Effective Workload Distribution

Moderators:
Cedric Bailey, MD, FCAP
Amanda Zand, MD, MPH

Panelists:
Karim Sirgi, MD, MBA, FCAP
Matthew Mastrodomenico, MD, FCAP
Adam Hoffhines MD, PhD, FCAP

April 30, 2024
Cedric Bailey, DO, FCAP

- Member – Practice Management Committee
- Clinical Instructor in Anatomic Pathology at Cedars-Sinai Medical Center
- Board certified in Anatomic/Clinical Pathology and Cytopathology
- Fellowship in Cytopathology
Amanda Zand, MD, MPH

- Member – Practice Management Committee
- Undergraduate studies at the University of California.
- Master of Public Health (M.P.H.)
- Post-Sophomore Fellowship with the department of Pathology and Anatomical Sciences.
- Third-year pathology resident at the University of California
Disclaimer

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Karim E. Sirgi, MD, MBA, FCAP

- Chair – Practice Management Committee
- Owner - CEO Sirgi Consulting LLC Denver, CO
- Chief Science Officer, BreathTech
- Chair, Colorado Delegation to CAP House of Delegates
- Past-President, CAP Foundation
- Board certified AP/CP and Cytopathology
- Fellowships in Cytopathology and Surgical Pathology
Workload distribution: A crisis for many groups!

- Ranks among the three highest reasons of stress and dysfunction in a group
- Cannot be ignored by the group’s leadership without consequences
- Permeates entire group and department mood (including non-pathologists)
- Affects recruitment and retention
Root causes of workload distribution challenges
Root Cause #1: The RVU System
The RVU system

• The RVU system was created to bring more uniformity to Medicare's reimbursement system, and to assist in controlling healthcare costs. This system was introduced in 1992, with the goal of objectively quantifying physician work, practice expense, and malpractice expense.

• Since the inception of RVUs, virtually all commercial health insurers use this as a basis of their payments. The RVU is the cornerstone of getting paid.
The RVU system

• “Physician work”: Only work identified by a CPT code (therefore, only an actual pathology specimen) is assigned an RVU and is linked to a clear payment scale by Medicare and private payers.
RVU Generating Activities

- Surgical Pathology
- Cytopathology
- Clinical Pathology Interpretation
- New Clinical Consultation activities
### Non-RVU Generating Activities

<table>
<thead>
<tr>
<th>Category</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and Accreditation</td>
<td>Review of QC, PT, Procedures, Performance of inspections, Autopsy</td>
</tr>
<tr>
<td>Clinical Consultation</td>
<td>Review clinical history and recommend testing, Investigate reference labs for special testing, Driving to cover remote facilities</td>
</tr>
<tr>
<td>Laboratory Instrumentation</td>
<td>Development of RFP’s, Demonstrations, Assessments, Selections, Validations</td>
</tr>
<tr>
<td>Meetings</td>
<td>Committees, Intradepartmental, Interdepartmental, System, Professional Society</td>
</tr>
<tr>
<td>Teaching</td>
<td>Technologists, Residents/Fellows (pathology and others), Medical Students</td>
</tr>
<tr>
<td>Clinical Conferences</td>
<td>Tumor Boards, Grand Rounds, Morbidity &amp; Mortality</td>
</tr>
<tr>
<td>Administration</td>
<td>Laboratory sections (local and remote), Department, Procedure development and review</td>
</tr>
<tr>
<td>Leadership</td>
<td>Group, Hospital, System, Professional Societies</td>
</tr>
</tbody>
</table>

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Root Cause #2:
The Lack of a National Standard for Workload Evaluation in the US
Useful Tips for Building your Own Workload Distribution System:

- Every practice and every practice setting is different (even within the same group or hospital system!)
- Address workload distribution with an open mind
- Allow plenty of time and input from all members and specialists of the group in creating and implementing a system
Useful Tips for Building your Own Workload Distribution System:

- Decide on a system and move on!
- Do not let the “perfect” be the enemy of “the good”
- Inform the group about the process in place to make changes
  - Practice elements change and so should the system
  - Re-evaluate on an annual basis
  - Continuously gather input, but do not undermine the system in place with every complaint
- Only adjust ad-hoc in case of impending crisis or unexpected change
Matthew Mastrodomenico, MD, FCAP

- Delta Pathology Group
- Regional Medical Officer – North Louisiana
- Technical Director – Flow Cytometry
- Board certified in Anatomic/Clinical Pathology and Hematopathology
- Fellowship in Hematopathology
DPG Markets

NWLA
NELA
Mid LA
S LA
Lake Charles
North Shore
Greater NOLA
Central MS
Northeast Texas

Hospital Clients Served
Relative workload discrepancy between markets

Hospital Clients Served
Workload distribution

Equitable case distribution - Case targeting software in DPG’s new LIS
Case distribution

• Automated company wide case distribution - Algorithm in DPG’s proprietary LIS Delta Phoenix

• Assign accessioned cases at the end of each day with the goal of evenly distributing work across all pathologists and all markets.

• For each individual accession - determine which pathologists are eligible to receive the case:
  1. Which pathologists are on service AND
  2. Credentialed at the facility where the specimen was obtained AND
  3. Assigned to read cases from the market in which the specimen originated AND
  4. Assigned to read cases in that specimen's subspecialty
<table>
<thead>
<tr>
<th>Pathologist</th>
<th>Markets</th>
<th>Specialties</th>
<th>Weight Percent</th>
<th>Current Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khare, Vivek</td>
<td>Shreveport, Texarkana</td>
<td>Dermatopathology, Neuroendocrine Pathology, Other, Pulmonary Pathology</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Mastrodomenico, Matthew</td>
<td>Monroe, Shreveport, Texarkana</td>
<td>Gastrointestinal Pathology, Genitourinary Pathology, Hematopathology</td>
<td>100</td>
<td>0</td>
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</tbody>
</table>
Case distribution

- Using the eligibility criteria, Delta Phoenix assigns cases to all pathologists equally by weight value and point value

  1. **Weight value:**
     - Percentage (0-100%) of full slide load each pathologist should receive for that day.
     - Full slide load = 100% weight
     - Allows a day to day adjustment for administrative or other duties
Case distribution

• 2. Point value
  • Each specimen type (each container) has a defined point value: 1-100
  • Based on the complexity of that specimen type
    o Gross only = 1 point, Colon polyp/GI biopsy = 5 points, Skin excision = 10 points, Thyroid FNA = 30 points, Mastectomy for cancer = 70 points
  • Accessions with multiple containers – Total points for the case is the sum of all of the containers associated with that accession
Point values continued

- **Examples of point calculation**
  - Accession #1 has three containers: 1. Mastectomy 2. Sentinel lymph node #1 3. Sentinel lymph node #2. The total points for this case would be 70 + 20 + 20 = 110 points
  - Accession #2 has three containers: 1. Gastric biopsy 2. Ascending colon polyp 3. Descending colon polyp. The total points for this case would be 5 + 5 + 5 = 15

- Point value on an individual specimen can be adjusted upwards to account for an increased block count above what is usually expected for that case type.

- Point value is credited to an individual pathologist only once.

- The end goal is to distribute all cases across all markets such that each pathologist has an equal number of daily points
Case distribution – additional information

- Cases preferentially assigned to pathologists in their “home market”
- Certain cases may be flagged by submitting physician or by case type as ones which should only be read in market of origin
- Cases can be manually pre-assigned – points are included in the next run of the targeting software
- If a case is re-assigned, then that case's point value is factored into that particular pathologist's total during the next run of the program
- Digital pathology - Cases are tagged by case type as whether they are amenable to digitization. If a case is assigned to be read by a pathologist residing outside the market served by the technical center from which the specimen originated or assigned to a digital only pathologist, it is then flagged for digitization
Adam Hoffhines, MD, PhD, FCAP

- Pathology Laboratory Associates
  Tulsa, OK
- Vice President, PLA Board of Directors
- Former OK Delegate – CAP HOD
- Board certified in Anatomic/Clinical Pathology and Hematopathology
- Section Director for flow cytometry and special coagulation
- Focus areas for case signout:
  - General Surgpath (emphasis in GU and breast)
  - Hematopathology
  - Clinical Pathology Interpretations
Current PLA Signout Locations

7 Signout locations in Tulsa + 5 other cities  
About 230 miles
Pathologist Workload Distribution

- Case signout
- Review
- Procedures (Frozens, Bone marrow, FNA)
- Meetings
- Lab Management – Board of Directors
- Lab Director visits
- Travel
Ever Increasing Productivity

• On average PLA pathologists signed out 40% more cases in 2016 than they did in 2006
• Increased travel and management responsibility has not decreased output/pathologist
Pathologist Subspecialties/Silos

Specimens can be directed to specific subspecialist pathologists through the case distribution system

- GI
- GU
- Breast
- Derm
- Cytology – Nongyn
- Paps
- Fine Needles
- Clinical pathology
- Physician directed
- Facility directed
Benefits of Case Distribution

- Increased pathologist productivity
- Allows us to do more work with the same or fewer pathologist FTE’s, thereby maintaining or improving income in an era of declining remuneration
- Tracking pathologist performance and reporting in dashboards for all to see
- Hawthorne effect
- Equivalent work makes for greater job satisfaction
Benefits of Case Distribution

Pathologist Satisfaction

Interaction of three primary factors affects perceived equality

Pay

Work Load

Time Off
The classic method of distributing cases involves dividing case numbers or slides evenly among available staff.
Experience shows this method, while ostensibly equal, can result in varied signout time or stress among the staff.
Workload Distribution by Cases Can Create Unequal Workload

A closer examination of case types can reveal different levels of total work due to the random (or necessary) distribution of higher complexity cases.
Internal time studies using automated data collection produced average time to sign out for each case type.

Assigning weights to each part of a case can allow the work for each case to be calculated and total work to be distributed evenly.

<table>
<thead>
<tr>
<th>Case Type</th>
<th>Median Time</th>
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<tr>
<td>GI bx</td>
<td>2</td>
</tr>
<tr>
<td>Breast bx</td>
<td>8</td>
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<tr>
<td>Skin bx</td>
<td>2</td>
</tr>
<tr>
<td>Colon resect</td>
<td>12</td>
</tr>
<tr>
<td>Nephrectomy</td>
<td>10</td>
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PCDMS Distributes Cases to Produce Equivalent Workload

This method distributes cases to equalize the total work across the group, resulting in more uniform workload.
# AP Staff Summary - 03/13/2019

<table>
<thead>
<tr>
<th>Staff</th>
<th>Assignment</th>
<th>Capacity</th>
<th>FTE</th>
<th>Current Points</th>
<th>Point Target</th>
<th>Management / Cares Day</th>
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<tbody>
<tr>
<td>AJH</td>
<td>Tulsa Routine Micro</td>
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<td>1.00</td>
<td>381.7</td>
<td>383.8</td>
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<tr>
<td>ANC</td>
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<td>443.1</td>
<td>555.5</td>
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<tr>
<td>EUB</td>
<td>HMC AP</td>
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<td>0.86</td>
<td>364.0</td>
<td>364.8</td>
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<td>EGK</td>
<td>SJMC AP 1</td>
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<td>451.0</td>
<td>363.0</td>
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<tr>
<td>IG</td>
<td>Bartlesville Gross</td>
<td>100%</td>
<td>1.00</td>
<td>424.0</td>
<td>363.0</td>
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<td>394.0</td>
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<td>79.4</td>
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<td>JRT</td>
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<td>HMC AP Frozen</td>
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<td>KSA</td>
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<td>PSG</td>
<td>OKO Deer PSC</td>
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<td>RH</td>
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<td>363.0</td>
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<tr>
<td>SH</td>
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<td>362.4</td>
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<td>TAW</td>
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</tr>
</tbody>
</table>

Case Point Total: (+) 3083.1
Credit Total: (+) 2384.6
Pool Removal: (-) 113.3

<table>
<thead>
<tr>
<th>Final Total</th>
<th>Effective FTE</th>
<th>Points Per Effective FTE</th>
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<tbody>
<tr>
<td>5354.4</td>
<td>13.95</td>
<td>383.8</td>
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<table>
<thead>
<tr>
<th>Staff</th>
<th>Point Type</th>
<th>Points</th>
<th>Distributed Points</th>
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<tbody>
<tr>
<td>AJH</td>
<td>S</td>
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<td>391.7</td>
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<tr>
<td></td>
<td>SH</td>
<td>30.9</td>
<td>30.9</td>
</tr>
<tr>
<td></td>
<td>Clinicals</td>
<td>300.0</td>
<td>300.0</td>
</tr>
<tr>
<td></td>
<td>Review</td>
<td>45.8</td>
<td>45.8</td>
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Workload Distribution in Pathology
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