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Part-Time, Job-Sharing Arrangements

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Background

Facing an aging population of anesthesiologists, and a new generation more focused on work/life balance, anesthesia practices are increasingly faced with the challenge of providing a flexible work environment. The question often arises as how best to handle physicians who are nearing the age of retirement, but are not quite there yet and wish to lighten their call load. Younger anesthesiologists may also be interested in working part-time, taking a reduced call burden, or having no call at all. The issue then becomes how to create options which are both fair to the group and to the individuals who are interested in reducing his/her hours.

The current practice environment, which includes an anesthesia provider shortage, an aging population, changing mix of medical school graduates, physicians needing to take care of family or elderly parents, and the younger generation's different approach to work/life balance, has forced anesthesia groups to find ways to create flexibility in job sharing and non-call arrangements. Due to the transition of many surgical cases to less invasive ones, more anesthesia is delivered outside the traditional operating room environment. The proliferation of ambulatory surgery centers and non-operating room anesthesia has increased the need for day positions, potentially reducing the overall need for those taking call. The intensity of work has also pushed many physicians to look for reduced or "no-call" positions.

Examples of Part-Time, Job-Sharing Arrangements:

There are multiple potential ways in which this can done. Regardless of which method is used, it must be easily understood, consistent and transparent to all group members.

Physicians can request a part-time position at 80%, 60%, 40%, etc. This is not automatic and depends on the circumstances that the group is undergoing at the time. Expansion of sites, additional lines of service, etc., can often make new, reduced arrangement problematic. The individual will be compensated at that percentage of the FTE rate and will take call pro rata.
Alternatively, physicians can request a "no-call" position and there is a percentage deduction, (e.g., 20-35%) from total compensation for the no call option. The compensation deduction for no call may increase if a large number of providers are vying to reduce their call burden. E.g., the price goes up depending on the market.

These types of schedule changes are proposed to the group partnership or leadership and will be approved based on workload, manpower, etc. These deals can be modified if situations warrant (e.g., bringing them back to full-time or other FTE level if manpower needs require). In a partnership structure, if any physician drops below a prearranged percentage, say 80%, that individual may be required to sell 50% (or some percentage) of their shares of company ownership and be paid a portion of their deferred compensation/AR. This ensures that the decision making for the group remains in the hands of those most engaged in the work of the practice and prevents the majority from being part-time providers.

Other Options:
Based on age and years of service, one would be allowed to move to a "no-call" slot for reduced pay (e.g., 1/3) for 2 years. This is limited to a small number of individuals per year. Anything longer would need to be voted on an annual basis.

Other options are situations where 3 individuals might share 2 FTE slots or 4 individuals would share 3 FTE positions. With this arrangement, call, vacation allotment, etc. are divided pro rata. If one of the members of the arrangement decides that he/she would like to go back to a full-time position, it is the responsibility of the job share group to find a replacement. If no replacement is found, the remaining physicians must also go back to full time status. Groups may often limit the job-share option to those over 50 years of age and who have provided more than 10 years of service to the group. In those situations, if there are four individuals sharing 3 positions, each would have ¾ share of the practice and ¾ of a vote at meetings.

Other options are to create a wide menu of options and let those partners interested in a reduced work program (RWP) to pick and choose what they would prefer:

RWP Guidelines: (percent changes from typical full partner compensation) The model below is used by physician anesthesiologists at a mid-west practice. These percentages can be adjusted based on the local circumstances.

No holiday call	-2%
No weekend call	-25%
No weekday call	-12%
Monday off	-14%
Tuesday off	-11%
Wednesday off	-11%
Thursday off	-11%
Friday off	-14%

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Job sharing	+2% (if three docs "share" two FTE, each of those would add-back 2% to total compensation; therefore, less of a penalty for the job-sharers)
% added per director year	+1% (caps at 2%, added per Director year: This is to avoid someone becoming partner and immediately going part time. If they are partner for at least two years, they get 2% added back to their compensation reduction).
Reduction for 60-99% part-time	-2%
Reduction 20-60% part-time	-4%
Reduction for < 20% part-time	-6%

Each of these adjustments is additive. Therefore, if someone chooses NO holiday or weekend calls, there would be multiple reductions/adjustments based on call reduction, FTE percent reduction, years as a director/partner, etc.

Most groups (72.8%) do allow members to reduce hours, workload or call. However, some groups do not and the rationale are the following:

- Group resistance to the idea of some physicians working less than others (26 percent)
- Can't decide appropriate financials (23 percent)
- Nobody interested in doing this right now (21 percent)
- Too difficult to manage in the schedule (19 percent)
- And the catchall, it's just too complicated (11 percent)

<u>Summary:</u>
These issues should be thought of in a systematic manner before the need arises. This has become even more imperative with an aging population of anesthesiologists, the changing mix of medical school graduates, and the younger generation's approach to work-life balance. Flexibility is also paramount as group circumstances may change and some of these arrangements may have to be pulled back or potentially even extended. While no one method will work for all practice types, the above examples are a few of the potential solutions to this growing issue.