Preventing Falls

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 (LTC). 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 (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative 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 previously 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 the American Geriatrics Society (AGS). Recently, he was recognized as an 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.*

Assisted living. What exactly should this term mean? The more advanced ALFs believe that it means providing assistance to those in need so they can live life to its fullest. While many facilities believe they are assisted living facilities, how many actually are providing complete assisted living?

Take fall prevention, for example. Falls represent a significant risk for frail seniors; in fact, many older people list falling as one of their greatest fears. So why are so few ALFs taking an active role in the prevention of falls for their residents? Most programs to prevent falls require very few resources from the facility. This issue of *Assisted Living Consult* deals with issues that can contribute to fall prevention: managing sleep disorders, preventing and treating influenza, and assistive bed devices.

To understand the root cause of falls, one needs to analyze the data. Most falls occur as a resident rushes to get from his or her bed to the bathroom without having an "accident." Therefore, to prevent falls from occurring, the interdisciplinary team must eliminate root causes such as sleepiness.

Fall prevention in any facility should start with the interdisciplinary team assessing the individual falls for root causes. The team then needs to look at the issue of falls from both an individual resident perspective and a facility-wide perspective. It is important to recognize that structural deficits, as well as difficulties in a facility's systems of care, all can be contributing factors.

When ALFs take the initiative to develop and promote disease state management programs such as those for insomnia, residents can truly be assisted in their living. This assistance will go a long way toward improving a resident's quality of life and ability to remain in the ALF for a longer period. We all know that when diseases are left untreated, they can result in falls that can have major consequences for facility residents.

Of course, insomnia is only one sleep disorder that can contribute to fall risk. Other problems such as sleep apnea can cause residents to be sleepy or less alert during the day and thereby susceptible to falls. All staff should be aware of the potential consequences of sleep disorders so that they can help identify residents with sleep disorders and get them the care they need.

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One article in this issue discusses the after hours activities that can keep residents active and alert during the evenings. It is important to offer seniors recreational activities and social events during the evening. Not only do these programs—especially ones involving

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Step 4: *Appeals Process.* If the decision by the IRE is adverse to the enrollee, the next step in the appeals process is requesting a hearing before an Administrative Law Judge (ALJ). The enrollees claims must be worth at least $110 in 2006. The next step in the appeals process is the Medicare Appeals Council. Finally, if the claim is large enough ($1090 in 2006), the enrollee may file an appeal in federal court.

If All Else Fails

CMS states that it is committed to making sure that beneficiaries under Part D get the drugs they need. To this end, they are urging enrollees and their prescribers to contact 1-800 Medicare *immediately* so that CMS case managers can intervene and help resolve issues quickly. Complaints about plans can also be filed with the Quality Improvement Organization (QIO), another Medicare contractor that is authorized by statute to review complaints about quality of care.

However, it is important to note that when faced with a denial or a delay in approving a requested medication, the only action that triggers the legal requirement of a plan to respond timely and in writing is to request a coverage determination.

Conclusion

While many initial problems in the roll out of Medicare Part D are being addressed and likely will diminish over time, disputes regarding coverage of specific medications are inevitable. Whenever a dispute arises that involves access to essential medications, filing a request for a coverage determination is a critical first step in protecting and promoting the right of Medicare beneficiaries to receive the medications that their doctors have prescribed. ALC

Claudia Schlosberg is a Partner at Blank Rome, LLP, in Washington, DC. She will be a regular contributor to *Assisted Living Consult* during the coming year.

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physical activities such as dancing—help residents stay physically fit; they also enable residents to sleep better at night. Some facilities leave seniors to their own devices in the evenings, but ALF leaders need to remember that their lives do not stop after 5 p.m. and neither do the lives of their residents.

Another area where facilities often lose focus is the structural design of the resident's environment. Many of the devices originally thought to decrease falls have actually been found to be contributors to accidents and fall-related injuries. Restraints have been banned from many facilities because of their potential to cause or contribute to much greater harm. Instead, innovative new devices are available to provide assistance in mobility for residents. These devices can provide a significant return on investment through improved resident quality of life, increased occupancy, and reduced liability.

The goal of *Assisted Living Consult* is to identify these areas where ALFs can play an active role in providing assistance in living so that residents can live a safer, healthier, and more productive life. Preventing falls through improved treatment of insomnia, prevention/treatment of influenza, and improving bed mobility are just three ways to achieve this objective and, therefore, more truly provide assistance in living. ALC

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