When this role was introduced to me in the summer of 2014, I remember a key turning point in my career in post-acute and long-term care. The new medical director at the facility where I had been working for several years began to give me recommendations on the impact of my care. Before that, I had barely known there was a medical director. And even as others complained about the new medical director “telling them what to do” or “not understanding how difficult this patient is to manage,” I welcomed the oversight as a learning opportunity.

As a direct result of the influence of a caring, engaged medical director, I began to read more journal articles, reviewed studies and best practices, and attended more conferences. The challenges of understanding how to read the evidence and recognize its limitations while being aware of bias in ourselves and others became a central part of my practice. For the first time I realized how much the culture and care in a facility could be influenced by this kind of leadership, and it shaped my desire to become more involved.

The medical director is a vital part of the nursing home’s health care team, ideally providing the clinical and administrative knowledge that leads to better outcomes for the patients and contributing to the success of nursing homes in a highly regulated environment. Some challenging trends facing PALTc facilities and their medical directors include the increased complexity of patients, the new Patient Driven Payment Model, the growing regulatory demands, antibiotic stewardship, and monitoring opioid and antipsychotic use. It is more difficult than ever for one person to do all that is expected of the medical director. One way to meet these growing demands is to delegate some of the medical director’s responsibilities to other physicians or to experienced nurse practitioners (NPs) or physician assistants (PAs).

Another trend in nursing homes is that the number of physicians has stayed stagnant — or, in some areas of the country, decreased — while the number of NPs and PAs working in nursing homes has grown. This is coupled with a growing trend among providers of becoming specialists working in nursing homes and skilled nursing facilities (so they are sometimes called "SNFists"). The fastest growing group of these providers in nursing homes is NPs and PAs who specialize in nursing home care.

Nursing homes are an opportunity for NPs and PAs. The teamwork-based nature of post-acute care provides a great learning environment. The providers gain access to experienced pharmacists, nurses, social workers, dieticians, physicians, and a multitude of specialists — all collaborating to provide the best care possible to some of the most frail, medically complex patients in U.S. health care. The NPs and PAs who specialize in nursing home care can take advantage of the team-based environment by dedicating themselves to learning and collaborating. These opportunities also make NPs and PAs an as-yet untapped resource for leadership roles such as assistant to the medical director.

In a working environment that is characterized by teamwork, we can also be very isolated from our peers. Outside of regular phone conversations, there is very little opportunity to spend time with other providers. Personally I never felt the educational relevance and sense of community in the PALTc environment until I finally found a professional home: my penchant for learning led me to attend my first annual conferences of CMDA — The Colorado Society for PALTc Medicine and then AMDA — The Society for Post-Acute and Long-Term Medicine. Over the years since, I have attended many other conferences, but the monthly meetings and annual conferences of CMDA and the Society have provided a much-needed collegial atmosphere, great networking opportunities, and a plethora of valuable educational offerings. My involvement in these organizations eventually led to becoming one of the first PAs elected to the CMDA board as well as gave me an opportunity to become an assistant to the medical director for multiple nursing homes.

The medical director whose involvement began to shape my patient care is also the chief medical officer for a large nursing home chain. He continued to express frustration over finding attended CMDA meetings, displayed the previously described attributes, and was actively seeking to attain skills and knowledge he didn’t yet possess.

In short, he was exactly what I’d been looking for. It would take two years and many meetings with leadership, but eventually they allowed me to hire him as a corporate “assistant to the medical director” to fill some glaringly obvious responsibility gaps among some of our medical directors. When this role worked out beyond expectations, it was only a minor tweak to add him to the team in a facility where most patients were followed by the medical director of record. Six months later, I received this feedback from the director of nursing/nursing home administrator: “Travis is an awesome addition to our team! He is collaborative and recommendations are very compatible for our vision. Psychopharm used to be a meeting everyone dreaded, and now it feels like everyone has a voice — no idea is shot down. [Travis] is a huge part of the positive transition for us. So much better than anything we had last year!”

The rest is history — a very positive one.

Supporting the Medical Director: An Opportunity for Physicians, NPs, and PAs
By Travis Neill, PA-C, MMS

A Perfect Fit
By Gregory Gahm, MD, FACP