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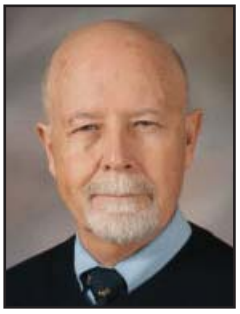
ALMDA
News & Notes

THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE

WWW.ALMDA.ORG

ALMDA: Membership improves advocacy for patients



ALMDA, Alabama's state chapter affiliate of AMDA – The Society for Post-Acute and Long Term Care Medicine, welcomes your involvement as we strive to provide the best medical care and compassionate service in one of the most challenging medical environments – our state's long-term care facilities.

Membership in ALMDA and AMDA provides many benefits including free webinars, national advocacy and national networking, clinical practice guidelines and unique education on topics tailored to help you survive and thrive in LTC.

We encourage you to join both groups to maximize your educational benefits through available opportunities and professional interactions.

ALMDA offers two educational events each year. In 2020 our Mid Winter Conference is in Birmingham on January 25, and our Annual Conference is set for July 23-26 in Sandestin, Fla.

The Alabama Nursing Home Association continues to be a valued partner in our work and we appreciate their support for our meetings and in the ADPH Advisory Committee, which meets in conjunction with our meetings.

There are several membership categories to encourage participation from providers at all levels of patient care. Individual 2020 Membership and Conference Registration forms are available on our website at ***www.almda.org/page/almda-membership***.

If you have any questions about a membership category or would like information on our Facility Memberships contact the Director of Specialty Society Management, Meghan Martin, at ***mmartin@alamedical.org***. We hope to see you as a member as we all strive to prevent suffering and advocate for a frail population.

Robert Webb, MD, CMD
2019-2020 President

SAVE THE DATE: JAN. 25, 2020
ALMDA's Mid Winter Conference

Birmingham Marriott | 3590 Grandview Parkway | Birmingham, AL 35243

Room Rate is $139. Room cutoff is Jan. 3, 2020.

Call (888) 426-5171 or reserve online: ***https://tinyurl.com/ALMDAMarriottBirmingham***

Deadline to apply for CMD designation is Oct. 1

The American Board of Post-Acute and Long-Term Care Medicine (ABPLM) currently administers a certification program for Certified Medical Directors (CMD) in post-acute and long-term care settings. Certification is valid for six years. Application review meetings are conducted in June and December of each year. **The next application deadline is Oct. 1.**

Step One General Eligibility

- Completion of a U.S. ACGME or AOA accredited post-graduate training program, or a Canadian Royal College of Physicians and Surgeons or College of Family Physicians accredited post-graduate training program; OR completion of relevant U.S. post-graduate training and successful attainment of U.S. state licensure to practice medicine[1,2].
- Current, unrestricted, state license as an MD or DO in the U.S. or an equivalent license to practice medicine in Canada.
- Spend a minimum of 8 hours each month in service as a medical director in a post-acute and long-term care setting.
- Completion of "AMDA's Core Curriculum on Medical Direction in Long Term Care" (or its equivalent[3]) within five years of application.
- Demonstrated current professional integrity, competence, training, and experience and moral character.

Select One Option each from Step Two and Step Three. Select the Options that best Match your Experience and Education for each Step[4].

Step Two Clinical Education and Experience

Option 1

- Two years of clinical practice in post-acute and long-term care within the past five years AND
- Current ABMS or AOA Certification in a Primary Specialty WITH EITHER
  - Completion of an ACGME or AOA accredited fellowship in geriatrics or other relevant clinical program completed within the preceding five years of application OR
  - ABMS Certificate of Added Qualifications in Geriatric Medicine or other equivalent certification

Option 2

- Three years of clinical practice in post-acute and long-term care within the past five years AND
- Current ABMS or AOA Certification in a Primary Specialty AND
- Sixty hours of *AMA PRA Category 1 Credits*™, AAFP-approved, or AOA-approved credits in Clinical Medicine relating to post-acute and long-term care in the preceding three. A minimum of 12 of these credits must come from live course-work. Up to 48 of these credits can come from self study activities.

Option 3

- Four years of clinical practice in post-acute and long-term care within the past five years AND
- Seventy-five hours of *AMA PRA Category 1 Credits*™ , AAFP-approved, or AOA-approved credits in Clinical Medicine relating to post-acute and long-term care in the preceding three years of application A minimum of 15 of these credits must come from live course-work. Up to 60 of these credits can come from self study activities.

Step Three Medical Management Education and Experience[5]

Option 1

- Two years post-fellowship, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting AND
- Completion of a fellowship in geriatric medicine within the past five years.

Option 2

- Three years, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting AND
- 14 hours of approved CMD Management courses within five years of application.

Option 3

- Four years, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting AND
- Completion of an Individualized Education Program (IEP) in post-acute and long-term care Medical Management equivalent to the Core Curriculum for a minimum of 75 contact hours within five years of application. A written plan for the IEP must be submitted and approved by the ABPLM Board of Directors prior to completion of the program and submission of the application (all IEP coursework must be reviewed and approved by the ABPLM Board of Directors).

Contact American Board of Post-Acute and Long-Term Care Medicine (ABPLM) Director Suzanne Harris at (410) 992-3117 or ***cmd@paltc.org*** with any questions.

Applications and full requirements are available at ***https://www.abplm.org/cmd-applications***.

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[1]If you have not completed an accredited post-graduate training program, please submit a letter describing your post-graduate training in the U.S. for the Certification Board to consider.

[2]A candidate may submit a letter requesting a waiver of a requirement to explain his/her special circumstances for Certification Board consideration.

[3] The Core is an intensive course with comprehensive content specific to Medical Direction in the Long Term Care setting. In lieu of completing the Core and prior to submission of the certification application, certification candidates may submit an Individualized Education Plan (IEP), under Step Three, Option 3, to the ABPLM Board of Directors for review. After the Board determines if the proposed coursework constitutes an "equivalency", the candidate will be advised of the Board's decision. Historically, true equivalent coursework has been difficult to find. The ABPLM Board of Directors does not want to discourage experienced Medical Directors from exploring their own education histories to determine if they have completed equivalent studies and includes the language about equivalent coursework out of fairness.

[4]In addition to meeting eligibility under Step One, applicants must complete education and practice requirements under one option for Step Two AND one option for Step Three. Options for Step Two and Step Three are independent of each other.

Select the option that best describes your education and experience under each Step.

[5]Applicants who do not hold an ABMS or AOA Certification in a Primary Specialty must apply under Option 3 for Step Two.

Are you ready for the Patient Driven Payment Model?

paltc.org

On Oct. 1, 2019, the Patient Driven Payment Model (PDPM) will change how skilled nursing facilities (SNFs) are reimbursed for post-acute care provided to Medicare A recipients. This not only represents a major change in how SNFs are reimbursed; it also will significantly impact the dynamic between clinicians and the facilities they service.

PDPM consists of the following five case-mix-adjusted payment components:

- PT: covers utilization of physical therapy (PT)
- OT: covers utilization of occupational therapy (OT)
- SLP: covers utilization of speech-language pathology (SLP) services
- Nursing: covers utilization of nursing services and social services
- NTA: covers utilization of non-therapy ancillary (NTA) services

Additionally, PDPM would maintain the existing non-case-mix component to cover utilization of skilled nursing facility resources that do no vary according to resident characteristics.

Read more about the PDPM patient classifications

Calculation of Payment Under PDPM

Like the RUG-IV model, per-diem payment under PDPM would be determined by two primary factors:

- Base rates that correspond to each of the five payment components; and
- Case-mix index (CMIs) that correspond to each payment group.

Each resident would be classified into a resident group for each of the five case-mix-adjusted components. The base rate for each case-mix-adjusted component would be multiplied by the CMI corresponding to the assigned resident group. Additionally, separate adjustments would be applied to each resident's PT, OT, and NTA payments depending on the day of the stay.

AMDA Resources

- ***AMDA On-The-Go episode - PDPM***
- ***PDPM for Medical Directors: Why Change is Necessary***
- ***SNF Medical Directors and Clinicians in PDPM Have Vital Role***
- ***The Quest for Quality: Red Flags in Skilled Therapy and the Changes Required by the Planned Transition to the New Patient Driven Payment Model (PDPM)***
- ***Patient Driven Payment Model (PDPM): An Opportunity for PALTC Clinician***
- ***PDPM Collaboration: The Non-Therapy Ancillary Clinician-Pharmacist Approach Webinar***

All Things 401(K): Participants education, plan structure and assessments

alabamamedicine.org

Article contributed by Jack Adams, Asset Management Member & Retirement Plan Consultant, Warren Averett

The ultimate goal of any retirement plan is for participants to prepare for retirement, but physicians must also maintain the appropriate structure of the plan. How can you be sure everything is handled correctly? Below, one of our 401(k) plan experts, Jack Adams, answers a few frequently asked questions about 401(k) plan education, structure and design.

How do we prepare our participants for retirement?

With participants, one of the most important things you want to do is talk to them about the reason they need to save for retirement. Other advisors seem to focus on the investments, but if a participant isn't properly saving for retirement, they will never reach their ultimate goal. What we do in our retirement meetings, from an education standpoint, is focus on how much a participant needs to be saving to accomplish their goals. Typically, we tell them they need to save eight to ten times their salary, because they will live off about 80% of their pre-retirement income when they retire. This money has to last them 20 to 25 years. So again, getting them to start saving and then try to increase the amount saved each year is going to be important in reaching those retirement goals.

You also want to talk to participants about Social Security. Many people believe Social Security is going to be a large portion of their income at retirement. During our retirement meetings, we show them an estimate of the percentage of their income that will come from Social Security and what percentage has to be made from their private sources.

I think it is important to educate participants along the way to ensure that they are not surprised when they are 65 years old and ask "am I going to have enough to retire?" The last thing we try to incorporate in every one of our meetings is a retirement estimate. That is something we put on the fourth quarter statement for our clients. We calculate a projected retirement income based on their personal contributions, along with their employer contributions. When you look at this calculation each year, if the number has gone up, you're doing the right things. That number is what you can expect to live on, along with social security, during retirement.

Tell us about the different kind of structures that could be in place for a physician practice

Typically, the ultimate goal is to try to get as much of a contribution into the physician's account as possible while attempting to minimize the required contribution to the rest of the staff. There are different ways you can structure a plan depending on which safe harbor contributions you choose to make. The two options we see most often include a 3% non-elective contribution, which means that every participant would receive a fully-vested 3% contribution based on their compensation or a basic safe harbor match of 100% on the first 3% they defer and 50% on the next 2% deferred. Which scenario a practice chooses depends on the ultimate goal of the practice. If the practice is going to make a profit-sharing contribution in addition to the safe harbor contribution, then choosing the 3% safe harbor, non-elective contribution is often the better approach. This is because this 3% contribution counts towards satisfying the practice's minimum required non-elective contribution that each eligible participant is required receive in a cross-tested profit-sharing plan. The two most common types of physician practice profit sharing plan designs are the aforementioned cross-tested design or the integrated design. Depending on the age of the physicians and their ultimate goal, we can look at each plan design to ensure the maximum benefit at the lowest cost.

Psychiatrists offer recommendations to help older adults with mental disorders

psychnews.org

As the percentage of U.S. adults older than 65 years continues to grow, so too does the need for preventing mental illness among older adults as well as improving clinical services and outcomes for older patients with psychiatric disorders. So said psychiatrists Warren D. Taylor, MD, MHSc, of Vanderbilt University Medical Center, and Charles F. Reynolds III, MD, of the University of Pittsburgh, in an article published in *JAMA Psychiatry*.

"There will never be enough geriatricians, so we need collaborative approaches that allow us to improve treatment and reduce disease burden," Taylor and Reynolds wrote. "Research in these areas requires transdisciplinary and translational team-based science, where psychiatrists and psychologists work with geroscientists, implementation scientists, and social scientists."

They outlined several areas of emphasis for research that could help reduce the burden of psychiatric illness in older adults:

- **Expand suicide prevention efforts, including early identification of those at greatest risk.** Despite a rise in suicide rates in other populations, older adults have the highest risk of suicide completion, they noted.
- **Develop strategies to prevent the recurrence of psychiatric disorders such as mood and anxiety disorders, which are common in older populations.** "While we have substantial information about the acute treatment of these disorders, we know far less about how to keep someone well and avoid future episodes," they wrote.
- **Determine best ways to treat older patients for substance use disorders.** This includes careful consideration of possible untreated general medical conditions and risk of cognitive impairment in these patients.
- **Continue to investigate the impact of mental illness on general medical disorders.** "Beyond addiction, other mental disorders negatively affect the outcomes of medical disorders, including cardiovascular disease and diabetes. Further research is needed to elucidate the biological mechanisms underlying these observations and to identify specific targets where intervention may improve both mental and physical prognosis," they wrote.
- **Elucidate the contribution of mental disorders to cognitive decline and dementia risk.** Depression and other mental disorders accelerate cognitive decline and increase risk of dementia. The mechanism underlying this relationship remains unclear, which complicates efforts to reduce this risk and preserve long-term cognitive function in this population, they wrote.

Although "these challenges are daunting … [w]e have a moral obligation to care for the most vulnerable in our society," Taylor and Reynolds concluded. "We need better research and clinical services focused on mental disorders in the elderly, along with integrated interventions promoting resilience, wellness, and successful aging."

Health, dental insurance available from the Medical Association of the State of Alabama

The Physicians Insurance Plan of Alabama (PIPA), administered through Blue Cross Blue Shield, is a benefit available to members of the Medical Association of the State of Alabama. PIPA provides the physician, their family and staff with strong benefits at affordable premiums.

Open enrollment is Oct. 1 - Oct. 31 for a Jan. 1, 2020, effective date. Current PIPA participants do not have to reapply. However, any changes to current plans must be made no later than Oct. 31.

Visit ***www.alamedical.org/insurance*** for full details of the plan and for links to applications and materials. Contact Brenda Green at ***bgreen@alamedical.org*** with questions specific to the insurance application procedure.

For information on joining the Medical Association of the State of Alabama, contact Meghan Martin, Director of Membership and Specialty Society Management, at ***mmartin@alamedical.org***.

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The Alabama Medical Directors Association (ALMDA) is the professional association of physicians and other professionals practicing in the long-term care continuum and is dedicated to excellence in patient care by providing education, advocacy, information and professional development.

The articles contained in ALMDA News & Notes are meant to provoke thought and comment and do not necessarily reflect the views and opinions of the members, Executive Council or staff of the Alabama Medical Directors Association. Comments and letters to the editor are welcome.