

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

DATE: Thursday, October 21, 2004 2:30 p.m.

PLACE: Division of Health Care Facilities
RSA Tower, 6th Floor
Montgomery, Alabama

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF
Don Williamson, M.D., State Health Officer
Jim Yates, M.D., President, ALMDA
Michael Reeves, M.D.
Jimmy Davis, M.D.
David McRae, M.D.
Tom Geary, M.D.
Malcolm Brown, M.D.
LeeAnn Cole, Executive Secretary, ALMDA
Louis Cottrell, Executive Director, Alabama Nursing
Home Association
Rick Harris, Director, Bureau of Health Provider Standards
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
Anna Burton, R.N., DHCF
Becky Hall, DHCF

Dr. Richard Esham welcomed attendees and called the meeting to order. Dr. Esham first addressed the Alabama Pressure Ulcer Initiative. Mia Sadler discussed this initiative. This is a collaborative effort between the Alabama Nursing Home Association and the Alabama Quality Assurance Foundation. There was a conference call last Thursday, October 14, 2004, which described the initiative and encouraged facilities to get involved. There is an extensive resource manual of 300 pages for every facility that contains a wealth of information, including articles about pressure sores, ALMDA Guidelines and wound care guidelines. Workshops have been planned and scheduled in Birmingham, Tuscaloosa, Dothan, Montgomery, Mobile, Gadsden and Decatur in November and December 1, 2004. Facilities are encouraged to attend this training. Three people from each facility are welcome to attend. Louis Cottrell stated that the information would be sent out in the ANHA Weekly Round-up. The Department is excited about the initiative and hopefully can reduce pressure sores. Sue Bolden, AQAF, and Carol Hill will be conducting the workshops. There has been discussion about clinical experts, such as Carol Jensen, who has done extensive research in the area of pressure sores, providing training.

Dr. Esham then introduced and welcomed Louis Cottrell, Executive Director, of the Alabama Nursing Home Association, to the meeting and expressed appreciation for his attendance and interest. Dr. Esham briefly explained ALMDA's purpose as an advisory committee to the Alabama Department of Public Health, Division of Health Care Facilities. This advisory committee was patterned after the EMS Medical Director's Advisory Committee. This advisory committee meets four times a year. The Committee usually meets quarterly and welcomes members attendance.

There was discussion about the conference call last Thursday. Dr. Esham noted and commented that three of the speakers on the conference call were present at this meeting, Louis Cottrell, Dr. Geary and Rick Harris. Dr. Esham was disappointed that conference participants were unable to acknowledge their presence or to ask questions. Dr. Geary explained that it was too complicated to take questions. Rick Harris stated that there was discussion about participants being able to email comments or for there to be web based access for asking questions similar to CMS conferences. There were approximately 180 participants on the call. Participants were told that they could submit written questions. Dr. Esham added that it made a lot of people aware of the issue. Louis Cottrell then added that dates would be circulated. Mr. Cottrell at this time stated his appreciation of the invitation and that he is looking forward to working with everyone. Dr. Yates pointed out that to significantly improved pressure sore numbers being reported, hospitals needed to be involved in this initiative. Dr. Geary stated that hospitals are included. Rick Harris stated that nursing homes have a lower pressure sore rate than other health care providers. Dr. Esham asked if the pressure sore rate has fallen in acute care settings. He stated it is his intuition that they would have fallen as length of stay has shortened. The average length of stay in an acute care hospital is five days. Rick Harris stated that the pressure sore initiative will not be successful if it is only education. We have to sell people on the idea of thinking about this problem in a very different manner.

Rick Harris told the group about the educational conference he had just attended in St. Petersburg, Florida, for state agency directors. Mr. Harris shared with the group the power-point presentation, "SSA-QIO Relationships: Six month Follow-up from the "Baltimore Summit" 20 April 2004 by Paul McGann, SM, MD, FRCPC, Senior Geriatric Advisor, Quality Improvement Group, CMS/OCSQ, Baltimore Central Office. In summary, last April all state agency directors attended a summit in Baltimore as did representatives from all the QIOs. Each state was required to sit at a table with its QIO representative. Alabama is fortunate in that our agency already knew our QIO, Sue Boldin and had established a strong relationship. Alabama was viewed as an advanced state. Dr. McGann talked about this meeting. For #5 – What are the next steps in your state? For some states, the response was the QIO and the state agency would meet. For our state, the next step was to put projects together. These projects are: the Pressure Sore Initiative, Culture Change and the Alabama Quality Award. As a survey agency director, Rick Harris is interested in the question, "How will we know we are successful?" What are we trying to achieve by surveying nursing homes? What do we hope will happen? The QIO is about to complete its 7th scope of work and will have to sign a contract for the 8th scope of work. QIOs get a grade from CMS. If the work is unsatisfactory, then the

contract is not renewed. There is no guarantee that the Alabama Quality Assurance Foundation will receive the contract in 2005. They have to produce results. We are entering Phase Three of the QIO program which is assisting providers to achieve transformational change. This is where we need to go, not only with nursing homes, but with all health care providers. It is certainly the goal of physicians, nursing homes and hospitals. Where are we trying to go in the nursing home regulatory program? For the first time CMS has written a statement that describes in very concrete terms a vision of what nursing home care can be.

Imagine a Different World!

In the year 2008:

All NH participating in “Quality First” have restraint rates under 2% and less than 4% pressure ulcers. No chronic care or post-acute residents ever experience untreated pain. The average tenure of a NHA is 10 years and DONs typically stay 15 years. There is a waiting list for Nursing Assistants who report very high satisfaction with their jobs and only 20% annual turnover, mostly attributable to promotion and advancement in their careers. Acute Hospitals acknowledge that the big improvements they are making in the care of Medicare beneficiaries started when Nursing Homes showed that it was, in fact, possible. Nursing Home employees are sought out by all sectors of health care as quality improvement consultants and the US Nursing Home Profession is widely respected by Congress and in other countries. School children around the country regularly visit nursing homes to learn the value of and respect for a life well lived, and to witness the sanctity of the health care profession. The “rate of citation” for the F-tags for physical restraints and for pressure ulcers is less than 5% in every state.

At first review, it looks impossible to achieve. But why don't we set goals like this for a health provider industry? Why shouldn't that be what nursing homes are like? As we discuss this vision, that's when we can begin talking about what it would take to get to this place. We may have to come up with radical, different strategies for QIOs and survey agencies without additional resources. We are going to have to improve in performance measurement and reporting, systems adoption and effective use, process redesign and organizational culture change. These changes are not just for nursing homes, but also for the QIOs and survey agencies. The entire slide presentation was distributed to the group. This provides a vision of what we could be doing that is stated in positive terms instead of negative terms for the first time. All three of the initiatives that we are putting together with the QIO and the Nursing Home Association are all about improving quality of care and life in nursing homes. Dr. Brown commented that he believes that this vision is possible to achieve and that one of his homes is at this level. Rick Harris said that we are actually not that far away from achieving the numbers in restraint reduction on a statewide basis. One of the components of the pressure ulcer initiative is addressing staff retention. The culture change initiative will take us to a place where nursing homes are viewed as great places to work. Dr. Davis voiced concerns about hospitals. Mia Sadler stated that the pressure sore initiative will involve hospitals. There was a project in Cullman between a local nursing home and the hospital. The QIO helped set up a good working relationship with the two entities to reduce pressure sore rates in both the hospital and the nursing home. It has been a successful project. Part of this initiative will encourage nursing homes to foster a positive relationship with the local hospitals. Dr.

Esham added that this presents an opportunity for physicians who are medical directors at nursing homes and prominent members of the hospital medical staff to have an impact on the process of care and to stand up for improving care on the hospital side. Mia Sadler added that if you are receiving patients from the hospital having pressure sores, it was time to collect data and then present these findings to the hospital. Rick Harris referred the group to page three of the material:

PrU Care

Excellence Requires

1. admission assessment and targeting
2. early detection: daily surveillance
3. pressure reducing surfaces: bed & chair
4. frequent changes of position for those at risk
5. nutrition
6. careful handling
7. aggressive wound healing
8. excellent community partners

The interesting thing about this information is there is nothing high tech about this. It is all common sense. Refer to the slide about failure rates:

Critical Processes: PrU

How often do we miss?

| Process of Care | Failure Rate |
|--|---------------------|
| Risk Assessment within 1 day: | 34% |
| Use of Pressure Reducing Surfaces: | 20% |
| Daily Skin Inspection of at-risk: | 50% |
| Weekly documented assessment of healing: | 55% |

The good news is there is a lot of room for improvement. These are all fixable with some very simple interventions. Rick Harris stated that at one of CMS’s weekly meetings, Dr. McGann told about a compelling presentation by a CNA who was in charge of the turning team at a nursing home. The CNA stated that the residents were turned every 2 hours. When questioned about assessments and pressure reducing devices, the CNA’s response was that residents are turned every two hours. At the end of six months, not one resident developed a pressure ulcer from that single intervention. The key to pressure ulcers is doing these simple things but most importantly, making sure that get done. It is a management, training, supervision issue. Nursing homes need to be structured in a way to make sure these interventions get done. Dr. Esham added that not only is this a quality of care matter and the right thing to do for patients, but for both physicians involved and nursing homes, this is also a risk management issue. It is also an

economic issue, i.e., the amount of money that could be saved if you didn't have pressure ulcers to treat. Dr. Davis also stated that he could control some pressure sores that come into his facility but hospitals need to be at the table and more directly involved as a unit in this process. One of the things that nursing homes are going to be asked and strongly encouraged into joining local collaboratives/partnerships with other nursing homes to share successes and failures about treating pressure ulcers. A big piece of that is how to get the local hospitals to sit down with the nursing home staff and discuss problems nursing homes are seeing in patients coming from the hospital to the nursing home. There have been some success stories. Dr. Macrae added that hospitals do have preconceived notions about care in nursing homes. Dr. Geary stated that there is no survey agency to go into hospitals and zing them for allowing patients to develop pressure ulcers. However, the involvement of the ombudsman statewide in this pressure ulcer initiative gives an avenue to go from the patient with the ulcer who arrives at the nursing home and the angry family through the ombudsman to the hospital to tell them that this is unacceptable. The ombudsman is not advocating for the nursing home, but for the patient and the family. The ombudsman who was on the subcommittee understands the problems in hospitals and understands the rates of pressure ulcers developing in nursing homes as compared to those developing in hospitals. There is also a problem with those patients who are neglected at home who go to the hospital and then to the nursing home. There is teeth in the initiative for the ombudsman to go to the administrator and DON at the hospital to tell them about the problems and that steps will be taken to stop the poor care. The ombudsmen are on the side of the nursing home about this issue ninety percent of the time. Rick Harris pointed out that pressure ulcer reduction has three separate goals: cut in half the rate of facility acquired pressure ulcers of low risk residents; cut the rate of facility acquired pressure ulcers of high risk residents; and to cut by ten percent the rate of pressure ulcers of post acute residents. If we can show a success in the reduction of pressure ulcers, we will be famous nationwide. We are blessed to have the best QIO person of Sue Boldin who works with both nursing homes and hospitals to make a difference in care of residents. Louis Cottrell added that working with hospitals is vital. The issue needs to be addressed globally. Dr. Geary added that hospitals know this emphasis on pressure ulcer reduction is coming just as restraints have now been reduced in hospitals. Dr. Esham thanked Rick and the group for the discussion.

Dr. Esham asked the group if there were any problems with the minutes as circulated knowing that the minutes are published on the Department's web site. Please remember that the site also archives previous minutes which includes a variety of topics. If there are no objections or revisions, then they are accepted as circulated. It was noted that the minutes were quite extensive.

Dr. Esham asked Rick Harris to comment on the status of re-organization for DHCF surveyors. Mr. Harris stated that DHCF is seeking volunteers to staff the Birmingham office. Notices are posted on our floor. We are anticipating that this office will be located in the Shelby County Health Department which is north of Montgomery and close to the interstate. There is numerous management issues involved in establishing an office 90 miles away. Rick Harris has been given the authority and money from Dr. Williamson to hire 38 additional surveyors. Not all of these surveyors would be assigned to the nursing

home program. Some would be assigned to the assisted living program or to the non-long term care unit. We are having tremendous difficulties with the State Personnel system. It is frustrating not to be able to hire, but we are hoping to have this resolved in the next six to eight weeks. We now have 25 long term care surveyors and there is no way we can keep up with the re-certification surveys. We have a substantial commitment to training. We could hire surveyors immediately, but couldn't train them. We are not willing to place surveyors in the field without proper training. Concerning abuse investigations, those where the facility determines that an employee has committed abuse or an allegation of abuse, these are reported to our office. There is a problem in conducting these abuse investigations so determinations can be made whether the employee will be placed on the abuse registry. There is a back-log of these reports. We are currently working a register to hire the classification – Special Investigators which is the same classification used by Medicaid Fraud Unit. These are usually people with law enforcement background. They will not be making compliance decisions about nursing homes but with a small amount of training they could conduct abuse investigations, especially interviewing staff about abuse. This would free up other staff to conduct surveys. Louis Cottrell asked the question if these employees would be issuing F tags. Rick Harris responded by stating they can not write an F tag. They will be supervised by someone who is SMQT qualified. Mia Sadler added that if these employees see deficient practices, they would report it to the supervisor which would generate an on-site visit by SMQT surveyors. Louis Cottrell asked if this work would be outsourced and Rick Harris responded that these would be Department employees. Dr. Yates asked if there was a projected date for opening the Birmingham office. Rick Harris responded that we have the space, but have some IT issues and need to hire a supervisor.

Dr. Esham then asked about comments from Dr. Yates and Mia Sadler about the joint presentation at the Alabama Nursing Home annual meeting and observations from Louis Cottrell. Dr. Esham asked how the presentation was received. Mr. Cottrell was not present at the meeting, but Mia Sadler added that Katrina Magdon at ANHA is tallying the evaluations. Dr. Esham asked Mia Sadler to give an overview of the intent of what is being done, who is involved, and what the plans are for the future. The intent was to provide education to all interested parties such as the Alabama Nursing Home Association, Alabama Medical Director's Association, DHCF survey staff about the legal, regulatory and medical issues surrounding feeding tubes. This was driven by the high rate of feeding tubes in our state. Alabama was third in the nation for the usage of feeding tubes. It is now fallen to number six. One of the possible reasons is the fear of facilities receiving deficiencies in weight loss. Therefore, facilities increased the number of feeding tubes as a solution to potential weight loss. A two and a half hour educational program was presented to the Alabama Nursing Home Association. Dr. Carol Griffin presented the medical issues; Rick Harris and Mia Sadler presented the regulatory issues; and Mark Ghivan presented the legal issues. At this time, program evaluations have not been reviewed to determine how the program content was received. Mia asked Mr. Cottrell to let DHCF know of other topics that could be presented in a joint, collaborative educational effort. There was a lengthy discussion of when this presentation would be given. Due to the length of the presentation, it was discussed that it would best fit the

summer, '05 meeting. Possible days were discussed. At the winter meeting planned for February 19th, an update on this presentation could be further discussed.

Dr. Esham asked Dr. Reeves to discuss the agenda item – AEDs in nursing homes. There was a lengthy discussion at the previous meeting. Dr. Williamson then joined the meeting. Dr. Esham began the discussion by adding that this issue affects the nursing home, perhaps more than the medical director. In our view, the AED issue is not so much an issue of having an appliance in a nursing home for residents but rather for others, such as staff and visitors just like in airports. AEDs come with visual instructions in the package. Dr. Esham noted that AEDs are numerous in airports, approximately every 10 feet. Dr. Searcy at the previous meeting indicated that Medicaid understood that there would be costs involved. It was discussed that the cost of an AED is in the range of \$1200 to \$1500. There is no training involved. Rick Harris added that there is a training course offered by the Red Cross. In assisted living facilities that have AEDs, the staff is required to have completed Red Cross training. Dr. Williamson added that in nursing homes, the staff is already trained in Basic CPR. Dr. Yates added if you do health care provider basic life support, you are required to have AED training. There is a separate course for a lay person. Rick Harris stated that the health department distributed thousands of AEDs to fire departments around the state and required that they be trained. It is not a lengthy training course. Dr. Esham discussed that the generic defibrillators used in hospitals required extensive training and expense. Based on this discussion, the medical directors came to the conclusion that they could not recommend this as a requirement for nursing homes. Dr. Reeves discussed again about the situation at the nursing home in Mississippi, where the medical director called him about a situation involving a young patient who suffered a cardiac event and no AED was available. The physician felt that the event could have been reversed with an AED. There were a lot of legal concerns. Since the AEDs are now everywhere but are not in nursing homes, then there is a question about liability. Circumstances about using AEDs have changed; does not require training. The unit has a picture showing you what to do. The question is what position would the association have. Would you look at it as improving care; or as increased liability; or as decreased liability. Dr. Williamson pointed out again that it is less for the residents and more likely to be used on staff and visitors. Louis Cottrell stated that ANHA is having a Board Retreat next week and this question would be discussed there with their legal counsel. There was a discussion about does this save lives and does the use of AEDs have an impact on public health. Dr. Esham pointed out that having AEDs in nursing homes would be voluntary and not a requirement. Dr. Esham asked Louis Cottrell if he could make comments about AEDs at the mid-winter meeting based on his Board retreat's thoughts and advice of counsel.

Dr. Williamson addressed the group about the flu vaccine shortage. There was extensive discussion about this situation. Different scenarios are being explored to protect the public. Dr. Esham stated that this group needs to be prepared to give reassurance and guidance to their patients, staff and public about the flu shortage. And this group should be involved in the decision making process with Dr. Williamson and with Louis Cottrell, ANHA. He recommended that the group may want to have a conference call to discuss the issue with other medical directors.

Dr. Esham stated that this concluded the planned agenda unless there were other issues anyone wanted to discuss. Rick Harris stated that there is a need to look at end of life care legislation and regulations in nursing homes. When we first came out with DNR bracelet regulations for EMS, we realized that we didn't have a way to deal with pediatric patients. This is an example of some of the holes and unanswered questions that still exist. The Patient Self Determination Act was written 10 years ago by lawyers representing the health care industry. The people not involved were practitioners. Rick Harris proposes that there be another meeting before the end of the year including the same group of lawyers, but also include practitioners. One of the things that we definitely want to do is have portable DNR orders and do away with the bracelets. Dr. Esham stated that the problem was being able to get the bracelets. It was a very cumbersome process. He believed that the education initiative by the department was not effective. Most practitioners did not know about the bracelets and how to acquire them. There needs to be a better way of providing information to practitioners. Dr. Esham was personally disappointed that forms were not available on the web site. Rick Harris stated that the national trend is not to have a bracelet. An easier way would be to distribute the forms to health care providers. Every health care entity would have a supply. If someone wants to get a DNR order then they would get it from the health care provider and the physician signs it. That controls people being able to download it. There was a discussion about the accessibility of these forms. Dr. Esham said that the real concern is the forms were not universal, not transferable and we need a registry. Forms were not honored by different health care entities. Rick Harris then said we need to have this meeting with the lawyers, health care providers and practitioners and discuss practical issues. The key is getting a system that everyone is comfortable with. Everyone agreed that we need something that is universally accepted and recognized. The medical directors are interested in being included at this meeting.

Dr. Esham adjourned the meeting. The next meeting will be February 19, 2005 at the Sheraton Medical Forum in Birmingham, second floor, meeting room A, from 7:30-8:30 a.m..

