



## Really Being Resident Focused



*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*.

**F**ounded by companies that had their origin in real estate and the hotel industry, ALFs historically have focused their attention on real estate development with service packages centered on a hospitality model. Recently, however, many of these companies have sold their ALF assets to organizations more focused on clinical issues. Because ALFs have always been resident focused and the management of clinical issues is clearly what residents are now asking for, this should come as no surprise.

Among the best groups to address the management of clinical issues in ALFs are the Eden Alternative, Well-spring, and the Pioneer Movement. As you will read, these groups provide services from the resident's perspective, evaluating their needs, and empowering the facility staff to determine what will most satisfy each individual resident's clinical needs. By building multidisciplinary teams focused on quality management, these groups have achieved exemplary results, with programs that are successful because of the important role placed on data.

For teams to work, they require two things—leadership and the team. Despite extensive discussion about the interdisciplinary team approach, this talk often takes place in silos and, worse yet, functions in silos. Recently, I had the opportunity at the American Society of Consultant Pharmacists mid-year meeting to be involved in a session on interdisciplinary care with a well-represented group that included an administrator, a director of nursing, a medical director, a social worker, and others. Yet, despite the interdisciplinary presentations, the meeting itself was a siloed gathering of professionals. It has become common for us to meet in our own professional silo rather than

meet and discuss the issues in an interdisciplinary manner as we do here in the articles that appear in *ALC*. In order to be successful, we need to meet in true interdisciplinary settings so that we can work effectively in interdisciplinary teams.

In this issue of *ALC*, we look at the interdisciplinary resident-centered model of care utilized by the Eden Alternative and others in the clinical management of urinary incontinence, dementia, and vision. At first, these clinical conditions may not seem related, yet all are known to be associated with falls and resident decline, which often can result in a resident's premature exit from an ALF. For example, Alzheimer's dementia is a progressive condition that, left unchecked, will in most cases require nursing home placement for its victims. Although current medications used to treat this condition are limited, they can help delay its progression, allowing a resident to remain in an ALF for a longer period of time. Knowing the reality of the situation and the abilities of the facility is vital to assure an appropriate match of the ALF resident and facility. A mismatching of a resident and a facility's ability is a recipe for disaster and probable lawsuit. This is among the major tenets of the American Geriatric Society ([www.americangeriatrics.org](http://www.americangeriatrics.org)) position statement on ALFs.

Additionally, having had the opportunity through my position with the University of the Sciences in Philadelphia's Health Policy Institute to serve as an expert in reviewing many ALF malpractice cases for both plaintiffs and defendants, a common theme has emerged among all of these cases, namely, a disconnection between the facility's ability and the resident's needs and expectations. Being involved in

*(continued on page 18)*

ordinary people," she writes. Chuck Chakrapani (author of *How to Measure Service Quality & Customer Satisfaction*) says it best when he suggests that to measure outcomes absent customer satisfaction is "to measure something without context." *Especially* in long term care, resident satisfaction is at least as important as clinical and service outcomes.

This is where many assisted living communities have taken the lead. Much more so than nursing facilities, they have pioneered the measurement of customer satisfaction. This is no small task, as customer satisfaction can be *difficult* to measure in any care setting. There are numerous questionnaires available purporting to be the definitive approach to doing so. They are produced by academicians, consultants, providers, and the associations that represent them. The challenge is distinguishing between those whose primary purpose is marketing and those whose critical focus is management. (That, by the way, is caveat number two.)

Everyone has seen survey results that "demonstrate" astronomical levels of resident satisfaction. Indeed, they may help in keeping the facility fully occupied, but they are of little use to a management team looking for areas on which to focus its quality improvement efforts. For that, it is important to find out what makes the customer unhappy or dissatisfied. Only then can ALFs work on improving levels of resident satisfaction.

Remember, important as data are, however, this information is only a tool (albeit an essential tool) in the quality management process. Ultimately, the successful quality management program is a part of the very culture of the facility. It must be a critical facet of all its policies and procedures. It must be interwoven within the very fabric of the enterprise. A customer-focus is not just the responsibility of social services. Data-driven management

is not just the responsibility of nursing. Staff empowerment is not just the responsibility of housekeeping.

All of these activities are everyone's responsibility. The only way to make that absolutely clear—to make it a part of the *facility's* culture—is for senior management to demonstrate regularly that it is a part of *their* culture as well. This is where quality management often has failed.

This leads to caveat number three: Paying lip service to quality management is to sentence it to an untimely death. Staff is intelligent, and they know when words are just words. They also know when management actually is committed to those words as reflecting something of real significance.

### **QM is More than Feeling OK**

After all, quality management is more than just a "feel good" concept. It is just as much in line with *fiduciary* responsibilities. The pioneers of quality management (W. Edwards Deming, Joseph M. Juran, and Philip B. Crosby) did not see themselves as altruistic social innovators. They were businessmen looking to create tools for improving business results. For them, profitability was not a dirty word. They looked to quality management primarily as a means of *improving* profitability.

Critical also is the recognition that quality management is not a *project*. Rather, it is a *process*. That is to say that it never stops. It functions as a continuous loop. AL facilities and their leaders determine priorities based on customer satisfaction. They measure. They empower staff to stimulate improvement. They reexamine priorities. And they measure again. But they must begin the journey by returning to a system that places people—the customers—first. ALC

**Paul R. Willging, PhD, is Senior Associate in the Bloomberg School of Public Health at Johns Hopkins University in Maryland.**

### **From the Editor**

*(continued from page 6)*

allows a first-hand view of these issues, providing the foundation for developing quality practices for one's own facility. In this issue of ALC, Dr. Scott M. Bolhack and his colleagues emphasize the importance of developing policies and procedures that are consistent both with residents' rights and their medical safety within an ALF.

Utilizing a resident-centered approach that requires a closer clinical focus on the part of ALFs produces positive outcomes for all involved. This approach can greatly increase the comfort and well-being of residents, whether from improved vision, elimination of urinary incontinence, or a delay in the progress of dementia. In addition, ALFs benefit by a significant increase in their occupancy, through attracting residents to the facility, as well as maintaining residents in the facility longer through improved health outcomes. This has been demonstrated by hard results in the resident-centered models that have shown 50% reductions in geriatric clinical issues in the areas of decubitus ulcers and behavioral incidents.

Of course, health outcomes are not the only items improved by a resident-centered focus—staff absenteeism and incidents such as employee accidents also are positively affected. By providing resident-centered care through a quality-driven interdisciplinary approach, everyone can benefit. However, the trick is doing more than just writing and talking about being resident focused, but really doing it as a team. ALC



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

[rstefanacci@assistedlivingconsult.com](mailto:rstefanacci@assistedlivingconsult.com)