PRACTICE MANAGEMENT MATTERS:

Step-down to Physician/Clinician Retirement

(Or to Other Life Priorities)

SYNOPSIS WITH HYPERLINKS

click on lime green text below to read more about each topic

Situation:

Healthcare professionals will retire at some point. Even before and aside from retirement itself, requests for step-downs (reduction of hours or call duty) may happen. These changes, often reflective of work-life shifts and attention to personal wellness, are important options to have in a workplace like ours, which cares deeply about the wellbeing of its members. However, such changes affect not only the person stepping-down but also the rest of their healthcare team, which may face challenges of increased patient care coverage, new hiring, and/or training of new leadership. All involved should feel supported at the same time that the exceptional care of patients continues. This report aims for smooth transitions.

Background:

Currently in the US, the average age of retirement is age 63, though for physicians this is closer to 65-66. Factors such as the Great Resignation after COVID affect the landscape. We list some potential personal barriers to retirement.

> **Note**: The different departments within Cook have been managing step-downs and retirements each in their own way. We have nested further background and their advice in the Recommendations section below.

Assessment:

Retirement and Step-down transitions require **advanced planning**.

Here are some questions the clinician stepping down and the rest of the team should ask themselves.

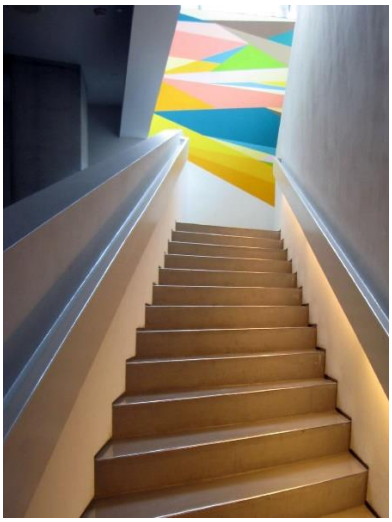
Recommendations:

1. Recommendations for the Individual Physician/Clinician, including a To-Do List per Dr. Howard Kelfer
2. Recommendations for the Office/Department of the Physician/Clinician
    - Learning pearls from Dr. Deborah Schutte based on the Cook Cardiology department's experience
    - Make a RETIREMENT ACTION PLAN. Overview is followed by a dive into individual components.
        - Set an Age for Step-down Options (section includes excerpt from Cook Rules&Regulations)
        - Determine the "Value" of Taking Call
        - Consider Ways to Contribute While Scaling Down
        - Determine a Maximum Time for the Step-down Perks
        - FTE Considerations, including BENEFITS
        - Consider Shared Expenses
        - Consider Patient Volumes
        - Transitioning Patient Care, including advice from VP Experience Megan Chavez
3. Recommendations for CCPN and Cook Children's as a whole
4. Take Home Points, Including a Closing Quote from Dr. Sara Garza

PRACTICE MANAGEMENT MATTERS

Step-down to Physician Retirement

(Or to Other Life Priorities)



S: Situation (and relevance of the topic)

1. Health care professionals –specialists and generalists included–will retire.
2. When retirement unfolds, groups and departments will need to make arrangements.

   The coverage of call and clinic duties will need to be determined, and roles and leadership may require transitioning. Extra responsibilities will likely fall to existing team members or may require new hiring or coverage arrangements. In the case of PCP groups, too, there will need to be discussions as to the feasibility of new hiring versus the remaining physicians' absorbing the overhead and patient panel.

3. Even before and aside from retirement itself, step-downs (like requests to continue working but part time or with no call) may happen, also requiring increased coverage by other teammates, new hiring, and/or training for new leadership. Reasons may relate to childcare, eldercare, personal wellness or other life priorities.
4. A smooth transition for all requires planning.
5. Ideally, all involved should feel supported and appreciated at the same time that exceptional care of patients continues.

B: Background (retirement ages and confounding issues)

- Currently, the average age of retirement for Americans is **63 years**.

- By contrast, the average age of physician retirement from clinical activities per 2018 data in the U.S. is **65 years**. Physicians even then often maintain leadership or advisory roles with complete retirement happening closer to **66 years.**
- Women physicians retire on average 1 year earlier than their male counterparts.
- Working in a rural versus urban setting does not significantly impact retirement age.
- The above numbers do not yet reflect **The Great Resignation** occurring since the pandemic. According to a study by the Mayo Clinic, surveying 20,000 responses at 124 institutions across the country, 1 in 5 physicians plan to leave medicine altogether and 1 in 3 doctors plan to reduce their work hours. Retirement ages (or age of changing career) can be quite young.

Potential Personal Barriers to a Smooth Retirement:

1. Uncertainty about when to retire and when to plan for it
2. Financial stressors and unknowns
3. Limited identity outside of work: "If not a doctor, who am I?"
4. Lack of institutional support (Cook's aim is for this NOT to be the barrier)
5. A perception that retirement is an individual/private decision.

A: Assessment

Retirement is an issue that merits planning. A lack of planning in the face of physician retirement can result in confusion in an office or department about next steps, feelings among retiring physicians and remaining teammates of being over-worked and under-appreciated, complications of understaffing, and a bumpy transition of patient care.

By contrast, efforts put forth into planning for provider retirement, even without yet knowing who precisely is retiring and when, can help assure a smooth transition in which the retiring physician as well as remaining team members feel appreciated and supported and in which a general road map aligns expectations. In much the same way that care providers develop action plans for patients with asthma or diabetes, we must know the questions to ask when a physician of the group is looking toward retirement. We should have a general plan of action laid out and then, once an individual decides to step-down to retirement, we can work to answer the pivotal questions and to cater the specific situation to the general plan. We can adjust as needed to the person and circumstances.

Questions Retiring/Scaling-down Clinicians Must Ask Themselves:

1. When do I want to retire or scale down? Gradually or abruptly?
2. What can I handle in so far as call/nights/weekends?
3. What do I hope to scale down on, specifically? Percent time, call, certain clinic patients, or all of the above?
4. Can I think of ways in which I might be helpful to my group in new ways, even as I go down on my FTEs or my call/night/weekend duties? In this way, my requests to my team to scale back might come with some benefits for them as well. Still with the result of scaling down, ways to contribute might include fielding certain types of parent calls or portal messages even if not

doing full call (see later description of how Endocrine handles parent calls), serving as the laboratory/radiology physician point-person for your group, mentoring new physicians in the group, or teaching rotating medical students.

5. Have I kept up with changes/advances in the field, and do I feel supported in keeping up (EMR training, training for new procedures, CME)? Are concerns about the challenges of keeping abreast of new information playing into my decision to retire?
6. How will I pay for my family's health care and other needs?
7. How will I inform my patients of transitions ahead and help their transition?
8. What will I do with my time? Will I still teach, administrate, work prn or be involved in medicine otherwise? What are my hobbies outside of medicine?

Questions for the Remaining Team Members:

1. How do we aid our teammate in their transition?
2. Does the request for retirement/step-down derive from the teammate's not feeling comfortable with new technology, procedures, EMR, or the like? If so, could extra training and support help?
3. How long will the step-down period last?
4. What is call worth? How will the retiring physician's and other teammates' salaries/income be affected by taking more or less call?
5. Will the department be able to function with one fewer provider taking call?
6. How will we make sure that all patients are cared for with our same top-level quality and accessibility during the transition and beyond? Will we need to consider adding/requesting more providers, and –if so—should we consider requesting the addition of an advanced practice provider or a physician to the team?
7. Will overhead expenses increase for remaining teammates?

R: Recommendations

Recommendations for the Individual Physician:

1. Start early in considering general plans for retirement/step-down, including target age and ideas for what to do after retirement (see the questions physicians stepping down should consider). Ask yourself if those plans will include teaching or prn medical practice.
2. Be open about your considerations and general time-line, as your transparency will help in planning and will encourage transparency within your group overall.
3. Determine your financial situation and level of financial security. Meet with investment advisors as needed.
4. Cultivate hobbies.
5. Discuss retirement with other recent physician retirees to help pave the way for your transition.
6. **Keep in mind that there are quite a few steps you will need to take to retire, beyond letting your section/group know.** Per Dr. Howard Kelfer, who retired recently from Cook's Neurology department, there were many things to do, but they were not spelled out plainly anywhere. So, with his help, let's spell out at least the big steps.

Link Should You Wish to Return to Synopsis

To Do List for the Retiring Physician

a. Notify CCPN in writing as per your contract, including notice to Dr. Matt Dzurik and Human Resources.
b. Notify the Cook Med Staff office and, if desired, initiate a process of maintaining Honorary Med Staff status (in order to stay better connected and maintain email) and keeping access to library.
c. Notify the other hospitals where you might have privileges of your plan to retire.
d. Notify your patients of the transition of care.
e. Make a plan for health insurance with no coverage gap. See Cook Benefits Team and meet with their Medicare expert. Dr. Kelfer strongly advises holding on to your Cook health insurance (even if that means paying for an extra month) until your Medicare (or other) coverage card is in your hand and definitively in effect!
f. If you think you might work prn or *locum tenens* after "retirement," make sure to maintain current credentialing and licensure—do not let these expire!

Link Should You Wish to Return to Synopsis

Recommendations for the Office or Department:

Several departments within Cook have developed retirement processes worth noting.

Cardiology: Some years ago, in the Cook Cardiology Department under the leadership of Dr. Deborah Schutte, many physicians expressed a desire to retire within the same limited span of time. The group hired a consultant and formed a five-person task force made up of department physicians at different stages in their career. Through this process, they arrived at some general decisions which helped their department to navigate the situation smoothly and which has helped since then as a roadmap to retirement. Their openness about their experience was part of the impetus for writing this document.

Other Cook departments have considered the topic perhaps less formally but still meaningfully. Still others have reported that they have not faced the need to have a pathway to retirement yet due to the young ages of their physician groups. However, they would like to know more about how to prepare. Thank you to the Cook directors and departments who have shared their experiences. It is our hope that this information will help other groups develop retirement roadmaps to suit their needs.

*If you take one point from this newsletter, let it be that your group/department needs to make a RETIREMENT ACTION PLAN. Here is an overview, and then we will consider the details.

Retirement Action Plan

- Have regularly scheduled "check-in" discussions for group
- Have CME/education in place to keep everyone up to speed
- Recognize an AGE for Retirement Step-down Options (recognizing that "step-down" requests can come up at any point)
- Determine the VALUE OF TAKING CALL and Feasibility of Allowing for No Call
- Consider ways the physician stepping-down can help the group, even while stepping down
- Determine a DURATION of time for "step-down perks"
- Determine the process, pay, and benefits for part-time work
- Consider how expenses shared among the group will change
- Consider how your department or group will care for the same or a growing number of patients with fewer covering providers
- Have a plan for patient care transition

Let's take a deeper look at the steps of making a Retirement Action Plan:

A. **Initiate discussions about potential retirement early. TALK.** You may want to designate a regular yearly (or every 6 month) meeting as a time to check in with providers in your group or department about their plans and wishes relating to their short and long-term career planning and life balance. It should be a conversation allowing for openness about life-balance issues and possible solutions. These "check in" meetings serve not just to give warning about those wanting to step-down to retirement but about those who might wish to decrease their hours for child or elder care or physician wellness considerations. Options and concerns among the group as to how the transition will happen and how the work will be divided must be discussed.

B. **Keep everyone up to speed in your specialty/field.** Offer CME or other training to help all members of the team feel comfortable with new technology and protocols in the field.

Link Should You Wish to Return to Synopsis

C. **Set an Age for Step-down Options.** Just as physicians in some departments must work a certain number of years to "ramp up" to partner status, consider also setting a general timeline for those who wish to start "stepping down." It may be helpful to set an age at which physicians might **elect** to begin their step-down to retirement (please note: they do not have to if they do not want to, and—if on the other hand they want to step-down earlier due to circumstances—we must be ready to approach this topic with flexibility and understanding).

- Of note, Cook has Rules and Regulations relating to specialty call coverage, specifically related to those age 60+ with a history of 5+ years of work for Cook **OR** younger but with a history of 25+ years of work for Cook. Here is the exact verbiage:

1) Specialty call-coverage obligations are set out in the Bylaws and apply regardless of the distance of the Practitioner's practice location from the Center.

2) Exceptions to specialty call coverage may be granted by the Medical Board for:

   a) Requesting members sixty (60) years of age and older who have practiced in the Center for at least five (5) years, depending on the Center's and community's needs in the medical specialty or subspecialty;

   b) Those areas specifically covered by an exclusive contract; or

   c) Requesting Active and Senior Active Staff members who have practiced at the Center for twenty-five (25) years or longer prior to age sixty (60), depending on the Center's and community's need for the medical specialty or subspecialty. All exemptions are subject to the approval of the Governing Body. The Medical Board may also revoke any exemption based on Center and/or community need.

- **Cardiology:** In the cardiology department, it takes 5 years to make partner, and then partners of age 60+ have the option of dropping out of the call pool as per the option in the bylaws.
- **Neurology:** The Neurology Department allows a drop of call after being in practice for 15 years, having extenuating medical circumstances, or reaching an age of 60+.
- **Endocrine:** The Endocrine Department allows for a drop out of call as per the above option in the bylaws as well, More details below.

Link Should You Wish to Return to Synopsis

D. **Determine the "Value" of Taking Call.** Depending on the compensation structure in a department or office, groups may choose to assign a value to call, for example as a precise monetary amount or as a percentage of take-home salary. When considering criteria for reducing call duties, it is also important for departments/groups to keep in mind the minimum number of providers essential to cover call for their group. Depending on how many people want to leave the call pool, there could be an unnecessary burden placed on other team members, and there may be a need for rearranging call, requesting that providers re-enter into the call pool (perhaps with added enticements), or new hiring.

- **Cardiology:** Call is Percentage of Take-home Salary. In the cardiology department where partners distribute pay equally based on a collective productivity compensation model, call was determined to be worth 20% of the physician salary. Consequently, a partner deciding not to take call any more can expect to earn 20% less than other partners who do take call.
- **Neurology:** Call is a percentage of Take-home Salary. The Neurology Department, also functioning on a collective productivity compensation model, puts the value of call at 25% of the total physician salary. The higher value makes it more enticing to stay in the call pool. However, if someone is concurrently going down on FTEs, they may not generate enough income for the group to justify the high payment for their proportion of call. This department, therefore, has set guidelines that someone working 0.8 FTE can opt to take from 0.8 to full call. Between 0.6-0.79 FTE, their call percentage drops along with FTE. Below 0.6 FTE, physicians are not allowed to participate in the neurology call pool.
- **Endocrine:** In the Endocrine department, physicians are on an individual compensation model, which provides some autonomy in terms of physicians setting their own schedules and placing limits on their hours/workload. Their group opted not to assign a monetary value to call but instead to view call relief as a free benefit that everyone will enjoy eventually. However, in truth their system establishes a bit of a barter system for call. Once they are age 60, physicians earn the chance to be part of Endo's No Call Group and no longer take call for admits/consults in the hospital. However, they call their No Call Group the "Mommy (and Daddy) Call" group, handling calls from families on weekdays (not on weekends, when diabetes educators manage parent calls) and thereby lightening the phone responsibilities of the On Call group. On the average, a person on endocrine's No Call team covers 4-8 Mommy Calls per call night on a rotation schedule. At present, the "No Call" group consists of 4 No Call physicians and 4 NNPs paid to be on the rotation schedule for Mommy Calls. Each member of the No Call team takes 2 weeknights of Mommy Call per month.
- **Orthopedics: Call has a Monetary Value.** In the orthopedics department, like endocrine, the physicians are paid on an individual productivity compensation model. Like endo, they feel this arrangement leads to some flexibility in that different physicians can choose to see or operate on fewer patients than others, but in turn they will not receive as much compensation as those higher producers in their group. Their call has a designated monetary value rather than a percentage value and carries with it the added value of billed RVUs during call. In their group, there are a couple of physicians not on the call schedule as per Cook bylaws, and those orthopedists do not therefore get the flat pay or the RVUs generated from call.

Link Should You Wish to Return to Synopsis

E. Consider ways the stepping-down physician might benefit the group, even while they are reducing their hours/call. The aim is that the retiring physician would find a way to contribute that still allows for a lighter workload.

- Ideas include working being the "lab physician" or "rad physician" with some oversight duties, mentoring new physicians, helping with the group's social media

presence, helping with the teaching of rotation medical students, and spearheading activities for staff morale.

- Physicians—that is, PCPs-- should keep in mind that **locum tenens** work is an excellent way to benefit the network while keeping ties to clinical work. And there is always a need! In the specialty setting, a similar way to keep up clinical skills and continue to benefit your group is to **work prn**. In both scenarios, physicians stepping down can be a tremendous help to their groups as they cover for others out for sick or maternity leave, travel, etc.
- Endocrine: See above (in Section D) for their arrangement in which physicians stop having hospital call but cover parent calls so that hospital call is not as onerous.
- PCP: Some physicians have found that doing some telemedicine visits while scaling down on in-office days can be a way to lighten their load while still being of help to their own patients, their practice, and/or to CCPN at large (i.e. helping with Urgent Care coverage helps CCPN more broadly).

F. **Determine a Maximum Time for the Step-down Perks.** Since taking call generally is perceived as one of the more taxing of physician duties, it might put an unnecessary burden on remaining teammates should no-call perks for a retiring team member go on for an indefinite time. Setting limits for this arrangement of no call and other such benefits is very important.

- **Cardiology:** In the cardiology department, if someone chooses to opt out of the call pool, the maximum amount of time they can continue working full time without sharing in call duties is 5 years. A physician opting out of the call pool can expect to see a 20% drop in salary as compared to other partners.
- **Endocrine:** In the endocrine department, physicians are in either the On-Call or No Call/Parent Call groups. There is no time limitation on this benefit, as the group views the No Call group as an earned privilege, and those No Call physicians are still helping their team significantly by answering parent calls. The only concern, however, is that their department has determined that they need 7 physicians at a minimum to take call. Although it has not happened yet, there could be a situation in which too few physicians are left in the On-call group. There would then have to be considerations about hiring needs or No Call physicians' helping out at least temporarily with call.

Link Should You Wish to Return to Synopsis

G. **Determine a basic understanding about the percent time worked (FTE), pay, and duration. Playing in to this discussion is the matter of how FTE plays into your physician benefits.**

- As part of the step-down, retiring physicians may want to decrease their days. Adhering to certain agreed-upon rules of thumb might help the whole group/department in planning for new hiring needs.

  - **Cardiology:** The cardiology group decided that physicians could continue working as long as they wished but with limits on percent time. After 5 years of a step-down process, a cardiologist stepping down to retirement can be

paid for 3 days a week for 2 more years. After those 2 years, retiring physicians can work only 1 day per week (or 2 half-days) for as long as they would like.

- **Neurology:** As explained above, the neurology department has determined that physicians choosing to work 0.6 FTE or less may not participate in the call pool. The pay for covering call is so substantial that revenue from a part-time physician does not cover it.

- Your **EMPLOYEE BENEFITS are tied to your FTE**, so you must go into any decisions of reducing time with an understanding of the benefits situation.

Benefits by % of Time Worked

Physician Employment Position Based on Hours	Medical Dental and Vision Benefits	Company Paid Life and Accidental Death	Supplemental Life/Spouse Life/Child Life	Retirement Plan 401 A Match Eligibility	Company Paid Disability Short Term and Long Term
Full Time (0.75 - 1.00 FTE)	Yes	Yes	Yes	Yes	Yes
Half Time (0.5 - 0.74 FTE)	Yes***	No	Yes	Yes	Yes
Less than Half Time (.1 -0.49 FTE)	No	No	No	Yes**	No

** Must work at least 1000 hours over calendar year and be employed as of 12/31.

***Half time employees age 50 and over, with at least two years of service, have the benefit of paying the lower rate of a Full-time employee's medical monthly premiums.

In summary,

- 0.75-1 FTE employees have full benefits
- 0.5-0.75 FTE employees have good benefits, but they have no company-paid life/accidental death coverage. Of note, health insurance premiums are higher for people in lower FTE categories. However, if you are 50+ yrs old with a history of 2 yrs+ of service to Cook, you still pay the lower rate for health insurance that a full time employee pays even if you move to 0.5-0.75 FTE.
- <0.5 FT no longer have benefits but still may qualify for retirement match (note: this may sound bad but might still be the right decision for you, depending on your situation and outside insurance).

For further reference: rules regarding benefits are covered under the Affordable Healthcare Act (ACA). Employee Retirement Match Eligibility is covered under ERISA legislation of 1974.

H. **Consider how your retirement will affect shared expenses among your remaining team members.** The group should discuss ways to mitigate any expense burden. This may be particularly relevant for collections-based compensation models such as that used in many CCPN PCP offices.

- Primary Care example: In one of Cook's PCP offices, there were at one point six physicians in the group, with two physicians job-sharing, which meant they shared one physician office and its cluster of patient rooms and therefore split the overhead. When another physician of the group announced plans for retirement, it was not felt the practice was full enough to justify a new hire at that time. Consequently, after the physician's retirement, there was a physician office and a whole set of patient rooms left empty, with one fewer physician paying their full rent. Questions as to the fair division of office space and rent arose. Ultimately, one of the job-sharing doctors opted to move into the empty physician office and use those nearby patient rooms, and the group decided to share the rent expense evenly (no more half-rent for the half time physicians, since everyone had equal space). However, this increase in rent expense decreased the part-time physicians' compensation considerably. Ultimately, through open communication and the desire of all to make the compensation as percentage of collections essentially even for all group members, the group adjusted some of the other expense sharing by percent time and collections such that the division of expenses was agreed upon as fair by all.

  *This anecdote highlights the importance of ongoing communication and cooperation within a group. Retirement discussions and planning sessions should happen in advance of these situations.

  ** It also highlights that sometimes a SHARED position, if feasible, can be the simplest way to cover patients and expenses.

Link Should You Wish to Return to Synopsis

I. **Consider how your department or group will care for the same number—or, more likely, a growing number– of patients with a smaller care team.**

It is possible your partners wish to grow their practices and are eager to care for additional patients without a second thought. That could be a nice situation, a mutually beneficial step-down to retirement. Most departments, however, will face increasing clinical demand over time and will need to devise a plan to continue to provide quality care to an ever-increasing volume of patients. Your group/department may determine a need to add an additional physician, either full or part-time, to the group. As touched on in a prior example, sometimes an arrangement where two part-time providers cover for each other and form a team equivalent to a whole FTE can be very helpful. Alternatively, you may consider adding an advanced practice provider to your group. APPs do not build their own official patient panels, but they can be extremely helpful in providing quality, personalized care within your medical home for shared patients on days a provider is out (or on days the provider is in but has overflow). APPs can be extremely helpful in providing sick care.

- Primary Care: Some PCPs, in scaling back on clinical time for more administrative time or for more time at home, have arranged to have an APP fill in for them when they are not in the office. This arrangement can shelter their partners from the stress

of –all of a sudden—having to cover larger patient volumes. If you are a PCP looking to scale down, there are factors specific to your practice that will affect whether or not adding an APP is a good financial option for you and your group. Please reach out to your Primary Care Medical Director if you are considering whether adding an APP would be feasible in your practice.

- **ENT:** The ENT department recognizes that part-time options need to be available to surgeons just as they should for other departments and groups. However, they note that part-time situations in the setting of a surgical specialty can bring added challenges. For example, Post-op Global dictates that surgeons' management of patients for the 90 days after surgery is part of the surgery fee. Therefore, a physician who performs a surgery but is not there to see those patients post-operatively for complications or concerns is relying on their group to cover a clinic visit without reimbursement. If one physician covers for another essentially equally, this can proceed smoothly. However, the provision of post-operative care has the potential to lead to imbalance and perceived unfairness and thus may require evaluation and creative solutions by the group.

Link Should You Wish to Return to Synopsis

J. Have a Plan for Transitioning Patient Care, clearly and lovingly.

The Texas Medical Board has requirements for informing patients about transitions. For your reference, these requirements are included as an addendum to this document.

Megan Chavez, Cook Vice-President of Patient and Family Experience, urges retiring physicians and their groups to be proactive in addressing the following patient/family questions before families even have to ask. These parent questions can help guide discussions as well as provide a framework for a letter going out to the retiring physician's practice.

- Will I bond with and trust this doctor as much as I trust you?
  - RECOMMENDATION: Include your personal experience with the doctor, how much you know and trust them and/or their credentials. For example, "I have worked alongside Dr. X for 10 years, and I would trust my own loved ones in his/her care." OR "Dr. X has 10 years of experience working with children just like yours and is board certified," etc.
- Will this doctor have my/my child's medical history and know what my concerns are?
  - RECOMMENDATION: Mention that the new doctor will have access to your medical documentation. Explain that detailed notes have been written about the medical situation but that talking directly to the new physician about concerns is an important part of the first visit.
- Will this doctor be covered by my same insurance? Will costs change?
  - RECOMMENDATION: Explain to families that their new doctor accepts their insurance plan, and the costs will be the same as always.
- How do I talk to my child about the change?
  - RECOMMENDATION: Tell your families the importance of talking to their child about the transition and about why it is happening. They should make sure their child understands that you care about them and that you know and trust their new doctor. You have shared information about the child with them.
- When will this change happen? Any other impacts to my child's care?
  - RECOMMENDATON: Be specific when possible.

Primary Care: PATIENTS' AGING OUT. One tip from a PCP group recently experiencing the retirement of a physician is that there should be a specific plan for patients over 18. Their group sent transition letters to all of the retiring physician's patients, but then—on assuming care of these patients—the remaining physicians realized many of the patients were over 18. It would have been a good plan to send a different letter to those patients to help them to transition to adult care. Keep this in mind!

Link Should You Wish to Return to Synopsis

Recommendations for CCPN and Cook Children's as a whole:

1. Provide opportunities for financial planning and guidance.
2. Support opportunities for continuing medical education, EMR training, and specialty base curricula.
3. Provide structure/opportunities for physicians considering retirement to meet with recent physician retirees.
4. Provide documents such as this one to get groups thinking about these issues and planning for changes in the future.
5. Continue thinking about how to make retirement/step-down smoother for all and branching into related issues such as maternity and paternity leave, the feasibility (or not) of offering sabbaticals for physicians who have served Cook a long time, etc. Please help us by sharing your ideas for topics and creative solutions!

TAKE HOME POINTS:

1. Have discussions with group members relating to potential retirement or stepping down to other life priorities. As for retirement, preferably sooner **but at least by age 60**, make sure you have discussed the 5 year outlook! Be transparent, both personally and professionally.
2. Make a **Retirement Action Plan** within your group or department so that expectations align within an agreed-upon framework. Make a plan that makes retiring physicians as well as remaining team members feel supported and appreciated.

To close, here are some thoughts from Dr. Sara Garza, Associate Physician Well-being Advocate for Cook Children's:

"We know how important it is to take the time to holistically consider what we value and want to prioritize in our personal and professional lives and to set our course toward that vision. Healthy integration of our personal and professional lives is necessary for well-being. We all have unique experiences that shape us, and then the responsibilities and pressures we face in our lives influence our decisions. We want to foster a psychologically safe community in which we can openly communicate, share creative ideas, welcome flexibility and support one another to promote healthy work-life integration at any career stage. This is an excellent step in the right direction."

Document written by Daphne Shaw, MD, Chair of Practice Management Committee 2022-2024, with significant help and motivation from Dr. Deborah Schutte, as well as Dr. Alice Phillips, Dr. David Gray, Dr. Sara Garza, and Ms. Megan Chavez. Thanks also to others for sharing their helpful insights, including Dr. Scott Perry, Dr. Michelle Marcincuk, Dr. Paul Thornton, Dr. Robert Gillespie, Dr. Tammy Hayward, and Dr. Howard Kelfer. Showers of thanks go out to the Cook PR's Sydney Hanes and Reilly Ternan and to videographer Tom Reihm for working so hard on the preview video, including going all over town for filming appointments. Thanks to Jeff Calaway for finding an online- home for Practice Management Matters documents. A gracious tip of the hat to Dr. Heetan Masters, Dr. Deb Schutte, Dr. Nick Ogunmola, and Dr. Howard Kelfer for being such good sports and speaking on the video. Finally, thanks to the Practice Management Committee as a whole for its review of this topic and dissemination of the message.

Link Should You Wish to Return to Synopsis

TMB rules for physicians who retire, close, or leave a practice

Physicians who are retiring, closing, or leaving a practice can notify patients electronically and by posting a notice on their practice website, according to rules from the Texas Medical Board (TMB). [1]

Required notification of discontinuation of practice

According to TMB Rules Chapter 165.5(a)(1-3): "When a physician retires, terminates employment, or otherwise leaves a medical practice, he or she is responsible for:

- Ensuring that patients receive reasonable notification;
- Ensuring that patients are given an opportunity to obtain copies of their records or arrange for the transfer of their medical records to another physician;
- Notifying the Texas Medical Board when he/she is terminating practice, retiring or relocating, and will no longer be available to patients;
- Specifying who has custodianship of the records; and
- Advising how copies of the medical records may be obtained."

"(2) Notification shall be accomplished by:

(A) EITHER:
(I) Posting such notice on the physician's or practice website; OR
(ii) Publishing a notice in the newspaper of greatest general circulation in each county in which the physician practices or practiced and in a local newspaper that serves the immediate practice area; AND
(B) Placing written notice in the physician's office; AND
(C) Notifying patients seen in the last two years of the physician's discontinuance of practice BY EITHER:
(i) Sending a letter to each patient; OR
(ii) Sending an email to each patient, in a manner that is compliant with state and federal law.

(3) A copy of the posted notices shall be submitted to the TMB within 30 days from the date of termination, sale, or relocation of practice.

(4) Notices placed in the physician's office shall be placed in a conspicuous location in or on the facade of the physician's office as a sign announcing the termination, sale or relocation of the practice. The sign shall be placed at least 30 days prior to the termination, sale or relocation of the practice and shall remain until the date of termination, sale or relocation." [1]

Leaving a group practice

These rule changes also apply when leaving a group practice, as the departing physician is responsible for providing proper notification. The physician must notify the TMB and his/her patients, and advise who has custodianship of the medical records and how a copy may be obtained.

Those remaining in the practice must be careful not to interfere with the departing physician fulfilling these responsibilities. The TMB has rules prohibiting the practice or physician group from interfering. (2)

Prohibition Against Interference 165.5(c)(1-2) rules state that:
(1) Other licensed physicians remaining in the practice may not prevent the departing physician from posting notice and the sign;

(2) A physician, physician group, or organization may not withhold information from a departing physician that is necessary for notification of patients. [2]

"When requested, the practice should provide the departing physician with the contact information of his/her patients to ensure the departing physician is allowed to fulfill patient notification responsibilities, and to avoid TMB disciplinary sanctions for the remaining physicians and possible legal risk to the practice." [3]

Sources

1. Texas Medical Board. Texas Medical Board Rules Chapter 165.5(a)(1-3) Transfer and Disposal of Medical Records. Accessed January 18, 2023.

2. Texas Medical Board. Texas Medical Board Rules Chapter 165.5(c)(1-2) Prohibition Against Interference. Accessed January 18, 2023.

3. Harris County Medical Society. Leaving a group practice. Accessed January 18, 2023.