The demand for hospice medical directors is rapidly increasing. A logical, organized approach to the decision to become a medical director, along with a careful evaluation of the prospective hospice, will lead to the highest satisfaction for all parties. A comprehensive and clearly written contract will delineate the roles and responsibilities of the medical director and hospice. Effective negotiation techniques will assist the prospective medical director to attain highest satisfaction with the position. This article addresses these issues using a review of the literature and the authors’ extensive experience as medical directors. (J Am Med Dir Assoc 2009; 10: 298–303)

Keywords: Hospice; medical director; contracts; negotiation

Hospice medical directorship is a relatively new discipline; however, medical directorship as a discipline is well ingrained in the US medical system. With the 1974 publication of Federal Regulations in Skilled Nursing Facilities, physician medical directors have been required for all skilled nursing homes. Since this mandate, the discipline has developed a specific set of knowledge and skills. A certification process has been developed to acknowledge the experience and knowledge needed to provide excellent medical directorship.

In 2007, the American Medical Directors Association (AMDA) reported 1900 active Certified Medical Directors (L. Coulter; private correspondence; August 2008).

The first US hospice began in 1974 with support from the National Cancer Institute. Hospice care became formalized with Congress’ creation of the Medicare Hospice benefit in the early 1980s, which required the addition of a medical director to the hospice.

Hospice growth has been phenomenal over the past 30 years. From the first program in 1974, the number of certified hospice programs increased to 1545 in 1985 (Fig. 1). Presently, there are more than 4500 programs serving 1,300,000 patients annually. The clientele served by hospice has become increasingly complex and diverse. While hospices initially cared primarily for patients with terminal cancer, the medical directors of hospices are now responsible for the care of those with disease processes as diverse as AIDS to Alzheimer’s disease to chronic pulmonary disease to heart failure. Medicare payment for hospice services has increased from less than $1 million in 1986 to over $9 billion in 2006. With this growth, the demand for medical directors has increased proportionately.

Despite this growing need for hospice medical directors, a review of the literature did not yield guidance for prospective medical directors on the evaluation and assessment of a hospice program and the medical director position. This article is designed to provide such guidance.

In this article, we review the pertinent literature on hospice medical directors. We describe the role of hospice medical director and provide demographics of physicians presently serving as hospice medical directors. Also, we discuss the evaluation of a hospice by the physician who is considering contracting as the medical director. This includes pertinent components of the contract and techniques to negotiate a satisfactory contract and position.

METHODS

A literature search of 1987 to present was conducted on MEDLINE/Pub Med and MEDLINE/EBSCO using the terms “Hospice and Medical Director” and “Hospice Medical Director.” Also searched was the American Academy of Hospice and Palliative Medicine (AAHPM) Web site (http://www.aahpm.org/), which provides an established resource for training of existing hospice medical directors, but provides limited guidance on initial decisions to become a medical director or the evaluation of a hospice.

Additionally, the AMDA and National Hospice and Palliative Care Association Web sites were searched and found to
not provide materials or resources specifically for hospice medical directors.

RESULTS

Review of Literature

A total of 7 articles were found: 6 were reviews or opinion articles regarding hospice medical directorship.3–8 The seventh provided a survey of practice patterns of medical directors.9

Chronologically, the articles provided increasingly complex advice for the hospice medical director. An initial article focused on the need for physicians with a broad background and level of experience working with patients and families, rather than specific palliative care skills to work as hospice medical directors.3 Later articles emphasized the need for cooperation in an interdisciplinary team. The most recent articles focused on the need for hospice medical directors to develop standards of care and protocol-driven management to unify the medical services provided by hospice programs.4–6 These processes included quality improvement activities and education of staff. One of these articles and an editorial advocated for direct rather than supervisory involvement in patient care by the hospice medical director.7–8

Although not all will agree with this model of care, it is generally accepted that to provide the best performance as a medical director and best outcomes for the hospice, a physician should anticipate that he or she will need to be involved.

The common theme expressed by all of these articles was the importance of the role of medical director in education. Educational efforts were aimed at the hospice team, the community, and referring physicians. The articles also point out that hospice medical directors must increase their knowledge and skills in palliative medicine through their own continuous medical education. Clearly, the articles support that the increased time spent in work for the hospice correlates with increased quality of care.

Hospice Medical Director Position Description

Medicare defines “medical director” as either an employee or contracted person who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospices’ patient care program.10 This global statement often can be subdivided into several roles and responsibilities (Table 1).

Another viewpoint on medical director responsibilities comes from AMDA, which recommends that the hospice medical director perform the following basic duties: confirm the diagnosis and prognosis for each newly admitted patient, visit patients as indicated, and recertify patients for each benefit period. The medical director’s educational responsibilities include in-services for hospice, nursing home, and hospital staff11 on topics to include but not limited to pain management, symptom management, end-of-life decision making, medical ethics, hospice Medicare regulations, and palliative care. They should exercise medical leadership in utilization review and quality assurance through chart audits and monitoring clinical practice of attending physicians. Additionally, administrative activities include directing medical interventions consistent with palliative care protocols and acting as liaison with attending physicians, consultants, and other health care institutions. They should be able to temporarily assume responsibility for medical care of their hospice patients and provide consultation and recommendations on an ongoing basis, which includes attendance at interdisciplinary team (IDT) meetings.

Who Becomes a Hospice Medical Director?

According to Parker-Oliver,9 approximately 30% of hospice medical directors are family physicians, 30% are oncologists, 25% are internists, and the remainder is divided among a variety of specialists. Although experienced physicians (41%) had practiced more than 20 years, they were inexperienced as hospice medical directors. Approximately one fifth reported being a medical director for less than 1 year; 61%
had no formal training in palliative medicine. Despite this, 94% of the programs reported high to very high confidence in their medical director's knowledge. Hospice programs demonstrated confidence by frequent consultation with their medical director. Over 40% reported more than weekly consultations with their medical director.10

**How Much Time Does Hospice Medical Directorship Require?**

Approximately two thirds of medical directors reported spending 6 to 10 hours a month.9

**What Can the Medical Director Expect in Education Support From the Hospice?**

Size and financial stability of the hospice determines whether these benefits are available. In 1999 only 50% of hospices provided reimbursement for continuing education, with 25% reporting never providing continuing education support.9

**Where Can New Medical Directors Get Performance Evaluation and Feedback?**

Unfortunately, a hospice medical director is a bit of a “Lone Ranger.” For better or worse, there is little evaluation and feedback available for hospice medical directors. The only formal evaluation they may receive would come from either highly organized or large hospices that provide regular evaluations to all employees, including contract employees such as the medical director. Informal, unstructured feedback for a new medical director comes from patient/family satisfaction surveys, colleagues on the hospice IDT, and community health care providers. Negative feedback may come from Centers for Medicare and Medicaid Services (CMS) surveys or rejection/denials of qualifications of patient’s candidacy for hospice services.

The medical director’s personal development educational activities may be the best area to get evaluation and feedback. The strongest indicator of education excellence is obtaining and maintaining board certification in hospice and palliative medicine. This subspecialty of hospice and palliative medicine was recognized by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) in 2006, and more recently has been recognized by CMS as a certified medical specialty.10 If not board certified, evaluation of the medical director’s educational performance can be attained through demonstrating regular continuing medical education (CME) on topics relevant to hospice and palliative medicine and most specifically hospice medical directorship. This could be done through formal programs and certifications or informally. For example, formally, the AMDA Certified Medical Director Certification requires performance of annual medical director continuing education. Also, the American Academy of Hospice and Palliative Medicine’s (AAHPPM) hospice medical directorship training would be highly recommended for a new medical director (http://www.aahpm.org/) as a source of CME. Informally, becoming a member of AAHPPM with regular attendance at meetings would provide a structured educational curriculum for a new medical director.

An additional mechanism of performance evaluation is through the use of established Clinical Practice Guidelines for Quality Palliative Care developed by National Consensus Project for Quality Palliative Care.13

**What Should Be the Expected Outcomes From a Good Medical Director?**

The expected outcomes of a quality medical director can be organized into process or outcome quality indicators. Process monitoring activities include ongoing chart review and post death/discharge reviews, looking for the medical director’s appropriate documentation (ie, notes on patient during IDT meetings, statements of prognoses, evaluations performed on patients [when needed], and communication with the patients and key nonhospice providers). An additional form of process monitoring is checking for signatures on key documents such as IDT meeting notes, certification, and recertification documents. Outcome monitoring activities include satisfaction surveys from patients/families and primary care providers, also, CMS replies monitoring for agreement or disagreement with the appropriateness of the patients chosen by the hospice, and last, monitoring for IDT meetings that are run effectively and efficiently.

**What are the Sources of Support for Hospice Medical Directors?**

A new medical director can find support at the local level with the state chapter of AMDA and informal meetings with other medical directors and colleagues in palliative medicine.
At the national level, AMDA has a working group of hospice medical directors and an extensive educational support system for medical directors. The AAHPM provides educational support and a vast array of information for hospice medical directors, which includes the One-on-One Mentoring Program and a forum for physicians to informally ask questions.14

**Recruitment of Medical Directors**

Word of mouth may still be the most common source of referral and recruitment of physicians to a hospice position. Even in large urban communities, hospices will recruit through channels trusted for good referrals. However, how does a physician evaluate the prospective hospice for the medical director position?

**Evaluation of the Prospective Hospice**

Careful search of the medical literature (PubMed and EBSCO) produced no articles addressing the issue of new position evaluation. If one uses standard Internet search engines, over 200,000 replies appear in the nonmedical literature base on evaluation of new positions. Narrowing the search in the business world, some commonly used resources appear.15,16 A review of some of the business world’s recommendations on new position evaluation can be summarized to the following criteria: content, culture, compensation, and challenge.17 Applying these criteria to a medical director position, content would include position responsibilities, the organization itself, and its administration. Culture includes the hospice’s organizational goals; approach to employees, patients, and members of the IDT; and quality improvement activities. Compensation includes salary, benefits, hours worked, and personal advancement. Last, challenge is perhaps, the most important consideration of all. Does the medical director position advance career goals? Will the increased knowledge and skills be of value in the future and, most important, will the additional workload be satisfying and worth the effort? On a personal note, will the physician’s family members and significant others see the additional work in a positive light?

Before formally engaging the hospice there are some initial steps to perform. From a practical standpoint, the first step is to obtain trusted colleagues’ opinions on the hospice’s performance. Other sources include consulting CMS and the local elder Ombudsman for reports on complaints, validation of complaints, and survey findings.

If the information obtained seems satisfactory, then engaging the hospice for a first-hand evaluation is the next step. Meeting and interviewing the key players in any hospice includes the administrator or CEO and director of nursing. The interview should focus on the hospice’s philosophy, goals, and profit/not-for-profit status. This series of questions gives some insight into the organization’s orientation; that is, is it more focused on financial security or patient care. (Note: these do not have to be mutually exclusive.)

Exploring the administrator’s experience, personal goals, and length of time in position are important. A review of the administrator’s previous employment and reason for change to the current position will help you gain insight into your future supervisor’s outlook. These questions will also help the physician learn about the hospice organization’s potential strengths and weaknesses. A strong administrator can help to smooth the medical director’s transition into the organization, allowing him or her to focus on the quality of medical care provided. Conversely, an inexperienced administrator may lack the skills needed to effectively run the business and the regulatory aspects of the hospice. This has the potential to place an undue burden of responsibility on the medical director and detract from the ability to achieve his or her goals of provision of superior medical care. Administrative turnover can be a clue to problems in the organization, such as incongruence between philosophies (financial versus patient oriented) or interpersonal problems in a hospice. In the nursing home industry, the length of time that higher-level administrators are in their positions has a direct correlation with higher quality of care. This principle very likely extrapolates to the hospice industry. Last, asking about their dreams and 5-year goals for themselves and for the hospice organization will further elaborate on the hospice’s potential for growth and success. Some very insightful questions are, “How long was the previous medical director in that position?” “Why is the previous medical director leaving?” It is often helpful to ask if you can contact the previous medical director to discuss his or her experience. This discussion can be quite revealing, as it may unveil undiscovered problems in the program.

If the physician is still interested at this point, one has to explore payment and benefits of the organization. Each region of the country has its own payment “standard.” Asking fellow hospice medical directors about their payment and benefit package will provide some idea of what to expect. If this information is unavailable, exploring benefit packages for high-quality nursing home medical directors is a reasonable start. A new physician without contacts in a community may be able to reach other medical directors through the AMDA state chapter.18 It is most common to be paid either a flat monthly or hourly rate. Liability coverage by the hospice is negotiable but highly desirable. Additional benefits can vary from nothing at all to a nice educational support package. (Any financial incentive encouraging physician referral of patients to the hospice should be considered a “Red Flag”—a very worrisome practice—as this is often considered fraud and abuse by the office of the Inspector General [OIG].)

The prospective medical director’s next step should be to look at the hospice’s medical director position description and compare that with their own capabilities and the Medicare definition of the medical director’s roles and responsibilities.10 In some cases the job description is detailed in the hospice medical director’s contract. Therefore, viewing the proposed contract can be helpful. (For more on contracts see the contract section of this article.)

If the physician chooses to continue to proceed, a joint interview with social workers and direct care nurses is advised. This can be done by an informal visit to the IDT meeting, which will provide some insight into the hospice organization's function, team dynamics, and strengths of key personnel.
Hospice documents provide a window to the organization’s dedication to quality care. Key documents to evaluate are patient intakes, care plans, and medication lists. Quality indicators include clarity, comprehensiveness, and capture of critical information on a hospice patient. Finally, a review of the agency’s quality improvement (QI) programs and outcomes can give a glimpse of the organization’s effectiveness. Most important is the presence of an outcome-oriented QI program—not just a process evaluation program. It is advised to review the QI program’s procedures and compare this to their actual performance. Some organizations have elaborate QI programs described in their procedures but never actually complete them. Last, ask how they use the information from the QI process, especially in areas of inadequacy.

At this point, prospective medical directors should have enough information to decide if they would like to pursue the next step—negotiation.

Negotiation

Mediation and negotiation with patients is an important skill in medical care; however, physicians receive no formal training in negotiations with employers. Nevertheless, some principles from the business community apply:

1. Determine your “bottom line” (salary, benefits, time spent, job requirements).
2. Prepare to negotiate (review the job evaluation described earlier, know the market values in your area for a medical director).
3. Request the organization to make an offer, rather than you revealing your bottom line.
4. Emphasize your value to the hospice rather than your needs/greed.
5. Neither accept nor reject too quickly; if the offer is below your bottom line, give them time to adjust their offer.
6. Counteroffer if you are interested in the position (choose 1 or 2 elements of importance to you and propose your requirements; example, benefits package versus salary versus educational support).
7. Ask for final offer in writing (all legitimate organizations should consider this standard operating procedure).

Contracts

The contract between the medical director and hospice is the blueprint defining the relationships and the responsibilities of each party. Contracts can vary greatly; however, all should contain basic items such as qualifications and position responsibilities of the medical director, responsibilities of the hospice, compensation, delineation of resignation, and termination procedures. The new medical director should anticipate that the contract will include responsibilities for assisting with admission and discharge, participation in IDT meetings, policy and procedures development, oversight of medical care and other hospice physicians, service on hospice committees, facilitating family meetings, and education of local physicians. Many contracts will require the hospice medical director to assume care for patients without attending physicians. In conjunction with this, there should be language describing situations in which the medical director can bill privately versus the hospice billing for physician’s services. Contracts often will include description of documentation responsibilities and recording hours worked. Finally, there will be language describing call coverage and backup for the medical director. Of course the contract will state that the medical director must maintain licensure, professional standards, Drug Enforcement Administration numbers, Medicare and Medicaid eligibility, medical staff privileges, and appropriate liability insurance.

There are no clear “boilerplate” contracts for hospice medical directorship. (A sample contract is available by contacting the author.) However, the parallel to nursing home medical directorship is significant, and many of the key issues in the nursing home medical director’s contract apply to hospice. A model contract for a nursing home medical director can be obtained from the AMDA Web site (http://www.amda.com/resources/print.cfm#model). A less secure and non—evidence-based, but sometimes quite fruitful, source is the forum maintained by the Center to Advance Palliative Care.

FUTURE DIRECTIONS

What Does the Lack of Literature Indicate?

The lack of literature on this topic was surprising. Some of the possible reasons for the minimal amount of literature can be postulated. For most medical directors, this is a “sideline” job and interest in progressing in the field is not a priority. Per Dr. Parker-Oliver’s article, many are practicing physicians who may not have interest in academic pursuits in this area. From the hospice’s point of view, the medical director may be seen more as an incidental part of their team and not integral, so support of research in this area also would not be their priority. Grants and national funding for research are minimal to nonexistent, so financial motivation for research is nonexistent. Last, until recently, federal (CMS) interest in surveying and monitoring hospices has been minimal; therefore, the impetus for improving quality of medical directors driven by survey mechanisms was not there. (The nursing home industry experienced a similar phenomenon as the regulations and intensity of surveying increased, the involvement and quality of the medical directors were pushed to improve.)

Future Research

Hospice organizations must realize there is very limited information to assist them in choosing ideal candidates for medical director positions. Similarly, physicians contemplating a hospice medical director position will find limited guidance to assist them in making their choice and decisions.

To provide hospices with well-prepared medical directors, research must be directed to investigate some of the following questions: What are best systems to identify and recruit good hospice medical directors? What is the ideal preparatory training for hospice medical directors? What is the most effective way for hospice medical directors to obtain training in
quality improvement and interdisciplinary team participation and leadership? The answer to questions on systems to identify and recruit medical directors, one way would be to evaluate systems currently used by national chain skilled nursing facilities or major health corporations. These organizations may have programs in place that have already effectively performed the service. To explore best mechanisms to train hospice medical directors, research must be directed at developing criteria for quality performance of hospice medical directors, with a corresponding curriculum to support these criteria. Some possible avenues are the following: Do AMDA Certified Medical Directors make a difference in the quality of care provided by hospices? If so, would a requirement for hospices to have Certified Medical Directors be possible and make a difference in quality of care? (A parallel movement is currently under way in selected states for all skilled nursing facilities to have certified medical directors.) Along this path, would a Certified Hospice Medical Directorship educational program and certification developed jointly by AAHPM and AMDA be possible and beneficial? Additionally, to support the performance of high-quality palliative care, the continued development of evidence-based clinical practice guidelines will be imperative. Sources of financial support for this research may possibly come from resources such as AMDA, AAHPM, and possibly federal funding from Central Illinois Medical Review (CIMRO) Quality Healthcare Solutions or Health Resources and Services Administration (HRSA).

CONCLUSION The demand for hospice medical directorship is on the rise. We have provided here an organized, sequential, and logical approach for physicians to evaluate a hospice medical director position, outlined an approach to evaluate a hospice program, and established techniques to negotiate a favorable contract. Future research is needed to determine the optimal path for preparation for this position, the skill set needed to perform optimally in this role, and the factors determining long-term satisfaction as a hospice medical director.

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