

# Best of Boards Award Entry

## Policies, Procedures, Guidelines Category

Topic: Physician and Physician Assistant Reentry, the North Carolina Medical Board Experience

Submitted by: C. Michael Sheppa M.D., Associate Medical Director, North Carolina Medical Board

Date: February 16, 2011

### Introduction

Reports predicting a shortfall in the supply of physicians in the United States have come from a number of entities. The American Academy of Family Practice has predicted a projected need of 39,000 additional primary care doctors by 2020 (1). The American Association of Medical Colleges has predicted a shortage of 91,000 physicians of all specialties by 2020 (2). Among the many factors that contribute to these predictions are federal government caps on funding for residency training positions (3), and physicians who take voluntary leave of absence from clinical practice.

As part of its mission to "regulate the practice of medicine ...for the benefit... of the people of North Carolina", the North Carolina Medical Board (NCMB) has taken steps to insure that physicians and physician assistants who take a voluntary leave of absence from clinical practice have a means to safely reenter practice should they wish to do so. The NCMB's experience with this category of licensees is described in this Best of Boards Award Entry.

### The North Carolina Medical Board Reentry Process

The NCMB recognizes that physicians not licensed in North Carolina, who have taken a leave of absence from clinical practice, need a process to help them demonstrate the fitness and competence required for North Carolina licensure. (For the remainder of this report the term physicians will mean physicians and physician assistants.) Starting in 2005, the Board requested physician license applicants who had not been in clinical practice for the immediate preceding two year period, to complete a reentry agreement with the Board as a condition of licensure. In 2006 the law was changed to make this

request a statutory requirement for licensure (Attachment A). At the time of this writing, rules are pending which will add specificity to the reentry law (Attachment B).

Hand in hand with the development of the statutory authority to require a reentry agreement between the Board and the reentry licensee, the NCMB refined the process reentry applicants used to develop and implement the content of the reentry agreement. The content of the reentry agreement became linked to a specific reentry plan developed by an individual licensee to demonstrate his or her fitness and competence to practice.

Currently, the reentry process begins when an applicant's chronology indicates that he or she has been absent from clinical practice for two or more years immediately preceding the date of license application. When this absence from clinical practice is identified by NCMB staff, reentry information is sent to the applicant (Attachment C). The information includes the requirement for a reentry agreement (Attachment D), guidelines for the development and implementation of the specific reentry plan to be associated with the reentry agreement (Attachment E), and requirements for the applicant's mentor (Attachment F). Instructions for how reports are to be sent to the Board are discussed in the guidelines sent to the applicant (Attachment E). A sample plan for the applicant's reference is also included (Attachment G).

The typical NCMB reentry applicant will work with an identified mentor to submit a written reentry plan to Board staff. The vast majority of plans follow a three phase timeline whose content is framed by the core competencies. The applicant's reentry plan is expected to include information about assessment and education, a description of the setting in which reentry is to occur, the acuity and volume of patients seen, a list of procedures to be performed, anticipated focused practice-based learning, plans for ABMS certification or maintenance of certification, how the applicant is to be supervised, and other information relevant to the responsibilities of applicant and mentor.

NCMB physician board staff is available to assist reentry applicants and mentors with development of each reentry plan. Uncommonly, and in selected cases, applicants whose reentry needs appear complex, extensive or unusual, may be referred for formal assessment and educational plan development to other entities (CPEP, PACE, other). Completed reentry plans, whether developed in conjunction with Board staff or by other entities, become part of the reentry applicant's license application which is reviewed by a committee of senior Board staff. After senior staff approval, the reentry plan and license application are reviewed by an individual NCMB Board member. The Board member interviews the reentry applicant. If the individual NCMB Board member approves the reentry applicant for licensure, the applicant signs the reentry agreement

with the Board, a license is issued, and the physician begins his or her reentry period under mentor supervision and in compliance with the terms of the reentry agreement.

The NCMB identifies reentry licensees on its public website. Date of the reentry agreement and date the reentry agreement is completed are provided.

To date the NCMB has processed approximately 100 reentry applications and associated plans. Approximately 75 applicants have completed reentry, approximately 15 applicants are in process, and approximately 10 applicants have withdrawn from the reentry process for various reasons.

The Board monitors reentry licensees. Since 2005, seven licensees have come to Board attention following completion of reentry. In six instances, the Board took no action on the information that brought the licensee to its attention. One licensee was issued a private letter of concern regarding a non-quality of care issue.

### Conclusion

Allowing appropriately selected reentry applicants to carry out their reentry to practice in geographic proximity to their home, at a cost that is not prohibitive, and under the supervision of a qualified mentor, has added fit and competent practitioners to the North Carolina physician workforce. Measured by the infrequent and relatively insignificant circumstances that have brought these practitioners to subsequent Board attention, it appears that this category of NCMB licensee performs well in practice, to the benefit of the citizens of the state.

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1. AAFP Workforce Study in FAMILY PHYSICIAN WORKFORCE REFORM: Recommendations of the American Academy of Family Physicians (AAFP Reprint No. 305b)
  2. <https://www.aamc.org/initiatives/workforce/>
  3. Feldman - *The Washington Post*. September 6, 2009.

**AIM - ATTACHMENT A** : NCMB current statutory authority regarding reentry requirement



**NORTH CAROLINA MEDICAL BOARD**

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**Current North Carolina Statute** (Medical Practice Act)

90-14(11a)

**§ 90-14. Disciplinary Authority.**

(a) The Board shall have the power to place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

Not actively practiced medicine or practiced as a physician assistant, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for an initial license from the Board or a request, petition, motion, or application to reactivate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

## **AIM - ATTACHMENT B** : NCMB pending rule



**NORTH CAROLINA MEDICAL BOARD**

pending rule

### **21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE (Pending Rule)**

(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 be required to complete a Reentry Agreement as a condition of licensure.

(b) The Applicant shall identify a Mentoring Physician acceptable to the Board.

(c) The Applicant shall propose a Reentry Plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board.

The Board shall review the proposed Reentry Plan and interview the Applicant.

(d) Factors that may affect the length and scope of the Reentry Plan include:

(1) The Applicant's amount of time out of practice;

(2) The Applicant's prior Intensity of Practice;

(3) The reason for the interruption in practice;

(4) The Applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;

(5) The Applicant's previous and intended Area(s) of Practice;

(6) The skills required of the intended Area(s) of Practice;

(7) The amount of change in the intended Area(s) of Practice over the time the Applicant has been out of continuous practice;

(8) The Applicant's number of years of graduate medical education;

(9) The number of years since completion of graduate medical education;

(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 will 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 should be described by the Applicant and confirmed by the Mentoring Physician.

The process may include self-reflection, self-assessment, and/or 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 Licensee and the Mentoring Physician practice together.

(h) The second component of the Reentry Plan is education. Education should address the Licensee's areas of needed improvement.

Education may consist of:

(1) a Reentry Period of retraining and education under the guidance of a Mentoring Physician, upon terms as the Board may decide, or

(2) a Reentry Period of retraining and education under the guidance of a Mentoring Physician consisting of the following:

(A) Phase I – The Observation Phase. During the Observation Phase, the Licensee will not practice, but will observe the mentoring physician in practice

(B) Phase II – Direct Supervision Phase. During the Direct Supervision Phase, the Licensee shall practice under the

direct supervision of the Mentoring Physician. Guided by the Core Competencies, the Mentoring Physician

shall reassess the Licensee's progress in addressing identified areas of needed improvement.

(C) Phase III – Indirect Supervision Phase. During the Indirect Supervision Phase, the Licensee shall continue to

practice with appropriate supervision of the Mentoring Physician. Guided by the Core Competencies, and using

review of patient charts and regular meetings, the Mentoring Physician shall reassess the Licensee's progress in addressing the areas of needed improvement.

(D) No later than 30 days after the end of phase I and II, the Mentoring Physician shall send a report to the Board

regarding the Licensee's level of achievement in each of the Core Competencies. At the completion of phase III

the Mentoring Physician shall submit a summary report to the Board regarding the Licensee's level of

achievement in each of the Core Competencies and affirm the re-entry physician's suitability to resume

independent practice.

(E) If the Mentoring Physician reassesses the Licensee and concludes that the Licensee requires an extended

Reentry Period or if additional areas of needed improvement are identified during Phases II and/or III, the

Board, the Licensee and the Mentoring Physician may amend the Reentry Agreement.

(i) Under the terms of either Reentry Periods Subparagraph (h)(1) or (h)(2) of this Rule, the Mentoring Physician may terminate his role as

the Mentoring Physician upon written notice to the Board. Such written notice shall state the reasons for termination. The Licensee's

approval is not required for the Mentoring Physician to terminate his role as Mentoring Physician. Upon receipt of the notice of termination, the Board shall place the Licensee's license on inactive status. Within six months from the effective date of the Mentoring Physician's termination, the Licensee shall provide a substitute Mentoring Physician, who must be approved by the Board in writing, and resume the Reentry Plan upon such terms as are acceptable to the Board. In such event, an Amended Reentry Agreement must be executed prior to resumption of the Reentry Plan. If Licensee does not resume the Reentry Plan as required herein within six months from the effective date of the Mentoring Physician's termination, then the Board will not return the Licensee to active status unless and until Licensee applies and is approved for reactivation of the license with a new Reentry Agreement and Reentry Plan, which must be in place before Licensee may resume practice as a physician or physician assistant.

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

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

(l) Unsatisfactory completion of the Reentry Plan or practicing outside the scope of the Reentry Agreement, as solely determined by the Board, shall result in the automatic inactivation of the Licensee's license, unless the Licensee requests a hearing within 30 days of receiving notice from the Board.

(m) If the Board determines the Licensee has successfully completed the Reentry Plan, the Board shall terminate the Reentry Agreement and notify the Licensee that the license is no longer restricted.

**AIM - ATTACHMENT C** : Reentry information letter to applicants



**NORTH CAROLINA MEDICAL BOARD**

Reentry Cover Letter to Applicants

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Date

John Sample MD  
Address, North Carolina

Dear :

Due to the time you have been away from active clinical practice you will be required to meet with a member of the Board as part of the application process for NC medical license. You should contact one of the Board members on the enclosed list to schedule the interview. Once you have made an appointment you must notify this office with the name of the Board member and the date of the interview in order that your file can be forwarded to them. The interview must be conducted no later than \_\_\_\_\_ or portions of the application may have to be updated.

You will be required to develop a reentry plan as part of your license application. It is your responsibility to be prepared to present a plan of re-training and supervision that will establish proof of competency in your chosen area of medicine. It will facilitate the license process to present a written plan for reentry at your interview. Although the Board does not take responsibility for developing reentry plans it has developed guidelines to assist the re-entry applicant in developing such a plan. I have enclosed a copy of those guidelines and a copy of a sample plan. I am also enclosing an example of a reentry *agreement*. This is a non-disciplinary consent order between you and the Board. As you will see by reviewing this document, it is not detailed and does not include a detailed description of a re-entry plan. If you have questions as you develop your re-entry plan, Drs. Michael Sheppa and Scott Kirby in the Board's Offices of the Medical Director are available to help and can be reached by telephone at the Board

The details from your re-entry plan will be reviewed with you during your Board member interview. It is not a public document but will be kept in your file. The public, non-punitive re-entry *agreement* between you and the Board will be available to the public on the Board's website.

Once an applicant's re-entry plan is approved, a re-entry *agreement* will be completed that will allow you to begin your re-entry plan. When you have completed your re-entry plan and fulfilled the terms of your re-entry *agreement*, a full and unrestricted license may follow. If you choose to not pursue a reentry plan a request for withdrawal of your application may be granted.

Sincerely,

Joy D. Cooke  
Director of Licensing  
[Joy.cooke@ncmedboard.org](mailto:Joy.cooke@ncmedboard.org)

**AIM - ATTACHMENT D** : NCMB sample reentry agreement



**NORTH CAROLINA MEDICAL BOARD**

*Sample Reentry Agreement*

BEFORE THE  
NORTH CAROLINA MEDICAL BOARD

In re: )  
 ) RE-ENTRY AGREEMENT  
Dr. Sample )  
 )  
Applicant. )

This matter is before the North Carolina Medical Board ("Board") on the application of Mike Sample, M.D. ("Dr. Sample") for a license to practice medicine and surgery. Dr. Sample admits and the Board finds and concludes that:

Dr. Sample has not practiced medicine since 1900, and acknowledges a need for him/her to successfully complete a program of re-entry into the practice of medicine in order for the Board to issue him a license to practice medicine; and

Dr. Sample met with a subcommittee of the Board to discuss his application, including the need for a program of re-entry to

ensure his safe transition back into the practice of medicine;  
and

Dr. Sample agrees to undertake a program of re-entry into the practice of medicine that will consist of a period of mentoring for 10 months by a physician colleague who will serve as Dr. Sample's mentor and provide the Board with a series of letters that describes his or her mentoring and makes an assessment of Dr. Sample's competency; and

Dr. Sample admits that any failure to comply completely and specifically with the terms of this Re-Entry Agreement and Order ("Agreement") will constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6), and he acknowledges that this Agreement and the admissions contained herein will be admissible in any hearing on charges arising from any failure to comply with the terms of this Agreement.

Based on the foregoing and by agreement with Dr. Sample, it is ORDERED that:

1. The Board shall issue Dr. Sample a full and unrestricted license to practice medicine and surgery.

2. Dr. Sample shall arrange to have a physician colleague mentor his practice of medicine for the 10 months following his resumption of practice; this period of mentoring shall consist of the following three phases:

- a. A 2 week period of observation-only practice during which time Dr. Sample will not be directly involved in

the evaluation and management of any patients but will observe his/her mentor in this activity. Dr. Sample and his/her mentor shall discuss aspects of the mentor's practice that includes: (1) patient care; (2) medical knowledge; (3) communication; (4) practice based learning; (5) systems based care, and (6) professionalism.

b. A 10 week period of directly supervised practice during which time Dr. Sample will be involved in the evaluation and management of patients under the direct supervision of his/her mentor. Dr. Sample and his/her mentor shall discuss aspects of Dr. Sample's practice that includes: (1) patient care; (2) medical knowledge; (3) communication; (4) practice based learning; (5) systems based care, and (6) professionalism.

c. A 7 month period of independent, supervised practice during which time Dr. Sample will be involved in the evaluation and management of patients and under the supervision of his/her mentor. Dr. Sample and his/her mentor shall discuss aspects of Dr. Sample's practice that includes: (1) patient care; (2) medical knowledge; (3) communication; (4) practice based learning; (5) systems based care, and (6) professionalism.

3. Dr. Sample shall have the physician mentoring his practice deliver to the Board's director of compliance letter(s) no later than 30 days after the end of each phase as described above in 2(a), 2(b), and 2(c), in which

he or she describes with detail the nature of the mentoring and stating an opinion as to the level of competency with which Dr. Sample practiced during that mentoring period. The detailed nature of the mentoring will include comments about Dr. Sample's competency in each of the following areas: (1) patient care; (2) medical knowledge; (3) communication; (4) practice based learning; (5) systems based care, and (6) professionalism.

4. If the Board requests, then Dr. Sample shall meet with members of the Board at such times as directed by the Board to discuss his transition back into the practice of medicine and his clinical skills.

5. This Agreement shall be treated as a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies, and clearinghouses, as required and permitted by law, including but not limited to the National Practitioner Data Bank and the Health Integrity and Protection Data Bank.

6. Dr. Sample shall notify the Board in writing of any change in his practice address within ten (10) days of the change.

7. If Dr. Sample fails to comply with any of the terms of this Agreement, that failure shall constitute unprofessional

conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and shall be grounds, after any required notice and hearing, for the Board to annul, suspend, revoke, condition, or limit Dr. Sample's license to practice medicine or to deny any application he might make in the future or then have pending for a license.

8. This Agreement shall take effect immediately upon its execution by both Dr. Sample and the Board, and it shall continue in effect until specifically ordered otherwise by the Board.

9. Dr. Sample hereby waives any requirement under any law or rule that this Agreement be served on him.

By Order of the North Carolina Medical Board this the \_\_\_\_\_ day of \_\_\_\_\_, 2010.

By: \_\_\_\_\_  
President,  
North Carolina Medical Board

## **AIM - ATTACHMENT E** : NCMB reentry physician guidelines



### **NORTH CAROLINA MEDICAL BOARD**

### **Reentry Plan Content Guidelines**

The following information is meant to assist North Carolina Medical Board Physician License Applicants who are requested to provide a reentry plan as a condition of licensure. Your reentry plan will become part of your license application. After your license application and reentry plan have been approved by the Board, the Board will create a formal Reentry Agreement that reflects information contained in your reentry plan. The Reentry Agreement is a non-disciplinary consent order between the applicant and the Board, an example is included in this packet of information for your review (The Reentry Agreement is for your information only, please do not submit a Reentry Agreement with your reentry plan). Please be aware that after your reentry plan and license application are approved, you will receive a full and unrestricted license. That license will be conditional upon the terms of the Reentry Agreement but will allow you to apply for malpractice insurance and hospital privileges, and charge for your services.

You will need to identify a suitable mentor prior to developing and submitting a reentry plan. Your mentor should not have a North Carolina Medical Board public disciplinary record, and preferably should be ABMS or AOA certified in the area of practice that you are reentering. You are expected to develop a reentry plan, with your mentor's help and guidance that best addresses your circumstances. When you have completed your plan, it should be submitted for Board staff review. Board staff may make suggestions that will help your plan receive Board approval. It is your decision whether or not to accept staff suggestions for improvement. Drs. Michael Sheppa (919-277-1850) and Scott Kirby (919-277-1833) are available to discuss your plan and any questions you may have about the reentry process

#### **A. Reentry Plan Content:**

1. You should provide a brief but detailed description of your previous clinical experience with emphasis on the 2 – 5 years directly preceding your period of clinical inactivity. You should describe how many hours you worked, your patient volume and acuity, on-call responsibilities, whether you provided inpatient care, and other details of your practice that gives the Board a good perspective of your clinical experience. You should describe your future scope of practice plans. If you are able, you should describe your future practice setting, referencing the number of hours you plan to work, expected patient volume and acuity, on-call responsibilities and inpatient work, along with other details that give the Board a good



understanding of what you plan to do. This is important information that helps guide the Board with regard to its review of your reentry plan.

2. You should provide a detailed statement in the language of the core competencies that describes your current strengths and weaknesses. You may wish to access the Good Medical Practice USA document for a general review of the core competencies at [gmpusa.org](http://gmpusa.org). The basis for your assessment should be described, e.g., self reflection, testing, mentor/previous colleague/educator evaluation, CPEP, or other pertinent sources.

3. You should provide a detailed statement describing your education program (Please see the enclosed example). The education program should address weaknesses identified by the assessments from item 2, above. The program should include a detailed timeline and detailed content description. It is strongly suggested that you use a three phase timeline for the Patient Care competency. This three phase timeline may also be used to guide education for the remaining competencies. With a three phase timeline, phase one should be a period of your observation of your mentor in clinical practice. The goals of this phase of observation should be described. Your time commitment, the observed patient volume and acuity, and the mentor's means of monitoring and assessing progress toward your goals during this phase should be specified. Your mentor will submit a written report to the Board at the end of this phase and you should reference this in your description.

4. Phase two will be a period of directly supervised practice. Your description of phase two should specify your goals and how your mentor will assess whether you meet them. You should specify that your mentor will directly witness fundamental aspects of your practice (including procedures) in order to confirm that you possess the knowledge and skills to perform these aspects of practice competently. Once confirmed, you and your mentor may decrease the degree of directly witnessed practice as appropriate. However, it is strongly suggested that all your clinical work during this phase be reviewed by your mentor prior to the implementation of any significant clinical management recommendations that affect a patient's care. For applicants who will be providing face-to-face patient care, it is strongly suggested that you and your mentor discuss each patient you care for *prior* to the patient's discharge from an outpatient or inpatient setting. You should provide a detailed description of your planned hours of work, your patient volume and acuity, and any procedures you will perform,. You may wish to begin this phase with an appropriately diminished patient volume and acuity level, and work towards a stated higher goal. You should specify a regularly recurring time for you and your mentor to discuss your progress. You should reference your mentor's phase two report to the Board. That report should include a statement of your goals for phase two and whether they have been met.



5. During phase three you may practice independently but with appropriate supervision. Your stated goals for this phase should include preparing you for independent practice. Your mentor's means of monitoring and assessing your patient care competency during this phase should be specified. You should specify your hours of work, your patient volume and acuity, and any planned changes in these parameters as phase three progresses. For applicants that are providing face-to-face patient care, it is suggested that all patients of high acuity and/or complexity, and all patients with problems that are new to the applicant be discussed with the mentor prior to each patient's discharge from an outpatient or inpatient setting. At the completion of phase three, you should specify that the mentor will provide a summary approval letter to the Board.

6. The three phase timeline established for the Patient Care competency may be used to guide focused retraining and education, and mentor reporting for the remaining competencies. For the topic of Medical Knowledge, the applicant should describe the content of focused category 1 and 2 CME including maintenance of competency activities pertinent to the applicant's specialty. If applicable, plans for obtaining ABMS certification or recertification in the applicant's area of specialty should be included. The focus of continued education plans should address weaknesses identified by previous assessments and/or the mentor. A plan describing how the applicant's mentor is to assess and approve the applicant's competency in this area should be specified. For the topic Communication, the applicant may choose focused CME or other activities pertinent to this competency. A plan describing how the applicant's mentor is to assess and approve the applicant's communication skills should be specified. For the topic Systems based practice, the applicant may choose to outline specific plans of selected readings, hospital QIM work or other focused CME. There should be a description of how the applicant's mentor is to assess and approve the applicant's competency in this area. For the topic Practice-based Learning, the applicant may choose to describe how the experience gained early during the reentry period will be applied to further augment re-entry period learning and/or help guide future practice-based learning. There should be a description of how the applicant's mentor is to assess and approve the applicant's competency in this area. For the topic Professionalism, the applicant should specify a plan to remediate weaknesses identified during assessment, and a description of how the applicant's mentor is to assess and approve the applicant's competency in this area should be included.

7. Other information and activities that the applicant feels are pertinent to reentry should be included.

## **AIM - ATTACHMENT F**: Mentor Information



**NORTH CAROLINA MEDICAL BOARD**

**Mentor Information**

### **Information obtained from the Mentor by the applicant and to be submitted to the Board:**

The applicant should obtain from the mentor:

1. A copy of the mentor's Curriculum Vitae
2. A statement from the mentor of his/her previous experience as an educator, mentor, and teacher. This may include experience gained from previous residency training, current experience in practice based learning, participation in practice/hospital quality improvement activities or other pertinent information.
3. A statement of financial arrangements between the mentor and the applicant that describe how the mentor is to be compensated by the applicant during the reentry period. If the mentor is serving on a voluntary basis, this should be specified.
4. A statement of the mentor's current and expected future personal and professional relationships with the licensee.
5. A statement that the mentor has reviewed and approved the licensee's scope of practice, assessment, and reentry program. The statement should include an estimate of the mentor's expected time commitment to each phase of the reentry program.
6. Other information that the mentor feels are pertinent to the applicant's re-entry plan should be included.

**AIM - ATTACHMENT G** : NCMB sample physician reentry plan



**NORTH CAROLINA MEDICAL BOARD**

**Sample reentry plan**

**Re-entry Plan of \_\_\_\_\_, MD Submitted to the North Carolina Medical Board**

**1. Introduction**

I initially obtained my license to practice medicine from the North Carolina Medical Board on July 24, 1999. I worked as an ABMS certified, Emergency Medicine physician at ----- from July 1999 to July 2006 on a full-time basis. I left the practice of Medicine in December of 2006 to care for my children. I wish to regain my license and reenter medical practice as an urgent care physician.

During my 7 years of active practice, there were no patients, peers or others familiar with my practice who indicated that there were any deficiencies in my abilities as a practitioner, either generally or in any of the domains of competency delineated in the National Alliance for Physician Competence's "Guide to Good Medical Practice – USA" .

**2. Scope of Future Practice Plans**

Upon re-entering into the clinical practice of medicine I plan to enter into an Urgent Care office with Dr. - ----- in ----- North Carolina. I ultimately plan to work full-time at approximately 30-40 hrs/week. I will be seeing patients of all ages. I will provide immediate, walk-in medical service (no appointment needed) offering outpatient care for minor acute illnesses and injuries. The office currently has 1 physician and 2 physician assistants. The acuity level is typically low with the exception of the occasional patient presenting with more serious complaints that require a higher level of care. Those patients are immediately transferred to the local hospital emergency department for further evaluation using the practice's existing policies and procedures for such patients. If needed EMS is called for transport. No direct admissions are done from this office, the practitioners in this office do not provide in-patient hospital service. Most patients present with complaints of minor musculoskeletal complaints, upper



## **NORTH CAROLINA MEDICAL BOARD**

### Sample reentry plan

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respiratory infections, ear infections, and other problems typical for an urgent care walk-in practice. The volume is approximately 80-90 patients/day. This aspect of Urgent Care Medicine requires a broad, comprehensive fund of knowledge. Having trained in Emergency Medicine, I am well qualified to provide such care.

To ensure the best patient care I plan on limiting my practice to no more than 2 patients per hour. This will allow complete history taking, physical examination, and appropriate treatment decisions relating to each patient. If, during a brief period of time where there is increased demand for medical care, I will add a third patient per hour as necessary.

Upon completing my re-entry plan, I would like to return to the practice of medicine in an urgent care setting or the urgent-care side of an Emergency Department. I intend on working no more than 40 hours a week and will not be taking any call. I intend on seeing patients in an Urgent Care or urgent-care side of an Emergency Department. There will be no in-patient care of patients. I would only request privileges, if working in a hospital, to see patients in an Emergency Department setting, and only in an urgent care side of an Emergency Department.

I plan on implementing my reentry plan and remediation at ----- clinic, in -----, North Carolina as soon as it is approved by the Board. -----, MD has agreed to serve as my mentor, he is an Urgent Care Provider, with an extensive practice teaching experience.

## 2. **Strengths and Weaknesses**

### **Strengths**

#### A. **Patient Care**

The patient care I have provided has been excellent. My strengths in this core competency include performing and obtaining adequate physical examinations, including social and psychological factors. I encourage patients to be involved in their medical care including lifestyle choices that can directly impact their health, wellness, and treatment outcomes. I encourage patients to make healthy choices to



## **NORTH CAROLINA MEDICAL BOARD**

### Sample reentry plan

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improve and maintain their health. I prioritize care based on clinical need and am an excellent physician with invasive and non-invasive procedures. I also have had very positive feedback from patients and other clinicians regarding the care that I have provided.

#### B. Medical Knowledge and Skills

It is very important for a physician to have sound medical knowledge. During the past 3 years I have completed over 150 hours of Category I evidence based CME. My CME has primarily been in Emergency Medicine and Urgent Care Medicine. I will continue to keep current with my CME and make certain that it is varied and inclusive of the areas addressed by Urgent Care and Emergency Medicine Care.

I will review my CME with Dr. -----and ask for additional appropriate CME to further my education and prepare me for working in an Emergency Department. We will review evidence based guidelines relevant to the practice of Urgent Care Medicine.

#### C. Practice-Based Learning and Improvement

As I re-enter the practice of medicine in Urgent Care Medicine, I will need to review pertinent medical literature relevant to Urgent Care Medicine. I will have an in depth and focused review/discussion of an individual medical disease entity each day which relates to a patient that I/we have seen during the day. I will read and review the literature that is relevant to the patients I have seen that day.

I will incorporate performance and practice improvements from feedback from my mentor, patients, and colleagues. Dr. ----- will assess my individual patient care abilities and evaluate my progress.

#### D. Interpersonal and Communications Skills

I have always had excellent interpersonal and communication skills. I will continue to listen to patients, staff and colleagues and will continue to improve these skills. I will continue to speak honestly and with compassion, especially when relaying unfortunate medical information to patients. I will be courteous



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with staff and colleagues and continue to work on improving my communication skills.

#### E. Professional Behavior

I feel that I behave in a professional manner. I will continue to do so and try to always be honest. I will be accountable for mistakes I make and will correct my mistakes and promptly admit it when I am wrong. I believe that medical professionals need to earn respect from patients, colleagues, staff and the general public by exhibiting professional behavior. By demonstrating respect and compassion to the patient this respect is earned.

#### F. Systems-Based Practice

Re-entering into the practice of medicine in Urgent Care Medicine will quickly expose me to various types of medical practice, delivery systems and payment methods as these are quite different from those encountered in the Emergency Department.

I believe it is important to utilize the medical delivery system to properly allocate resources to provide cost-effective, accessible, and high quality patient care. As a medical provider, one of my goals is to educate the patient of their role, as well as the other medical personnel, to effectively utilize the system's resources to provide optimal medical care.

### **Weaknesses**

#### A. New Medications

I will need to ensure that I have current knowledge of new medications that have become available during the time I have been away from practice. Although I have kept my CME current, I will need to do further review of these new medications and/or dosing changes of previously available medications.

#### B. Current Practice Guidelines

I will need to further review practice guidelines relevant to Urgent Care Practice, as some of these will



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vary from those in Emergency Medicine.

#### C. Clinical Skills

I will ensure that my skills are appropriate, particularly in the areas of performing histories, physical exams, generating differential diagnoses, and formulating treatment plans.

#### 4. Education Program

##### **Phase I – Clinical Observation**

Prior to beginning my re-entry, I will attend a 30 hour category 1 CME conference providing and intensive review of Urgent/Emergency Medicine. Phase I will consist of a 2 week period of shadowing Dr. -----in his Urgent Care practice. He is an excellent physician who has a wonderful rapport with his patients, family, staff and colleagues. The goal of this phase is to refresh my recognition of what is involved in obtaining a history, performing the physical exam, ordering the appropriate ancillary studies, establishing a differential diagnoses and developing a treatment plan. This time period will allow me to become familiar with Dr. -----s office, his practice's system processes with regard to the delivery of care and for me to become refreshed through observation with outpatient medicine. I will be working approximately 30-40 hours per week during which time I will be seeing patients with Dr.-----. He sees approximately 2 patients per hour. There will be no on call during the entire re-entry plan. At the end of each day, Dr. - ----- and I will discuss the various medical conditions that have presented during the day, the treatments of those conditions, and the how practice processes involved in the evaluation and management of those patients with those conditions.

Phase I will consist of a two week time period of direct observation by Dr. ----- . He will address discussions on refreshing my recognition of the components of the history and physical examinations, the appropriate use of ancillary tests, establishment of a differential diagnosis and the formulation of a treatment plan.



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#### **Phase II – Patient Care with Supervision**

Phase II will be a four week time period in which I will provide Urgent Care patient care under the direct clinical supervision of Dr. -----in his ----- Urgent Care office. This four week period will be structured in phases of increasing patient acuity and volume. Initially I will be seeing patients with simple complaints not complicated by other existing medical conditions. If there is a patient complaint not familiar to me, Dr. ----- will provide one-on-one mentor review of history, physical examination, and medical treatment. If there is a simple procedure that needs done such as suturing, foreign body removal, etc., Dr. ----- will directly supervise such procedures. Dr. ----- will provide direct supervision of all patient history and physical examinations performed until he confirms my ability to take an adequate history and do an appropriate physical examination. Dr. ----- will provide one-on-one supervision of all medical decision making. During this phase I will present every patient I see to Dr. -----before the patient's discharge and he will be review the chart on every patient I see prior to the patient's discharge. I will be seeing 1 patient per hour. After 2 weeks into Phase II, I will begin seeing patients with simple complaints, but with other existing medical problems such as diabetes, hypertension and cardiac disease. I will gradually increase patient volume and at the end of Phase II I will be seeing approximately 2 patients per hour. I will continue to present every patient I see to Dr. \_\_\_\_\_ prior to the patient's discharge from the clinic and the patient's chart will be reviewed by Dr. \_\_\_\_\_ no later than the end of the day of the patient's visit. I will be working 30-40 hours per week and will be seeing approximately 60-80 patients per week. I will be doing CME at home relative to Urgent Care Medicine to add to my knowledge base. At the end of every day, Dr. ----- and I will discuss areas of improvement, disease models in patients that we have seen during the day, and medical treatment rendered. No on call will be done during the entire re-entry plan. Dr. ----- and I will meet once a week for an hour to discuss my progress during this phase and review cases of interest, focused CME, my records and other items as appropriate. The goal of this phase is to re-introduce me to direct patient contact and to establish my competency in doing a history and physical exam, generating a differential diagnosis, and establishing a treatment plan.

Phase II will consist of a four week time period of direct observation by Dr. ----- . At the end of this time period, a second written evaluation of his assessment of my skills and competency in performing a history and physical examination, deciding on appropriate ancillary testing, differential diagnosis



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formulations and appropriate treatment planning will be forwarded to the Board. Dr. -----'s written evaluation will incorporate reference to the core competencies in his discussion of my performance.

#### **Phase III – Independent Supervised Care**

Phase III will be a four and a half month time period in which I will provide independent supervised patient care. The goal will be to re-introduce me to more independent and unsupervised patient care. I will be working 30-40 hours per day and seeing approximately 2 patients per hour. I will be responsible for seeing the patient, performing the history and physical examination, medically treating the patient, and completing chart documentation. Dr. ----- will monitor this phase by focused chart reviews of all new practice patients, higher acuity patients, patients with problems not seen in Phases I or II, and random chart audits with a minimum of 50% charts reviewed. Patients new to the practice, high acuity patients, and patients with problems not seen in Phases I or II will be discussed with Dr. ----- prior to patient discharge. Record review as described above will occur at the end of every practice day. At the end of every other week, Dr. ----- and I will meet for one hour and discuss patients of interest, my focused CME, my medical record documentation, and other items as appropriate.

I will keep a log of all procedures I do during phase 2 and 3 and Dr. ----- will supervise all procedures that I do until he confirms that I performed the procedure competently. He will sign the procedure log when he confirms my competency for the procedure.

Upon completion of Phase III, Dr. ----- will provide the Board with a summary approval letter stating my completion of the re-entry plan and on my ability and competence to practice independent unsupervised patient care. His letter will provide the Board a detailed summary and final report of my clinical skills and progress, including an assessment of my remediation activities, clinical skills, procedural skills, and medical record documentation in the context of core competencies