Developing a national role description for medical directors in long-term care

Survey-based approach

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ABSTRACT

OBJECTIVE To develop a national role description for medical directors in long-term care (LTC) based on role functions drawn from the literature and the LTC industry.

DESIGN A questionnaire about the role functions identified from the literature was mailed or e-mailed to randomly selected medical directors, directors of care or nursing (DOCs), and administrators in LTC facilities.

SETTING Long-term care facilities in Canada randomly selected from regional clusters.

PARTICIPANTS Medical directors, DOCs, and administrators in LTC facilities; a national advisory group of medical directors from the Long Term Care Medical Directors Association of Canada; and a volunteer group of medical directors.

MAIN OUTCOME MEASURES Respondents were asked to indicate, from the list of identified functions, 1) whether medical directors spent any time on each activity; 2) whether medical directors should spend time on each activity; and 3) if medical directors should spend time on an activity, whether the activity was "essential" or "desirable."

RESULTS An overall response rate of 37% was obtained. At least 80% of the respondents from all 3 groups (medical directors, DOCs, and administrators) highlighted 24 functions they deemed to be "essential" or "desirable," which were then included in the role description. In addition, the advisory group expanded the role description to include 5 additional responsibilities from the remaining 18 functions originally identified. A volunteer group of medical directors confirmed the resulting role description.

CONCLUSION The role description developed as a result of this study brings clarity to the medical director's role in Canadian LTC facilities; the functions outlined are considered important for medical directors to undertake. The role description could be a useful tool in negotiations pertaining to time commitment and expectations of a medical director and fair compensation for services rendered.

EDITOR'S KEY POINTS

- This study was initiated because no standard role description for medical directors in long-term care (LTC) existed in Canada. A standard role description that outlines important tasks provides direction to both medical directors and administrators on how the role adds value to LTC organizations, helps set expectations for both groups, and provides a sense of priorities for medical directors.
- The role functions identified as important by the medical directors, directors of care or nursing, and LTC administrators who responded to the survey were organized into 6 categories: leadership; administration; quality improvement; medical staff management; services for residents of LTC facilities; and rights of LTC residents.

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Élaboration d'une description nationale du rôle des directeurs médicaux de centres de soins de longue durée

À partir des données d'une enquête

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RÉSUMÉ

OBJECTIF Élaborer une description nationale du rôle des directeurs médicaux de foyers de soins de longue durée (SLD) à partir de modèles de rôles tirés de la littérature et de l'industrie des SLD.

TYPE D'ÉTUDE Un questionnaire sur les rôles identifiés d'après la littérature a été adressé par courrier électronique à un échantillon aléatoire de directeurs médicaux, de directeurs de soins ou de nursing (DDS) et d'administrateurs de foyers de SLD.

CONTEXTE Foyers canadiens de SLD choisis au hasard à partir de regroupements régionaux.

PARTICIPANTS Directeurs médicaux, DDS et administrateurs de foyers de SLD; un groupe conseil formé de membres de l'Association canadienne des directeurs médicaux de foyers de soins de longue durée et un groupe de directeurs médicaux volontaires.

PRINCIPAUX PARAMÈTRES ÉTUDIÉS Les répondants devaient indiquer, à partir de la liste des fonctions identifiées, 1) si les directeurs médicaux consacraient du temps à chacune des activités; 2) s'ils devraient en consacrer à chacune des activités; et 3) s'ils devaient en consacrer à une activité, cette activité était « essentielle » ou « désirable ».

RÉSULTATS Un taux de réponse global de 37 % a été obtenu. Au moins 80 % de l'ensemble des répondants (directeurs médicaux, DDS et administrateurs) jugeaient 24 fonctions « essentielles » ou « désirables », celles-ci étant alors incluses dans la description de tâches. À cette liste, le groupe conseil a jouté 5 responsabilités choisies parmi les 18 fonctions initialement identifiées. La description des fonctions résultante a été confirmée par un groupe de directeurs médicaux volontaires.

CONCLUSION La description des fonctions qui a résulté de cette étude précise le rôle des directeurs médicaux des foyers canadiens de SLD; on estime que les fonctions retenues sont des tâches importantes pour les directeurs médicaux. Cette description de tâches pourrait être utile lors des négociations au sujet des contraintes de temps des directeurs médicaux, de ce qu'on attend d'eux et d'une juste rémunération de leurs services.

POINTS DE REPÈRE DU RÉDACTEUR

- Cette étude a été effectuée parce qu'il n'existait pas de description type du rôles des directeurs médicaux de soins de longue durée (SLD) au Canada. Une description type mettant en relief les tâches importantes permet aux directeurs médicaux et aux administrateurs de voir comment leur rôle valorise l'organisation des SLD, de mieux cerner ce qu'on attend de ces deux groupes, tout en indiquant les priorités qui relèvent des directeurs médicaux.
- Six catégories de fonctions ont été reconnues importantes par les directeurs médicaux, les directeurs de soins infirmiers et les administrateurs de SLD qui ont répondu à l'enquête : leadership; administration; amélioration de la qualité; gestion du personnel médical; services aux pensionnaires des centres de SLD; et droits des pensionnaires.

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The position of medical director in long-term care (LTC) was created in the United States and Canada during the 1970s to improve physician participation in and enhance the quality of medical care delivered to residents of LTC facilities.[1-3] The American Medical Association has worked to enhance the role of the medical director and has developed broad guidelines to support the role.[2]

However, in Canada, no such guidelines were developed. The challenge with the role of medical director is that it is highly variable, can have a large scope of responsibility, and generally is neither clearly defined nor well understood. Historically, medical directors were recruited into the role because they took care of most of the residents in a particular facility and were asked to fill a vacant position.[4] Our research revealed that there was no standard role description for medical directors in Canada that was consistently or commonly referenced. Respect and remuneration for the role are minimal and not consistent with the requirements of the position; this has made it a difficult position to fill.[3-6] Thus, we embarked on developing a role description that could become a national standard and that would prioritize functions to guide Canadian medical directors.

METHODS

In June 2006, we conducted a survey of LTC facilities across Canada. A comprehensive electronic database, the Guide to Canadian Healthcare Facilities 2005/2006,[7] was used to identify all LTC facilities in Canada that had medical directors. Facilities for the mentally or physically handicapped were excluded. The facilities were clustered by region, and a representative random sample of facilities was obtained. A total of 336 facilities were selected, and the survey was sent to the medical directors, directors of care or nursing (DOCs), and administrators in those facilities (N=991). Respondents had the option of completing the survey on-line or on paper. A modified Dillman method was used to achieve optimal return rates.[8]

The survey questionnaire was developed using medical director role functions identified from the literature, American Medical Directors Association position statements and resources, and feedback from the Centre for Healthy Aging at Providence's 2nd Annual Leadership Program for Long Term Care in BC.[1-3,9-12] The role functions were organized into 6 categories: leadership; administration; quality improvement; medical staff management; services for residents of LTC facilities; and rights of the LTC residents. Three questions were posed for each role: 1) Does the medical director spend any time on this activity? 2) Should the medical director spend time on this activity? and 3) If "yes" to question 2, is the activity "essential" or "desirable"? *Essential* activities were described as core requirements for medical directors and were considered priorities; *desirable* duties were defined as those that should be performed if time permitted. The purpose of the latter question was to gauge the level of importance attached to the activities that participants thought medical directors should spend time on.

Other questions covered such topics as reporting structure, time per month spent in the role of medical director, time per month the medical director thought he or she would need to perform the essential functions, and the size of the respondent's facility. An advisory group consisting of medical directors from the Long Term Care Medical Directors Association of Canada validated the questionnaire before its distribution.

Descriptive statistics were used to analyze functions deemed essential and desirable. A total of 42 functions were outlined in the questionnaire. The responses of the 3 groups of respondents were analyzed separately; if 80% or more of the respondents in a group identified a function as essential or desirable, it was considered for inclusion in the role description. These activities were ranked then reviewed for consensus among the groups; the functions that were identified as essential or desirable by all 3 groups were included in the role description. Because the national advisory group for this project wanted the role description to be as comprehensive and inclusive as possible, they expanded the role description to include 5 additional responsibilities, based on their expertise as well as criteria provided to them. A volunteer group of medical directors reviewed and confirmed the draft role description.

Ethics approval was obtained from the University of British Columbia and Providence Health Care Research Ethics Board. The results of this study are also available on the Long Term Care Medical Directors Association of Canada website[13] and the Centre for Healthy Aging at Providence website.[14]

RESULTS

A 37% (370/991) response rate was obtained overall. The geographic location, facility, and respondent characteristics are shown in **Table 1**.

At least 80% of the respondents in each group identified a total of 27 functions as "essential" or "desirable" for medical directors to spend time on. These 27 activities were ranked then reviewed for consensus among the groups. Consensus was reached on 24 functions (**Box 1**), all of which were included in the role description. **Box 2** illustrates the remaining indeterminate or *gray* functions that were considered by the national advisory group. Consensus among the members of the advisory group resulted in 5 of these gray functions being added to the final role description.

Table 1. Characteristics of respondents: *N* = 370.

CHARACTERISTIC	N (%)
Respondent	
• Director of Care	139 (37.6)
• Administrator	126 (34.1)
• Medical director	105 (28.4)
Facility size*	
• ≤ 99 beds	139 (38.6)
• 100–199 beds	158 (43.9)
• ≥ 200 beds	63 (17.5)
Regional breakdown*	
• East	312 (86.7)
• West	30 (8.3)
• Atlantic and Territories	18 (5.0)

*360 respondents answered these questions.

The resulting role description is available on the Centre for Healthy Aging at Providence website (**www.centreforhealthyaging.ca**) and the Long Term Care Medical Directors Association of Canada website (**www.cmda.info/**).

DISCUSSION

Developing a national role description that can be modified locally is only a starting point for this longer journey of ensuring that medical directors are effectively and appropriately engaged in the continuing care system. Having a role description for medical directors not only validates and brings credibility to the position, but it also provides clarity for how the role can be implemented. Having a standard role description that outlines important tasks provides direction to both medical directors and administrators on how the role can add value to the organization, helps set expectations for both stakeholders, and provides a sense of priorities for medical directors.

In some parts of Canada, the allocation of physician sessional payments (sessions are 3.5-hour blocks of time) to facilities has been inconsistent and without a standard formula or approach. By understanding the functions of the role of medical director, regional health authorities can derive a formal method of allocation that includes the prioritized functions and the size of the facility to decide how many sessions a facility needs. Therefore, the role description can be a key tool in negotiations between facilities and their respective authorities to define the amount of remunerated time designated for the medical director; it can also be used by medical directors when they discuss their role with their administrators and negotiate expectations and accountabilities.

The next steps include knowledge translation and ensuring organizations such as the ministries of health and the health authorities understand how the role description can be used and how it can support

Box 1. Functions of medical directors in LTC rated as essential or desirable by at least 80% of respondents from all 3 groups

Leadership
- Keep up with current knowledge and practice in medicine
- Work collaboratively with administration on innovations

Administrative
- Serve as liaison with Director of Care and Director of Nursing
- Serve as member on the Medical Advisory Committee and other committees as required

Quality improvement
- Coordinate physician response in the event of a serious incident or outbreak
- Advise on infection prevention and control issues and approve specific infection-control policies
- Promote a culture of patient safety in your facility
- Participate in the accreditation process
- Develop, review, and revise medical and clinical policies and procedures based on best practice
- Support quality improvement planning and the development of quality improvement indicators for potential areas of concern
- Develop quality of care standards in conjunction with the facility administrator and interdisciplinary team

Medical staff management
- Collaborate with attending physicians when concerns are raised about their residents' care
- Ensure medical coverage for residents 24 hours a day, 7 days a week
- Ensure a process is in place for addressing medical staff members who do not comply with policies, procedures, and bylaws
- Ensure all members of medical staff are aware of their responsibilities as attending physicians
- Monitor quality of care provided by attending physicians
- Develop and communicate expectations of attending physicians (eg, bylaws, rules and regulations, facility policies)
- Review pharmacist medication management reports
- Review prescribing by attending physicians through medication safety or pharmacy reviews

Services for residents of facility
- Participate in the planning of resident care by ensuring the appropriateness of services and treatments
- Perform attending physician duties

Rights of LTC residents
- Ensure residents' end-of-life decisions are honoured
- Confirm appropriate use of restraint
- Ensure that residents with the cognitive function to do so have the right to refuse medications

LTC—long-term care.

Box 2. Gray functions: *These functions were identified in the literature but were rated by less than 80% of survey respondents as being important to the role of medical director in LTC.*

Leadership
- Advocate for appropriate funding in all aspects of LTC, educational support, etc
- Conduct research

Administrative
- Serve as liaison between medical staff, nursing staff, and administration*
- Work with the interdisciplinary team and administrator to develop tools for communication with community resources (eg, acute hospital, pharmacy)
- Serve as liaison with health authorities or regions, Ministry of Health, etc
- Act as a liaison with community clinical resources on behalf of the facility
- Train medical residents interested in working in residential care
- Undertake CME planning and provisioning
- Promote and participate in ongoing training of medical and nonmedical staff related to their functional requirements
- Serve as a member of the facility's senior management team*

Quality improvement
- Attend Quality of Care Committee meetings*
- Work with the facility administrator and interdisciplinary team to develop risk management policies (eg, complaints process, critical incident policy)

Medical staff management
- Provide orientation for new physicians
- Monitor attending physicians' performance
- Assist with physician recruitment and resource planning*
- Grant credentials and privileges to physicians

Services for residents of facility
- Act as consulting physician to staff and other physicians*
- Lead care conferences; summarize care issues and communicate these to attending physicians

CME—continuing medical education, LTC—long-term care.
*These functions were added to the role description by the national advisory group, based on their experience and the criteria provided to them, in order to make the role description as comprehensive as possible.

recruitment and retention efforts. From the medical director's perspective, it might be useful in prioritizing his or her time or in negotiating support to fulfill the role.

Subsequent to the knowledge translation phase, the role description can be used to facilitate discussions of systemic issues that affect the medical director's role in LTC (eg, issues of remuneration, training, recruitment and retention, and resources to support the role). Once the standard role description is adopted across Canada, the next phase would be to evaluate the effectiveness of the medical director's role in LTC facilities.

While exposing physicians to LTC is critical to recruitment, the system needs to undergo substantial change to retain medical directors in the continuing care system. Therefore, retention issues around the prominence of the role of medical director; compensation; reasonable allocation of time for physicians to perform their duties while in the facility; and ensuring there is opportunity for physician engagement in a number of clinical and nonclinical issues, allowing medical directors to be exposed to diverse issues (beyond the delivery care), are all important elements to maintaining their interest. Further, the role description, because it encompasses a number of dimensions and areas of responsibility, can become a guide for medical directors on areas or skills they can develop over time.

Finally the authority of the medical director in the domain of so-called medical oversight or authority over the attending medical staff varies from province to province in Canada. This survey acknowledged and accommodated the heterogeneous nature of this authority. For example, the hospital-based model of credentialing and granting privileges through medical departments has been extended in some jurisdictions to continuing care, while other jurisdictions rely on individual contracts between providers and physicians. The medical director has both a moral and professional responsibility to supervise and support their medical staff and promote the best available practices, and systems do exist that support this authority to a greater or lesser extent. The results of this survey suggest that all groups of respondents recognize and appear to support a medical oversight function for medical directors. How much authority actually lies with individual medical directors will depend on local governance structures. As models of chronic care evolve away from institutional structures (eg, assisted living to more community-based models) the authority of the medical director in supervising attending physicians in the community will require further discussion and study.

Limitations

The limitations of this study include the challenge of identifying medical directors because of the fragmentation in the LTC sector and the lack of organized systems at the regional, provincial, or national levels. The Guide to Canadian Healthcare Facilities 2005/2006 database,[7] the best available resource, did not provide the medical directors for all LTC facilities in Canada; some information was already outdated.

Another limitation is the regional disparity in the responses received. A very low response rate was received from the western and Atlantic regions, making the results more attuned to the needs of the eastern regions. In addition, the low overall response rate

(37%) limits generalization to all LTC facilities. However, our results represent a sizable minority that spans medical directors, administrators, and DOCs across Canada. Finally, we did not explore the perspectives of attending physicians working in LTC facilities, and this might have had implications for the role description.

Conclusion

The role description for medical directors in LTC, which has been developed with feedback from administrators, DOCs, and medical directors from across Canada, provides guidance regarding the potential responsibilities of such a position, and the functions outlined were considered important by all 3 groups surveyed. Consensus among the 3 groups is important, as evidence shows that historically these 3 groups of professionals have often had different perceptions of medical directors.[15] In addition, the functions included in the role description are supported by the literature.[3,12,16,17]

The role description will also serve as a starting point for negotiations about reasonable expectations of a medical director given the time allocated, the size of the facility, and the priorities of that facility; it can also be useful to medical directors in seeking fair compensation for services. Remuneration of medical directors has been an issue since the advent of this role and continues to be so today.[1,3-5]

We hope that this role description will be taken up by LTC facilities with a view to improving patient care. This role description is an important starting point to maximize the effectiveness of the role of medical director.

Once the role is well understood and leveraged, it will be necessary to evaluate the role of the medical director in LTC. Not all facilities in Canada have medical directors, and it is important to determine whether there is a difference in the quality of care being delivered to residents of LTC facilities by virtue of having (or not having) medical directors. Future research should focus on this question, and LTC facilities with and without medical directors should be compared for quality of care and other relevant outcomes.

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Contributors

Dr Quail and **Ms Bhaloo** played instrumental roles in developing the study protocol, provided feedback on the survey tool, and assisted in the analysis and review of the results. They also reviewed and edited the manuscript. **Ms Rahim-Jamal** developed the study protocol and the survey tool, analyzed the results, and wrote the manuscript. All authors approved the final version for submission.

Competing interests

None declared

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