Medical Director Onboarding Checklist

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

- ■ Executed agreement on file
- ■ NPI verified
- ■ Malpractice coverage reviewed
- ■ Services and patient population reviewed
- ■ Delegation/supervision requirements reviewed
- ■ Policies/protocols supplied
- ■ License(s) verified
- ■ DEA status reviewed if relevant
- ■ Practice ownership/entity structure reviewed
- ■ Provider roster reviewed
- ■ EHR/access established
- ■ Emergency/escalation contacts established

Medical Director _____

Practice / entity _____

States / locations _____

Effective date _____

Outstanding items _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Monthly Medical Director Oversight Checklist

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

- ■ Provider roster/current licenses reviewed
- ■ Protocols reviewed/updated as needed
- ■ Medication/prescribing issues reviewed
- ■ Training/competency issues reviewed
- ■ Open corrective actions followed up
- ■ Required chart reviews completed
- ■ Adverse events/complaints reviewed
- ■ Lab/pharmacy/vendor issues reviewed
- ■ Regulatory changes requiring action reviewed
- ■ Meeting/communication documented

Month _____

Key findings _____

Required actions _____

Owner / due date _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Clinical Chart Review Worksheet

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

- ■ Identity/demographics complete
- ■ Medication/allergy reconciliation
- ■ Required exam/data documented
- ■ Prescribing consistent with plan
- ■ Follow-up/escalation documented
- ■ History and indication documented
- ■ Assessment supports plan
- ■ Consent documented where applicable
- ■ Labs/imaging reviewed as appropriate
- ■ Signature/credentials/date complete

Patient/record identifier _____

Reviewer _____

Findings _____

Corrective action / education _____

Follow-up date _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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Medical Director Meeting Agenda & Minutes

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

Practice _____

Meeting date _____

Attendees _____

Standing Agenda

- ■ Clinical quality metrics
- ■ Adverse events / incidents
- ■ Medication / pharmacy issues
- ■ Protocol changes
- ■ Vendor/lab concerns
- ■ Chart review findings
- ■ Patient complaints
- ■ Provider performance / training
- ■ Regulatory/compliance updates
- ■ Open corrective actions

Decisions made _____

Action items / owner / deadline _____

Next meeting _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Incident & Adverse Event Governance Review

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

Incident date _____

Patient/record identifier _____

Location / service _____

People involved _____

Description _____

Immediate clinical response _____

Notifications / transfer _____

Outcome _____

Governance Review

- ■ Protocol followed
- ■ Documentation complete
- ■ System/process issue identified
- ■ Reporting obligation considered
- ■ Escalation timely
- ■ Training issue identified
- ■ Vendor/device/product issue
- ■ Corrective action required

Root cause / contributing factors _____

Corrective action _____

Owner / due date _____

Closure verification _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Delegation / Scope Responsibility Matrix

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

Practice / state _____

Service / procedure _____

Responsible physician _____

APRN/PA role _____

RN role _____

MA/unlicensed staff role _____

Required supervision / availability _____

Training/competency requirement _____

Protocol / policy reference _____

Restrictions / notes _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Quarterly Clinical Governance Review

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

- ■ Licensure/credential status reviewed
- ■ Clinical protocols current
- ■ Adverse events analyzed
- ■ Prescribing trends reviewed
- ■ Emergency readiness reviewed
- ■ Privacy/security issues reviewed
- ■ Provider capacity and coverage reviewed
- ■ Chart audit trends reviewed
- ■ Complaints/grievances analyzed
- ■ Pharmacy/lab/vendor performance reviewed
- ■ Training/competencies current
- ■ Corrective action plan updated

Quarter / year _____

Top risks _____

Top improvements _____

Priorities next quarter _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Corrective Action Plan Template

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

Issue / finding _____

Date identified _____

Source of finding _____

Risk level _____

Immediate containment action _____

Root cause _____

Corrective action _____

Responsible owner _____

Target completion date _____

Evidence of completion _____

Effectiveness check / date _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Provider Competency & Training Record

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

Provider / credentials _____

Role _____

Service/procedure _____

Training completed _____

Trainer / source _____

Competency method _____

Date validated _____

Renewal/review date _____

Restrictions / notes _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

Vendor / Pharmacy / Laboratory Due-Diligence Checklist

MEDICAL DIRECTOR & CLINICAL GOVERNANCE PACK

- ■ Business identity verified
- ■ Scope/services reviewed
- ■ Quality processes reviewed
- ■ Data/privacy/security considerations reviewed
- ■ Escalation contacts documented
- ■ Licensure/accreditation reviewed
- ■ Contracts/BAA reviewed as applicable
- ■ Complaint/adverse-event pathway reviewed
- ■ Turnaround/service standards reviewed
- ■ Periodic re-evaluation scheduled

Vendor _____

Service _____

Reviewer _____

Key risks / conditions _____

Approval / follow-up _____

Medical Director / Reviewer Signature: _____ **Date:** _____

Clinician/Reviewer: _____ **Date:** _____

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