INESSS
LE SAVOIR PREND FORME

MARCH 2022

Organization of medical care and services in long-term care facilities

English summary

Une production de l'Institut national
d'excellence en santé
et en services sociaux (INESSS)

Québec

SUMMARY

Organization of medical care and services in long-term care facilities

Introduction

The Ministère de la Santé et des Services sociaux (MSSS) would like the medical management arrangements and multidisciplinary care models used in long-term care facilities in other countries to be explored. The objectives of this report are, therefore, to document, in Canada and other OECD (Organisation for Economic Co-operation and Development) member countries, i) the offer of medical care and services and how medical care is provided, ii) the composition of medical care and services teams and the roles and responsibilities of their members (physicians, nurses, specialized nurse practitioners and pharmacists), and iii) physician involvement in the facilities' management.

Methodology

The Institut national d'excellence en santé et en services sociaux (INESSS) has prepared a state-of-knowledge report based on the scientific literature and websites of organizations, learned societies and government bodies. A total of 58 primary studies, 9 reviews, 9 expert opinions published in a scientific journal, reports from 7 governments and 23 organizations were examined.

Results

Two organizational models for medical practice in long-term care facilities are frequently mentioned in the literature reviewed: the open staffing model and the closed staffing model. A third, a hybrid model, is also mentioned, but only in the United Kingdom. The open staffing model allows any physician interested in practising in a long-term care facility to work there. It commonly involves additional, explicit medical practice commitments and fee-for-service remuneration. The closed staffing model involves physicians, usually salaried, who are dedicated to one or more long-term care facilities. The facilities can therefore choose the physicians who will care for their residents. None of the models appears to have been evaluated rigorously enough to determine which one should be recommended.

The availability of physicians in long-term care facilities varies around the world. Some countries and provinces (e.g., the U.S., Ontario and British Columbia) have standards or legislation governing how care is provided. The implementation of standards appears to create value by clarifying medical expectations and providing more medical care and services in a timely fashion. Physician involvement outside of normal work hours varies as well (i.e., daytime from Monday to Friday). To meet the needs of residents outside these hours, access to telephone support and telemedicine between the facility's care team and a physician seem to be methods used in some provinces and countries (e.g., Ontario, France, Norway and Australia). As for the number of medical visits per

year per resident, it seems to vary between 7 and 10, according to information from British Columbia, Manitoba and the United States. In the United States in 2015, there was the equivalent of 1.37 full-time equivalent (FTE) physicians per 1,000 occupied nursing home beds. This is far from the ratio recommended by U.S. experts of one FTE physician per 10 skilled nursing facility beds (facilities with, among other things, temporary physical rehabilitation beds) and 100 nursing facility beds. In Ontario, it is recommended that 4 hours per week be spent on medical practice in long-term care facilities for every 25 to 30 residents.

Different practices and types of collaboration are used among different professionals working in long-term care facilities in order to optimize the provision of care for the residents. The three main types of skill mix described in the literature are (1) delegation (the physician assigns a task to another health care professional but remains responsible for it), (2) substitution (expanding the responsibilities of a health care professional, who may then provide some of the same services as the physician and becomes responsible and autonomous in performing these tasks), and (3) supplementation (increasing the scope of a health care professional's work by allowing them to provide additional services that complement or extend those provided by the physician). Although a combination of all three types is reported in practice, physician substitution with different professionals, such as specialized nurse practitioners (SNPs) and physician assistants, is the one most documented in the publications reviewed.

Much of the information examined concerns the roles and responsibilities of members of the medical care and services teams. Physicians' responsibilities in long-term care facilities include providing medical care to the residents, such as performing medical evaluations, considering the need for medical referrals, participating in the development of the residents' care plans, and collaborating on advance medical directive planning. Quite often, there is a psychosocial dimension to the physicians' role, such as participating in decision-making regarding psychosocial issues and communicating with the residents' families. Coordination with a facility's partners (e.g., a hospital) and further training of other professionals on the team are some of the other frequently reported responsibilities. In addition, several groups of experts have voiced their support for physician involvement in the management of long-term care facilities. However, according to the literature consulted, there seems to be little legislation governing the management role of physicians at these facilities. It is recommended that physicians assuming this role – such as medical directors and medical coordinators – have certified expertise in geriatrics as well as leadership and conflict management skills. These physicians' most common duties are to evaluate and supervise medical practice, act as advisors in the development of internal policies, support the long-term care facility in quality improvement projects, and contribute to the professionals' further training.

For their part, nurse clinicians are described as being key to the identification of situations requiring a medical evaluation. SNPs participate in providing care through different collaborative practices, especially skill substitution. The degree and extent of SNPs' roles and responsibilities regarding medical tasks vary considerably from one country, state or province to another. The optimal division of labour between the physician and the SNP in

the various collaborative practices remains unknown. A considerable body of literature also points to the regular and sustained involvement of the pharmacist in long-term care facilities. Given the emergence of pharmacists' roles and responsibilities in these settings, various recommendations, guidelines and training courses aimed at providing a framework for their skills and improving them have been reported in several countries, such as the United States, France and the United Kingdom.

Limitations

Several professional and organizational practices are discussed in this state-of-knowledge report. The different contexts in terms of the structure of the health and social services system, funding, and the organization of medical care and services in long-term care facilities influence the interpretation of all the results and their transferability to the Québec context. Although they were not identified, other contextual characteristics, particularly in terms of legislation, may have an impact on the organization of medical care and services in long-term care facilities.

Outlook

The results presented in this state-of-knowledge report provide relevant avenues for reflection on the organization of medical care and services in long-term care facilities. The topics discussed include the different staffing models in place across the OECD countries, the variability in the level of physician involvement in the management of these facilities (and the form of this involvement), and the several forms of skill mix. These results provide insight on the organization of care and services and the sharing of responsibilities among the various members of the care team. Given the aging of the population, the increasing complexity of the residents' profile, and the difficulties recruiting qualified workers, efforts will certainly have to be made to adjust the way things are done and to continue to offer quality care and services. This reflective work is all the more necessary given the significant impact the COVID-19 pandemic has had on the health and social services system. Lastly, there are several tensions in the mission of long-term care facilities, which is to offer quality care and services in a quality living environment. The combination of these two goals in the reflection on the organization of medical care and services is essential for ensuring residents' well-being.

Siège social

2535, boulevard Laurier, 5e étage
Québec (Québec) G1V 4M3
418 643-1339

Bureau de Montréal

2021, avenue Union, 12e étage, bureau 1200
Montréal (Québec) H3A 2S9
514 873-2563
inesss.qc.ca