The Living is "Easy" or at Least Should Be Easier

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

Dr. Stefanacci continues to build on his work as the 2003-2004 Health Policy Scholar at the Centers for Medicare & Medicaid Services (CMS), where he helped develop and implement the Medicare Part D Pharmacy Benefit. He is currently creating a LTC Management Degree Program for undergraduate and graduate students in the Geriatric Health Program, Center for Medicare Medication Management (cm3), Mayes College, University of the Sciences in Philadelphia (USP).

As a geriatrician, Dr. Stefanacci has worked in LTC for decades as medical director for several nursing facilities and continuing care retirement communities. He has also served as a medical director for primary care private practices, full-risk provider groups, Medicare + Choice HMO (M+C) programs, and PACE (Program for All-inclusive Care for the Elderly) in Philadelphia. Dr. Stefanacci provides direct patient care for the St. Agnes LIFE program and works with NewCourtland Elder Services on innovative LTC services such as electronic dispensing and prescribing systems for the company's facilities. He also serves as executive director of HepTREC, the Delaware Valley Hepatitis Treatment, Research and Education Center (HepTREC).

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey (UMDNJ) in internal medicine and earned a fellowship in geriatrics at the same institution.

Dr. Stefanacci participates actively in the American Medical Directors Association (AMDA), Academy of Managed Care Pharmacy, American Society of Consultant Pharmacist (ASCP), and the American Geriatrics Society (AGS). He is a fellow in both the College of Physicians of Philadelphia and AGS and an honorary lifetime member of ASCP. He is editor-in-chief of the *Assisted Living Consult* and *Medicare Patient Management* and serves on the editorial boards of *Consultant Pharmacist, American Psychiatry News, LTC Interface, Managed Care,* and Jefferson's *Health Policy Newsletter*.

Dr. Stefanacci's proudest accomplishment is as founder and member of the board of directors of www.Go4TheGoal.org.

As I review the topics covered in this issue of *ALC*, I am immediately struck by the song title—"Summertime and the Living Is Easy." Or perhaps it is the fact that I am drafting this editorial at the end of a very busy summer as we enter Labor Day weekend. Or maybe it's the fact that I'm watching Hurricane Gustav and hoping that frail seniors in "The Big Easy," who did not fair well during Hurricane Katrina, are able to live a little easier this time around. But also, I am thinking that the relationship between easy living and assisted living (AL) cannot be missed.

Easy living, of course, should not be limited to summertime; rather, we should be providing easier living for older adults through AL. This easy living should be the objective for providers in the AL environment.

Breathing Easy

In the past, tobacco advertisers made a living connecting smoking to easy living. Of course, the truth is that smoking is far from easy, but smokers often say that smoking makes them relaxed. The healthcare risks of smoking are well documented. What is less well known are the problems related to smoking for high-risk AL residents. Smoking affects not just the smoker, but those around the smoker too. Smoking causes problems of secondary smoke and is a major cause of fires in the AL environment.

Proper monitoring and management of smoking is extremely important in long-term care (LTC) facilities. Smoking accounts for 72% of fire-related deaths and 43% of fire-related injuries in LTC facilities.[1] A very recent case report and literature review published in the *Journal of the American Medical Directors Association* by Drs. Lester and Kohen noted that residents with cognitive impairment and various physical disabilities may be unsafe smokers and present safety risks.[2] It has also been noted that physical challenges such as tremor, paresis (reduced movement), and cognitive and visual spatial deficits make the smoking resident 2 to 3 times more likely to be severely burned than his or her community-based counterparts.[3]

Estimates are that 9.1% of older adults are chronic smokers.[4] Within skilled nursing facilities, the numbers reported vary but remain consistent near the 10% mark. That is supported by a study of nursing home administrators who reported the number of smoking residents to be between 2% and 10%.[5] These numbers are somewhat higher for those within a Veterans Affairs (VA) nursing home. In a study of VA homes, the range is from 5% to 80% of residents with an average of 22% reported.[6] Researchers postulate that the reason for the higher rate of smoking among VA residents is lower socioeconomic status.[7]

The dangers of smoking in the nursing home setting have led to increased government regulation. Over the past 30 years, Medicaid and Medicare regulations have required that smoking by LTC residents be supervised and controlled. The regulations include a mandate that residents may not smoke in their sleeping rooms unless directly observed by staff. In 1994 the Joint Commission published standards for LTC, mandating that "the organization disseminate and enforce an organization-wide policy that discourages the use of smoking materials by patients/residents."[8] However, when smoking is permitted, policies must "minimize to the greatest extent possible the use of smoking materials, and confine al-

lowed smoking to a designated location(s) that is separated from nonsmoking patients/residents."[8]

In a survey of directors of nursing in LTC,[9] developed to identify nursing home standards related to resident smoking, we found that the monitoring of nursing home residents is based on a resident's mental acuity, physical restrictions, and equipment requirements. Once a resident was identified as a smoker at risk of harm to self or others, staff involvement ranged from distributing cigarettes to direct supervision.

Monitoring policies of LTC residents who smoke starts with identifying those residents at risk, based on an assessment of mental acuity, physical restrictions, and equipment requirements. Those who are identified as being at-risk smokers must have their cigarettes controlled and distributed by nursing staff, and they must be supervised by facility staff when they smoke. This policy is implemented through written procedures and staff education. Despite some discrepancies in the actual implementation of policies to supervise residents who smoke, the policies for assessing and monitoring at-risk smokers are consistent across the country. See our Experts Roundtable on page 41 of this issue to hear what members of our editorial board think about this issue.

Table 1.
Medicare Incentives

Incentive	Percentage Increase		Action Needed
	2008	2009	
Medicare Provider Reimbursement	0.5%	1.1%	None
E-Prescribing	–	2.0%	Use of qualified E-prescribing system
PQRI	1.5%	2.0%	Positive submission of 80% PQRI data in 3 categories
TOTAL	**2.0%**	**5.1%**	

Depression

Also in this issue of *ALC* is the second in our series of articles on the treatment of depression among AL resident (page 28). The article discusses comorbid conditions and depression. Depression increases patients' sensitivity to existing medical conditions, can lead to poorer overall health, and can subsequently worsen the prognosis associated with disorders such as cardiovascular disease, diabetes, and cancer. As a result, being aware of the need for accurate and timely diagnosis of depression in AL residents is vital.

The information presented here can be used as a guide for the development of an AL depression management program. Our next issue of *ALC* will feature the final article in this series that is set to serve as the basis of best practices in the management of AL residents with depression. It will discuss implementation of resident support groups within the AL environment, the use of nurse practitioners and physician assistants, and the development of an efficient and effective process for diagnosis and management of depression in AL residents. This last article in our series will pull together everything we have covered thus far and further assist you in developing a depression management program for your AL facility. Stay tuned.

Easing Provider Lives

Not only should the lives of our AL residents be easy, but so too should those of providers. Long talked about by the Institute of Medicine and others, technology is viewed as an opportunity to increase quality while reducing costs. The recently passed *Medicare Improvements for Patients and Providers Act of 2008* provides incentives for electronic prescribing for practitioners who use a qualified E-prescribing system in 2009 through 2013. There are additional incentives, albeit negative ones (a reduction in payments of up to 2%), for practitioners who fail to use a qualified E-prescribing system in 2011 and beyond. Although these incentives will apply to most prescribers, they do not apply to those who write prescriptions infrequently. Further, the Secretary of Health and Human Services can establish a hardship exception for providers who are unable to use a qualified E-prescribing system—such as prescribers in very rural areas.

As a result of this and other incentives, physicians can earn an extra 5.1% on their Medicare reimbursement in 2009 (Table 1). This can mean an additional $15,000 for many geriatricians who are able to receive all 3 increased payments. Of course for at least 2 of the 3 increases, there are some additional costs involved in participation. But the rewards will be more than just financial; they will include improved patient outcomes and practice efficiencies.

Complicating Forces

Reaching a state of "easy living" is not easy. As we get ready to vote in a

Presidential election, we see that both candidates are calling for change—some more positive than others.

To evaluate the Presidential healthcare platforms, one needs to understand what is being proposed and how the proposed plans will be financed. Additionally, one must consider possible unexpected consequences, both positive and negative. For example, a policy that places a large burden for healthcare costs on the heads of small businesses may restrict growth of these businesses—businesses that historically have been the foundation of innovation and economic growth.

A relatively painless way to review each candidate's healthcare platform is by viewing their videos on the following sites.

McCain
www.kaisernetwork.org/health_cast/presidentialhc.cfm?hc=2429

Obama
www.kaisernetwork.org/health_cast/health2008hc.cfm?hc=2164

This information should provide a foundation on which to base one's vote in November and to prepare for changes in one's practice.

Be assured that *ALC* will continue to work to make life easier for you and your residents. Despite forces that are trying to complicate your professional lives, you will always be able to find the path to easier living here in the pages of *ALC*, even when it's no longer summer. ALC

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

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