

**ALABAMA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITIES
MEDICAL DIRECTORS' ADVISORY COMMITTEE**

DATE: Saturday, July 24, 2004 7:30 a.m.

PLACE: Sandestin Golf and Beach Resort
Sandestin, Florida

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF
Jim Yates, M.D., President, ALMDA
Jerry Harrison, M.D.
Michael Reeves, M.D.
Dick Rutland, M.D.
Jimmy Davis, M.D.
David McRae, M.D.
Steve Furr, M.D.
David Barthold, M.D.
Tom Geary, M.D.
Mickey Dichiara, M.D.
Wayne Stanley, M.D.
Thomas Stevens, M.D.
Don Williamson, M.D., State Health Officer, ADPH
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
Brenda Furlow, DHCF
Becky Hall, DHCF

Agenda:

Welcome	Dr. Esham
Minutes of the May 20, 2004 meeting	Dr. Esham
Defibrillators in Nursing Homes	Dr. Reeves
Medicaid Pharmacy Initiatives and Their Impact	Dr. John Searcy
Closing Remarks	Dr. Esham

Dr. Richard Esham welcomed attendees on behalf of Dr. Williamson and the Alabama Department of Public Health and called the meeting to order. Dr. Esham expressed, as he has on numerous occasions, the importance of medical directors serving as keys to making long term care safe in Alabama for our patients. Strong medical directors in nursing homes make for high quality of care for residents. Both Dr. Esham and Dr. Williamson are supportive of the medical directors and will help in any way. The minutes from the meeting held May 20, 2004, were accepted and approved by the

committee. Dr. Esham reminded the committee that the minutes of these meetings are posted on the DHCF website for review of content.

The first item for discussion on the agenda was Defibrillators in Nursing Homes. Dr. Reeves was given the floor by Dr. Esham. Dr. Reeves shared that this subject was discussed a few years ago. At that time some fairly vocal and logical opposition was raised about the issue. He brings it up again because he was working in Mississippi and an incident happened in one of the nursing homes regarding a young patient in his forties that had a cardiac event. A doctor happened to be there. It wasn't a medical director or someone actively involved in long term care. The doctor was mortified that no defibrillator was available. With this particular patient, the doctor believed it would have made the difference between life and death. The medical director, whom Dr. Reeves had been working with there, asked why there were no defibrillators in the home. He explained about the previous discussion with Alabama medical directors, the opposition and that he had supported that argument at the time. Dr. Reeves stated he would ask the Division of Health Care Facilities about regulations concerning defibrillators. The doctor (Dr. Glen Peters) discussed that defibrillators are everywhere such as airports so why would you not have them in a nursing home. Dr. Reeves pointed out that he now has younger patients in nursing homes and that it is worth revisiting this issue.

Dr. Harrison clarified that defibrillators that are in airplanes, airports and schools are automatic defibrillators and are not generic. He is opposed to generic defibrillators in nursing homes due to the lack of adequately trained, certified personnel. You would have a piece of equipment that no one knows how to operate safely. He also pointed out the low percentage of residents in nursing homes who survive after coding. According to the Minnesota study, less than half of one percent of residents survive after coding in the nursing home and make it to a successful hospital stay. Successful hospital stay means they were discharged from the hospital, however, nothing about quality of life. No code status requires two physicians. The automatic defibrillators actually have pictures to show you what to do and I agree, this is acceptable.

Dr. McRae added that the Minnesota study is 20 years old and doesn't mean much. In light of what we are seeing in nursing homes, such as short stays, I think it is worth taking another look at defibrillators in nursing homes. The most logical type to consider would be the consumer grade, automatic defibrillator.

The committee discussed that they do not want to have staff involved with ACLS or Lifepac's 5 training. Staff are intimidated by this type of specialty training and many nurses have quit.

Dr. Williamson would not encourage requiring nursing home staff to have ACLS training. It also creates an expectation that you are going to have ACLS staff in the nursing home 24/7 to respond. He stated that Public Health has made available about 1,000 automatic defibrillators. Defibrillators have been made available to fire departments, schools and police and sheriff departments. The automatic defibrillator would be placed in a nursing home not to resuscitate the average resident, but to help resuscitate others who may be at risk for cardiac arrest who are visiting residents in the nursing home or possibly for a short stay resident. You need to define what is the rationale for having the automatic defibrillator in the nursing home. Legal counsel needs to be involved in answering questions about usage.

There was discussion about the need for developing guidelines about usage and the point was made that nursing homes are health care facilities.

Dr. Strickland stated that defibrillators are in his nursing home and have been used about six times. He added that the experiences have been good.

Dr. Esham asked the question, 'what percentage of in-house nursing home residents are clearly DNR and do staff understand?'

The response was not as many as should be and that it is often not clear.

Dr. Esham discussed that we need to re-think how each of our homes establishes early on whether a resident is DNR so that we eliminate errors and problems in how we handle the situation.

Dr. Harrison responded to this discussion and has had experience with DNR in the nursing home and the ambulance service picking up the DNR resident. If the resident begins to code, then EMS, according to regulations, initiates life-saving procedures. Dr. Harrison told the story about his father, who was a no code, but who underwent numerous shocks. Dr. Esham stated that there would be a discussion about the DNR issue and EMS bracelets if time allowed and the viewpoint of the Department.

Dr. Harrison again stated that he is not opposed to automatic defibrillators in nursing homes.

Dr. Williamson stated that there are no regulations about automatic defibrillators and is not inclined to formulate regulations. We will follow the best medical practice and it is a rationale decision to have an automatic defibrillator in a nursing home.

Dr. Reeves discussed does this increase the expectations for nursing homes?

Dr. Esham asked the group if it would satisfy them if there was communication with the nursing home association leadership for discussion about this issue and to invite a representative to attend our next meeting to solicit their views.

There was another discussion about the liability if resuscitation failed, a complaint filed, and there is no training manual to prove that it was done properly.

Dr. Esham responded that you don't have training manuals in airports and schools.

Dr. Harrison stated that the training manual is pictures on the machine itself. He briefly discussed a case in 1980 in Atlanta, Georgia, involving a patient with a DNR order who was shocked. The wife sued and won the case.

Dr. Esham asked Dr. John Searcy, Medical Director, Medicaid, if defibrillators could be treated as a cost item. Cost would definitely be a concern.

Dr. Esham ended this discussion by again stating that the nursing home association would be asked to send a representative to discuss their viewpoints at the fall meeting. There is nothing to prohibit a nursing home from installing an automatic defibrillator.

Dr. Esham introduced Dr. John Searcy, Medicaid to discuss pharmacy initiatives and their impact. This discussion is documented by notes taken during the meeting as the tape cannot clearly be heard. Dr. Searcy provided the following hand-outs:

Long Term Care Drug Claims – Beginning date: 04/01/03 and Ending date: 03/31/04

Alabama Medicaid Statistics 2003 – Total population, Medicaid eligible population,

Total child population, Medicaid eligible children, and Total payments

Dr. Searcy explained that during the past year there has been a short fall as of 2004 in the amount of 750 million dollars. Medicaid will spend 3 billion dollars on claims this year. The legislature gave Medicaid \$160 million for this year and next year. Medicaid received \$180 million from the General Fund. Gov. Riley directed that growth be cut by 50%; however, there has been an increase by 8%, so the question is how do you cut? You can't cut nursing homes or hospitals. This can be done by increasing taxes. There is a 6 to 7% a year growth; however, estimated and budgeted by 3 to 4%. There is a difference in what is needed and what was allocated. Pharmacy has grown by 14 to 18%. There is a shift to a PAT committee that recommends best price (preferred status). 100 drugs are on the preferred status. This is a savings of 100 to 120 million. Dr. Searcy is currently reviewing costs to determine effectiveness. It takes 7 months to get claims paid. Preferred drug program will save up to \$25 million and rebates up to \$25 million. Projected savings for this year is 7 million but will come in at 12 to 13 months. The list will continue to change. Eight classes have been reviewed and anticipating to look at 12 to 13 classes. As of July 1, patients will be limited to 4 brand name drugs with the remainder as generic drugs. This does not apply to children and nursing homes. If physicians go from brand name drugs to generic drugs, there will be a savings of 73%. Dr. Searcy asked that nursing home physicians discuss and work together to help cut costs such as a direct formulary or another way to cut costs and develop a system. There was a discussion about drug interactions and that physicians receive letters from pharmacists requesting that drugs be increased. It would be helpful if Dr. Searcy would work with this group to enlighten. The physicians discussed that the regulations state to decrease antipsychotic drugs while the other side says to increase. The economic news is worse for next year. Alabama has done better economically than other states, but needs another 58 million for next year.

Dr. Esham closed this discussion by considering this the first part of dialog about pharmacy issues and asked that Dr. Searcy meet with this group quarterly to discuss ideas and best practices. Dr. Esham asked that Mia Sadler coordinate with Dr. Searcy meeting dates and times.

The next discussion was about DNAR orders. Dr. Esham expressed that he was unaware that the Board of Health eliminated the requirement that a bracelet be worn.

Dr. Williamson explained that ADPH tried to identify individuals that EMS and paramedics did not have to resuscitate by wearing the bracelets. The reality was this did not get used a lot. Therefore, a new form was created which is easy to complete and is more accessible. Dr. Esham clarified that the form presented is the new form.

The question was asked about why the requirement to wear bracelets was removed. Dr. Williamson explained that this was not a recommendation in regulation, because if so, it becomes a requirement. Since no one is using the bracelets and it is cumbersome to implement, it is easier to complete a form in the patient's chart. The form can be sent home with the patient.

Dr. Esham asked where will we get these forms. Dr. Williamson proposed that the forms not be made available on the website. These forms are available in the Alabama MD and from ADPH at no cost. Information on how to get the forms is on the website.

Dr Esham discussed that weren't many physicians from 1995 to now who knew this program existed. However, he realized that there were efforts made by the Department to make physicians aware of the program; however, there was a lack of understanding. Dr. Esham recommended that we come up with a better plan for education rather than scrap this program.

Dr. Harrison discussed that it was difficult to get the bracelets. He recommended that the Department send the physicians the bracelets and that residents be registered online with the Department. This eliminates mailing information back and forth. The Department would issue numbers for the DNAR order. Dr. Esham added that originally you got the bracelets from EMS regional office. Dr. Harrison explained that if a resident in a nursing home did not have the DNAR bracelet on and EMS was on-site, called and the resident coded, EMS would initiate life-saving procedures. There was discussion about if the bracelets were required. Another physician stated that it would not be necessary if the physician were on-site and took responsibility.

The physicians discussed that the new form is portable and goes with the patient.

Dr. Williamson and Mia Sadler discussed that this was an effort to make it easier to get DNRs and the failure of the bracelets to be worn. The paramedics are concerned about legal liability of being sued. The purpose of the form is to prevent residents from being resuscitated who have a DNR order but were not wearing the bracelet. Dr. Williamson stated that he has no problem in going back to the Board to discuss adding the bracelets. Dr. Esham discussed the problem with the forms becoming invalid once the resident was transferred from the nursing home to the ER. Invalid for the EMS personnel and invalid for the ER staff. Dr. Esham recommended a universal DNR form. Dr. Williamson responded that this is the intent of the new form. Dr. Esham pointed out that the form states EMS. Dr. Harrison recommended that the form state that it is portable.

Dr. Williamson stated that there are two things that need to be done:

- Take Emergency Medical Services off

- This form is valid unless revoked by state statute

Dr. Williamson and Mia Sadler will talk to Jim Prince about revisions. The Board will try to make revision by the August meeting.

Dr. Esham brought this discussion to a close and stated it would be carried over to the next meeting. Dr. Williamson stated that it would be fixed before the October meeting.

Dr. Esham closed the meeting and stated the next meeting would be in October.

The discussion went on to cover bracelets that would identify patients that do not wish to be resuscitated, and that the requirement for bracelet be removed from the state form. It is no longer required that EMS resuscitate a patient that does not want to be. The form is valid unless revoked by the state statute. Dr Williamson stated that the board would try to have this fixed by the August 31, 2004 meeting