

ALABAMA DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROVIDER STANDARDS
MEDICAL DIRECTORS' ADVISORY COMMITTEE

DATE: Saturday, February 28, 2009 7:30 a.m.

LOCATION: Sheraton Medical Forum
Birmingham, Alabama

BOARD OF DIRECTORS: Robert Webb, MD, Board Chairman
Michael Hanna, MD, CMD, President
Jimmy Davis, MD, CMD, President-Elect
Michael Reeves, MD, CMD, Secretary/Treasurer

ATTENDEES: W.T. Geary, MD, Medical Director, BHPS
Robert Webb, MD, Board Chairman
Jimmy Davis, MD, CMD, President
Michael Hanna, MD, CMD
Robert Moon, MD
Malcolm Brown, MD
John MacLennan, MD
Louis E. Cottrell, Jr.
James R. Yates, MD
Jerry Harrison, MD
Clare Hays, MD
David MacRae, MD
Rick Owens, MD
John Wagner, MD
David R. Barthold, MD
Edwin Mayo, MD
Diane Mann, BHPS

Dr. Tom Geary welcomed Dr. Moon and Louis Cottrell, Jr., and the other attendees to the advisory board meeting and thanked them for their attendance. The minutes from the previous meeting were approved.

Residents discharged from Assisted Living Facilities

Dr. Davis had a question concerning the direction in which the ALF industry was headed pertaining to eligibility. Dr. Geary explained that there had been several meetings to discuss cognitive impairment assessment. Facilities admit residents and later, the resident begins to decline, resulting in the resident's inability to safely administer their meds. This may not mean residents are at significant risk for fights or elopements. At these meetings, various evaluations and cognitive tests were discussed. The first to be discussed was the Mini Mental Status Exam score, and what would be a good cutoff point for admission or continued stay at a facility. In these preliminary discussions it was suggested that if the mini mental score would be 18 (or possibly 19 or 20), the applicant couldn't enter an ALF. If a current resident scored 15 and below, he would have to be discharged.

Secondly the psychological dependency rating scale was also discussed. This is not a good scale for ALF residents since it is dependent on observations over time. Often a resident is admitted to an ALF, thought to be doing fine, when actually he was not doing well at home. In this case, the resident may not be appropriate and should not have 30 days to be discharged.

3) If acutely ill, an ALF resident would be immediately discharged because skilled care is required and the MMSE score drops below 15. If the facility staff can meet the resident's needs, and the resident could get back to normal, then there might be a place for a 90-day rule be followed allowing the resident to recover and score above 15 on the MMSE and the resident would not have to be discharged.

Dr. Geary shared information on a study from a facility regarding elopement. The mini mental score determined the number of residents likely to elope. In the study, if the average mini mental score was 24, 44% of residents were likely to elope. If the score was 19, then 64% were likely to elope. A score of 10 indicated that 37% were likely to elope. The last meeting held on this issue was at ADPH with Rick Harris, Dr. Geary, Frank Holden, and O'Neal Green. Dr. Geary stated that ADPH had a significant amount of resistance to rapid implementation of new cognitive assessment rules and said that he is not sure where we are right now.

Dr. Davis commented that this issue is politically complicated; it comes down to private pay versus nursing home. Dr. Geary commented that residents are resistant to moving out if there is no SCALF nearby, and they have to be away from their families; it's hard. Some operators might not be completely honest with the test when the loss of residents is involved. The Department would be dependent on the operators to test.

Dr. Davis stated that the Mini Mental exam is not the greatest tool.

Dr. Geary replied that there are other tests out there, but they are complicated.

Frank Holden, from the ALF Association, shared with Dr. Geary that the ALF Association is willing to purchase the copyrighted Folstein MMSE material package for the right to use the test.

Other tests such as the SLUMS, BOST, and BRIMS were discussed and thought to be too complicated.

Dr. Hays commented that when CMS releases 3.0 for MDS that it will correlate with the BRIMS.

Dr. Reeves asked Mr. Cottrell what was the opinion of the Nursing Home Association.

Louis Cottrell stated that operators run on different levels and Frank Holden deals with ALF's. Usually when a nursing home has an ALF associated with it, there is no problem because the residents have somewhere to go.

Dr. Geary commented that the Department is taking enforcement action against ALFs all the time. At present we have 3 – 4 cases pending. He went on to explain the problems that would cause enforcement action.

Much discussion ensued concerning problems with unlicensed facilities.

Mr. Cottrell stated that unlicensed homes have become a problem. Everyone needs to be inspected to identify where residents need to go to be taken care of and residents be better served.

Tag F309 New CMS Guidance for Pain Control (Handout distributed.)

There was discussion of treating residents with pain and how well meds are tolerated and the possibility of dependency. It's important that knowledge of a resident's dependency and tolerance of meds is known in the nursing home setting before the resident goes to hospice.

There will be a presentation on F309 at the Galleria on March 16 by the BHPS and industry presenters.

Review of CMS guidance of dialysis care for nursing home residents

The nursing home needs to put in writing who is responsible for the care of the resident (ex: changing diaper). This should be reflected on the plan of care. This will let the surveyor know that the nursing home did everything they could to provide for the resident. If a surveyor can't tell whether the nursing home made an effort to ensure continuity of treatment or if the dialysis center made any effort, it's possible that both entities would get a deficiency. The nursing home needs to be proactive in working out the details and following up on the care.

Dr. Reeves commented that Carolyn Duck cites facilities all the time regarding this issue. Dr. Hanna asked who he would call with a complaint on a dialysis center. Dr. Geary said that Dr. Hanna could call the complaint hotline, 1-800-356-9596, let him personally know about it, and he could possibly write a letter to the center. Dr. Davis commented that part of the problem is that there is no communication between the facility and the dialysis center. Dr. Harrison told Dr. Hanna that he could also call Carolyn Duck's unit. Ms. Mann stated that the Medicare Other Unit main line is (334) 206-5075.

Tight control of Type II Diabetes and increased mortality

In treating Type II diabetes, according to several recent studies in the elderly, when the goal of getting the HbA1C below 7, the resident outcome is worse than less tight control.

The recommendations discussed were to give information to survey staff, ask pharmacy to look at studies; stop doing so many finger sticks; let sugar run higher; focus on other things; look at policies and results; go through them and relax your guidelines.

Dr. Reeves gave the example of a fresh doctor who starts tight control – folks go to hospital.

Dr. Hays: It's evidence-based data which does not always apply to elderly.

Dr. Hanna – How will Blue Cross look at this issue?

Dr. Harrison said to just do A1C ; followed by Dr. Brown saying to document it.

Medical Literature

Dr. Geary commented how hard it is to obtain entire articles of medical literature unless you buy it. He suggested that ALMDA buy a membership and give out passwords so that the committee could access databases of medical literature. Dr. Hays commented that UAB had a great library database.

Dr. Harrison commented that the University of South Alabama librarian is very helpful. He suggested that the Advisory Board have her make a presentation to ALMDA. She might be able to assist the

membership to get articles without having to pay for them. Dr. Geary and the committee agreed that this would be the thing to do. Dr. Geary said that the Department would check into it.

Routine Lab Test in Elderly

Dr. Reeves wanted to discuss the topic regarding the volume of routine labs. He had discussed with Richard Brockman whether routine labs were a requirement. Routine labs require a lot of time, are costly, some are needless, and the time could be better used in providing care to residents. It is now a new day and labs should be based on clinical issues.

Dr. Hays stated that she has looked at this in her facility and agrees that there are too many routine labs. One problem is that the labs are pharmacy driven. She stated that UAB listed on their charts, "Noted, order labs as needed."

Dr. Geary read two articles regarding routine labs that discussed periodic monitoring and legal issues. One solution would be to meet the consulting pharmacy group; work out the problem and correct the facility's policy and procedures to reflect the solution.

Dr. Reeves said that he saw two approaches to this issue. 1) Form a committee to look at cost and value; 2) stop writing routine labs and change policy.

Dr. MacRae had a dissenting view. He said the patients in nursing homes' world are the frailest of the frail. Good doctors do good jobs which means ordering labs. Nursing home care should be brought up a notch by doing appropriate lab tests.

Dr. Reeves acknowledged Dr. MacRae's point was well taken.

Dr. Yates commented that there is no policy on the regulatory side. You have to deal with the pharmacists and trial lawyers.

Dr. Moon, Medical Director for Medicaid

Dr. Geary acknowledged Dr. Moon and asked if the committee had any questions for him. Dr. Reeves asked Dr. Moon what was his job at Medicaid.

Dr. Moon stated that there was not just one thing he did. His job covers a broad spectrum of issues; a wide variety of things. One of his duties dealt with Medicare policy.

Dr. Davis wanted to know how he could get in touch with someone at Medicaid to follow-up on a computer program. Dr. Moon gave him his card, said they would connect him with the right person.

Dr. Moon mentioned the program, Q tool, a program that pulls lots of information together, anything from claims to customer service. Dr. Moon stated they were still working on the E-prescribing program.

Respite care

Dr. Brown had asked that this subject be discussed. A nursing home can accept residents on respite care, short term in-patient care. CMS guidelines state that the nursing home has to have an RN or a 24-

hour nursing service. The Board of Nursing states that an LPN can't assess, only an RN can. The Alabama Hospice rules were discussed. The Board of Nursing is not familiar with CMS regulations. It was suggested that a rule change take place so that respite care can be separate from inpatient care. This would only apply to ones receiving Medicare-Medicaid. Private pay does not apply.

Dr. Harrison informed the group that the legislature planned to introduce a Physician Assistant (PA) in Supervisor Position – Allowing prescription of Class 2,3,4, and 5 controlled drugs, no class 2 authority. Nurse Practitioners are pushing for independence. PAs in favor of independent practice needed to call Senator Coleman. Dr. Harrison said that if PAs were not in favor of independent practice, he wouldn't mention it.

Dr. Geary asked if there were survey issues or other issues to be discussed. There were none. The meeting was then adjourned.

The next meeting will be at 7:30 a.m., on Saturday, July 25, at the Sandestin Golf and Beach Resort in Sandestin, Florida.