



TENNESSEE BOARD OF MEDICAL EXAMINERS

RE-ENTRY TASKFORCE

Teleconference

Tuesday, April 5, 2016

MINUTES

The Re-entry Taskforce meeting of the Tennessee Board of Medical Examiners was called to order by teleconference at 4:00p.m. in the Iris Room, Ground Floor, Metro Center Complex, 665 Mainstream Drive, Nashville, Tennessee 37243.

Members Present: W. Reeves Johnson, MD
 Melanie Blake, MD
 Deborah Christiansen, MD

Staff Present: Andrea Huddleston, JD, Chief Deputy General Counsel
 Maegan Carr Martin, JD, Executive Director
 Rene Saunders, MD, Medical Consultant, BME

The formalities required to convene a meeting by teleconference were observed and the requirements met.

Ms. Martin acted as meeting moderator and referred the group to the agenda.

I. **Trigger for application of re-entry policy**

The Board's current practice is to require an applicant who has been out of practice for two or more years to undergo some type of remediation to ensure that he or she is clinically competent and poses no risk to patients. The Taskforce was asked to consider whether two years is the appropriate "trigger" and also when someone can be said to be actively engaged in clinical practice.

Dr. Christensen and Dr. Blake spoke in favor of keeping the two year trigger. Dr. Blake added that re-entry should be understood as re-entering practice in the specialty for which one was previously trained. A physician's entrance into a practice specialty outside his or her initial training really requires re-training rather than re-entry.

Dr. Johnson agreed that the two year trigger seems appropriate but acknowledged that there may be situations where flexibility would be helpful. He stated that specialties should be considered on a case-by-case basis because some specialties pose a greater risk than others when there has been a lapse in practice.

Ms. Huddleston said that she understands the desire for flexibility but does not believe that the trigger should be where the Board preserves it. It is important that an applicant knows when applying whether his or her time out of practice may result in a re-entry issue. Dr. Christensen agreed with Dr. Johnson, and spoke in favor of the North Carolina Board's take on re-entry. She believes the trigger can remain rigid, but the re-entry plan could be customized to fit a particular scenario. Dr. Blake asked the group to consider when the clock would start ticking on two years. The group agreed that two years out of practice would mean that two years had lapsed since the physician last saw/treated a patient and the date of the application.

After further deliberation the taskforce agreed on the following points.

- Two years out of practice will trigger application of policy. It shouldn't matter what took the physician out of practice: could be due to impairment, discipline, or voluntary leave.
- Two years means two years has lapsed from the last patient contact to the date the application is received in the administrative office.
- The Board will look at the physician's activity before the interruption in practice; however, unsupervised, independent practice will not be required.
- Re-entry is appropriate when someone is returning to a specialty in which he or she was previously trained. When someone is returning to a new specialty after 2 or more years of clinical inactivity, retraining is needed.

Dr. Christiansen will review this topic and related issues further and report back to the group with specific recommendations at its next meeting.

II. Assessing clinical competence

The group next considered the methods that the Board may employ in assessing a physician's clinical competence. The group agreed that the two year trigger will not necessarily require a physician to undergo remediation, rather, it will require some type of assessment of the physician's skills. Generally, the group agreed on the following:

- The following tools may be utilized to evaluate an applicant's clinical competence to determine whether a remediation program should be required.
 - SPEX.
 - Formal assessment (CPEP, KSTAR, PACE, etc.).
 - Certification activities such as initial certification, or recertification, but MOC activities alone will be insufficient.
 - Recent training, such as a residency or fellowship.

Dr. Blake will review this topic and related issues further and report back to the group with specific recommendations at its next meeting.

III. Types of re-entry programs that should be available to applicants

Lastly, the group considered remediation tools and programs that the Board may use to assist the physician in his or her re-entry to medical practice. Generally, the group agreed that the following tools and programs may be appropriate:

- CME – Good, quality CME might be a part of a remediation program, but is not likely to be sufficient remediation in and of itself.
- SPEX is probably best used as an assessment tool, but might also be utilized as a post-program assessment.
- Preceptorship/mentor program.
- Formal remediation program (CPEP, Drexel, Cedars Sinai, etc.)
- Recent training, such as a residency or fellowship.

Dr. Johnson will review this topic and related issues further and report back to the group with specific recommendations at its next meeting.

IV. Challenges/considerations/concerns

Ms. Huddleston urged the group to consider the following when determining the feasibility of a particular method, program or approach:

- Applicant investment (cost, time, etc.)
- Access to healthcare in Tennessee considerations
- Anticompetitive considerations

The group agreed to convene again once more by teleconference before the Committee's in-person meeting on Monday, May 16th.

The meeting adjourned at 5:41 p.m.