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Original Study

The Role of the Medical Director in Ontario Long-Term Care Homes: Impact of COVID-19

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ABSTRACT

Objectives: The pandemic has uncovered a broad lack of understanding of the role of the Medical Director in Canadian Long-Term Care (LTC) Homes. Our objectives were to identify the current demographics and practices of LTC Medical Directors, discover how the pandemic affected their practice habits, and inform the content of the Ontario Long-Term Care Clinicians Medical Director Course, to ensure that Medical Directors have the requisite knowledge of the responsibilities of their role.
Design: Email survey.
Setting and Participants: Medical directors in Ontario long-term care homes.
Methods: Responses to open-ended, close-ended, multiple-choice, and free-text questions.
Results: A total of 156 medical directors (approximately 24%) completed the survey. Ninety-four percent were family physicians. Approximately 40% of participants had been a medical director for fewer than 5 years, whereas more than 11% have been in the role for greater than 30 years. More than 60% spend fewer than 2 hours per week in their administrative role, with fewer than 23% completing formal evaluations of the attending clinicians. Greater than 75% are either satisfied or extremely satisfied in their medical director role, citing excellent engagement and collaboration with team members. Feelings of dissatisfaction were associated with pandemic stress, increased hours and responsibility, inadequate remuneration, lack of ability to make decisions and lack of acknowledgement that physicians add value to the interdisciplinary team.
Conclusion and Implications: It is clear that medical directors are in a unique position to impact the care of residents within LTC. It is imperative to engage medical directors as integral members of the LTC health care team. This can be achieved by acknowledging their medical expertise for improving outcomes, providing them with the authority for decision making, compensating them appropriately, and clearly defining the role. By making these changes, we can ensure that there is a higher likelihood to sustain effective medical leadership in LTC.

The long-term care (LTC) sector has been subject to some unflattering commentary throughout the pandemic. During the first 2 waves, when many homes had large outbreaks, attention was concentrated on the ownership style of the home (for profit vs not for profit), structural factors such as multibed rooms and ventilation, and infection prevention and control practices.[1] Questions were also raised about medical leadership in LTC.

The role of the medical director in LTC in Ontario was established almost 50 years ago to improve physician participation in and enhance the quality of medical care delivered to LTC residents.[2] LTC homes in Ontario are part of the provincial publicly funded health care system, which provides funding for all staff and supplies required for nursing and personal care, recreational and social programs for residents, support services, and raw food used to prepare meals. This same funding model provides for a medical director stipend of $0.36 per resident per day.[3] Compensation, however, is variable as individual

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medical directors can negotiate directly with the homes to which they are contracted for improved compensation. There is also no standard contract for medical directors, so the role description and expectations are at the discretion of the home. There are 627 long-term care homes in Ontario providing care for approximately 115,000 residents. A recent study determined that more than 1500 family physicians provide care as most responsible physician (MRP) to residents in Ontario long-term care homes, with 51% of those providing more than 90% of the care.[4] The total number of medical directors remains unclear, however, is as there exists no database in Ontario and some practice at more than 1 home. Although the American Medical Directors Association has worked to enhance the role of the medical director and has developed broad guidelines to support the role, Canada does not have a standard role description. An article published in *Canadian Family Physician* in 2010 recommended a national role description for medical directors in LTC, based on a survey of 370 LTC home administrators, directors of care, and medical directors.[5] The key functional areas described as essential included leadership, administration, quality improvement, medical staff management, and residents' rights and services. Although the Ontario Long-Term Care Home's Act (LTCHA) legislates the presence of a medical director and requires every licensee of an LTC home in the province to have an organized program of medical services for the home, there is no clear role description, and the key responsibilities are somewhat vague. These include monitoring and evaluating medical services, advising on clinical policies and procedures, participating in interdisciplinary committees and quality improvement activities, and communicating expectations of the attending physicians and nurse practitioners.[6] Further, there is no oversight and little visibility into the engagement of individual medical directors at their respective homes. A recent overview of medical care in nursing homes provides insights into the three critical pillars of commitment, competency, and medical staff organization models.[7]

In March 2021, the College of Family Physicians of Canada and the Canadian Society for Long-Term Care Medicine released a joint statement on the role of family physicians in LTC homes.[5] The statement identified 4 key areas of urgent focus: national standards for LTC, enhanced funding for staffing, family physician leadership in the medical director role in each LTC home, and effective and integrated communication for patient-centered care. They identified that appropriate support for physician leadership was crucial to ensuring high-quality care and that having a family physician as an LTC medical director would enable that high-quality care through leadership, administration, quality improvement, medical staff management, resident services, and resident rights. There has not been a Canadian study outlining specific demographics, the number of hours required to perform the administrative duties, or variations in practice of medical directors. Health care in Canada is a provincial responsibility and the profile of LTC residents is similar.[8] Twenty-two years ago, the Institute of Medicine in the United States report "Improving the Quality of Long-Term Care"[9] strongly recommended that LTC medical directors be given greater authority and hold more accountability for medical services. The American Medical Directors Association (AMDA) in the United States has 4 clearly defined roles of the LTC medical director: physician leadership, patient care—clinical leadership, quality of care, and education, information, and communication.[10] An association between certified medical directors and improved quality outcomes in US nursing homes has been demonstrated through analysis of Center for Medical Services data.[11] The study, published in *JAMDA*, concluded that the presence of a certified medical director in US nursing homes was an independent predictor of quality.

Ontario Long Term Care Clinicians (OLTCC) is a not-for-profit association providing education and advocacy for a membership of LTC medical directors, attending physicians, nurse practitioners and pharmacists. Starting in 2013, OLTCC has offered an LTC Medical Director course to meet the perceived and unperceived learning needs for Ontario LTC medical directors. This is a provincial course as although Canada has universal health care, the delivery of this is province specific. The curriculum meets accreditation standards of the College of Family Physicians of Canada and uses a blended learning model with pre-course readings, didactic sessions, interactive facilitated small group, case-based discussions, and an online LTC medical directors manual. During the pandemic, the curriculum pivoted to a virtual interactive course. The course is modeled on the well-established Core Curriculum delivered by AMDA, recognizing the need for a Canadian course to meet the specifics of the LTC sector in Ontario. Topics cover 20 leadership themes, including the legislative framework, quality improvement, leadership and medical staff management, infection prevention and control, documentation, and resident-centered care. By 2021, the scientific planning committee of the OLTCC Medical Director Course created a survey to adapt the course to meet the changing role of medical directors.

Methods

The authors created a 20-question anonymous survey on Survey Monkey that consisted of 12 multiple-choice questions, 4 multiple-choice questions with optional free text, 3 free text requiring numeric responses, and 1 that was entirely free text. The link was sent via email and newsletters on June 22, 2021, to medical directors through various long-term care associations: Ontario Long-Term Care Clinicians, Canadian Society for Long-Term Care Medicine, the Ontario Long-Term Care Association, and AdvantageOntario, an association of not-for-profit LTC home operators. There was a 45-day deadline to complete with reminder notifications sent out at 21 and 36 days. Ontario Long-Term Care Clinicians staff provided data on all participants who have completed the medical director course since its inception in 2013.

Results

A total of 156 respondents completed the survey and the characteristics of these practitioners can be found in Table 1. The vast majority of respondents are family physicians, with 21.72% having received a Certificate of Added Competence from the College of Family Physicians of Canada. Almost 20% have completed additional leadership training that would pertain to the role of a medical director in a long-term care home, and more than two-thirds have completed additional training in palliative care, a critical skill in this environment. More than one-half of respondents practice in a community with a population greater than 100,000, whereas another 36.54% practice in small to medium population centers. Although more than one-quarter of the medical directors surveyed work in long-term care exclusively, the majority practice in other settings as well, such as family practice, hospital medicine, and emergency medicine. Other areas of practice included palliative care, geriatric outreach teams, and complex continuing care. Practice characteristics also included the number of homes practiced in and the number of residents cared for in addition to the medical director role and the length of time as medical director, which had a large range from less than 2 weeks to 54 years.

Prior to the pandemic, 61.07% reported spending less than 2 hours per week in the medical director role whereas 13.42% spent more than 4 hours weekly in the role. Conversely, 73.68% spent more than 4 hours weekly in their clinical role, whereas only 2.63% spent less than 2 hours doing so.

More than 70% of respondents participated in each of interdisciplinary advisory committees, quality improvement initiatives, and staff education whereas only 22% were involved in formal performance evaluations of attending clinicians. In their clinical roles, more than 72% regularly attend resident care conferences with the interdisciplinary teams. Changes to clinical practice during the pandemic

Table 1
Demographics and Practice Patterns

Characteristic	Percentage
Background	
Family practice	93.59
Geriatrics	3.21
Other	3.21
Certificate of added competence from College of Family Physicians of Canada	
Care of the elderly	16.03
Palliative care	4.49
Emergency medicine	1.2
Focused practice designation from the Ontario Medical Association, yes	14.74
Additional management or leadership training	
Yes	17.95*
Master of business administration	1.80
Additional training in palliative care, yes	67.52
Community size	
Large (≥100,000)	55.77
Medium (30,000-99,999)	12.82
Small (1000-29,999)	23.72
Rural (<1000)	7.69
Practice locations	
Long-term care exclusively	26.75
Family practice	61.15
Hospital practice	17.83
Emergency medicine	5.73
Other	12.74
Number of homes practiced in	
1	42.9
2	26.0
3	19.5
4	4.4
≥5	7.0
Number of residents cared for in addition to medical director role	
Does not provide care	3.2
≤30	7.05
31-60	31.13
61-90	20.51
91-12	17.95
>120	21.15
Length of time as medical director, y	
<1	9.09
1-2	14.29
3-5	17.53
6-10	11.04
11-20	25.08
21-30	11.69
31-40	6.49
>40	3.90

*Sources: Canadian Medical Association, Saegis, Joule, Harvard, Rotman, Bruyere Research Institute.

included more virtual visits, more time engaging with residents and families, and more phone calls. More than one-half of those surveyed spent between 0 and 4 additional hours per week in their nonclinical role because of the pandemic. The table also demonstrates a high level of satisfaction in the medical director role, with more than 58% being satisfied and almost 17% being extremely satisfied. Participants were also asked to comment on their level of satisfaction. This was a free-text question with 131 individual responses. The primary reasons cited for high satisfaction rate involved support, cooperation, and collaboration with the team in the home. Many described excellent relationships with the opportunity to improve quality of care and the feeling they were a valued member of the team. Primary reasons for dissatisfaction included the increased amount of work throughout the pandemic without appropriate compensation, limited ability to make decisions, lack of standardization of role and expectations, and corporate-level decision making that does not involve physicians.

Discussion

The physician workforce in LTC is almost 95% family physicians, with more than 28% having a certificate of added competence in care of older people, palliative care or emergency medicine. More than 67% of LTC medical directors have completed additional training in palliative care. Almost three-quarters of those doing clinical work attend care conferences regularly and almost 84% attend their professional advisory or medical advisory committees regularly. A total of 421 participants have completed the OLTCC Medical Director Course over the past 7 years, with 160 completing it during the pandemic.

There is a U-shaped distribution of years of experience of medical directors, with 41% being in the role for fewer than 5 years, and 48% being in the role for more than 20 years. This survey was completed 15 months into the pandemic, at which point more than 9% of respondents reported less than 1-year experience and a further 14% had less than 2 years' experience. This indicates that a significant turnover of medical directors had occurred early within the initial 2 waves of COVID-19. New medical directors were challenged with maintaining access to medical services at a level much higher than baseline, in addition to coordinating infection prevention and control requirements when in the early months there was significant limitation to adequate personal protective equipment and COVID testing capacity. This was also at a time when the networking opportunities critical for new Medical Directors were limited. Of note, more than 10% of the respondents had more than 30 years' experience suggesting they were in the age range that puts them at higher risk for poor outcomes if they were to contract COVID-19. This may have been a factor in the turnover and may also have led to the decision to provide more virtual than in-person care when homes were in outbreak. Almost 27% have a dedicated LTC practice, but most continue to have practices in a variety of areas, with family practice being most common.

The vast majority of those who were not too new to comment (7.14%) spent more time doing administrative work as a result of the pandemic; many dedicated significant hours providing clinical and administrative support to their homes. More than a third (38.96%) reported spending between 0 and 2 additional hours each week. An equal number (20.78%) spent either 2-4 or 4-10 additional hours per week, and 8.44% spent greater than 8 additional hours per week. Forty-four of the respondents commented on the impact of the pandemic on their practice. Themes of the comments included daily calls to the charge nurse, improving knowledge of infection prevention and control, assisting other homes in outbreak and spending more time in the homes. They experienced hardship and stress and recognized that they had medical responsibility without the authority to make changes related to resources and staffing.

Remuneration was not adjusted to compensate for the additional pandemic workload, especially when compared to their acute care colleagues. It has been suggested previously that remuneration for physicians in LTC should recognize the increasing complexity and acuity of residents in LTC.[12]

More than 75% of medical directors surveyed were either satisfied or extremely satisfied with their role. A previous study of medical directors in LTC in 2006 demonstrated a similar level of satisfaction.[13] The authors of that study aimed to gain insight from medical directors on recruitment and retention to address potential physician shortages in LTC. Like our study, there were similar themes for satisfaction (teamwork with other long-term care staff, administrative role as medical director, and administrative support) and dissatisfaction

(financial compensation and remuneration for on-call coverage). It also identified an aging medical workforce where 82.7% of respondents felt there was a physician shortage in LTC and recommended several strategies for recruitment and retention that included increasing the fee schedule, increasing exposure to LTC during residency, and increasing nursing staff.

The findings of this survey suggest that our LTC medical director course needs to include case studies relevant to both experienced and new medical directors. Also, demands on medical directors during the pandemic suggest continued emphasis on outbreak management and on dealing with residents and families.

Limitations and Strengths of This Study

This study relied on anonymous, self-reported data that can introduce response bias in areas such as additional hours spent during the pandemic. We do not have an accurate count of medical directors across the province and, therefore, do not know if this is generalizable to all medical directors. Each of the 627 LTC homes in Ontario requires a medical director, but some medical directors cover more than 1 home. The response rate would be 23.9% if medical directors were attached to only 1 home; however, the response rate is likely higher because of the number of medical directors who practice at more than 1 home. Despite multiple distribution channels for the survey, the response rate is lower than expected. According to the National Center for Health Statistics, response rates for physician surveys are generally in the 40% to 50% range.[14] The number of additional hours spent weekly in the medical director role was free text. As a result, there were multiple responses that ranged from single numbers to broad ranges, and some responses (3.9%) were nonnumeric (eg, minimal, variable, twice as many) and could not be captured meaningfully. The results may have been more accurate if specific ranges were offered as multiple choice.

We know how many people have completed the medical director training because these data have been tracked since the beginning of the course. What we do not know is how many of those who completed the course are still practicing, or how many of the survey respondents have taken the course. We could not cross-reference that list with the results from the survey, because it was anonymous. Also, although we know the total number of medical directors who have completed training, that question should have been embedded into this survey for more relevance to the answers that pertain to additional administrative activities such as performance evaluations, quality improvement activities, and involvement in professional advisory committees.

Conclusions and Implications

COVID-19 has identified many challenges facing LTC practitioners. The experience in the 627 LTCHs in Ontario is replicated across Canada, the United States, and Europe. A special article in *European Geriatric Medicine* concluded that physicians providing medical care to nursing home residents should have a formal competence in geriatric medicine and old age psychiatry to provide clinical leadership for a broad range of complexities of care.[15] The number of medical directors who were in their role for less than 2 years at the time of our survey suggests high turnover that might have occurred as a result of the pandemic. Conversely, almost 11% of the respondents have been in practice for more than 30 years, potentially close to retirement. There is a risk of further physician shortage in the future if steps are not taken to recruit and retain more physicians to the sector. This is in keeping with findings from Michel and Ecarnot,[16] who reported that 38% of physicians in Europe are aged ≥55 years, which is impacting on the practice of geriatric medicine. They highlighted the need to identify ways in which to attract and retain health care professionals to cope with the increasing demands for geriatric care.

There was not a clear correlation between the size of the medical director's LTC practice and the number of hours spent in the administrative role. Given the self-reporting nature of the survey with no corroborating evidence, we can only rely on the numbers provided. Future studies should focus on the size of the home vs the size of the practice to determine if that has more of an impact on time dedicated to the medical director role. In addition, consideration of tracking not only the number of hours spent in the role but other metrics may add additional information to the value of the role.

It is refreshing to see such a high number of satisfied medical directors. If we wish to retain these dedicated physicians and recruit talented new ones, we need to listen to the reasons for their satisfaction and dissatisfaction. Medical directors must be in an environment in which they feel supported and work as an integral member of the team.

Their role must be clearly delineated and appropriately compensated, and they need to be empowered to make decisions as a key member of the leadership team. In Ontario, at the present time, there is no mechanism to identify medical directors in the LTC setting. The new Fixing LTC Act, 2021, which replaces the 2007 Long Term Care Homes Act, partially addresses this information gap. Opportunities to enhance delivery of medical services include more formal evaluation of attending physician and nurse practitioner services, more palliative care education, and more dedicated administrative time to focus on delivery of care services.

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