

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

DATE: Saturday, February 19, 2005 7:30 a.m.

PLACE: Sheraton Medical Forum Conference Room A
Birmingham, Alabama

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF
Don Williamson, M.D., State Health Officer, ADPH
Louis Cottrell, Exec. Director, Al. Nursing Home Association
Jim Yates, M.D., President, ALMDA
John Searcy, M.D., Medical Director, Alabama Medicaid Agency
Billy August, M.D.
Rob Webb, M.D.
Joe Downs, M.D.
Jimmy Davis, M.D.
David McRae, M.D.
Tom Geary, M.D.
Jerry Harrison, M.D.
Dick Rutland, M.D.
Steve Furr, M.D.
David Barthold, M.D.
Mickey Dichiara, M.D.
Wayne Stanley, M.D.
Thomas Stevens, M.D.
Carol Griffin, M.D.
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
Becky Hall, DHCF

Dr. Richard Esham welcomed attendees to the advisory meeting. He called the meeting to order and thanked everyone's participation. Minutes from the October 21, 2004, which had been circulated to the committee were accepted as written.

Dr. Esham first addressed AED's in nursing homes and asked Louis Cottrell, Executive Director of the Alabama Nursing Home Association, to give an update. The ANHA Board has reviewed the situation about AED's in nursing homes along with legal expertise provided to us. ANHA will not mandate AED's in nursing homes, but will suggest that each nursing home have an AED. The Board has looked at liability issues and believes that since AED's are available everywhere, they need them in our facilities. His Board has already taken the step to recommend to his members that they purchase AED's. ANHA has had demonstrations on "Stop Heart Attack" from the Floyd Larkin company and will give this information to facilities as an option. They will also distribute

protocols from the American Heart Association and are hoping that most of the nursing homes will follow these recommendations. They would hope that the medical directors will be supportive of this effort. We would also hope that Alabama Department of Public Health would not mandate them, but would also be supportive of this effort. Dr. Williamson responded that ADPH is supportive of nursing homes having AED's but is not interested in mandating them, as mandating them would infer they are there for the residents' use. AED's are there for visitors and employees. Louis Cottrell injected that occasionally they may be used for residents. Dr. Harrison added to this discussion about coding in nursing homes. He re-stated that it was more for the employees and visitors and that he is against coding in nursing homes. It is very infrequently beneficial. If families see the AED's, their perception is their relatives will be saved from a heart attack. Dr. Davis added that if there are no advance directives, would the facility be obligated to use it on residents? Dr. Williamson responded that if there is no DNR order on the chart, if it were a hospital, you would have an obligation to resuscitate. Do you think in a nursing home that in the absence of a DNR order, you would be under obligation to resuscitate? A responsive discussion from Drs. McRae, Harrison and Stevens included the following: because of the litigious society we live in, if you didn't resuscitate, you can expect something to occur. Minnesota for many years has had a policy that if you go into a nursing home, you are a no code unless two physicians sign to make you a code. Dr. Williamson asked is that by statute or by regulation. Dr. Harrison responded that he thinks it is by regulation. Dr. McRae stated that they are under a requirement to resuscitate a resident in a nursing home who doesn't have a no code unless there is something written. We would call 911 and initiate CPR. Dr. Williamson responded that this answers the question that you would use the defibrillator if indicated. Dr. McRae responded that this is acceptable knowing that the success rate is extremely small. Dr. Harrison stated that ADPH needs to get out the DNAR forms.

Mia Sadler conveyed to the committee that Rick Harris is discussing making the DNAR form portable so it would accompany residents to wherever they go, such as the hospital or nursing home. He has contacted all the major provider associations and they are agreeable to the portable form. The department will be working on this. In addition, it will require rule changes for all provider groups such as the nursing home rules, hospital rules and EMS rules. Ms. Sadler conveyed that Rick said there is an agreement that some attorneys and physicians and hopefully some involvement from this committee and others will work towards simplifying The Natural Death Act. Dr. Williamson asked if this would be put on the Licensure Advisory Board agenda. Ms. Sadler was not sure if the project would be completed in time. All agreed that this represents monumental progress. This committee is definitely interested in providing input. The medical association is also very interested. Dr. Williamson stated that this needs to be on the Licensure Advisory Board agenda on April 12 to get their permission to put it out for public comment or alternatively to get it on the State Committee agenda to put it out for public comment. This could be accomplished within six months. It would take action by the Licensure Advisory Board, which only meets twice a year, and the State Committee. Unless there are some objections by a plaintiff attorney or other legal objections, it does not appear to be controversial. Dr. Steve Furr is on the Board of Censors and it is on that agenda. Dr. Esham stated that some members of Board of Censors are not on the State Committee. Dr. Esham expressed that he would hope the Board of Censors would support this project

since also getting the backing of the medical community is important. Dr. Williamson stated that this is on everyone's radar screen and has been discussed by the Board of Censors. Mr. Cottrell asked if the ANHA should delay sending out the recommendations about AEDs until after this is accomplished. Dr. Williamson stated that these are parallel issues and if he were visiting a nursing home, it would be good to know that a defibrillator was available.

Dr. Esham welcomed and thanked Dr. Searcy. The following is a summarization of Dr. Searcy's Alabama Medicaid update. The budget continues to be an issue. As of yesterday, the 15 year fight with CMS, was settled. CMS was to have recouped an exorbitant number of dollars from Medicaid which was never a real number. This would have bankrupted the entire process. The pharmacy tax issue was settled in the amount of \$200,000 to be paid over four years. The General Fund does not have to have millions of dollars every year for the next 5 years to keep Medicaid in business. Dr. McRae asked if the hospitals will continue using their operating capitol to fund Medicaid. Dr. Searcy stated that Alabama is a reformed state and will not abuse the system. What is in place will stay in place; therefore, hospitals will continue to transfer money to Medicaid. Nursing home bed tax is still in place as is the pharmacy tax, 10 cents per prescription. There will be no additional taxes. When Medicaid conducted presentations earlier in the year, it was stated there was a need for \$158 million from the General Fund. That number dropped to \$129 which is the number Medicaid would ask from the legislature. During the reformation process as part of the reform, CMS told Mike Lewis and others about things going on in other states. As a result another \$50 million is being raised through some contributions, clarified as offerings. Then we went from \$129 million to needing \$80 million. Twenty-five million dollars of the \$50 million is one time money. We are getting \$25 million this year and \$25 next year, but we are taking the \$25 million this year and carrying it forward to next year and not spending it this year. That leaves Medicaid needing \$80 and the legislature and governor have committed to keeping the agency whole. Medicaid is asking for \$65 in new money. There are more drugs coming on line for the Preferred Drug program. There is a projected cut in the pharmacy budget costs by \$15 million. The good news is John Knight has been very vocal as have many other legislators and Carol Hermann was positive that the money would be appropriated. There are no rate increases anticipated. There is a proposal that some of the hospitals have found some ways to transfer money to Medicaid. University teaching hospitals are having trouble keeping teaching physician positions. They are requesting that Medicaid pay teaching positions than they currently do. There are about six states that have worked out deals with the Federal government to pay differential rates. They pay teaching facility physicians more than they pay community physicians. Medicaid is exploring this. If this happens and CMS agrees, retroactive to about February 1, Medicaid will adjust claims with University teaching physicians and will pay them some percentage of Medicare greater than a 100% of Medicare. Medicaid will take part of the money that hospitals are transferring and will put that into community physicians. There will be some discrepancies and there will be two rates. If this is implemented, it is money that will go into procedure codes but not into office visits. The amount could be 8 to 10 million dollars. Dr. Esham asked with respect to the Education Fund, will community physicians involved in formal education have any role in the diferential reimbursement. Dr. Searcy stated for this to work, one would have to be directly employed as a provider of services

by the university in a teaching position and also in primary care. Dr. Esham asked what sort of accountability was in place for these funds. Dr. Searcy stated that Medicaid would pay doctors directly. Dr. Esham discusses that in his association with teaching universities, his efforts were being paid to the University three times for attending rounds on Medicaid patients. Universities get paid whatever they bill and they receive both state money and Medicare education money. Dr. Esham stated that he has issues with how universities use and acquire their money. It does not always appear to be in good faith. Dr. Esham expressed that he would hope that Medicaid has in place accounting methods for these Deans. Dr. Searcy acknowledged this concern. Dr. Searcy stated if a physician makes rounds, Medicaid will pay that individual for services rendered. Dr. McRae congratulated Dr. Searcy (Medicaid) for getting to the heart of the issue. If you can get the physicians on board, the others will follow. Dr. Searcy stated that getting the money to the community physicians was Carol Herman's idea. Alabama will be the first state to do it this way. This was discussed with the third party task force about a month ago and they are not in favor of a tiered system. If you are interested in CMEs, you can receive 9 hours of CMEs – DVD – “Every Patient Care Physician.” Physicians have the opportunity to turn in their CMEs and get their case management fee increased by ten cents per patient. To get 15 million dollars, Medicaid will probably look at the drug program. As more drugs come on line in the Preferred Drug List and more Prior Authorizations (PA) are required, we will be rolling out the “Electronic PA System” starting in December. There will be three classes of drugs. These can be processed without a PA up front. The drug normally requires a PA. The pharmacist submits a claim as if it were any other prescription. It goes to Electronic Data Solutions (EDS) who sends it to Health Information Designs (HID) who sends it back to EDS and back to the pharmacist with the total time of 4 seconds. In that time, it has also all checked for all claims history that are available. If the drug requires two failed therapies, it searches for two prescriptions for 30 day supplies of drugs in the appropriate class. It also looks for diagnosis. The pharmacist receives a notice of claim paid. The system automatically assigns a PA number without paper and FAXes. HID will continue a paper trail. The pharmacist and physician who wrote the prescription will receive a FAX that the drug receives approval and was given a PA. The reason you need to know that is that you will FAXes stating that your PA was approved, but you didn't request one. You will be receiving explanatory letters to remind you of this so you won't wonder why you are getting approvals and denials for something you didn't request. Once the Preferred Drug List of drugs goes into electronic PA mode, about 40% will be approved electronically. There will be no paper. More drugs can be brought in. Antibiotics go on the list in March. Any drugs can become preferred status if the drug company will give Medicaid rebates and the best price. On another class of drugs, Medicaid got discounts down so we are paying approximately 15% retail on a drug net price. After the Federal rebate, we went from the drug costing \$2 a tablet to costing \$1.15 a tablet. Medicaid is now paying 25 cents per tablet net price. Dr. Searcy discussed getting together as a group to develop specific formularies since Medicaid can't do one. He would like, with the permission of the committee, to develop a proposal that gives physicians a way to say, without sharing proprietary information, that if you are going to use an atypical antipsychotic, here are the ones that are preferred. These drugs would be listed in a voluntary formulary in the nursing homes we serve. It would also include a range for cost differences such as net

savings. Dr. Searcy referenced the hand-outs distributed, "Alabama Medicaid Preferred Drug List." The committee also needs to discuss generic substitutions when appropriate which would save 50 to 70% over prescribing the brand name drug. He again emphasized that tons of money are saved with generic drugs. The hand-out lists all the approved preferred drugs with the exception of antibiotics. It lists by drug class every brand name drug. For every brand name drug with an asterisk, a generic is available in at least one form. It may not be available in every strength, so there is some trial and error. For example the drug "Remeron" went generic ("Mirtazapine") about 6 months ago and may not be available in all strengths. If you like a brand name drug, check with the pharmacist to see if there is a generic. For example, the drug "Prozac" has been available as a generic for two years and is available in every strength. About 85% of the drug prescriptions physicians write on a daily basis are one of about ten to twelve drugs. So physicians probably don't need to reference an extensive preferred drug list to write a prescription once the drug of choice is selected. Dr. Searcy encouraged the committee to review the list. Dr. Webb asked why are nursing home residents receiving Zocor or a 95 year old resident receiving Aricept. The group needs to develop some recommendations about these drug prescribing habits. It is a terrible waste of resources to prescribe some of these drugs that the residents don't need. Literature is not that supportive of using these drugs. Dr. McRae added that the pharmacist reviews the drug regimens which becomes official on the record and requires the physician to document a rationale. Dr. Yates and Dr. Harris pointed out there is conflicting information about antipsychotics. Dr. Searcy responded that CMS is supposed to be correcting and changing their algorithms for geriatric patients. Remember the numbers are advisory. Dr. Harris stated that it creates a lot of work by not doing it; it needs to be corrected and also makes for a larger target. Dr. Searcy briefly commented on the Blue Cross Info Solutions E Prescribing. Blue Cross has added tools specific for steroids. This allows you to pull down patient specific information for anyone you have written a prescription on and information on all prescriptions written. You can also access information about drug interactions. If you look at drug specific information, the program will advise you if a generic is available and the preferred status. Dr. Searcy provided information on how to sign up for this and the web site. If you already have a Blue Cross contract, it can be downloaded for free. Physicians can receive a discount after using the program one thousand times. Whether this tool is used or not, Blue Cross already has the information. The advantage would be physicians could find out if a patient is on multiple drugs from different physicians or have multiple prescriptions for the same drug such as OxyContin. Dr. Harris added that the Alabama Control Substance Data Base will be available in January. Dr. Esham thanked Dr. Searcy for this extensive update and information. The committee looks forward to receiving a more specific proposal at the spring meeting. Given a logical proposal, this group will be very supportive. This is the kind of project that everyone benefits from. With prescriptions being logical and supported by best evidence, patient population will be best served. High quality care is cost effective care. Dr. Esham does not see any problem in the Alabama Medical Directors Association coming up with a series of recommendations to the membership and others in long term care about best practices. Dr. Esham again thanked both Dr. Searcy and Dr. Williamson for their attendance and input into this meeting. Dr. Esham asked if there were any additional business that needed to be discussed before adjourning.

Dr. Barthold stated that he believes the survey process is out of control. He has been involved in some very adverse surveys recently that in his opinion were not justified. There were three G-level deficiencies, two were deleted and one substantiated. Dr. Barthold stated there was one IJ that in his opinion was not necessary and was not supported by the facts. This involves a tremendous amount of time by Dr. Barthold, the nursing staff, and the owners. It also involves a tremendous amount of investment in money and detracts from ongoing patient care. Dr. Barthold stated that Mia Sadler had informed him there is no longer a QA process. Mia Sadler clarified that it is a retrospective QA whereas before all tags were reviewed before being mailed out. Our current process involves pulling a sample of deficiencies already submitted to facilities and those tags are reviewed for quality assurance. If problems are found, corrective actions are taken. Dr. Barthold stated that it is his understanding that final decisions are made by the individual surveyor. In his personal opinion some of the surveyors are "loose cannons". When surveyors are accusatory and trying to brow beat the staff, like good cop/bad cop, this is unacceptable. Dr. Barthold stated that we are a team and should be working towards improving patient care, trying to do the very best that we can and in some cases, with less resources and with sicker patients than what we have had in the past. After the company spends significant staff and financial resources, the surveyors return and put the tags back into compliance or it is deleted in the IDR process. Dr. Barthold stated that he is not sure DHCF understands what a facility goes through when a G and/or IJ is cited. There needs to be some oversight. Dr. McRae responded that this is a good forum to discuss these issues since the people directly involved are present, but in the interest of time, asked that Dr. Barthold discuss this with DHCF. Dr. Esham said this could be included as an agenda item at the spring meeting. This is an important issue that requires further discussion. Dr. McRae stated that all need to be familiar with the process used by DHCF. Dr. Esham expressed that he is appreciative that Dr. Williamson can personally hear these issues. Dr. Williamson is empathetic and concerned as evidenced by his attendance and participation. Dr. Esham stated that the changes in the department's QA process had been discussed at a previous meeting. Dr. Williamson briefly responded stating that the survey process is not a model process, but is one federally mandated by CMS. At the federal level, there is a growing concern about the number of deficiencies that are cited, then deleted and are not reflected on the 2567 Statement of Deficiency. Senator Grassley has had hearings where surveyors have stated deficiencies are deleted from the final 2567 report. The inference is deficiencies were deleted because there were pay-offs or kick-backs or that the survey process is in the back pocket of the industry. At DHCF, attempts are being made to decentralize the survey process because of lack of staff to support a central office. The department is short by 20 surveyors. Also the department can't compete financially with hospitals. Surveyors are asked to travel three nights per week. The department has gone through a process to try to increase salaries and learned Alabama surveyor salaries are comparable with other state agencies. But in the state of Alabama, it is not a competitive salary. Growing pains are understood. The ultimate vision is that DHCF will have two to three district offices with self-regulating teams. Quality will be viewed retrospectively, but will also be achieved through enough trained survey staff. There will be an emphasis on training and education to address problems. Dr. Williamson stated that this process has not been completed and that he

requested additional money from the legislature to hire more surveyors, with no success. Dr. Williamson agreed that further discussion is needed.

Dr. Esham thanked everyone and adjourned the meeting. The next meeting will be Thursday, May 19, 2005, at 2:00 p.m., RSA Tower, 201 Monroe Street, 15th floor Board Room.