

Report of the Special Committee on Reentry to Practice

Adopted as policy by the Federation of State Medical Boards in 2012

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EXECUTIVE SUMMARY

In 2010, the Federation of State Medical Boards (FSMB) formed a Special Committee on Reentry to Practice and charged it with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the clinical practice of medicine. It is reported that a growing number of physicians have or will take a temporary leave from the practice of medicine. Physicians may take a temporary leave from practice for multiple reasons, including personal lifestyle decisions, or to pursue research, administrative or other professional interests not involving the clinical practice of medicine.

Regardless of the reasons for an interruption in clinical practice, it is critical for state medical and osteopathic boards (hereafter referred to as state member boards or SMBs), to address physician and physician assistant reentry as part of their mission to insure patient safety. As part of this mission, state member boards should provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice. State member boards should also be aware that physician reentry may offer an additional means of addressing the anticipated national physician shortage.

The Special Committee recognizes that physician reentry can be a normal aspect of a physician's career. The Special Committee believes that concepts and standards for physician reentry should be consistent with lifelong learning expectations for all physicians, which include reflective self-assessment, assessment of knowledge and skills, and performance in practice.

In formulating this report, the Special Committee reviewed existing reentry activities and programs of state member boards, sought guidance from published literature, and consulted with other advisors. The Special Committee identified key reentry issues, and has developed 12 Reentry Guidelines.

The goal of the Special Committee's Report and 12 Reentry Guidelines are to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry. The Special Committee has purposefully linked its recommendations to discussions and activities regarding Maintenance of Licensure (MOL), the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC), and the American Osteopathic Association and Bureau of Osteopathic Specialists' (AOA BOS) Osteopathic Continuous Certification (OCC).

The Special Committee recommends 12 Reentry Guidelines to the FSMB. These guidelines are organized as follows:

- Education and Communications Issues
- Determining Fitness to Reenter Practice
- Mentoring Practitioners Who Want to Reenter the Workforce
- Improving Regulation of Licensed Practitioners Who Are Clinically Inactive
- The Relationship between Licensure and Specialty Certification

For state member boards, implementation of the Special Committee's Reentry Guidelines may require review and revision of existing medical and osteopathic practice acts, consideration of staffing, costs and resource issues, modification of license application and renewal forms, integration of reentry with MOL activities, and initiation of proactive communications with prospective and current licensees and applicants.

INTRODUCTION AND CHARGE

Freda Bush, MD, Immediate Past Chair of the FSMB Board of Directors, recently stated: “The question of how physicians reenter the practice of medicine after an extended absence for a significant period of time has always been important – and challenging – to SMBs. Ensuring physicians are qualified to reenter practice after a period of clinical inactivity is a complex process, which involves close coordination of education, testing, monitoring and regulation.”¹

The Federation of State Medical Boards (FSMB) Special Committee on Reentry to Practice was convened in the late summer of 2010. The Committee was charged with issuing recommendations to the FSMB Board of Directors concerning physician and physician assistant reentry to the practice of medicine as outlined below.

1. Review and evaluate the recommendations relative to reentry in the Special Committee on Maintenance of Licensure as contained in its 2008 draft report;²
2. Review and evaluate the policies, procedures and other mechanisms currently used by state member boards to oversee physicians and physician assistants in reentering the active practice of medicine;
3. Review and evaluate the work to date on issues related to reentry to practice from medical professional organizations and other entities, including the AMA, AOA, AAP, et al;
4. Review and evaluate the FSMB’s recommendations related to Maintenance of Licensure (MOL) and its implementation and develop recommendations as to how MOL requirements can be aligned with reentry to practice requirements;
5. Establish and recommend guidelines that state member boards can utilize to determine the competence of physicians who have been out of clinical practice for a significant period of time for non-disciplinary reasons;
6. Provide guidance about the potential application of guidelines developed as part of #5, to disciplinary, impairment or retraining issues that may be associated with reentry.

Recognizing that physician reentry is becoming a common career trajectory and a normal part of a physician’s continuing practice of medicine, the goal of the Special Committee’s Report is to provide to the FSMB and its state member boards a framework of common standards and conceptual processes for physician and physician assistant reentry.

Reentry programs are consistent with lifelong learning expectations for physicians and there is some evidence that physicians who participated in a supportive, structured educational program were generally successful in achieving their goal of restoring licensure and returning to practice.³

Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants. Implementation of the Special Committee’s recommendations should result in a reentry process that is appropriately comprehensive, but practical and flexible enough to address a variety of situations and specialties. The Special Committee also specified that its report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point. They agreed that important outcomes would be to fulfill SMBs’ mission of ensuring public safety, an increase in public confidence in physicians and their licensing boards,

enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.

The Special Committee developed a description of desired outcomes for this project and the audience, scope and organization of the report. This information is contained in Attachment A. A glossary is included in Attachment B. Attachment C provides a listing of barriers to reentry as developed by The Physician Reentry into the Workforce Project of the American Academy of Pediatrics. Attachment D is a summary of the FSMB policy on Maintenance of Licensure, which is referred to frequently in this report. Attachment E provides a number of resources from state member boards that are intended to provide practical assistance on reentry. Attachment F provides references for additional literature on reentry.

NEED FOR REENTRY GUIDELINES FOR STATE MEMBER BOARDS

It is reported that a growing number of physicians are making the decision to take leave from the clinical practice of medicine, with many seeking to return at some future point⁴. Physicians may take a break from practice due to family responsibilities or they may decide to temporarily focus on research or administrative careers not involving the everyday practice of medicine. Other reasons physicians take time off from clinical practice include birth of a child, child care, caring for an ill family member, personal health, military service, humanitarian leave, and change in career path and career dissatisfaction.⁵

Regardless of the reasons for an interruption in practice, it is critical for SMBs to address reentry for the following reasons:

- To advance patient safety and quality of care;
- For SMBs to provide a standardized process for physicians and physician assistants, who may take a temporary leave from practice, to demonstrate their competence prior to reentering practice;
- For physicians who leave practice and do not reenter, there is:
 - A loss of physician contributions to the health care delivery system;
 - A worsening of the current access problems, especially in underserved areas;
 - The forfeiture of the investment in medical education and specialty/subspecialty training;
- Reentry to practice may offer an additional and more cost-effective means of addressing the anticipated national physician shortage and/or responding to national or local emergencies, such as natural disasters.

Several SMBs have already addressed reentry in response to the above points in order to assure citizens of their respective states that physicians who leave clinical practice are qualified to return. There is research that indicates that physicians who have been out of practice a certain number of years lose their skills.⁶ With the emphasis on outcomes measurement in health care reform, it is anticipated that there will be increased demand for programs of quality assessment for those in practice as well as those reentering it.

SMBs are also concerned that Maintenance of Licensure (MOL) requirements^{7, 8} and the ongoing rollout of American Board of Medical Specialties Maintenance of Certification (ABMS MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) Osteopathic Continuous Certification (OCC) requirements may uncover a significant number of physicians who are not in active

clinical practice. The same activities that physicians may need to meet MOL and specialty board certification requirements should also be used as part of a reentry process. SMBs are anticipating that there will be a link between MOL/MOC/OCC and Performance in Practice requirements, and reentry guidelines are needed to avoid unnecessary duplication.

Finally, there are a host of barriers for physicians who want to reenter practice (see Attachment C for a listing developed by the American Academy of Pediatrics Physician Reentry Project). The FSMB, working with its state member boards, can develop a more unified system to help address and reduce those barriers to reentry.

There are concerns that Maintenance of Licensure and certification requirements will identify a significant number of physicians who will need reentry activities. There is also anecdotal evidence that the problem is increasing in part because of economic and demographic changes among physicians. It appears that there are increasing numbers of retired physicians who desire to return to practice to augment their incomes during the current economic recession.⁹ With women comprising a larger percentage of the physician workforce, they often, although not exclusively, may take on responsibilities of childbirth, childcare, and caring for an ill or elderly family member.¹⁰

KEY REENTRY ISSUES

Physician reentry into clinical practice can be defined as returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended period.¹¹ Reentry is an issue that cuts across genders and specialties. However, anecdotal evidence indicates that reentry into the workforce affects women more often than men.¹² Although there is paucity of data on this complex topic, many agree that it is an issue that is gaining prominence,¹³ and is crucial to continuing public safety.

The Special Committee identified several key issues to be addressed during its work. The following list is neither exhaustive nor in an order of priority.

- **Timeframe:** More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process. The two-year timeframe is based on a 15-year-old FSMB policy, but further information is needed. In the absence of data, the Committee recognizes the need for flexibility when applying the two-years-away-from-practice timeframe to an individual practitioner, as there is great variability in specialty, type of practice, etc.
- **Data Needs:** More data are needed to know how many physicians are impacted by reentry issues. Information about how many physicians are clinically inactive but maintain an active license to practice is needed. The number of physicians who have been out of practice and have sought or are currently seeking reentry is needed. Although data are lacking, the Committee believes that anecdotal evidence speaks to the need for reentry interventions and that a growing number of physicians will need reentry tools and programs.
- **SMB Data Collection:** There is an urgent need for SMBs to add questions to their license renewal applications in order to help determine the status of physicians and the magnitude of the reentry problem.

- **Congruence with Maintenance of Licensure and Maintenance of Certification:** SMBs need to ensure that licensees and applicants are ready to reenter after a period of inactivity. However, as SMBs design or redesign their reentry programs, they should allow activities that physicians may need to meet MOL and specialty board certification requirements to satisfy the reentry process.
- **Barriers to Reentry:** There are difficulties associated with identifying entities that provide reentry services to physicians. Cost, geographic considerations, eligibility requirements, licensure, malpractice issues and lack of uniformity among alternatives available to physicians seeking reentry are problematic.
- **Mentors of Reentry Physicians:** The availability of physician mentors and the processes of vetting their skills, paying them for their work, and defining the types of tools they should use in assisting those physicians who are on a reentry path are considerations that need to be addressed.
- **Role of Academic Medical Centers (AMCs) and Community Hospital Training Centers:** Because they already have the facilities and resources, AMCs could play multiple roles in the reentry process. They could provide a complete reentry package from initial assessment of the reentry physician to his or her final evaluation of competence and performance in practice. Academic Medical Centers could provide selected services on an as-needed basis such as assessment testing, focused practiced based learning, procedure labs and providing and vetting mentors. Potential incentives to stimulate AMC involvement in reentry include research opportunities and generation of revenue.
- **Resources for Funding:** There is a need for funding to help cover the costs of physician reentry. Federal, state and local funding driven by physician shortages may become a funding source. Potential employers, including community hospitals and large group practices, may be willing to offset individual physician reentry costs in exchange for later service. There is a challenge to creatively find new funding, both nationally and locally, and promote its availability.
- **Medical Liability Insurance:** Better understanding is needed about how malpractice coverage works when physicians leave and when they reenter practice. It would also be helpful to know how coverage for mentoring physicians is handled.
- **Maintaining Licensure if Not in Active Clinical Practice:** SMBs are facing the question of whether physicians who are not in active clinical practice should be allowed to maintain an active license. Some states consider the work done and decisions made by medical directors of health care programs to be the practice of medicine and therefore they are required to have an active license. Other states recognize administrative medicine as a distinct area of practice and issue full and unrestricted licenses to administrative physicians with the expectation that administrative physicians, like all other licensees/applicants, appropriately limit their practice to areas where they are competent.
- **Retraining When Practice Differs or is Modified from Area of Primary Training:** Some physicians who seek reentry want to practice in a specialty or area that differs from their area of primary training. For example, an obstetrician/gynecologist may wish to practice family medicine. Another example is when a physician seeks to modify his or her primary area of practice, such as when an

obstetrician/gynecologist seeks to only practice gynecology. It is uncertain how much, if any, additional training might be needed for these types of physicians.

- **Simulation:** Simulations will play an important role in the future because they replicate cognitive and procedural skills and simulate team interaction. How can reentry activities take advantage of simulation centers and also pay for the services these centers might provide?

INPUT FROM ADVISORS

As part of its work, the Committee invited several professionals experienced in reentry to help inform its opinions and recommendations via two webinars. These presenters, which included representatives from previously or currently active reentry programs, had firsthand experience with physician reentry programs and were willing to discuss their experiences. The Committee would like to thank: Robin Wooton, Executive Director, Society for Simulation in Health Care (SSH); Barry Manuel, MD, Associate Dean, Professor of Surgery, Boston University School of Medicine; Elizabeth J. Korinek, MPH, Board Member, Coalition for Physician Enhancement (CPE); and Joann Baumer, MD, John Peter Smith Hospital in Ft. Worth, Texas.

The participants discussed several issues including costs, effectiveness and need for reentry programs. Some specific considerations involved:

Costs: It appears that, depending on design, costs for participating in and completing a formal reentry program can range from \$5,000-\$20,000 per individual participant. For those who have been ill, taken family medical leave, or for those in primary care specialties, limited funds can make program costs especially prohibitive.

Need for Programs: It appears that currently the number of participants is relatively small. For example, approximately 30 physicians are participating in a three-year period at one program and approximately 60 are completing another six-month university program.

Program Completion: It appears that most physicians who begin the programs complete them successfully, although one program found through prescreening that 20-30% were judged not to have the capacity to complete the program.

Programs Tailored to Individuals: All of the presenters agreed that it was desirable to have flexible programs that addressed the tremendous variety of individual needs.

Two-Year Minimum: It was agreed that there is a need for a commonly accepted “out of practice” timeframe for physician reentry.

ROLE OF STATE MEMBER BOARDS IN REENTRY

The Special Committee recognizes that several state member boards have strong policy and significant experience with the reentry process. The North Carolina Medical Board, for example, has supervised the reentry of approximately 60 physicians and 40 physician assistants. The Special Committee noted that Oregon, Massachusetts, and others have reentry rules (see Attachment E for examples). Based on

this experience, there appear to be a number of roles that state member boards can play in the process. For example, state member boards may:

- Develop a policy and provide advice to those desiring to reenter.
- Proactively identify those who are not complying with MOC or MOL requirements and inquire about their practice status and advise them of how to reenter.
- Notify all applicants/licensees about what they should do in advance of taking a leave from the practice of medicine in order to avoid future reentry problems.
- Directly supervise the reentry process using Board staff, while others will rely on programs in place for this purpose or academic medical centers
- Cooperate, perhaps on a regional basis, to best serve licensees/applicants and make best use of limited resources.
- Facilitate or support programs at academic medical centers in their state or region.

Recently, Nebraska enacted a law to provide for reentry licenses under its Medicine and Surgery Practice Act. Upon recommendation of the state board, a physician who has not been actively practicing medicine for the two-year period immediately preceding, or who has not otherwise maintained continued competency during such period as determined by the board, may qualify for a reentry license, which can then convert to a regular license after completion of assessment and supervised practice.

SUGGESTED REENTRY GUIDELINES*

The following 12 guidelines are intended to help SMBs facilitate a physician's reentry to practice while simultaneously ensuring the public is protected. Building on the FSMB's work in Maintenance of Licensure (MOL), the Special Committee believes that for individual physicians the reentry process should segue into MOL. Whenever possible, the three MOL components (Reflective Self-assessment, Assessment of Knowledge and Skills, and Performance in Practice) have been included as part of the reentry process.

While some of the guidelines contained herein may be appropriate for physicians whose absence is due to disciplinary or impairment reasons, the guidelines are primarily intended to address situations where a physician has taken a voluntary leave of absence. For purposes of this report, the recommendations apply to both physicians and physician assistants.

The Special Committee discussed the issue of impaired physicians and how the following guidelines might affect them and their SMBs. After a review of the FSMB Policy on Physician Impairment, which was adopted by the FSMB as policy in 2011, it was decided that these guidelines do not conflict with the FSMB policy and, in fact, enhance it.¹⁴ It is suggested that SMBs use these guidelines on Physician Reentry to augment their programs and to convey the importance of a reentry plan to the physicians participating in an Impaired Physician Program.

**This section is adapted from the draft final report of the Special Committee on Maintenance of Licensure (2008).*

Education and Communication Issues

Guideline 1: Proactive Communications

To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, SMBs should proactively educate licensees/applicants about the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment).¹⁵ For example, SMBs could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant consult the Inventory created by the Physician Reentry to the Workforce Project (www.physicianreentry.org).¹⁶ State member boards could include such information with the initial license, with the license renewal application, in the board's newsletter and on the board's website.

Guideline 2: Flexibility

The medical community will have to determine how to make the system flexible enough to accommodate reentering practitioners whose personal lives or professional goals interfere with the ability to remain clinically active. All entities that depend on physicians to provide clinical care should be encouraged to accommodate individuals who are interested in returning to clinical practice but who may need flexible or part-time scheduling. A recent study concluded that the lack of opportunities for part-time work and flexible scheduling may preclude some who otherwise would reenter practice from returning to practice.¹⁷ This systemic issue is difficult for SMBs to address, but it remains a significant issue.

Determining Fitness to Reenter Practice

It is the responsibility of SMBs to determine whether a licensee/applicant who has had an interruption in practice should demonstrate whether he or she is competent to return to practice. Of the 30 boards that have a reentry policy, a majority use a two-year continuous interruption in practice as an indicator for the need for a reentry activity, although requirements range from one to five years.¹⁸ The FSMB recommends that for licensure by endorsement, SMBs should adopt a flexible approach based on an applicant's individual needs, and guidelines established by the licensee/applicant specialty society or specialty board. SMBs may be guided by the concept that those who have not been in active practice for the previous 24-month period may be required to demonstrate their continued competence. Despite SMB requirements and FSMB recommendations, little research is available to inform discussions about how time away from clinical practice impacts competence.

Guideline 3: Case-by-Case Basis

Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an extended leave should be considered on a case-by-case basis. Decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including

length of time out of practice, what the practitioner has done while away from practice, the licensee/applicant's prior and current or intended area of specialization, prior disciplinary history, hospital privilege reports, and the licensee/applicant's participation in continuing medical education and/or volunteer activities during the time out of practice. Licensees/applicants who wish to take some time away from clinical practice should be encouraged to remain clinically active in some, even if limited, capacity, and urged to participate in continuing medical education and MOC, OCC, National Commission on Certification of Physician Assistants (NCCPA) certification maintenance processes and MOL activities if available.

Guideline 4: Documentation

All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans. The degree of documentation required may vary depending on the length of time away from clinical practice and whether the licensee/applicant's scope of practice is consistent with his or her medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

The Special Committee distinguishes between the need for reentry and the need for retraining. A physician returning to a scope or area of practice in which he/ she is previously trained or certified, or in which he/ she previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which he or she has NOT previously trained or certified or in which he/ she has NOT had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. Because the licensee/applicant's intended scope of practice may not be the same as the specialty in which he/ she is trained or board certified, the reentering licensee/applicant should also be required to provide information regarding the environment within which they will be practicing, the types of patients they anticipate seeing, and the types of clinical activities in which they will be engaged.

Guideline 5: Reentry Plan

Licensees/applicants who have been clinically inactive should become involved in a reentry plan approved by the state member board before reentering the workforce. The reentry plan should include three fundamental components: reflective self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and the licensee/applicant's performance in practice as defined by the FSMB requirements for Maintenance of Licensure.¹⁹

State member boards should approve the elements and scope of the reentry plan prior to its initiation. Subsequently, the licensee/applicant should be required to present the outcomes of the reentry plan to the state member board.

If the licensee/applicant has not previously implemented a reentry plan, then SMBs may be authorized as needed to use non-punitive, time-limited license mechanisms to return a practitioner's license to active, unrestricted status. Such a mechanism permits the licensee/applicant to participate in activities necessary to regain the knowledge and skills needed to provide safe patient care, such as participation in a mini-residency.

5a: Reflective Self-assessment

Reentry documentation should reflect the licensee/applicant's participation in assessment and/or self-reflection activities with subsequent successful completion of educational activities tailored to address weaknesses or deficiencies identified through the assessment. These activities should be congruent with Component One of the FSMB MOL Framework. (See Attachment D) Continuing medical education activities presented by the licensee/applicant in support of his/ her competence should be relevant to the area of practice in which the licensee/applicant intends to engage and should be certified by an agency acceptable to the state member board.

5b: Assessment of Knowledge and Skills

Congruent with MOL Component Two: Assessment of Knowledge and Skills, state member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.

SMBs should provide guidance about the appropriate content of a reentry plan. For example, SMBs could ask licensees/applicants to provide the results of their self-assessment, the processes used to assess knowledge and skills, and the means by which performance in practice was evaluated. Other appropriate content should include the qualifications of the mentoring physician, information from the mentor about the licensee/applicant's clinical duties and responsibilities, location of the practice, approximate number of hours worked, patient volume and acuity, procedures done, results of chart audits, method of mentoring, and frequency of direct observation.

Documentation of such activities should be required. For example, mentors should be sufficiently vetted to participate with the licensees/applicants' process of assessment. There are also recognized assessment programs that are available and could be an option for meeting this requirement.

5c: Performance in Practice:

Consistent with MOL Component Three: Performance in Practice, licensees/applicants should also be required to provide documentation showing their satisfactory performance in practice as part of a reentry plan. Qualifying activities could include a variety of methods that incorporate reference data to assess physician performance in practice as a guide to improvement. Potential resources that may be used to specifically address the component include standardized testing (e.g., SPEX, COMVEX, other), practice mentors, chart audits, "mini-residencies," individualized, tailored continuing medical education and evaluation by a formal assessment program, or other equivalent activities.

Guideline 6: SMB Collaborative Relationships

State member boards should foster collaborative relationships with academic institutions, community hospital training centers and specialty societies within their jurisdictions to develop assessment, educational and other interventions and resources for the various types of practices. The National Board of Osteopathic Medical Examiners, the National Board of Medical Examiners, the American Board of Medical Specialties, and the American Osteopathic Association Bureau of Osteopathic Specialties may likewise serve in a supportive role to state member boards in this regard. These institutions and organizations may have readily adaptable programs or simulation centers that meet the individual needs of reentering physicians.

Mentoring for Practitioners Who Want to Reenter the Workforce

Guideline 7: Board-approved Practice Mentors

Practice mentors may be selected by either the state member board or the licensee/applicant, but in all cases should be approved by the state member board. At a minimum, the practice mentor should be ABMS or AOA board certified and practice in the same clinical area as the licensee/applicant seeking reentry.

The state member board should set forth in writing its expectations of the practice mentor, including what aspects of the reentering licensee/applicant's practice are to be mentored, frequency and content of reports by the mentor to the state member board and how long the practice is to be mentored. The board's expectations should be communicated both to the mentor and the licensee/applicant being mentored. For physician assistants, the role of practice mentor may be fulfilled by the supervising physician.

The practice mentor should be required to demonstrate to the board's satisfaction that he/ she has the capacity to serve as a practice mentor, for example, sufficient time for mentoring, lack of disciplinary history, proof of an active, unrestricted medical license, and/or demonstration of a prescribed number of years in clinical practice. The practice mentor may be permitted to receive financial compensation or incentives for work associated with practice mentoring. Potential sources of bias should be identified and in some cases may disqualify a potential mentor from acting in that capacity.

State member boards should work with the state medical and osteopathic societies and associations and the medical education community to identify and increase the pool of potential practice mentors. For example, to protect the pool of mentors, some SMBs have made them agents of the board.

Guideline 8: Transition to a Full Unrestricted License

Physicians and physician assistants who have gone through a reentry process and receive a full, unrestricted license should then be subject to the same rules and regulations as other licensees.

Improving Regulation of Licensed Practitioners Who Are Clinically Inactive

State member boards should implement the following mechanisms to improve regulation of licensed practitioners who are clinically inactive but may return to clinical practice in the future.

Guideline 9: Identifying Clinically Inactive Licensees

State member boards should require licensees to report information about their practice as part of the license renewal or registration process, including: type of practice, status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Such information will enable SMBs to identify licensees who are not clinically active and to intervene and guide, as needed, if and when a licensee chooses to return to patient care duties. State member boards should advise licensees who are

clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior to resuming patient care duties.

The report of the FSMB Workgroup to Define Minimal Data Set is expected to provide additional recommendations regarding a minimal physician demographic data set that state member boards should collect as part of the licensure process. In addition, the report of the FSMB Maintenance of Licensure Workgroup on Non-Clinical Physicians is expected to provide recommendations regarding how non-clinically active physicians may participate in a state member board's MOL program and how participation in such a program should be evaluated at the time of reentry to clinical practice.

Guideline 10: Licensure Status

Licensees who are clinically inactive should be allowed to maintain their licensure status as long as they pay the required fees and complete any required continuing medical education or other requirements as set forth by the board. Upon a licensee's decision to return to clinical practice, he or she should be required to participate in a reentry process.

Guideline 11: Consistency of Reentry across Jurisdictions

State member boards should be consistent in the creation and execution of reentry processes. In recognition of the differences in resources, statutes and operations across states and acknowledging that implementation of physician reentry should be within the discretion and purview of each SMB, these guidelines are designed to be flexible to meet local considerations. At the same time, physicians may be concerned about an overly burdensome reentry process where they might have to meet varying criteria to obtain licensure in different states. For purposes of license portability, FSMB should coordinate the implementation of these guidelines so there is as much consistency as possible.

Relationship between Licensure and Specialty Certification

A physician's ability to maintain specialty board certification during a leave of absence will depend on whether the physician has voluntarily allowed his or her license to lapse. The 24 boards of the American Board of Medical Specialties (ABMS) have implemented Maintenance of Certification (MOC) programs, which require, in part, the physician's ability to demonstrate good professional standing by virtue of having a full and unrestricted license. In addition, the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) is implementing an Osteopathic Continuous Certification (OCC) program, which also requires, in part, demonstration of a full and unrestricted license.

Guideline 12: Maintenance of Specialty Certification

In situations where a licensed, board certified physician is returning to clinical practice, state member boards should make every effort to ensure that any conditions for the physician's reentry to practice do not hinder the physician's ability to maintain specialty certification.

IMPLICATIONS FOR STATE MEMBER BOARDS AND THE ROLE OF FSMB

The Special Committee on Reentry to Practice discussed possible implications of reentry on SMBs and the role of the FSMB in implementing the Special Committee's recommendations. For state member

boards, there will be a need to review and perhaps revise their medical practice acts, to consider staffing, costs and resource issues, to modify license application and renewal forms, to integrate reentry with MOL activities and to initiate proactive communications with prospective and current licensees/applicants.

To assist SMBs with implementing reentry requirements, FSMB should consider the following suggestions:

- FSMB should develop a uniform set of questions for SMBs to add to their license renewal application.
- Once guidelines are adopted as policy, FSMB should offer advice and consultation to their member boards.
- FSMB should commit to reviewing its reentry recommendations and policy every three to five years to ensure it remains current.
- FSMB could develop standards for language, forms and checklists to assist in implementation. For example, FSMB could provide sample guidance on issues like the importance of engaging in clinical practice, if even on a limited and part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice.
- FSMB can help share best practices, information and resources across states through conferences, the FSMB Annual Meeting, publications and web-based reporting tools.

CONCLUSION AND NEXT STEPS

Widespread and well-defined physician reentry processes will probably not be fully realized nationwide for several years. During that time, the Special Committee recommends that FSMB launch a systematic effort to encourage states to share with each other what is working and what may need improvement in order to define best practices. Most immediately, there is a need to understand the magnitude of the problem.

As indicated in Guideline 9, state member boards should require licensees/applicants to report information about their practice as part of the license renewal or registration process. When these data are collected nationwide and reported, there will be a much stronger understanding of the opportunity to increase the physician and physician assistant workforce.

Secondarily, there is a significant need to develop an evidence base for reentry. Research is needed about the type and degree of assessment that is required to determine educational needs. Another question deserving study is the effectiveness of various types of reentry programs.

Finally, the short and long term results of reentry programs must be evaluated. Although there is evidence from the existing reentry programs that most physicians who begin a reentry program complete it successfully, more systematic research needs to be undertaken, especially regarding the two-year time frame precedent. Also, longer term follow up studies will be necessary to determine if those completing program make a successful transition to practice and what, if any, obstacles they may encounter.

SPECIAL COMMITTEE DESIRED OUTCOMES

The Special Committee agreed that its work should be focused on the following desired outcomes:

- The overall goal should be to establish physician reentry as a common career trajectory with an expectation that it is a normal part of a physician’s continuing practice of medicine.
- Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to make its recommendations useable for physicians and physician assistants; implementation of the Special Committee’s recommendations should result in a reentry process that is rigorous, but practical and flexible enough to address a variety of situations and specialties.
- The report should provide common standards and conceptual processes for state member boards to implement the recommendations, and not necessarily be a specific “tool box” at this point.
- Recommendations from the Special Committee should increase public confidence in physicians and their licensing boards; the ideal would be for the recommendations to be linked to the enhancement of patient outcomes.
- An important outcome will be enhanced communications between SMBs and physicians about the implications of what taking a leave from practice means and increased awareness of how physicians should prepare for such an event.
- The Special Committee believes involvement of academic medical centers in reentry activities, including focused research on this topic, is highly desirable.
- The report should explicitly link reentry with Maintenance of Licensure (MOL), ABMS Maintenance of Certification (MOC), and AOA BOS Osteopathic Continuous Certification (OCC).

THE AUDIENCE, SCOPE AND ORGANIZATION OF THE SPECIAL COMMITTEE REPORT

The Special Committee discussed the nature of the report and provided the following guidance.

- The primary audience for the report will be state member boards, with the understanding that the report could be useful and easily adapted to the following secondary audiences of individuals and groups: physicians and physician assistants, students, residents, specialty organizations, hospital credentialing groups, national and state legislators and regulators, and the public.
- It will be important to establish the rationale for the work; the audience must be able to clearly understand why guidelines or pathways for state member boards are needed.
- The report should be of journal quality, media-worthy and also be clear and relevant to SMBs and their licensees/applicants, perhaps including diagrams and algorithms; perhaps a 10-page document with additional appendices.
- Clear definitions of what is meant by reentry, active practice and inactive practice, for example, should be provided in the glossary.

- The tone of the report should be positive and reinforce the concept that reentry is an accessible and professionally rewarding process.
- The report will focus on undifferentiated licenses and not address administrative licenses, which should be deferred until the FSMB Maintenance of Licensure Initiative progresses.
- The Committee also discussed whether its recommendations should address non-physician clinicians beyond physician assistants and decided that the recommendations will be available to other groups that could chose what to adopt for their use.

GLOSSARY

The following definitions were adapted from the AAP Physician Reentry into the Workforce Project, the AMA, the AOA, the American Board of Medical Specialties, and the FSMB Special Committee report on Maintenance of Licensure.

AMA Definition of Physician Reentry: A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment; distinct from remediation or retraining.

AAP Definition of Physician Reentry: Returning to professional activity/clinical practice, for which one has been trained, certified or licensed after an extended period.

Clinically Active Practice: Clinically active status is defined as any amount of direct and/or consultative patient care that has been provided in the preceding 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

Clinically Inactive Practice: No direct and/or consultative patient care that has been provided in the past 24 months. STANDARDS FOR ABMS MOC® (PARTS 1-4) PROGRAM, Approved March 16, 2009

Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX): The evaluative instrument offered by the National Board of Osteopathic Medical Examiners for osteopathic physicians who need to demonstrate application of clinical knowledge for the practice of osteopathic medicine.

Education: The process whereby deficiencies in physician performance identified through an assessment system are corrected.

Impaired Physician: A physician who is unable to fulfill personal or professional responsibility because of psychiatric illness, alcoholism, or drug dependency.

Maintenance of Certification: In 2000, the 24 member boards of the American Board of Medical Specialties (ABMS) agreed to evolve their recertification programs to one of continuous professional development – ABMS Maintenance of Certification® (ABMS MOC®). ABMS MOC assures that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by ABMS and ACGME in 1999.

Maintenance of Licensure: Maintenance of Licensure is a system of continuous professional development that requires all licensed physicians to demonstrate, as a condition of license renewal, their involvement in lifelong learning that is objective, relevant to practice and improves performance over time.

Mentoring: a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an advanced career incumbent and the other is a less experienced person. The relationship is aimed at fostering the development of the less experienced person. (Baucher H. Mentoring Clinical Researchers. Archives of Diseases of Children. 2002;86; 82-84.)

Osteopathic Continuous Certification: The American Osteopathic Association's Bureau of Osteopathic Specialists (AOA BOS) has mandated that each specialty certifying board implement "Osteopathic Continuous Certification" (OCC). OCC will serve as a way for board certified DOs can maintain currency and demonstrate competency in their specialty area. The American Osteopathic Association's seven core competencies are: 1) medical knowledge, 2) patient care, 3) practice-based learning and improvement, 4) interpersonal and communication skills, 5) professionalism, 6) systems-based practice, and 7) osteopathic philosophy and osteopathic manipulative medicine.

Physician Assistant Certification Maintenance Process: The National Commission on Certification of Physician Assistants is expanding its long-standing requirements of continuing medical education and regular retesting to include new self-assessment activities and performance improvement activities.

Physician Reentry Program: Structured curriculum and clinical experience which prepared physicians to return to clinical practice following an extended period of clinical inactivity.

Physician Reentry Program System: Provides a way of organizing and planning physician reentry programs.

Physician Retraining: The process of updating one's skill or learning the necessary skills to move into a new clinical area.

State Member Boards: State medical and osteopathic licensing boards that oversee the activities of the physicians licensed in the states, District of Columbia and U.S. Territories, assuring that a high standard of practice by the physicians is maintained. (Adapted from McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.)

REENTRY BARRIERS
(from the Physician Reentry into the Workforce Project
of the American Academy of Pediatrics)

The Physician Reentry into the Workforce Project maintains that decisions to leave and then reenter the workforce should be regarded as part of a physician's career trajectory, and not as an unusual event. Physicians who are considering leaving clinical practice, as well as those who are planning to reenter, should understand and acknowledge that there can be barriers to this process. Not all physicians will encounter all or even most of these barriers on the following list, but it is wise to be prepared.

- Physician/Practitioner Factors:

- Lack of confidence and/or psychological concerns;
- Lack of knowledge and skills, both clinical and documentation skills (i.e., EMR experience);
- Lack of experience and comfort with other technological advances (i.e., internet searches, PDA use, etc.);
- Lack of knowledge of requirements, sometimes leading to decisions that cause difficulty in returning (such as allowing a license to lapse or become inactive);
- Failure to maintain knowledge in their clinical specialty because they do not anticipate a return to medicine;
- “Unconscious incompetence” – even though the practitioner may have tried to prepare, s/he may be unaware of or unable to anticipate all areas in which s/he needs to update; inability to self-assess educational needs relative to the needs of the prospective practice setting; personal feelings of adequacy or ability to practice medicine as needed;
- Pride: difficulty admitting that one is in need of further training;
- Lack of time to address the educational needs; and inability to plan for oneself how to address the needs;
- Difficulty determining when the educational gap is sufficiently addressed.

- Licensure and Licensing Board Factors:

- Failure to educate practitioners who allow their license to lapse of these requirements and potential consequences;
- Requirements that may be vague, arbitrary, and may have changed over time (or may in the future);
- Requirements that differ in vigor from state to state;
- Limited options given by which to demonstrate competence for any given state;
- Limited means available by which to demonstrate competence;
- Lack of understanding whether the options to demonstrate competence actually do so; lack of understanding of what can be used as a proxy for “competence”;
 - Often the criteria used is hands-on patient care in the U.S. (and the only criteria accepted by boards);
 - If criteria exist (such as the “two-year rules”) they often do not

differentiate between specialties. For example, perhaps “hands-on” care is more relevant for maintaining “competence” in surgical and procedural based specialties, and the critical time out period should be different for procedural and non-procedural specialties;

- Licensing organizations do not usually risk-stratify practitioners in deciding how a physician should prove competency after a time away (based on factors such as whether the practitioner is/was ever board certified, or whether the physician has required to recertify periodically, and has done so).

- Hospital and Other Privileging Bodies:

- Discomfort with and/or lack of willingness to allow privileges to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between hospitals (even for the same specialty);
- Varying ability to provide proctoring or work with physicians in a staged re-entry process (i.e., gradually lessening levels of supervision);
- Hesitance of managed care organizations and medical insurance companies to accept a re-entering physician onto their provider panel.

- Liability Coverage Factors:

- Discomfort with and/or lack of willingness to provide liability coverage to a physician who has not been in recent clinical practice;
- Significant variations in this comfort level between insurers and from individual to individual.

- Prospective Employer Factors:

- As with all the other levels, lack of understanding of how to judge competence of a clinician who does not have recent clinical experience;
- Limited availability of flexible work options;
- Lack of support from the institution and colleagues for those integrating back into the workplace.

- Reentry Program Factors:

- Discomfort with and lack of practicality in providing a “certificate of competence”;
- Variability in what each program can offer to the practitioner and offer to the prospective board/hospital/malpractice insurer, etc.
- Limited availability of sites where re-entry programs can provide hands on clinical experiences for physicians because of the above factors;
- Cost of and distance to established programs; need for convenient and affordable programs;
- Need for flexible programs;

- Lack of standardization of how these evaluations are done and/or reentry process is conducted.
- Home and Family Barriers:
 - Ongoing needs such as childcare and needs of other family/household members;
- Multi-level Factors:
 - Multiple different layers of regulating and certifying bodies with different criteria for demonstration of aptitude and proficiency (which may or may not equate to competence), all of which the practitioner must fulfill; for example, requirements to maintain specialty board certification are not considered adequate demonstration of competence by boards and licensing authorities;
 - Unclear who is/should be the decision-maker in such matters;
 - Need for counseling to provide direction regarding the kind of learning and training needed.

For more information on The Physician Reentry into the Workforce Project visit www.physicianreentry.org

Physician Reentry into the Workforce Project. Issue Brief: Reentry Barriers. Elk Grove Village, Ill. American Academy of Pediatrics; 2010.

FSMB MAINTENANCE OF LICENSURE FRAMEWORK

As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:

- medical knowledge
- patient care
- interpersonal and communication skills
- practice based learning
- professionalism
- systems based practice

The following requirements reflect the three major components of what is known about effective lifelong learning in medicine.

1. Reflective Self Assessment (What improvements can I make?)

Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)

Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. Performance in Practice (How am I doing?)

Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

STATE MEMBER BOARD RESOURCES

Oregon Administrative Rules on Reentry for Physician Assistants (p. 27)

Oregon Administrative Rules on Reentry for Physicians (p. 28)

North Carolina Rule on Reentry to Practice (p. 30)

Nebraska Reentry License (p. 33)

A detailed overview of state board requirements for reentry is also available in the *2012 State Medical Licensure Requirements and Statistics* book published by the American Medical Association. The book includes data such as number and percent of boards that currently have a reentry policy, the average length of time out of practice after which boards require a reentering physician to complete a reentry program, and a table of physician reentry regulations by board.

**OREGON MEDICAL BOARD PROPOSED RULE ON REENTRY FOR PHYSICIAN ASSISTANTS
CHAPTER 847, DIVISION 050 – OREGON MEDICAL BOARD**

PROPOSED RULES CHANGES - FIRST REVIEW – JULY 2011

Proposed rule amendment establishes requirements for re-entry to practice after ceasing practice for more than one year and contains general language and grammar housekeeping.

847-050-0043

Inactive Registration and Re-Entry to Practice

(1) Any physician assistant licensed in this state who changes location to some other state or country, or who is not in a current supervisory relationship with a licensed physician for 6 months or more, will be listed by the Board as inactive.

(2) If the physician assistant wishes to resume active status to practice in Oregon, the physician assistant must submit the Affidavit of Reactivation and processing fee, satisfactorily complete the reactivation process and be approved by the Board before beginning active practice in Oregon.

(3) The Board may deny active registration if it judges the conduct of the physician assistant during the period of inactive registration to be such that the physician assistant would have been denied a license if applying for an initial license

(4) If a physician assistant applicant has ceased practice for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to do one or more of the following:

(a) Obtain certification or re-certification by the National Commission on the Certification of Physician Assistants (N.C.C.P.A.);

(b) Provide documentation of current N.C.C.P.A. certification;

(c) Complete 30 hours of Category I continuing medical education acceptable to the Board for every year the applicant has ceased practice;

(d) Agree to increased chart reviews upon re-entry to practice.

(5) The physician assistant applicant who has ceased practice for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the re-entry plan may contain one or more of the requirements listed in section (4) of this rule and such additional requirements as determined by the Board.

Stat. Auth.: ORS 677.265

Stats. Implemented: ORS 677.512

**OREGON PROPOSED ADMINISTRATIVE RULES FOR PHYSICIANS
CHAPTER 847, DIVISION 020 – OREGON MEDICAL BOARD**

FIRST REVIEW RULE ADOPTION – OCTOBER 2011

The amendment includes the new Osteopathic school opening in Oregon and clarifies the standards for re-entry to practice.

847-020-0183

Re-Entry to Practice – SPEX or COMVEX Examination, Re-Entry Plan and Personal Interview

If an applicant has ceased the practice of medicine for a period of 12 or more consecutive months immediately preceding the application for licensure or reactivation, the applicant may be required to demonstrate clinical competency.

(1) The applicant who has ceased the practice of medicine for a period of 12 or more consecutive months may be required to pass the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX). This requirement may be waived if the applicant has done one or more of the following:

(a) The applicant has received a current appointment as Professor or Associate Professor at the Oregon Health and Science University or the Western University of Health Sciences College of Osteopathic Medicine of the Pacific; or

(b) The applicant has within ten years of filing an application with the Board:

(A) Completed one year of an accredited residency, or an accredited or Board-approved clinical fellowship; or

(B) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) The applicant has subsequently:

(A) Completed one year of an accredited residency, or

(B) Completed one year of an accredited or Board-approved clinical fellowship, or

(C) Been certified or recertified by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or

(D) Obtained continuing medical education to the Board's satisfaction.

(2) The applicant who has ceased the practice of medicine for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must

review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out-of-practice, the applicant may be required to do one or more of the following:

(a) Pass the SPEX/COMVEX examination;

(b) Practice for a specified period of time under a mentor/supervising physician who will provide periodic reports to the Board;

(c) Obtain certification or re-certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOA-BOS);

(d) Complete a re-entry program as determined appropriate by the Board;

(e) Complete one year of accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director;

(f) Complete at least 50 hours of Board-approved continuing medical education each year for the past three years.

(3) The applicant who fails the SPEX or COMVEX examination three times, whether in Oregon or other states, must successfully complete one year of an accredited residency or an accredited or Board-approved clinical fellowship before retaking the SPEX or COMVEX examination.

(4) The Limited License, SPEX/COMVEX may be granted for a period of up to 6 months. It permits the licensee to practice medicine only until the grade results of the SPEX or COMVEX examination are available and the applicant completes the initial registration process. If the applicant fails the SPEX or COMVEX examination, the Limited License SPEX/COMVEX becomes invalid, and the applicant must cease practice in this state as expeditiously as possible, but not to exceed two weeks after the applicant receives notice of failure of the examination.

(5) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application. The interview must be conducted during a regular meeting of the Board.

(6) All of the rules, regulations and statutory requirements pertaining to the medical school graduate remain in full effect.

Stat. Auth.: ORS 677.175, 677.265

Stats. Implemented: ORS 677.010, 677.175, 677.265

NORTH CAROLINA REENTRY RULE

21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE

(a) A physician or physician assistant applicant ("applicant" or "licensee") who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license from the Board shall complete a reentry agreement as a condition of licensure.

(b) The applicant shall identify a mentoring physician.

(c) The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reentry plan and interview the applicant.

(d) Factors that may affect the length and scope of the reentry plan include:

- (1) The applicant's amount of time out of practice;
- (2) The applicant's prior intensity of practice;
- (3) The reason for the interruption in practice;
- (4) The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;
- (5) The applicant's previous and intended area(s) of practice;
- (6) The skills required of the intended area(s) of practice;
- (7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;
- (8) The applicant's number of years of graduate medical education;
- (9) The number of years since completion of graduate medical education; and
- (10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and the mentoring physician.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a restricted License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.

(g) The first component of a reentry plan is an assessment of the applicant's current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant's strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.

(h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:

- (1) a reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or
- (2) a reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:
 - (A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.
 - (B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.
 - (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.
 - (D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.
 - (E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.

(i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are

acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

(k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice-related matters.

(l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

(m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

*History Note: Authority G.S. 90-8.1; 90-14(a)(11a);
Eff. March 1, 2011.*

NEBRASKA REENTRY LICENSE

TITLE: Provide for reentry licenses under the Medicine and Surgery Practice Act

05/12/2011 PASSED ON FINAL READING 46-0-3.

05/12/2011 PRESIDENT/SPEAKER SIGNED.

05/12/2011 PRESENTED TO GOVERNOR ON MAY 12, 2011.

(1)(a) Present proof that he or she is a graduate of an accredited school or college of medicine, (b) if a foreign medical graduate, provide a copy of a permanent certificate issued by the Educational Commission on Foreign Medical Graduates that is currently effective and relates to such applicant or provide such credentials as are necessary to certify that such foreign medical graduate has successfully passed the Visa Qualifying Examination or its successor or equivalent examination required by the United States Department of Health and Human Services and the United States Citizenship and Immigration Services, or (c) if a graduate of a foreign medical school who has successfully completed a program of American medical training designated as the Fifth Pathway and who additionally has successfully passed the Educational Commission on Foreign Medical Graduates examination but has not yet received the permanent certificate attesting to the same, provide such credentials as certify the same to the Division of Public Health of the Department of Health and Human Services;

(2) Present proof that he or she has served at least one year of graduate medical education approved by the board or, if a foreign medical graduate, present proof that he or she has served at least three years of graduate medical education approved by the board;

(3) Pass a licensing examination approved by the board covering appropriate medical subjects; and

(4) Present proof satisfactory to the department that he or she, within the three years immediately preceding the application for licensure, (a) has been in the active practice of the profession of medicine and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year, (b) has had at least one year of graduate medical education as described in subdivision (2) of this section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has completed a refresher course in medicine and surgery approved by the board, or (e) has completed the special purposes examination approved by the board.

Sec. 3. (1) The department, with the recommendation of the board, may issue a reentry license to a physician who has not actively practiced medicine for the two-year period immediately preceding the filing of an application for a reentry license or who has not otherwise maintained continued competency during such period as determined by the board.

(2) To qualify for a reentry license, the physician shall meet the same requirements for licensure as a regular licensee and submit to evaluations, assessments, and an educational program as required by the board.

(3) If the board conducts an assessment and determines that the applicant requires a period of supervised practice, the department, with the recommendation of the board, may issue a reentry license allowing the applicant to practice medicine under supervision as specified by the board. After satisfactory completion of the period of supervised practice as determined by the board, the reentry licensee may apply to the department to convert the reentry license to a license issued under section 38-2026.

(4) After an assessment and the completion of any educational program that has been prescribed, if the board determines that the applicant is competent and qualified to practice medicine without supervision, the department, with the recommendation of the board, may convert the reentry license to a license issued under section 38-2026.

(5) A reentry license shall be valid for one year and may be renewed for up to two additional years if approved by the department, with the recommendation of the board.

(6) The issuance of a reentry license shall not constitute a disciplinary action.

ADDITIONAL LITERATURE ON REENTRY

The following peer-reviewed articles provide a more in-depth overview and analysis of the issues associated with reentry.

Bower, EA, English C, Choi D, Cedfeldt AS, Girard DE. Education to return nonpracticing physicians to clinical activity: A case study in physician reentry. *Journal of Continuing Education in the Health Professions*. 2010;30(2):89-94.

Freed GL, Dunham KM, Abraham L. Protecting the public: State medical board licensure policies for active and inactive physicians. *Pediatrics*. 2009;123:643-652.

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