AMENDED
ALMDA/BHPS Medical Directors'
Advisory Committee Meeting

DATE:	February 19, 2011	7:30 a.m.
LOCATION:	Sheraton Hotel Medical Forum 2nd Floor Birmingham, Alabama	
BOARD OF DIRECTORS:	Michael Reeves, MD, CMD, Board Chairman Dick Owens, MD, President James Yates, MD, CMD, Secretary/Treasurer	
ATTENDEES:	WT Geary, Jr., MD, Medical Director, BHPS Robert Moon, MD, Alabama Medicaid Agency Louis Cottrell, Nursing Home Association Katrina Magdon, Nursing Home Association Byron Nelson, MD CMD John MacLennan, MD Chivers Woodruff, MD, CMD Joe Downs, MD Kevin Jackson, MD Kendra Sheppard, MD Steve Furr, MD, CMD Jerry Harrison, MD, CMD John Wagner, MD, CMD	

Dr. Geary welcomed everyone to the meeting. He explained briefly the challenges the Department faces with budget cuts of 15% this year, and possibly 20% next year. He assured the members that the Bureau would still be working with them to ensure good care for the residents.

Dr. Geary informed those present that some corrections had been made to the minutes from the last meeting. He stated that copies of the corrected minutes were available. He then asked if there were other corrections or comments. There were none, and the minutes were approved.

Access to "Ovid"

Dr. Geary reminded the group that they had been talking about access to journals. He related that since the last meeting he had spoken with Diane with Lippincott, Williams, & Wilkins. She informed Dr. Geary that they had hundreds of journals that have the portals to access the information. Dr. Geary stated that he had brought this to the attention of Dr. Tom Miller, who is

now an assistant state health officer, who is interested in this. The packages range in price somewhere between $15,000-$40,000 a year.
Dr. Geary mentioned that the Department of Health & Agriculture has a packet of 20 journals. South Carolina has signed up for that. Dr. Geary was reminded by one of the doctors present that someone from South Alabama had mentioned having journals. Dr. Geary stated that South Alabama, UAB, University of Alabama in Huntsville have 300 journals. Their subscription is with Ovid. Dr. Geary stated it would be an advantage to be able to access an entire article rather than just the abstract. Dr. Geary distributed the information about the availability of the journals.

An impromptu question was asked about bringing nurses and perhaps others into the membership of the Medical Directors Association, due to the present small size of the association. The commenter wanted the group to consider setting up dual tracks in the meetings so as to have a session for the nurses as well as the doctors, sessions geared specifically to the nurses: peer planning, whatever their issues are; that perhaps it would stimulate an interest in the nursing home association to put more of the nurses into coming to the physician program. The advantages would be: (1) hearing talks that were geared to them; (2), they would then be in association with the medical directors they work with, and the doctors they work with and work toward establishing a more cohesive bond so that everybody's on the same page working together. A discussion followed about finding the money for the project, generating interest within the nurse directors association, enrolling those medical directors who are not already members of this association, about the Louisiana Medical Directors association and its involving various disciplines with their own tracks at their meetings.

Mr. Cottrell expressed that it would benefit the nursing home association to have a closer relationship with the Medical Directors Association. He mentioned plans being considered of having a reception at the July meeting involving the administrators and the board of directors of the nursing home association.

<u>Assisted Living Survey Issues – The role of the medical director</u>

Dr. Geary stated that the specialty care assisted living facilities must have a medical director. Those medical directors, in addition to routine medical care, need to be involved with quality assurance issues: the number of falls; the number of elopements; the nutrition and weight loss; skin problems; wounds; and therefore need to understand the regulations and the situation the employees are working in.

Dr. Geary reminded the doctors that they had previously expressed interest in being involved in decision-making at the state health department level. The Bureau is considering a request from the Assisted Living Association and some physicians who are members of this group, to allow intravenous therapy in the assisted living facility.

At the present time, skilled care that is considered beyond the capacity of a regular assisted living facility is not allowed. Regular assisted living facilities usually don't have to have a nurse on staff at all. They have high school graduates (sometimes they're not even a graduate) working as care attendants, and the rules are written in a very broad way to allow these care attendants to assist cognitively intact people with all kinds of activities that are health related:

help with diabetes, with catheters and ostomies, and other things if the resident is able to manage his or her own care. These aides can be trained and can assist residents. If the resident's mental capacity is gone, then these care attendants cannot perform those services: they can't administer medications, manage Foley catheters, can't give injections and eye drops; suppositories, etc. Dr. Geary proposed that the organization talk at their business meeting to come with a designee to work with the Department, the ALF association, some of the providers, and someone from the Board of Nursing, about this issue. In a licensed assisted living facility, having a home health nurse turn over the care and management of intravenous fluids being administered over three days with no nursing observations whatsoever. The highest trained person is the administrator, who may have another job somewhere else and be working as administrator part-time.

The multi-disciplinary committee will meet in Montgomery to discuss these issues.

He went on to say that doctors are used to ordering IVs for people at home. And they make the comparison that there's nobody in the home monitoring them. But actually there is: family members are in the home. We all know what our obligation is if we know that everybody there is an alcoholic or on crack. This is not a situation where we want to send Home Health to start IV fluids to an elderly person, IV antibiotics, or chemotherapy, anything else at home. We need to make some other arrangements. In a licensed health care facility where the people who would be responsible for the observations really have no training or experience, it is a real risk to the home health nurse to delegate care to these people; if something happened everyone involved would likely be held liable for allowing this to go on. This would cause their license to be in question. Public Health would be held liable for allowing this to happen. In addition to the doctor and the assisted living people, I think we need to get together and talk about this; about the real details that are involved. Perhaps this will be the beginning of more dialogue.

A discussion then followed about how improperly some hospices are marketing their businesses, taking advantage of grieving family members, promising care if they will choose a particular hospice agency, bypassing the patient's medical director, and sending the patient on to the hospice to which they are affiliated. It was brought up that the new rules on health care requires the hospice to have a face-to-face meeting with the patient. The face to face could be with an employee of the hospice, but they cannot bill for it. There has to be a face-to-face meeting 30 days before or after admitting to hospice. One doctor asked if it was appropriate for hospice staff to go into a patient's room without their doctor's evaluation. Dr. Geary stated that they can have an initial meeting with the family without violating any rules or laws. Dr. Geary reminded them that signing up inappropriate people for hospice is a violation and the Department would investigate any physician complaint that a particular hospice agency had improperly signed up people for hospice. Dr. Geary informed the doctors that the Department has a section that deals with hospitals, home health agency, abortion clinics, hospices, and other licensed health care facilities, and gave them the name of Carolyn Duck, RN, the director of the Medicare Other unit.

The discussion then moved to DNR orders and codes. Dr. Geary stated that a meeting with the hospital association, nursing home, Richard Brockman, the Department, and Dr. Williamson, is coming up next month. Dr. Geary stated that we have an opportunity, with a physician as the governor, to get some information to the legislators and the governor and his staff of how important this is. He stated he would contact Lee Ann and let them know what comes of the

initial meeting with Richard Brockman. In response to a question, Dr. Geary said he would ask Dr. Williamson about the medical directors association sending a representative.

New business

Survey issues – Dr. Geary said that he would speak to some issues he had run across, and told the doctors he wanted to hear their issues. Dr. Geary related that the Department had an interesting situation with a leg immobilizer and the rigid boots placed on a patient after a fall and fracture in a non-ambulatory person. The nursing staff and the physician did not think about the fact that the boot would increase the person's risk for decubitus ulcers, and they did not generate a plan to take the thing off and look underneath to see what was going on with the skin. So, naturally, the lady developed a decubitus ulcer of the heel. That resulted in a deficiency being cited.

Dr. Geary: The attending physician and the Medical Director must consider the skin problems, not leave this to the orthopedist. They're not thinking about the skin. The ER Doctor or Orthopedist just wants to get them out of the ER, put them in an immobilizer, and send them back to the nursing home. But it's this kind of thought process that we need to engender in the nursing staff, the skin care nurses, and ourselves is when something out of the ordinary. We need to think about that as a risk. We need to sit down or call the DON and say, you know, we really need to think about this; call the orthopedist and ask, how often can we take this off? How many people need to hold and keep the leg immobilized to look at that foot be sure the bottom of the bed is dropped, the pressure is off the heel. Do whatever we can because the surveyors are looking for information not just about whether the ulcer developed or not. They're looking for documentation of the process: Did you think about this as a risk? Did you come up with some kind of plan? Did you put the plan in place and actually do it every day? Did you monitor how well it was doing and if it looked like it wasn't working, did you try to think of something else? Did you call the orthopedist? Did you call the wound care clinic? Did you call the Bureau and talk to me? To talk about what we can do with the immobilizer. Did you do anything? And that's all we're looking for. If you've done that, you're not going to get a deficiency cited.

Another skin problem in a survey was: the surveyors decided that the doctor was not personally involved enough in the care of this skin problem, and therefore, we should not let that doctor be part of the plan of correction. That was overstepping the bounds of a surveyor. Surveyors do not have the authority to limit or regulate or direct a physician's practice. If a physician's practice is so egregious that I believe that should be reported to the Board of Medical Examiners, we will report them, but it is not our practice to tell doctors what to do. So all the survey staff has been advised of that; understand where they're coming from. In the past, if the administrator was stealing drugs and diverting them to people, we didn't let that administrator be part of the plan of correction for stealing drugs in the nursing home. That makes sense. And if it was the nurse on that floor who was negligent in care, and abusive to people, we didn't let that nurse be a part of the plan of correction. So, these surveyors assumed that they could apply that to the doctor as well, but that is not the case. I think everybody understands that this should never happen. If any of you feels like the surveyors are trying to restrict your practice, or tell you how to practice, you need to call me right away, because the surveyors are trying to do what they think is in the best interest of the patients.

I had several other people call and say that the surveyors, although they were very nice, they seemed to be questioning the competency and intelligence of the doctor because they kept asking all of these detailed questions. Our response is the same that we've said all along. The surveyors are gathering evidence in an investigation. The information and evidence will either support or refute what they think might be down wrong in the nursing home. The surveyors have to ask all sorts of questions. This doesn't mean they are questioning the intelligence or the skill of the physician. We're just trying to get the kind of information that we have to have if we're going to say that the nursing home failed to do the right thing by a person, say, in a leg immobilizer. We need to ask all these kinds of questions: what would you do? What would you expect to be done? What does the literature say about heel ulcers? and so on. But those kinds of questions are not directed at any one individual; they're simply ways of getting information about the understanding of the appropriate assessment and care of the residents.

One of the doctors said "Like if they ask me if I've read the package insert on the glucometer." Dr. Geary stated, that's exactly why. But you would not necessarily be expected to have read that. Someone in the facility should have read it. You weren't the only person they asked; they asked the DON, they asked the charge nurse on the unit, and they asked the infection control nurse: "do you know what agent to use to clean it?" Because clearly some of these that are chemical reactants cannot be cleaned with alcohol. Alcohol disturbs the optical function on some of the glucometers. So then you get a situation in which it's clean, but you have absolutely no confidence in the results that you're getting. So that would throw it into another set of regulations, not using your equipment properly. So for every piece of equipment, we ask that the nursing homes get a package insert, or a manufacturer's instructions on how to use it properly, and follow those instructions. If the facility is going to deviate from the instructions, there should be a group decision with physician input, and it's documented. If you're going to deviate from what the manufacturer said, clearly you're running some risks. I've certainly seen injuries from patient lifts being used improperly. You don't spread the legs out, you swing around to fast, you sling them into the walls, all kinds of bad things go on because the CNAs are not trained or if they were trained they've forgotten; they're not being observed doing it, they're just not doing it right and not following the manufacturer's instructions which are there for safety. So, yes, the surveyors are going to ask you some things like that. But the answer is: "No, I didn't read that; I rely on the infection control nurse and the people who purchased the equipment to understand how it's used and to inform me if I write an order that is inconsistent with proper policy. They're supposed to inform me of these things."

The discussion came to a close, and the meeting was adjourned.

These minutes were amended July 25, 2011.