INNOVATIONS IN PALTC

Supporting the Medical Director: An Opportunity for Physicians, NPs, and PAs

By Travis Neill, PA-C, MMS

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).

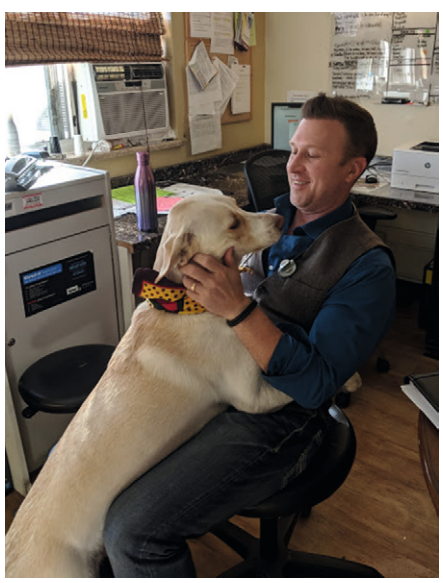

Photo courtesy of Travis Neill.

Travis Neill, PA-C, MMS, and his dog Jack, who comes to work with him often, at a nursing station.

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 continually expressed frustration over finding the personnel and the time to meet the growing challenges that face all medical directors. He began to mentor me on a specific subset of medical director responsibilities; if an existing medical director did not have the time or ability to meet the growing demands, I would be asked to fill in the gaps. This began the process of finding an actual title and position for me as an assistant to the

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A Perfect Fit

By Gregory Gahm, MD, FACP

The facility medical director role is changing. The days of signing forms, attending a meeting, and receiving monthly stipends are over. Welcome to active oversight, interventions for improving patient care, combating polypharmacy, evaluating and enforcing antibiotic stewardship, reducing inappropriate psychotropics, understanding the letter and intent of the regulations from the Centers for Medicare & Medicaid Services ... and hourly rates for work actually done.

As an aging group of "old-time" medical directors prepares to retire, finding younger replacements has been challenging. Finding physicians who want to assume this role — which requires staying educated (academically and administratively) as well as being involved in patient care decisions and frequently being the "bad guy" to patients, families, and peers — isn't easy. As the president of CMDA — The Colorado Society for PALTC Medicine from 2012–2016 and chief medical officer for a long-term care chain, I was always scoping out new prospects.

Let's rewind to 2014: Enter a young provider, whom I had come to know and respect for his clinical acumen, intellectual curiosity, participation in psychopharmacology meetings, and, luckily, his willingness to thoughtfully challenge recommendations. I relish finding this kind of provider, but unfortunately my successes have been few and far between. Most either blindly follow recommendations without thinking or questioning, or they simply ignore them. I have little respect for either.

Now let's jump to 2016: The young provider has asked me what it would take to be a medical director. My reluctant response was simply, "Different initials after your name" — MD or DO rather than PA-C. Nonetheless, I tucked the information away, knowing he actively 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. Psychpharm 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.

Dr. Gahm is a geriatrician serving as chief medical officer for Vivage Senior Living and medical director for a number of Denver-area nursing homes. He served as president of CMDA — The Colorado Society for PALTC Medicine. Dr. Gahm serves on several task forces, including antibiotic stewardship, inappropriate use of antipsychotics and psychoactive agents, prevention of *Clostridium difficile* infections, and strategies for discharging very difficult long-term care patients. For the past five years, he has led a monthly Geriatric Journal Club for LTC providers in Colorado.

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medical director. He worked through the legal concerns and had a separate contract created for my new position.

Improved quality is just one of the advantages of dividing responsibilities between the medical director and their assistant.

The medical director responsibilities I am assigned are agreed upon by a nursing home's administrator and existing medical director, and I bill separately for the work that I do. When I am added, it can be cost neutral to the facilities because we simply divide up the responsibilities. The administrator may sometimes ask for additional things to be done as well because, as a team, we now have the bandwidth to accomplish more.

For the past two years, I have been working in multiple nursing homes as an assistant to the medical director, supporting the existing medical directors by doing antibiotic stewardship reviews, psychopharmacology meetings, quality assurance and performance improvement (QAPI) meetings, and chart reviews. I work hand-in-hand with the existing medical director as well as consult regularly with a team of medical directors from around the state who provide guidance and mentorship. The work is challenging but incredibly rewarding, and there is no doubt it has made me a better clinician.

The physician medical director and I divide up the role based on our own preferences, strengths, weaknesses, and schedules. For example, I have become somewhat of a subject matter expert in antibiotic stewardship, and I perform hundreds of reviews at a dozen facilities each month. This experience has improved the quality of the reviews, reduced the cost to the facilities, and allowed me to perform more reviews in less time as my experience grows.

As our team approach to medical direction has produced better results, the facilities have shown more of an interest in trying out new ideas. If something new appears to be working at one nursing home, it can be applied to several nursing homes simultaneously. This gives the most skilled and engaged medical directors the ability to make a difference for hundreds more patients than they could if they were the sole medical director at fewer facilities. The medical directors that I work with have voiced that sharing the responsibilities has allowed them to focus more on their strengths and find a better balance with a busy schedule between patient care and medical director oversight.

The nursing home environment must change to meet the demands of an older and more medically complex patient population, and in such a dynamic clinical and regulatory environment it is imperative that we work together. As the number of NPs and PAs specializing in nursing home care continues to grow, I encourage experienced medical directors to seek out and mentor the most dedicated NPs and PAs. Experienced medical directors also should consider mentoring a new generation of physician medical directors, along with NPs and PAs, to eventually become assistants to the medical directors. This can help recruit, retain, and energize physicians, NPs, and PAs to become more involved in the success of nursing homes through leadership, collaboration, and contributing to a culture of high-quality care.

Mr. Neill is a physician assistant who has been working in PALTC for over 10 years. He teaches at the University of Colorado PA program, serves on the executive board of CMDA — The Colorado Society for PALTC Medicine, and contributes regularly to the education provided by CMDA and the Colorado Geriatric Journal Club.

Photo courtesy of Travis Neill.

Travis Neill, PA-C, MMS, and A. Lee Anneberg, MD, CMD (left), a multifacility medical director and former president and treasurer of CMDA – The Colorado Society for PALTC Medicine, at the 2019 Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine.