Who Should Define Us?

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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 served on the National PACE Association board. 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, The Journal of Quality Healthcare,* and *Medicare Patient Management.*

Communication is impossible without a common language, but much of what we do in assisted living (AL) is poorly defined. It has often been said that if you have seen one AL facility, you have seen one AL facility because there is no complete definition for these entities. There is a movement afoot to be more specific about what we do in AL, including defining terms like AL facilities, medical necessity, and even the specifics of clinical treatment through evidence-based medicine.

The problem with forming a tight definition of AL facilities is that while such a definition helps to eliminate some negative outlying brakers, it also eliminates positive outlying accelerators. For example, Figure 1 illustrates early adopters of innovative methods versus the laggards or those still holding onto old or even unsuccessful methods of care. By teeing all providers to the same tight definition for what can be provided, laggards may move forward, but early adopters may fail to develop new ideas. While other industries embrace innovative technology, medicine lags far behind.

A perfect illustration of this trend is telemedicine or Internet-based medicine. Because Medicare defines a billable physician patient encounter as requiring face-to-face interaction, telemedicine has been limited to small demonstration projects. This contrasts with far less restrictive industries that are based on a competitive market environment where innovation is rewarded, not punished.

Defining an AL Facility

Many regulators are rushing to define an AL facility. The American Geriatric Society (AGS) and several others have advocated keeping the definition of AL facilities open. Rather than a strict definition that results in all AL facilities looking alike, a better approach is to allow innovation so that these care settings can continue to develop superior models of care. One of the problems with skilled nursing facilities (SNFs) is that the definition of what they are has led to all of them coming to a common middle ground that prohibits innovation. Therefore, when you have seen one SNF, you have basically seen all SNFs with some minor exceptions.

The reason for the rush to define AL facilities is that the industry laggards have provided poor quality or misrepresented their services to their residents. Hence, the American Geriatric Society (AGS) position statement starts by advocating that AL facilities have a responsibility to

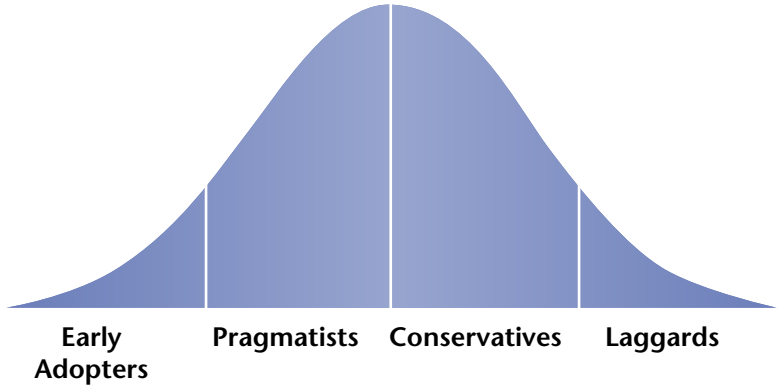

Figure 1. Graph of the Accelerators and Brakers in AL

provide complete information to prospective residents to ensure an appropriate match between resident and facility. The stated rationale for this position is that consumers of AL need to have detailed information regarding the services provided and the associated costs. In contrast to SNFs, which are primarily funded by Medicaid, AL facility payers tend to be the residents themselves. As a result, AL facilities are subject to less state and federal regulation and are more affected by market pressures. For consumers to make optimal decisions, AL facilities need to fully disclose the services they provide, the limitations of their facility, the amount of functional decline they can handle effectively, and the criteria residents must continue to meet to remain in the facility. In addition, the staffing levels and expertise should be discussed with all potential AL residents.

The AGS position statement advocates for some specific quality measures, but it leaves the "how to" best deliver those requirements up to the innovation of the facility.

Evidence-based Medicine

Regarding the delivery of medical care, we find ourselves increasingly being defined by clinical practice guidelines based on evidence-based medicine. These roadmaps attempt to dictate the exact course that we drive. Although medical necessity was traditionally left to providers to decide, the Centers for Medicare and Medicaid Services (CMS) is now pushing to define the term.

Some of these evidence-based practices will and should define care in AL facilities. Take for example the treatment of congestive heart failure, which we address in this issue (see page 22). Clearly we can all do a better job by following a roadmap, but it should be one that directs care instead of forces care. The importance of proactive care within an AL facility cannot be understated. Recently an article in the *Journal of the American Medical Directors Association* noted the importance of early diagnosis and treatment of dementia. This treatment not only improved the quality of life for residents, but allowed them to remain in their homes for a longer period of time—something that can really improve the occupancy rate and turnover for facilities.

AL facilities need to fully disclose the services they provide...and the criteria residents must continue to meet to remain in the facility.

So an evidence-based wellness program built around the needs of each individual resident can go a long way in serving as a marketing tool and keeping residents in the facility longer. Such a program must be specific to the needs of each senior resident rather than a combination of several off-the-shelf disease management programs that are not coordinated and do not take into account the difficulties of managing comorbid conditions.

A new approach is needed to teach evidence-based practices in a way that changes provider behavior. We will continue to do our part in the pages of *Assisted Living Consult* by working to positively change provider behavior and set the stage for defining our world in a way that promotes innovation.

Future Defined

So who is going to dictate the definitions of our AL world? I believe strongly that definitions should be in the hands of providers and not regulators. Organizations such as the Center for Excellence in Assisted Living (CEAL), the AGS, and the National Conference of Gerontological Nurse Practitioners (NCGNP) will likely step to the front to define the practice and setting of AL to maintain the highest level of quality of life for our seniors. This definition-setting must occur in a way that continues to promote innovation yet forces the bad apples out. Working together, we can achieve this goal. ALC

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THOUGHTS ON AGING

When we were children, we used to think that when we were grown-up we would no longer be vulnerable. But to grow up is to accept vulnerability...to be alive is to be vulnerable.

– Madeleine L'Engle