Minutes of the Bureau of Health Provider Standards/
Medical Directors'
Advisory Committee Meeting
July 27, 2012

ATTENDEES:
James Yates, MD, CMD, President Elect
Regina Harrell, MD, CMD, Secretary/Treasurer
Grier Stewart, MD
David R. Barthold, MD
Steve Furr, MD, CMD
Robert Webb, MD
Jerry Harrison, MD, CMD
Byron Nelson, MD, CMD
John MacLennan, MD
Chivers Woodruff, MD, CMD
Malcolm Brown, MD
George Sutton, MD
Michael Reeves, MD, CMD
Richard Brockman, Esq.
Sam Salle, MD
Katrina Magdon, Nursing Home Association
Walter T. Geary, MD, Medical Director, Bureau of Health Provider Standards
Diane Mann, Public Health

Dr. Geary welcomed everyone to the meeting. After a correction in the spelling of the antibiotic drug mentioned in paragraph 3, page 2, the minutes were adopted.

Possibility of a Change in Prescribing Authority for CRNPs

Dr. Harrison discussed proposed legislation to allow a CRNP to have greater authority to independently prescribe controlled drugs in Classes 2 – 5. He attended a meeting with the Board of Nursing and proposed a parallel licensing mechanism that would have allowed a CRNP to be licensed as an advance practice category similar to a Physician Assistant under the BME. This would allow the same prescribing authority that a PA now has. There was no support voiced by those in attendance, including the Nurse Practitioners, for this proposal to change the oversight for CNRPs. However, legislation will be introduced next term to allow the Board of Nursing to extend the prescribing authority of a CRNP to be comparable to a PA. He urged those physicians who work with Nurse Practitioners to encourage then to contact the Board of Nursing and the Nurse Practitioners Alliance of Alabama and voice support for such an extension in prescribing ability. This would improve the care of nursing home residents and relieve some of the burden placed on the attending physicians and medical directors in the nursing home of the need for multiple calls, sending emails, faxes, and prescriptions to and from the office during busy work hours.

CMP Funds

CMP Funds – The State has been accumulating at Medicaid a lot of money from penalties collected from nursing homes. This money has primarily been used to help relocate residents when a facility was closed either voluntarily, or involuntarily. Some of this money has been used to help train and support the Ombudsman program. In the Affordable Care Act, CMS obtained control over the CMP funds and the utilization of these funds. CMS has come up with a series of guidelines for applying for funding (copy given to LeeAnn). It's an opportunity for certified nursing homes and other organizations to develop programs to improve resident outcomes or advance resident care and services and quality of life.

For example, there's an interest in setting up some pilot computer program; a computerized communication program between the residents and their families. Monitors would be provided for video-conferencing between residents and family members. CMS is vague as to what they would fund and what they would not fund. Some medical directors may be interested in a project. Dr Geary stated that he and LeeAnn had discussed the possibility of some of the medical directors here working with their nursing home to get some of the money and put in place a program that could be directed at training CNAs, or nursing, or the resident council, or utilizing resources in the community and putting together a program that would be funded using some of these funds. $10 million dollars are available in Medicaid for transportation of patients when the facility is closed, but there aren't that many closings and that many people needing to be transported. The money could be used to improve Quality of Care.

The steps for the program are very regimented. The initial application for the program comes to the State Agency to be reviewed and approved. It can't be mailed or faxed; it has to be electronically sent to the State Agency. The application has to meet certain formatting criteria. Resumes of everyone involved in the pilot program must be submitted. CMS recommends that the program be monitored at six months and 12 months. Dr. Geary offered his assistance to anyone who was interested in participating in this program.

Psychotic Drug Reduction Initiative

The next major issue is the Psychotropic Drug Reduction Program CMS is pushing. This effort is coming from advocacy groups, from academic groups such as psychiatrists who are doing studies and finding, in their opinion, that psychotropic drugs are being used inappropriately. It's also coming from the Office of the Inspector General (OIG), from a study nursing assessments in nursing homes that recently came out. Dr. Yates voiced a brief review of the deficiencies pointed out in the OIG report. Dr. Geary noted that the report was completed prior to MDS 3.0 so the methodology is not current. In addition the AMDA has put out a response letter and Dr. Geary urged everyone to read the AMDA position paper on this topic. The AMDA paper was passed around for review and he offered to provide copies to anyone needing such. Dr. Geary urged everyone not to entertain an administrative decision to discontinue all use of psychotropic drugs thinking that state surveyors would automatically write deficiencies; our staff won't be doing that.

Dr. Geary stated that a meeting was scheduled for July 17, 2012, involving several organizations including the Nursing Home Association and the Regional Office. CMS is encouraging us to look at nursing homes that have a high percentage of use of antipsychotic drugs. These numbers

are going to show up on the quality indicators. As of now, our survey staff is not allowed to use Quality Indicators in planning the survey.

In this program they will capture short-and long-term patients, and will take into consideration in particular patients with Schizophrenia, Tourette Syndrome and Huntington's disease. These are considered a pass through for the antipsychotics. What they're looking at is off-label uses of antipsychotics especially for behaviors related to dementia. Dr. Geary wrote to the CMS person in charge of this initiative and asked about the FDA-approved use of antipsychotic medication for resistant severe depression. She wrote back and is of course aware that this is an appropriate use of such meds but they felt that this was an uncommon scenario in the nursing home. So at this time in Alabama, documentation of severe and resistant depression not responsive to antidepressant therapy alone is an acceptable rational for the use of antipsychotic medications in the nursing home

CMS considers that antipsychotic drugs are often being used for the convenience of nursing home staff. In their YouTube presentation, they gave data from a nursing home somewhere in the northeast. This facility had 181 residents; 11 activity personnel; five programs for dementia patients, depending on the degree of dementia, (and even one spoken in Korean for these residents) that go on all day – seven days a week – enough programs for residents who don't use psychotropic drugs. What CMS is saying is that if you have enough behavioral programs in place for your residents, going on all day, every day, then you do not need to use antipsychotics as much as we frequently see when CMS surveyors do their investigations.

The State Agency is also being looked at by CMS as to how frequently we cite F329, Drug Regimen is Free from Unnecessary Drugs. In 2011 we cited this 4.4% of our surveys, not too different from most other state agencies in our region. CMS is telling six states in our region that we are under-citing F329. The average is about 7.1%. Take Florida at 28% and North Carolina at 13% out and we're right at the average for citing F329. Of course this F tag covers multiple other medication problems that might be found on survey, not just the use of antipsychotic drugs. The primary concern of CMS is that there is a failure to have adequate behavioral modifications plans developed and in place before using medications.

The first thing is to do an adequate assessment of those taking antipsychotic drugs. Surveyors will be looking to see if a resident triggers a CAA (Care Assessment Area) on the MDS 3.0. There are 18 areas on the MDS 3.0 which trigger and indicate there needs to be further assessment. Work with your nursing home and know MDS 3.0 and what triggers Care Assessment Areas. Additional assessment is required if the CAA is triggered – but this is not restricted to the CAA in the MDS. There is a full page of resources available. Interventions have to be appropriate to standards of care. Documentation needs to show, in the record, that the physician was involved in assessment of the resident. Develop a comprehensive plan of care. Implementing the care plan is important; start with comprehensive behavioral care plans; pay attention to the environment and individual care needs. Activities will be looked at more in detail. For example – do they actually help the resident; do they keep the resident from being bored? Make a thoughtful decision before placing a resident on antipsychotic drugs. Have a goal; start with an effective dose. Once control of behavior has been reached, then consider reducing meds as quickly as possible to the lowest effective dose as part of your overall plan. And then follow the guidelines for gradual tapering of antipsychotic meds. Dr. Harrison

mentioned not just tapering meds but to possibly increase the dose or change medications if the first is not effective.

Dr. Geary stated that CMS will be revising F329; it has not been published for comments yet, and informed them they could check the CMS web site for final surveyor guidance online.

Dr. Geary went on to say that there are no federal rules about getting permission from the family before you prescribe a drug; but you have to let the resident and/or family know about their medications. CMS is looking for family involvement at the time the drug was initiated. In the care planning process involvement means notifying them of what you plan to do; what drug you're going to use, what the potential side effects are; what the black box warning is, and the fact that you're going to be monitoring the response. Dr. Harrison mentioned the difficulty in getting family involvement in many cases.

Dr. Geary suggested the medical directors to have their facility pharmacist on board; they need to understand we have a heightened awareness of these drugs now, and they need to be looking at the medications so they can be part of the record that this medicine has been analyzed based on the overall medical picture of the medications.

.CMS has set a goal of a 15% reduction in the use of antipsychotic medications by the end of the calendar year. The question was raised as to how to reduce the use of antipsychotic drugs by 15%. The data will be captured on the MDS and will be reported on the Quality Indicators. Dr. Geary replied that this is a state-wide average reduction. Katrina Magdon noted that the initial calculations did not exclude the patients with schizophrenia and Tourettes; thus the next calculation will necessarily be lower. Dr. Yates commented that the diagnosis should not be dementia. He stated that there should be diagnosis documented from a psychiatrist. Dr. Geary interjected that the psychiatrist should provide a statement that the antipsychotic dosage is appropriate and can't be reduced and there is documentation that our surveyors can copy and send to the the RO if necessary. Just to state that this med cannot be tapered will not be acceptable without adequate documented reason.

After much discussion of mental health problems with hospital closures and lack of care, and a quick hand poll of the members present, Dr. Geary said it might be helpful to report to Alice Bonner that we discussed this at the meeting and that 10 out of 14 medical directors reported they were using atypical antipsychotic drugs for severe resistant depression. Dr. Geary suggested that the members could write Dr. Thomas Hamilton, the Director of the Survey and Certification Group, at HHS/CMS, and ask him to consider adding severe resistant depression to the Quality Indicators and exclusions for antipsychotic drugs.

Dr. Harrison brought up the topic of DNR.

Richard Brockman commented that a draft for legislation has been written that will allow a DNR for any end of life issue to be placed in a health care record. It defines what DNR means and includes other acronyms. It does two things: 1) allows the DNR and any end of life order to travel with the patient; and, 2) provides the same level of protection from civil and criminal prosecution to those health care providers who follow the order in good faith. The Department of Public Health is designated in the draft to write the rules for a valid DNR order. This needs to be done so that the DNR can be relied on to be the true wishes of the resident and their

surrogate/family/legal guardian/etc…. There followed a discussion on why the legislation has not passed yet.

Dr. Yates mentioned the initiative on Care Transitions and the need for physician involvement in this process. Dr. Reeves initiated a discussion on the limitations to the Physician Assistant system. He noted concern that the system requires more involvement and greater time requirements. He questioned the advisability of the independent practice provision for a PA. Dr. Harrison indicated that he wants to use the Physician Assistant as a physician extender: he just doesn't want them to replace him. Dr. George "Buddy" Smith reassured the group that there is no prospect of completely independent practice und unlimited and unsupervised medication prescribing for Physician Assistants in Alabama.

Katrina Magdon invited everyone to the NHA reception that evening. She reminded them to vote "YES" on the September 18 Constitutional Amendment.

The meeting adjourned.

The next meeting will be held February 16, 2013, at the Birmingham Marriott, 3590 Grandview Parkway, Birmingham, AL.