

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

DATE: Saturday, July 23, 2005 7:30 a.m.

PLACE: Sandestin Golf and Beach Resort
Terrace Board Room I and II
Sandestin, Florida

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF, ADPH
Don Williamson, M.D., State Health Officer, ADPH
Louis Cottrell, Exec. Director, Alabama Nursing Home Association
Steve Furr, M.D., 2005-2006 ALMDA President
Robert Webb, M.D., Vice President, Program Chairman
David McRae, M.D., Board Chairman
John Searcy, M.D., Medical Director, Alabama Medicaid Agency
Jim Yates, M.D.
Billy August, M.D.
Jimmy Davis, M.D.
Tom Geary, M.D.
Jerry Harrison, M.D.
Dick Rutland, M.D.
David Barthold, M.D.
Mickey Dichiara, M.D.
Michael Reeves, M.D.
Buddy Reeves, M.D.
Thomas Stevens, M.D.
Carol Griffin, M.D.
Kevin Jackson, M.D.
John Wagner, M.D.
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
Eddie May, R.N., DHCF

Dr. Richard Esham welcomed attendees to the advisory meeting and thanked them for attending at such an early hour. He thanked the staff of the Division of Health Care Facilities for the time and effort spent in the development of informational packets. The minutes from the May 19, 2005, meeting were approved as written.

The first agenda topic "Hospice Services in SNF vs. Assisted Living Facilities" and "Survey Requirements of Home Health Services Provided in the ALF" was addressed by Mr. May, DHCF, assisted living supervisor. Eddie May provided an informational hand-out "Skilled Care in ALFs and SCALFs" which outlines these regulations. The Department's enforcement of the following regulations can be summarized as Skilled care can be "provided" in ALFs and SCALFs for up to 90 days for

residents who already reside in an ALF or SCALF and develop the need for skilled care. The skilled care may be provided by appropriately licensed facility staff or appropriately licensed home health or hospice staff. Skilled care may exceed 90 days when a resident is admitted to hospice. Dementia cannot be the reason for admission into hospice for ALF residents. The ALF or SCALF still remains responsible for the care provided to the residents and therefore must be knowledgeable about the resident's needs and what the outside provider is doing to ensure residents receive the needed care including providing care that the home health or hospice agency is not available to provide. It should be noted that these facilities are not private homes where family members are instructed how to provide care. Only licensed staff may provide skilled care. It should also be noted that hospice and home health staff do not routinely provide care in these facilities on a day-to-day basis. If a treatment or a skilled need must be addressed each day, it is the responsibility of the assisted living facility to provide the needed care. This is a common deficiency; often the assisted living facility or specialty care assisted living facility failed to meet the resident's needs in the absence of the home health agency or hospice. We require that the facility has knowledge of the services the resident is receiving through hospice or home health. The best way to accomplish this is to have a copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care (HCFA Form 485/487) for each resident receiving care from an outside provider [420-5-4.-5(d)5] (p.2 of hand-out). Sometimes facilities don't have these forms because the Home Health Agency and/or Hospice state that disclosure would be a HIPPA violation. Please note that this is not a HIPPA violation; however, outside providers are reluctant to provide this information. Facilities need to impress on outside providers the need for this information. The ALF and SCALF ultimately have the responsibility to assure that care and services are provided regardless of the plans of care developed by the Home Health Agency and/ or Hospice. Dr. McRae presented the following scenario: a resident has a wound in the assisted living facility and the home health agency goes out to provide care but care needs to be given every day. What is the required level of training for ALF staff to do dressing changes? Eddie Mae responded that it would have to be at least a LPN to do the dressing change. There was a discussion by Eddie May that the ALF is not required to have a LPN on staff; however, if the ALF admits residents who require treatments such as dressing changes, that is the burden they undertake. However, if the ALF states that they cannot provide the services required, then the resident is transferred to a facility that can provide the level of care needed. The Department does not want ALFs becoming nursing homes. Ninety days is the bench mark; however, if the resident's condition is improving or the situation resolves itself within for example, 115 days, that is acceptable. If a resident has the hospice benefit, he/she is eligible to remain in the ALF and/or SCALF. The 90 days refers to skilled care that the facility is providing. The 90 day limit is extended for hospice beneficiaries. It was the intent not to displace terminally ill residents. If a resident is capable of providing his own skilled care such as treating a stasis ulcer (dressing change), then the 90 day limit does not apply. Dr. McRae commented that hospices are becoming more aggressive in diagnosing what is a terminal condition. Dr. Harrison commented that some hospice residents are not receiving the best care because they are not placed in the most appropriate facility. Mr. May stated that this is a concern as judgments about care are left to unlicensed staff such as what needs to be reported and what issues need more thorough assessment. Regulations do not require that

licensed staff be there 24 hours a day. We assess did the resident have a need, did the staff not respond appropriately, or were they not proactive, knowing the resident's diagnosis and risk factors. Dr. Webb asked what can be done when patients are in unlicensed private homes, a referral is made to hospice to cover skilled care; however, the patient is not hospice eligible. Eddie May responded that unlicensed facilities are a problem for the Department of Public Health. The department usually finds out about unlicensed homes by word of mouth. There are probably more unlicensed homes than licensed homes. The department encourages that unlicensed homes be reported through the complaint line. Some complaints that are received about unlicensed homes are vague and do not contain enough specific information to investigate. If the owner of the home and residents living in the home are related, there is no licensing requirement. Etowah county tops the list for unlicensed homes. Mia Sadler stated the Department has had discussions with the Alabama Nursing Home Association and a working plan is in place to address and work collaboratively on the issue of unlicensed homes. The Department may not be the agency to investigate, but a referral will be made to the appropriate agency to investigate that hospice. Dr. Davis asked about a list of all licensed facilities. Eddie May stated that all licensed facilities are listed on the Department's web site: <http://www.adph.org/providers/> . The current penalty for operating an unlicensed nursing home is a Class A Misdemeanor up to a \$5,000 fine. Dr. Griffin discussed a situation where the hospital wants to discharge a patient to a skilled facility with hospice care. The skilled facility responds that they are going to skill the patient for the first 21 days and if receiving custodial care, will convert the patient to the hospice benefit. The VA's position is it will pay for room and board and Medicare will pay for hospice. Some facilities will not take these patients because it will be viewed as double dipping. Dr. Griffin asked for clarification. Ms. Sadler responded that she can understand the nursing home wanting to receive the 21 day payment. Dr. Geary said that outside of the VA, it costs the family more to go into a facility directly under hospice and bill Medicare Part A. It is better for the resident, if criteria are honestly and ethically met, to receive the skilled nursing home care and then convert to hospice. Dr. Geary further clarified that a patient can be skilled for one thing and receive hospice for something else. A patient could be skilled care Part A (rehab) for a broken hip and on hospice for terminal lung cancer. This is not double dipping. There was further discussion about reimbursement issues. Mia Sadler stated that the Department does not get involved with reimbursement but some inquiries could be made for clarification. Concerning assisted living facilities, Dr. Geary asked for a discussion about orders given by the attending physician in the ALFs and SCALFs to home health nurses. The tendency is when the home health nurse calls to simply give her/him orders. The problem is the orders are not communicated to the nurse at the assisted living facility to the appropriate person. Mr. May responded that it is the responsibility of the ALF and/or SCALF to have knowledge of what the resident needs so that appropriate services are provided. When an outside agency provides the care, the ALF and/or SCALF must communicate with the agency to know when orders have changed to understand their role in carrying out these orders. Dr. Geary commented that the situation is the home health nurses are used to going into the home, calling the attending physician, receiving orders and implementing them. The orders are not communicated to the nurse in the ALF. All of the orders were not documented. It is important for physicians, nurses and administrators in ALFs, that policies and procedures

reflect required communication between the home health agency nurses and/or hospice nurses in great detail to assure that patient care is delivered properly. Ms. Sadler commented that this is also important in the nursing home setting. There have been situations where the ball was dropped due to lack of communication between the home and the contract agencies. Dr. Esham brought this discussion to a close and asked Mr. May to discuss survey requirements. There are no specific survey requirements for home health agency as part of the ALF and/or SCALF survey. The intent of the survey is to verify that the facility has provided the needed care for residents even though home health and/or hospice may be providing part of the care. The ALF surveyor will assess what the facility is doing to carry-out its portion of providing the resident's care. This is a deficiency that would be cited if the resident's care was not provided. As Dr. Geary stated, if an order was written by the home health physician and the facility did not carry-out that order, that would be cited under the regulation that states the medical care of residents shall be under the direction and supervision of a physician (420-5-4.06 Care of Residents (1) Medical Direction and Supervision). The home health agency is not reviewed during the ALF survey. Dr. Esham asked Mr. May to comment on issues surrounding the medical director. Mr. May responded that in the assisted living facility (ALF) there is no requirement to have a medical director; however, the facility is required to have a physician's agreement. This requirement means that if a resident requires the services of a physician and this physician cannot be reached, the contract physician agrees to provide the service to the resident to fulfill the need. The medical director role came into being in 2000 when the specialty care regulations were written. Refer to 420-5-20.04 (8) Medical Director. "Each specialty care assisted living facility (SCALF) shall have a medical director who is a physician currently licensed to practice medicine in Alabama. The medical director is responsible for implementation of resident care policies, and the coordination of medical care in the facility. The medical director shall participate in quality assurance activities in the facility." In specialty care facilities, the Department identified five issues of concern: falls, weight loss, behavioral problems, elopements, and abuse. The Department envisions medical directors in a quality assurance role, to be utilized in the development of resident care policies and procedures and an active participant in the quality assurance process. It is not the intent for the medical director to be onsite to verify that this is being accomplished. However, the medical director may desire to actively monitor to assure that what he/she ordered for the resident is rendered. From the survey perspective, if the facility has falls, the surveyor will ask about the involvement of the medical director in the fall prevention policy. If there are residents at risk for pressure sores, what has the medical director said about the policy for reducing the risk for treatment of pressure sores. If there are issues about the questionable practice of another physician in the SCALF which concerns the administrator and staff, the medical director should step in and provide guidance to the physician in explaining the requirements in the SCALF and how the practice places the facility out of compliance. The intent of the medical director requirement is to, in a broad sense; assure that the facility is operated according to the care the medical director desires residents to receive. This is to be accomplished by giving advice into policies and procedures. Onsite visits by the medical director may be made as is necessary. Dr. McRae asked about the meaning of the word "implementation" in reference to the responsibilities of the medical director. Mr. May responded with an example: resident has

experienced a weight loss. The physician has some general services he/she wants provided for this resident and upon follow-up, the physician can compare the policies and procedures that were supposed to be implemented with the interventions provided. The “implementation” is did the facility follow the physician’s intentions for the issue of weight loss. Again, it does not mean that the physician has to be there to observe the care and services rendered. They physician would assist the facility in developing a quality assurance program, including policies and procedures on the front end and then would monitor outcomes of care and services. Dr. McRae commented that the word “implementation” has a lot of meanings in the regulatory process. In a narrow sense, one could take “implementation” to mean that the physician is supposed to be supervising every aspect of the facility’s policies and procedures. Physicians are not able to accomplish that supervisory responsibility. Dr. McRae stated that there will be an evolving interpretation of the word “implementation” as tag F 501 (Medical Director) is surveyed more closely. Ms. Sadler responded that the new guidance for F 501 states that the medical director has to be involved in the development of care policies and procedures to assure that standards of practice are followed. “The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice.” The medical director should try to ensure that the facility has appropriate systems in place to facilitate good medical care and good monitoring systems. It is important to note the paragraph on page 6 of the recent CMS notice, “This requirement does not imply that the medical director must carry out the policies and procedures or supervise staff performance directly, but rather must guide, approve, and help oversee the implementation of the policies and procedures”. This is how this requirement was interpreted in the past and Ms. Sadler further stated that she does not foresee this interpretation changing. Following this paragraph are examples of resident care policies that CMS recommends for medical director involvement. She stated DHCF does not expect the medical director to be on the floor ensuring that nurses and nursing staff are turning residents as reflected in the plan of care. Dr. McRae expressed there is concern about that expectation and also about litigation. Would all of the surveyors reviewing resident care policies and procedures apply the same interpretation? Dr. McRae stated that as long as there is consistent interpretation of the requirement medical directors will be satisfied. Dr. Esham responded that he sees this requirement as emphasizing the role of the medical director and the responsibilities of the medical director. There have been discussions about this tag in the past so this requirement is not new, but emphasizes the importance of the medical director’s role in resident care. Not every medical director has understood his/her role and responsibilities. And perhaps facilities have not appreciated and understood the importance of the medical director’s role. Mr. Cottrell agreed and recognized the importance of the medical director’s role and further stated there is a wide range of how medical directors have accepted their roles. His concern is that the Department, since this tag has been infrequently cited, would begin citing this tag which affects both the facility and the medical director, but more so, the facility. Mr. Cottrell is also concerned about the interpretation or emphasis of this tag and its implementation. Dr. Esham responded that some facilities have not opened the door to involve their medical directors in resident care policies and procedures. Dr. Reeves asked Mr. Cottrell about the position of the nursing home association. He

responded that an education seminar is planned for facilities. He wants the facilities to understand their role with the medical director and requests that this committee assist with this education. There is support of this initiative as it will have a positive impact on the care of residents in nursing homes. Dr. Webb stated that it is frustrating when facilities are not up to speed with quality improvement programs and don't understand what is involved. Ms. Sadler stated that the Alabama Quality Assurance Foundation (AQAF) along with the association and the Department emphasize the message of how to track data and how to use the data to improve performance, assess problems, and identify the root cause of a problem. Further guidance on these issues can be provided. Ms. Sadler stated that if the committee is planning educational seminars related to these tags, the Department is available to present the regulatory perspective. Mr. Cottrell commented that facilities have the ability to obtain data collection reports called "My InnerView." He encouraged the medical directors to emphasize to facilities the importance of this data. Ms. Sadler responded that the Department can't endorse a private company, but the department strongly encourages facilities to take advantage of something like "My InnerView" as it gives comparative data so facility performance can be evaluated in relationship to the performance of other facilities. The final issuance of the Revised Interpretive Guidelines for Tag F501 – Medical Director is November, 2005. This is to allow State Survey Agencies and providers time to complete training on the new guidance. Dr. Reeves asked what medical directors and facilities should expect. Would there be an increase in the number of deficiencies cited? Ms. Sadler again stated that from her review of the guidelines, she did not envision an increase in the number of deficiencies cited. Dr. Esham made the point that if medical directors are not fulfilling their responsibilities at least at a minimum competence level, would we not want the Department to cite the problem? Dr. Reeves stated that there are medical directors who have no involvement with their facilities. He too believes that these facilities should be cited. Dr. Esham commented that this committee could be supportive and provide education about F 501 to facilities who are cited. A possible plan of correction could include education from this committee. Dr. Reeves agreed and stated that this is an opportunity to improve health care. Ms. Sadler stated that this CMS survey protocol will primarily be reviewed during initial certification surveys or during an extended survey when substandard quality of care is determined. The extended survey criterion includes a review of the medical director requirement. Usually physician services requirements are reviewed only if resident care problems are identified. It is anticipated that this requirement will not be reviewed during every survey. Dr. Reeves commented that he has seen this requirement reviewed when medication problems were identified. Ms. Sadler stated that if a surveyor is investigating a concern, he/she may want the resident's physician or medical director's input into the situation. Surveyors are encouraged to contact the medical director to discuss the issues so your perspective is known. The medical director's information will assist the surveyor in making compliance decisions. If a survey is being conducted in your facility, the Department encourages medical directors to approach the surveyors and to be involved during the process.

Dr. Esham discussed his meetings with DHCF surveyors on April 18, 2005. These were conducted in small groups to encourage discussion of ideas. He clarified his role as medical director for the agency as one of helping the surveyors during the survey process and also conveyed the importance of the role of the medical director in health care

facilities, especially nursing homes. Dr. Esham expressed that it was a positive experience to have a dialog with surveyors and managers and hoped it was helpful to the staff. The surveyors are very dedicated and view their jobs very seriously and understand the impact of the survey process on residents, providers and communities.

Dr. Esham asked Dr. Barthold to discuss survey process issues. Some of these have been discussed at previous meetings. Dr. Barthold indicated that he has had no problems with surveys since it was last discussed. He had previously noted the aggressive nature of some of the surveyors as to how they approached facility staff. Overall, he stated that it has improved. Dr. Harrison asked if there has been a paradigm shift in positioning devices. During current surveys positioning devices are viewed as restraints. Ms. Sadler responded that each individual resident has to be assessed to determine if the device is for positioning or as a restraint. Dr. Harrison stated that it is both - a positioning device and a restraint. All positioning devices are restraints and this is the view of the State Agency. Ms. Sadler again stated that it has to be viewed individually for the resident – what is the device being used for and what was the impact on the resident. The Department has requested that the Regional Office in Atlanta provide training to the survey staff about restraints. When the Department receives further clarification about restraints and positioning devices, this information will be communicated to the advisory committee and providers.

Dr. Searcy briefly reported that Medicaid received \$65 million in the budget, but needs \$172 million. Part B will be discussed during the conference. There have been discussions with the hospice industry as to how patients are certified. For additional information, the contact telephone number is (334) 353-8473.

Dr. Esham stated at the Medical Association Meeting, members of the Board of Medical Examiners had a special session about nurse practitioners going beyond their scope of practice. There have been very few problems with Physician's Assistants (PAs) but increased problems with nurse practitioners. Legally, these are the same in the state of Alabama but their educational background is different. There was a discussion by several physicians about the role of the nurse practitioner which was discussed at the previous meeting. Dr. Esham brought this discussion to a close and pointed out that there will be presentations on this topic during the conference. If this topic needs further discussion, it can be added to the agenda for future committee meetings.

Dr. Esham stated that committee meetings have been on a quarterly basis. These meetings have been very useful. Attendance at the spring and fall meetings in Montgomery has been poor. The Department has tried to accommodate the committee by sending out dates and packets well in advance so schedules can be adjusted. Dr. Esham stated that future meetings have been suspended for the spring and fall quarterly. We will continue having committee meetings at the annual meeting and winter meeting. Additional meetings can be scheduled at other times if the president of ALMDA and/or Dr. Esham believes issues need to be discussed. Dr. Reeves suggested that the time be expanded to allow more discussion. Dr. Esham stated that he is open for any suggestions. Any comments or suggestions about meetings can be directed to Mia Sadler, Diane Mann or to Dr. Esham. Dr. Esham thanked everyone and adjourned the meeting. The next meeting will be Saturday, February 25, 2006, in Birmingham, Alabama.

