

**POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
HOUSE OF DELEGATES**

RESOLUTION # A26

SUBJECT: Subspecialty Groups in Post-Acute & Long-Term Care

INTRODUCED BY: PALTmed Washington and PALTmed Georgia

INTRODUCED ON: March 2026

1 **Whereas**, reports from across the country describe an expanding role of subspecialty medical
2 groups in skilled nursing facilities (SNFs), offering *subspecialty medical care*—including
3 services from specialists such as Otorhinolaryngology, Cardiology, Nephrology, Physiatry, and
4 disciplines beyond standard SNF internal medicine, behavioral health, dentistry, podiatry, and
5 wound care—highlighting opportunities for improved coordination with the medical director,
6 attending SNF physician, and facility Advanced Practice Practitioners (APPs); therefore be it
7

8 **RESOLVED**, that our Post-Acute and Long-Term Care Medical Association (PALTmed) create
9 evidence-based practice guidelines to guide collaboration between the medical director,
10 attending physician, Advanced Practice Practitioners (APPs), and subspecialty groups, and to
11 promote optimal care for all residents, standard credentialing, and minimum training.
12
13

FISCAL NOTE:



RESOLUTION RESULTS: < FOR PALTmed OFFICE ONLY >

**POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
HOUSE OF DELEGATES**

RESOLUTION # B26

SUBJECT: Vaccine Recommendations Based on Evidence-Based Medicine To Advance Person-Centered Care

INTRODUCED BY: PALTmed Colorado, PALTmed Washington, and PALTmed Georgia

INTRODUCED ON: March 2026

1
2 **Whereas**, the expressed mission of PALTmed is that *PALTmed leads the way in empowering*
3 *compassionate and skilled clinicians to deliver person-centered care in the post-acute, and long-*
4 *term care (PALTC) continuum*¹;

5
6 **Whereas**, evidence-based practice is critical to advancing benefits and reducing risks of clinical
7 interventions for patients²;

8
9 **Whereas**, practitioner and medical director skills include the responsibility to provide vaccine-
10 related education community-wide to medically vulnerable patients, responsible parties, staff and
11 medical providers; therefore be it

12
13 **RESOLVED**, that our Post-Acute and Long-Term Care Medical Association (PALTmed)
14 evaluates and endorses vaccine-related schedules and recommendations that are based on
15 scientific review and evidence-based medicine to advance person-centered care in post-acute and
16 long-term care (PALTC).
17

FISCAL NOTE:



RESOLUTION RESULTS: < FOR PALTmed OFFICE ONLY >

REFERENCES

1. <https://paltmed.org/about-paltmed>. Accessed 1/23/26.
2. *Implementation of Evidence-Based Practice in Long-Term Care: A Scoping Review*. McGough EL, Thompson HJ. J Am Med Dir Assoc. 2024;25(7):105026. doi: 10.1016/j.jamda.2024.105026

**POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
HOUSE OF DELEGATES**

RESOLUTION # C26

SUBJECT: Medical Director and Clinical Practitioners’ gain share in I-SNPs and IE-SNPs

INTRODUCED BY: PALTmed Value Based Care Work Group/ Public Policy Committee

INTRODUCED ON: March 2026

1 **Whereas**, Value Based Care (VBC) programs aim to promote best practices in clinical care of
2 patients in all settings of care; and
3

4 **Whereas**, improved patient care in VBC programs is expected to produce better clinical
5 outcomes for their beneficiaries and avoid unnecessary hospitalizations resulting in substantial
6 savings in patient care expenses; and
7

8 **Whereas**, most VBC programs including Accountable Care Organizations (ACOs) reward
9 physicians and clinical practitioners for improved clinical outcomes and reduced care spend for
10 the plans’ beneficiaries by sharing program generated savings with clinical practitioners; and
11

12 **Whereas**, Institutional- Special Needs Plans (I-SNPs) and Institutional Equivalent- Special
13 Needs Plans (IE-SNPs) belong to the VBC category, and are designed to improve long term care
14 (LTC) residents’ clinical outcomes and reduce care spend by treating them in place at long term
15 care facilities by the provision of complex and coordinated clinical care by clinical practitioners
16 and Medical Directors designed to prevent unnecessary hospitalizations, but most I-SNPs and
17 IE-SNPs do not currently share savings generated by these programs with clinical practitioners
18 and medical Directors; and
19

20 **Whereas**, Medicare Advantage (MA) plans generate savings by managing utilization at the
21 expense of increased workload on the clinical workforce coupled with diminished
22 reimbursements despite higher patient acuity in post-acute and long- term care settings; therefore
23 be it
24

25 **RESOLVED**, that our Post-Acute and Long-Term Care Medical Association (PALTmed)
26 advocate for legislative and regulatory changes in concert with American Medical Association
27 and other like-minded parties to ensure a fair and equitable distribution of generated savings
28 from Institutional Special Needs Plans (I-SNPs) and Institutional Equivalent- Special Needs
29 Plans (IE-SNPs) with nursing home Medical Directors and clinical practitioners providing
30 clinical, administrative, quality improvement, and clinical care co-ordination services to the
31 plans’ beneficiaries, commensurate with the time and effort expended by the clinicians to
32 achieve better clinical outcomes and generate savings for the said plans; and to require Medicare
33 Advantage Organizations (MAOs) to pass through acuity-adjusted capitated payments to
34 clinical practitioners, ensuring that those delivering care to the most complex patients receive
35 commensurate resources.
36

FISCAL NOTE:



RESOLUTION RESULTS: < FOR PALTmed OFFICE ONLY >

**POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
HOUSE OF DELEGATES**

RESOLUTION # D26

SUBJECT: Discharge Summaries from Skilled Nursing Facilities

INTRODUCED BY: New York Society for Post-Acute and Long-Term Care

INTRODUCED ON: March 2026

1 **Whereas**, when patients transition between different settings, i.e. community to hospital,
2 hospital to skilled nursing facility (SNF), and SNF to community, the quality of care and patient
3 safety can be compromised due to high rates of medication errors, incomplete/inaccurate
4 information transfer, and lack of follow-up care ^{1,2,3,4,5,6}; and

5
6 **Whereas**, published recommendations for optimization of transitions of care including a 2016
7 best practice consensus from SGIM-AMDA-AGS ⁷ includes a recommendation that SNFs
8 transmit a formal discharge summary to the patient’s outpatient PCP within 72 hours of patient
9 discharge from SNF; and

10
11 **Whereas**, the Centers for Medicare and Medicaid Services (CMS) has issued a policy
12 regulation⁸ in 2017 requiring SNFs to create a discharge summary that includes but is not limited
13 to a recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of
14 illness/treatment or therapy, medications and pertinent lab, radiology, and consultation results, to
15 improve follow-up care; therefore be it

16
17 **RESOLVED**, that our Post-Acute and Long-Term Care Medical Association (PALTmed)
18 educate their members as to CMS Policy⁸ regarding SNF’s responsibility to create and timely
19 deliver a comprehensive patient discharge summary to a patient’s outpatient primary care
20 physician (PCP); and be it further

21
22 **RESOLVED**, that PALTmed advance education and clinical tools to facilitate PALTmed
23 medical providers to meet the recommended standard for discharge summary communication to
24 PCPs; and be it further

25
26 **RESOLVED**, PALTmed advocate for inclusion of efficient, high-quality tools for SNF
27 discharge summary completion and distribution in EHRs.

FISCAL NOTE:



RESOLUTION RESULTS: < FOR PALTmed OFFICE ONLY >

REFERENCES

1. Coleman EA, Min SJ, Chomiak A, Kramer AM. Posthospital care transitions: patterns, complications, and risk identification. *Health Serv Res.* 2004;39(5):1449–1465.
2. Grabowski DC, O'Malley AJ, Barhydt NR. The costs and potential savings associated with nursing home hospitalizations. *Health Aff (Millwood).* 2007;26(6):1753–1761.
3. Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of rehospitalization from skilled nursing facilities. *Health Aff (Millwood).* 2010;29(1):57–64.
4. van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during postdischarge visits on hospital readmission. *J Gen Intern Med.* 2002;17:186-192.
5. Moore C, Wisnevesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *J Gen Intern Med.* 2003; 18:646-651.
6. van Walraven C, Mamdani M, Fang J, Austin PC. Continuity of care and patient outcomes after hospital discharge. *J Gen Intern Med.* 2004;19:624-631.
7. Lindquist LA, Miller RK, Saltsman WS, Carnahan J, Rowe TA, Arbaje AI, Werner N, Boockvar K, Steinberg K, Baharlou S. SGIM-AMDA-AGS Consensus Best Practice Recommendations for Transitioning Patients' Healthcare from Skilled Nursing Facilities to the Community. *J Gen Intern Med.* 2017 Feb;32(2):199-203. Doi: 10.1007/s11606-016-3850-8. Epub 2016 Oct 4. PMID: 27704367; PMCID: PMC5264673.
8. F661 483.21(c)(2)