

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

**DATE:** Saturday, July 30, 2010 7:30 a.m.

**PLACE:** San Destin Golf and Beach Resort  
San Destin, Florida

**BOARD OF DIRECTORS:** Jimmy Davis, MD, CMD, Board Chairman  
Michael Reeves, MD, CMD, President  
Dick Owens, MD, President-Elect  
Clare Hays, MD, Secretary/Treasurer

**ATTENDEES:** Walter T. Geary, Jr., MD, Medical Director, BHPS  
Ms. Diane Mann, BHPS  
Robert Moon, MD, Medical Director, Alabama Medicaid  
Louis Cottrell, Alabama Nursing Home Association  
Katrina G. Magdon, Alabama Nursing Home Association  
David Barthold, MD  
David MacRae, MD  
Michael Reeves, MD  
John MacLennan, MD  
Malcolm Brown, MD  
Regina Harrell, MD  
Chivers Woodruff, MD  
Kenny Smith, MD  
Joe Downs, MD  
Steve Furr, MD  
Mickey DiChiara, MD  
James Yates, MD  
Jerry Harrison, MD  
John Wagner, MD  
Kevin Jackson, MD  
Anneke Parker, RN

Dr. Geary welcomed everyone and called the meeting to order. The minutes were read and approved, and will be posted on the ADPH website. Dr. Geary then turned the meeting over to Dr. Moon, who spoke first about HIE and then Health Care Reform.

## Health Information Exchange (HIE)

Dr. Moon explained that HIE is a statewide exchange of information among all payers and non-payers. Every patient in the state will be in the exchange. Dr. Don Williamson will be on the board along with 25 others in the healthcare field who have been working to put it together. About 50 others are working on the technical side: how to set it up; how to run it; what it's going to look like. Dr. Moon went on to say that HIE would allow the exchange of demographic, insurance, and clinical information. A lot of the information will be based on the input from all the different state boards involved. The program should be up and running by the spring of 2011. Dr. Moon stated that it wouldn't really matter who your insurer is, that all doctors should be able to get some information about some of the patients they are seeing. A lot of security and privacy work is being done on this with a lot of attorneys having input and reviewing it.

Dr. Furr asked how to log into the program. Dr. Moon explained you could just log into the program, providers could log into it from that site, or providers could log into TFQ (Together For Quality) and then log into the program from there.

Dr. Harrison asked if this would be an extension of the ACS. Dr. Moon said that this is an entirely different program. Dr. Harrison explained that ACS was a variation on TFQ, a pharmacy program with eight million dollars invested so far that was supposed to be for physicians, but never involved physicians. It was not a good program; it was very cumbersome. The program was not practical for physicians.

Dr. MacRae asked what was the actual purpose of the HIE program. Dr. Moon responded that it is to improve quality of care nationwide.

Dr. Harrison touched on the software program, HL7, now HL7-B, and how it was to be used for interchanging data. This program has several issues, and has cells within the program which could be manipulated.

Dr. Moon said we have to start somewhere, and HIE was it. Dr. Harrison offered that the program is mandated.

Dr. Hays asked what data would be exchanged. Dr. Moon stated the primary goal is to get lab test and x-ray results to the physician. The good thing is that doctors can give input at this point. Dr. Harrison said that HIE should automatically interface with PMT.

\*Dr. Furr wanted to know when the first check would be cut. Dr. Moon said Medicaid incentive money should be available by Spring of 2011. The first check would be approximately \$21,250 for adoption, implementation, or upgrade to a certified E.H.R. (electronic health record) and then \$8,500 per year for "meaningfully using" the E.H.R. The maximum amount you could receive from Medicaid would be \$63,750. From Medicare the maximum amount would be \$44,000. Physicians will have to choose one or the other, Medicare or Medicaid. Hospitals are allowed to do both."

Dr. Harrison pointed out that a physician could have a provider number in more than one place and how flexibility will be allowed for the number of patients, and the number of visits. Dr. Moon stated that another goal of the program is to make it physician friendly, and set the bar for complexity low. In addition, more information can be obtained by going to the Medicaid website and following the links.

Dr. Moon mentioned the PACE pilot program that is taking place in Mobile. PACE is the Program of All-inclusive Care for the Elderly and both Medicare and Medicaid participate in it. It is a project to move the elderly to the appropriate location and still receive the correct level of care. Dr. Hays commented that she had heard it was coming to Dothan in the next year. Dr. Moon responded that he was only aware of the project in the Mobile area which is set to begin in October of next year. This is sponsored by Mercy Medical. You have to be at least 55-years-old to participate in the program.

### Health Care Reform

Health Care Reform, as presented in the recent health care act will result in a series of monetary grants. The federal government agencies are looking at organizing health care in general, not just at the nursing home level. A questionnaire was distributed two to three months ago to collect ideas and thoughts on how consumers would like to see Medicaid operate in terms of encouraging health, delivery systems, and payment. There were 14 responses.

Another project Medicaid will be perusing in the spring is piloting a series of Networks like those in North Carolina. This program looks at how local physicians take charge of driving quality of care in their area. Two to four areas are being looked at. Networks will be organized in those areas. These networks will provide services for the complicated, high-cost patients. This will help identify more cost-effective ways to practice. Dr. Harrison reported that he is familiar with the North Carolina project and stated that it continued on for several years, and increased payment from Blue Cross/Blue Shield. The project really helped to support patient care.

### Glucometers

Dr. Geary stated that the State Agency has written several immediate jeopardy (IJ) tags for failure to clean and disinfect glucometers. The agency and the facilities were all concerned on trying to figure out how this rose to the level of IJ, not a less severe risk. During a conference call with the regional medical director for CMS Region IV, Dr. Geary was told of an article which presented evidence that in a hospital setting, 80% of the glucometers have microscopic blood on them. Even though nurses are following standard infection control procedures, there is still a possibility that a gloved finger with the hepatitis virus and microscopic blood on it could infect another patient.

In a study by CDC, it was found that whenever lancets were being used for more than one patient, an outbreak of hepatitis occurred. The first such outbreak occurred in Sweden in 1999. Dr. Geary stated that ADPH's policy as of today is: if the nursing home updates its policy on cleaning and disinfecting glucometers; if nurses are educated and can tell the surveyor what they

do; if nurses are careful to disinfect glucometers used on a person with hepatitis or one who is in isolation for another communicable disease; if they follow all standard precautions; If they are following the manufacturer's instructions; but despite evidence for all this a nurse forgets to disinfect one glucometer used on a prior resident who is not on isolation or known to have a chronic, transmissible infectious disease, the citation would be at a D level deficiency instead of Immediate Jeopardy for the facility. Dr Geary stated that he hopes that CMS follows with the same idea. The facility needs to document cleaning and disinfecting of the glucometers and should have a log to record the documentation.

FDA should require in their brochure that the glucometer be cleaned and disinfected according to CDC guidelines. Dr. Geary stated that FDA should require that a person using a glucometer at home should follow the CDC guidelines for disinfecting. Any multiple-use glucometer cleaning should follow CDC's guidelines for disinfecting. FDA should inform the consumer that some alcohol-cleaned glucometers could give a bad reading. Dr. Geary said that cleaning with a 10% Clorox solution and allowing the glucometer to air dry would be a safe method of disinfecting the glucometer. The State Agency is waiting for a letter from CMS to clarify their position. There was discussion of patients having their own glucometers.

The next item discussed was the DEA/Drug problem. Dr. Geary explained that there would be information from Dan Yarbrough presented at the meeting. The DEA has posted the Federal Register about Class II drugs in the nursing home setting, and sent out some 56 questions to which they request comments. Some apply to pharmacy, some to nursing home physicians. DEA has requested comments. Dr. Geary recommended that the Alabama Medical Directors look at it and answer the questions. Dr. Yates stated that the national association is also looking at it. Dr. Geary requested that the response be sent to him. August 30 is the deadline for responding. The questionnaire was emailed, but not to everyone. Dr. Geary stated that he will email the questionnaire to Lee Ann Cole, who, in turn, will send it to ALMDA.

A non-agenda item discussed dealt with a number of complaints about end-of- life care in nursing homes. Dr. Geary explained that the agency had investigated the complaints, but no deficiencies were cited. He gave the example of a resident with cancer who couldn't eat or swallow, and he died. There was no documentation of the doctor talking to the family of this resident. In another case a lady with dementia for eight years experienced weight loss, developed aspiration pneumonia and died. Again, there was no documentation of the doctor having ever spoken to her family. Dr. Geary suggested that to avoid angry family members, bad press and other repercussions, it is best to talk to families; and document in the chart that you talked with family members about what will ultimately happen.

### Physician Visits in the Nursing Home

There has been discussion with the nursing home association about the designation of a patient and the regulations defining the physician visits in a skilled nursing facility versus a nursing facility. According to CMS, the difference is the funding. If the patient is fully funded by Medicare, they are governed by the regulations for skilled nursing facility; if not, the rules for visits to a resident in a nursing facility are in force..

### Delegating Physician Tasks

Dr. Geary next spoke about the delegation of duties to physician extenders such as a nurse practitioner. Both the Board of Nursing and the Board of Medical Examiners have regulations regarding nurse practitioners. CRNPs are not allowed to prescribe certain drugs which would preclude allowing the CRNP to automatically sign all the monthly order review sheets. The classes of medications that the PA or ARNP can prescribe must be documented in the facility. Both the physician and the CRNP have to sign the practice protocol. The best thing to do is to follow the Board of Medical Examiners rules, or you could have trouble with the board. It's best to contact the Board with any questions.

### Brief overview of Regulation USP797

The government has come out with new regulations about sterile medication compounding guidelines. Room air quality required for preparation of compounds determines if you're compliant. If a nurse mixes two ingredients in a syringe (insulin for example) use the compound immediately, it's okay. If the compound sits for an hour you have to follow the guidelines. Bacterial growth is related to the length of time a mixture remains unused and it may become contaminated if it sits too long. Adding a third agent to an IV triggers the same guidelines. When compounding medication, the ambient air is supposed to be purified. Dr. Geary suggested that each physician review the process in the nursing home and call ADPH's Dr. Charles Thomas with questions.

### DNR

No thoughts were expressed on DNR since the last meeting. The issue will be discussed in the meetings later.

### Feeding Tube Guidance

ADPH/NHA will send out guidelines if different from present ones.

Dr. Geary asked if there were any questions or anything else anyone wanted to discuss. There were no questions and no other topics voiced. Dr. Geary then adjourned the meeting.

The next meeting will be held in Birmingham, at the Sheraton-Birmingham Hotel, on February 19, 2011, at 7:30 a.m.

\*Amended 2/10/11