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**Report from the Special Committee on
Reentry to Practice**

DRAFT

September 20, 2011

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EXECUTIVE SUMMARY

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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.

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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 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.

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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.

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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.

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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).

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

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- 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

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For state member boards, implementation of the Special Committee's Reentry Guidelines may require review and revision of existing medical 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.

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183 **INTRODUCTION AND CHARGE**

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

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

- 193
- 194 1. Review and evaluate the recommendations relative to reentry in the Special Committee on
195 Maintenance of Licensure as contained in its 2008 draft report;²
 - 196 2. Review and evaluate the policies, procedures and other mechanisms currently used by state
197 member boards to oversee physicians and physician assistants in reentering the active practice of
198 medicine;
 - 199 3. Review and evaluate the work to date on issues related to reentry to practice from medical
200 professional organizations and other entities, including the AMA, AOA, AAP, et al;
 - 201 4. Review and evaluate the FSMB’s recommendations related to Maintenance of Licensure (MOL) and
202 its implementation and develop recommendations as to how MOL requirements can be aligned with
203 re-entry to practice requirements;
 - 204 5. Establish and recommend guidelines that state member boards can utilize to determine the
205 competence of physicians who have been out of clinical practice for a significant period of time for
206 non-disciplinary reasons;
 - 207 6. Provide guidance about the potential application of guidelines developed as part of #5, to
208 disciplinary, impairment or retraining issues that may be associated with reentry.

209

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

214

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

218

219 Although reentry affects a broad spectrum of health care providers, the Special Committee’s intent is to
220 make its recommendations useable for physicians and physician assistants. Implementation of the
221 Special Committee’s recommendations should result in a reentry process that is appropriately
222 comprehensive, but practical and flexible enough to address a variety of situations and specialties. The
223 Special Committee also specified that its report should provide common standards and conceptual
224 processes for state member boards to implement the recommendations, and not necessarily be a
225 specific “tool box” at this point. They agreed that important outcomes would be to fulfill SMBs’ mission
226 of ensuring public safety, an increase in public confidence in physicians and their licensing boards,
227 enhanced communications between SMBs and physicians about the implications of what taking a leave
228 from practice means and increased awareness of how physicians should prepare for such an event.

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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 E 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.

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NEED FOR REENTRY GUIDELINES FOR STATE MEMBER BOARDS

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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

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

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- 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.

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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.

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SMBs are also concerned that Maintenance of Licensure (MOL) requirements⁷ 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

275 there will be a link between MOL/MOC/OCC and Performance in Practice requirements, and reentry
276 guidelines are needed to avoid unnecessary duplication.

277

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

282

283 There are concerns that Maintenance of Licensure and certification requirements will identify a
284 significant number of physicians who will need reentry activities. There is also anecdotal evidence that
285 the problem is increasing in part because of economic and demographic changes among physicians. It
286 appears that there are increasing numbers of retired physicians who desire to return to practice to
287 augment their incomes during the current economic recession.⁸ With women comprising a larger
288 percentage of the physician workforce, they often, although not exclusively, may take on responsibilities
289 of childbirth, childcare, and caring for an ill or elderly family member.⁹

290 KEY REENTRY ISSUES

291 Physician reentry into clinical practice can be defined as returning to professional activity/clinical
292 practice for which one has been trained, certified or licensed after an extended period.¹⁰ Reentry is an
293 issue that cuts across genders and specialties. However, anecdotal evidence indicates that reentry into
294 the workforce affects women more often than men.¹¹ Although there is paucity of data on this complex
295 topic, many agree that it is an issue that is gaining prominence,¹² and is crucial to continuing public
296 safety.

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

299

300 • **Timeframe:** More than two years away from practice is commonly accepted as the timeframe
301 for when physicians should go through a reentry process. The two-year timeframe is based on a
302 15-year-old FSMB policy, but further information is needed. In the absence of data, the
303 Committee recognizes the need for flexibility when applying the two-years-away-from-practice
304 timeframe to an individual practitioner, as there is great variability in specialty, type of practice,
305 etc.

306

307 • **Data Needs:** More data are needed to know how many physicians are impacted by reentry
308 issues. Information about how many physicians are clinically inactive but maintain an active
309 license to practice is needed. The number of physicians who have been out of practice and have
310 sought or are currently seeking reentry is needed. Although data are lacking, the Committee
311 believes that anecdotal evidence speaks to the need for reentry interventions and that a
312 growing number of physicians will need reentry tools and programs.

313

314 • **SMB Data Collection:** There is an urgent need for SMBs to add questions to their license
315 renewal applications in order to help determine the status of physicians and the magnitude of
316 the reentry problem.

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318 • **Congruence with Maintenance of Licensure and Maintenance of Certification:** SMBs need to
319 ensure that licensees and applicants are ready to reenter after a period of inactivity. However,

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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.

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

372 **INPUT FROM ADVISORS**

373

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

382

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

385

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

390

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

394

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

398

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

401

402 **Two-Year Minimum:** It was agreed that there is a need for a commonly accepted "out of
403 practice" timeframe for physician reentry.

404 **ROLE OF STATE MEMBER BOARDS IN REENTRY**

405

406 The Special Committee recognizes that several state member boards have strong policy and significant
407 experience with the reentry process. The North Carolina Medical Board, for example, has supervised
408 the reentry of approximately 60 physicians and 40 physician assistants. The Special Committee noted
409 that Oregon, Massachusetts, and others have reentry rules. (See Attachment E for examples.) Based
410 on this experience, there appear to be a number of roles that state member boards can play in the
411 process. For example, state member boards may:

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- 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.

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

429 **SUGGESTED REENTRY GUIDELINES***

430

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

437

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

442

443 The Special Committee discussed the issue of impaired physicians and how the following guidelines
444 might affect them and their SMBs. After a review of the FSMB Policy on Physician Impairment, which
445 was adopted by the FSMB as policy in 2011, it was decided that these guidelines do not conflict with the
446 FSMB policy and, in fact, enhance it.¹³ It is suggested that SMBs use these guidelines on Physician
447 Reentry to augment their programs and to convey the importance of a reentry plan to the physicians
448 participating in an Impaired Physician Program.

449

450

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

451 **Education and Communication Issues**

452

453 **Guideline 1: Proactive Communications**

454

455 To help prepare licensees/applicants who either are thinking about taking a leave of absence or are
456 considering returning to clinical practice, SMBs should proactively educate licensees/applicants about

457 the issues associated with reentering clinical practice.¹⁴ For example, SMBs could develop written
458 guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time
459 basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they
460 are ready to reenter practice. They might also suggest that the licensee/applicant consult the Inventory
461 created by the Physician Reentry to the Workforce Project ([www. physicianreentry.org](http://www.physicianreentry.org)).¹⁵ State member
462 boards could include such information with the initial license, with the license renewal application, in
463 the board’s newsletter and on the board’s website.

464

465 **Guideline 2: Flexibility**

466

467 The medical community will have to determine how to make the system flexible enough to
468 accommodate reentering practitioners whose personal lives or professional goals interfere with the
469 ability to remain clinically active. All entities that depend on physicians to provide clinical care should be
470 encouraged to accommodate individuals who are interested in returning to clinical practice but who
471 may need flexible or part-time scheduling. A recent study concluded that the lack of opportunities for
472 part-time work and flexible scheduling may preclude some who otherwise would reenter practice from
473 returning to practice.¹⁶ This systemic issue is difficult for SMBs to address, but it remains a significant
474 issue.

475 **Determining Fitness to Reenter Practice**

476

477 It is the responsibility of SMBs to determine whether a licensee/applicant who has had an interruption
478 in practice should demonstrate whether he or she is competent to return to practice. Of the 30 boards
479 that have a reentry policy, a majority use a two-year continuous interruption in practice as an indicator
480 for the need for a reentry activity, although requirements range from one to five years.¹⁷ The FSMB
481 recommends that for licensure by endorsement, SMBs should adopt a flexible approach based on an
482 applicant’s individual needs, and guidelines established by the licensee/applicant specialty society or
483 specialty board. SMBs may be guided by the concept that those who have not been in active practice
484 for the previous 24-month period may be required to demonstrate their continued competence.
485 Despite SMB requirements and FSMB recommendations, little research is available to inform discussions
486 about how time away from clinical practice impacts competence.

487

488 **Guideline 3: Case-by-Case Basis**

489

490 Because competence is maintained in part through continuous engagement in patient care activities,
491 licensees/applicants seeking to return to clinical work after an extended leave should be considered on a
492 case- by-case basis. Decisions about whether the licensee/applicant should demonstrate readiness to
493 reenter practice should be based on a global review of the licensee/applicant’s situation, including
494 length of time out of practice, what the practitioner has done while away from practice, the
495 licensee/applicant’s prior and current or intended area of specialization, prior disciplinary history,
496 hospital privilege reports, and the licensee/applicant’s participation in continuing medical education
497 and/or volunteer activities during the time out of practice. Licensees/applicants who wish to take some
498 time away from clinical practice should be encouraged to remain clinically active in some, even if
499 limited, capacity, and urged to participate in continuing medical education and MOC, OCC and MOL
500 activities if available.

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504 **Guideline 4: Documentation**

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

511

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

522

523 **Guideline 5: Reentry Plan**

524

525 Licensees/applicants who have been clinically inactive should become involved in a reentry plan
526 approved by the state member board before reentering the workforce. The reentry plan should include
527 three fundamental components: reflective self-assessment by the licensee/applicant, assessment of the
528 licensee/applicant's knowledge and skills, and the licensee/applicant's performance in practice as
529 defined by the FSMB requirements for Maintenance of Licensure.¹⁸

530

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

534

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

540

541 **5a: Reflective Self-assessment**

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

550

551

552

553 **5b: Assessment of Knowledge and Skills**

554

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

558

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

566

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

570

571 **5c: Performance in Practice:**

572

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

580

581 **Guideline 6: SMB Collaborative Relationships**

582

583 State member boards should foster collaborative relationships with academic institutions, community
584 hospital training centers and specialty societies within their jurisdictions to develop assessment,
585 educational and other interventions and resources for the various types of practices. These institutions
586 and organizations may have readily adaptable programs or simulation centers that meet the individual
587 needs of reentering physicians.

588 **Mentoring for Practitioners Who Want to Reenter the Workforce**

589

590 **Guideline 7: Board-approved Practice Mentors**

591

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

596

597 The state member board should set forth in writing its expectations of the practice mentor, including
598 what aspects of the reentering licensee/applicant's practice are to be mentored, frequency and content

599 of reports by the mentor to the state member board and how long the practice is to be mentored. The
600 board's expectations should be communicated both to the mentor and the licensee/applicant being
601 mentored.

602
603 The practice mentor should be required to demonstrate to the board's satisfaction that he/ she has the
604 capacity to serve as a practice mentor, for example, sufficient time for mentoring, lack of disciplinary
605 history, proof of an active, unrestricted medical license, and/or demonstration of a prescribed number
606 of years in clinical practice. The practice mentor may be permitted to receive financial compensation or
607 incentives for work associated with practice mentoring. Potential sources of bias should be identified
608 and in some cases may disqualify a potential mentor from acting in that capacity.

609
610 State member boards should work with the state medical and osteopathic societies and associations and
611 the medical education community to identify and increase the pool of potential practice mentors. For
612 example, to protect the pool of mentors, some SMBs have made them agents of the board.

613
614 **Guideline 8: Transition to a Full Unrestricted License**

615
616 Physicians who have gone through a reentry process and receive a full, unrestricted license should then
617 be subject to the same rules and regulations as other licensees.

618 **Improving Regulation of Licensed Practitioners Who Are Clinically Inactive**

619
620 State member boards should implement the following mechanisms to improve regulation of licensed
621 practitioners who are clinically inactive but may return to clinical practice in the future.

622
623 **Guideline 9: Identifying Clinically Inactive Licensees**

624
625 State member boards should require licensees to report information about their practice as part of the
626 license renewal or registration process, including: type of practice, status (e.g., full-time, part-time,
627 number of hours worked per week), whether they are actively seeing patients, specialty board
628 certification status, and what activities they are engaged in if they are not engaged in clinical practice
629 (e.g., research, administration, non-medical work, retired, etc.). Such information will enable SMBs to
630 identify licensees who are not clinically active and to intervene and guide, as needed, if and when a
631 licensee chooses to return to patient care duties. State member boards should advise licensees who are
632 clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior
633 to resuming patient care duties.

634
635 The report of the FSMB Workgroup to Define Minimal Data Set is expected to provide additional
636 recommendations regarding a minimal physician demographic data set that state member boards
637 should collect as part of the licensure process. In addition, the report of the FSMB Maintenance of
638 Licensure Workgroup on Non-Clinical Physicians is expected to provide recommendations regarding how
639 non-clinically active physicians may participate in a state member board's MOL program and how
640 participation in such a program should be evaluated at the time of reentry to clinical practice.

641
642 **Guideline 10: Licensure Status**

643
644 Licensees who are clinically inactive should be allowed to maintain their licensure status as long as they
645 pay the required fees and complete any required continuing medical education or other requirements

646 as set forth by the board. Upon a licensee's decision to return to clinical practice, he or she should be
647 required to participate in a reentry process.

648

649 **Guideline 11: Consistency of Reentry across Jurisdictions**

650

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

658 **Relationship between Licensure and Specialty Certification**

659

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

667

668 **Guideline 12: Maintenance of Specialty Certification**

669

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

673 **IMPLICATIONS FOR STATE MEMBER BOARDS AND THE ROLE OF FSMB**

674

675 The Special Committee on Reentry to Practice discussed possible implications of reentry on SMBs and
676 the role of the FSMB in implementing the Special Committee's recommendations. For state member
677 boards, there will be a need to review and perhaps revise their medical practice acts, to consider
678 staffing, costs and resource issues, to modify license application and renewal forms, to integrate reentry
679 with MOL activities and to initiate proactive communications with prospective and current
680 licensees/applicants.

681

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

684

- 685 • FSMB should develop a uniform set of questions for SMBs to add to their license renewal
686 application.
- 687 • Once guidelines are adopted as policy, FSMB should offer advice and consultation to their
688 member boards.
- 689 • FSMB should commit to reviewing its reentry recommendations and policy every three to five
690 years to ensure it remains current.

- 691 • FSMB could develop standards for language, forms and checklists to assist in implementation.
692 For example, FSMB could provide sample guidance on issues like the importance of engaging in
693 clinical practice, if even on a limited and part-time basis, or seeking counsel from their insurance
694 carriers prior to withdrawal from practice.
- 695 • FSMB can help share best practices, information and resources across states through
696 conferences, the FSMB Annual Meeting, publications and web-based reporting tools.

697 **CONCLUSION AND NEXT STEPS**

698
699 Widespread and well-defined physician reentry processes will probably not be fully realized nationwide
700 for several years. During that time, the Special Committee recommends that FSMB launch a systematic
701 effort to encourage states to share with each other what is working and what may need improvement in
702 order to define best practices. Most immediately, there is a need to understand the magnitude of the
703 problem.

704
705 As indicated in Guideline 9, state member boards should require licensees/applicants to report
706 information about their practice as part of the license renewal or registration process. When these data
707 are collected nationwide and reported, there will be a much stronger understanding of the opportunity
708 to increase the physician and physician assistant workforce.

709
710 Secondly, there is a significant need to develop an evidence base for reentry. Research is needed
711 about the type and degree of assessment that is required to determine educational needs. Another
712 question deserving study is the effectiveness of various types of reentry programs.

713
714 Finally, the short and long term results of reentry programs must be evaluated. Although there is
715 evidence from the existing reentry programs that most physicians who begin a reentry program
716 complete it successfully, more systematic research needs to be undertaken, especially regarding the
717 two-year time frame precedent. Also, longer term follow up studies will be necessary to determine if
718 those completing program make a successful transition to practice and what, if any, obstacles they may
719 encounter.
720
721

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723

ATTACHMENT A

724 **SPECIAL COMMITTEE DESIRED OUTCOMES**

725

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

727

- 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.

728

729

- 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.

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- 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.

737

738

739

- 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.

740

741

742

- 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.

743

744

745

746

- 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).

747 **THE AUDIENCE, SCOPE AND ORGANIZATION OF THE SPECIAL COMMITTEE REPORT**

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749

750

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

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756

- 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.

757

758

759

- 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.

760

761

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763

- 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.

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- 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.

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782 **GLOSSARY**

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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.

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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.

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794

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

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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

799
800
801
802

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

803
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805

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

806
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808

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

809
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811
812

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.

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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.

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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.)

824
825
826

827 **Osteopathic Continuous Certification:** The American Osteopathic Association's Bureau of
828 Osteopathic Specialists (BOS) has mandated that each specialty certifying board
829 implement "Osteopathic Continuous Certification" (OCC). OCC will serve as a way for board
830 certified DOs can maintain currency and demonstrate competency in their specialty area.
831

832 **Physician Reentry Program (PREP):** Structured curriculum and clinical experience which
833 prepared physicians to return to clinical practice following an extended period of clinical
834 inactivity.
835

836 **Physician Reentry Program (PREP) System:** Provides a way of organizing and planning physician
837 reentry programs.
838

839 **Physician Retraining:** The process of updating one's skill or learning the necessary skills to move
840 into a new clinical area.
841

842 **State Member Boards:** State medical and osteopathic licensing boards that oversee the
843 activities of the physicians licensed in the states, District of Columbia and U.S. Territories,
844 assuring that a high standard of practice by the physicians is maintained. (Adapted from
845 McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies,
846 Inc.)
847

849

REENTRY BARRIERS

850

(from the Physician Reentry into the Workforce Project

851

of the American Academy of Pediatrics)

852

853 The Physician Reentry into the Workforce Project maintains that decisions to leave and then reenter the

854 workforce should be regarded as part of a physician's career trajectory, and not as an unusual event.

855 Physicians who are considering leaving clinical practice, as well as those who are planning to reenter,

856 should understand and acknowledge that there can be barriers to this process. Not all physicians will

857 encounter all or even most of these barriers on the following list, but it is wise to be prepared.

858

859 • Physician/Practitioner Factors:

860

861 ▪ Lack of confidence and/or psychological concerns;

862 ▪ Lack of knowledge and skills, both clinical and documentation skills (i.e., EMR
863 experience);864 ▪ Lack of experience and comfort with other technological advances (i.e., internet
865 searches, PDA use, etc.);866 ▪ Lack of knowledge of requirements, sometimes leading to decisions that cause difficulty
867 in returning (such as allowing a license to lapse or become inactive);868 ▪ Failure to maintain knowledge in their clinical specialty because they do not
869 anticipate a return to medicine;870 ▪ “Unconscious incompetence” – even though the practitioner may have tried to
871 prepare, s/he may be unaware of or unable to anticipate all areas in which s/he
872 needs to update; inability to self-assess educational needs relative to the needs of the
873 prospective practice setting; personal feelings of adequacy or ability to
874 practice medicine as needed;

875 ▪ Pride: difficulty admitting that one is in need of further training;

876 ▪ Lack of time to address the educational needs; and inability to plan for oneself
877 how to address the needs;

878 ▪ Difficulty determining when the educational gap is sufficiently addressed.

879

880 • Licensure and Licensing Board Factors:

881

882 ▪ Failure to educate practitioners who allow their license to lapse of these
883 requirements and potential consequences;884 ▪ Requirements that may be vague, arbitrary, and may have changed over time (or may in
885 the future);

886 ▪ Requirements that differ in vigor from state to state;

887 ▪ Limited options given by which to demonstrate competence for any given state;

888 ▪ Limited means available by which to demonstrate competence;

889 ▪ Lack of understanding whether the options to demonstrate competence actually do so;
890 lack of understanding of what can be used as a proxy for “competence”;

891

892 ○ Often the criteria used is hands-on patient care in the U.S. (and the only
893 criteria accepted by boards);

- 894 ○ If criteria exist (such as the “two-year rules”) they often do not
895 differentiate between specialties. For example, perhaps “hands-on” care is
896 more relevant for maintaining “competence” in surgical and procedural based
897 specialties, and the critical time out period should be different for
898 procedural and non-procedural specialties;
899 ○ Licensing organizations do not usually risk-stratify practitioners in
900 deciding how a physician should prove competency after a time away
901 (based on factors such as whether the practitioner is/was ever board
902 certified, or whether the physician has required to recertify periodically,
903 and has done so).
904
- 905 • Hospital and Other Privileging Bodies:
 - 906
 - 907 ▪ Discomfort with and/or lack of willingness to allow privileges to a physician who has not
908 been in recent clinical practice;
 - 909 ▪ Significant variations in this comfort level between hospitals (even for the same
910 specialty);
 - 911 ▪ Varying ability to provide proctoring or work with physicians in a staged re-entry process
912 (i.e., gradually lessening levels of supervision);
 - 913 ▪ Hesitance of managed care organizations and medical insurance companies to accept a
914 re-entering physician onto their provider panel.
915
 - 916 • Liability Coverage Factors:
 - 917
 - 918 ▪ Discomfort with and/or lack of willingness to provide liability coverage to a
919 physician who has not been in recent clinical practice;
 - 920 ▪ Significant variations in this comfort level between insurers and from individual
921 to individual.
922
 - 923 • Prospective Employer Factors:
 - 924
 - 925 ▪ As with all the other levels, lack of understanding of how to judge competence of a
926 clinician who does not have recent clinical experience;
 - 927 ▪ Limited availability of flexible work options;
 - 928 ▪ Lack of support from the institution and colleagues for those integrating back into the
929 workplace.
930
 - 931
 - 932
 - 933 • Re-Entry Program Factors:
 - 934
 - 935 ▪ Discomfort with and lack of practicality in providing a “certificate of
936 competence”;
 - 937 ▪ Variability in what each program can offer to the practitioner and offer to the
938 prospective board/hospital/malpractice insurer, etc.
 - 939 ▪ Limited availability of sites where re-entry programs can provide hands on
940 clinical experiences for physicians because of the above factors;

- 941 ▪ Cost of and distance to established programs; need for convenient and affordable
- 942 programs;
- 943 ▪ Need for flexible programs;
- 944 ▪ Lack of standardization of how these evaluations are done and/or reentry process is
- 945 conducted.

946

- 947 • Home and family barriers: ongoing needs such as childcare and needs of other
- 948 family/household members;

949

- 950 • Multi-level Factors:

- 951 ▪ Multiple different layers of regulating and certifying bodies with different criteria
- 952 for demonstration of aptitude and proficiency (which may or may not equate to
- 953 competence), all of which the practitioner must fulfill; for example, requirements
- 954 to maintain specialty board certification are not considered adequate
- 955 demonstration of competence by boards and licensing authorities;
- 956 ▪ Unclear who is/should be the decision-maker in such matters;
- 957 ▪ Need for counseling to provide direction regarding the kind of learning and
- 958 training needed.

959

960

961

962 For more information on The Physician Reentry into the Workforce Project visit

963 www.physicianreentry.org

964

965 *Physician Reentry into the Workforce Project. Issue Brief: Reentry Barriers. Elk Grove Village, Ill. American*

966 *Academy of Pediatrics; 2010.*

967

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.

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1007

ATTACHMENT E

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1009

STATE MEMBER BOARD RESOURCES

1010 **Oregon Administrative Rules on Reentry for Physician Assistants**

1011 **Oregon Administrative Rules on Reentry for Physicians**

1012 **North Carolina Rule on Reentry to Practice**

1013 **Nebraska Reentry License**

1014
1015 **OREGON MEDICAL BOARD PROPOSED RULE ON REENTRY FOR PHYSICIAN ASSISTANTS**
1016 **CHAPTER 847, DIVISION 050 – OREGON MEDICAL BOARD**
1017 **PROPOSED RULES CHANGES - FIRST REVIEW – JULY 2011**

1018 **Proposed rule amendment establishes requirements for re-entry to practice after ceasing practice for**
1019 **more than one year and contains general language and grammar housekeeping.**

1020 **847-050-0043**

1021 Inactive Registration and Re-Entry to Practice

1022 (1) Any physician assistant licensed in this state who changes location to some other state or
1023 country, or who is not in a current supervisory relationship with a licensed physician for 6 months or
1024 more, will be listed by the Board as inactive.

1025 (2) If the physician assistant wishes to resume active status to practice in Oregon, the physician
1026 assistant must submit the Affidavit of Reactivation and processing fee, satisfactorily complete the
1027 reactivation process and be approved by the Board before beginning active practice in Oregon.

1028 (3) The Board may deny active registration if it judges the conduct of the physician assistant
1029 during the period of inactive registration to be such that the physician assistant would have been denied
1030 a license if applying for an initial license

1031 (4) If a physician assistant applicant has ceased practice for a period of 12 or more consecutive
1032 months immediately preceding the application for licensure or reactivation, the applicant may be
1033 required to do one or more of the following:

1034 (a) Obtain certification or re-certification by the National Commission on the Certification of
1035 Physician Assistants (N.C.C.P.A.);

1036 (b) Provide documentation of current N.C.C.P.A. certification;

1037 (c) Complete 30 hours of Category I continuing medical education acceptable to the Board for
1038 every year the applicant has ceased practice;

1039 (d) Agree to increased chart reviews upon re-entry to practice.

1040 (5) The physician assistant applicant who has ceased practice for a period of 24 or more
1041 consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The
1042 Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan.
1043 Depending on the amount of time out of practice, the re-entry plan may contain one or more of the
1044 requirements listed in section (4) of this rule and such additional requirements as determined by the
1045 Board.

1046 Stat. Auth.: ORS 677.265

1047 Stats. Implemented: ORS 677.512

1048

1049

1050 **OREGON PROPOSED ADMINISTRATIVE RULES FOR PHYSICIANS**

1051 **CHAPTER 847, DIVISION 020 – OREGON MEDICAL BOARD**

1052 **FIRST REVIEW RULE ADOPTION – OCTOBER 2011**

1053

1054 **The amendment includes the new Osteopathic school opening in Oregon and clarifies the standards**
1055 **for re-entry to practice.**

1056

1057

1058 **847-020-0183**

1059 Re-Entry to Practice – SPEX or COMVEX Examination, Re-Entry Plan and Personal Interview

1060

1061 If an applicant has ceased the practice of medicine for a period of 12 or more consecutive months
1062 immediately preceding the application for licensure or reactivation, the applicant may be required to
1063 demonstrate clinical competency.

1064

1065 (1) The applicant who has ceased the practice of medicine for a period of 12 or more consecutive
1066 months may be required to pass the Special Purpose Examination (SPEX) or Comprehensive Osteopathic
1067 Medical Variable-Purpose Examination (COMVEX). This requirement may be waived if the applicant has
1068 done one or more of the following:

1069

1070 (a) The applicant has received a current appointment as Professor or Associate Professor at the Oregon
1071 Health and Science University or the Western University of Health Sciences College of Osteopathic
1072 Medicine of the Pacific; or

1073

1074 (b) The applicant has within ten years of filing an application with the Board:

1075

1076 (A) Completed one year of an accredited residency, or an accredited or Board-approved clinical
1077 fellowship; or

1078

1079 (B) Been certified or recertified by a specialty board recognized by the American Board of Medical
1080 Specialties or the American Osteopathic Association; or

1081

1082 (c) The applicant has subsequently:

1083

1084 (A) Completed one year of an accredited residency, or

1085

1086 (B) Completed one year of an accredited or Board-approved clinical fellowship, or

1087

1088 (C) Been certified or recertified by a specialty board recognized by the American Board of Medical
1089 Specialties or the American Osteopathic Association, or

1090

1091 (D) Obtained continuing medical education to the Board's satisfaction.

1092

1093 (2) The applicant who has ceased the practice of medicine for a period of 24 or more consecutive
1094 months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must
1095 review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the
1096 amount of time out-of-practice, the applicant may be required to do one or more of the following:
1097
1098 (a) Pass the SPEX/COMVEX examination;
1099
1100 (b) Practice for a specified period of time under a mentor/supervising physician who will provide
1101 periodic reports to the Board;
1102
1103 (c) Obtain certification or re-certification by a specialty board recognized by the American Board of
1104 Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists
1105 (AOA-BOS);
1106
1107 (d) Complete a re-entry program as determined appropriate by the Board;
1108
1109 (e) Complete one year of accredited postgraduate or clinical fellowship training, which must be pre-
1110 approved by the Board's Medical Director;
1111
1112 (f) Complete at least 50 hours of Board-approved continuing medical education each year for the past
1113 three years.
1114
1115 (3) The applicant who fails the SPEX or COMVEX examination three times, whether in Oregon or other
1116 states, must successfully complete one year of an accredited residency or an accredited or Board-
1117 approved clinical fellowship before retaking the SPEX or COMVEX examination.
1118
1119 (4) The Limited License, SPEX/COMVEX may be granted for a period of up to 6 months. It permits the
1120 licensee to practice medicine only until the grade results of the SPEX or COMVEX examination are
1121 available and the applicant completes the initial registration process. If the applicant fails the SPEX or
1122 COMVEX examination, the Limited License SPEX/COMVEX becomes invalid, and the applicant must
1123 cease practice in this state as expeditiously as possible, but not to exceed two weeks after the applicant
1124 receives notice of failure of the examination.
1125
1126 (5) The applicant may be required to appear before the Board for a personal interview regarding
1127 information received during the processing of the application. The interview must be conducted during
1128 a regular meeting of the Board.
1129
1130 (6) All of the rules, regulations and statutory requirements pertaining to the medical school graduate
1131 remain in full effect.
1132
1133 Stat. Auth.: ORS 677.175, 677.265
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1135 Stats. Implemented: ORS 677.010, 677.175, 677.265
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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 reenter 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.

1184 (h) The second component of the reentry plan is education. Education shall address the licensee's areas
1185 of needed improvement. Education shall consist of:

- 1186 (1) a reentry period of retraining and education under the guidance of a mentoring
1187 physician, upon terms as the Board may decide, or
1188 (2) a reentry period of retraining and education under the guidance of a mentoring
1189 physician consisting of the following:
- 1190 (A) Phase I – The observation phase. During the observation phase, the licensee
1191 will not practice, but will observe the mentoring physician in practice.
 - 1192 (B) Phase II – Direct supervision phase. During the direct supervision phase, the
1193 licensee shall practice under the direct supervision of the mentoring physician.
1194 Guided by the core competencies, the mentoring physician shall reassess the
1195 licensee's progress in addressing identified areas of needed improvement.
 - 1196 (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the
1197 licensee shall continue to practice with supervision of the mentoring physician.
1198 Guided by the core competencies, and using review of patient charts and
1199 regular meetings, the mentoring physician shall reassess the licensee's progress
1200 in addressing the areas of needed improvement.
 - 1201 (D) No later than 30 days after the end of phase I and II, the mentoring physician
1202 shall send a report to the Board regarding the licensee's level of achievement in
1203 each of the core competencies. At the completion of phase III the mentoring
1204 physician shall submit a summary report to the Board regarding the licensee's
1205 level of achievement in each of the core competencies and affirm the licensee's
1206 suitability to resume practice as a physician or to resume practice as a physician
1207 assistant.
 - 1208 (E) If the mentoring physician reassesses the licensee and concludes that the
1209 licensee requires an extended reentry period or if additional areas of needed
1210 improvement are identified during Phases II or III, the Board, the licensee and
1211 the mentoring physician shall amend the reentry agreement.

1212
1213 (i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring
1214 physician may terminate his role as the mentoring physician upon written notice to the Board. Such
1215 written notice shall state the reasons for termination. The licensee's approval is not required for the
1216 mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of
1217 termination, the Board shall place the licensee's license on inactive status. Within six months from the
1218 effective date of the mentoring physician's termination, the licensee shall provide a substitute
1219 mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon
1220 such terms as are acceptable to the Board. In such event, an amended reentry agreement must be
1221 executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as
1222 required herein within six months from the effective date of the mentoring physician's termination, then
1223 the Board shall not return the licensee to active status unless and until licensee applies and is approved
1224 for reactivation of the license with a new reentry agreement and reentry plan, which must be in place
1225 before licensee may resume practice as a physician or physician assistant.

1226
1227 (j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may
1228 terminate the relationship with the mentoring physician upon written notice to the Board. Such written
1229 notice shall state the reasons for termination. The mentoring physician's approval is not required for
1230 the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall
1231 place the licensee's license on inactive status. Within six months from the effective date of the

1232 mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who
1233 must be approved by the Board in writing, and resume the reentry plan upon such terms as are
1234 acceptable to the Board. In such event, an amended reentry agreement must be executed prior to
1235 resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within
1236 six months from the effective date of the mentoring physician's termination, then the Board shall not
1237 return the licensee to active status unless and until licensee applies and is approved for reactivation of
1238 the license with a new reentry agreement and reentry plan, which must be in place before licensee may
1239 resume practice as a physician or physician assistant.

1240
1241 (k) The licensee shall meet with members of the Board at such dates, times and places as directed by
1242 the Board to discuss the licensee's transition back into practice and any other practice-related matters.

1243
1244 (l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry
1245 agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's
1246 license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

1247
1248 (m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall
1249 terminate the reentry agreement and notify the licensee that the license is no longer restricted.

1250

1251 *History Note: Authority G.S. 90-8.1; 90-14(a)(11a);*
1252 *Eff. March 1, 2011.*

1253

1254 **NEBRASKA REENTRY LICENSE**

1255 TITLE: Provide for reentry licenses under the Medicine and Surgery Practice Act

1256 05/12/2011 PASSED ON FINAL READING 46-0-3.

1257 05/12/2011 PRESIDENT/SPEAKER SIGNED.

1258 05/12/2011 PRESENTED TO GOVERNOR ON MAY 12, 2011.

1259

1260 (1)(a) Present proof that he or she is a graduate of an accredited school or college of medicine, (b) if a
1261 foreign medical graduate, provide a copy of a permanent certificate issued by the Educational
1262 Commission on Foreign Medical Graduates that is currently effective and relates to such applicant or
1263 provide such credentials as are necessary to certify that such foreign medical graduate has successfully
1264 passed the Visa Qualifying Examination or its successor or equivalent examination required by the
1265 United States Department of Health and Human Services and the United States Citizenship and
1266 Immigration Services, or (c) if a graduate of a foreign medical school who has successfully completed a
1267 program of American medical training designated as the Fifth Pathway and who additionally has
1268 successfully passed the Educational Commission on Foreign Medical Graduates examination but has not
1269 yet received the permanent certificate attesting to the same, provide such credentials as certify the
1270 same to the Division of Public Health of the Department of Health and Human Services;

1271 (2) Present proof that he or she has served at least one year of graduate medical education approved by
1272 the board or, if a foreign medical graduate, present proof that he or she has served at least three years
1273 of graduate medical education approved by the board;

1274 (3) Pass a licensing examination approved by the board covering appropriate medical subjects; and

1275 (4) Present proof satisfactory to the department that he or she, within the three years immediately
1276 preceding the application for licensure, (a) has been in the active practice of the profession of medicine
1277 and surgery in some other state, a territory, the District of Columbia, or Canada for a period of one year,
1278 (b) has had at least one year of graduate medical education as described in subdivision (2) of this
1279 section, (c) has completed continuing education in medicine and surgery approved by the board, (d) has
1280 completed a refresher course in medicine and surgery approved by the board, or (e) has completed the
1281 special purposes examination approved by the board.

1282 Sec. 3. (1) The department, with the recommendation of the board, may issue a reentry license to a
1283 physician who has not actively practiced medicine for the two-year period immediately preceding the
1284 filing of an application for a reentry license or who has not otherwise maintained continued competency
1285 during such period as determined by the board.

1286 (2) To qualify for a reentry license, the physician shall meet the same requirements for licensure as a
1287 regular licensee and submit to evaluations, assessments, and an educational program as required by the
1288 board.

1289 (3) If the board conducts an assessment and determines that the applicant requires a period of
1290 supervised practice, the department, with the recommendation of the board, may issue a reentry
1291 license allowing the applicant to practice medicine under supervision as specified by the board. After
1292 satisfactory completion of the period of supervised practice as determined by the board, the reentry
1293 licensee may apply to the department to convert the reentry license to a license issued under section
1294 38-2026.

1295 (4) After an assessment and the completion of any educational program that has been prescribed, if the
1296 board determines that the applicant is competent and qualified to practice medicine without
1297 supervision, the department, with the recommendation of the board, may convert the reentry license to
1298 a license issued under section 38-2026.

1299 (5) A reentry license shall be valid for one year and may be renewed for up to two additional years if
1300 approved by the department, with the recommendation of the board.

1301 (6) The issuance of a reentry license shall not constitute a disciplinary action.

1302

ENDNOTES

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- ² Federation of State Medical Boards. *FSMB Report Provides Roadmap for Maintenance of Licensure*. *Fsmb.org*. Federation of State Medical Boards, 28 Apr. 2010. Web. 4 Sept. 2011.
- ³ Grace, et al: Physicians Reentering Clinical Practice: Characteristics and Clinical Abilities. *Journal of Continuing Education in the Health Professions*. 2011; 31(1):49-55. Print.
- ⁴ Mulvey, MA, Holly J., Ethan A. Jewett, MA, Alicia Merline, PhD, and Kelly J. Towey, MEd. "Pediatricians Over 50 Reentering Clinical Practice: Implications for Physicians and the Regulatory Community." *Journal of Medical Regulation* 96.2 (2010): 7-12. Print.
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- ¹⁰ *The Physician Reentry into the Workforce Project - Home*. Web. 20 Jan. 2011. <http://www.physicianreentry.org/>.
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- ¹² Freed, G., L. Abraham, and K. Brzoznowski. "Inactive Physicians: The State of Our Understanding." *The Journal of Pediatrics* 151.4 (2007): 431-34. Print.
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October 2011

Midwestern Licensure Portability Grant Program

The Declaration of Cooperation

The Declaration of Cooperation (DOC) and expedited endorsement attachments are the culmination of over a year of discussion among members of the Task Force, with input from an Advisory Committee. The Task Force is made up of Directors and Staff of ten Midwestern State Medical and Osteopathic Boards. The Advisory Committee is comprised of representatives from State Medical Societies, a Hospital Association, the Wisconsin Association - Medical Staff Services and the Public Health Law Network at William Mitchell College of Law.

The DOC is a non-binding agreement that does not obligate the Boards in any way, with the exception of the confidentiality provisions. It is intended to indicate each Board's recognition of the importance of licensure portability, regional cooperation and a commitment to pursue the legal, administrative and policy changes to improve licensure portability through expedited endorsement.

The Task Force approached the DOC and expedited endorsement attachments by balancing each Board's current licensure requirements with the proposed best practices. In most cases, the Boards had similar, if not identical, requirements. In other cases, the Boards' requirements differed slightly. When differences emerged, the negotiations commenced by relying on a "highest common denominator" approach to ensure that the Boards with more stringent requirements maintained them. The highest common denominator approach was important because the purpose of the DOC and attachments was not to lessen any Board's current requirements. Rather, it was to maintain each Board's ability to protect the public while improving licensure portability.

The developed expedited endorsement attachments describe a more efficient process through which the physicians with demonstrated competence and safety can obtain licensure in multiple states. It will improve the ability of physicians that pose the least threat to the public to obtain licenses in multiple states by reducing the redundancies of state-specific application requirements and decreasing the complexity in obtaining multiple licenses with highly variable requirements.

Still, the expedited endorsement requirements and process attached to the DOC are merely foundation standards that should not limit a Board's ability to expedite licenses from states outside of the region or use different criteria. The DOC and attachments are only intended to describe the best practices as identified by the Task Force. Still, the more Boards that fully adopt the expedited endorsement attachments as written, the greater licensure portability becomes in our region.

Therefore, please consider moving to approve the Midwestern Licensure Portability Grant Program Declaration of Cooperation and Expedited Endorsement Attachments.

Grant Program Information

- Title: American Recovery and Reinvestment Act (ARRA) Licensure Portability Grant Program
- Amount: \$498,000
- Grant Period: March 2010 – February 2012
- Grantor: Health Resources and Services Administration of U.S. Department of Health and Human Services
- Grantee: Wisconsin Department of Safety and Professional Services of which the Wisconsin Medical Examining Board is part
- Purpose: Create a multi-state Task Force that will, through a collaborative process, implement an interstate licensure portability program that reduces and eliminates statutory and regulatory barriers to cross-border licensing.
- Task Force States:
 - Illinois
 - Indiana
 - Iowa
 - Kansas
 - Michigan
 - Minnesota
 - Missouri
 - South Dakota
 - Wisconsin
- The Advisory Committee provided practical, non-governmental input into the Task Force's proposals and reviewed the Task Force's proposals to determine how they may affect practicing physicians in the states.
 - Members:
 - Illinois State Medical Society
 - Indiana State Medical Association
 - Iowa Medical Society
 - Kansas Medical Society
 - Minnesota Medical Association
 - Wisconsin Medical Society
 - Wisconsin Association- Medical Staff Services
 - Wisconsin Hospital Association
 - Public Health Law Center at the William Mitchell College of Law

Midwest Licensure Portability Task Force

Declaration of Cooperation

WHEREAS, the Parties to this Declaration have developed licensure standards and procedures to ensure public health and safety within their jurisdictions using their authority to interpret and implement laws, draft administrative rules and develop licensure procedures;

WHEREAS, the Parties recognize that most of their licensure standards and procedures are identical or substantially similar to the licensure standards and procedures of the other Parties;

WHEREAS, the licensure procedures that physicians must complete to obtain a license to practice medicine in multiple Parties' jurisdictions are redundant and may be onerous to physicians applying to multiple jurisdictions;

WHEREAS, the Parties have information about physicians currently licensed by them that is pertinent to the licensure decisions made by other Parties and other jurisdictions;

WHEREAS, there is no national or regional standard or process for Parties to share information pertinent to another jurisdiction's licensure decision with the other jurisdiction;

NOW, THEREFORE, the Parties, by a representative, freely and voluntarily sign onto this Declaration under the following terms and conditions:

1. Definitions

When used in this Declaration, the following terms have the meanings ascribed below:

- a) **Confidential Information** is any information of a Disclosing Party that it is obligated by statute, rule or other law not to disclose, whether or not marked or designated as confidential. It may include, but is not limited to, filed complaints and information regarding a Pending Investigation.
- b) A **Disclosing Party** is a Party to this Declaration which discloses its Confidential Information to a Receiving Party.
- c) The **Expedited Endorsement Process** is a licensure process that reduces and eliminates redundancies associated with applying for licensure in multiple jurisdictions while allowing Parties to retain their current licensing discretion.
- d) **Licensure Portability** is the ability of a license holder to obtain and maintain licenses granted by multiple jurisdictions.
- e) A **Pending Investigation** is a public or confidential investigation that is ongoing within a medical or osteopathic board or other licensing authority.

- f) A **Party** is a state medical board, osteopathic board or other licensing authority that signs onto to this Declaration.
- g) A **Receiving Party** is a Party to this Declaration which accepts, receives, views, or otherwise obtains Confidential Information from a Disclosing Party.
- h) The **Steering Committee** is made up of two (2) members of the Task Force that represent two (2) different Parties. The Steering Committee is responsible for planning and leading Task Force meetings and ensuring the Task Force makes progress.
- i) The **Task Force** is the Midwest Licensure Portability Task Force. It is made up of one (1) or two (2) representatives of each Party to this Declaration.

2. Purposes

The purposes of this Declaration are for the Parties to cooperate to:

- a) Improve the Parties' licensure procedures, creating more efficient processes for sharing relevant information among Parties and ensuring that public health and safety are fully protected in each Party's jurisdiction;
- b) Improve the ability of physicians who meet the requirements delineated in Section 9 and Attachments to obtain licenses to practice medicine in multiple jurisdictions;
- c) Improve the quality and increase the quantity of relevant information Parties share among themselves during a Party's licensure decision-making procedures; and
- d) Identify the current and potential issues facing the Parties that may be best addressed through interstate cooperation and to develop and implement a plan to solve any such identified issues.

3. Scope & Authority

This Declaration is a voluntary and, unless otherwise noted, nonbinding agreement among the Parties. Unless expressly stated, nothing in this Declaration is intended to create a legal obligation or create any right in, or responsibilities to, third parties. However, with its signature on this Declaration, each Party declares its intent to:

- a) cooperate with the other Parties to pursue the legal, administrative, procedural and other changes or amendments required to become and remain compliant with the requirements and specifications delineated in Section 9 and Attachments;
- b) share information about physicians licensed by it with the other Parties that is necessary to other Parties' licensure and disciplinary decisions;
- c) abide by Sections 3 through 8; and
- d) be legally bound by the terms and conditions of Section 10.

This Declaration is not an exclusive agreement and shall not prevent or limit other agreements or declarations, unless inherently incompatible with this Declaration, among Parties to this Declaration or between Parties and other entities.

Nothing in this Declaration is to be construed as an encroachment on the full and free exercise of United States federal authority, as an interference with the just supremacy of the United States or its several states, as affecting the federal structure of the United States or as enhancing the political power of the Parties at the expense of each other or other United States jurisdictions.

Nothing in this Declaration is to be construed in any way as an encroachment on the Parties' or any states' authority to grant licenses to physicians, regulate the practice of medicine within its jurisdiction or issue discipline to physicians.

All Parties warrant that they have the authority to sign this Declaration under their own laws and any other applicable laws or rules.

4. Effective Date

This Declaration is effective on the date that it is executed by any two (2) Parties, and is effective as to any other Party on the date that it is executed thereby. Nothing in this Declaration precludes additional parties with jurisdiction over licensing physicians from becoming Parties, subject to approval of the Steering Committee and a majority of current Parties.

The Declaration may be executed in multiple counterparts or duplicate originals, each of which shall constitute and be deemed as one and the same document.

5. Withdrawal

Parties are free to withdraw from this Declaration by sending written notice of intent to withdraw to the Steering Committee and other Parties. A Party's withdrawal shall be effective thirty (30) days after written notice of intent to withdraw is sent to the Steering Committee and other Parties.

6. Organization & Meetings

One (1) or two (2) representatives designated by each Party shall constitute the Task Force. A Party only gets one vote on business before the Task Force, whether it is represented by one (1) or two (2) people.

The Task Force shall be governed by the Steering Committee made up of two (2) members of the Task Force that represent different Parties. The two (2) members of the Steering Committee will be Co-Chairs of the Steering Committee and have equal rights and responsibilities. The Co-Chairs of the Steering Committee shall be voted on by the Task Force, including the current Co-Chairs of the Steering Committee, at every other required annual meeting.

As needed, the Task Force shall have at least one (1) annual meeting per calendar year. Every meeting shall be scheduled and conducted by the Steering Committee. The purpose of each required annual meeting shall be:

- a) to discuss Parties' licensure laws, rules and procedures;
- b) to review the Declaration and propose new issues that may need to be addressed; and
- c) to discuss other relevant information as determined by the Steering Committee.

The Steering Committee may schedule additional meetings.

7. Reports to Parties

Parties' representatives on the Task Force shall report progress, results and recommendations to the Parties during the Parties' scheduled meetings.

8. Amendments to this Declaration

At any time, a Party may propose amendments to this Declaration. The Steering Committee shall either conduct a meeting in addition to the annual meeting for the Task Force to vote on the amendment or have the Task Force vote on the amendment at the subsequent annual meeting. Approval by a majority of Parties is required to amend this Declaration.

9. Common Expedited Endorsement Process

Parties agree to use the Expedited Endorsement Process described in Attachment 2 for physician applicants who meet the eligibility requirements described in Attachment 1, both of which are incorporated by reference herein as though fully set forth.

10. Use of Confidential Information

By signing this Declaration, Parties agree to be legally bound by the terms and conditions of this Section and related definitions. Therefore, this Section is intended to create a legal obligation on the Parties. Confidential Information shall be maintained and kept by a Receiving Party according to the law by which the Receiving Party is bound and for the reasons intended by the Disclosing Party. A Receiving Party will endeavor to protect Confidential Information received from the Disclosing Party to the fullest extent permissible under law. A Receiving Party shall at a minimum apply a reasonable standard of care to prevent the unauthorized disclosure, dissemination or use of Confidential Information.

Receiving Party shall permit access to Disclosing Party's Confidential Information only to its employees who must know such information for furthering the specific expedited licensure objectives of the Parties to this Declaration.

Receiving Party shall not disclose, permit access to or share Confidential Information with another medical board, osteopathic board or licensing authority that is not a Party to this Declaration.

No term of this Declaration is intended to compel the disclosure of Confidential Information that a Party is prohibited from sharing with other Parties by statute, rule or other state law. To the extent that Confidential Information may be disclosed to another Party or other agency with jurisdiction over acts or conduct, or medical licensure, any Confidential Information disclosed shall not be redisclosed by the receiving agency except as otherwise authorized by law.

11. Severability

The provisions of this Declaration are severable. If any portion of this Declaration is determined by a court to be void, unconstitutional or otherwise unenforceable, the remainder of this Declaration will remain in full force and effect.

12. Signatures

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

Date

Party Name

Signature

Authorized Person Name

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**ATTACHMENT 1:
COMMON EXPEDITED ENDORSEMENT
ELIGIBILITY REQUIREMENTS**

When a physician holds a verified full, unrestricted, current and active license to practice medicine issued by any Party to the Declaration of Cooperation, it is presumptive evidence that the physician possesses the basic requisite skills and qualifications that each of the Parties require. While Parties retain discretion in their issuance of licenses, Parties agree that a common expedited endorsement licensure process should be available to the most qualified physicians.

Therefore, Parties agree to deploy the Common Expedited Endorsement Process, which is described in Attachment 2 and incorporated by reference herein as though fully set forth, to increase licensure portability by allowing physicians meeting or exceeding the following requirements to apply using a less redundant licensure process.

To be eligible to apply using the Common Expedited Endorsement Process, a physician must:

- Hold at least one verified, full, unrestricted, current and active license that was issued by a Party to the Declaration
- Not have ever held or currently hold a license that is or has ever been the subject of any Disciplinary Action¹
- Not currently hold a license that is the subject of any Pending Investigation²
- Not have ever withdrawn an application to practice medicine or ever had an application to practice medicine denied by any United States or Canadian jurisdiction's licensing authority
- Not be the subject of an unsatisfied Agreement for Corrective Action
- Have been engaged in the Active Practice of Medicine³ for at least three (3) years immediately preceding the application date

¹ A "Disciplinary Action" is a public or confidential restriction, sanction, condition, cancellation or other professional limitation issued by a medical or osteopathic board, licensing authority, hospital, clinic, federal agency or the United States military, surrendering a license for cause, an agreement to place a license in inactive status in lieu of any disciplinary action or an institution staff sanction in any United States or Canadian jurisdiction

Satisfied Agreements for Corrective Action, letters of warning and other expressly non-disciplinary measures used to resolve a complaint are not "Disciplinary Actions."

² A "Pending Investigation" is a public or confidential investigation that is ongoing within a medical or osteopathic board, licensing authority, hospital, clinic, federal agency or the United States military.

³ The "Active Practice of Medicine" includes private practice, employment in a hospital or clinical setting, employment by any governmental entity in community or public health or practicing administrative, academic or research medicine. It does not include residency, fellowships or postgraduate training of any kind.

Education:

- Be a graduate of an accredited medical school or college of osteopathic medicine:
 - For United States and Canadian graduates, this means that the school was a medical school accredited by the Liaison Committee on Medical Education (LCME) or a college of osteopathic medicine accredited by the American Osteopathic Association- Commission on Osteopathic College Accreditation (AOA-COCA)
 - For international graduates, this means that the school was recognized and approved by the Party from whom a license is sought and the physician possesses an “indefinitely valid” Educational Commission for Foreign Medical Graduates (ECFMG) Certificate or possesses a valid Fifth Pathway Certificate

Postgraduate Training:

- Have completed a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

Examinations:

- Have passed an examination or combination of examinations approved by the Party from whom a license is sought

Specialty Board Certification:

- Possess a current specialty board certification from the American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)
 - Lifetime certificate holders that are not currently engaged in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC) do not meet this requirement

Criminal Background Check:

- Have an acceptable criminal history as determined by the Party

State-Specific Requirements:

- Satisfy all licensure requirements of the Party from whom a license is sought

**ATTACHMENT 2:
COMMON EXPEDITED ENDORSEMENT
PROCESS**

When a physician holds a verified full, unrestricted, current and active license to practice medicine issued by any Party to the Declaration of Cooperation, it is presumptive evidence that the physician possesses the basic requisite skills and qualifications that each of the Parties require. The presumption is valid because each Party undertakes similar, if not the same, licensure review procedures. While Parties retain discretion in their issuance of licenses, Parties agree that a regional expedited endorsement licensure process would complement their current licensure processes and improve the portability of the most qualified physicians.

Therefore, Parties agree to work towards deploying the following licensure review procedures when reviewing an applicant who satisfies the Common Expedited Endorsement Eligibility Requirements, which are described in Attachment 1 and incorporated by reference herein as though fully set forth. In doing so, Parties agree to work towards adopting licensure review procedures that follow to increase licensure portability:

- Parties may require applicants to complete the Federation of State Medical Boards' Uniform Application
 - Applicants must:
 - Disclose all malpractice history and provide documentation when requested
 - List all jurisdictions where he or she is currently or was previously licensed
 - Cause submission of verifications of all licenses currently or previously held
 - List the chronology of all activities for the time since completing medical school
 - Submit an NPDB-HIPDB Self-Query Report
- Upon receipt of an expedited endorsement application, Parties shall:
 - Obtain Electronic AMA or AOA Profiles
 - Both of which primary source verify ABMS/AOA Specialty Board Certification
 - Obtain an FSMB Disciplinary Report
 - Determine whether the applicant has an acceptable criminal history
- When a physician licensed by a Party applies for a license in a different Party's jurisdiction, the Party that already licensed the physician shall indicate, disclose or otherwise make known to the other Party whether there are any Pending Investigations, as defined by the Declaration, against the physician.
- Each Party retains the discretion to grant licenses to physicians within its jurisdiction according to its specific laws, policies and regulations.