The Benefit of Staying Put

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long-term care. Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice HMO (M+C), and—currently—a Program for All-inclusive Care (PACE) program in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as a American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages, LTC Interface, Jefferson's Health Policy Newsletter,* and *The Journal of Quality Healthcare.*

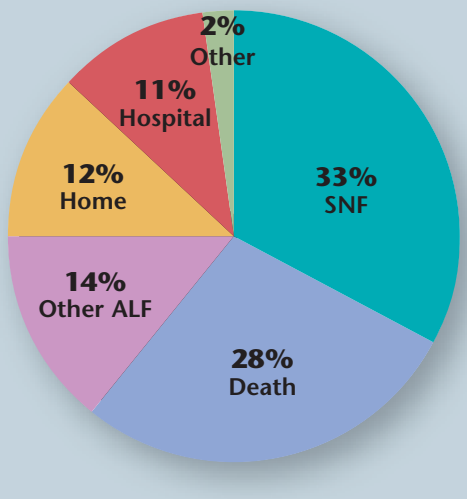
Aging in place. This phrase often is considered to be synonymous with assisted living. Staying in one place often makes sense from a financial or even an emotional standpoint; it also can help protect the resident's health as well. Despite the promotion of ALFs as places where seniors can age in place, over 70% of ALF residents eventually require transfer out of the facility (see Table 1). This is significant because those moves to hospitals and other acute setting can put seniors at risk for a wide range of iatrogenic events, such as infections or pressure ulcers.

How serious are these potential problems? The number of people having in-hospital adverse drug reactions (ADR) to prescribed medicine is 2.2 million.[1] The number of unnecessary medical and surgical procedures performed annually is 7.5 million.[2] The number of people exposed to unnecessary hospitalization annually is 8.9 million.[3,4,5,6] The total number of iatrogenic deaths is estimated to be 783,936 annually. This is not an insignificant problem, but it can be reduced by preventing transfers and keeping residents in one place.

One of the goals of this issue of *ALC* is to enable our readers to help their resident age in place and avoid unnecessary moves—however temporary—that may put them at risk for illnesses or worst. Specifically, *ALC* focuses attention on several best practices that can help facilities care for residents in their homes.

To help avoid the preventable transfers to the hospital, we have included two articles. First is a summary of the American Medical Directors Association Clinical Practice Guideline on Acute Change of Condition, specifically revised for assisted living facilities. By preparing our staff to recognize sudden changes in a resident's condition, we can take a proactive step toward reducing unnecessary transfers. Secondly, we offer a "Primer on Medication Management,"

Table 1. Residents Leaving ALFs by Destination



Source: National Center for Assisted Living, 2001

which includes comments from medication management experts such as Jerry Gurwitz, MD, and *ALC* Advisory Board member Rich Marasco.

An example of a 'best' practice that we can borrow from the nursing home world involves the increased use of nurse practitioners. Nurse practitioners provide access to primary care in assisted living facilities as well. While NPs are major factor in this setting, they are only part of the interdisciplinary team. In the discussion lead by Dr. Paula Podrazik on negotiating the complexities of the long term care continuum, she makes a case for the benefit of a strong interdisciplinary team as well as for connecting the ALF with other components of the continuum.

Two articles take a closer look at the new Medicare prescription drug benefit. In my article, "As the MMA Storm Moves Toward Us…," I discuss some of the steps ALFs can take to prepare for implementation of the drug benefit. In "Are ALFs Long-Term Care Facilities?," David Farber and Karen Thiel talk about the Centers for Medicare and Medicaid Services hesitation to include ALFs in the official definition of LTCFs, thereby eliminating AL residents from an array of benefits under the prescription drug benefit.

Of course, there are many more examples of assistance in living that facilities can apply to allow their residents to age in place—from cutting-edge Alzheimer's disease programs and interventions to innovative end-of-life and palliative care initiatives. We couldn't pack everything into this issue, but we invite you to watch future issues of *ALC* for more best practices, research findings, and insights and guidance from clinical leaders in AL and experts on Alzheimer's disease, palliative care, medication management, mental health, and other issues. So read on, and stay tuned!

Richard G. Stefanacci, DO,
MGH, MBA, AGSF, CMD
Editor-in-Chief
215-596-7466
rstefanacci@assistedlivingconsult.com

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We welcome your input.

Please send your **Letters to the Editor** to:

Richard Stefanacci, DO
Editor-in-Chief
Assisted Living Consult

e-mail
rstefanacci@assistedlivingconsult.com

fax
215-489-7007