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

DATE:	Saturday, July 25, 2009	7:30 a.m.
LOCATION:	Sandestin Golf and Beach Resort Sandestin, Florida	
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 Rick Harris, BHPS Louis E. Cottrell, Jr., ANHA Katrina Magdon, ANHA Robert Webb, MD, Board Chairman Jimmy Davis, MD, CMD, President Michael Hanna, MD, CMD Robert Moon, MD Malcolm Brown, MD John MacLennan, MD James R. Yates, MD Jerry Harrison, MD Clare Hays, MD David MacRae, MD Dick Owens, MD John Wagner, MD David R. Barthold, MD Henry Baily, MD Mickey Dichiara, MD Kelvin L. Jackson, MD Joe Downs, MD Steve Furr, MD Michael Reeves, MD Diane Mann, BHPS	

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

The first item of business was the progress on changes to the determination of cognitive status in residents of regular Assisted Living facilities. Dr. Geary reviewed the Agency's concerns about using the Mini-Mental Status exam in assisted living facilities. One concern is

that surveyors might have to conduct mini-mental status exams on numerous residents of an assisted living facility because surveyors didn't believe that the staff's exams were correct. In addition, the staff might suggest that the survey's exams were not correct. This problem has not been resolved. Dr. Geary will be talking to Dr. Powers on August 7 and will be discussing this concern and will provide an update to board members.

Dr. Geary expressed concern that the patients' physicians come under an enormous amount of pressure from the families and administrators to document certain things to facilitate admission and retention of residents. One problem that has been seen in Specialty Care Assisted Living Facilities relates to people who are very sick at home and the family can no longer care for them. They are admitted to the SCALF on day # 1; and on day # 2 are admitted to hospice for failure to thrive. They stay on hospice for a long time, for example a year and a half. They are bedfast, with bedrails in the up position and are totally dependent for feeding, toileting and all care. What people think they are doing is skirting the regulations that require transfer of skilled–care residents. The actual rule states that if you are living in an assisted living facility and you have a terminal illness, you don't need to be transferred elsewhere to die. The point of the regulation is not that it is a loophole to admit residents from the hospital or home so they can avoid going to a level of appropriate care (skilled care) in a nursing home. Some facilities are using this as a way to get around the regulation.

The next item of business was to introduce Dr. Moon to discuss "Negative Pressure Wound Therapy." Medicare initially stopped paying for negative pressure wound therapy but then worked out criteria and will now continue to pay for this modality. He wanted to make sure that the board was aware of available literature on wound vacs. Medicaid will continue to study this issue with respect to payment for NPWT. A study published last year indicated that wound vacs are no better than other wound care modalities and there are other interventions that are a lot cheaper. There was a discussion about wound vacs and wound care centers.
Dr. Geary stated that Alabama is the best state in Region IV and is doing well in respect to the nation in terms of pressure ulcers. This is a testament to this group and to all the hard work on this issue by your nursing home staff. Dr. MacRae added that wound technology is changing and sometimes not clear. Some wounds heal and some don't. Just because literature and scientific studies may be inconclusive does not mean that we should reject wound vacs.

Dr. Geary introduced the next agenda item: AQAF Update. Diane Richmond, formerly with UAB, was introduced. AQAF is contracted by CMS through the Office of Clinical Standards and Quality. This office is directly responsible for QIOs across the country. Every state has a QIO. QIOs are not regulatory. They assist providers with improving their care processes related to management of the Medicare beneficiaries. This ninth scope of work as defined by CMS limits the number of facilities that the QIO works with. The Alabama QIO has a list from CMS that the QIO is required to collaborate with for this scope of work beginning August 2008 through July 2011. The themes for this two-year period are listed in the hand-out given to each participant, but the traditional theme of beneficiary protection continues. There is also a patient safety component in which the QIO has a lot of interaction with nursing homes. Two themes that Ms. Richmond addressed were pressure ulcers and restraints. These were selected because of the extensive literature that supports how these care areas should be managed to reduce harm to residents. The graph in the hand-out shows the work in the state of Alabama compared to the region and the nation. The state of Alabama is doing extremely well in the

management of restraints. Alabama is leading in restraint management. Ms. Richardson also addressed the nursing homes in Alabama that have been identified for the QIO to work with in the reduction of restraints. However, the interim target has been met and the overall target will be met at the end of the scope of work. The next area discussed was pressure ulcers. Alabama is doing much better than the other states in our region and the nation. Within the group identified by CMS as targeted for assistance, the picture is not positive. Some progress is being made toward the goal. For example, the goal in restraint utilization for the nation is 3% or less utilization. For pressure ulcers, it's 6% or less. In the nursing homes, it is difficult to differentiate those who were admitted with pressure ulcers in the reporting process from those who acquired them in the nursing home. In subsequent MDS tools, we expect the reporting to be more reflective about pressure ulcers.

Ms. Richardson discussed a new project that CMS will implement in August: the rural focus project. Many of the rural states did not have nursing homes on the J17 list from CMS. The patient safety project was expanded by making the assistance of the QIO available to focus facilities in rural areas. CMS supplied an additional list to the QIOs to recruit. These nursing homes have not been recruited as of this date. When nursing homes are recruited by the QIO, they have to agree to participate. CMS expects all nursing homes contacted to participate; however, it is voluntary. According to the focused facility tables, the A table shows facilities that were recently put on the list. The B table reflects nursing homes that have made no progress. The C table reflects those homes that have made progress and will most likely graduate from the list. There are only two facilities in Alabama on these lists: one is on the C table and one is on the B table. The B table facility has agreed to participate with the QIO. The QIO will conduct root-cause analyses that are in any of these components and not just pressure ulcers or restraints. The QIO will help the facility resolve deficiencies and improve their ability to provide quality of care and to pass state inspections.

Care transitions is not one of the components that the Alabama QIO has been working with, but it is one of the themes that CMS is very interested in because of the high cost of readmissions, particularly those within 30 days. This describes a project currently in progress in the Tuscaloosa area where the readmission rate for this population is about 20%. Even in the National Quality Forum that met last year, there was a lack of knowledge about coordinated care; however, we do know what care looks like when there is not coordination of care. One of the areas of focus is heart failure and how it should be managed across the continuum of care; what should be done to prevent the 30 day re-admissions. Ms. Richardson discussed the concept called "Interact." This was designed to help reduce those acute care transfers back to the hospital that are unnecessary. Nursing homes can benefit from this on two levels. It should help staff be able to differentiate when to call the physician and what things are significant enough to return a resident back to the hospital. This study was conducted in Georgia. Ms. Richardson recommended that the study be presented at the ALMDA Winter 2010 meeting, to include the successes they had in reducing re-admissions. Additionally, AQAF worked with nursing home leadership and their nurses in getting them to use this algorithm that would assist them in knowing when to call the physician, what is immediate, what can wait until the next day, what can wait until the normal routine and when it is absolutely necessary to return the resident to the hospital. She asked the group what AQAF could do for them to better help them manage their patients. A question was asked about the correlation between restraints and falls; for example, a

resident who repeatedly falls. Dr. Geary discussed this with the group and reminded them of his presentation on restraints last year. There was an article distributed at that time about this topic. Dr. Geary reminded them that every device has a potential for harm. It doesn't matter if you call it a restraint or an enabler or a mobility enabler, the device, whether it's a bedrail or a chair, has some potential for harm. The facility has to go through a rationale process to determine the risks and what the resident needs to use the device. Dr. Geary's prediction is facilities will eventually have computer-assisted technology that will allow 90-year old residents who have had strokes to walk. Even with sophisticated technology, there will be risks and benefits. Facilities need to assess the risks of the device, whether a restraint or an enabler, to the resident to ensure that the resident benefits and is not harmed. Dr. Harrison stated that it should be a risk/benefit ratio. He suggested that we assess for the benefit. For example, the resident who uses the merry walker ambulation device is able to do things that otherwise were not possible. Ms. Richardson said that the goal is not for a restraint-free environment, but for appropriate use. Dr. Geary stated that the new MDS 3.0 will contain a variety of newer approaches to these kinds of mobility devices that will allow different coding so that data can be better analyzed. Dr. Yates stated that transition of care is a hot topic. Joint Commission has already sent information to hospitals about it. There is a National Transition of Care Committee and legislation before Congress that views current practices as wasteful. Ms. Richardson stated the worst thing that could happen is bundling the reimbursement. She is concerned about this as it would not help us do the care in the manner that it should be done.

The subject about the Georgia study was discussed again. Dr. Hays has heard this presentation and praised it. She has attempted to implement some of this in her facility; however, she commented that the concept of SBAR communication to the average LPN is very difficult. This is the staff person who calls the physician the majority of the time. LPNs are not trained that way and fail to understand. Ms. Richardson stated that they are having some success at the nursing home because they took the Department of Defense's concept of team steps and carved out that piece to just train SBAR (Situation – Background – Assessment – Recommendation). Dr. Hays stated that it requires some assessment skills of LPNs. Usually LPNs have task skills but not assessment skills. Ms. Richardson stated that in "Interact," templates were developed around care paths so it is outlined for the LPNs. It is packaged in a SBAR format. There was a comment that a sick patient in a nursing home takes up more time of a facility than it is staffed for and sometimes the facility is marginally staffed. The nursing home wants the patient to go back to the hospital so care can be rendered. When the patient's condition is improved, then the nursing home wants the re-admission. Another comment was that financial incentives are aligned to make this financially advantageous.

Dr. Geary introduced the next agenda item: Cell Phones in Nursing Homes. This came about from an email received from the Alabama Nursing Home Association about cell phone use and a protocol for cell phone use in nursing homes. Katrina Magdon, Alabama Nursing Home Association, said that they attended a Region IV meeting in Atlanta. At this meeting it was discussed that in one state, Tennessee, facilities had received several immediate jeopardy citations. Staff had taken very explicit, inappropriate cell phone pictures of residents and posted these on YouTube with sexually explicit RAP music. Everyone was shocked and it had happened repeatedly. There should be appropriate use of cell phones as staff needs to be able to take calls, including emergency calls. Dr. Harrison described a situation where the nurse practitioner was

assessing a wound, took a picture of the wound and sent it to him to review. This better contributed to prescribing the appropriate care for the resident. Just because there were deviates inappropriately using cell phones shouldn't result in everyone being punished. Those staff should be prosecuted. Another comment was that one way staff could communicate was through cell phones. Rick Harris stated there have been two instances in Alabama where nursing assistants took inappropriate pictures. It was investigated and appropriate actions were taken. The facility was not cited at immediate jeopardy. He further stated that he couldn't speak about how the Tennessee State Agency handles their cases. If CNAs are appropriately supervised but do something that is clearly inappropriate, unreasonable behavior and the facility responds, investigates, and takes appropriate action, the facility probably won't be cited. Facilities have to develop their own policies about the use of cell phones. Dr. Geary commented on a template policy that was developed as a possible policy: "The facility prohibits the use of concealed audio, video or photographic devices of any kind in or on the grounds of the facility." This would immediately adversely affect family, physicians, and nurses.

Dr. Geary introduced the next agenda item with Dr. Harrison: Availability of Medical Literature in the Nursing Home, being able to search literature. Dr. Harrison discussed a handout presented to MASA. This hand-out has web sites that are useful. Dr. Harrison will make this information available.

Dr. Geary introduced the next agenda item along with Dr. Reeves: Concerns about Excessive Laboratory Studies in Nursing Homes. Since it was discussed at the previous meeting, Dr. Geary has completed further investigation. He reviewed the State Operations Manual and in the pharmacy section, there are explicit statements in many drug categories that require monitoring. Surveyors would review this requirement. In addition, since the last meeting, the agency had a look behind survey where the federal surveyors review the state's findings. The agency was cited for not citing lack of therapeutic laboratory monitoring for Dilantin in a particular resident. Unless concerns are communicated to the national level, physicians should review the recommended monitoring. In researching the drug Dilantin, it was recommended that you get an albumin level to accurately calculate the actual available Dilantin as it can be toxic even at a normal level for those with low albumin. The consensus of the articles reviewed suggests that monitoring is medically necessary. Most information to patients states that your physician will be doing laboratory tests in order to monitor while the resident is taking the medication. There are also legal considerations. Dr Reeves responded, for example, the physician orders monitoring the Dilantin level every six months. But what about monitoring it every day since at any point in time, the level is likely to be abnormal? The focus should be away from making assessments based on diagnostic studies. Our assessments should be based on clinical aspects. Dr. Harrison asked about information in the SOM so it could be reviewed for comment in an appropriate manner. Dr. Geary responded that he would summarize the SOM in this area and what the surveyors would be reviewing. Rick Harris responded that if there are concerns about interpretative guidelines, he would submit these to CMS in August. Dr. Geary added if the physician has written a very comprehensive note explaining why he doesn't believe that for this resident, the diagnostics shouldn't be done at this particular time, it would probably not be a regulatory problem. The problem is that residents are taking so many medications such as anti-seizure medications and Lasix, and no labs have been done in the last year. Dr. Reeves restated that he believes some physicians are relying on diagnostics, are not seeing their patients and not

making clinical assessments. Doing appropriate examinations and not just reflexively getting lab and X-Ray tests would also save money. The key is documenting the physician's rationale.

Dr. Geary presented the last agenda item: an update about Vitamin D. He referenced an article about treating young pre-menopausal women in the state of Maine with Vitamin D and only 80% of the participants reached a level in the therapeutic range. This suggests that physicians should be checking Vitamin D levels after prescribing 800 units to be sure the level will be brought up to the therapeutic range. Dr. Geary recommended checking levels. He stated that in one article, people were using 50,000 units once a month. This reduces the number of pills. Another comment was it should be 50,000 units twice a month. Dr. Geary restated that as presented at the last meeting, optimizing Vitamin D makes a significant difference in reducing falls in the elderly. Another comment was Vitamin D levels were checked in his routine office patients (all ages) and two thirds were significantly low, which includes farmers who are in the sun all day long. He followed the UAB dosing guidelines and for him, it didn't make a difference. Dr. Geary summarized that in frail, elderly nursing home populations, Vitamin D makes a difference.

Dr. Geary apprized the group that the state passed a bill allowing physician's assistants to prescribe control medications, Class 3 to 5. This is effective in October and the rules will be written by the Board.

There was a question about changes in the Interpretive Guidelines. The response was that every time there are changes there is staff education and coordinated training with the Alabama Nursing Home Association. There were changes made to the Quality of Life tags, F309 (pain management) and F441 Infection Control. Five tags were combined into one.

The meeting was adjourned. The next meeting will be held on February 27, 2010, at the Sheraton Medical Forum in Birmingham, AL.