The Preliminary Impact of Maryland’s Medical Director and Attending Physician Regulations

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Objectives: To identify the impact of the regulations implemented in Maryland in 2001, related to nursing home attending physicians and medical directors, and nursing home quality assurance requirements, on Maryland nursing homes, administrators, and physicians.

Design: Two surveys were mailed to all nursing home administrators in Maryland, one for their completion and one to give to their medical directors to complete. These surveys were to be returned by mail to the authors.

Setting: All nursing homes in all jurisdictions in Maryland.

Participants: Two-fifths of administrators and medical directors in Maryland nursing homes completed and returned the survey.

Measurements: Results were tabulated for each question of each survey, and were calculated as percentages of the total responses. Additionally, individual comments were reviewed.

Results: A relatively large sample of administrators and medical directors in Maryland responded. Most respondents were positive or at least neutral about the impact of these regulations on them and their organizations. Many administrators agreed that there had been improvements in medical director participation and performance. There were significant advances in medical director compensation. There were relatively few negative comments about the impact.

Conclusion: Requirements for physician and medical director accountability appear to have had a positive impact on medical director performance and relationships with nursing home administrators. Additional study is warranted to measure the impact of that performance on patient care outcomes and facility performance.

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tions in Maryland responded. Respondents included administrators in 23 of the 24 jurisdictions. Some administrators called the post office returned 15 of these mailings as undeliverable. An accompanying survey for the medical director’s completion was included, with a separate self-addressed stamped return envelope. Medical directors were asked questions primarily about their education and training, and their relationships with the administrator. The administrator was asked to give these surveys to the medical directors. All medical director responses were received in separate envelopes. We could not determine how many of the medical directors actually received the survey from their administrators. The administrator portion of the survey contained 23 separate questions and the medical director portion contained seven. Appendix 1 contains the questions presented in the surveys. The total number of responses varied by question. The surveys were returned to the authors without any identification of the person completing it or the facility. A log was kept in order to monitor responses from the 23 Maryland counties and Baltimore City. Some administrators called the authors to indicate they were responding and to express their interest in knowing the results of the survey.

RESULTS

Facilities Represented by the Survey

The respondents represent a broad cross-section of Maryland nursing homes. Administrators in 23 of the 24 jurisdictions in Maryland responded. Respondents’ facilities included those of all sizes: 37 percent (n = 38) had under 100 beds, 53 percent (n = 55) had between 100 and 200 beds, and 10 percent (n = 10) had over 200 beds.

Administrator Respondents

Forty-three percent (n = 102) of the administrators responded to the questionnaire. Of these administrators, 30 percent (n = 31) had been a licensed administrator for 1 to 4 years, 25 percent (n = 26) between 5 and 9 years, and 45 percent (n = 46) for 10 years or longer.

Medical director respondents

Seventy-five medical directors responded to the questionnaire. Some physicians are medical director of more than one nursing home. But a current list of medical directors of each nursing home in Maryland was not readily available. So, it was not possible to identify exactly how many physicians were active as medical directors in Maryland at the time of the survey.

According to the administrator respondents, in 24 percent (n = 24) of facilities, the current medical director had been serving in that capacity for less than 2 years, 24 percent (n = 24) had been serving between 2 and 5 years, and 54 percent (n = 53) had been serving for 5 years or longer.

KEY ISSUES

Medical Director as a Primary Care Provider and Patient Referral Source

Our survey found that the medical director had fewer than 10 percent of the patients in 34 percent (n = 35) of the facilities; in another 18 percent (n = 18) of facilities, the medical director had between 10 and 20 percent, and in 48 percent (n = 49) of facilities, the medical director had more than 20 percent of the patients.

Medical Director Education and Training

According to the administrators surveyed, about two-thirds (66%, n = 59) of the medical directors in the sample had completed at least one of the three American Medical Directors Association (AMDA) curriculum modules since June 2000. And, as of the date of the survey, the administrators noted that 70 percent (n = 58) of their medical directors were working towards certification as a certified medical director (CMD). But there was not an appreciable increase (75 percent [n = 72] versus 68 percent [n = 76]) in AMDA membership (national or state chapter) after the implementation of the regulations.

Of the medical director respondents, 27 percent (n = 20) had completed a geriatric fellowship and 59 percent (n = 41) had taken all of the AMDA curriculum modules. Of those who completed the modules, 39 percent (n = 15) felt that their relationship with their administrator had changed, although they were not asked how much or in what direction it had changed.

Of those administrators whose medical directors had completed AMDA certification, 86 percent (n = 48) agreed that the medical director had a better understanding of the roles of the medical director and administrator.

Medical Director Compensation

The information provided by the administrators on medical director compensation is shown in Table 1.

As to any links between reimbursement and performance, 90 percent (n = 45) of the administrators whose medical directors had had a salary increase felt that there had been at least some improvement in the medical director’s performance along with the increased monthly stipend. Of those whose medical directors were getting paid more now than 3...
years ago, 72 percent (n = 36) agreed that the medical director's performance justified the increase.

**Administrator Relationships with Medical Directors**

Almost two-fifths of the administrators surveyed (37 percent, [n = 34]) agreed that their relationship with their medical director had changed since the implementation of the regulations. Most of those who commented as to the nature of the change indicated a positive trend (Appendix 2).

All of the medical director respondents indicated that they valued the administrators' roles and responsibilities and felt that the administrator also valued their roles and responsibilities. Almost all (99 percent [n = 74]) of the medical directors felt that they were working together effectively with their administrators.

Before the regulations, only 31 percent (n = 29) of administrators met with their medical directors more than 5 hours a month, and 33 percent (n = 31) met for 2 to 4 hours per month, while 37 percent (n = 35) met with their medical director for no more than an hour a month. Since implementation of the regulations, 48 percent (n = 48) of administrators have met with their medical directors more than 5 hours a month, and 43 percent (n = 43) have met for 2 to 4 hours per month, while only 9 percent (n = 9) have met with their medical director for no more than an hour a month. After the regulations were implemented, 91 percent (n = 91) of the administrators now met with their medical directors for at least 2 hours a month, compared with only 64 percent (n = 60) previously.

Regarding reporting to the administrator, 46 percent (n = 34) of medical directors surveyed provided the administrator with a time log of their activities; however, medical directors were not asked about alternative means of formal communication nor about what the log included.

**Medical Director Roles in the Facility**

Of the administrators surveyed, 47 percent (n = 48) said that they relied on their medical director more than before, and 53 percent (n = 54) indicated that they relied on the medical director to about the same extent. Interestingly, no administrator claimed to be less reliant on their medical directors. The administrators were asked to rate the medical director's importance to their facility on a scale of 1 to 10 regarding certain areas. Table 2 summarizes the responses in those areas.

Regarding oversight of the medical director's performance as an attending physician, only 61 percent (n = 37) of administrators in facilities where the medical director had more than 30 percent of the patients indicated that their facility had a plan for assessing the quality of the medical director's care.

**Table 1. Medical Director Compensation Before and After Implementing Maryland Regulations**

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt; $1,000/mo.</th>
<th>$1,000–$2,000/mo.</th>
<th>$2,000–$3,000/mo.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999*</td>
<td>18% (n = 17)</td>
<td>58% (n = 56)</td>
<td>24% (n = 23)</td>
</tr>
<tr>
<td>2002</td>
<td>9% (n = 9)</td>
<td>44% (n = 43)</td>
<td>46% (n = 45)</td>
</tr>
</tbody>
</table>

* Source: Nursing home administrators surveyed.

**Overall Impact of the Regulations**

Regarding the impact of the quality assurance, attending physician, and medical director regulations, 78 percent (n = 74) of administrators felt that these regulations in total had resulted in at least some improvement in the quality of nursing home care in Maryland.

**DISCUSSION**

We believe that, despite its limitations, our study provides useful information about the potential benefits and consequences of Maryland's regulations for nursing home attending physicians and medical directors. The results appear to show positive trends and should allay many of the concerns about the potential negative impact of these requirements. The study also presents areas that warrant additional investigation.

**Medical Director as a Primary Care Provider and Patient Referral Source**

Traditionally, many nursing homes nationwide have appointed their principal physician (the physician with the most patients) as the medical director. And, many have been reluctant to expect much of their medical directors for fear of losing the medical director's patient referrals. Some Maryland nursing home owners and administrators objected to these regulations on the grounds that they would chase physicians away, thereby adversely affecting patient referrals.

But the results of our survey do not appear to corroborate these concerns. Fully one-third of the responding administrators indicated that their facility's medical director had little or no importance as a patient referral source, and only one-fourth indicated that the medical director was very important.

Additionally, our survey indicates that at least half of the medical directors have fewer than 20 percent of the patients in their facility, and an appreciable number of physicians serve only as medical director, and are not the attending physician for any patients in the facility.

Thus, our survey seems to contradict the common notion that nursing homes are too dependent on their medical directors for patient referrals to risk chasing them and their patients away by trying to hold them more accountable for their administrative functions. Additionally, the regulations apply equally to all nursing homes in Maryland, reducing the threat that physicians can simply go elsewhere and do as they please.

These regulations have clarified the notion that nursing home attending physicians have certain critical responsibilities that no one else can adequately perform. By extension, the medical director must ensure that physicians fulfill their responsibilities and must oversee the quality of the facility's care.
one but the medical director can perform these important functions appropriately. While medical directors should be a role model for the attending physicians, and should have some experience in caring for a nursing home population, they can function effectively as a facility's medical director without necessarily being an attending physician at that facility. Accountability is an essential management principal, especially in a setting where people’s lives depend on it. Physicians have to perform essential tasks and functions, no matter how many patients they refer.

Medical Director Education and Training

The Maryland regulations required medical directors to meet educational requirements related to medical management. Some owners, administrators, and physicians were concerned that the educational requirements would be too costly and time-consuming for physicians.

In fact, only a minority of Maryland medical directors had previously received significant education about issues important to performing effectively as a medical director, such as relevant regulations or management techniques. Our survey appears to show that a number of physicians have tried to comply quickly with this educational requirement. The rest have up to 3 years from the date of implementation of the regulations or from the time of becoming a medical director (whichever comes later) to complete the course work.

The value of any such education or training should be reflected in greater knowledge or improved performance, or both. Of those administrators whose medical directors had completed AMDA certification, 86 percent agreed that the medical director had a better understanding of the roles of the medical director and administrator.

Despite the fact that these regulations did not require AMDA certification, as of the date of this survey 59 percent of the medical directors in the sample had taken all of the AMDA modules and 70 percent were working towards certification as a CMD. Of those who completed the modules, 39 percent felt that their relationship with their administrator had changed, although they were not asked how much or in what direction it had changed. Based on the feedback from the administrators, it would appear that the majority of such change was positive.

Another aspect of medical direction is to promote effective clinical practice in nursing homes. To this end, physicians need to understand relevant geriatrics and medical principles and practices. Of the medical director respondents, 27 percent had completed a geriatric fellowship. However, geriatric fellowships vary widely in the extent to which they expose trainees to nursing home care or to the physician’s role as a medical director. Therefore, regardless of formal clinical training, a medical director must know how to manage others and how to attain desired performance.

So, our survey appears to suggest that these regulations have had a positive impact on the knowledge, understanding, and general participation of Maryland medical directors.

Medical Director Compensation

Many physicians had been concerned about whether their increased responsibilities would be compensated appropriately. Administrators wondered whether increasing medical director compensation would be accompanied by improved or expanded performance.

Our survey indicates that the customary compensation for a medical director in Maryland has increased in the past 3 years, and would appear to be more consistent with the time and commitment necessary to do the job properly.

Our survey also suggests that many medical directors have at least somewhat improved their performance and participation. A majority of administrators felt that this improved performance justified the level of reimbursement. There was no indication that these costs have become a major burden on individual nursing homes, especially considering the great potential of medical directors to influence care quality and to help prevent major regulatory and financial problems related to care.

Administrator Relationships with Medical Directors

Medical director regulations should promote effective working relationships between medical directors and their facilities. There were some concerns before their implementation that these regulations might impair such relationships.

The results of the survey, plus the individual comments from many administrators, appear to indicate that many medical directors and administrators recognize and appreciate each other’s roles and responsibilities. All of the medical directors who responded valued the administrator’s roles and responsibilities and felt that the administrator also valued their roles and responsibilities. Almost all (99 percent) of the medical directors felt that they were working together effectively with their administrator.

Most administrators and medical directors indicated that their relationship is working well together. Particularly noteworthy are increases in direct communication between the two groups.

Table 2. Summary of Administrator Rankings of Importance of Medical Director in Specific Areas

<table>
<thead>
<tr>
<th>Item</th>
<th>Little or no importance (Rated 1–3 out of 10)</th>
<th>Moderately important (Rated 4–7 out of 10)</th>
<th>Very important (Rated 8–10 out of 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census referral source</td>
<td>35% (n = 35)</td>
<td>38% (n = 38)</td>
<td>25% (n = 25)</td>
</tr>
<tr>
<td>Member of quality assurance team</td>
<td>5% (n = 5)</td>
<td>18% (n = 18)</td>
<td>78% (n = 78)</td>
</tr>
<tr>
<td>Resource to administrator and nursing staff on care issues</td>
<td>2% (n = 2)</td>
<td>10% (n = 10)</td>
<td>88% (n = 88)</td>
</tr>
<tr>
<td>Resource in overseeing physicians</td>
<td>5% (n = 5)</td>
<td>18% (n = 18)</td>
<td>78% (n = 78)</td>
</tr>
</tbody>
</table>
and the many comments about increased medical director participation in quality-related activities and meetings.

The regulations appear to have increased direct communication between administrators and medical directors. Administrators and medical directors appear to be meeting more often and for a longer time. While this alone does not prove the value of such meetings, at least some positive impact can be inferred from the overall comments of administrators that medical director participation has improved and administrators rely more on their medical directors.

**Medical Director Roles in the Facility**

The regulations were meant to clarify and promote key medical director responsibilities including their participation in facility quality assurance activities, their vital role in overseeing care-related policies and practices, and their responsibility to oversee physician performance.

Most administrators viewed their medical director as very important in these three key areas: as a member of the quality assurance team, an important resource on care-related issues, and a resource for overseeing physicians. Almost half of the administrator respondents indicated increased reliance on their medical directors since these regulations were implemented, and no respondent indicated less reliance. This suggests that these regulations have had some positive influence on key aspects of medical director performance.

There were also initial concerns that facilities in rural parts of Maryland would have difficulty finding physicians willing to provide medical direction under these regulations. Although Maryland has several urban centers, much of the state is rural in character.

Over the years, some nursing homes in Maryland have had difficulty finding physicians and also in getting physician compliance and finding willing, qualified medical directors. However, the authors’ personal communications suggest that this is a national problem. Our study does not seem to indicate that these regulations have exacerbated the problem in Maryland.

Our survey did not examine in depth actual physician performance and practice in Maryland nursing homes. Some Maryland physicians relinquished their nursing home practices or medical directorships because they were unwilling or unable to adhere to more detailed, stringent requirements. But other physicians have apparently assumed such responsibilities more willingly. In fact, there were at least some positive responses to this survey from almost every jurisdiction in Maryland, indicating that there is not a discernible “urban-rural” effect. Thus, it appears from our data that Maryland has not suffered a shortage of medical directors, but will instead have a high percentage of trained medical directors.

**Overseeing the Medical Director as an Attending Physician**

One issue raised by several sources, including the Office of Health Care Quality, is how to ensure adequate oversight of the care of the medical director’s patients. Of those facilities where the medical director had more than 30 percent of the patients, only 61 percent had a plan for assessing the quality of the medical director’s care. The Office of Health Care Quality subsequently has implemented pertinent oversight guidelines.

**Impact on Administrators**

There was some concern that the quality assurance, medical director, and attending physician regulations would adversely affect recruitment and retention of long-term care administrators by Maryland nursing homes because of the strain of trying to deal with so many requirements.

Before the implementation of these and other related regulations, some feared that these regulations would be costly and time-consuming without appreciably impacting the quality of nursing home care. However, the general trend of the comments of respondents to this survey was neutral or positive. A large majority of administrators felt that there had been at least some improvement from the aggregate of the quality assurance, attending physician, and medical director regulations in Maryland.

It appears that these regulations may have stimulated nursing home administrators in Maryland to focus more on the medical director’s and attending physician’s roles and responsibilities. They appear to have helped at least some administrators clarify critical medical director functions.

**Limitations of this Study**

Our study was based on feedback from administrators and medical directors. We cannot tell what portion of the non-responders may have already made some compliance efforts. Therefore, we cannot say precisely how many medical directors have not yet begun to comply with the training requirements or are not taking these regulations seriously. But we estimate that as of late 2002, perhaps one-fifth of the medical directors in Maryland—and probably an equal number of nursing homes—had yet to make serious compliance efforts.

It would help to objectively measure specific aspects of physician, medical director, and facility performance in Maryland nursing homes before and after the implementation of these regulations, or to be able to compare performance among various levels of facilities; for example, those where medical director and physician performance was adequate before these regulations, those where performance has improved since these regulations were implemented, and those who still have relatively little effective compliance.

**CONCLUSIONS**

Our preliminary survey suggest that regulations implemented in Maryland regarding attending physician and medical director responsibilities appear to have had a positive impact on medical director performance and relationships with nursing home administrators.

**REFERENCES**

APPENDIX I
Survey (Administrator)

This questionnaire is designed to assess the effectiveness (outcome) in the way that Medical Directors are functioning in Maryland Facilities since June, 2000.

Was your Medical Director a member of the American Medical Directors Association (AMDA) prior to January 1, 2002? (Yes/No)

Is your Medical Director a member of AMDA now? (Yes/No)

Has your Medical Director attended AMDA’s mandated A,B,C modules? (Yes/No)

Has your Medical Director completed any of the modules since June 2000? (Yes/No)

Was your Medical Director a Certified Medical Director prior to June 2000? (Yes/No)

Is your Medical Director working toward certification as a Certified Medical Director (CMD)? (Yes/No)

Is your Medical Director now a Certified (CMD)? (Yes/No)

How long have you been the Administrator of your current facility? (Less than 2 years/2 years/5 or more years)

How long has the Medical Director been the Medical Director of your facility? (Less than 2 years/2 years/5 or more years)

Has the relationship between you and your Medical Director changed since the implementation of COMAR 10.07.02.11? If yes, describe examples of the changed working relationship. (Yes/No)

How many hours per month did you meet with your Medical Director since the implementation of COMAR 10.07.02.11? (1 hour/2–4 hours/more than 5 hours)

How many hours per month did you meet with your Medical Director prior to the implementation of COMAR 10.07.02.11? (1 hour/2–4 hours/more than 5 hours)

What percentage of your patients does your Medical Director care for as Attending Physician? (Less than 10%/10%–20%/More than 20%)

If your Medical Director is Principal Physician for over 30% of your patients, do you have a back-up oversight plan for patients under the care of your Medical Director? (Yes/No)

If your Medical Director has completed the AMDA Certification Program, does the Medical Director have a better understanding of the roles of the Medical Director and Administrator? (Yes/No)

As an administrator, do you rely on your Medical Director more, less, or the same? (More/Less/Same)

The Department of Health and Mental Hygiene implemented COMAR 10.07.02.11 and COMAR 10.07.02.11-1, which is unique in this country. Has the implementation of this regulation affected the function of the Administrator and Medical Director? (No Improvement/Improved Somewhat/Improved Greatly)

In the calendar year 1999, what was the monthly salary of your Medical Director? (Less than $1,000/$1,000–$2,000/$3,000)

What is the current monthly salary of your Medical Director? (Less than $1,000/$1,000–$2,000/$3,000)

If there was an increase in the salary of the Medical Director since June of 2000, do you feel the increase has improved the functioning and results achieved by your Medical Director? (No Improvement/Improved Somewhat/Improved Greatly)

Were the services provided worth the salary change? (Yes/No)

On a scale of 1–10 with 10 being best, value the importance of your Medical Director. Please circle your choice for a., b., c., and d., and e.

Referral source for census
Member of the QA&A Team
Resource to Administration and Nursing in case of care concerns
As a clinical resource to Administration and Nursing in the oversight of attending physicians.

The QA&A process required by Maryland regulation positively effects patient care.

DEMOGRAPHIC DATA
Your facility is located in which county/city?
Your facility size is? (Less than 100 beds/100 to 200 beds/More than 200 beds)

You have been a Licensed Administrator for? (1–4 Years/5–9 Years/More than 10 Years)

NOTE: The 1999 information came from this current survey.
This questionnaire is designed to assess the effectiveness (outcome) in the way that Medical Directors are functioning in Maryland Facilities since June, 2000.

Following is a survey that Harold B. Bob, MD, CMD and myself are conducting. The purpose of this survey is to obtain data regarding the modification in the way that Medical Directors are functioning in our Maryland facilities. Your responses will be used for research purposes only and will be kept confidential. There are not any indicators to identify you as a responder.

In an effort to understand the impact of the new regulations on medical direction, I would be grateful if you would complete the survey and return it to me in the enclosed self-addressed stamped envelope.

Do you feel your Administrator values your functions/responsibilities as the Medical Director? (Yes/No)

Do you value the functions/responsibilities of the Administrator? (Yes/No)

Do you consider that you and the Administrator are working together effectively? (Yes/No)

Have you taken the AMDA “A”, “B”, and “C” Modules? (Yes/No)

If your answer to #4 is “Yes”, has your relationship with your administrator changed subsequent to the Modules? If so, how? (Yes/No)

Have you completed a geriatric fellowship? (Yes/No)

Do you provide your administrator with a time log of your administrative activities? (Yes/No)

APPENDIX II

Administrator Respondents’ Comments

“More regular review of regulations: working together on QI audits: more discussion on quality of care, policies, and procedures.”

“We have always had a good relationship, however since new regulations for Medical Director we have focused on the criteria and how we are meeting it as well as discussing the information module.”

“Increased interaction and collaboration.”

“Has an active role in QA/QI process. Improvement in peer reviews.”

“We have changed Medical Director during this time period to an individual who was a CMD.”

“More interaction and better understanding of the Medical Directors interest to the facility.”

“Have worked together on physician credentialing, Medical Director oversight plan, etc.”

“We tend to communicate more directly.”

“In the QA meeting, makes a MD report. More collegial.”

“More communication, discussion of administrative issues involving docs.”

“More involved with QA + QIs. Also watching/monitoring other physicians. Thank God_”

“Increased communication and time spent working with QA team as a true ‘member.’”

“I believe our Medical Director is very attuned to his responsibilities. He is always available to meet with me.”

“The functioning of our Medical Director has been exceptional over the years and remains so. The increased salary is really a matter of justice.”