MODEL MEDICAL DIRECTOR AGREEMENT AND SUPPLEMENTAL MATERIALS

Medical Director of a Nursing Facility

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THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

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MODEL AGREEMENT FOR MEDICAL DIRECTOR OF NURSING FACILITY

MEDICAL DIRECTOR AGREEMENT

THIS MEDICAL DIRECTOR AGREEMENT ("Agreement") is entered into as of the _____ day of _____, 20_____ (the "Effective Date") by and between **[name of physician]**, an individual residing at OR **[(name of legal entity), a (State) (legal entity), having its principal place of business at (address)]** (the "Physician") and [(name of nursing facility), a (State) (legal entity), doing business as (name), having its principle place of business at (address)] ("Facility"); individually, a "Party"; together, the "Parties."

RECITALS

WHEREAS, Facility is in the business of owning and operating a nursing facility or facilities;

WHEREAS, Physician is duly qualified and licensed to practice medicine in the State in which Facility is located and is an experienced physician with a special expertise in long term care medicine;

WHEREAS, Facility and Physician have agreed that Physician will provide the Services (as defined hereinafter) to Facility; and

WHEREAS, the Parties to this Agreement desire to provide a full statement of their respective covenants, agreements and responsibilities in connection with Physician's appointment and Physician's performance of the Services during the Term of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Physician and Facility agree as follows:

1. Term:

1.1 The term of this Agreement shall commence as of the Effective Date and shall continue thereafter for a period of one (1) year (the "Initial Term"). At the conclusion of the Initial Term, this Agreement, upon mutual agreement of the Parties, may be renewed for successive one (1) year terms (each, a "Renewal Term") unless terminated as provided for under Section 9 of this Agreement. Upon renewal of this Agreement, all other terms and conditions of this Agreement in existence at the end of the Initial Term shall continue in

place. The word "Term," when used in this Agreement shall mean the Initial Term and any Renewal Term.

2. <u>Engagement</u>:

2.1 Facility engages and appoints Physician to serve as the Medical Director of Facility for the Term.

2.2 [**Option #1 - Independent Contractor:** At all times during Physician's performance of the Services pursuant to this Agreement, Physician shall be an independent contractor. Physician shall be responsible for paying all taxes due on all amounts paid to Physician hereunder and shall indemnify and hold Facility harmless from any failure to pay such taxes, including any interest and penalties assessed against Facility. Facility shall have no responsibility for withholding taxes or for employee benefits of Physician. The Parties shall cooperate if any taxing authority asserts that Physician is not an independent contractor under this Agreement. Except as expressly set forth herein or as may be required by Applicable Laws, as defined herein, Facility shall neither have nor exercise any control or direction over the methods by which Physician shall perform the Services hereunder, nor shall Facility control how Physician's Services are accomplished hereunder, as long as said Services are performed as required by this Agreement.]

[**Option #2 - Employee:** Physician shall be an employee of Facility for all purposes. Facility shall withhold amounts from Physician's compensation in accordance with the requirements of Applicable Laws for federal and State income tax, FICA, FUTA, and other employment or payroll tax purposes. It shall be Physician's responsibility to report and pay all federal, State and local taxes arising from Physician's receipt of compensation hereunder.]

[**Option #3-Employee of External Health Care Entity:** A medical group or an external health care entity that employs physicians (sometimes referenced hereafter, "Medical Center") must designate a physician to be the medical director and provide covering physicians as necessary in the designee's absence. The Medical Center will receive reimbursement for the Services and compensate the designee and covering physicians for all Services rendered, under similar terms and caveats outlined under option #1 for independent contractors.]

2.3 Nothing in this Agreement shall limit or restrict Physician's right to serve as medical director of another nursing facility or other entity.

3. **<u>Services of Physician</u>**:

3.1 As Medical Director of Facility, Physician shall have the responsibilities and perform the duties set forth in Section 3 (the "Services").

3.2 Physician shall guide, approve, and help oversee the development, implementation, and monitoring/evaluation of Facility's resident care policies and procedures in the following areas:

3.2.1 Admission policies and care practices that address the types of residents that may be admitted and retained based upon the ability of the Facility to provide the services and care to meet their needs;

3.2.2 The integrated delivery of care and services, such as medical, nursing, pharmacy, social, rehabilitative and dietary services, which includes clinical assessments, analysis of assessment findings, care planning including preventive care, care plan monitoring and modification, infection control (including isolation or special care), transfers to other settings, and discharge planning;

3.2.3 The use and availability of ancillary services such as x-ray and laboratory;

3.2.4 The availability, qualifications, and clinical functions of staff necessary to meet resident care needs;

3.2.5 Resident formulation and Facility implementation of advance directives (in accordance with State law), relevant order sets (e.g., POLST paradigm forms and pre-hospital DNR forms) and end-of-life care;

3.2.6 Provisions that enhance resident decision-making, including choices regarding medical care options;

3.2.7 Mechanisms for communicating and resolving issues related to medical care;

3.2.8 Conduct of research, if allowed by State law, within the Facility, under the guidance of an Institutional Review Board;

3.2.9 Provision of physician services, including (but not limited to):

a. Availability of physician services 24 hours a day in case of emergency;

b. Review of the resident's overall condition and program of care at each visit, including medications and treatments;

c. Documentation of progress notes with signatures;

d. Frequency of visits, as required;

e. Signing and dating all orders, such as medications, admission orders, and re-admission orders; and

f. Review of and response to consultant recommendations relating to the provision of physician services.

3.2.10 Systems to reasonably ensure that other licensed practitioners (*e.g.*, nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law;

3.2.11 Procedures and general clinical guidance for Facility staff regarding when to contact a practitioner, including information that should be gathered prior to contacting the practitioner regarding a clinical issue/question or change in condition/transfer and discharge of resident;

3.2.12 Care of residents with complex or special care needs, such as dialysis, hospice or end-of-life care, respiratory support with ventilators, intravenous medications/fluids, dementia and/or related conditions, or problematic behaviors or complex mood disorders;

3.2.13 Systems to ensure appropriateness of care as it relates to clinical services (for example, following orders correctly, communicating important information to physicians in a timely fashion, etc.);

3.2.14 Processes for accurate assessment, care planning, treatment implementation, and monitoring of care and services to meet resident needs;

3.2.15 Risk management programs; and

3.2.16 [**Optional Provision for CCRCs or ALFs:** Participating, as needed, in level of care assessments and placement recommendations for prospective residents and residents of Facility.]

3.3 Physician shall review and participate in updating resident care policies and procedures to reflect current standards of practice for resident care and quality of life. Current standards of practice refer to approaches to care, procedures, techniques, and treatments that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

3.4 Physician shall be responsible for the coordination of medical care in the Facility. Physician shall help the Facility obtain and maintain timely and appropriate medical care that supports the healthcare needs of the residents, is consistent with current standards of practice, and helps the Facility meet its regulatory requirements. Physician shall address issues related to the coordination of medical care identified through the Facility's quality assessment and assurance committee and quality assurance and performance improvement (QAPI) program, and other activities related to the coordination of care, which may include, but is not limited to, helping the Facility:

3.4.1 Reasonably ensure that residents have primary attending and backup physician coverage;

3.4.2 Reasonably ensure that physician services are available 24 hours a day and in case of emergency;

3.4.3 Reasonably ensure that physician and health care practitioner services are available to help residents attain and maintain their highest practicable level of functioning, consistent with current standards of practice and regulatory requirements;

3.4.4 Reasonably ensure that physicians visit residents, provide medical orders, and review a resident's medical condition as required by Applicable Laws;

3.4.5 Collaborate to develop a process to review basic physician and health care practitioner credentials.

3.4.6 Address and resolve concerns and issues between the physicians, health care practitioners and Facility staff;

3.4.7 Resolve issues related to continuity of care and transfer of medical information between the Facility and other care settings;

3.4.8 Facilitate feedback to physicians and other health care practitioners about their performance and practices;

3.4.9 Review individual resident cases as requested to evaluate quality of care or quality of life concerns or other problematic situations and take appropriate steps to resolve the situation as necessary and as requested;

3.4.10 Discuss and intervene (as appropriate) with a health care practitioner about medical care that is inconsistent with applicable current standards of practice;

3.4.11 Review consultant recommendations that affect Facility's resident care policies and procedures or the care of an individual resident;

3.4.12 Assure that a system exists to monitor the performance of the health care practitioners, and guide physicians regarding specific performance expectations;

3.4.13 Assure that other practitioners who may perform physician delegated tasks act within the regulatory requirements and within their scope of practice as defined by State law;

3.4.14 Address concerns between the resident's attending physician and the Facility;

3.4.15 Identify Facility or practitioner educational and informational needs, and provide information to the Facility practitioners from sources such as nationally recognized medical care societies and organizations where current clinical information can be obtained; and

3.4.16 Help educate and provide information to Facility staff, practitioners, residents, families and others.

3.5 Physician shall review, respond to, and participate in federal, State, local, and other external surveys and inspections. Facility shall notify Physician of any such survey or inspection as soon as practicable. Physician shall review all quality of care and medical issues noted during the survey or inspection. Physician shall provide input on any plan of correction or in any dispute resolution resulting from a survey or inspection.

3.6 Physician shall at all times render Services in a competent, professional and ethical manner, in accordance with prevailing standards of medical practice in the relevant community, perform professional and supervisory services in accordance with recognized standards of the medical profession, and act in a manner consistent with Applicable Laws.

3.7 Physician shall not discriminate or differentiate in the treatment of any resident of Facility based on sex, marital status, age, race, color, disability, religion, sexual orientation, gender orientation or otherwise, including by reason of the fact that the resident is a federal health care program beneficiary. Physician agrees to ensure that Services provided to residents pursuant to this Agreement are provided in the same manner, and in accordance with the same standards and with the same availability as offered to any other individual customarily receiving Services from Physician, which shall be in accordance with accepted standards of competence and ethics.

3.8 During brief absences, Physician may, subject to Facility's approval, designate another physician as substitute Medical Director.

4. Duties of Facility:

4.1 During the Term of this Agreement, Facility shall provide reasonable and necessary infrastructure and support including but not limited to appropriate office space, supplies, equipment, furnishings, and telephone and facsimile, computer and internet access for Physician's provision of Services, all of which shall remain the property of Facility.

4.2 During the Term of this Agreement, Facility shall provide such staff assistance necessary for the efficient performance of the Services by Physician.

5. Compensation:

5.1 Fees: For the Services described in Exhibit A hereof and performed during the Term, Medical Center or Physician, as the case may be, shall be paid a rate of XXX Dollars and 00/100 ($XXX.00) per hour ("Fee") and such Fee shall compensate Physician for the Services provided for the Facility. Physician shall expend such time in performance of the Services as shall be necessary for the full and adequate completion of such Services, which Facility and Medical Center or Physician agree shall not be more than xx (##)) hours per month during the Term without express written permission from the Facility.

5.2 Each Party acknowledges and agrees that the Fee is intended to, and in the reasonable belief of each Party, is the fair market value of the Services. The Parties further acknowledge and agree that, as a compliance requirement of Facility, there may be an independent assessment of fair market value determinations. In the event that such assessment determines that the Fee does not meet fair market value, then either Party may terminate this Agreement in accordance with Section 9.

The Parties further acknowledge and agree that there may be changes (e.g., passage of time, additional qualifications and experience obtained by Physician, etc.), or a Change in Law, as defined hereafter, that are sufficient to cause the Parties to reevaluate the Fee and make such changes as are necessary to keep the Fee consistent with the fair market value of the

Services and the applicable policies of the Facility. The Fee may be changed to reflect the findings of any such re-evaluation only at the completion of a Term. No other changes to the Fee are permitted hereunder unless made to correct an error in the Agreement or a Change in Law.

Compensation Not Based On Referrals: Facility and Medical Center or Physician acknowledge that none of the benefits granted Physician under this Agreement or in relation to the performance of Services hereunder is conditioned on any requirement that Physician or Medical Center make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the Facility or any other facility owned or operated by the Facility.

5.2.1 Facility shall not pay Physician for otherwise compensated professional services rendered by Physician to individual residents of Facility.

5.3 Medical Center or Physician agrees to submit monthly invoices and a detailed record of time spent performing the Services, as set forth in this Agreement.

5.4 The Parties acknowledge and agree that the compensation set forth herein represents the fair market value of the Services provided by Medical Center or Physician to Facility negotiated in an arm's length transaction and has not been determined in a manner that takes into account the volume or value of referrals or business that may otherwise be generated between the Parties. Nothing contained in this Agreement shall be construed in any manner as an obligation or inducement on the making of any referrals by Medical Center or Physician to Facility, or by Facility to Medical Center or Physician. The Parties further agree that this Agreement does not involve the counseling or promotion of a business arrangement that violates Applicable Laws.

5.5 If, during the Term of this Agreement, Facility wishes to engage Physician to perform additional services outside the scope of this Agreement, Facility and Physician agree to negotiate a mutually acceptable time commitment and appropriate compensation for the provision of such additional services by Physician.

5.6 Optional alternative call compensation: In consideration of the Physician's 24/7 emergency call availability to Facility and considering 720 hours in an average month, Medical Center or Physician will receive additional baseline compensation of $XXX monthly regardless of the frequency of actual emergency and after-hours calls. In addition, Medical Center or Physician may bill the usual rate for actual emergency and after-hours calls.

6. **Physician Representations and Warranties**:

6.1 Physician represents and warrants to Facility that he/she:

6.1.1 Is and shall at all times be, during the Term of this Agreement, duly licensed to practice medicine under the laws of the State or Commonwealth of the Facility; duly licensed to prescribe controlled substances issued by the appropriate governmental agencies; is certified to participate as a provider in the Medicare and

Medicaid programs, and any other federal health care program; has obtained and maintained appropriate professional liability coverage; and has obtained and maintained appropriate board certification, if applicable. Physician further states that his/her license, certification, professional liability coverage, and board certification are current, unrestricted, and unconditional, and have not been suspended, revoked, or restricted in any manner.

6.1.2 Is not currently under investigation for nor has he/she been convicted of any offense related to the delivery of a health care item or service under any State or federal or private health care benefit program;

6.1.3 Has not been required to pay any civil monetary penalty regarding false, fraudulent, or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of any State, federal, or private health care benefit program; and

6.1.4 Has not been excluded from participation in any State, federal or private health care benefit program.

7. **Insurance**:

7.1 Facility shall maintain, on behalf of Physician, adequate professional liability insurance to cover Physician for Services provided under this Agreement. Facility shall deliver to Physician, upon Physician's written request, satisfactory evidence of such insurance.

7.2 If Physician also serves as attending or consulting physician for individual residents of Facility, Physician shall obtain and maintain throughout the Term of this Agreement adequate general and professional liability insurance at Physician's expense.

8. **Disclosure of Confidential Information and Records**: Medical Center or Physician further acknowledges that in connection with this Agreement and the Services provided pursuant to it, he/she/it will be acquiring and making use of confidential information and trade secrets of Facility (the "Confidential Information") which include, but are not limited to, financial statements, internal memoranda, clinical forms, reports, resident lists (including names and addresses), and other materials or records of a proprietary nature. In order to protect the Confidential Information, Medical Center or Physician agrees that he/she/it will not, after the date hereof and for so long as any such Confidential Information may remain confidential, secret, or otherwise wholly or partially protectable, use such information, except in connection with the performance of his/her Services pursuant to this Agreement. Medical Center or Physician also agrees that he/she/it will not divulge the Confidential Information to any third party, unless Facility consents to the disclosure in writing, or as required by Applicable Laws. In furtherance hereof, the Parties agree to enter into the Business Associate Agreement attached hereto and incorporated herein as Addendum D.

9. **Termination**:

9.1 This Agreement may be terminated as described below; provided, however, that if such termination occurs prior to expiration of the Initial Term, the Parties may not enter into another agreement for Services for the remainder of the Initial Term:

9.1.1 Upon mutual agreement of the Parties to terminate this Agreement;

9.1.2 Upon sixty (60) days prior written notice of intent to terminate by either Party;

9.1.3 By Facility, upon Physician's death;

9.1.4 By Facility, upon Physician's physical or mental incapacitation such that Physician is unable to perform Services under this Agreement for a period of thirty (30) consecutive days unless Physician provides, at his/her cost, an appropriately credentialed physician acceptable to Facility to render all Services incident to this Agreement;

9.1.5 By Facility, if disciplinary action is concluded against Physician by any governmental authority;

9.1.6 By Facility, if Physician is convicted in a court of law of any felony, any crime or offense involving property of Facility, or any federal health care program-related crime, including the Medicare and Medicaid programs;

9.1.7 By Facility, upon Physician's breach of Section 8, which breach has not been cured to the sole satisfaction of Facility;

9.1.8 By Physician, upon Facility's dissolution or the filing of a voluntary petition in bankruptcy, or an assignment for the benefit of creditors or other action taken voluntarily by Facility, under any State or federal statute for the protection of debtors, or the filing of an involuntary petition in bankruptcy or other similar involuntary proceeding against Facility under any State or federal statute for the protection of debtors if such involuntary petition or other involuntary proceeding is not dismissed within thirty (30) days of its filing; or

9.1.9 By Physician, upon revocation of the Facility's Medicare and State Medicaid certification, or the suspension or termination of the Facility's license.

9.2 In the event of termination pursuant to Section 9.1, Physician shall be entitled to any unpaid compensation through the date of termination.

10. **Indemnification**:

10.1 Facility hereby agrees to indemnify, defend, and hold harmless Physician and his/her agents, employees, successors and assigns from and against any and all actions, claims, suits, demands, damages, judgments, losses, and any other costs, liabilities, and expenses, including reasonable attorneys' fees and collection costs, arising from any act, error, or omission of Physician and the provision of or failure to provide any of the Services within the scope of this Agreement, including but not limited to, advisory, supervisory, consulting, and administrative services.

11. General Provisions:

11.1 Applicable Laws: For purposes of this Agreement, Applicable Laws shall mean all applicable local, State, and federal laws, rules, and regulations, and all standards and guidelines of all applicable accrediting bodies and the bylaws, policies, procedures, rules, and regulations of the Facility that may be in effect from time to time.

11.2 Change in Law: If there is a change in an existing (or adoption of a new) law ("Change in Law") during the Term of this Agreement that alters a Party's rights or responsibilities hereunder in a material way, then upon request by the affected Party, the Parties will in good faith negotiate the terms of this Agreement, as applicable, so that for the remainder of the Term of this Agreement, the Parties will be in the same position in performing this Agreement that they would have been in without the Change in Law. If the Parties are unable to agree upon such an amendment despite good faith negotiations over a period of ten (10) days, either Party may thereafter terminate this Agreement by giving the other Party ten (10) days written notice of termination.

11.3 Assignment:

[**Option #1:** Physician shall not, directly or indirectly, assign or otherwise transfer this Agreement, or any interest herein or obligation hereunder, without the prior written consent of Facility. Facility shall be permitted, without the consent of Physician, to assign or otherwise transfer this Agreement or any of its rights hereunder to any purchaser of Facility.]

[**Option #2:** This Agreement shall not be assigned by either Party without the prior written consent of the other Party.]

11.4 Entire Agreement; Binding Effect: This Agreement contains the entire and final agreement among the Parties hereto with respect to Facility's appointment of Physician as the Medical Director of Facility, and supersedes all prior agreements, whether written or oral, with respect thereto. No provision hereof may be modified, amended or waived in any manner whatsoever other than by a supplemental writing signed by the Parties hereto or their respective successors in interest. Subject to Section 11.3, this Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors, assigns, heirs, executors and legal representatives.

11.5 Notices: Any notice required or permitted to be given under this Agreement shall be sufficient if the notice is in writing and delivered in person or sent by registered or certified mail to the principal place of business of the Parties as set forth herein.

11.6 Waiver: The waiver by either Party of any term or condition of this Agreement or the breach of this Agreement shall not constitute a waiver of any other term or condition of this Agreement.

11.7 **[Optional Provision:** 11.5 Dispute Resolution: All disputes between Physician and Facility shall be submitted to alternative dispute resolution under the supervision of a

qualified arbitrator. The findings, conclusions and award of the arbitrator shall be final and binding upon the Parties.**]**

11.8 Invalidity: The invalidity of any provision(s) or portions of provision(s) of this Agreement shall not affect any other provision(s) or portions thereof. In the event that one or more provision(s) or portions of this Agreement are declared legally invalid, the remainder of this Agreement shall remain in full force and effect.

[Signature page follows.]

IN WITNESS THEREOF, the Parties have caused this Agreement to be executed and delivered as of the Effective Date.

[NAME OF FACILITY]

By:_____

Its:_____

[NAME OF PHYSICIAN]

By:_____

[Name of Physician]

[NAME OF MEDICAL CENTER, if applicable]

By:_____

Its:_____

ADDENDUM A

PERFORMANCE REQUIREMENTS AND DUTIES AND RESPONSIBILITIES OF A NURSING FACILITY MEDICAL DIRECTOR

Minimum Qualification Standards:

(The minimum education, work experience, credentials and standards to qualify for a specific job. These must be "job-related" and "consistent with business necessity.") Facilities may waive some of these qualifications at their discretion)

Education: graduation with a recognized medical doctorate (MD, DO, or equivalent foreign degree) from an Accreditation Council for Graduate Medical Education (ACGME) accredited medical school.

Certificate/Licenses: Active, unrestricted State medical license; valid, active DEA Controlled Substances Registration, and National Provider Identification (NPI) number.

Board-certified/eligible in a medical specialty and/or certified medical director (CMD) by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) expected within two (2) years of assuming the position of medical director.

Work Experience: At least two years of experience relating to skilled nursing facility care as a medical director, attending physician or consultant.

Substance Use Record: Freedom from illegal use of drugs, and freedom from use and effects of drugs and alcohol in the workplace.

[Optional] Continuing Education in Post-Acute and Long-Term Care Medicine: At least 8 hours annually of continuing medical education credit in PALTC medicine or related topics. CMD-eligible hours and other CME content relevant to geriatrics or PALTC qualify for this educational requirement. Medical Director to provide evidence of successful completion of these hours to facility no less frequently than every 2 years. Up to 8 hours of such professional education and enrichment annually may be considered part of medical director compensated time.

Note: Medical Directors with valid CMD certificate are exempt from this requirement.

Note: Persons who have been found guilty by a court of law of abusing, neglecting or mistreating individuals in a health care setting are ineligible for this position.

Performance Requirements:

Demonstrates current knowledge of appropriate medical care of frail elder individuals and other relevant nursing facility patients.

Demonstrates current knowledge of legal and regulatory requirements for medical care in a nursing facility setting, including applicable federal, State and local regulations.

Demonstrates knowledge of and respect for the rights, dignity, and individuality of each resident in all interactions.

Demonstrates compliance with all federal and State laws and regulations.

Duties and Responsibilities of a Medical Director (Essential Functions):

This statement includes activities that medical directors of nursing facilities should perform as essential functions.

1. Provide medical decision input and support to the Administrator and governing body of the facility.

1.1 Participate in developing resident care policies, as well as policies regarding services of physicians and other professionals.

1.2 Participate in meetings with the administrator and/or the governing body, director of nursing or other professional staff to discuss clinical and administrative issues, specific patient care problems and professional staff needs for education or consultants. Offer solutions to problems and identify areas where policies should be developed.

1.3 Help prepare for, review, and respond to federal, State, and local surveys and inspections.

1.4 Participate in establishing policies and procedures to enhance and promote the quality of life for residents.

1.5 Advise administration of current developments regarding patient care and new treatment modalities.

1.6 Communicate on a regular basis with administration and organization leadership regarding actions, recommendations and concerns of the medical director.

1.7 Acquire, maintain and apply knowledge of social, regulatory, political, and economic factors that relate to resident care services in the post-acute and long-term care setting.

1.8 Update skills and knowledge regularly regarding federal and State regulatory requirements, as well as professional service and administrative requirements of third-party payers.

2. Implement resident care policies.

2.1 Implement resident care policies regarding: admissions; transfers and discharges; physician privileges and practices; and responsibilities of non-physician health care workers (e.g., nursing, rehabilitation therapies and dietary services in resident care, emergency care, and resident assessment and care planning). (These are specifically listed as responsibilities of the medical director in CMS surveyor guidelines.)

2.2 Implement resident care policies regarding: accidents and incidents; ancillary services such as laboratory, radiology and pharmacy; use of medications; use and release of clinical information; and overall quality of care. (These are specifically listed as responsibilities of the medical director in CMS surveyor guidelines.)

2.3 Monitor compliance with facility requirement that residents have the right to choose a personal physician (483.(d)(1)) and know how to contact him or her.

2.4 Monitor compliance with requirement that facility immediately inform resident and consult with resident's physician in cases of accidents with injuries that have the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; or a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.

3. Coordinate and oversee medical care and treatment, including physician services and services of other professionals as they relate to resident **care.**

3.1 Participate in evaluating the adequacy of the professional and support staff and the facility to meet the medical and physical, psychosocial, cultural, and spiritual needs of residents.

3.2 In cooperation with the administration and with the approval of the governing body, represent the medical staff in developing rules, regulations and policies for the attending physicians who admit their patients to the facility.

3.3 Monitor the clinical practices of attending physicians, and intervene as needed on behalf of the patients or the facility's administration.

3.4 Monitor compliance of attending physicians with any facility credentialing requirements and bylaws.

3.5 Develop, amend, recommend to facility staff, and implement appropriate clinical practices and medical care policies to help insure that each patient's medical assessment and regime is incorporated appropriately into the plan of care on a timely basis.

3.6 Monitor physician participation in assessment and care planning.

3.7 Monitor provision of physician services to provide services to meet the highest practicable physical, mental, and psychosocial well-being of each resident.

3.8 Act as a liaison between the attending physicians and other health professionals caring for residents.

3.9 Monitor that services provided or arranged by facility meet professional standards of quality and are provided by qualified persons.

3.10 Assist physicians in understanding the importance of timely visits, timely orders, and appropriate documentation of provided care.

3.11 Supervise compliance by attending physicians with requirements for: admission orders, timely reviews of residents' total program of care, including medications and treatments; written, signed & dated progress notes at each visit; frequency of physician visits; orders signed and dated--as well as specified frequency of physician visits. See also re: admission, transfer and discharge requirements; complete and accurately documented compilation of clinical records on each resident according to accepted professional standards, monitor drug regimen review, fully inform residents in advance about health status and care and treatment, and have residents participate in care planning and treatment, unless residents are adjudged incompetent; oversee medical care to assure that residents' abilities in activities of daily living (ADLs) do not diminish unless clinically unavoidable (483.25(a)); exercise medical and clinical leadership in a multi-disciplinary approach to resident care and care planning within the long-term care setting, and interact with the attending staff as a colleague and peer; monitor that physician tasks that are delegated to nurse practitioners, clinical nurse specialists or physician assistants are delegated appropriately.

4. Oversee that medical services provided to residents are adequate and appropriate.

4.1 Participate in the development of systems providing for a medical care plan for each resident that stresses appropriate use of medications, nursing services, social services, activity services, nutrition services, rehabilitation and dental services, and when appropriate, a plan for discharge.

5. Coordinate the facility's quality assurance/performance improvement (QAPI) process, to ensure the quality of medical and medically related care.

5.1 Coordination of quality assurance includes but is not limited to a continuous quality improvement program, as well as participation on relevant committees, such as the pharmacy and therapeutics committee, the infection control committee, and the safety committee.

5.2 Assist those who must handle various ethical, social, psychological and functional issues by providing timely and relevant information, interpretation and consultation.

5.3 Lead facility quality assessment and assurance (QA&A) committee activities to identify care issues related to individual residents as well as care throughout the facility and take appropriate and timely action as needed to implement recommendations.

5.4 Overseeing infection prevention and control program, in conjunction with the facility's infection preventionist and director of nursing.

5.5 Review recommendations and reports of drug regimen review efforts, and take appropriate and timely action as needed to implement recommendations.

5.6 Help the facility administrator and professional staff ensure a safe and sanitary environment for residents and personnel by reviewing incident reports, identifying hazards to health and safety, providing corrective strategies, and advising about improving the environment.

6. Advise the facility administration and governing body of current medical issues affecting the residents.

6.1 Maintain current knowledge of clinical developments to promote the highest possible functional level and well-being of residents, as well as best clinical outcomes possible.

6.2 Advise administrator and governing body regarding quality and other patient care issues related to current or potential managed care Contracts.

7. Provide "on-call" availability and respond to medical or regulatory or other emergencies.

7.1 Assist in arranging for continuous physician coverage for medical emergencies and in developing procedures for emergency treatment of residents.

7.2 Assure that physician services are available 24 hours a day, in case of emergency. In an emergency, be prepared to assume temporary responsibilities for the care of a resident, if the resident's own attending physician or the designated alternate physician is not available.

7.3 When the medical director is not available in an emergency, ensure that a backup physician is available to serve in his or her stead, and notify facility administration in advance of expected unavailability.

8. Participate in the development and presentation of education programs.

8.1 Organize in-service training and other educational programs and materials for the attending physicians and other professional staff within the institution, in cooperation with the director of nursing and the administrator.

8.2 Make presentations to local and regional medical groups, hospital staff, etc., as needed.

8.3 Serve as resource to physicians, staff, residents and families about patient care, new treatment modalities, and the pathophysiology of illness.

9. Participate, as appropriate, in matters of employee health, and promotion of the health, welfare and safety of employees.

9.1 Assist administration in developing employee health and wellness plans.

9.2 Advise the employee health nurse and/or administrator regarding specific issues in employee health including particularly issues addressed in federal regulations or guidance, such as blood-borne pathogens, tuberculosis control, and ergonomic health.

10. Help articulate the facility's mission to the community and represent the facility in the community.

10.1 Help individuals and families form realistic expectations of long-term care.

10.2 Serve as a speaker in the areas of geriatrics and long-term care, as needed.

11. Provide medical leadership for research and development activities in geriatrics and long-term care.

11.1 Coordinate the management of medical information and the interpretation of data from multiple sources.

11.2 Oversee or participate in institutional review board, if any, to oversee research in the facility and monitor compliance with full disclosure of the nature and consequences of participating, as well as the rights of residents to refuse to participate in experimental research.

12. Participate in establishing policies and procedures for assuring that the rights of individual residents are respected and enhanced.

12.1 Monitor physician compliance with residents' advance directives or other preferences, as well as right to refuse treatment.

12.2 Oversee compliance with requirement that residents are free from any physical or chemical restraints not required to treat the resident's medical symptoms. Direct restraint reduction programs, as needed, and monitor appropriate documentation by physicians in the clinical record of medical symptoms that require restraint, and of alternative measures that have been evaluated and found to be not effective.

12.3 Supervise residents' drug therapies, to ensure that drug regimens are appropriate, not contraindicated, and properly documented and administered.

12.4 Participate in interdisciplinary team assessment of resident ability to self-administer drugs.

12.5 Monitor to ensure that each resident's drug regimen is free from unnecessary drugs and that residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated.

13. Serve as patient advocate, as needed, to secure medically necessary services.

13.1 Work with patients, families, managed care organizations and other insurers to obtain coverage and reimbursement for medically appropriate services.

14. Advise Facility with regard to Risk Management matters.

14.1 Advise the facility staff with regard to matters involving adverse events, quality concerns and risk management and the mitigation of potential claims relating to the care provided to residents to the facility.

14.2 Review medical records and collaborate and cooperate with facility's administration and/or governing body matters involving claims related to the care being provided to residents of the facility.

14.3 Assist the facility in assessing matters involving risk management and the defense of claims asserted against the facility related to care provided by the facility.

AMDA WHITE PAPER ON The Nursing Home Medical Director: Leader and Manager

UPDATES RESOLUTION A06

MARCH 2011

Introduction

In 1974, in response to identified quality of care problems, Medicare regulations first required a physician to serve as medical director in skilled nursing facilities and to be responsible for the medical care provided in those facilities. Following the passage of the Nursing Home Reform Act in 1987, AMDA—Dedicated to Long Term Care Medicine (AMDA) House of Delegates, in March 1991, approved the *Role and Responsibilities of the Medical Director in the Nursing Home*, a document setting forth AMDA's vision for nursing facility medical directors. It outlines the medical director's roles in nursing facilities and is the foundation for:

- AMDA's Certified Medical Director credentials;
- AMDA's *Model Medical Director Agreement and Supplemental Materials: Medical Director of a Nursing Facility* and;
- Resolutions on medical direction in other long term care settings.
-

Since 1991, the long-term care field has been affected by changes in medical knowledge, clinical complexity of patients, societal attitudes, legal influences, demographics and patient mix, reimbursement, and shifts in the scope of care in various settings. Increasingly, medical directors are held accountable by State legislators, regulators, and the judicial system for their clinical and administrative roles in these diverse facilities. At least one State[1] has enacted legislation outlining the specific regulatory responsibilities and educational pre-requisites for medical directors, and other States may follow its lead.

The 2001 Institute of Medicine report *Improving the Quality of Long Term Care* urges facilities to give medical directors greater authority and hold them more accountable for medical services. The report further states, nursing homes should develop structures and processes that enable and require a more focused and dedicated medical staff responsible for patient care. These organizational structures should include credentialing, peer review, and accountability to the medical director (Institute of Medicine 2001, 140). These developments required AMDA to revise and update its 1991 document to develop a clearer vision for enhanced medical director responsibilities.

In April 2002, AMDA convened a panel to review the document in the context of changes within long-term care. Their work product outlined the medical director's major roles in the facility and was geared toward ensuring that appropriate care is provided to an increasingly complex, frail, and medically challenging population. These concepts were considered when the Centers for Medicare & Medicaid Services revised the Surveyor Guidance related to F-Tag 501 (Medical Director) in 2005. This AMDA

[1] The State of Maryland enacted this legislation. *Code of Maryland Regulations. 10.07.02.11 .11 Medical Director Qualifications.*

policy statement has therefore been updated to be congruent with current regulatory requirements and their related interpretive guidelines, and as such reflect the current roles and responsibilities of the medical director.

AMDA's Core Curriculum Faculty has further developed and teaches the roles, functions and tasks of the medical director. The functions and tasks were last updated in 2009 to include person-directed care. This current document has been revised in late 2010 for presentation to the AMDA Board of Directors and the AMDA House of Delegates at the March 2011 meeting in Tampa, Florida. It is AMDA's most recent position statement to harmonize the leadership role and management responsibilities of today's medical director.

Certified Medical Director (CMD)

The mission of the American Medical Directors Certification Program (AMDCP) is to recognize and advance physician leadership and excellence in medical direction throughout the long-term care continuum via certification. The Certified Medical Director in Long Term Care (AMDA CMD) recognizes the dual clinical and managerial roles of the medical director. The CMD credential reinforces the leadership role of the medical director in promoting quality care and offers an indicator of professional competence to long term care providers, government, quality assurance agencies, consumers, and the general public.

The Assistant or Associate Medical Director

Due to the expanded role of medical director, some facilities or organizations have identified a need for an assistant or associate medical director. The assistant or associate medical director should be a physician who has comparable knowledge and skills to those of the medical director.

Roles, Functions, and Tasks

The position of the nursing home Medical Director can be identified in terms of the Role, Functions, and Tasks hierarchy.

- Roles: the set of behaviors that an individual within an organization is expected to perform and feels obligated to perform.
- Functions: the major domains of activity within a role.
- Tasks: the specific activities that are undertaken to carry out those functions.

Roles

In defining the role of the medical director, and ultimately the foundation for the individual medical director agreement, it is important to begin with a framework that identifies core principles. This framework is based on functions related to providing high quality of care to the individuals served. These functions include providing input into the clinical policies governing the organization or facility, supervising the medical staff, reviewing and participating in quality assurance activities, and directly overseeing clinical safety and risk management.

The medical director is involved at all levels of individualized patient care and supervision, and for all persons served by the facility. The medical director serves as the clinician who oversees and guides the care that is provided, a leader to help define a vision of quality improvement, an operations consultant to address day-to-day aspects of organizational function, and a direct supervisor of the medical practitioners who provide the direct patient care.

AMDA has identified four key roles of the long-term care medical director, as follows.

Role 1—Physician Leadership

The medical director serves as the physician responsible for the overall care and clinical practice carried out at the facility.

Role 2—Patient Care-Clinical Leadership

The medical director applies clinical and administrative skills to guide the facility in providing care.

Role 3—Quality of Care

The medical director helps the facility develop and manage both quality and safety initiatives, including risk management.

Role 4—Education, Information, and Communication

The medical director provides information that helps others (including facility staff, practitioners, and those in the community) understand and provide care.

Functions and Tasks

Although individual job duties will vary among organizations, there are basic, universally relevant functions that are embedded in the overarching roles. The functions represent the foundation for developing the individual medical director's tasks. The relevance and nature of some tasks may vary; for example, due to different patient populations, facility requirements, or State or local regulations. Therefore, it is useful to divide tasks related to various functions into 1) essential tasks that all medical directors should perform (Tier 1) and 2) tasks that, while desirable, may vary in importance depending on a medical director's situation or setting (Tier 2).

The manner in which different medical directors perform various tasks (regardless of whether a task is essential or optional) may vary.

Function 1—Administrative

The medical director participates in administrative decision-making and recommends and approves relevant policies and procedures.

Function 2—Professional Services

The medical director organizes and coordinates physician services and the services provided by other professionals as they relate to patient care.

Function 3—Quality Assurance and Performance Improvement

The medical director participates in the process to ensure the quality of medical care and medically related care, including whether it is effective, efficient, safe, timely, patient-centered, and equitable.

Function 4—Education

The medical director participates in developing and disseminating key information and education.

Function 5—Employee Health

The medical director participates in the surveillance and promotion of employee health, safety, and welfare.

Function 6—Community

The medical director helps articulate the long-term care facility's mission to the community.

Function 7—Rights of Individuals

The medical director participates in establishing policies and procedures for assuring that the rights of individuals (patients, staff, practitioners, and community) are respected.

Function 8—Social, Regulatory, Political, and Economic Factors

The medical director acquires and applies knowledge of social, regulatory, political, and economic factors that relate to patient care and related services.

Function 9—Person-Directed Care

The medical director supports and promotes person-directed care.

9.4.1 Tasks

The tasks are listed as they relate to the nine functions and are divided into two tiers.

- Tier 1—essential, universally applicable tasks
- Tier 2—tasks that may vary with the individual's situation, availability, facility needs, and so on.

Function 1—Administrative

Tier 1

Task 1

The medical director communicates regularly with the administrator, the director of nursing, and other key decision makers in the nursing home and provides leadership needed to achieve medical care goals.

Task 2

The medical director participates in the development and periodic evaluation of care-related policies and procedures.

Task 3

The medical director guides and advises the facility's committees related to quality assurance / performance improvement, pharmacy, infection control, safety, and medical care.

Task 4

The medical director participates in licensure and compliance surveys and interacts with outside regulatory agencies.

Task 5

The medical director informs medical staff about relevant policies and procedures, including updates.

Task 6

The medical director collaborates with the administrator to identify a job description that clearly defines the medical director's roles and functions in the facility.

Tier 2

Task 7

The medical director stays informed about factors that affect long term care and incorporates relevant information about social, medical, and fiscal issues into policies and procedures.

Task 8

The medical director helps the facility develop or incorporate policies and procedures and utilize pertinent strategies to effect and manage change.

Function 2 -Professional Services

Tier 1

Task 1

The medical director organizes, coordinates, and monitors the activities of the medical staff and helps ensure that the quality and appropriateness of services meets community standards.

Task 2

The medical director helps the facility arrange for the availability of qualified medical consultative staff and oversees their performance.

Task 3

The medical director assures coverage for medical emergencies and participates in decisions about the facility's emergency equipment, medications, and supplies.

Task 4

The medical director collaborates with the DON and other clinical managers to help ensure that practitioners in the facility have adequate support from staff to assess and manage the patients (e.g., when they are making patient rounds or responding to calls about changes in condition).

Task 5

The medical director develops and periodically reviews and revises, as indicated, policies that govern practitioners in the facility other than physicians, including physician assistants and nurse practitioners; and guides the facility regarding the professional qualifications of other staff related to clinical decision-making and the provision of direct care.

Task 6

The medical director guides the administrator in documenting the credentials of the facility's practitioners.

Task 7

The medical director collaborates with the facility to hold practitioners accountable for their performance and practice, including corrective actions as needed.

Tier 2

Task 8

The medical director develops and periodically reviews and updates, as needed, key documents governing physician services, such as by-laws or rules and regulations.

Task 9

The medical director helps the facility establish affiliation agreements with other health care organizations and helps the facility establish effective outside relationships; for example, with regulatory agencies, various professional groups, insurers, ambulance companies, and emergency medical systems.

Task 10

The medical director helps support the care-related activities of the interdisciplinary team.

Task 11

The medical director helps the facility ensure that its medical records systems meet the needs of patients and practitioners.

Task 12

The medical director helps the facility ensure adequate documentation of patient care and related information.

Task 13

The medical director advises the facility on interacting with utilization review organizations.

Task 14

The medical director develops policies and procedures related to activities of health care trainees within the facility (e.g., physicians in residency programs, medical students).

Task 15

The medical director advises the facility about the appropriateness of admissions and transfers, including related orders and the facility's case mix.

Task 16

The medical director advises and supports the practitioners and the facility regarding family issues; for example, concerns about the appropriateness and timeliness of the care.

Function 3—Quality Assurance and Performance Improvement

Tier 1

Task 1

The medical director participates in monitoring and improving the facility's care through a quality assurance and performance improvement program that encourages self-evaluation, anticipates and plans for change, and meets regulatory requirements.

Task 2

The medical director applies knowledge of State and national standards for nursing home care to help the facility meet applicable standards of care.

Task 3

The medical director monitors physician performance and practice.

Task 4

The medical director helps ensure that the facility's quality assurance and performance improvement program addresses issues that are germane to the quality of patient care and facility services.

Task 5

The medical director helps the facility use the results of its quality assurance and performance improvement program findings, as appropriate, to update and improve its policies, procedures, and practices.

Task 6

The medical director participates in quality review of care, including (but not limited to) areas covered by regulation (e.g., monitoring medications, laboratory monitoring).

Tier 2

Task 7

The medical director helps the facility interpret and disseminate information gained from the quality assurance and performance improvement program in a form that is useful to patients, family members, staff members, attending physicians, and others as appropriate.

Task 8

The medical director helps the facility consider the feasibility and appropriateness of any proposed research projects and helps ensure that they meet pertinent standards and contain appropriate safeguards.

Task 9

The medical director periodically reviews admission, transfers, and discharges of patients.

Task 10

The medical director helps the facility identify private and public funding for research activities.

Task 11

The medical director provides medical leadership for research and development activities in long term care.

Task 12

The medical director includes physician input in identifying and applying quality assurance standards.

Function 4—Education

Tier 1

Task 1

The medical director sustains his or her professional development through self-directed and continuing education.

Task 2

The medical director helps the facility educate and train its staff in areas that are relevant to providing high quality patient care.

Task 3

The medical director serves as a resource regarding geriatric medicine and other care-related topics, and helps the staff and practitioner identify and access relevant educational resources (e.g., books, periodicals, articles).

Task 4

The medical director informs attending physicians about policies and procedures and State and federal regulations, including updates.

Tier 2

Task 5

The medical director participates in the development, organization, and delivery of education programs for patients and patients' families, board members, and the community at large.

Task 6

The medical director encourages the facility to support staff membership in professional organizations.

Task 7

The medical director contributes to facility publications, as appropriate.

Task 8

The medical director supports educational opportunities within the nursing home for trainees in the health care professions.

Function 5—Employee Health

Tier 1

Task 1

The medical director helps the facility foster a sense of self-worth and professionalism among employees.

Task 2

The medical director advises the facility about infectious disease issues related to employees.

Tier 2

Task 3

The medical director helps the facility identify, evaluate, and address situations that increase the risk of employee injury and illness.

Task 4

The medical director helps the facility implement a program to identify job requirements and assess employee capabilities relative to those requirements.

Task 5

The medical director advises the facility's safety committee, in areas where medical expertise is helpful.

Task 6

The medical director advises the facility on establishing and implementing employee wellness programs (e.g., weight reduction, stress reduction, cholesterol reduction, blood pressure reduction, nutrition, exercise).

Task 7

The medical director guides the facility in developing and implementing programs for employees experiencing physical, social, or psychological problems.

Task 8

The medical director advises the facility on policies related to the health and safety of staff, visitors, and volunteers.

Task 9

The medical director advises the facility on preventing and managing employee injuries.

Function 6—Community

Tier 1

Task 1

The medical director helps the facility identify and utilize collaborative approaches to health care, including integration with community resources and services.

Tier 2

Task 2

The medical director acts as an advocate for the facility, encourages and facilitates community involvement in the activities of the facility, and helps the facility educate the community about its capabilities and services.

Task 3

The medical director participates in the activities of geriatrics and long term care committees of medical organizations and identifies issues and seeks solutions to problems that involve other institutions and programs.

Task 4

The medical director participates in health care planning in the community, including innovative cost-effective alternative health care programs for long term care.

Task 5

The medical director serves as a mentor to physicians-in-training within the facility.

Task 6

The medical director helps the facility address and communicate regarding situations that have brought the facility to the attention of the public and/or the media.

Task 7

The medical director meets with other long-term care professionals in the community as appropriate.

Function 7—Rights of Individuals

Tier 1

Task 1

The medical director helps the facility ensure that its policies and practices reflect and respect resident rights, including the opportunity for self-determination; e.g., via tools such as living wills and durable powers of attorney.

Task 2

The medical director helps the facility ensure that the ethical and legal rights of residents (including those who lack decision-making capacity, regardless of whether they have been deemed legally incompetent) are respected. This includes the right of residents to request practitioners to limit, withhold, or withdraw treatment(s).

Task 3

The medical director helps the facility accommodate patients' choice of an attending physician.

Tier 2

Task 4

The medical director participates in the activities of the institutional biomedical ethics committee and identifies community resources that can assist in resolving ethical and legal issues.

Task 5

The medical director helps the facility establish a system for identifying and reporting abuse, as well as criteria for identifying potential abuse among both residents and staff.

Task 6

The medical director helps the facility identify and use available community resources to help address ethical issues (e.g., ombudsman, health department, ministerial association).

Task 7

The medical director participates, when necessary, in family meetings and similar activities to help the facility and attending physicians promote and protect resident rights.

Function 8—Social, Regulatory, Political, and Economic Factors

Tier 1

Task 1

The medical director helps the facility identify and provide care that is consistent with applicable social, regulatory, political, and economic policies and expectations.

Task 2

The medical director helps the facility identify, interpret, and comply with relevant State and Federal laws and regulations.

Tier 2

Task 3

The medical director seeks and disseminates information about aging, long-term care, and geriatric medicine to the facility's practitioners, staff and residents.

Task 4

The medical director helps the facility make decisions about resource allocation including financial considerations that affect medical care (e.g., use of formularies, contracts, appropriate use of lab tests).

Task 5

The medical director participates in the facility budget process to help the facility allocate sufficient resources for essential medical functions and patient care activities.

Task 6

The medical director provides feedback, as appropriate, to legislators and public policy makers about existing and proposed laws and regulations.

Function 9—Person-Directed Care

In addition to the following tasks, many of the tasks covered under the other functions relate directly or indirectly to the provision of person-directed care.

Tier 1

Task 1

The medical director oversees clinical and administrative staff, to help maintain and improve the quality of care including the success of person-directed care and patient and family satisfaction with all aspects of the care.

Task 2

The medical director guides the physicians and other health care professionals and staff to provide person-directed care that meets relevant clinical standards.

Task 3

The medical director collaborates with facility leadership to create a person-directed care environment while maintaining standards of care.

Tier 2

Task 4

The medical director helps the facility encourage active resident participation in, and promotes the incorporation of resident preferences and goals into development of, a person-directed plan of care.

Task 5

The medical director helps the facility develop, implement, and review policies and procedures that ensure residents are offered choices that promote comfort and dignity (e.g., choices regarding awakening, sleep, and medication administration times, discussions of risks/benefits regarding therapeutic diets, medications and treatments).

Task 6

The medical director collaborates with the interdisciplinary team (IDT), families, and allied services within and outside of the organization to encourage planning, implementing, and evaluating clinical services to maximize resident choice, quality of life, and quality of care.

Appendix I – Break down of the numbers of tasks (Tier 1 and 2) for each function

Function	Tier 1 Tasks	Tier 2 Tasks
1	6	2
2	7	9
3	6	6
4	4	4
5	2	7
6	1	6
7	4	4
8	2	4
9	3	3
TOTAL	35 (44%)	45 (56%)

ADDENDUM B

AMDA STATEMENT ON COMPENSATION OF A NURSING FACILITY MEDICAL DIRECTOR

A medical director's compensation should be based on the roles and responsibilities enumerated in the contract for services and the attached statement of performance requirements and roles and responsibilities (Addendum A). In addition, the medical director's compensation should also reflect the complexity and intensity of the responsibilities.

Factors influencing complexity and intensity of a medical director's responsibilities include but are not limited to:

- facility size;
- number of licensed/certified beds;
- case mix/resident acuity;
- length of stay;
- presence of specialized units (e.g., subacute programs); number and diversity of medical and ancillary staff members; geographical location of the facility;
- support services available;
- responsibilities under managed care contracts; and scope of required duties.

Furthermore, the effort needed to perform each of the roles and responsibilities may vary from time to time in a facility's life cycle and should be considered in calculating compensation. For example, during one year the medical director and the facility may agree that the medical director's efforts in organizing the medical staff will require a great deal of time for a variety of reasons while the continuous quality improvement program will require little time other than oversight, due to the strength of the program. The following year the medical director's efforts having been successful in organizing the medical staff, the emphasis for the medical director may shift to other issues such as developing a stronger ethics committee. (Those additional expectations should be specifically addressed in each annual contract completed between the medical director and the facility.)

In compensation negotiations, medical directors will want to consider the time required to develop, implement, oversee, and periodically review and update all required elements of the contract and statement of roles and responsibilities, including but not limited to those related to:

- Providing medical input and decision support to the Administrator and governing body;
- Ensuring development, implementation and evaluation of resident care policies and procedures;
- Coordinating and overseeing medical care and treatment between the nursing facility and attending physicians and other health care providers;
- Overseeing that all necessary medical services provided to residents are adequate and appropriate;

- Coordinating the quality assurance program to continuously improve the quality of health care provided to the residents; and
- Advising the Administrator and governing body of current medical issues affecting the residents;
- Providing "on-call' availability and responding to medical, regulatory or other emergencies in the nursing facility;
- Conducting in-service education programs and preparing educational materials for the staff of the nursing facility and other professional staff; and
- Participating, as needed, in matters of employee health for the staff.

Compensation must be consistent with the time spent, the required physician skill, the complexity and intensity of the medical director's responsibilities at the facility, and fair market value for the medical director's time and services.

Compensation should never be based on or linked to the volume or value of referrals, or to occupancy rate. Medical directors should not quote a specific formula (such as a dollar amount per licensed bed per month) as the mechanism for reimbursement unless the dollar amount has been clearly calculated using the time and complexity of work done to complete the tasks outlined in the job description.

ADDENDUM C

CMS REQUIREMENTS REGARDING MEDICAL DIRECTOR DUTIES TO NURSING FACILITIES
GUIDANCE TO SURVEYORS-LONG TERM CARE FACILITIES
42 CFR SECTION 483.70(h)- November 2017

Tag Number	Regulation	Guidance to Surveyors
F 841	§483.70(h) Medical Director (1) The facility must designate a physician to serve as medical director. (2) The medical director is responsible for (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.	Guidelines: Section 483.70(h) "Resident care policies" include admissions, transfers, and discharges; infection control; use of restraints; physician privileges and practices; and responsibilities of non-physician health care workers, (e.g., nursing, rehabilitation therapies, and dietary services in resident care, emergency care, and resident assessment and care planning). The medical director is also responsible for policies related to accidents and incidents'; ancillary services such as laboratory, radiology, and pharmacy; use of medications; use and release of clinical information; and overall quality of care. The medical director is responsible for ensuring that these care policies are implemented. The medical director's "coordination role" means that the medical director is responsible for assuring that the facility is providing appropriate care as required. This involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and the medical care of residents. It also includes having a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate. When

Tag Number	Regulation	Guidance to Surveyors
		the medical director identifies or receives a report of possible inadequate medical care, including drug irregularities, he or she is responsible for evaluating the situation and taking appropriate steps to try to correct the problem. This may include any necessary consultation with the resident and his or her physician concerning care and treatment. The medical director's coordination role also includes assuring the support of essential medical consultants as needed. A medical director whose sole function is to approve resident care policies does not meet this requirement. <u>Probes: Section 483.70(h)</u> • What does the medical director do to coordinate medical care services for residents of the facility? • How does the medical director identify and confirm problems of inadequate care?

F841

(Rev. 173, Issued: *11-22-17,* Effective: 11-28-17, Implementation: 11-28-17)

§483.70(h) Medical director

§483.70(h)(1) The facility must designate a physician to serve as medical director.

§483.70(h)(2) The medical director is responsible for –

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

DEFINITIONS §483.70(h)

"*Medical director*" means a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

"Physician/practitioner" (physician assistant, nurse practitioner, clinical nurse specialist) means the individual who has responsibility for the medical care of a resident.

"***Current professional standards of practice"*** refers to approaches to care, procedures, techniques, treatments, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies.

"***Resident care policies"*** refers to the facility's overall goals, directives, and governing statements that direct the delivery of care and services to residents consistent with current professional standards of practice.

GUIDANCE §483.70(h)

If the medical director does not hold a valid license to practice in the State where the nursing home is located refer to F839 - §483.70(f) Staff qualifications. The facility must designate a physician to serve as medical director (unless waived per §488.56(b) by CMS).

The facility must identify how the medical director will fulfill his/her responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility. This may be included in the medical director's job description or through a separate facility policy. Facilities and medical directors have flexibility on how all the duties will be performed. However, the facility must ensure all responsibilities of the medical director are effectively performed, regardless of how the task is

accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. For example, some, but not all, duties may be conducted remotely using various technologies (e.g., phone, email, fax, telehealth, etc., that is compliant with all confidentiality and privacy requirements).

It is important that the medical director's responsibilities require that he/she be knowledgeable about current professional standards of practice in caring for long term care residents, and about how to coordinate and oversee other practitioners.

If the medical director is also an attending physician, there should be a process to ensure there are no concerns with the individual's performance as a physician (i.e., otherwise, the medical director is monitoring his/her own performance). If there are concerns regarding his/her performance, the facility's administration should have a process for how to address these situations.

While medical directors who work for multi-facility organizations, such as corporate or regional offices, may be involved in policy development, the facility's individual policies must be based on the facility's unique environment and its resident's needs, and not based on a broad, multifacility structure.

Although the medical director is not required to sign policies, the facility must be able to show that the development, review, and approval of resident care policies included his/her input.

Medical director responsibilities must include their participation in:

- Administrative decisions including recommending, developing and approving facility policies related to residents care. Resident care includes the resident's physical, mental and psychosocial well-being;
- Issues related to the coordination of medical care identified through the facility's quality assessment and assurance committee and other activities related to the coordination of care;
- Organizing and coordinating physician services and services provided by other professionals as they relate to resident care;
- Participate in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent him/her. (Refer to F865).

NOTE: Having a designee does not change or absolve the Medical Director's responsibility to fulfill his or her role as a member of the QAA committee, or his or her responsibility for overall medical care in the facility.

In addition, the medical director responsibilities should include, but are not limited to:

- Ensuring the appropriateness and quality of medical care and medically related care;
- Assisting in the development of educational programs for facility staff and other professionals;
- Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents. Refer to Infection Control requirement at §483.80;
- Cooperating with facility staff to establish policies for assuring that the rights of individuals (residents, staff members, and community members) are respected;

- Supporting and promoting person-directed care such as the formation of advance directives, end-of-life care, and provisions that enhance resident decision-making, including choice regarding medical care options;
- Identifying performance expectations and facilitating feedback to physicians and other health care practitioners regarding their performance and practices;
- Discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current standards of care; and
- Assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners (e.g., nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law.

PROCEDURES §483.70(h)

If a deficiency has been identified regarding a resident's care, also determine if the medical director had knowledge or should have had knowledge of a problem with care, or physician services, or lack of resident care policies and practices that meet current professional standards of practice and failed:

- To get involved or to intercede with other physicians or practitioners in order to facilitate and/or coordinate medical care; and/or
- To provide guidance for resident care policies.

Interview the medical director about his/her:

- Involvement in assisting facility staff with resident care policies, medical care, and physician issues;
- Understanding of his/her roles, responsibilities and functions and the extent to which he/she receives support from facility management for these roles and functions;
- Process for providing feedback to physicians and other health care practitioners regarding their performance and practices, including discussing and intervening (as appropriate) with a health care practitioner regarding medical care that is inconsistent with current professional standards of care;
- Input into the facility's scope of services including the capacity to care for residents with complex or special care needs, such as dialysis, hospice or end-of-life care, respiratory support with ventilators, intravenous medications/fluids, dementia and/or related conditions, or problematic behaviors or complex mood disorders;
- His/her participation or involvement in conducting the Facility Assessment and the Quality Assessment and Assurance (QAA) Committee.

Interview facility leadership (e.g., Administrator, Director of Nursing, and others as appropriate) about how they interact with the medical director related to the coordination of medical care, the facility's clinical practices and concerns or issues with other physicians or practitioners.

Also, refer to §483.30 Physician Services for more information.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F841, the surveyor's investigation will generally show that the facility failed to do any of the following:

- Designate a physician to serve as medical director; or
- Ensure the medical director fulfilled his/her responsibility for the implementation of resident care policies or the coordination of medical care in the facility.

DEFICIENCY CATEGORIZATION

- An example of Level 4, immediate jeopardy to resident health and safety, includes, but is not limited to:
    - The facility's medical director was aware of and did not intervene when a health care practitioner continued over several months to provide inappropriate medical care for infection prevention to a resident that was inconsistent with current professional standards of care. As a result, this resident's health continued to decline, and was hospitalized with a severe infection.

- An example of Level 3, Actual harm (physical or psychological) that is not immediate jeopardy, includes, but is not limited to:
    - The Director of Nursing repeatedly requested the medical director's assistance in coordinating medical care with attending physicians for residents receiving psychotropic medications. In particular there were several physicians who had a known history of failing to provide justification for continued use of these medications and not attempting a gradual dose reduction for the residents under his/her care. As a result of the medical director's failure to intervene, several residents continued to receive these medications without medical/clinical justification. Based on record review and interviews with residents, their representative's and staff, there was no supporting evidence to indicate that an Immediate Jeopardy situation existed. However, due to the continuation of the use of these psychotropic medications, the residents withdrew from activities and from eating in the dining room. This caused decreased appetite and substantial weight loss for several residents. Actual harm, both physical and psychosocial was indicated. Unnecessary Medications was also cited for not ensuring the residents were receiving the lowest dose possible.

- An example of Level 2 - No actual harm with a potential for more than minimal harm that is not immediate jeopardy, includes but is not limited to:
    - The administrator had made multiple requests for the medical director to meet with physicians to ensure that they were familiar with the facility's resident care policies. At the time of the survey the medical director was interviewed and stated that she had not yet had an opportunity to introduce herself to or meet with physicians. Although no actual harm

occurred, due the medical director's failure to ensure implementation of resident care policies, the potential for more than minimal harm existed.

SAMPLE

ADDENDUM D

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "Agreement") is effective as of _____ (the "Effective Date") by and between _____ and its affiliates (collectively or individually, "Facility") and _____ ("Physician"), individually, a "Party;" together, the "Parties."

Recitals

WHEREAS, the Parties have entered into an agreement (the "Medical Director Agreement") in order for Physician to provide certain services to Facility ("Services") that involve the access, use and/or disclosure of Protected Health Information as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and

WHEREAS, Physician acknowledges that the Parties must meet the requirements of the HIPAA Privacy and Security Rules and Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") (Pub. L. 111-5) also known as the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") and the HITECH Act Final Rule published January 25, 2013 ("HITECH Act Final Rule"), and that under § 13404 of the HITECH Act (42 U.S.C. § 17934), its use and disclosure of PHI must be in compliance with the terms of this Agreement pursuant to 45 C.F.R. § 164.504(e); and

WHEREAS, both Parties are subject to HIPAA and are required to agree to specific terms that govern the use and disclosure of Protected Health Information ("PHI") disclosed by Facility to Physician in conjunction with the Medical Director Agreement; and

WHEREAS, the Parties wish to enter into this Agreement in order to comply with HIPAA.

NOW, THEREFORE, in consideration of the mutual promises and covenants set forth below, the Parties as agree as follows:

1. Definitions

(a) General. Capitalized terms used, but not otherwise defined, in this Agreement shall have the meanings set forth under the HIPAA Rules, including but not limited to 45 C.F.R. §§ 160.103, 160.202, 160.302, 160.401, 160.502, 162.103, 162.402, 164.103, 164.304, 164.402, 164.501, 164.504, and 164.514, as currently drafted and as subsequently updated, or revised.

(b) Breach Notification Rule. "Breach Notification Rule" shall mean the rules governing Breaches at 45 C.F.R. Part 164.400 *et seq*.

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and 164.

(d) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

(e) Security Standards. "Security Standards" means the security standards for protection of PHI promulgated by the Secretary in Title 45 C.F.R. Part 164, Subpart C.

2. Obligations and Activities of Physician

(a) Use or Disclosure of Information. Physician agrees not to use or further disclose PHI received from, or created for or on behalf of, Facility other than to perform the Services described in the Medical Director Agreement, and as expressly permitted or required by this Agreement or as Required By Law.

(b) Mitigation. Physician agrees to mitigate, to the extent reasonably practicable, any harmful effect that is known to Physician of a use or disclosure of PHI by Physician in violation of this Agreement.

(c) Safeguards. Physician shall use appropriate safeguards and comply where applicable with the Security Standards and the Breach Notification Rule with respect to electronic PHI to prevent the use or disclosure of PHI other than as provided for in this Agreement.

(d) Reporting.

(i) Physician agrees to promptly report to Facility any use or disclosure of PHI in violation of the applicable HIPAA Rules or this Agreement of which Physician becomes aware, including, without limitation, any Security Incident or any Breach.

(ii) In the event of any such impermissible or improper use, disclosure, Security Incident, Breach, or action as described above, Physician shall report the surrounding circumstances to Facility to the extent available and reasonable, and in the case of any Breach, the names of each individual whose Unsecured PHI has been, or is reasonably believed by Physician to have been, accessed, acquired, or disclosed as a result of such Breach and any other available information needed by Facility to enable it to comply with its notification obligations under the Breach Notification Rule.

(iii) Notwithstanding anything to the contrary contained in this Agreement, to avoid unnecessary burden on either Party, Physician shall not be required to report to Facility any unsuccessful Security Incident, further defined as insignificant or trivial attempts that occur on a daily basis, including but not limited to scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by Physician.

(e) Subcontractors and Agents. Physician shall ensure that any agent or subcontractor to whom he/she provides PHI agrees to substantially the same or similar restrictions and conditions that apply to the Physician under this Agreement with respect to such PHI in his/her possession.

(f) Access. If Physician maintains PHI in a Designated Record Set, Physician agrees to provide access, when requested by Facility, to PHI in such Designated Record Set in order to

comply with the requirements under 45 C.F.R. § 164.524. Such access shall be provided by Physician in the time and manner reasonably requested by Facility or the Individual.

(g) Amendment. If Physician maintains PHI in a Designated Record Set, when requested by Facility, Physician agrees to make any amendment(s) to PHI in such Designated Record Set that Facility or the Individual directs or agrees to pursuant to 45 C.F.R. § 164.526. Such amendments shall be made by Physician in the time and manner reasonably requested by Facility or the Individual. In the event Physician receives an amendment request directly from an Individual, Physician shall forward the request to Facility promptly upon receipt.

(h) Audit and Inspection. Physician agrees to make its internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI, available to the Secretary or his or her designee for the limited purposes of the Secretary determining Facility's compliance with HIPAA, as requested by Facility or the Secretary.

(i) Documentation of Disclosures. Physician agrees to document such disclosures of PHI and any information related to such disclosures as would be required for Facility to respond to a request by an Individual for an accounting of disclosures of PHI by Physician in accordance with 45 C.F.R. § 164.528.

(j) Accounting. Upon request from Facility or an Individual, Physician agrees to provide information collected in accordance with Section 2(i) to permit Facility to respond to a request by an Individual for an accounting of disclosures of PHI by Physician in accordance with 45 C.F.R. § 164.528.

(k) Compliance with Privacy Rule. To the extent that Facility is a Covered Entity and Physician is to carry out an obligation of Facility under the Privacy Rule, Physician shall comply with the requirements of the Privacy Rule that apply to Facility in the performance of such obligation.

3. Permitted Uses and Disclosures by Physician

(a) Services. Subject to the provisions of Section 4 below, and except as otherwise limited in this Agreement, Physician may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Facility or Physician if such use or disclosure of PHI would not violate HIPAA or the HIPAA Rules.

(b) Minimum Necessary. Physician will limit the use, disclosure, or request of PHI, to the extent practicable, to the minimum necessary (as reasonably determined by Physician) to accomplish the intended purpose of such use, disclosure, or request.

(c) Business Activities. Except as otherwise limited in this Agreement, Physician may use PHI for his/her proper management and administration or to meet his/her legal responsibilities.

4. Obligations of Facility

(a) Restrictions. To the extent that such limitations may affect Physician's use or disclosure of PHI, and if Facility is a Covered Entity, Facility shall notify Physician of (i) any

limitations in Facility's notice of privacy practices that Facility produces in accordance with 45 C.F.R. § 164.520, as well as any changes to that notice, (ii) any changes in, or revocation of, permission by an Individual to use or disclose PHI, and (iii) any restriction to the use or disclosure of PHI that Facility has agreed to in accordance with 45 C.F.R. § 164.522. If Facility is a Business Associate, Facility shall notify Physician of any of the events in subparagraph (i)-(iii) herein as applied to the Covered Entity that provided the PHI that has been disclosed to Physician.

(b) Requests. Facility shall not request Physician to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Facility.

5. Term and Termination

(a) Term. This Agreement shall be effective as of the Effective Date and shall continue unless or until this Agreement is terminated in accordance with the provisions of Section 5(b), or the Medical Director Agreement between the Parties terminates.

(b) Termination for Cause. Upon one Party's knowledge of a material breach by the other Party, the non-breaching Party shall either (i) provide an opportunity for the breaching Party to cure the breach or end the violation and, if the breaching Party does not cure the breach or end the violation within the cure period specified in the Medical Director Agreement or if none is specified, then within ten (10) days, terminate this Agreement and the Medical Director Agreement; (ii) immediately terminate this Agreement and the Medical Director Agreement if cure is not possible; or (iii) if neither termination nor cure are feasible, the non-breaching Party shall report the violation to the Secretary.

(c) Effect of Termination.

(i) Upon termination of this Agreement or the Medical Director Agreement for any reason, Physician shall return to Facility or destroy all PHI received from Facility. Physician shall retain no copies of PHI in any form. Physician shall promptly provide written confirmation of such destruction to Facility.

(ii) Notwithstanding the foregoing, in the event that Physician determines that returning or destroying the PHI is infeasible, Physician shall provide to Facility notification of the conditions that make return or destruction infeasible. If the return or destruction of PHI is infeasible, Physician shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Physician maintains such PHI.

6. Miscellaneous

(a) Survival. The respective rights and obligations of Physician under Sections 5(c) and 6(a) of this Agreement shall survive the termination of this Agreement.

(b) Amendments. No amendment to this Agreement shall be effective unless it is in writing and signed and dated by the Parties hereto or as required by law or regulations. The Parties recognize that the Secretary may issue further amendments to the HIPAA Rules pursuant to the Secretary's authority under law.

(c) Interpretation. Construction of this Agreement shall be resolved in favor of a meaning that permits both Parties to comply with applicable law protecting the privacy, security and confidentiality of PHI, including but not limited to HIPAA and the HIPAA Rules. To the extent that any provisions of this Agreement conflict with the provisions of any other agreement or understanding between the Parties, this Agreement shall control.

(d) Waiver. No failure to exercise and no delay in exercising any right, remedy or power hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy or power hereunder preclude any other or further exercise thereof or the exercise of any other right, remedy or power provided herein or by law or in equity.

(e) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended or shall be deemed to confer upon any person other than Facility, Physician, and their respective successors and assigns, as permitted pursuant to the Agreement, any rights, obligations, remedies or liabilities.

(f) Other Privileges and Laws. Notwithstanding anything herein to the contrary, this Agreement shall not replace, nullify or amend any other privileges or confidentiality obligations that may exist under law, or that apply to Physicians under the laws for physicians.

(g) Other Federal and State Law. The Parties agree to comply with other federal and State law as may apply to the PHI. In the event of a conflict between the requirements of such other law and the requirements stated herein, the applicable law under a conflict-of-law analysis, including the analysis required under HIPAA, shall apply.

(h) Signatures. This Agreement may be executed in counterparts, each of which when so executed and delivered shall be deemed an original and all of which taken together shall constitute one instrument. This Agreement and any counterpart original may be executed and transmitted by facsimile. The facsimile signature shall be valid and acceptable for all purposes as if it were an original.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement as of the Effective Date.

Facility:	**Physician:**
_____	
By: _____	**By:** _____
Title: _____	**Date:** _____
Date: _____	