Really Caring Where Seniors Live

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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.*

There is a growing drive in this nation to provide care where seniors live or want to live—and not to insist that seniors live where the care is. The introduction of home- and community-based waivers that provide funding for services that would otherwise be provided in a nursing home is a major move toward satisfying this growing demand.

The increasing move away from traditional skilled nursing facilities to senior homes and home-like settings will result in a growing number of seniors living in assisted living facilities (ALFs). In other words, the popularity of ALFs is not likely to diminish anytime soon. However, we will see the acuity level of ALF residents growing as well—and beyond what we have typically seen today.

What we currently see is that the average ALF resident looks more like a SNF resident of a few years ago. This individual is 80 years or older, has multiple chronic illnesses, has some cognitive impairment, and receives an average of between 5.1 and 6.1 prescription medications daily.[1,2]

However, despite the fact that ALF residents are looking increasingly like those in SNFs, AL residences have fought and ultimately prevented the intrusion of federal regulations into their business. Combined with the typical operator philosophy that ALFs are nothing more than real estate ventures, ALFs are largely void of clinical services that are a standard for residents with similar characteristics living in nursing facilities.

A recent article by Philip Sloane, MD, illustrated the extent of medication undertreatment in assisted living settings, and a previous article of his showed generally inappropriate medication prescribing in this same setting.[3,4] In a corresponding editorial, Jerry Gurwitz, MD, proposed that these findings were the result of several factors, including the need for systems of care that improve drug safety and enhance adherence in elderly persons on complex medication regimens and the persistence of financial barriers to medication access.[5] Clearly, greater clinical involvement in ALFs and other places where seniors will reside is needed.

This shift in seniors' residence preferences already are apparent in real estate value increases in non-traditional areas. Historically, real estate increased most based on family values—such as good school districts. Now, however, we are seeing real estate values increase where demographics favor seniors—such as lower taxes and easy access to services and vendors they use most frequently. This is resulting in a growth in "senior-friendly" cities. It is also increasing the growth of naturally occurring retirement communities (NORCs).

At the same time, we are seeing an expansion of programs such as the Program for All-inclusive Care for the Elderly (PACE); and the new Special Needs Plans (SNPs) introduced under MMA are already bringing clinical services to where seniors live. PACE has been shown to deliver comprehensive care for the frail elderly through an interdisciplinary team.[6] This program provides and coordinates all needed preventive, primary, acute, and long term care services so that older individuals can continue living in the community. The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. As discussed in the article in this issue by Willy Orr, MD, PACE is

available and growing as an option for seniors living in ALF.

Another opportunity introduced as a result of MMA is the development of SNPs. This option also is discussed in this issue as another approach to bringing services to alternative settings for seniors in need. PACE and SNPs are prime examples of market-driven innovative models of care that seniors are demanding.

Despite the move to provide care where seniors want to live, there still exists significant disparities in available treatment. One example is the fact that seniors living within the walls of a skilled nursing facility have access to several unique benefits under the Medicare Modernization Act that ALF residents don't get. These benefits include access to a special enrollment period, no cost sharing for those that are dually eligible, access to special packaging and services through LTC specific pharmacy providers, and enhanced access to non-formulary medications through a longer transitioning period. There also is a requirement on the part of prescription drug plans in the Medicare prescription drug benefit program to provide a one-time fill for medications subject to the exceptions and appeals process. Several groups are arguing that this results in a disparity of treatment, which—in turn—presents liable under Section 504 of the Rehab Act since the drug benefit is not provided equally on a site-neutral basis. Rather, seniors and the disabled effectively receive additional protections only if they enter nursing homes. Such disparity between nursing facilities and ALFs is not new. For example, physicians and nurse practitioners are subject to lower reimbursement for ALF visits than they are for the same visit in a SNF or private home.

The good news is that there are signs that the Centers for Medicare and Medicaid Services (CMS) is looking to change some of this disparity and provide equal care to seniors regardless of site. CMS Administrator Mark McClellan recently stated "that the payment needs to follow the patient, indicating a move to site-neutral payment policies."

Later this fall, CMS will provide a revised fee schedule for ALF clinical visits. We hope that agency leaders will recognize the current disparity and resultant disincentive for ALF clinical visits.

It is promising to see that not only is the market continuing to invent new models of care but the government—working through CMS—is evolving too. We will continue to update you on these and other important activities in future issues of ALC. And don't forget the clinical topics—such as Parkinson's Disease, osteoporosis, and mosquito-transmitted illnesses—that we will continue to address.

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