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

DATE:	Saturday, February 27, 2010	7:30 a.m.
LOCATION:	Sheraton Hotel, Medical Forum 2nd Floor Birmingham, Alabama	
BOARD OF DIRECTORS:	Jimmy Davis, MD, CMD, Chairman Michael Reeves, MD, CMD, President Dick Owens, MD, President Elect Clare I. Hays, MD, CMD, Secretary/Treasurer	
ATTENDEES:	W.T. Geary, MD, Medical Director, BHPS Louis E. Cottrell, Jr., ANHA Katrina Magdon, ANHA Jimmy Davis, MD, CMD, Board Chairman Michael Reeves, MD, CMD, President Clare Hays, MD, Secretary/Treasurer Malcolm Brown, MD James R. Yates, MD Jerry Harrison, MD John Wagner, MD David R. Barthold, MD Joe Downs, MD Steve Furr, MD Kenny E. Smith, MD Diane Mann, BHPS Becky Hall, BHPS	

Dr. Tom Geary welcomed attendees to the advisory board meeting and thanked them for their attendance. The minutes from the previous meeting were reviewed and approved as written.

Dr. Geary reported on his review of the State Operations Manual (SOM) about laboratory testing for medications. A hand-out was distributed - **"Routine" (Recommended) Laboratory Tests for Monitoring of Medications in the Nursing Home**." Dr. Geary pointed out the listing of drugs, the companion recommended laboratory monitoring criteria, and surveyor guidance. Dr. Reeves commented that routine lab rules were implemented because physicians were infrequently in long term care facilities. Currently many physicians and nurse practitioners are in long term care facilities every week making assessments and should order labs based on clinical basis rather than adhere to a recommendation. Ordering labs according to the guidelines is both costly and cumbersome. Dr. Geary pointed out that the SOM states "monitoring" is

necessary. If the physician is monitoring the resident and the drug, and documents that a particular laboratory test is not necessary, that should be acceptable as long as it is within reason. There are some drugs that are extremely dangerous such as Coumadin and others such as Dilantin that have to be monitored. The Investigative Protocol that surveyors utilize is included in the hand-out. This deficiency (failure to monitor) is not frequently cited in Alabama nursing homes. It is cited occasionally. The Regional Office has stated that Alabama doesn't cite this deficiency as much as it should be cited; and in our Region IV, it is cited more by other states, particularly Florida. There is some encouragement to cite facilities at F329 Unnecessary Drugs, and lack of monitoring is a problem. Monitoring means if the dose is excessive or duplicative therapy or continues beyond the normal duration without adequate monitoring. Dr. Harrison commented that there are issues on the pharmacy side with generics. Manufacturers of generics are changed which have variability. There should be some mechanism for the pharmacist to be consistent in what is ordered and to notify physicians when manufacturers are changed. Dr. Geary commented that pharmacists have a responsibility to monitor and failure to do so results in a deficient practice. Dr. Harrison recommended it would be helpful if the pharmacist put a note on the chart about the change in generics. This would alert us to a potential area of concern. Dr. Geary suggested that this is not covered in the Federal Regulations and should be resolved on an individual basis.

Dr. Geary began a discussion on the second agenda item – Glucometer Infection Control Issues. The confusion relates to whether the glucometers in use for more than one resident must be cleaned between uses or can simply be cleaned if contaminated, or do they have to be cleaned and disinfected between uses to prevent the spread of hepatitis. There have been numerous reports of hepatitis outbreaks in long term care due to improper handling of blood in testing for blood sugar. The department has not received a final confirmation from CMS about the glucometer issue. One is pending, but has been pending for months. There was discussion of various types and models of glucometers with different characteristics. Regional CMS personnel stated on an informal conference call that if you use common sense, and if the glucometer is not being taken from room to room and being shared by residents, and if the lancets are properly used and are not in a spring loaded device that is taken from resident to resident such that they could be contaminated with splattered blood, and if materials are properly discarded and the glucometer on the cart where the sugars are actually tested is not left exposed so that residents wandering in the hallways - who may have a broken area of skin on a hand - can't touch it; then the glucometer does not have to be disinfected after every use. It has to be cleaned according to the manufacturer's recommendations. Dr. Geary referred the attendees to the hand-out. This hand-out has been forwarded to CMS for review and confirmation; however, no response has been received. If changes are made, these will be communicated to Lee Ann Cole for distribution. At the present time, the policy of the state of Alabama is: If the devices are not shared with different residents and everything is handled properly, so that hepatitis cannot be transmitted, then failure to disinfect the glucometer would not result in an immediate jeopardy.

The next item on the agenda – Improved Coordination between the ALMDA and the Bureau of Health Provider Standards was discussed by Dr. Reeves. Dr. Reeves began this discussion by complimenting Dr. Geary on his assistance to medical directors. Dr. Reeves then outlined a case involving a 41-year-old MR male who was placed in the facility for 21 days. The resident was moved to a locked unit due to his wandering. He and a female resident had a sexual encounter.

The male was taken to the ER; however, the female resident refused. Dr. Reeves explained that this was a nurturing need between two residents. This is a biological need – socialization, nurturing, touching, and loving that resulted in intimacy. The argument made by the BHPS was that the female resident did not consent and did not have the ability to consent. Dr. Reeves and the facility's argument was that it was a biological need and a violation of human rights to deny this resident intimate contact. There were arguments back and forth, but Dr. Reeves' point is that this Advisory Committee is a most wonderful organization and should be more utilized with ADPH. He further stated that even though Dr. Geary is part of this group as a medical director who has been on the firing line, he now works for and represents ADPH. He asked whether there is a way, when such things happen and the state agency makes rules to apply to these situations to prevent them from happening again or to protect the agency, that this group and/or board can make comments to the agency early on in the process. Is there a way that this organization's perspective can be heard when rules and regulations are made? Dr. Geary stated that Rick Harris would be presenting at the conference on sexuality and assessment of competency. When problems develop in more than one nursing home, it was suggested that the board could work together to develop some suggestions. Dr. Geary further stated that BHPS works closely with ANHA and recently had a meeting on intimacy and sexuality in dementia and institutionalized residents, and that Mr. Harris would be sharing the presentation at this meeting. It is important that resident safety and autonomy be respected and that the opinion of the administration and the physicians are respected. Rick Harris and the BHPS do not make any rules. Rules have to be approved by the State Board of Health. Rick and the bureau develop commonsense approaches and guidance on policy – how the agency will view individual policies which allow residents to be sexually intimate in nursing homes. If a resident has dementia and is living in a locked unit, this person is not a competent decision-maker. Dr. Harrison commented about a married couple in the nursing home and one has dementia. Dr. Geary reiterated that residents have to be protected unless able to make competent decisions for themselves.

As a lead-in to the next agenda item, Dr. Hays made comments about the role of the medical director with the Department of Public Health especially during a survey. Some facilities are very reluctant to allow the medical director to make any phone calls to Dr. Geary or to anyone at ADPH during a survey. During the survey, there was an issue about a determination of death in the nursing home; however, the physician's voice was not heard in that survey. The hours the surveyors spent talking with the physician were not reflected in the survey report. What is the doctor's role in the survey process? How can the doctor have a role if the surveyors don't listen to what we have to say during a survey? When is it appropriate to call Dr. Geary? Facility staff panic during a survey, are fearful of the surveyors and don't want anyone to be upset. Dr. Geary responded that there are two determinations that surveyors make onsite: one is strictly set forth in the regulations, interpretive guidelines and investigative protocols of the State Operations Manual; and the other is a judgment call. For example, a surveyor might raise the question: "why didn't they get another pro time three days after the last PT/INR?" for a resident with GI bleeding three days after a normal PT/INR. The surveyor talks to the physician who provides a reasonable explanation. The surveyors would probably accept the physician's reasonable explanation; however, this conversation might not be reflected in the form 2567 - Statement of Deficiencies. Dr. Geary further stated that in years past, when working as a Medical Director and attending physician, administrators have called him stating the resident had a pressure sore and requested that he write a note about it being unavoidable. In this case, the surveyors are

going to complete their investigation and review the medical record. Was there an assessment? Were policies and procedures followed? Was the physician aware of it? Was treatment initiated? Was treatment monitored, and was the treatment adjusted? The surveyors will review everything surrounding avoidability. This is outlined in the investigative protocol at F314. In some cases, it doesn't matter what the physician says when surveyors are determining regulatory noncompliance. There was a question whether physicians ever call Dr. Geary during a survey and the response was "yes". Additionally, the surveyors often call for guidance about clinical issues. Dr. Geary provided several examples of clinical guidance provided to surveyors during a survey. Sometimes based on a physician's call about a wound, Dr. Geary has contacted the surveyors for clarification and provides guidance. But he does not intervene in the survey team's decisions. Dr. Geary stated that he appreciates receiving calls during a survey. Even though Dr. Geary does not intervene in the survey process, he can be actively involved in the QA process. He stated that BHPS has a rigorous QA process which means if the survey team did not conduct a thorough investigation and lacks proof of a deficient practice, the deficiency is deleted. Dr. Geary encouraged the physicians to call him about issues. It would not be very beneficial for a physician to call Rick Harris during a survey and voice concerns about the survey issues. It would be more appropriate to contact Rick Harris through a letter after the survey is completed to relate concerns. Several voiced that they have called and it is an effective process with positive results. Dr. Geary reiterated that he has very little impact or input into regulatory processes that are prescriptive; however, he can make a difference in areas of judgment. Dr. Reeves again requested that this association or the Board be involved before decisions are made about how regulations are interpreted. He suggested that, for example, when the sexuality issue came up, Dr. Geary could get the ALMDA board involved in how competency and consent will be determined. Dr. Reeves and others suggested sending an email query. Another suggestion was to have an ad hoc committee that could quickly meet with BHPS to offer input. Dr. Geary stated that the committee previously had four meetings each year. The problem was low attendance and difficulty in coordinating schedules and travel. It is difficult for the agency to solicit comments and lengthy discussions after a survey is completed due to the time frames required by CMS. Many times, the Regional Office requests changes in the Statement of Deficiencies. In addition, physicians should note that the Regional Office monitors the work of the state agency as the agency monitors long term care facilities. Dr. Hays commented that perhaps a couple of weeks or a month after a survey, would it be possible for a small group of people to get together to discuss what the outcome of this survey is going to be on the state? Based on what happened during a survey, how will that affect the other nursing homes? Dr. Reeves commented his concern about as these interpretive guidelines are developed, more rules will be added. Dr. Geary commented that this issue about sexuality was brought to the attention of the Alabama Nursing Home Association, information was transmitted and expert opinions were sought. As a result, a state-wide meeting was planned and conducted. Dr. Harrison asked if AMDA was involved in the planning process. Dr. Geary responded that AMDA was not involved before the meeting but probably should have been. Katrina Magdon, ANHA, stated that information about education seminars are transmitted to all facilities. Dr. Yates commented that AMDA should not only be involved in the planning but also in the presentation. Katrina Magdon commented that Dr. Richard Powers, Teppa Snow, a dementia expert from North Carolina sponsored by ANHA, and Rick Harris were involved in the planning process. Some of the physicians and facility staff attended this training. It was recommended that notices of training be sent to the medical directors. This information is available in the ANHA Weekly

Round-Up. Dr. Harrison commented that when recommendations are written that affect medical directors, could these be published for ALMDA? Dr. Geary stated that face-to-face meetings would be more effective since the BHPS just provides non-binding information leading to a reasonable approach to an issue – as opposed to the Feds who produce written guidance. Dr. Hays stated she is interested and Dr. Yates stated that prior to such a meeting, the physicians need to know the issues so they can be researched. Dr. Geary stated that these meetings could be held in Montgomery or, if preferred, Birmingham to make it more centralized and more convenient to attend. Dr. Geary stated that he will discuss this proposal with Rick Harris. There was a discussion about the need to have every medical director's email address. Katrina Magdon stated that she will work on developing an email listing of medical directors in the state.

Dr. Harrison discussed the issues surrounding the control substances rules from the DEA. It involves the locked medication boxes. The DEA has taken the position that the nurses at nursing home are not the physicians' agents. In the hospitals, the nurses are considered the physicians' agents. In Dr. Harrison's opinion, since medical directors are employees of the nursing home, then the nurses would be our agents. Katrina Magdon commented that ANHA was told that because a hospital has an institutional pharmacy, the hospital nurses are agents. In a nursing home, if you have an institutional pharmacy located in the building, this is not an issue. Louis Cottrell commented that this would probably require a congressional action. Dr. Hays stated that this issue would be discussed at the AMDA meeting. Dr. Geary suggested writing your congressman about the issue. Dr. Yates stated that recently the Senate on Aging toured a nursing home and the medical director explained this issue about the drugs in detail. Dr. Geary stated that all the surveyors are aware of this issue. If there is an unavoidable delay in getting pain medications to residents and complaints are received, the survey team will take this into consideration. Facilities would not be cited at F309 for delays in addressing pain due to DEA pharmacy issues beyond their control.

The final agenda item was: Do not Resuscitate Orders and Determination of Death in the Nursing Home. Dr. Barthold began the discussion. Dr. Geary noted that the resident (and family) under discussion requested that she be a full code – and the facility did not attempt resuscitation. Dr. Hays stated that the same situation happened at her facility. There was a lengthy discussion about when a person is actually dead. Dr. Hays stated she spent hours talking to surveyors over the definition of "dead". The nurse did not document a measure of the amount of dependent lividity in centimeters or inches in the nurses' notes. Due to this situation, a new policy was initiated which is, in her opinion, unworkable. It requires that everyone's code status reverts by default to "full code" until the physician has entered a hand written (FAX unacceptable) "do not resuscitate" order in the char, and DNR orders on transfer are not acceptable. A family member stating, "do not code my mother" is unacceptable. Dr. Harrison stated that a resident who had a purple bracelet (do not resuscitate) fell and broke her hip. As she was being transported, she arrested, and EMTs began coding her. This is following state law. The Medical Association has been working on the DNR issue for about two years, and this organization (ALMDA) has been discussing this issue for about fifteen years. Dr. Harrison asked: "how many employees are certified ACLS? What is the percentage of success in a code?" Dr. Hays stated that the impression that the surveyors gave the nursing staff is that they could be charged with murder if CPR is not initiated. Dr. Harrison stated that his first order is call me and the second one is to terminate the code. He recommended that standing code orders be written. Dr. Geary stated that

EMS rules have a variety of situational determinates for a implementing a "Do Not Resuscitate" order in the field, which he listed. This is an entirely different environment than a Nursing Home. Most all residents are seen every two hours in a nursing home. No one can be dead for longer than two hours. This is often charted in the nurses' notes upon death. Many residents on blood thinners bruise very easily and stay cold and their skin feels cool all the time. So body temperature is unreliable. The regulations state that the resident's wishes have to be honored. If the resident is a full code, then they are supposed to be coded. There is no guidance on how long the code must last and who can discontinue the code. For example, an LPN on duty at 2 a.m. is not competent to make a determination of death based on his or her assessment that the dependent lividity is so significant that the resident is too far gone and does not require resuscitation. Such an LPN is certified to begin chest compressions and call 911 and the attending physician for assistance. Dr. Hays stated that all LPNs in her facility are BLS certified. There was a brief discussion about the need for portable DNR orders. Dr. Barthold stated that Richard Brockman is drafting a law that will protect physicians. Dr. Geary stated this is a very complicated issue that will require a legislative solution. Dr. Geary gave a brief definition of the two types of law: common law and statutory law - as he understands the issue of implementing a DNAR order.

Dr. Geary adjourned the meeting and thanked everyone for their attendance.

The next meeting will be held Friday, July 30, 2010, 7:30 a.m., in Terrace Rooms I and II, Bayside, Sandestin Golf and Beach Resort.