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

DATE: Saturday, July 22, 2006 7:30 a.m.

PLACE: Link Side Terrace Rooms 1 & 2
Sandestin Golf and Beach Resort
9300 Emerald Coast Parkway, West
Sandestin, Florida

ATTENDEES: Richard Esham, M.D., Medical Director, DHCF
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
Harrison Wallace, Dep.Dir., Bureau of Health Provider Standards
Malcolm Brown, M.D.
Charles T. Nevels, M.D.
Dick Owens, M.D.
Jimmy Davis, M.D.
Tom Geary, M.D.
Jerry Harrison, M.D
Dick Rutland, M.D.
. Michael Reeves, M.D.
Thomas Stevens, M.D.
Kevin Jackson, M.D.
Phil Sisk, M.D.
Alan Gibbs, M.D.
David Barthold, M.D.
Mia Sadler, R.N., DHCF

Dr. Richard Esham welcomed attendees to the advisory meeting and thanked them for attending. The minutes of the last meeting were circulated and approved. The first item discussed was contracts between the Medical Director and Nursing Homes by Dr. Furr and Dr. Webb. The contract that was reviewed involved the role of the medical director when the attending physician was not doing his job by not performing history and physicals. That role is directed back to the medical director; and therefore, the attending physician can not charge for that service. The part about not being able to charge for the assessment is confusing as is, and the legal reason why the charges are not allowed. Dr. Harrison responded that you can't do a history and physical without charging. The law needs to be researched about this. If you don't charge one Medicare

patient, you can't charge any Medicare patients. Another physician stated that Medicare is required to pay for are those items spelled out in the regulations and what is medically necessary. It was discussed that no one has ever been denied a charge that has been submitted. Dr. Reeves commented that here in Alabama, physicians are probably under seeing patients. Some physicians in his organization have been denied payment by Medicare. In Florida, some patients are seen three to four times a month and there have been denial of payment. Mr. Cottrell commented that most long term care facilities are probably using contracts that their attorneys are giving them. He encouraged the physicians to review the contract carefully and if there are problems to address it. If there are widespread problems about the specifics in contracts, ANHA attorneys can review these. Dr. McRae encouraged the physicians to email AMDA with questions about contracts and payments.

Dr. Esham stated that the Medicaid report from Dr. Searcy was deferred until his arrival.

Dr. Esham stated that Dr. Webb was next on the agenda to discuss "RAI Coding Instructions for Pain and Quality Measures." Rick Harris was unable to attend the meeting due to his father's illness. Before Dr. Webb's report, Dr. Esham and the group congratulated and applauded Dr. Harrison's election to the Alabama Medical Association Board of Censors. This means that AMDA now has two seats on the fifteen member board. Dr. Esham stated to have this kind of representation is very strong. Dr. Harrison will carry forward the issues that are important to long term care patients and their physicians who provide their care. Dr. Esham encouraged the group to remain active. Dr. Webb addressed a question that was brought forward in a facility's performance improvement committee meeting. When the data that Quality Measures are reported publicly from the MDS, the pain score question can be unfair. The pain score question is: do you have pain, what is the frequency of the pain, and the severity of the pain. Most of the patients in our facility have aches and pains every day and especially those patients receiving rehab, in their knees and hips. These patients get scored high and it appears that it gives us an artificially high score on that pain question. Is there some way to supplement that question to include: is the pain relieved by the treatment given? The question does not differentiate whether the pain was treated. The second part involves those patients who choose not to take a lot of pain medication because of the side effect and prefer tolerating the pain. The question does not always address the issue. Dr. Harrison responded that in pain studies, the pain scores are very unreliable. In his facility, the survey team wrote a tag because the resident gave the pain a score of ten with no relief. Dr. Webb stated that we need to improve on the scoring system. Dr. McRae responded that this would be a good question to ask AMDA at the national level. Facilities are getting criticized on the basis of one or two responses about pain. Dr. Webb stated that the facility is penalized because of the way the questionnaire was developed. Ms. Sadler stated that it was her understanding that if the pain medication relieved the pain and there is no break-through pain with the pain medication, then it is not scored as pain. This is being observed during a seven day assessment period. Then the surveyor would verify that the pain was assessed and treated. The issues raised would not affect scoring and the quality measures as to how that falls out. If the resident has pain that is relieved, this should be well documented in the RAP assessment. The RAP assessment should clearly outline what the facility is thinking. The RAP assessment document would

explain the concerns that you have voiced. The Quality Measures themselves are not actual indicators of poor care. The Quality Measures/Quality Indicators are one piece of information for surveyors to consider. For example, a facility may have residents who develop pressure sores which were unavoidable. Even with proper care and treatment the residents still developed the pressure sores. This will still trigger on the QM/QI reports as a potential concern. Ms. Sadler offered to provide assistance if the facility had questions and concerns. The facility may provide surveyors with additional information on-site. Ms. Sadler reminded the group that the MDS is a minimum, basic screening assessment involving coding and in many cases, requires additional investigation and assessment. This should be well documented in the RAP assessment which describes risk factors and the issues the residents have that contribute, such as refusing to take pain medication, and how the facility plans to manage the issues or risk factors. Dr. Webb again stated that with these Quality Measures being published and accessible to the public, it appears, for example, that the facility has 16 % of its residents having chronic, unrelieved pain. Ms. Sadler stated that in the Offsite Task of the survey process, the Quality Measures/Quality Indicators are assessed. When there are high numbers, care areas are triggered as concern; however, during the survey, the surveyors learn that the facility has a hospice unit or a rehab unit which would explain the high percentiles. This is a starting point; however, it is understood that it may give a false impression to the public. The RAI is a national program which is constantly being reviewed and revised. Ms. Sadler encouraged the group to make suggestive revisions to the RAI to CMS.

Dr. Esham asked Dr. Harrison to address the next agenda item: Status Report: Universal DNR. The legislative DNAR law is proceeding slowly. ADPH is rewriting the Emergency Management Services (EMS) rule: “EMS will not institute a code if there is no DNAR form.” A question was asked about the concerns of the Hospital Association. Dr. Harrison responded that hospitals don’t know that this protects them and hospitals don’t know if it is an informed consent. Dr. McRae responded that the ER physicians are uncomfortable. There was a discussion about the Alabama National Death Act which allows the nursing home to pronounce without transport to the hospital. Dr. McRae stated that it is important for Medical Directors to routinely ask administrators and staff about codes in plain language. Dr. Webb added that he has information on the myths of CPR. He will distribute copies and a True/False Myths Fact Sheet to Ms. Sadler, Mr. Cottrell, and Ms. Cole. This information reviews the pros and cons about CPR.

For the Legislative Update: 72 Hr. RX Class II, Ms. Sadler distributed copies of the actual act and a one page summary from the Board of Pharmacy web site. This allows long term care facilities, hospice and home health agencies to give an oral prescription of Scheduled II medications for 72 hours. Pharmacists can only dispense enough doses for the 72 hours. After that time, the practitioner, within seven days of the emergency oral prescription, will provide the dispensing pharmacy a written prescription of the quantity prescribed. Dr. Esham added that electronic prescriptions are still an issue and provided an update.

Dr. McRae and Ms. Sadler briefly discussed potential evacuation plans and facilities building status in the event of a hurricane or other environmental threat. Ms. Sadler further stated there is a software program that will allow ADPH to know of available beds. Facilities are encouraged to develop a workable plan for sustainability.

ADPH is developing a check list. There was also a discussion about physicians volunteering in other states and the requirements that must be met.

There was a discussion about future CMS guidance changes and enhancements in pharmacy, pain and immunization programs.

Dr. Geary discussed the problem with the ALF rule and regulations requiring annual physicals. He requested the timeframe be extended to ten working days to allow physicians to bill and be reimbursed. Ms. Sadler stated that Dr. Williamson, Mr. Harris and she agreed to the ten day extension.

Dr. Esham adjourned the meeting and thanked each of the participants. The next meeting will be held on Saturday, February 17, 2007, Hilton Hotel, 8 Perimeter Park, Birmingham, Alabama.