Good Behavior

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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 (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.*

"Good Behavior" can mean many things when it comes to assisted living (AL) facilities, but one thing that is consistent with all good behavior is that it always produces positive results. These positive results may be in the form of improved health outcomes for AL residents, reduced caregiver burden, increased length of stays within facilities, or simply making a particular AL facility more attractive to potential residents. Obviously, producing "good behavior" is important on everyone's part.

In his own inimitable way, Dr. Marvin Herring has illustrated that "good behavior" of provider's means much more than identifying issues. It also means developing and implementing solutions. In his letter to the editor, he discusses some of the solutions that AL facilities can implement to achieve improved outcomes when it comes to end-of-life care. Both of these points seem rather obvious; after all, AL facilities have always been thought of as places where residents can age in place. However, many residents are transferred out of their AL home because of inadequacies in our current system. While most recognize the issues, few are able to come up with solutions.

When one thinks of behaviors in AL, the first thing that jumps to mind, of course, is Alzheimer's disease. A significant and growing number of AL residents are victims of this disease and have behavioral issues associated with it. Some of these behavior issues, such as memory loss, are well known. Others, such as Involuntary Emotional Expression Disorder (IEED), are less well known. And still others, such as wandering and elopement, are known all too well because of the liability associated with them. Elopement liability cases that end in the death of the resident result in an average of almost a quarter of a million dollars in liability judgment against the facility—obviously an area of focus for AL.

In a study completed by the University of Missouri, administrators were asked to describe occasions when residents with dementia were discharged. The findings of the study were based on analysis of the audiotapes of exit interviews. According to the administrators, resident behaviors that influenced discharge decisions included behaviors indicating progression of dementia, the need for more assistance with activities of daily living, incontinence, wandering, aggression, behaviors that did not meet the facility's expectations, and behaviors reflecting changes in physical condition. Controlling these behaviors so that residents could remain in the facility for a longer period of time is something that would benefit residents and facilities alike.

Our "Experts' Roundtable" tackles the question of the place of Alzheimer's medications in improving behavior. As is often the case, a critical component of case management is communicating with residents and family the true benefits and risks of these medications. Often, disappointment results from expectations that are not realized because they are out of line with reality. Access to these medications has become a real issue because of Medicare Part D; many prescription plans require mini mental status examinations before agreeing to pay for Alzheimer's medication. The National Institute for Health and Clinical Excellence (NICE), the organization that decides coverage for medication for the United Kingdom (UK), has gone even further in refusing to cover

these medications in many situations. In the UK, the Alzheimer's Society has been campaigning against guidance from NICE, which is restricting access to Alzheimer's drugs to people in the moderate stages of the disease.

Elsewhere in this issue, we introduce ACE Cards—a series of educational resources developed by Dr. Michael Malone and his colleagues. Dr. Malone has done what Dr. Herring asked—he has provided answers. He identifies issues common to AL residents and has developed a resource to assist in improving care. The first ACE card we present deals with delirium. Unfortunately, it is all too common to AL residents, yet timely recognition often is delayed. Many times, the diagnosis of delirium is lost because the resident is thought to be suffering from dementia instead.

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Behavior is a major and growing issue in AL. Studies suggest that behavior problems in AL are similar to those in nursing homes but less frequent, despite the fact that AL facilities typically are not as focused on clinical management as are nursing homes. "The Interdisciplinary Team" section of the issue will introduce you to team members who can assist in achieving "good behavior," including the dietitian. After all, socialization resulting from a pleasant eating environment can go a long way in producing positive behavioral effects.

There are, of course, other actors whose behavior needs to be improved in order to help achieve better outcomes for AL residents. Medicare is perhaps the biggest actor. With Medicare planning a 5% decrease in physician reimbursement, we can expect a decrease in physician involvement in AL care. The American Medical Association and others have advocated against these deep cuts and have asked that those with vested interests to urge their Congressmen and women to stop the impending Medicare cuts.

Achieving "good behavior" is something that we all shoot for in everything we do. While this has always been important, it is gaining in importance because of the emphasis that Medicare and other payers are placing on it. Historically, third-party payers, unlike the private sector, have reimbursed providers without regard to good versus bad behavior. Reimbursement for physician services or nursing facility rates was paid without regard to the quality of care delivered. This is all about to change as Medicare moves to a pay-for-performance system in which higher performing/better behaving providers are paid more. So being ahead of the curve and starting to pay attention through investments in those systems will be vitally important for success. ALC

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