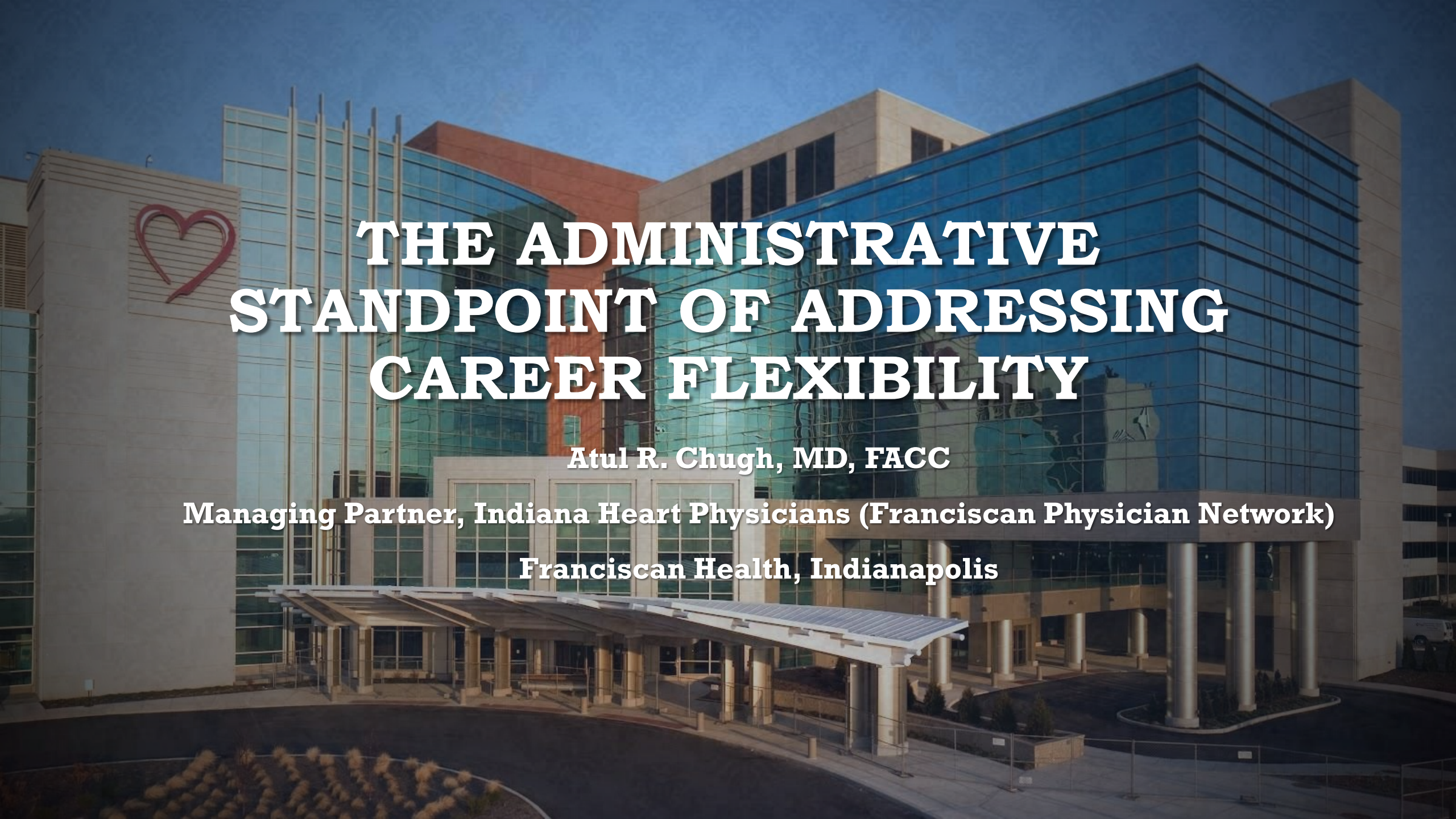

THE ADMINISTRATIVE STANDPOINT OF ADDRESSING CAREER FLEXIBILITY

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DISCLOSURES

- None

CAREER FLEXIBILITY-NEED TO BE FLEXIBLE TO FLEXIBILITY: SCOPE OF THE PROBLEM

>60% of all cardiologists are age >55 years, 25% are >65 years, and 10% are >70 years.

General cardiologists are oldest on average, whereas electrophysiologists are the youngest.

It is anticipated that there will be a net loss of >500 cardiologists per year because of the rate of retirement outpacing the fixed rate of graduating cardiology fellows.

Anecdotally, we are seeing an increasing trend among early career cardiologists, (both men and women) to work a reduced schedule (eg, 80% full-time equivalent) to preserve a greater work-life balance

Sauer J. "The Vexing Challenge of Physician Slowdown: How to Create an Effective Policy". MedAxiom Blog September 24, 2020.

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FLEXIBILITY TO CAREER FLEXIBILITY

- Given these realities, there is no choice but to be flexible to career flexibility.

- However, there are multiple operational matters that need to be considered in view of these emerging employment engagements.

FLEXIBILITY FOR ALL?!?

Let's play out a scenario:

A current group of 20 cardiologists begins to start offering <0.8 FTE positions both outside and within the group. This includes adjustment of call schedule to 0.8 of the FTE's allotment.

The group's policy suggests that compensation is adjusted by the FTE by 0.2. In other words,
pay is simply 80% of the total annual compensation of a full time employee.

What happens? Does this happen….

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GENERAL CONCERN: EQUALIZING THE FTE

Cardiologist A: 0.6 FTE

- Cardiologist Shortages
- Difficulties with recruitment (e.g. compensation, geographic limitations, etc.)

Cardiologist B: 1.4 FTE

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WHAT DO WE NEED TO THINK THROUGH?

Clinical Gaps

- Call Schedule
- Inbox Management
- Outpatient Access/Patient Care Continuity

Non-clinical gaps

- Programmatic Development
- Education
- Referral Base Communication
- Administrative Duties

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IS CALL STILL CURRENCY?

- Currently, most groups will have a larger amount withheld than a mere yearly correction for compensation adjustment. (“The No Call Penalty”)

- Amounts are very high currently which impedes feasibility of FTE flexibility (3-6 call day comp: 1 non-call day comp ratio)

- Bridging Tactics:
  - Nocturnist programs
  - Involvement of APPs in call responsibilities
  - Greater involvement of medicine hospitalist team for overnight responsibilities

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POSSIBLE GUIDELINES FOR EXISTING GROUP CARDIOLOGISTS

- The "Sweat Equity" Method: 10 or more years in the practice gives one the ability to enter into a ramp down model if feasible:
  - Example: 0.8 FTE with full call first 1-2 years, drop down to 0.5 FTE with half-call model, etc.

- "Net Even Method":
  - Aggregation of all days by specialty
  - Days and comp then evened out based on an individual's desire to work less or more.
  - Better for larger groups with more in-group heterogeneity

DIFFERENT PRACTICE MODELS FOR DIFFERENT PROVIDERS

Non-Invasive Cardiologist A:

- In a small outreach center 75% of total time
- Clinical Hours shorter due to windshield time
- Sees a total of 8-12 patients per day
- No inpatient responsibilities

Non-Invasive Cardiologist B:

- Metro based
- Seeing 25 patients/day
- Higher patient acuity

NEED FOR NON-PATIENT ENCOUNTERING ACTIVITIES

- There are many activities that a cardiologist performs which are of no monetary value but of great clinical importance.

- Can these translate to a "return on investment" whereby clinical productivity increases for clinicians while retired or ramping down cardiologists aid in these activities?

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SUMMARY

- The need to be flexible with how a practice engages with a cardiologist has never been greater.
- While the need is paramount, logistical challenges must be considered and reconciled.
- Cardiology career flexibility cannot be achieved without administrative flexibility

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