Impact

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.*

Based on the true memoir of real-life surgeon Ed Rosenbaum, in his book *A Taste of My Own Medicine*, the 1991 movie *The Doctor* follows a doctor who learns that there's more to medicine than skill in the operating room. Played by William Hurt, the doctor is profoundly impacted by becoming a patient and experiencing first-hand the process to which patients are subjected. In the end, the doctor is positively impacted by this experience. He learns a tremendous amount from his first-hand experience—knowledge that he takes with him in his treatment of others in his practice and life.

A common theme of the articles for this issue of the *Assisted Living Consult* is "impact." Of course, it's the effects of impact that matter. All of our work deals with impact—producing a beneficial impact or preventing an adverse impact to assure only positive results. Some of *ALC*'s articles deal with positive impact, such as the introduction of hospice into assisted living (AL). Whereas in other articles, the results are mixed, such as with "The Impact of Medicare Part D." Clearly, having as much information as possible is the best way to ensure the best possible results.

Recently, I had an event thrown upon me that, like *The Doctor*, is a rather tough experience that will undoubtedly help evolve my perspective on the ideal health care system. My oldest son was suddenly diagnosed with metastatic bone cancer. Again, nothing changes one's perspective on things as much as personal experience. Through this process I am learning first-hand what it's like for an anxious caregiver to attempt to navigate our confusing health care system. Through this process, I've also gained an increased appreciation for the team approach. The team approach has always been embraced in geriatric care, but is often missing from general medical practices. Having a coordinated team of experts makes the journey through a difficult illness, such as cancer or Alzheimer's disease, much easier, with improved outcomes for all involved. In addition to the team being actively involved, allowing the caregiver into the entire process can be extremely beneficial.

The interdisciplinary team section of this issue of *ALC* focuses on the role of the physical therapist in AL. Given that physical therapy services strive to maximize functional independence in assisted living environments and the community by restoring functional mobility and preventing disability, their involvement as key members of the interdisciplinary team is critical. It is noted that physical therapists bring expertise and insight, not just to the functional level of each resident, but to facility-wide programs, such as fall prevention, group exercise, and staff education.

All of our work deals with impact—producing a beneficial impact or preventing an adverse impact to assure only positive results.

Besides our own team, we also can bring outsiders into our facilities who can have a positive impact on the care of our residents. Several

(continued on page 8)

From the Editor

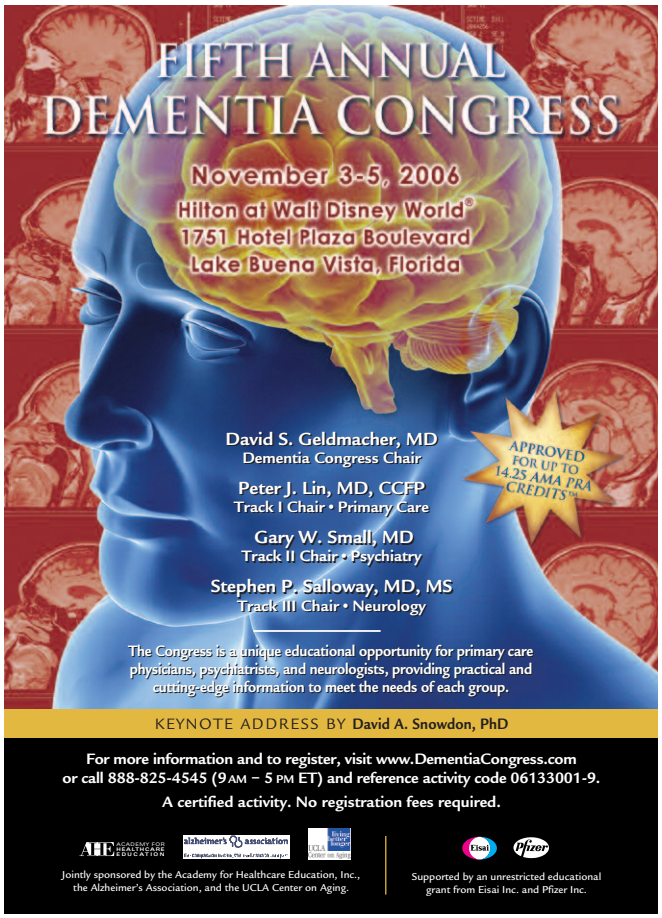
(continued from page 6)

articles in this issue of *ALC* point out the benefit of introducing hospice within AL. Hospice is a Medicare program for individuals who no longer want aggressive interventions to cure their disorders. Hospice supports those beneficiaries who are looking to receive services that will enhance their quality of life through palliative or symptom management of their disease. The importance of this resource was noted by a finding of the National Center for Assisted Living (NCAL), which found that a third of AL residents were transferred from their homes to nursing facilities, where they subsequently passed away. Many of these residents could have been cared for in their homes until their death. Successful end-of-life care in AL requires the coordination of care and services with hospice organizations.

In another impact-related topic, ask yourself, "How often do we develop processes in facilities without surveying the experiences of the people directly impacted?" Staff and residents who are on the receiving end of these processes are often left out of the planning cycle. The next time you walk into a facility and feel confused or uncomfortable about the surroundings, think about the design process. In most cases, it probably means that the planning process did not include input from the residents. This can be a costly mistake—one that, fortunately, is easily prevented if the proper work is done up front. One of this issue's articles, "Integrated Solutions Mean New Independence for Residents" by Owen Roberts, deals with facility design and the use of the neighborhood approach, as well as technology, to produce a safe and friendly environment for AL residents.

Additionally, some events are thrown at us, forcing us to respond in such a way as to assure the best outcome—such is the case with Medicare Part D. One of the most significant issues facing AL providers with regard to Medicare Part D is the restriction on accessing medications, especially medications for Alzheimer's disease. Dr. Stephen Axelrod's article addresses these issues with regard to the confusion, lack of clear guidelines, miscommunication, lack of education, variation in state policies, added administrative burdens and, worst of all, interruptions in appropriate drug therapy that have overwhelmed even the most prepared. In addition, Dr. Axelrod notes that this has diverted the attention of providers, who are trying to take better care of residents, from implementing quality initiatives such as greater adherence to the Beers criteria (a listing of medications to avoid in the elderly), to having to deal with administrative logistics.[1] Of note is the fact that Merck & Company has developed a Web-based program titled "Recognition and Avoidance of Medication-Related Problems in Elderly Patients," which focuses on the Beers criteria and Medicare Part D to assure access to appropriate medications for seniors.

Assuring that the things that impact AL residents and staff produce only positive results is, of course, what we are all dedicated to do. In this issue as well as future issues *ALC* will provide the tools needed to create positive outcomes from either events that we create or the ones that are thrown upon us. As always, we are interested in hearing stories from you about your personal "best practices" that go a long way in producing positive results. ALC



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

Reference

1. Beers MH. Explicit criteria for determining potentially inappropriate medication use by the elderly. *Arch Intern Med.* 1997;157:1531-1536.