

Impact of Competence Assessment and Reentry Programs

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CPEP

- ◆ **Competence assessment/education**
 - ◆ Independent, not-for-profit
 - ◆ Located in Colorado; national in scope
 - ◆ Referrals from medical boards, hospitals and others
- ◆ **Conducted more than 1200 competence assessments**
- ◆ **Clinical Practice Reentry Program**

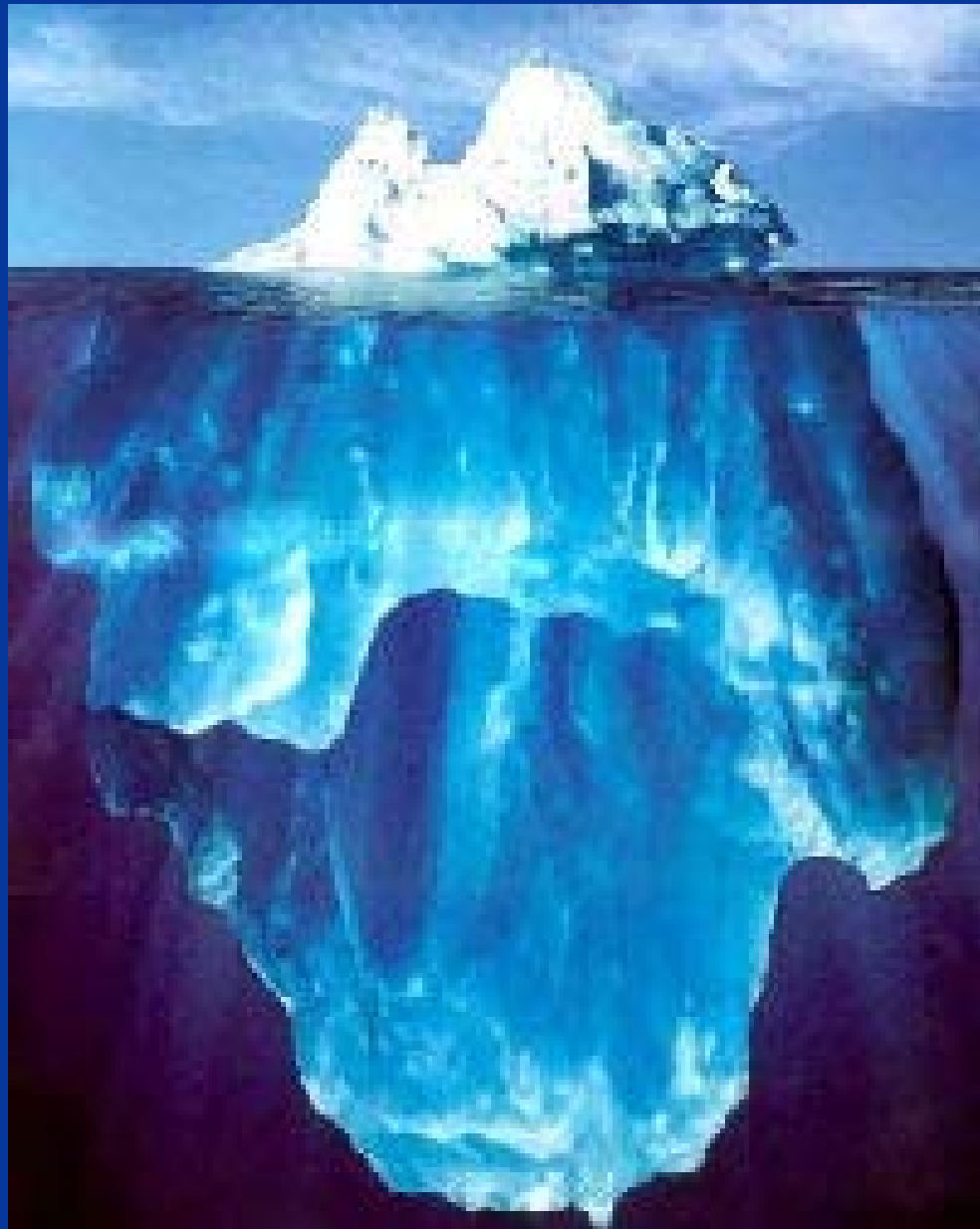
Celebrating 20 years of service!

Objectives

- ◆ **Discuss differences in characteristics and performance of physicians referred for competence assessment**
- ◆ **Provide an update on physician reentry**
- ◆ **Focus on implications for Board licensure and disciplinary processes**



"Some guys from the state board of medicine are here to see you."



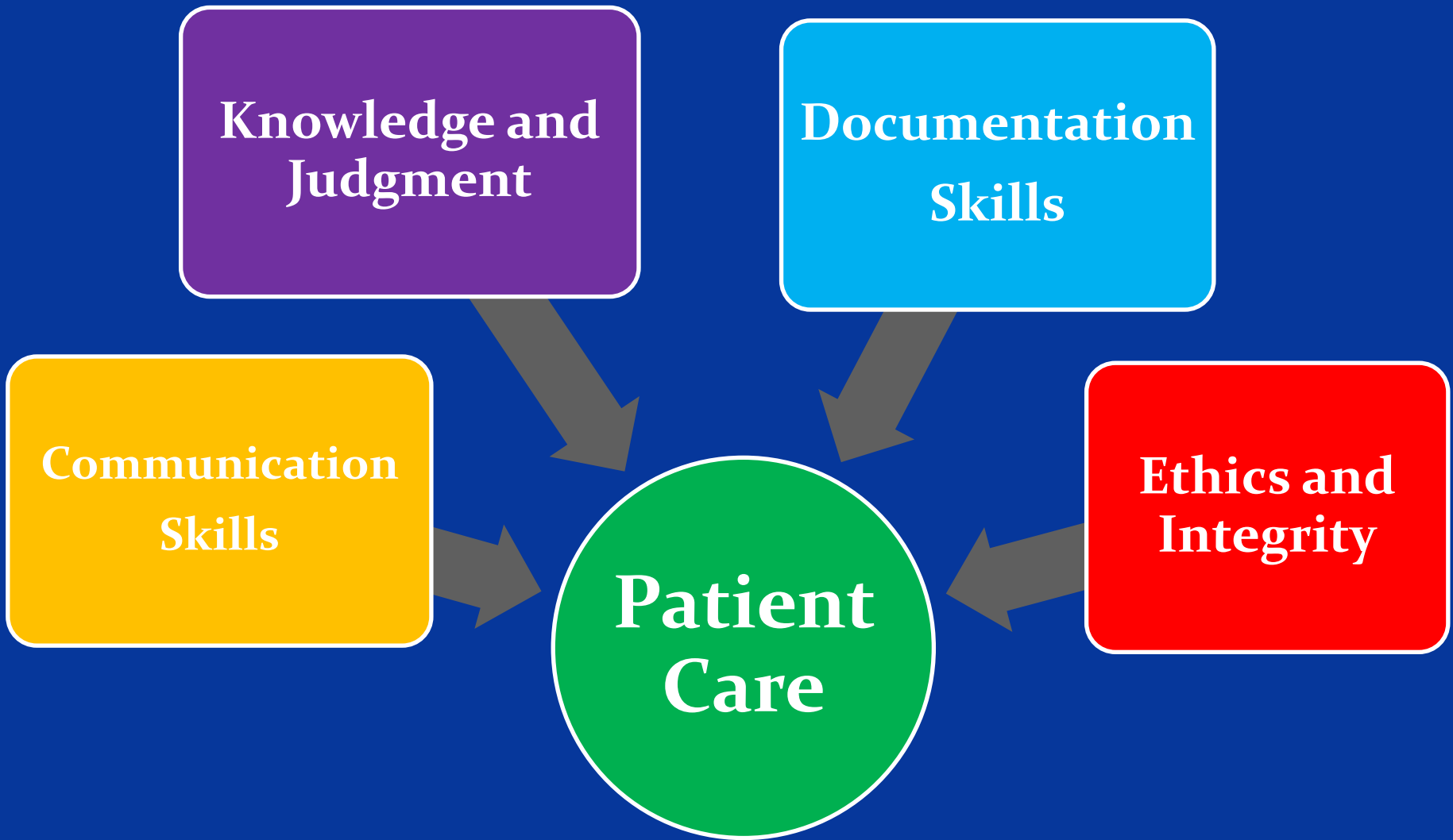
**Knowledge and
Judgment**

**Documentation
Skills**

**Communication
Skills**

**Ethics and
Integrity**

**Patient
Care**



Assessment/Education Programs

- ◆ Focus on physicians whose clinical competence has been questioned
 - ◆ Referred by a regulatory agency
- ◆ Conduct comprehensive assessment
 - ◆ Relevant to ACGME competencies
- ◆ Provide remedial education that identifies specific expected activities and goals

Difference in Physicians Referred by Boards and Hospitals

- ◆ **Data from 502 assessments (7/2002 – 6/2010)**
 - ◆ **Board-referred (N=400)**
 - ◆ **Hospital-referred (N=102)**
 - ◆ **Excluded other referral types (86 physicians)**

**Published in *Journal of Medical Regulation*,
Vol. 96, No. 3, pgs 8 – 15, 2011**

Differences by Referral Source

	Board referred	Hospital referred	p value
Male gender	88%	75%	p<0.001
Average age	54 yrs	50 yrs	p<0.001
Medical school US, Canada Other int'l school	80% 20%	83% 17%	p=0.415 (NSS)
Board-certified *Current	62%	80%	p<0.001
Mean Performance Rating *Scale: 1 (best) to 4 (worst)	2.62	2.36	p=0.007

Gender

- ◆ **Majority of Board-referred were male (88%)**
 - ◆ **Disproportionate to US physician population (71% male - AMA master file 2007)**
- ◆ **Hospital group included more females (25%)**
 - ◆ **More closely reflects general physician population**

Board Certification

- ◆ **Current board certification more common among hospital group**
 - ◆ Logical given trends in privileging
 - ◆ Reflect specialty board requirements that physicians maintain unrestricted license
- ◆ **Different implications for those who lost certification due to licensure issues vs. those who were never certified**

Differences in Specialties by Referral Source

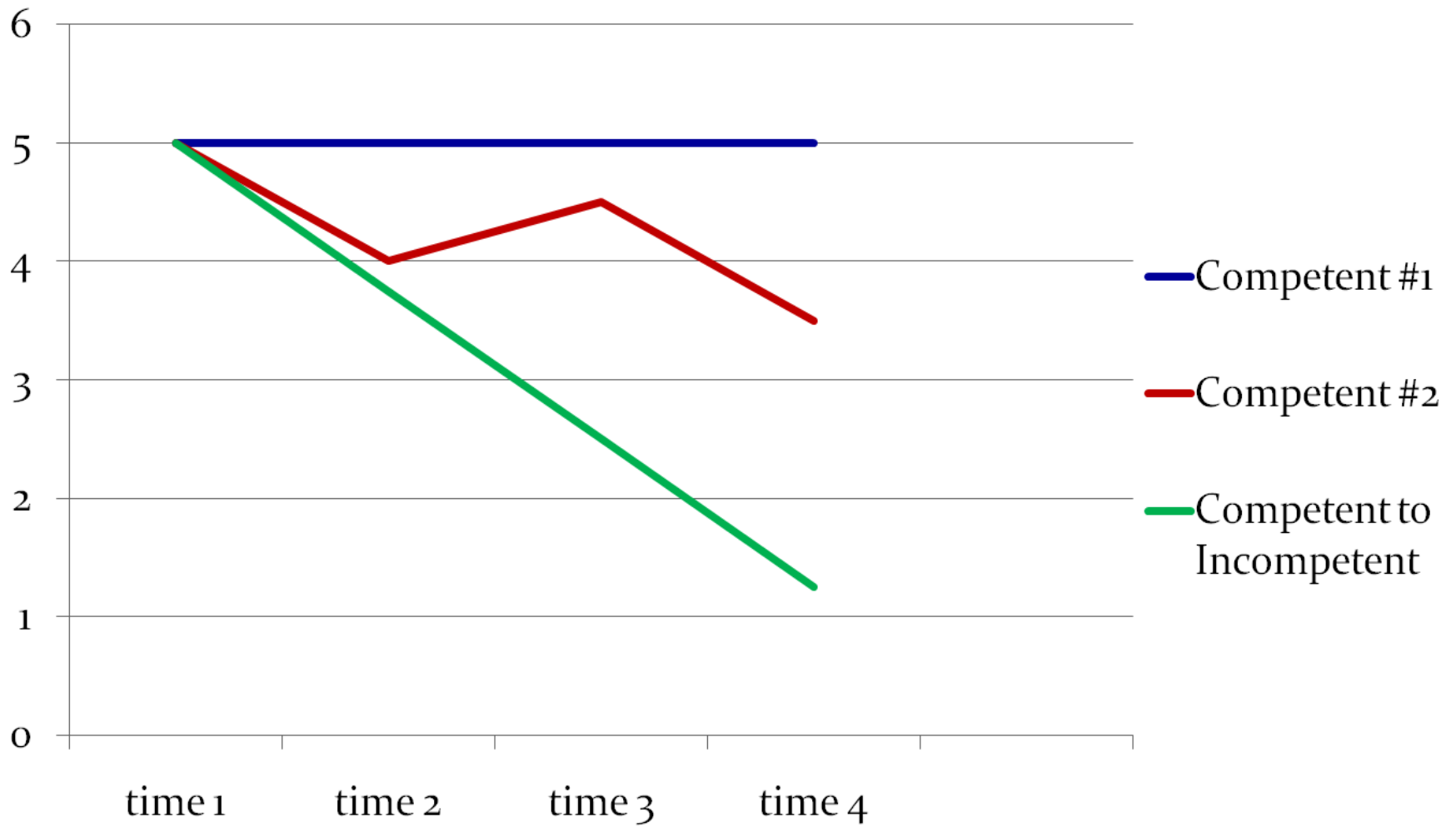
Ranking	Board-referred		Hospital-referred	
	Specialty	%	Specialty	%
1	FM	25%	OBG	30%
2	IM	15%	FM	18%
3	GP	9%	GS	13%
4	GS	8%	IM	8%
5	P	6%	ANE	6%

FM=family medicine, IM=internal medicine, GP=general practice, GS=general surgery, P=pediatrics, OBG=obstetrics and gynecology, ANE=anesthesiology

Specialty Differences

- ◆ May reflect that the care of Ob/Gyns and anesthesiologists are largely provided in the hospital setting
- ◆ May reflect the medico-legal risks for the hospital related to these specialties

Competence Over Time



Performance

- ◆ **Hospitals may identify concerns earlier**
 - ◆ **Routine peer review processes**
 - ◆ **Local resource, more closely involved with physician**
- ◆ **If hospital does not address problem, the problem may progress and worsen**
- ◆ **There may be significant delay before brought to Board**
- ◆ **Current board-certification may be a factor in performance differences**

Concluding Thoughts

- ◆ **Significant differences between physicians referred by boards and hospitals**
- ◆ **Physicians in different circumstances may come to the attention of each entity**
- ◆ **Demonstrate complementary nature of these entities in the safety net of the self-regulation of medical profession**
- ◆ **Support early intervention**

Clinical Practice Reentry

**A growing number of
physicians are
reentering medicine...**

Definition of Reentry

Physician returning to professional activity/clinical practice, for which he/she has been trained, certified or licensed, after an extended absence

- ◆ **Refers to those who left practice in good standing**

National Focus

- ◆ National attention focused on physicians returning to practice after an absence
- ◆ Recognition that these physicians possess valuable skills that are desired by the medical community
- ◆ AMA, AAP, ACOG and others are developing guidelines to support reentry efforts

Physicians Returning to Practice

- ◆ Many have outdated skills, but a solid clinical foundation
- ◆ Have insight about their situation
- ◆ May need specific educational assistance
- ◆ Are motivated to participate in education and transition safely into practice

Pediatrician

- ◆ **Left practice to raise young children**
 - ◆ **Out of practice for four years**
- ◆ **Wants to return to practice in a part-time urgent care setting**

Radiologist

- ◆ Got “tired” and retired
- ◆ Three years off and ready to return
- ◆ Wants to return to part-time work in a rural or small hospital



"No, I haven't performed the procedure myself, but I've seen it done successfully on 'E.R.' and 'Chicago Hope.'"

Challenge:

Demonstrate Current Competence

- ◆ Can they safely return to practice?
 - ◆ Boards no longer assume returning physicians have maintained skills
 - ◆ Establish reentry policies, including requiring demonstration of competence
 - ◆ Range 1 to 5 years; 2 years most common

Challenge:

Determine Educational 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 educational content areas need to be addressed for future practice setting?
- ◆ How do you know when educational needs are sufficiently addressed?

Pediatrician *Findings*

- ◆ Knowledge acceptable, with gaps

Recently passed boards

- ◆ Judgment marred by lack of confidence

*Lacked experience to allow her to apply
knowledge in practical setting*

- ◆ Participated in structured education program, including initial supervision

Characteristics and Clinical Abilities of Reentry Physicians

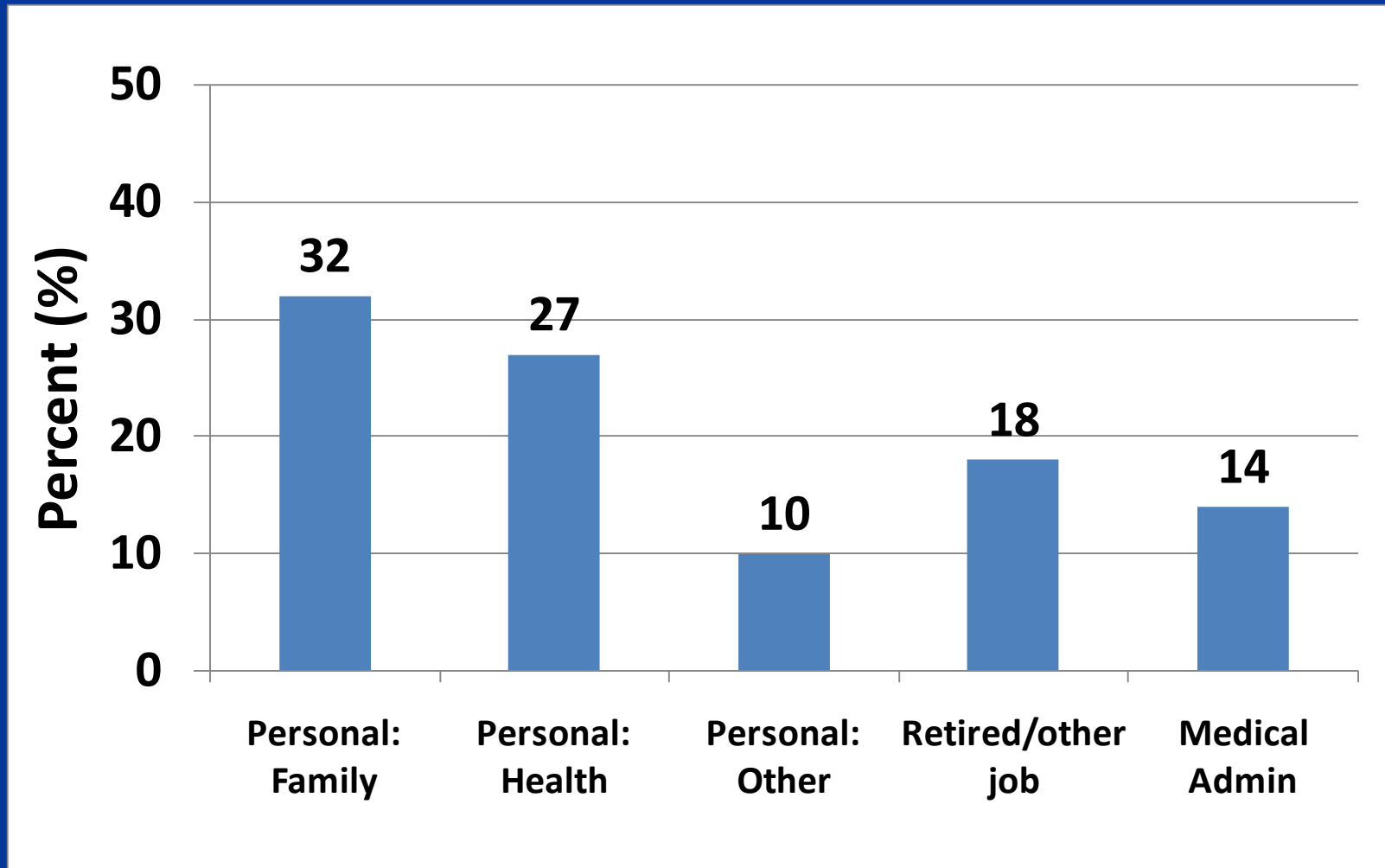
- ◆ Study key characteristics of reentry program participants (N=62)
- ◆ Examine correlations between characteristics and performance on initial assessment
- ◆ Evaluate outcomes and ability to return to practice

Originally published in *Journal of Continuing Education in the Health Professions* 30(3):180-186, 2010;
republished with erratum *JCEHP* 31(1):49-55, 2011

Characteristics

- ◆ 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)

Reason for Leaving Practice



Correlations

- ◆ Females were more likely than males to have left practice for child rearing
- ◆ There is an association between leaving for an administrative position and male gender

Educational Needs

Pervasive,
7%

Minimal:
Ready for
Practice,
24%

Significant,
34%

Moderate,
35%

Performance Rating by Years Out of Practice

Years Out Of Practice	# of Participants to Achieve Rating				Average Rating
	1	2	3	4	
1-5 yrs	7	5	7	0	2.00
6-10 yrs	6	13	7	2	2.18
11-15 yrs	2	2	5	1	2.50
>16 yrs	0	2	2	1	2.80
Total	15	22	21	4	2.23

*Performance rating scale: 1 (no/limited educational needs) to 4 (global deficits)

Performance Rating by Age

Age	# of Participants to Achieve Rating				Average Rating
	1	2	3	4	
30-39 yrs	1	2	2	0	2.20
40-49 yrs	6	6	3	0	1.80
50-59 yrs	4	11	10	0	2.24
60-69 yrs	3	3	5	1	2.33
70-79 yrs	1	0	1	3	3.20
Total	15	22	21	4	2.23

*Performance rating scale: 1 (no/limited educational needs) to 4 (global deficits)

Do They Succeed?

- ◆ Evaluated data from those who who completed education through CPEP
 - ◆ Data from other participants not available
- ◆ **Can successfully return to practice**
 - ◆ 22 who entered education process
 - ◆ 16 completed, 3 withdrew
 - ◆ 3 still active at time of study

Discussion

- ◆ Participants left practice for various reasons, some for extended periods of times
- ◆ The majority demonstrated educational needs requiring moderate to considerable education
 - ◆ A few needed residency training
- ◆ Increasing age and time away from practice correlated with worse performance

Conclusions

- ◆ Many reentry physicians are not ready to “jump into” practice
- ◆ Findings support Board mandates for demonstration of competence prior to licensure
- ◆ Physicians can successfully reenter practice through a process of assessment/education
- ◆ Emerging patterns may help guide future policy

Colorado Reentry Experience

- ◆ Ten years ago, CMB established rule for demonstration of competence
 - ◆ Any physician seeking new license/reactive license
 - ◆ If no direct patient care in past 24 months
- ◆ If educational needs identified, received probationary license until education completed
 - ◆ *Limited license* reported to NPDB with unintended negative consequences

2010 Reentry License

- ◆ **Physician must submit assessment and education plan**
- ◆ **Receive reentry license that allows physician to practice while completing education**
- ◆ **Physician may receive unrestricted license when program completed**
 - ◆ **Reentry license valid for no more than 3 years**

Impact: Assessment Programs

- ◆ Provide objective information to help Boards reach decisions about physician competence
- ◆ Provide an effective means to remediate physicians and change behavior over time

Impact: Reentry Programs

- ◆ Provide objective means to demonstrate competence
- ◆ Facilitate the physician's return to practice
- ◆ Help address physician workforce shortage
- ◆ Collaborate with Boards to identify and remove barriers to return to practice

Resources

- ◆ **AAP/AMA Physician Reentry into the Workforce Project**
 - ◆ www.physicianreentry.org
 - ◆ http://physicianreentry.org/yahoo_site_admin/assets/docs/IssueBriefRe-EntryBarriers.23782515.pdf

- ◆ **Physician re-entry to the workforce: Recommendations for a coordinated approach**
 - ◆ <http://www.ama-assn.org/ama1/pub/upload/mm/40/physician-reentry-recommendations.pdf>

Thank you!

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