Improving medical services in Canadian long term care homes

by Rhonda Collins MD BScN; Jocelyn Charles MD MScCH; Andrea Moser MD MSc; Brad Birmingham MD; Allan Grill MD MPH; Maureen Gottesman MD MEd

Introduction: COVID-19 has exposed vulnerabilities in the long overlooked Long Term Care (LTC) Sector. These include older building designs, inadequate and high part-time staffing, insufficient supplies, lack of pandemic preparedness, and inconsistent infection prevention and control (IPAC) practices.[1] A lack of understanding of this novel virus, including knowledge of asymptomatic and pre-symptomatic spread and presentation of atypical symptoms, created a perfect storm in which these risks became apparent. There are emerging strategies to mitigate the impact of COVID-19 on LTC,[2] but there is limited data on the impact of physician services. We seek to provide guidance on systemic improvements that will improve the delivery of medical care in LTC for our most vulnerable population.

Background: COVID-19 disproportionately affects older adults, with the greatest impact in Canada being felt in the LTC sector.[3] Older adults are more prone to worse outcomes, with a 23-fold greater risk of death in those over 65 years of age versus their younger counterparts.[4]Frequently unrecognized atypical or initially mild symptoms results in potential for increased viral spread and marked variability in severity of outbreaks. The pandemic has also exposed many long-standing challenges in this sector. Older homes with rooms containing three or more beds and communal bathrooms increase risk of transmission of pathogens and reduce ability to effectively isolate and cohort infected residents.[5]Inadequate education, training, and supervision in IPAC measures, and limited access to personal protective equipment (PPE) created significant challenges for LTC staff. Within the sector, 90% of residents have cognitive impairment[6] creating difficulty in their understanding of the need for isolation, physical distancing, wearing masks and frequent hand sanitizing. Those with behavioural symptoms such as wandering also increase the risk of transmission between residents.

As a result of the potential risk of COVID-19 in LTC homes, many physicians adopted virtual care strategies, advocated by the provincial medical regulatory boards. The College of Physicians and Surgeons of Ontario (CPSO) policy on telemedicine was updated at the beginning of the pandemic with COVID-19 guidance that recommended virtual care as the "default modality" to minimize the spread of the virus and conserve PPE.[7] The Canadian Medical Protective Association (CMPA) website also included a COVID-19 action hub to remind physicians of the limitations of virtual care and ensure patients are provided the opportunity for in-person care where appropriate and available.[8] As a result, medical models of care in LTC have ranged from regular, on-site visits to providing exclusively virtual care. Multiple reasons have been suggested for a virtual model with minimal on-site presence, including personal health reasons, inadequate training and limited access to PPE and IPAC practices, and concerns raised by LTC staff and management about transmission of the virus by physicians who work in multiple clinical settings. Lack of a clear directive from the Ministry of Long Term Care about expectations of LTC physicians, including whether in-person visits are essential (when virtual care is available) and whether the one-site directive applies to physicians, has created confusion for the sector.

In homes where only virtual care by physicians was practiced, concerns raised by staff, management and community healthcare partners included the inability to provide on-site collaboration with the care team to identify changes in residents' health status, and increased time commitment for an already strained nursing staff by having to facilitate the virtual visits. In contrast, the presence of a physician was associated with a greater feeling of support for staff, and residents and families are comforted by the attending physician's care of their loved one in person. In some cases of LTC outbreaks, local acute care hospitals deployed additional teams to provide onsite medical coverage that was lacking.

Medical Care: In Ontario, the delivery of medical services in LTC varies, though it is governed by legislation. According to the LTC Homes Act,[9] "Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home" and delineates some of the key responsibilities of the

Medical Director, including 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. The organization of medical staff can also vary in LTC, with some homes having multiple physicians care for small numbers of residents, while others choose to have one physician care for as many as 100 or more. This is often dependent on the ability to recruit family physicians, especially in rural and underserviced areas. Although service agreement templates exist for both attending physicians and Medical Directors, there is no time commitment suggested.[10] For example, an LTC home may stipulate frequency of physician/Nurse Practitioner (NP) attendance in the service agreement, but the agreement may not require a specific number of hours or clinical service expectations.

There is limited Canadian data surrounding the medical workforce in LTC. In a 2012 Ontario study, Lam et al. identified that 1,190 family physicians were responsible for a cohort of 50,375 LTC residents.[11] The mean number of residents per physician was 27 and the average number of visits to a home 2.6 visits in 30 days. Two U.S. studies reviewed the medical staff organization, one identifying it as an independent predictor of clinical outcomes,[12] the other relating it to lower re-hospitalization rates.[13] The same study indicated that a more formal staff appointment also resulted in fewer re-hospitalizations. Katz et al. have proposed a nursing home medicine specialty characterized by the degree of commitment, practice competencies and structure of medical staff organization.[14] They further go on to suggest that nursing homes specialists devote 20% of their practice to nursing home care recommending at least 4 hours per week at each home as the minimal time commitment.

Residents are moving into LTC with advanced and complex health care needs,[15] and these vulnerable individuals deserve skilled clinicians to manage a multitude of issues including atypical presentations of common illnesses in the frail elderly, antibiotic stewardship, polypharmacy, interpretation of published best practice guidelines as they pertain to this population and managing behavioural and psychological symptoms of dementia. They must possess the compassion and sensitivity to engage in conversations about goals of care, and support conversations about when to treat acute illness within the home and when to send a resident to acute care, recognizing the inherent risks of hospitalization for frail seniors.[16]

It is also important to recognize that LTC is very different from in-hospital care. The Institute of Medicine published a report entitled Improving the Quality of Care in Nursing Homes in which they "emphasized the home part of the description more than the nursing part".[17] An increasing number of issues that previously required hospitalization are now being managed in LTC homes, through proper advance care planning discussions in keeping with residents' wishes. Ongoing medical services in LTC must continue to embrace a resident-centered focus of health promotion and quality of life, in alignment with the individual's values and goals of care.

Recommendations:

1. Time Commitment: There is currently a lack of established expectations surrounding the frequency and duration of attending physician visits in Canada. We suggest an equivalent of four hours/week for every 25-30 residents for whom care is provided to allow management of acute and chronic illness, quarterly medication reviews, attendance at care conferences, goals of care discussions and thorough documentation.
2. Physical Presence and Virtual Care:. Virtual care has limitations. It can be useful for non-urgent and administrative tasks, but in-person assessment should be considered for an acute illness or significant change in a resident's condition. A standardized process to support virtual care is required including hardware, software, privacy and security for virtual communication and transfer of health information off-

site.

3. Adequate Remuneration: Remuneration for physicians in LTC should be reflective of the increased complexity and acuity of LTC residents' conditions, and enhanced billing codes for both virtual and in-person assessments and on-call responsibilities need updating. Given the lack of established expectations surrounding the time commitment for Medical Directors, there should be a minimum base rate stipend of eight hours per month as well as a per resident rate as the basic responsibilities do not change due to the size of the home. This stipend should reflect the additional work required during outbreaks and pandemics and should recognize the time commitments for the role as outlined in the Long Term Care Homes Act.
4. Maintenance of Competency: Continuing Medical Education (CME) for LTC physicians should be funded to strengthen their clinical skills and expertise including palliative care, IPAC, and other areas of importance for LTC primary care providers. All Medical Directors should receive support for additional training such as the Ontario Long Term Care Clinicians Medical Director course. Peer reviews should address performance expectations and use standard quality improvement metrics such as recommending CME and improving practice habits and documentation[18].
5. Access to Clinical Resources: The availability of laboratory services, diagnostic imaging, medical supplies, staff trained in intravenous therapy and specialist consults for the timely diagnosis and treatment in acute situations is variable and can be an added cost for homes. Service agreements for timely and consistent access to laboratory services and diagnostic imaging, and collaboration with community partners (Nurse Led Outreach Team, Emergency Medical Services) could improve urgent access to needed services and supplies to allow treatment of illness/injury on-site. Prompt access to specialty supports via telephone or virtual consultation would also reduce avoidable transfers and improve quality of care for the residents.
6. Access to PPE: While working in the LTC setting, attending physicians require access to PPE. Funding for PPE should take the number of physicians into account to ensure adequate supply.
7. Credentialing: A standardized credentialing process should be developed by a body familiar with the sector to identify the core competencies and clinical skill set required to meet the unique needs of LTC residents. Examples of specific competency domains for training and certification include management of issues related to quality improvement, transitions of care, frailty, polypharmacy, and cognitive and behavioral disorders.[14]

In summary, the COVID-19 pandemic has exposed many vulnerabilities within the LTC sector including a variability in provision of medical leadership and clinical care. There should be a standardized approach to recruitment and retention of both attending physicians and Medical Directors. This should include demonstration of a core set of competencies that encompasses ethics, professionalism, communication, knowledge, maintenance of standards and professional growth. Physicians working in LTC homes should be working within an organized medical services model with clearly articulated expectations, appropriate compensation and support for the work provided, and access to continuing professional development opportunities. As a group of family physicians dedicated to LTC, we are hopeful that the lessons learned during the pandemic to date will pave the way for improvements in this sector including the acknowledgement of the role of family physicians as engaged and valued providers. Investment in these areas will allow improved care and quality of life for our residents and reduced pressure on the acute care sector.

Dr. Rhonda Collins: Assistant Clinical Professor, Department of Family Medicine, McMaster University,

Hamilton, ON, Canada, Chief Medical Officer, Revera Inc.

Dr. Jocelyn Charles: Associate Professor, Department of Family & Community Medicine University of Toronto, North Toronto Primary Care Co-Lead, Medical Director, Veterans Centre Sunnybrook Health Sciences Centre

Dr. Andrea Moser: Associate Professor, Department of Family and Community Medicine, University of Toronto, Associate Medical Director, The Jewish Home for the Aged, Baycrest Health Sciences

Dr. Brad Birmingham: Medical Director, Belmont House Retirement & LTCH, Medical Director, Chester Village LTCH

Dr. Allan Grill: Associate Professor, Department of Family & Community Medicine, University of Toronto. Chief, Dept. of Family Medicine, Markham Stouffville Hospital

Dr. Maureen Gottesman: Assistant Professor, Department of Family and Community Medicine, University of Toronto, North York General Hospital

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