Physicians Returning to Practice: Do They Have a Place on Your Medical Staff?

Session Code: TU15

Time: 2:30 p.m. – 4:00 p.m.

Total CE Credits: 1.5

Presenter: Elizabeth Korinek, MPH
Physician Reentry To Practice: Do they have a place on your medical staff?

Elizabeth J. Korinek, M.P.H.
Chief Executive Officer
CPEP
The Center for Personalized Education for Physicians

Objectives

• Understand the unique challenges faced by the medical staff when working with a physician who is returning to practice after a voluntary absence
• Consider implications for credentialing policies related to physicians who have a 2+ year practice gap
• Identify resources or processes to support the physician’s return to direct patient care activities
• Discuss case studies

Definition of “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”

AMA - State Medical Licensure Requirements and Statistics 2011

Key Points

• Participant is returning to the same specialty
• Participant left practice voluntarily, not due to disciplinary action
Common Reentry Situations

Seeking privileges after absence for:

• Time out to raise children or care for family member
• Pursuit of other career options (medical administrator, non-clinical career)
• Returning to practice after an illness
• Seeking to expand scope of practice (e.g., resume obstetrics care)
• Financial needs

U.S. Faces Shortage of Physicians

Shortage of up to 94,000 physicians by 2015*
– 31,000 primary care
– 64,000 surgeons and specialists

78% of hospital executives report physician shortages**
– 83% of hospital leaders “extremely concerned” or “somewhat concerned” about clinical staff vacancies

*American Association of Medical Colleges: Physician Supply and Demand through 2025: Key Findings. March 2015
**AMR Healthcare: Clinical Workforce Survey 2013

Medically Underserved Areas are Widespread

[Map of medically underserved areas]
Geographic Maldistribution

“The supply of physicians varies a lot depending upon the community… In some areas, the loss of just one subspecialist can be a big blow to the community.”

Greg D’Argonne
CFO, HCA-HealthONE & the HCA Continental Division

FSMB Census of Physicians 2014

• Aging physician population
  • 31% active licensed physicians > 60 yrs old
  • 55% active licensed physicians > 50 yrs old
• Changing gender distribution
  • 30% of female physicians are < 40 yrs old
  • 16% of male physicians are < 40 yrs old

“…The aging physician population and the shift in gender composition could have a considerable impact on health workforce determinations, considering the different work patterns ascribed to both male and female physicians.”

A Census of Activity: Licensed Physicians in the United States, 2014; Young et al., Journal of Medical Regulation Vol 101, No.2

Impact of Aging Physicians

A third or more of physicians could retire in the next decade*

*Based on AHA-Masterfile data. Source: HCS Inc. The Complexities of Physician Supply and Demand: Projections from 2013 to 2025: Key Findings, March 2015
Changing Models, Changing Needs

“Population health is best served at the primary care level and the supply of PCP’s is insufficient to meet demand…

the need to increase the number of providers, especially in the primary care field, is likely not going to stabilize for well over a decade.”

David Watson, M.D.
CMO, Centura Health Physician Group

AAMC Report on Physician Supply and Demand
March 2015

• Demand for physicians continues to grow faster than supply
• Total physician demand is projected to grow by 17%
• By 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000
  • In primary care, medical, and surgical specialties

Because physician training can take up to a decade, a physician shortage in 2025 is a problem that needs to be addressed in 2015.

HIS Inc. The Complexities of Physician Supply and Demand: Projections from 2013 to 2025: Key Findings, March 2015

Local Impact of Shortage

• Increasing cost and difficult to recruit candidates
• Financial impact of vacancy
  • Each month costs hospital $100,000 or more
• Strain on other providers when short staffed
Where’s the Magic Pill?

• Expanding the number of new physicians?
• Telemedicine?
• Working to grow the number of allied healthcare providers?

Pipeline for Physician Training

National Focus on Reentry

• Recognition that physicians reentering practice can help address provider shortage
• Responsibility to ensure competence and patient safety
• FSMB, AMA, ACOG releasing guidelines

Special Committee Report on Reentry to Practice
Federation of State Medical Boards

Physician Reentry: What Employers Need to Know
Physician Reentry into the Workforce Project sponsored by the AAP
www.physicanreentry.org
Reentry provides a Partial Solution

“Reentry physicians are like a ‘rapid deployment force’ - a relatively quick way to expand the number of practicing physicians when compared to expanding the medical school-residency-fellowship pipeline.”

Steven Summer
President, Colorado Hospital Association

Communities, patients, practices and healthcare systems benefit tremendously from helping good physicians return to clinical practice…(I)t is both appropriate and potentially more cost-effective to facilitate a physician’s return to practice than to recruit a new physician.”

Holly Mulvey, MA, Physician Reentry into the Workforce Project

However, skills fade

• Substantial evidence that time out of practice does impact an individual’s skills
  • Declines occur over periods ranging from 6 to 18 months, according to a curve, with steeper decline at the outset and more gradual decline as time passes

• Factors can mitigate skills fade
  • Keeping in touch with peers, staying aware of developments, etc.

• The higher the level of learning and proficiency prior to the break from work, the higher the level of retained skill

• There is evidence that self-assessment of competence does not necessarily match the findings of objective assessments

Graduate Medical Council; UK; Skills Fade Review
http://www.gmc-uk.org/about/research/26013.asp
Characteristics and Abilities of Reentry Physicians

62 physicians in CPEP Reentry to Clinical Practice Program

- Majority enrolled to demonstrate competence for licensure (79%)
- Time away from practice averaged 8 years
  - Range 1.5 to 23 years
- Majority were male (60%)
- Average age 54 years
  - (female 48; male 58)

Clinical Abilities of Reentry Physicians

- Many reentry physicians are not ready to “jump into” practice
- Increasing age and time away from practice correlate with more educational needs
- Physicians can successfully return to practice
  - Those with greater educational needs may need assistance

Participant Educational Needs

- Pervasive: 7%
- Significant: 34%
- Moderate: 35%
- Minimal: Ready for Practice, 24%

Characteristics and Clinical Abilities of Reentry Physicians; Elizabeth S. Grace, M.D. et al. Journal of Continuing Education in the Health Professions 2011; Reprinted: Journal of Medical Regulation 2011
Credentialing Conundrums
How would you proceed?

The Physician

The Hospital/Medical Group

CASE STUDIES

Roadmap to Reentry

The Roadmap provides direction for:
• Clinicians seeking to navigate the process of reentry after an absence
• Stakeholders to facilitate their work with reentry clinicians

www.roadmaptoreentry.org
Practical Considerations

- Licensure
- Specialty board certification
- Malpractice insurance
- Credentialing
- Practice circumstances and logistics
- Readiness to return

Licensure Requirements

2010

- 30 of 78 licensure boards had reentry policies, including requiring demonstration of competence

- Requirements for licensure vary
  - CME
  - Testing
  - Formal reentry program or self-guided plan

Ref: State Medical Licensure Requirements and Statistics, 2011, AMA

Licensure

How long is a lapse?
- 2 years in the most common cut off
- Range 1-5 years

AMA – State Medical Licensure Requirements and Statistics 2012
Board Certification

- Full and unrestricted license is a prerequisite for board certification
- May be required for employment or credentialing

What will it take to regain certification?

Health Plan Credentialing*

- Generally ask about gaps in practice
  - If > 2 years, want explanation for leave
  - Look for shadowing, working in a free clinic, reentry program or other educational activities
  - If concerns, may credential for 1 year and ask for an update/letter
    - This credential status would still be full and the physician could bill for services

*varies by company

Practice Considerations

- Determine scope of practice
  - Full spectrum or narrowed spectrum?
- Determine practice
  - Settings/responsibilities
Credentialing and Privileging Considerations

- Explanation of chronological gaps in education, training, or work history
- Handle exceptions on a case-by-case basis
- Minimum criteria for privileges usually include:
  - Documentation of training (residency, fellowship or other training) and/or
  - Performance of a minimum number of procedures within the previous 24 months

This can be a significant barrier for a clinician who has been out of practice for a number of years.

The BIG Question:
Is he/she ready to return to practice?

“We cannot step twice into the same river.”
Heraclitus of Ephesus (535 BC – 475 BC)

Goals

The Physician
Am I adequately prepared to return to practice?

The Hospital/Medical Group
Is this physician still competent to allow to practice?

Different but Overlapping
Challenge: Determine Current Competence

What criteria will be used for demonstration of current competence?

Challenge: Determine Education Needs

What are their educational needs?
  • The physician may self-identify needs
  • There may be additional needs of which the physician is unaware

Challenge: How to Prepare

• What resources are needed to retrain?
• What content areas need to be addressed for future practice setting?
• How do they reacquire technical skills

How do you know when educational needs are sufficiently addressed?
Paths to Reentry: Self-guided process

- Clinician undertakes self study and other activities to prepare for practice, including:
  - Review courses or online reading
  - Board certification preparation
  - Shadowing/volunteer
  - Identifies preceptor or consultation resources
- FPPE process of proctoring as resumes practice

Paths to Reentry: Reentry Programs

Ensure patient safety while supporting safe return to practice

A means to address the questions of both the clinician and the hospital/employer

- Inform hospital about the clinical competence of professional returning to practice
- Assist the clinician in the preparing for transition to practice
- Provides documentation/record of vetting/training process

Determining Educational Needs

“The literature indicates there is often a gap between a physician’s opinion of his or her competence vs. the results of an objective, third-party assessment.”

“Working with an established, structured assessment and education program may result in the best outcomes for reentry physicians and their prospective employers.”

Scott Kirby, M.D.
Medical Director, North Carolina Medical Board
Reentry Programs Vary

Initial educational needs assessment (evaluation)
- Some may begin with evaluation (1-2 days) to determine competence and direct education
- Others do not complete initial assessment

Educational components may include any of the following:
- CME: on-line; home study; in-person classes
- Observation (shadowing) in clinical setting
- Hands-on clinical experience in supervised setting (academic or community-based)

Directory of Reentry Programs

Physician Reentry into the Workforce Project
http://physician-reentry.org/program-profiles/reentry-program-links/

AMA website page on Physician Reentry

Pipeline for Physician Reentry

- Reentry process takes 4 to 12 months
- Physician usually has license to practice
- In some programs, the physician begins providing patient care early in this process
Reentry to Clinical Practice Program

- Founded in 2003
- Designed for professionals returning to practice following voluntary absence
  - Physicians
  - Physician Assistants
  - Podiatrists
  - Advanced Practice Nurses
- 187 participants from 31 states

Reentry Participants

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER</td>
<td>10</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>15</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>14</td>
</tr>
<tr>
<td>Surgical Specialties</td>
<td>10</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>12</td>
</tr>
<tr>
<td>PRIMARY CARE</td>
<td>100</td>
</tr>
</tbody>
</table>

Clinical Skills Evaluation

One-two day evaluation
- Reviews background – reason for leaving practice
- Tailored to the physician’s specialty and proposed practice
- Addresses core competencies (patient care/knowledge, communication, documentation, etc.)
- Report includes recommendations and reentry education plan
Reentry Education

Practice-based educational experiences
Completed in physician’s home community

- Point of Care Education
  - Supervised patient care as participant updates technical skills and knowledge
  - Gradually increase levels of independence

- Transitional clinical experience
  - Independent clinical experience

*CPEP works with participant to identify appropriate preceptor/training sites; cannot guarantee that training

Use of FPPE and OPPE Tools

In either a self-guided reentry process or formal reentry program process, physician will need to gain direct patient care experience

Use FPPE and OPPE tools to monitor progress
- May overlap with Reentry Plan objectives
- Would be more intensive than usual FPPE/OPPE process

- Proctoring and direct observation of care
- Case reviews for specific time period or number of cases, or of specific procedures/diagnoses
- Consulting arrangements and check-ins
- Monitoring performance data
CASE STUDIES

Executive Summary

• Clinician shortages are adversely impacting healthcare systems today and into the future
• Evolving models for healthcare delivery favoring value over volume add new stresses on healthcare systems
  • Highlight the need for more primary care clinicians
  • In certain geographic regions, a lack of specialists can leave communities vulnerable

Executive Summary

• Clinicians reentering practice may be a largely untapped reservoir of physician care capacity
• MSPs may need to facilitate the evaluation of reentry professionals and support MS leaders as they determine the appropriateness of accepting them back into patient care
• Reliance on physician self-assessment may be problematic
• Formal, structured evaluation and education resources are available
Resources

• Roadmap to Reentry
  http://www.cpepdoc.org/programs-courses/reentry/roadmap-to-reentry
• FSMB Report from the Special Committee on Reentry to Practice, Dec 2011
• Physician Reentry into the Workforce Project
  www.physicianreentry.org
• ACOG Reentry Statement and Resources

Thank you!

Elizabeth J. Korinek, M.P.H
bkorinek@cpepdoc.org
www.cpepdoc.org
303-577-3232