

ROUGH DRAFT

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

DATE: Thursday, May 19, 2005 2:00 p.m.

PLACE: RSA Tower, 15th Floor Board Room,
Montgomery, Alabama

ATTENDEES: Don Williamson, M.D., State Health Officer, ADPH
Rick Harris, Bureau Director, Health Provider Standards
Louis Cottrell, Ex. Director, Alabama Nursing Home Association
John Searcy, M.D., Medical Director, Alabama Medicaid Agency
Tom Geary, M.D.
Michael Reeves, M.D.
Malcolm Brown, M.D.
Lee Ann Cole, Ex. Director, Medical Directors Association
Liz Prosch, R.N., AQAF
Mia Sadler, R.N., DHCF
Diane Mann, DHCF
James K. Reid, R.N., DHCF
New Long Term Care Surveyors, DHCF
Carter Sims
Sylvia Foreman
Rocky Ciesick
Sharon Parker ?
Becky Hall, DHCF

In the absence of Dr. Richard Esham, Dr. Don Williamson, M.D. State Health Officer, welcomed attendees to the advisory meeting. He called the meeting to order and thanked everyone's participation. Rick Harris introduced new long term care surveyors to the group and referenced the positive outcomes from the newly developed surveyor training program. He welcomed Liz Prosch, R.N., AQAF (Alabama Quality Assurance Foundation), who replaced Sue Boldin, R.N. and who is in charge of the Nursing Home Initiatives for the QIO (Quality Improvement Organization). He is very pleased with Liz's appointment to this position and praised the work of Sue Boldin. He has been very impressed with the pressure sore initiative and the collaborative efforts of AQAF, the Alabama Nursing Home Association, Medical Directors Association, Ombudsmen, and DHCF. Rick Harris updated the group about the CMS Leadership Summit held in Baltimore, Maryland, which was attended by Liz Prosch, Mia Sadler, Anna Burton and him. At this meeting all of the QIOs and State Agency Directors are in attendance. CMS was presenting awards to those states who had participated in a pilot project about

pressure ulcers. Rick Harris pointed out based on this meeting, how radically different Alabama is from the other states. He stated that Alabama has 85 nursing homes participating in the pressure ulcer collaborative and another large number who couldn't get into the project but who received the materials and are doing aggressive and amazing things about preventing and treating pressure ulcers. We and this initiative will have a huge impact on care. Alabama will be the only state that could achieve and implement pressure sore initiatives. There is excitement about this initiative from AQAF and from DHCF. The next initiative is Culture Change and the same model is being utilized.

Dr. Williamson directed the group to the February 19, 2005 minutes which were circulated to the advisory committee. The minutes were accepted and approved with no changes.

The next agenda item was the DHCF surveyor meetings on April 18, 2005 with Dr. Esham. Rick Harris stated that Dr. Esham met with all survey staff. This agenda item will be deferred to the next meeting so that Dr. Esham can share his impressions with the committee.

Agenda item "Survey Process Issues" will be deferred to the next meeting due to the absence of Dr. Barthold.

Agenda item "The Role of Mid-Levels (PAs/NPs) in LTC" was discussed by Dr. Reeves. Dr. Reeves distributed CMS Transmittal 168. Dr. Reeves had asked the question about nurse practitioners practicing in nursing facilities. He directed the committee to page 6, second paragraph. It is his understanding that the nurse practitioner can see residents in the nursing facility beds indefinitely and no physician was required to see these residents. This is referenced at 483.40(f). For SNF regulations, Dr. Reeves directed the committee to review pages 11 and 12. Under **Dually Certified Facilities**, Dr. Reeves pointed out that the physician knows if these residents fall under Code 31 or 32. On page 12, there is a graph/guideline outlining the responsibilities of the NPs, CNS and PA in SNFs and NFs as to Initial Comprehensive Visit/Orders, Other Required Visits, Other Medically Necessary Visits and Orders, and Certification/Recertification. Dr. Reeves said the exciting thing to him is it means that in the more rural areas where it is difficult to find physicians to see residents, a nurse practitioner could in fact see the NF residents as frequently as required. This allows a medical team to see that resident and for the nurse practitioner to look at the global needs of the resident.

Dr. Williamson reiterated that in a dually certified nursing home, the Medicaid residents are NF residents so the nurse practitioner or PA can see all of these residents all of the time. If the resident is a Medicare resident, then only every other visit can be conducted by the nurse practitioner or PA. Dr. Brown and Dr. Geary pointed out at F388 483.40(c)(3) and 483.40(c)(4), the physician may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. Dr. Williamson stated that in a dually certified facility, a Medicare resident will be in a SNF bed and for that resident a physician would have to see that resident every other visit. For 72% of the residents, that are Medicaid covered, a nurse practitioner or PA can cover physician services. Dr. Gerry asked the question is it the resident or the bed? Dr. Williamson stated that it would have to be the resident. Dr. Geary stated that in his facility all beds are all designated as skilled beds. There is not a particular section for skilled versus nursing facility. Dr. Reeves stated it is based on the payor for that resident's bed. The facility knows what the payor is whether it is Medicare or Medicaid.

This opens the door to provide better medical coverage to residents, especially in rural settings. Dr. Williamson posed the question, “do nurse practitioners and PAs operating in Alabama in a private office setting, have to operate under an agreement with a physician?” Dr. Reeves responded that there has to be a collaborative agreement. Rick Harris stated that based on the discussion that this is a correct interpretation of the rule. From a policy point of view this would be a good thing and we should let CMS know that this is our interpretation of the rule. Previously, DHCF had interpreted this rule as every other visit was required to be conducted by a physician. Rick Harris agreed that this would provide greater medical access for residents. DHCF believes that nurse practitioners working in nursing homes are doing a good job. Dr. Reeves stated with weight loss medication issues and other medical issues that haven’t been brought forward the nurse practitioners will look for these issues and bring them forward for action. The nurse practitioners are able to address these issues before they become problems and get out of hand. Rick Harris stated that he has a meeting in Atlanta with the RO in two weeks and will bring this topic up for discussion. Mia asked the question about the QA committee and if a physician should continue to be a member. Dr. Reeves responded that in his opinion, the physician or medical director should continue being involved with the QA committee. Based on this discussion about the use of nurse practitioners and PAs, Louis Cottrell asked if clarification would be sent out to nursing homes. Mr. Cottrell stated that this is helpful especially for those facilities in rural areas. Dr. Reeves discussed what nurse practitioners may sign. Table 1, page 12 clearly delineates what may and may not be signed. The nurse practitioners are employed by the physician and not by the facility. They may sign certification and recertification subject to state requirements. Rick Harris stated that Alabama does not restrict nurse practitioners. It does require that they have an agreement with a physician. Dr. Reeves asked if this discussion of the rule interpretation can be taken back to his CEO and staff. Rick Harris responded that this discussion can be repeated.

Rick Harris discussed with the committee an update on a “Portable DNR Form.” Dr. Geary has a copy of Washington State’s form and will forward a copy to Rick Harris. Rick Harris stated that he has talked to executive directors and lawyers of provider associations that would be affected by a portable DNR form. This would include the nursing home association, the hospital association, hospice association, assisted living association, and the ambulance association. All agree that this would be of value. What is keeping this from moving forward is the perceived need to address the whole advance directive issue. The advance directive law needs to be re-visited and revisions made. This has been overshadowed by the controversy surrounding the Terri Schiavo case. Representative Brewbaker introduced a bill in the legislature that essentially reflects that you can not remove a feeding tube absent explicit, written advance directive from the resident/patient. The house judiciary committee met and at the urging of provider groups, appointed a study committee to review advance directives. The health department will move forward on portable DNR form because it is not controversial, is supported, a law does not have to be passed and can be accomplished through a rule change. There is a meeting to discuss these issues in June in the RSA Board Room. Invitations will be extended to interested parties including the Medical Directors Association. Rick Harris is an advocate of discontinuing the DNR bracelet and just having the form. The most difficult issue will be whether the form will be mandatory. There are three options: are

we going to say that if you are going to write a DNR order in any licensed health care facility in Alabama, you must use this form; or are we going to say this is an optional form and not required; or are we going to say if you use this form, it becomes portable, goes with the patient and the receiving facility must honor the form. Dr. Reeves clarified stating that a portable DNR form does not mean a bracelet, but an actual paper form. Rick Harris confirmed this is correct and accompanies the resident/patient from one facility to another. Dr. Reeves stated that for the residents they serve, these documents are located in medical record charts. When the resident is transferred to the hospital, these forms are frequently not sent. If this new system is put into place, how can you make facilities more diligent in sending the DNR form? Most communication Dr. Reeves receives from the receiving ER, whether or not the patient is a DNR. Rick Harris stated that perhaps something that is easier to send can be developed. The bracelet also raises HIPAA issues and patients do not like them, especially the hospice community. It needs to be very simple to determine if the patient is a DNR. Dr. Geary discussed the Washington State form which is bright pink. They did a study after the form was introduced and there was 85% compliance in terms of transferring the form with the patient. Currently nursing homes have white pages and everyone has something different and it has to be copied so that the sending facility has the original. The pink form goes with the patient to the hospital in Washington State. The hospital has clear instructions as to what to do. The form then goes back to the nursing home. Dr. Williamson asked if this is done by statute. Dr. Geary responded that is done by statute. Dr. Williamson said the question for discussion is: are we going to mandate this or will it be voluntary. Dr. Reeves commented if mandated, what effect does this have on the individual. Does this mean if a resident is admitted to a facility that he/she must decide about DNR. Some residents do not choose to make their wishes known. Rick Harris stated that DNR is a small part of advance directives. The problem with advance directives is the law was written by lawyers who represent providers. There were never any practitioners at the table. Rick Harris pointed out the importance of practitioners being involved in this upcoming meeting and raising these issues. He believes that a workable system can be developed and implemented. The physicians expressed interest in being involved. Dr. Geary stated that he was made aware of the Washington State procedure by a palliative care representative in Birmingham. He then went online, found information from the article where Washington State evaluated the effectiveness of the system and printed a copy. Dr. Williamson ended this discussion by saying this would be a win situation for all involved associations and patients.

Dr. Searcy gave a brief Medicaid update. Medicaid needs \$161 million in the '07 year. Medicaid will be sent forth a budget that has zero dollars. It was discussed that the \$161 is state money which is \$530 million total dollars. The total budget is 4 billion. This represents approximately one-eighth of the budget, a 12 and a half percent reduction. The 161 figure does not have a number in it for how much it is going to cost to have Medicare pay for drugs instead of the state paying for these drugs. Dr. Williamson said that Part B Medicare concerns him the most due to the confusion caused. Dr. Searcy said that a large number of people will be without medications. Dr. Williamson is concerned about the different plans that may be selected; medicines that will have to be changed to match the plans; if formularies will have to be changed every 60 days; and confusion for providers and physicians. Dr. Searcy said that once the patient selects a plan, he/she is locked into this plan for a period of time. Rick Harris stated that the insurance company can change the

formulary but the patient can't change the insurance company. There was a discussion about those with dual eligibility who can change in 30 days with a 30 day notice. Dr. Searcy stated that dual eligibility represents 88,000 people which is a small part of the pie. Dr. Searcy stated that the cost per prescription is about 2 to 3% increase this year as compared to last year. The pharmacy program as a whole has been growing 18 to 20% per year. Dr. Geary said that he has been asked to be on the Blue Cross Pharmacy Therapeutics Committee representing the elderly. Efforts are being made to get their formulary to coincide with the Medicaid present formulary.

Dr. Williamson and Rick Harris adjourned the meeting. The next meeting will be on Saturday, July 23, 2005, from 7:30 to 8:30 a.m. at Sandestin Golf and Beach Resort.

