to setting visitation parameters. And Nancy you have your grand raised.

1:26:39

NANCY STEVENS | Resident: Hi, can you hear me okay?

JULIETTE MULLIN | Manatt: Yep, we can hear you.

1:26:46

NANCY STEVENS | Resident: Okay Sorry, I was asked to start my video but unfortunately it can't be on camera, so sorry about that. So, for the first bullet point where it says long-term care facility may limit simultaneous resident designated visitors but must allow at least one at any given time, can we specify at least one per resident.

JULIETTE MULLIN | Manatt: Yes thank you for that comment. Ellen I see you've raised your hand.

ELLEN SCHMEDING | CCoA: Yes, you know the comment I have is that whatever limitations are being imposed by the facility have to tie back to the emergency, so that it will impact facilities within a certain grouping and there's a reason for it, and I'll just use the pandemic as an example. When, when there was an active outbreak that brought risk to residents and visitors, the visitation policy was changed, and there was guidance on how to make that happen. So, I think it just goes back to the comment it can't be a location specific, it has to tie back to the conditions at large.

1:28:03

JULIETTE MULLIN | Manatt: Thank you for that comment Ellen. Melody I see you've raised your hand

1:28:09

MELODY TAYLOR STARK: And, on the third item, the hours of visitation. I see that it must include weekend and evening options, and that's helpful. The language I feel should be changed to options, 24 hours, at points there are situations where maybe a family member works, you know, they've just done a double shift themselves and they're not getting out until 11 o'clock, and it's I know it's probably not usual time that a visit would, it would take place but that that needs to be open. And so many times visitation was subjective, you know, to, to the facility for example, the facility where my chosen family are, and my husband was, even for, you know, window visits the parameters were set at there were, there were three slots during the week between 11 and 2 p.m., they would only schedule two residents to have visitors during that time, and you could only have one visit per month. And that was subject to the availability of the activities director schedule, and so that meant, you know, if you do the math in a 99-bed facility not everyone could even get a visit during that month. So just that we're not that we're allowing the facility to make some decisions based on what some of their needs are. We want to be you know open to that, but at the same time to recognize that the priority is that connection with the family and the resident designated support persons. Thank you.

1:29:56

JULIETTE MULLIN | Manatt: Thank you Melody. Eric I see you have your hand raised

1:30:04

ERIC CARLSON: Yeah. I'd suggest that this language is really problematic in a few areas. The basic problem is that this may be an area where we don't want it to be resident centered, there should be rights, the people, people should be able to to visit, and to the extent that we start talking about reasonable and resident-centered and based on needs, those are opportunities for a facility to say, well under this situation all this required is this, that, or the other thing. So, I would recommend rethinking the, a focus

on flexibility, because flexibility, you know, we if we're running facilities maybe that would be a great thing, but in practice flexibility to the facility operator is that they're going to do things in a way that may not be beneficial to to residents and and visitors. So, I think yeah, I think that language through this particular slide is, is problematic.

And then, an example of this, just a specific example, the evening and weekend hours, it suggested it's a good thing that people would be able to maybe have a couple hours on the weekends. Yeah of course, which is what the previous commenter said, it should be you know around the clock, or is is accessible as, as is possible, whatever, whatever that is, you know, it under the basic nursing facility standards generally you do have a right to visit or a resident has a right to accept visitors in any hour of the of the day or night so the way it's written right now reading between the lines it suggests that, well maybe if the facility will do you a favor they'll give you a couple hours on Saturdays and Sundays. And that's when people are most likely to visit, it may be less convenient for the staff, maybe it may be lesser staff but that's when, when adult children and grandchildren and neighbors and whatnot are off of work and are more able to visit. So, I, that's my impression first take on looking through this, I think it would give way too much leeway to a facility to, to turn this in ways that would be unhelpful.

1:32:26

JULIETTE MULLIN | Manatt: Thank you for that comment Eric. I do just have a follow-up for you if you don't mind. So, I think you kind of spoke to the balance between flexibility and, kind of setting a standard and saying this is what it needs to be. I think what we're trying to thread the needle on here and would love your your kind of thoughts maybe not necessarily right now on the spot but would love, love kind of the thoughts on how, whether set this concept of setting a baseline, but then acknowledging the baseline may actually not be enough for all people and so for certain people you may need to go above the baseline. That's kind of the intent here. I'm wondering how that resonates for you, or if that general approach is kind of where you see the problem.

ERIC CARLSON: I would think that, again, we're not looking at specific language, but a framework that had some solid guarantees to begin with, but offered the option to expand that in certain circumstances is necessary for particular needs, that would be a positive thing.

JULIETTE MULLIN | Manatt: Okay, so it's, maybe the kind of feedback here is about strengthening what those baseline requirements are. So not saying must include weekend and evening options, but actually being much more directive about, and expansive and what that looks like.

ERIC CARLSON: Yeah, yeah, I think you need a baseline here because this, there's not much of a baseline here. If you looked at this and said, okay what does the facility absolutely positively have to offer, and there's, I don't think there's much here that's that's solid on in from that.

JULIETTE MULLIN | Manatt: Okay tracking. Thank you Eric. Catherine you're next on the line.

1:34:19

CATHERINE BLAKEMORE: I can't, you know this goes back to the way earlier comment that Tony and others made, is, who are we talking about here right. So facilities have policies currently and there's regulations about visitors, so is this the assumption that those visitation policies have been suspended and now we're carving out a different group of people, which is really then not visitors, right, not all visitors so I feel like that fundamental question that was asked about sort of who are we talking about and who should we call them is, is in part why this is getting more challenging as we as we go through it, because it seems like we're not really talking about visitors, that there's sort of this underlying assumption that in a state of emergency visitation has, is not happening but there's now going to be a carve out for resident designated visitors that's different than regular visitation. And I think it's when you say they have to post their policies, visitation policies, well, is that different than what they currently allow for visitors or, it's just, I think it's, I think it's getting very muddled at this point honestly.

1:35:42

JULIETTE MULLIN | Manatt: Okay that's helpful Catherine. I think maybe like a first blush response to that and then we'll keep going in the line to hear what other folks think. The intent here was to start to capture a recommendation for specifically resident designated visitors, so I'm acknowledging the, I think we've sort of acknowledged we're setting aside and putting Ombudsman, state surveyors, health care providers into kind of a different category, although welcome thoughts if people disagree with

that. But that's kind of where I was operating on from here. And the idea here is to say, in a state of emergency if a facility is saying that there needs to be some limitations to visitation, related to a reasonable public health or safety risk caused by the state of emergency, this is what it at least has to look like to enable visitation. That's kind of the general concept but certainly welcome refinements or additional questions or ways we can make that more clear.

CATHERINE BLAKEMORE: So maybe it's just being cleared throughout like it says, as a standard during a state of emergency. Well, it's not just a state of emergency it's a state of emergency in which there are restrictions, right. So, to link those two more specifically, and I don't, I mean sort of a conundrum I face during the pandemic was people providing other kinds of care could go in, so a physician or a nurse or a hospice person could go in, but I was a relative visitor, and I couldn't. So, I'm not sure making a distinction about, between, between those groups that you you mentioned make makes particular sense if like, so you're limiting general visitation, but why would a nurse have a different set of rights, who, a nurse is providing a certain kind of care, but in this case these are family members or designated people in the broadest sense that are also providing care. So, I agree with separating them but I'm not sure it makes the right to being at the facility providing that support any different between them right.

1:38:00

JULIETTE MULLIN | Manatt: Okay, yep tracking that. Thank you Catherine. Karen.

1:38:07

KAREN JONES | CLTCOA: HI, I kind of want to reiterate I think the word reasonably kind of messes up the policy. The facility must allow resident designated visitation or whatever we're calling it, but when you add the word reasonable it starts to change what my definition of reasonable is compared to somebody else's definition of reasonable. And I think it just must allow, there really can't be any, any reasonable test to that. And I would say that throughout this section, and you know, one of my kind of personal pet peeves is the, you know, the second bullet point there on limiting where the visitation can occur. You know we, we, and I know you kind of quoted what I had mentioned in a previous meeting that, you know,

when you've got a resident who is fairly bed-bound or mostly bed bound or fully bed bound and they have a roommate who may or may not leave the room, this still leaves that person kind of high and dry with visits. So, we need to beef up that second bullet point that you know the visit has to be allowed in the residents room when, when that resident cannot or will not be able to leave their room. It's got to be stronger language or we're going to continue to have people who can't leave their room in a reasonable manner, especially during, you know, with COVID we saw people they didn't have the staff to get people up regularly, and, and then to ask them to do that for a visit, they were the least likely to get an access to a visitor appointment because it was so hard to get them out of their room. So, we need to have those room, those visits allowed in their room, even during the pandemic of some kind you know the PPE will protect them in a giant visiting room, it'll certainly protect him in a bedroom or a facility room.

1:39:54

JULIETTE MULLIN | Manatt: Thank you Karen. I'm hearing a couple things there, there's this challenge around the reasonably, and maybe having that actually be more of something that reflects a person's centeredness and reframing that language, maybe, based on what we're hearing. And perhaps on that second criteria around location, having a very specific parameter around shared rooms specifically. Great thank you.

KAREN JONES | CLTCOA: Well shared room or where the person can't leave the room because part of the challenge was these designated visitor areas were kind of near the front of the facility and they didn't want wandering the building, and so that caused its own trouble.

JULIETTE MULLIN | Manatt: Thank you. DeAnn I see you've raised your hand.

1:40:38

DeANN WALTERS | CAHF: Thank you. just to comment from the facility side. when we're looking at all of these different requirements on the facility, I do just want to to say that it has to be feasible for a facility in an emergency to actually be able to implement. And so having giant lists of who who could be a designated visitor, or having, changing things that must be put on a website or, you know, not allowing certain, certain changes, we just have to be cognizant that a facility will be in an

emergency, and we do have to think about their ability to, to follow all of these things which allow visitors to, to be in the facility. And it can get very difficult because they are getting all of the recommendations and requirements from multiple different outside places, and then they have to, you, right, follow the most strict of those and then then we're going to have a separate thing. And so, I want I'd love to have something that's really easy for all the facilities to follow, but it also can't be labor intensive because the reason that so many things were limited with visitors during the pandemic was because there wasn't enough staff to have people watching, and that was one of the requirements was that we had to observe some of these interactions. And I can tell you facility staff don't necessarily want to be observing interactions, but it was one of those requirements. So, you know I just want to throw that out there that we do need to be understanding and when we say we want to be person-centered, the only issue being there is that we also have to be equitable. And so, if I make reasonable accommodation for what's happening with this one family I need to understand I'm gonna have to probably do the same thing for another. And then again we come into that how do I feasibly make that happen for everybody when I have 99 residents, and they all have different wants and needs, and you know you can try but in an emergency there is some limitations to the things that we can do. And and a lot of these restrictions were initially imposed by outside forces, and it wasn't necessarily what the facility was used to doing or wanting to doing. We've always had all week and all weekend visiting, we did limit overnight unless there were special circumstances, just because we have to still keep the residents safe and be aware of who's in the facility. So, you know, facilities need to have something they can reasonably follow, but we all have to understand it has to be feasible in an emergency for them to follow it. So, thank you for your time.

1:43:22

JULIETTE MULLIN | Manatt: Thank you for that really appreciate you lifting up those considerations as well. Nancy I see you've raised your hand.

1:43:29

NANCY STEVENS | Resident: Hi. Thanks for letting me speak again. I'm not sure about the reasonably allow, like, who's, who's the voice of reason?

I guess, because if I, so my facility for instance just didn't, in my own experience, I had had some help from Tony Chicotel when my facility was putting up signs saying that there was only six hours of visitation per day allowed to the public, and that was a sign up on the door, there were several signs up on the front door actually that all stated the same thing. But in small print it said unless you've been given previous permission. And I hadn't seen my mom in three years, and she wanted to come out and I was not given permission to see her outside of those hours because I had contacted and filed a grievance with CDPH, and through my insurance company and contacted the Ombudsman. And I was also assisting other residents with getting the Ombudsman's phone number, which was really frowned upon, and so I was not given permission by the person who was the voice of reason to have a visit. It was actually in the evening but during, but after the administrators visiting designated visiting hours. That's all. Thank you.

1:45:02

JULIETTE MULLIN | Manatt: Thank you. Yeah, I have my eye on the time so I'm just going to keep moving through the list but thank you. Sally you have your hand raised

1:45:14

SALLY MICHAEL | CALA: Thank you just a couple of comments. I think piggybacking on, on what DeAnne said specifically looking at the website requirement, I think that's an example of something that might be too specific in an emergency, and you've got all hands-on deck, keeping a website updated may not be the best use of people's time. So, I think there might be another way to to look at that, there's certainly active communication processes with both residents and family members that perhaps might be more efficient.

And then the other thing is, it's more of a question, I wonder as we've talked through these protocols previously if there was any discussion around what would happen if there were an active outbreak of COVID, if we're using that as an example, how would that impact these, these protocols?

1:46:08

JULIETTE MULLIN | Manatt: Thank you for that comment Sally. I'm gonna go to Mark.

1:46:16

MARK BECKLEY | CDA: Great. Why don't we do Tony and Jason first and I'll, I'll go last.

JULIETTE MULLIN | Manatt: Okay great, Tony.

1:46:29

TONY CHICOTEL | CANHR: Yeah, hi think this is the first place in the principles or recommendations where we talk about a facility having a specific visitation policy that might be different from another facility's. And I wanna be a little bit careful there because I think a lot of, part of, part of our principles are to avoid very variation between the facilities. And I can certainly see situations where a facility's policies would be different from another like this is how, this is the number you call to let us know you're coming, or this is the person you report to when you get here, this is the room that you go to, so there's going to be some variation there. But I would suggest adding another bullet point here, you know, policies must include, policies must be, I would include something like policies must be, must provide the legally required access, or policies must avoid any impermissible illegal restrictions on visitation, something that says we start, we're all starting from the same point based on your county or the state guidance, and then you've got your own, you know, idiosyncratic things that that don't infringe on those state, county, federal standards.

1:47:46

Great thank you Tony. Jason.

1:47:54

JASON SULLIVAN-HALPERN | LTCOA: Hey. Yeah. Just to piggyback and add to what a couple of other people here said, and the comments and, and on video. I just want, I think a good way of framing this is to say the least restrictive, you know, the least restrictive parameters allowable under state local and federal law. I saw comment in the chat about well that's confusing because you know the federal law trumps the state law for example, but I mean, I think, I think it fundamentally does make sense

because whatever the least restrictive most authoritative, you know, law applies that's, I think that would set the baseline, and I think it does, it is coming at it from a completely different perspective, kind of to Tony's point where we're looking at it from the perspective of a resident's right, it's a right, or doesn't have visitors, so any anything that would limit that right in any way should be justifiable. And I want to make sure that, like, I do think that it gets away from some of the problem that could be created by allowing, by the word reasonably, and people differing on what's reasonable. Because it's really more objective to, to say like, the least, you know because we have to also acknowledge on the facility side like facilities could be designed differently, it's a space itself could be designed in a way that it makes it difficult for people to interact in a certain space. And, and, and so I think, I think just, I think really just making it, coming at it from that opposite perspective would help.

1:49:47

JULIETTE MULLIN | Manatt: Thank you for that comment. I will go to Mark next.

1:49:54

MARK BECKLEY | CDA: Yeah, and what I was really going to suggest that to these points Tony, said and Eric made earlier about, you know the language and the paradigm maybe not being right, right, or maybe there needs to be a stronger more specific ways to establish baseline, we would love to get a language, you know that would really help, because you know we can come up with things but really if you have something very specific in mind, like language that, that you find suitable, I think it's important. But then there, the only other sort of option of entertaining, and you know, I don't want this to be really bureaucratic, because of course in times of emergency, you know, time's vital, but it does strike me that every emergency is going to be different. I mean the COVID pandemic was was one, thing, there there will be future pandemics, there will be other emergencies that we we can't contemplate because we haven't experienced them, but it may be, it may be necessary to adopt different baselines for different situations. And you know, we contemplate things like workgroups and public health officials and facility operators and advocates and family members, you know, possibly that's something that you could contemplate here, is a, convening such a workgroup to establish baseline

standards in, you know, in times of emergency. So just another thought, but really any language any additional thoughts very welcome in this space. But I really think this is the crux, and that's why I'm glad DeAnn spoke up from a facility's perspective, because this is where, we really have to hear from facilities and public health, about what they think would work or what concerns that they have, so that we can start getting to some good middle ground or opportunities or...

1:51:41

JULIETTE MULLIN | Manatt: Thank you for those comments Mark. I'm gonna take a stab at summarizing this feedback. I took many pages of notes from, I mean I've been taking notes all the time, so I'm gonna try and and I might miss some things from this one. I think the biggest, there's really, really a few big ones. A lot of concern with the term reasonably allow, heard that loud and clear, and so I think what we'll do, what we endeavored kind of the spirit of that was getting to the person-centeredness that has been raised in a few different places. And so, we'll revise a language there and take, a take, a new path at that to see how it lands. The intent, the intent there is really to empathize that a one-size-fits-all approach may not work all of the time. At the same time, we want to set a standard.

So, I do invite, we are going to move on in terms of public comments, or in terms of verbal comments. But if folks generally don't think that framework of having, here is the minimum, here's what you have to do, but then acknowledging some person-centeredness that may require facilities to go beyond that in certain scenarios, if anyone feels that that general framework isn't landing right for them really invite you to drop that in the chat, because we'd love to, to look at that and iterate on it make sure we're really hearing everyone's perspective on that general approach of saying this is the baseline it has to be for every facility and then there's going to be some person-centeredness we need to consider around things like language, translation, accessibility, mobility etc. So that's one thing that I'm hearing.

The second I'm hearing is to strengthen some of these standards and so there again really going to ask folks if they can drop in the chat for some of these standards, I think I heard a lot of feedback around specifically that third one, around hours of visitation. Really welcome people to drop in the chat what they would recommend setting as the standard there, as the

baseline. And we'll review that and iterate on it and pull together something additional.

Also hearing just kind of moving through, in this last one around policies. That the posting on the website may not be exactly the right approach there, under, that we want to ensure there's transparency, and so let's look at exactly what the right way to frame that is, that, that last requirement, and being clear there.

And then I’ll also note, just a global up, a global comment I think that applies to this one, and other ones, it's to be much more clear about what we mean by during a standard, a standard during a state of emergency. That we are talking about a state of emergency in which a reasonable public health or safety standard related to that emergency may impact visitation in any way.

That was my attempt to summarize our conversation. If I missed anything really please Invite you folks to drop that in the chat. I don't know that it makes sense for us to vote on this one because I think we have enough things to iterate on, that I'm sure folks are not quite comfortable voting yet, or sorry, I don't mean voting, this is not a vote as I said, not quite comfortable kind of giving an indication of support. I will just kind of open one last time to see if there are any additional points of feedback, because as Mark noted this is kind of the crux of the issue here. Any additional comments, and we'll go over, if we go to the next slide. Into the public comments.

And if there's any, Teresa, I see you have your hand raised.

SLIDE 47

1:55:29

TERESA PALMER: Yeah, I think you should throw this out and start over. This profoundly shows that someone's not getting it. Basically, it should be, the clinical and ethical standard for everything else in long-term care facilities is least restrictive. Any, any restriction needs to be person-centered and flexible, and any restriction has to be justified. And there is no justification for limiting time of visitation or even simultaneous visitation. It's, it's got to be, I mean, I just, I think, just throw it over, throw it out and start over thanks.

1:56:25

JULIETTE MULLIN | Manatt: Thank you for your comments. Karen.

1:56:30

KAREN KLINK: Yes. So, this question about most restrictive and less restrictive, I don't understand, what, what, what they use is most restrictive, and then someone said, well, we'll just use less restrictive, but who makes that decision? You can't just say that. The agencies use most restrictive, that's what they're, that's what they tell us when we call, or that's what, that's what, that's, that is the rule, so you can't just throw it out. And, and a number of people have said that is what they use, most restrictive. And in this particular case, in say our state which we're talking about, the local, the local counties were usually the most restrictive, and then the state was above that, and then CMS was least restrictive. So, for most of us, you know, our facilities, you know, particularly say in Los Angeles it was very restrictive because of the rate of COVID. so that's what we, that's, that's the way it was, it was for us, so you can't just say, I mean, I'd love to use the least restrictive because I was told that so many times my head would spin. So, we need to figure out if that’s if that's a possibility and who makes that decision. I mean, I would love for the facility to use least restrictive, because they were always telling me you have to use most restricted, and when I went to the, to the licensing agency, who in my case is Department of Social Services, they were told, they said to me you have to use the most restrictive. So, you know, I don't know who makes that decision but, that, you know, we have to know what, what is, what's being used, least restrictive or most restrictive. Thank you.

SLIDE 48

1:58:10

JULIETTE MULLIN | Manatt: Thank you for your comments Karen. All right. I do have my eye on the time we have about 20 minutes left today, I think what we'll do, we're likely not going, well we're not going, I will I’ll just say it, we're not going to be able to cover the conversation about what it looks like in a situation that we don't anticipate, where the standards that this workgroup will eventually land on, may not apply. So, we'll, we'll kind of, I think at this stage, given we have 20 minutes left, we'll go ahead and say that that'll be kind of the core conversation of meeting four, in addition

to the appeals process, grievance is an appeals process. We will ask people to provide some offline feedback on that. We're going to talk about that more in a moment because since we only have one more meeting of this group we are going to ask for some feedback between the meetings, so that we can really land some of these pieces, just acknowledging that time is running out.

So, this last section that I want to cover with the group today relates to compassionate care. And, great. So, if we could just go to the compassionate care section. Thank you.

So, this is around setting a recommendation for long-term care facilities to expand their efforts to enable visitation in a situation requiring like in a compassionate care situation. And so, this is one of those areas where we want to acknowledge some of the comments made earlier about, like a situation where someone's not eating, a situation where someone's not drinking, and acknowledging that those are urgent situations, and, and weaving that into their recommendations, that acknowledgment that those are urgent, and they can't wait. So here what we've taken a first pass at is, is stating what that might look like, so we begin by stating, by an initial definition of compassionate care, and I don't think we'll fully get through a definition today so we're going to ask for a lot of offline feedback on this one as well, as well as invite people to put it in the chat right now. We'll note compassionate care is defined in the CMS definition as visits for a resident whose health is sharply declined or is experienced a significant change in circumstance. And so, the workgroup can decide to put a lot more definition on that if we'd like, or we can leave that as the very broad definition of, of compassionate care, acknowledging, as I think many folks have noted on this workgroup, it's not just one or two situations there are a number of different situations that may require compassionate care.

Then we indicate here in the case of, sorry I'm losing my ability to speak, in the case of compassionate care, visiting parameters established due to a legitimate public health safety or operational risk, must allow as many simultaneous visitors as determined by the resident of space and safety protocols reasonably allow and should not limit the hours of visitation.

So, I'm going to pause here, and I think a core piece to consider, kind of as a subtext on this whole recommendation is whether the group wants to kind

of provide very specific standards in a situation of compassionate care, that is elevated and kind of acknowledge that in the recommendation.

And I'm seeing some notes in the chat about, noting it's not just a physical health decline. And, and some agreement around keeping the parameters broad around what constitutes compassionate care because it's not just one or two situations. Karen I see you've raised your hand.

2:02:26

KAREN JONES | CLTCOA: So, two things. I want to agree that it's definitely more there's behavioral issues also during the pandemic, a lot of facilities struggled with having staff who were just overwhelmed. And when residents were having behavioral challenges for whatever reason, having family come in and help made a huge difference. And when they couldn't come in it made also a huge difference. But along that line I think we have to be careful with the word compassionate care just, it's almost like a hospice term, and some people may find it offensive to say they're giving compassionate care to a loved one, with the connotation that maybe they're, you know towards the end of life, so we may need to either add to it or wordsmith it a bit.

2:03:10

JULIETTE MULLIN | Manatt: Thank you. Melody.

MELODY TAYLOR STARK: Yeah I had my hand raised but basically what Karen said. I, and, I agree on, on, you know that language on compassionate care and also the policy in and of itself is, is going, you know, to include resident designated support persons at any time. So, what I'm getting from, what I'm seeing in the language, is the compassionate care would go above and beyond that, to, to those outside of those resident designated support persons, and, you know, as noted it could not be just end of life but, you know, critical situation that could be physical or mental emotional health as well but thank you Karen well very well said.

2:04:01

JULIETTE MULLIN | Manatt: Maitely, I see you've raised your hand.

2:04:08

MAITELY WEISMANN: Right, so my concern is that these, you know, these situations, you know, when someone's not eating enough, or drinking enough, they're not necessarily being recognized and reported and, I, you know, I don't want to say that the staff means to miss, it, it's just they're overwhelmed in a pandemic an emergency whatever it is, it's gonna happen again. I don't think that there is really any solution to that other than ensuring that they're not the ones we're relying on for that information, that's pretty much what I have to say about that. And also, retaliation does happen too, so that's something to consider. Lately that's been a big topic, you know, at a lot of the advocacy organizations. I don't know why it's suddenly being discussed maybe it's because it's too hard to pin down, and to prove but that's a factor to consider as well.

2:05:13

JULIETTE MULLIN | Manatt: Thank you. Thank you for that comment. So, hearing some general alignment behind the workgroup having a recommendation for elevated standards in a situation of crisis, and we can talk about the language of it whether it's compassionate care or a different term but elevated standards in a moment of crisis, to, to really enable robust visitation to support residents.

I think if there's no additional comments on this one we can kind of move to a pulse check to see where people are, and if anyone has concerns with this approach and wants to say that they're not, kind of, feel like, that their level of support for this is not currently very high. So, we'll open up that survey again, and ask folks to weigh in on how they feel about this particular standard, this particular recommendation at this point.

SLIDE 49

2:06:12

And just flagging because I'm seeing some questions about this in the chat. The survey itself is for workgroup members although we'll invite public comment in just a moment, but the survey itself is for workgroup members, but members of the public can see the results as they're coming through right now. This is, this is this particular exercise is to get a pulse check from the workgroup.

Okay, seeing some support. Okay. We've got we've got some concern about a compassionate care recommendation. All right, I think in that situation we can pause for a moment and just talk us through a little bit further. So, if we could go back to the recommendation.

SLIDE 48

2:08:10

So, the core concept here is the concepts that the workgroup would recommend elevated access to visitation in a situation where a state of emergency is, sorry looking at the chat at the same time and distracting myself, in a situation where a state of emergency does have public health or safety risks directly associated with the state of emergency that may impact in any way visitation. This recommendation would state that as a minimum in a case of compassion, in a case of crisis, in a moment of crisis, facilities would allow as many visitors as the space allows and safety protocols allow and should not limit the hours of visitation. So, I'm going to encourage folks, if anyone, if there are kind of red flag areas here for people or particular phrases in this that they are so very concerned with, to either kind of raise their hand and share that or drop it in the chat. Or if there's particular things that we could add to this recommendation. Karen, I see you've raised your hand.

2:09:51

KAREN JONES | CLTCOA: You just want to be careful with that first bullet, or the sub bullet point on the need for compassionate care visit may be identified, there was certainly a kind of a standard that started that if the resident designated visitor or any visitor sort of said whoa, my loved one needs compassionate care visit, that, that held significantly less weight than if the facility staff or, you know, some public health type person identified it, so you need to make sure that the verbiage is that they're, they have equal equal weight so that the visitor doesn't get sort of just, just kind of ignored because they're saying wow, my loved one's having these issues, as opposed to somebody associated with the facility.

2:10:56

JULIETTE MULLIN | Manatt: Tracking that, thank you Karen. Any other comments related to a compassionate care recommendation. I'm using the

term compassionate care because I don't have another term for it right now, but we will think through that.

We have a raised hand, I'm not able to see who it is because they're listed as Long-Term Care Facility Policy Workgroup Panelists but hoping they can come off mute.

2:11:28

MERCEDES: Mercedes, I wrote on the, on the chat. So one issue that I had already with existing definition that's provided by the CDPH, so my brother, he's not verbal, and he's, so, and most of the patients are residents in that facility are not verbal, so it's hard for me to justify because administrator gives me a lot of like, pushback, when I said, oh, we're considered, you know, compassionate visitors and he's like, oh, well if you're one, everybody here's one and I'm like yeah, what's wrong with that. So the issue I'm having is ,you know, it's so hard for me to say, well, my brother, my, I can't say hey, my brother said he's feeling depressed, he, it's so hard, only, I am and my mother are better interpreters of him, of his care, and we can read him much better and so there's that, to me feels like this loophole where because he, he doesn't eat he, he has a feed, feeding tube, you know, maybe these things may not apply but it doesn't mean that, you know, he he didn't suffer you know depression and isolation and all these things that I know he did suffer.

So, I just kind of wanted to bring that up because I don't feel like, in any of this, we are considering these cases or residents with, you know, he, he's severely disabled. My mom are literally the people who interpret his needs, and then again, you know, the facility where he's at wouldn't consider him to be, you know, they said oh, nothing, you know, his health is the same and everything and we're like, it clearly isn't. So, I'm not sure if that made sense to you all, but yeah, but I continue to look at this and I continue to look at this definition of like, you know, on their, the DPH guidance and it just, it's a little frustrating because to this day, because in order to get this title of becoming an ascent, sorry a compassionate visitor, I have to have a meeting with the administrator, the doctor, and the care care plan team and basically they refuse to give me that meeting. So, yeah, I'm just pointing these things out because they may seem trivial, but when it comes to the nitty-gritty these are the things that we're trying to eliminate, you know. That's all.

2:14:14

JULIETTE MULLIN | Manatt: Thank you, appreciate those comments. I'm just looking at our at our line, we have Blanca Castro with her hand raised.

2:14:26

BLANCA CASTRO | SLTCO: Hi, good afternoon everyone, and thank you for excellent facilitation. I just wanted to flag two items, one is with regard to the term compassionate care and recognizing that that is troublesome for for a number of reasons. One of the reasons the initial bill included essential caregiving is because that could then be more person-centered, and trauma informed.

And then secondly I wanted just to echo my colleague Mark Beckley's point that was really good to hear from CAHF, these are, this conversation right now this is when we really need the voices of everyone, so to whatever extent I encourage public health and my other, you know, hearing from some of the other folks that represent not just the residents and, and, and advocates for consumers, but just as importantly public health and facilities because that's where we got stuck, and we want to be able to move this forward and, and, and to whatever extent possible have it be a, you know, a new bill that's passed. So, I just wanted to add those two. Thank you.

2:15:56

JULIETTE MULLIN | Manatt: Thank you Blanca. I think that brings us to the end of the core of our workgroup conversation today. We're going to talk about next steps in a moment but first i'm going to turn one more time to the public comments. And I see Teresa, you have your hand raised.

2:16:15

TERESA PALMER: HI think all care should be companionate, and I think the compassionate care is, is a vestige of the inappropriate limitations that were put on

JULIETTE MULLIN | Manatt: Oh, we just lost you Teresa.

TERESA PALMER: And yeah, can you hear me? Yeah, and I think you should scrap it. All care should be compassionate. There should be minimal limitation at a baseline, and people should get what they need, in this

facility, in, in a long-term care facility. And having this vestige of inappropriate limitations continue, It just shows that the task force kind of isn't getting it. And I think you need to scrap the compassionate care. There have, has to be robust rights for visitation. Thank you.

2:17:20

JULIETTE MULLIN | Manatt: Thank you for your comments Teresa. And I think with that, that wraps up our last section of public comment today. I'm just turning my pages here and at this point I want to thank everyone for your engagement throughout the conversation today. I'm going to introduce the Director of the Department of Aging, Susan DeMarois to, to provide a few closing comments before we close.

2:17:47

SUSAN DeMAROIS | CDA: Thank you Juliette and the Manatt team for such fantastic work. And hello to the workgroup and our and those joining us from the public. I just wanted to join for a quick minute today to thank everyone, especially our workgroup members, and in particular our residents who are part of the workgroup for completing three meetings. It's it's exciting to see straw, straw scenarios laid out after just three meetings to really be focused on some really concrete recommendations and moving this work forward as quickly as you are. There is a sense of urgency and I thank you for sharing that sense of urgency. I also want to thank of course our legislative partners who made this possible by carrying the legislation forward, and the governor for signing the bill that that brings us all together here today to talk and will bring us together for our our fourth meeting coming up. And to the members of the public who joined today, and those that were part of the two prior meetings that have helped shape the work today. I'm very grateful to the public as well, and our team Mark and Brandie thank you, and and Blanca Castro thanks for your great work. I am impressed. I'm impressed to see how much progress has made in a short period of time when a when a group of people who share common goals, but perhaps different views come together for the good of California. So, my thanks to all of you. Back to you Juliette.

2:19:27

JULIETTE MULLIN | Manatt: Thank you Susan. And I think with that I'm going to hand it over to Brandie to close us out today.

2:19:34

BRANDIE DEVALL | CDA: Thank you. So, we are going to talk about next steps. Prior to the next workgroup meeting on August 22nd, CDA intends to circulate an updated draft of principles and recommendations based on today's discussion, and that'll go out to the workgroup. Workgroup members will be invited to provide written feedback on this updated draft prior to the next meeting. All drafts and feedback provided by workgroup members will be posted on the CDA website. The last meeting of the Long-Term Care Facility Access Policy Workgroup is scheduled for August 22nd and that will be from 12 30 to 3 30. CDA will circulate the agenda for this workgroup meeting to the public at least 10 days prior to August 22nd. CDA will send materials for the workgroup members in advance of the meeting and will post all materials to the public on our website. Workgroup members are encouraged to review materials prior to the meeting and consult with individuals within your organizations as needed. Materials will be listed on the Long-Term Care Facility Access Policy Workgroup webpage which the team will drop into the chat shortly. Thank you again for participating in this very important work and for your conversation and your discussions and your patience and your willingness to collaborate. If you have questions please reach out to us at the email listed on our slide, and our team will also drop that in the chat. Now thanks again and have a great afternoon.