Centers for Medicare & Medicaid Services
COVID-19 Call with Long-Term Care Ombudsman from All States
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Operator: This is Conference #: 1199028.

CMS - Alina Czekai: Good morning and thank you for joining today's CMS COVID-19 call with Long-Term Care Ombudsmen from All States. This is Alina Czekai leading stakeholder engagement in the Office of CMS Administrator Seema Verma.

On today's call, CMS will discuss nursing home visitation policy issues and we will hear from ombudsmen around the country regarding best practices that can help combat the loneliness that some nursing home patients and their families are suffering from.

Here at CMS, it's really important to us that we hear from those of you on the frontlines as you continue to care for nursing home residents and their loved ones during this very challenging time.

At the end of today's call, we will open up the conversation to hear from you all. So, we do encourage you to think about ideas and solutions that you'd like to propose to the agency.

We also have several ombudsmen from around the country who have agreed to get our conversation started today. We'll be joined by Mark Miller from D.C., Bev Laubert from Ohio, and Patty Ducayet from Texas.

But first, I'd like to turn it over to Dr. Lee Fleisher, CMS's Chief Medical Officer, for an overview of CMS's current policy and our framing of the conversation. Dr. Fleisher, over to you.

CMS - Lee Fleisher: Sure. Thank you. It's a pleasure to be here. And on behalf of the Vice President and the White House Coronavirus Task Force, and most importantly on behalf of our Administrator Seema Verma, we really are glad you're joining us for something that is very important to all of them and has been

tasked by the administrator to ask me to really focus today on getting your guidance and your voice.

As you know, we've been issuing guidance since the pandemic has begun. And at the beginning, we felt that very important to restrict visitation to issue of compassionate care. But we now recognize that it's critically important to revisit the visitation policies to really think about the psychological wellbeing of the residents, of our elderly, and that has profound impacts also on their physical wellbeing.

We want to develop guidance that really balances the risks of transmission within the facilities versus the risks that social isolation has on these residents. And as I said, our goal today is to listen. We won't be providing much in the terms of feedback.

We also want to acknowledge that we invited Mark Parkinson from AHCA to be a listener so that at the end the people from CCSQ from CMS who are here, as Jean Moody-Williams, my deputy, Shari Ling, the Deputy CMO; and Evan Schulman, who many of you may know, leads our nursing home section.

With regard to how we've been thinking about this to give some frame, to have you thinking while the presentations are ongoing, we want to talk a lot about outdoor visits and whether there should be any limitations, how we should think about it from the perspective of perhaps the county positivity rate or other issues with regard, most importantly, adhering within to the existing core principles of infection control.

The second this is, we want to expand and how to think about expanding indoor visitation beyond just compassionate care situations. Again, within that framework of core infection principles, but what facilities should and should there be any facilities that should not expand visitation based upon things like county visitation, county positivity rates or what is happening inside the home as well as cohorting.

How we should think about issues of those residents with roommates? How we should think about issues with respect to the age of the individuals coming into the home? And lastly, how we could potentially help you with regard to

novel physical structures to allow these visitations to go on even in some of the areas with higher positivity rates?

So, on that note, I'm going to turn it back to Alina. But hopefully, that provides you with a framework. But just want to make sure from my team, Evan, Shari or Jean whether there's any other things that you want to hear before I turn it over to Alina or did I outline the key questions?

CMS - Shari Ling: Yes. This is Shari. You outlined the key questions and just want to thank you all for coming to this call today and for the service that you provide to our beneficiaries. What you do matters. And we really look forward to your suggestions and input. So, thank you.

CMS - Jean Moody-Williams: Agree with you.

CMS - Evan Schulman: Yes. And I echo that. This is Evan. Thank you.

CMS - Lee Fleisher: Absolutely. So, on that note, it's most important, Alina, that we hear from you for what you do and how you can provide incredible insight to us.

CMS - Alina Czekai: Terrific. Thanks so much, Dr. Fleisher. First, we'll hear from Mark Miller, the state long-term care ombudsman in Washington, D.C. He's also legal counsel for the elderly at AARP Legal Counsel for the Elderly, and treasurer of the National Association of State Ombudsman Programs. Mark, we'll turn it over to you first for brief remarks.

Mark Miller: Thanks, Alina. I appreciate it. Just a couple of program notes. One, I'm currently the president of National Association of State Long-Term Care Ombudsman Programs. The other is, I just wanted to make sure the people understood that we are recording this today so that they can share this call with their local program staff at some point. Is that correct?

CMS - Alina Czekai: That's correct, Mark. Yes, we'll make sure that attendees of this call get a link to the recording so you can share that with your colleagues after the call.

Mark Miller: Perfect. Thank you so much. Just a couple of – just a couple of notes, one, I just want to say thank you to you, Alina, for arranging this and to Dr. Fleisher

and to Evan Schulman for providing us the opportunity to talk about visitation, obviously, a critical issue at this point.

It's been more than five months now since residents have been able to physically engage and see their families. And I think the isolation has taken a terrible toll as we hear from both residents and families on the physical and mental health of residents. And certainly, the support that families provide is critical to the wellbeing of residents. And so, we're very anxious to engage in this discussion, hopefully, open up visitation.

I think, two, just general comments. One is, we believe at this time with appropriate protocols in place, every facility ought to be able to provide at least some outdoor visits for residents and families.

The other thing I would say from the ombudsmen visitation perspective, we would definitely want CMS to consider reevaluating the guidance to make ombudsmen essential so that while we may not go into every facility right away that we have the option to be able to go in if we deem it necessary to investigate a complaint or to look at a particular issue.

So again, we appreciate the opportunity. And that's pretty much all I needed to say this morning. Thank you.

CMS - Alina Czekai: Great. Thanks so much, Mark. Next, we're joined by Bev Laubert, the state long-term care ombudsman from Ohio. Bev, we'll turn it over to you to hear your perspective and best practices from Ohio.

Beverly Laubert: Thanks very much. I'm happy to be here. I appreciate you doing this and seeking the input of ombudsmen.

When CMS initially issued recommendations about visitation, it caused great consternation in my state and I'm sure many others. And honestly, my first reaction was that residents would never hug their families again based on those recommendations because they were just so stringent even in phase three requiring weekly testing. And I just don't know that that's possible in every nursing home.

So, obviously, the point-of-care testing has come up since then and that may open up possibilities, but definitely still some concerns.

So, Ohio has been working on our own phases. We started with assisted living with outdoor visitation so we could learn some lessons from assisted living. And we've gotten some resident counsel input. Our ombudsmen office has had a few calls with resident counsel presidents in groups to get their thoughts, get their experiences of what was happening in their facilities.

And basically, I think everything can be summed with the word inconsistency. Each facility is kind of doing their own thing based on whatever science they believe. For example, residents not being able to receive packages in some facilities. Absolutely no packages.

And some facilities let them sit for 72 hours for any virus to die. Some facilities sanitize – open and sanitize packages. So, that's been a problem for residents as well as inconsistency in being able to go outside and talk to one another. Provider input has been of high value in Ohio with developing visitation plans.

So, what we learned – what we've learned, so, nursing home visitation began July 20th; assisted living started in June. And right around the time that nursing home visitation was opened up in Ohio for outdoors, the governor's office and health department initiated a county level alert system.

And so, the considerations that are in the visitation order for Ohio include the CMS considerations from the recommendations that were issued. And at the same time, we were also – well, I guess, nearing the end of testing that was being done by the National Guard baseline testing of staff to some nursing homes that had not yet completed their National Guard baseline testing of staff were not opened up for visitation.

So, families felt this great promise that July 20th they would finally be able to see residents and it just didn't work out that way. They continued to be upset that they don't have more frequent and regular visits. And families from one nursing home may be able to visit and families from another may not.

So, some nursing homes even stopped doing window visits because of county alert systems or levels. And so, we've had at the beginning of the pandemic, ombudsmen complaints were largely about visitation, about rights, about things like being able to go outside and receiving packages.

And now that visitation has opened up more, now our top five complaints are more about care. And families are identifying serious concerns with personal hygiene and just the overall condition of residents' weight loss and so on.

So, we've done some ombudsmen visit inside facilities. We've done both outdoor and indoor visits. We've had a couple of facility closures that have required ombudsmen to be there. It's critical to being able to do that is that the state emergency support function aid is providing an allocation of PPE specifically for ombudsmen, so that's been great and very helpful to us.

And I will tell you that when we've been inside, residents have actually been tearful with relief that they are seeing people again. And that's only happened in a couple of occasions – a couple of places where we've been able to get inside buildings.

And outdoor visitations, some facilities are doing a great job with ombudsmen outdoor visitation, making plans with residents, helping residents get to the ombudsmen. Their monitoring of the visit is done from inside or from a distance to allow privacy.

So, I think as you're continuing to develop guidance, privacy should be an important consideration and directive from CMS specific to ombudsmen as well as families, but especially where our residents are uncomfortable complaining to an ombudsmen if they are kind of identified or overheard what they're saying. So, I think that's important.

When I talk to our local ombudsmen, I had a call yesterday afternoon saying I've been invited to – I have this great opportunity with CMS. And so, I had a call with them to get some additional input from them.

And unfortunately, I didn't hear a lot of best practices. So, at the end of the call, I said, OK. So, pretty much well I'll say and these are the problems and

best practices would be the opposite of these things because we have had a number of concerns about limitations and actually, facilities just saying no for compassionate care visits, end-of-life visits.

We have families who are enrolling residents in hospice believing that then qualifies for end-of-life and that will get them in the facility. And for a resident, being enrolled in a hospice, I mean, that's just heartbreaking that they didn't think that they were at the end of life and they needed hospice. So, that's been a big challenge.

Outdoor visits, we're hearing from ombudsmen, from families really aren't much different from window visits because of the distancing. And they just can't see the residents in their own environment.

Scheduling has been an issue. Some facilities saying you can only visit once a week. You can only visit for 15 minutes. And that's just really not sufficient. And not having staff available on weekends to supervise visits. So, families can't visit on weekends in many cases.

Another key thing that we're hearing is about spouses. Let's say spouses are living together maybe in the assisted living portion of a continuing care retirement community. One spouse becomes ill, goes to the nursing home. The assisted living spouse can't visit with them any longer because they're not living together in the assisted living. And so, that's an issue.

People who have lived together should be able to continue being together even if they're not in the same room and they should be able to visit within the same building.

So, we're seeing families trying to do some workaround going to doctor appointments to try to meet up with their family member and so on. And so, these workarounds probably are causing more problem than just being able to have a visit with the resident.

We have seen some good practices for accommodations for weather. Online scheduling, one of the barriers we're hearing from facilities is we just don't have the staff to manage this. So, we're just not going to do it.

And so, we've seen one facility in particular does online scheduling. So, it doesn't really stress the staff resources as much.

And in general, as I'm summing up here, in general, communication has been a major issue with long-term care facilities, families, residents, and ombudsmen from the very baseline of getting someone to answer the phone at the facility and then being able to get a phone to a resident.

Maybe you weren't surprised. But really, residents living in nursing homes just don't have access to phones, whatever happened to the landlines and residents being able to have phones in their room. I know that CMS has made some efforts to get technology out, but that doesn't work always for people with dementia.

They are much better understanding what it is to talk on a phone than it is to look at an iPad. So, definite changes are needed there with regard to communication.

And we don't need nurses. We don't need administrators to be the ones answering the phone and getting phones to people. Why not have facilities have someone who doesn't have to go through training, certification, and so on to answer the phone, facilitate visitation, and just make it easier for families to be reunited.

So, those are my initial comments. I'm happy to participate in conversations later on in the call. Thank you so much.

CMS - Alina Czekai: Thanks so much, Bev. And next, we'll hear from Patty Ducayet. Patty is the State Long-Term Care Ombudsman in Texas. Patty, turning it over to you.

Patty Ducayet: Hi and thank you. Again, this is Patty from Texas. And I certainly want to thank Bev for her helpful comments. Certainly, I just can't agree more with what Bev has shared with you today.

And so, I want you to hear from at least one other state perspective that the problems that she's describing that residents and families are experiencing and ombudsmen are, at least, being felt in Texas, and I know many ombudsmen listening would agree that they're seeing it in their states too.

So, from Texas's perspective, I'd like to say first and foremost that our position is that the resident's right to visitors needs to be restored, and that we do not see virtual visitation as an adequate or effective means of visiting for too many people.

As Bev has described, you have to have access to a phone for virtual visitation to work. That cuts out a lot of residents. It also makes residents who don't have a personal device very much at the mercy of their facility. The staff there, the administration, the quality of services, are tied to whether you have good access to something like virtual visitation.

So, the facilities with the lowest quality of care are often doing the very worse job at ensuring that residents within that building are connecting to their loved ones. And that's just – I want to put that emphasis there because there really is this heightened concern at facilities that were already performing at a low level.

And I want CMS to hear that and see that this concept of trying to make something work during the pandemic, a virtual visitation, is really failing a lot of people. And to emphasize the point that Bev made about people with dementia, not only is recognizing a phone difficult but so are window visits, so are outdoor visits where you can't touch another person.

There are so many barriers for the – about 50 percent of nursing home residents that have moderate to severe dementia. Making these visits meaningful and the need for contact with people who they may still recognize is simply just so important.

We did a survey in Texas of some family members. It was opened for two weeks. We got about 250 responses from family members about their experiences with virtual and window visiting because at the time of that

survey in July, that's all the information – all the options that we had available in Texas.

And it's clear that most people were connecting virtually by a smart phone. And so again, that emphasizes to me that the person with a smart phone and the person who can use a smart phone are the only residents who are benefiting from it.

And secondly – and then I asked about the effect of those visits, how meaningful were they from the family's perspective by the resident. And certainly, there were people who said that they were very meaningful, somewhat meaningful. But there were at least a third of our respondents in this survey telling us that it was almost – it was useless or it was actually harmful to the resident trying to engage this way.

And similarly on the window visit, we got almost higher – really higher results in terms of the usefulness of that either harmful or not at all effective in visiting with their loved ones by a window side.

So, while I recognize that well meaning policies were put out there to try and respond to a crisis, it has been a long time and the frustration is so high by residents and family members at this point.

And people are really fearful. One of the things that I have learned from this experience that I think long-term care ombudsmen who visit facilities day after day, which I don't as a state ombudsman, but they know this that there are family members who provide a lot of care in our nursing facilities. And that has become abundantly apparent to me during COVID-19 restriction.

And for that to be five-and-a-month in my state where residents and family members are not any longer in physical contact with one another is devastating to the level of care that residents were receiving prior to a facility essentially being locked down from anyone on the outside.

So, I talked about residents with dementia and our need to do something different for them and the effects – I want to just mention that the effects of COVID-19 on our residents with cognitive impairment seems to be the very

worst because they can't benefit from our virtual options of visiting. So, we really need to look at that issue.

Second to that is that I, again, feel that visitors should be restored as a right. I take the position that outdoor visiting, if I take out the situation of Texas heat, which is a real factor for us, outdoor visiting seems safe with social distancing. And we should be doing that now.

And I believe that should happen in any facility even those with COVID-19 as certainly regardless of the county positivity rate. Separate people and at least let people put eyes on the residents who can be outside. That seems reasonable when you consider what is happening in the real world outside of our nursing facilities. So, I really urge CMS to move us in that direction.

And then finally, I will say on essential support person, I want to talk about this concept. It's got various names. In Texas, family members have called it an essential family caregiver. And this is a person who meets the needs, ensures that a resident has the health supports they need, that they get equal access to healthcare.

And it's helping a person who is disabled and needs someone else to act as their physical assistant or their voice in a long-term care facility. We believe that regardless of whether a facility has COVID-19 in it that every person should be eligible to have that essential support person, and let them wear PPE, let them provide support and care sometimes that they provided prior to COVID-19.

I feel strongly that the federal government needs to look at this issue and consider it. And from our state, we've provided you with an example of how that could be done. That was actually developed by family advocates in Texas.

And finally to Bev's points about end-of-life care and compassionate care reasons for visits, we have a very narrow experience in Texas where you have to be actively dying to visit your loved ones at the end of their life. And even then, we have had terrible barriers because all of these decisions about

visiting; end-of-life visits or any kind of window visits or virtual visits, are wholly dependent on a facility deciding to allow it. That is so problematic.

We need to require our facilities to provide that visitation and restore that right. And we need that CMS to enforce that resident's right. We need all those factors to actually make it happen. Because as Bev has said earlier, we've got too many facilities just deciding not to for any factors they want. And our state requirements certainly leave it to the facility to decide whether visitation is going to occur and how.

So, I thank you for giving me a chance to talk about these things. And I have some other thoughts about some of those suggestions that Dr. Fleisher mentioned earlier and hope to hear from other ombudsmen and can contribute more ideas. Thanks.

CMS - Alina Czekai: Thank you. And thank you, Mark, Bev, and Patty for sharing your perspectives. It really does mean so much to the agency to hear from you all, what you're seeing at the state and local level, and the solutions that you're hoping to bring to bear. So, we hear it. CMS is in a listening mode and we're taking down your ideas and solutions as we consider policies going forward.

So, before we open it up to other call attendees, I'd first like to invite my CMS colleagues to share any perspectives or questions to Mark, Bev or Patty today.

CMS - Lee Fleisher: Yes. Hi. This is Lee Fleisher. And thank you so much for putting a human voice to the issues to outlining the critical issues and outlining the difficulty in making sure that this actually happens as opposed to the goals of saying we can't because of.

Certainly, we have within our statutory authority, we are going to think long and hard about ensuring this is the administrator's commitment to figure out a visitation policy, again, that is safe.

So, my key point as we get – and you've sent in some very useful information – my key point is for the rest of the listening is we're committed. We're committed to try and to figure this out. Correct Evan? You'll be producing new guidance.

CMS - Evan Schulman: Correct.

CMS - Lee Fleisher: So, the real question is – help us figure this out to do it in the best way possible, additionally, as other speakers come on the line. So, thank you. And Jean, Evan, and Shari, anything else? Again, thank you so much.

CMS - Jean Moody-Williams: Yes. No. This is Jean, and really do appreciate the thoughts and the ideas that have been put forth before us. As we've said, we want make the changes that are necessary expeditiously as possible. So, your concrete ideas are really going to help us with this. So, look forward to hearing your remarks. Thanks.

CMS - Evan Schulman: Yes and this is Evan. And there's no question that we want to facilitate as much visitation as possible. The question is – how to do it safely. So, we need both ends of the spectrum. What can we do and how can that be done safely? Thank you.

CMS - Shari Ling: Yes. This is Shari. Just really look forward to hearing more from you. So, thanks.

CMS - Alina Czekai: Thanks so much. Operator, let's please open up the line to hear from the audience. Thank you.

Operator: To ask a question by the telephone, please press star one. If you would like to withdraw your question, please press the pound key.

We have our first question from the line of Kathleen Heren. Your line is now open.

Kathleen Heren: Good morning everyone. And I wish to thank you for making this call possible. I'm the long-term care state ombudsman from Rhode Island. I have it a lot easier than my colleagues of ombudsmen because the state is small.

But one of the things – and I have said this publicly to the providers when we have the calls with the health department – that I find very aggravating is

some of these providers are just looking for everybody else to come up with plans for visitation.

They don't use any common sense. They call this office with things that are just so stupid that I get very angry at them. You know, you should know better than to do this. Health can't think everything out for them.

And the problem is one facility will call the other facility and adopt whatever they're doing instead of trying to find ways around the more innovative to let this people come in and visit.

I haven't had a lot of problems with end-of-life visits because when I get a call from a family I get right on the phone with the facility. And thank God, our director of health, Dr. Scott, has been very supportive of the end-of-life visits. But there shouldn't even be a question that they have to call here and tell me that they can't get into see somebody who's dying and spend some time with them.

And I'm a nurse. So, I'm very conscious of germs and spreading things and things like that. But even though I'm an old nurse, I can't remember ever not being able to think out a problem. We were trained that way and come up with a solution for people.

It's just very aggravating because you have to be self sufficient during this COVID. And you have to come up with things that are going to be pertinent to your facility. And yes, you can make a plan and then you can turn around and say, well, if this isn't going to work, this might have to happen afterwards. But they don't even make the attempt.

And so, everybody's kind of running helter-skelter within Rhode Island asking everybody questions and not really relying on anything that they should do on their own, and that's very aggravating to me because it's the residents that suffer for this.

I said my piece.

CMS - Alina Czekai: Thank you so much for sharing your perspective from Rhode Island, Kathleen. We really appreciate hearing that. Operator, we'll take our next comment or question for the agency. Thank you.

Operator: We have our next question. Please state your first and last name and your line is now open.

Donna Fischer: Donna Fischer.

CMS - Alina Czekai: Great. Hi, Donna. Nice to hear from you.

Donna Fischer: I'm from South Dakota. And I was just trying to bring from here on best possible solutions as we move forward with trying to figure out the visitation for everyone.

And wouldn't there be some kind of way, I mean, that we were cohorting individuals that were COVID positive versus COVID negative. Couldn't we also take into consideration those individuals that want visitation and cohort those folks together versus the individuals that do not want visitation because they are so deathly afraid of the COVID virus and cohort those together and somehow then open up for visitation in a very safe way using appropriate PPE and screening, whatever the facility is doing for their staff, I think many families would be more than willing to do in order to be able to come in and see their loved ones.

We have staff members who have flown to Vegas for three or four days and then shown up to work on the next day after coming home from Vegas, but we can't get a family member, who themselves have probably been quarantining to the best of their ability and not traveling, in to see their loved ones.

It's becoming almost dangerous for some individuals. We had end-of-life situation where family actually heard a staff member trying to get in to see their loved ones who was dying. We have people – family members kind of accosting the facility staff out in the public and really – it's just – we do have to put our heads together and solve this problem.

And so, could we brainstorm together to solve that problem now here today and thinking of can we cohort somehow even within the same facility individuals that want the visitation versus those that do not and determine the best way to do that; PPE, the masking, allowing the family members to touch their loved ones.

We had a situation where an individual was on end-of-life hospice. Family was allowed to come in. This person turned around. They are alive. They are in the wheelchair. They are out of beds. It just goes to show that when family is there and they are able to hold their hands and they are able to make a presence that it does impacts the residents in such a way that it goes from death to life.

And we really do need to solve this problem today. I don't think we can hold long the solutions any longer. Thank you.

CMS - Lee Fleisher: Yes. This is Lee Fleisher. And thank you for that and that important lesson of the power of touch and what our elders need.

One of the key things that you said is we can't solve it today. Well, we're actually in a very tight timeline to try to give some new guidance. So, as you start talking about the cohorting and how to think about it, that's what we hope to get today. So, if others have some additional ideas that would be great.

I'll quickly get off the line. And then, I'm sure you all have Evan's e-mail or can get it and so that we can get those ideas as soon as possible because we're not – we are on a quick timeline to figure this out.

Patty Ducayet: Dr. Fleisher, this is Patty again from Texas. So many people say to me – why can't I be screened for COVID symptoms and be expected to limit my connections to other humans out in the community. Why can't I wear the same PPE as a staff person and have that physical touch to provide support care to their loved ones? What is CMS's position on that?

CMS -Lee Fleisher: We're going to be listening mode today. And we will talk with our CDC colleagues to balance those efforts. But those are sort of things that we're

happy to hear and use as the basis as we think through this. Am I correct, Evan?

Hilary Dalin: Dr. Fleisher, this is Hilary Dalin from Administration for Community Living. Wondering if you can say a little bit more about that timeline so that the ombudsmen will know when they need to send their ideas in and when we can all expect to see some policy from you all.

CMS - Lee Fleisher: I can't answer the latter. Evan, when would you like any input?

CMS - Evan Schulman: Well, I think it would need to be quick. And the way that we operate because of the sheer number of you and others out there is that we really need some point people, whether it's Mark or whether it's anyone from the ACL to really be the collector and then send us a single, consolidated position.

So, I mean, that accomplishes a couple of things. Number one, again, it's the sheer volume. We were not equipped to really handle e-mails from tens and hundreds of people on this.

And second, we really need a single voice from ombudsmen. And believe it or not, some of you do disagree with each other. So, we really – we need there to be a single voice on where you would stand on a particular position and really need that by – and probably by close of business tomorrow at the latest.

And in terms of timing, we've always been – we try to always be as transparent as possible of when things are coming out, but we can't give very specifics right now, which is largely because it's not always dependent on – it's not always within our control of when things can come out because of other things that happen. I hope that answers your question.

Mark Miller: Evan, this is Mark. Just to comment on that point. Obviously, this has been a fluid situation. Things have changed. You put out revisions to kind of your initial memos on visitation a couple of times.

I don't necessarily look at this as like – well, in the next 24 hours, we'll sure have one single position consolidating everything that state ombudsmen think

on this. I'm looking at this more as, this is one conversation we're trying to have to open the door to visitation but that this is going to go on for some time and that there might have to be a number of these conversations to eventually get back to whatever the new normal becomes.

So, I mean, I hope you don't see this as like this is the one shot that advocates and ombudsmen have to put in our comments because it's evolving the same way your guidance has evolved. And our experiences, I think, educate us on what's a best practice move forward with.

So again, I just hope that (inaudible) time.

CMS - Lee Fleisher: Thank you, Mark. And yes, this is our next iteration. And we would like – at the administrator's behest, we would like to move sooner than later. And I think what Evan – it doesn't necessarily have to be a declarative – this is what we want. It would be great to say that a large majority suggest this or something else would all be helpful.

And I will assure that Evan as well as the clinical side of CCSQ, Jean, Shari, and myself, both RNs and MDs can look at it. But as Evan said, the sooner we can get your thoughts the better for the next iteration.

Hilary Dalin: Yes. So, this is Hilary. I wanted to ask Mark if he can be in touch offline about whether we can be at ACL support in light of that type timeline, just be in touch and just all of you should know we're here to support the effort of getting your thoughts forwarded on.

Mark Miller: Right. Thanks, Hilary.

Female: Dr. Fleisher, you specifically asked about cohorting. So, I wanted to mention that I feel like there – I heard from a family member the other day saying, the nursing home staff snuck me in a back door to see my mother. Like why are people sneaking anyone anywhere?

I mean, there are multiple doors to a long-term care facility. And many long-term care facilities are set up in wing structures. So, if residents are cohorted and you've got a wing of residents who do not have COVID-19 and are fine,

why can't families access that wing through like a fire exit door with proper – making sure the facility reassess it and that sort of thing.

I just feel like we're – everybody's focused on one single door going into the facility and I understand that for screening purposes and so on. But I just think very short-term, clear-cut, concrete recommendation is use the structures of the facility to allow something to happen, not use the structures of the facility to prevent something from happening.

CMS - Lee Fleisher: Thank you for that idea. We're continuing to listen.

CMS - Alina Czekai: Thank you. And we'll take another comment from the line, operator. Thank you.

Operator: Yes, ma'am. We have – next is Salli Pung. Your line is now open.

Salli Pung: Thank you. This is Salli Pung, the state ombudsman from Michigan. I thank all of you so much for the comments that were shared today and this opportunity to provide feedback to you.

I have three issues that we're seeing in Michigan that I was hoping CMS might be able to give more guidance to providers or to the state to help address these situations.

One is that we have facilities that are conducting baseline testing. And while they're waiting results, they are quarantining all residents in the facility pending those results and not allowing any visitation, even compassionate care visits because they're classifying, if you will, or categorizing all residents in the facility as being under observation.

And that takes in Michigan sometimes up to two weeks to get testing results for some facilities. And that's a long time for residents especially those that are at the end of their life to go without having a visitor particularly if they're at end of life.

The other situation that we have happening in Michigan that we just like to see clarification for providers is that when residents are going out for medical

appointments, either the appointments that can't be conducted during – through telehealth, and they're leaving the facility. Upon their return, they're being quarantined for 14 days and being isolated in their room.

And for some residents that don't have private rooms, which many of our facilities can't accommodate, they're being told you either have to go on the appointment and not return to this facility or not go on the appointment. And that's just not effective care for people that need these critical services.

They're not seeing their cardiologist. They're not going out for an oncology appointments or dialysis. And that's a real concern. And I don't believe that the CDC recommendation is that those individuals have to be quarantined. We believe they should only be under transmission-base precautions. So, I think that clarification could be helpful for providers.

And the other thing that I just wanted to mention is that issue of outdoor visits. Michigan is not allowing outdoor visits. They're considering that an in-person visit. And they're not allowing that to happen across the state. And we're missing an opportunity as other state ombudsmen have mentioned.

The weather is ideal at this time in most states to conduct those outdoor visits. And it's a real missed opportunity with fall on its way and colder weather that this isolation that residents are feeling. We're not going to have an opportunity to break it.

And then, I just had one fourth one that I wanted to be sure that as we're thinking of best practices that we also think about loosening up the restrictions on activities in dining as many residents I think could benefit greatly from that opportunity of returning to what feels a little normal with eating out of their room or doing an activity, maybe even in the hallway with physical distancing so that they can engage with others.

They really lost their community. They've lost, in some situations, their roommates or their friends within the facility or even the staff that they're used to having care for them. And they need the stability of being able to engage with others and have that community and that connection.

So, I just wanted to leave you with those. I don't know if I have a lot of best practices to offer today. As Bev said in Ohio, I think the opposite of what I've shared today could be the best practice. So, thank you.

CMS - Alina Czekai: Thank you so much, Salli. And I think we have time for one more comment from the line, operator.

Operator: Yes, ma'am. Next in line, please state your first and last name, and your line is now open.

Donna Fischer: This is Donna Fischer from South Dakota again. I just want to reiterate what Salli said. Folks are really confused on if an individual leaves for dialysis that they have to be quarantined. So clarification on that would be very helpful.

And I would echo – I can't remember who said it I guess – but I would echo the fact that – I think it was Patty who says, why cannot family, at least one individual for each person be screened like staff and wear PPE and be allowed to come in to the facility.

And I also think where possible, facilities themselves should, within their facility, survey their residents that are able to be surveyed and determine what they want. And let's ask the residents what they want and how they want to proceed with visitation. And let's really make that consideration.

We have a facility in South Dakota that did just that and they are kind of cohorting, like I said, the folks that don't want visitation are kind of down the hallway and then the folks that do down different hallways. And they're just really trying to balance that.

And they're doing an essential caregiver orientation. The facility is providing this; infection control and a few things like that on the agenda I really think would be helpful and beneficial. Facilities have to provide that education to their staff periodically. I think they could invite family members to those trainings as well. Thank you for your time today.

CMS - Alina Czekai: Thank you so much. Dr. Fleisher, I'll turn it over to you so we can close.

CMS - Lee Fleisher: Yes. No. This was incredibly impactful and incredibly important to hear. It echoes why the administrator is so concerned to make sure that we do have good policies out there. And importantly as was just outlined by the last speaker, to make sure that our guidance is properly interpreted. So, if you see guidance and you think that it's not being properly interpreted, knowing that would help.

One of the things that I wanted to really say is that while Evan has outlined that it would be great to have one voice, I'll modify that in a way that if we, by the end of tomorrow, can get even a couple of pages and please include me. Alina, feel free to have my e-mail shared with the group if that's possible.

CMS - Alina Czekai: Absolutely, Dr. Fleisher. I'll send out a follow up e-mail to the group to distribute, both contact information as well as the link to the recording so you all can look out for a note from me later this morning. Before noon, we'll get that out to you all.

CMS - Lee Fleisher: And if we can have sort of what you think, again, need that, we've already provided guidance, i.e., the outdoor, and how it is not necessarily being followed and some suggestions for that.

And again, as was discussed, some of the suggestions with regard to cohorting or PPE, with regard to the families that the one visitor, some of those things would be incredibly helpful as Evan and his team and then as I said, our clinical team of Shari, Jean, and myself, and working closely with the CDC.

Just to be clear, we can't answer – we really work as teams here and really think through and value the importance of the psychological wellbeing and the power of touch for these residents, but really balancing not only for the resident themselves but the risk to other residents within the nursing home if that individual contracted COVID-19. And we use our CDC partners in thinking through this.

So again, thank you so much. We look forward to your thoughts. And if it comes aggregated, and again, it doesn't have to be a single voice, but sort of a gestalt of the things we should think through both in terms as well on what we should do and what may not work, that would be helpful because we are

committed to get something out, as Evan said, as soon as possible given the constraints of the federal system of what we need to go through.

Mark Miller: Dr. Fleisher, this is Mark Miller again. Just want to make sure that my colleagues know to expect a Zoom invite for us to get together later this afternoon. And then, the other thing is just, Dr. Fleisher, just make sure that I know that both Patty and Bev shared some materials, and I think those are worth looking at in terms of kind of some of the best practices and kind of where we're – our perspective on a few of these things.

CMS - Lee Fleisher: I could assure you they're actually already in Evan's, myself, Dr. Ling, Ms. Moody-Williams, they're in all of our inboxes and are being evaluated. So, we very much appreciate that.

And if there are other policies that people have, we're happy to look at anything we can and will be over the next several days. Thank you so much for doing that and for the Zoom to get your group together. It's greatly appreciated.

CMS - Alina Czekai: Perfect. Well, thank you again everyone for joining us this morning. You can be on the lookout for a follow up from me later today, and appreciate all that you are doing. Have a great rest of your day.

End