COLLEGE of AMERICAN PATHOLOGISTS

Practice Management Roundtable

Topic: Effective Workload Distribution
Date of Event: April 30, 2024

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Questions and Answers		
Question(s) Asked	**Answer**	**Responder(s)**
Dr. Mastrodomenico, can you address what type of courier system you use to GET those slides to the assigned pathologist?	Delta has its own courier network that we've built ourselves. Having our own courier network has given us the flexibility to add routes, subtract routes, etc. as necessary to get slides to assigned pathologists.	Matthew B. Mastrodomenico, M.D.
Would you be able to address the process you used to agree on point values and why you chose to move away from RVUs?	Doing time studies was the most objective measure we could think of to gauge pathologist efforts on their caseloads. Coming to a consensus on that was relatively straightforward. Because of the inherent inequality in RVUs as a measurement of pathologist effort in sign-out, our group has never focused on RVU as a parameter on which to measure pathologist productivity and workload distribution. Delta used a "load balancing" committee comprised of several pathologists across several markets including generalists and subspecialists and as a group, we came to a consensus on the point value for each specimen type. These point values may not be perfect, but they are values that we agreed for our company work for us and seem fair to us.	Adam J. Hoffhines, M.D., PhD, MBA Matthew B. Mastrodomenico, M.D.

Does this mean that the specimens are not ordered from the operating room? Or does the staff re-classify the specimen type in the lab? Do you have the options of "Tissue-Other" or "Tissue-NOS" that have to be clarified in the lab?	They are ordered from the OR, yes, but our accessioners are the ones who 'classify' (or 'subclassify') the appropriate case type. I am not sure if there is an orderable (on the clinician/client side) for "Tissue-NOS." The accessioners are the ones that are tasked with selecting the correct specimen source for each accession and as a double check, the gross room staff verifies that the correct source has been selected at the time of grossing. We do have some generic specimen types such as "other", and "soft tissue" that can be used when classification is not clear and that gets sent to our sub-specialty service of "other".	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
Who developed your algorithm and how long did it take to implement it?	I cannot answer this (we have had this system in place since 2011, which pre-dates my tenure in the practice). Our chief technology officer designed the concept of the algorithm, and the actual code was written by outsourced healthcare informatics programmers.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
When you consider skin excision is 10 points, does this include biopsies as well?	Skin excisions and skin biopsies are weighted differently in our system. Our system also has different weights assigned to a skin excision vs a skin biopsy.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
What point value is bone marrow?	Ours are valued at 42 points; I think. A total bone marrow case, similar to any other surgical case, is the sum of all of its components. For example, a bone marrow case is typically comprised of a core biopsy, clot biopsy, aspirate smear, peripheral smear, and flow cytometry, each of which has a point value assigned. On average, a bone marrow case in our system is approximately 100 points in total.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
Do you give extra points to special stains and IHC?	No, those elements are factored in (averaged) in our time studies. No, as there is no predictable way of prospectively knowing what special stains and IHC will be needed. We felt it was best to not incorporate these factors.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
What thoughts do the presenters have on incentive-based pay models for physicians wherein higher producers are awarded more personal income? How do you	In some settings where pathologists' work is only defined by reading cases with no additional admin or leadership responsibilities (commercial labs for example) productivity based on CPT or RVU units may be considered as a basis for salary and	Karim E. Sirgi, M.D., MBA

incorporate the inherent variability of individual efficiency and speed?	bonus (caveat: as long as other non-CPT based activities are not also included in the pathologist's job description). A ramp-up of cases needs to be considered for newer in-practice (less experienced) pathologists. Different pathologists have different amounts of non-RVU producing activities (management, tumor boards, medical directorships) so we felt it would cause too much internal conflict to directly pay individuals based solely on their RVU production.	Matthew B. Mastrodomenico, M.D.
How do you account for different pathologist thresholds for feeling busy? A sub-specialist may feel fine doing 100 cases in their specialty but could take much longer doing general pathology. So, a specialist could take advantage by only having their specimen type. While a generalist may feel overwhelmed by the same 'volume'.	Those are the kind of considerations that are very practice-specific where collegiality and strong and fair leadership make a big difference in building and implementing a fair workload distribution system. Once the system is built and implemented, it also needs to be monitored with appropriate data to avoid or decrease abuses (such as the one described in the question for example)	Karim E. Sirgi, M.D., MBA
Is anyone using AI, this would seem like the way forward.	We are not, but I don't discount its utility. At the moment we are not.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
Would it be easier to just pay more for more work? Just get paid you collect/bill.	It might be easier, but I would not like to be in a practice like that, as it would significantly cut across any sense of being a team.	Adam J. Hoffhines, M.D., PhD
What about assigning cases fairly among subspecialties? For example, breast service compared to cardiovascular service. The breast service will be chronically overloaded compared to the cardiovascular service. The point system you describe seems great for general practices where cases have to be equally divided among the entire group but may not work for subspecialties.	The systems described during the webinar addressed the fair distribution of "duties" not only cases. Point values were assigned not only to pathology cases but also to non-CPT-generating activities. Even all subspecialists in our practice will still have the capacity and are expected to do some form of generalized sign-out, if necessary. This accounts for different subspecialty services being lighter or heavier on different days. On the days when one may be lighter, that particular subspecialist would end up receiving more general surg path to even out the points total.	Karim E. Sirgi, M.D., MBA Matthew B. Mastrodomenico, M.D.
Have you experienced problems related to efficiency in particular systems? For example, someone has Epic which might be more efficient than Meditech, or the histology/grossing IHC quality varies.	No, these have not been factors in our environment. No, all of our pathology reports get generated in our proprietary LIS system and cross over to each hospital's electronic medical records, but it has not been an issue.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.

Who is developing these "homegrown" distribution applications for you all? How much does this cost?	Ours was developed by our own IT personnel. It was just another project that we gave them. The only cost was the opportunity cost which reduced their efforts on other projects they had on their task list at the time. Obviously, if this had to be farmed out to an outside party there would be a more tangible cost, and I cannot hazard any reliable guess as to what that would be.	Adam J. Hoffhines, M.D., PhD
Another big factor for speed, besides the complexity of the case and the speed of the pathologist in interpreting a case, is streaming the navigation of the AP software, via shortcuts, even faster using Dragon commands if possible. We have done that with Epic and Dragon Medical One.	I agree. Leverage whatever you can to make your practice better. Agree, we utilize Dragon Medical One to navigate via voice commands and hotkeys in our proprietary LIS.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
In determining salaries, do you factor in outcome variables for each pathologist such as accuracy, customer satisfaction, generation of new revenue-producing services, etc.?	These are important factors to consider in the overall evaluation of a pathologist's performance. I am not aware of an automated (algorithmic) system that integrates these variables at this point in time. We do not. These factors might come up during the evaluation while evaluating a pathologist for partnership but no, we do not use these factors in determining salary.	Karim E. Sirgi, M.D., MBA Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
How do you determine Admin/CP time? That's a HUGE variable.	It is certainly more difficult to objectively measure this kind of effort, to be sure. We try to get a sense of how much time these kinds of duties take and get consensus from the groups as best we can on how to value/point/weight this effort. Factoring these things into the workload is delegated to our individual market administrators since they are the ones working in these individual markets and can best judge the time necessary and adjust the workload accordingly.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
What advice do you have for younger pathologists who work in groups where seniority/legacy has influenced the distribution of slides/call/tumor boards and financial compensation/time off? How much additional staff do you need to distribute these slides?	Any workload distribution system becomes obsolete and can even be abusive if not initially based on strong and fair leadership and collective collegiality looking at the good of the group and not of individual "protected" people. If not based on strong and fair leadership, it may as well be called an uninspired dictatorship.	Karim E. Sirgi, M.D., MBA

	Given the level of workload equality we desire/are achieving, the staff needed for slide distribution with the software is probably less than if we did not have the software (certainly not more).	Adam J. Hoffhines, M.D., PhD
Do the transparent reports only include AP tasks? How do you include the CP on those reports?	No, CP efforts are also included. CP interpretive reports are their own line item, while lab visits or other CP-type meetings are recorded as such.	Adam J. Hoffhines, M.D., PhD
We cover different hospitals with different LIS. Would this all be fed into your work distribution system so that they can be distributed? If so, who does that data entry work?	Our distribution system is separate from our LIS (and the LISs of the hospitals we provide services to). As of now, the case distribution staff that physically places the slides into the appropriate courier buckets are the ones that also update our central LIS with the information regarding which pathologist a given case is assigned to, but we are evaluating ways in which we can have the software push this information to the LIS(s) automatically.	Adam J. Hoffhines, M.D., PhD
How do you factor in time for activities that may benefit the hospital/institution, but not necessarily directly benefit the pathology group (tumor board, giving lectures, teaching students and residents, autopsies)?	All of the activities mentioned in the question are exactly the kind of activities not supported by CPT codes … but are necessary to fulfill a pathology group's obligations in support of the hospital mission. Following this logic, these activities allow the pathology group to stay in good standing with the hospital contract grantor and, therefore, the pathology group directly benefits from assuming these non-CPT activities … Also, these activities directly support safe and excellent patient care, an obligation for all of us physicians. Agree with Dr. Sirgi. Any activity that supports one of our client hospitals/institutions benefits our group to at least some degree. We, thus, willingly factor in these efforts in our workload distribution,	Karim E. Sirgi, M.D., MBA Adam J. Hoffhines, M.D., PhD
My group uses a time-based point system developed by the Royal College of Pathologists (RCP) to assign point values to all specimens, like what has been described by the panelists. However, it is a very time-consuming manual method that doesn't integrate with our LIS. I've investigated whether specimen types can be automatically tagged with a point value in Epic Beaker (or other LIS) to help automate this work. Are you aware of	It seems like I have heard some commercial LIS companies beginning to try things like this (LigoLab, perhaps?), but am not aware of pathology groups who currently use them.	Adam J. Hoffhines, M.D., PhD

anyone tagging cases with point values in their LIS?		
how do you handle "overflow" or extra work that is left over?	Depending on what is meant by “overflow,” it may simply be assigned to part of the next day’s workload.	Adam J. Hoffhines, M.D., PhD
Is there any benchmark data (from your or others' experience), on the total of daily “points” a pathologist should do on average by combining their various duties?	Our group generally considers 450 to the daily maximum for a day’s work. If we exceed this with significant frequency, then we have a reasonably objective indicator that it is time to hire!	Adam J. Hoffhines, M.D., PhD
How have you factored in time for training and performing succession planning and what have you done to spread out the work with nonpaid administrative duties with meetings, teaching conferences, etc.?	Yes, we account for these with various ‘meeting’ credits.	Adam J. Hoffhines, M.D., PhD
How do we as an entire profession elevate the dollar value of our intellectual services so that we all earn more money (and invest that money back into our communities)?	Support your PathPAC and continuously advocate for what you do as a physician with all relevant stakeholders.	Karim E. Sirgi, M.D., MBA
Your systems are proprietary. Any thoughts on what other groups should do without these systems?	I would suggest that whatever system you utilize for your workload distribution process, you strive to achieve as broad a consensus as possible among your members that the system is as equitable as it can be within whatever limitations you may be working with. If the group has strong leadership and strong cohesion, as long as everyone is working together then they should be able to come up with an equitable system that fits your specific situation. Our load balancing committee served this purpose as far as getting our points system up and running.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
How would this work if the laboratory has 3 shifts?	I suppose it would depend on the details, but I could envision an adjustment to the rules engine that distributes across multiple shifts. Our algorithm runs once a day at 9 pm so any cases that would get done by a third shift would roll over and get accounted for the next day.	Adam J. Hoffhines, M.D., PhD Matthew B. Mastrodomenico, M.D.
Would it be possible for you to share your time study to be used as a reference?	Possible.	Adam J. Hoffhines, M.D., PhD
How do you handle "hand-offs"? Like before a week's vacation, e.g.	Our group’s practice is to just do each other these favors without officially accounting for it (if you help someone out you can count	Adam J. Hoffhines, M.D., PhD

	on them to help you out when the time comes, honor system style). Agree with Dr. Hoffhines. But objectively, and I mentioned this in my presentation, a transfer of a case would then be factored into the next pathologists' points for that day.	Matthew B. Mastrodomenico, M.D.
Would Dr. Mastrodomenico be willing to share your 400 specimen types and associated point system?	Our actual source list and associated points are proprietary information, but the examples given in the presentation are a reference point. What I presented is a broad overview of the system that we put into place with the consensus from the load balancing committee. Therefore, this source list and associated points may not be applicable or agreeable to another group.	Matthew B. Mastrodomenico, M.D.
Is there an advantage to not making everything equal? Just everyone getting paid for the work they do?	It is very practice culture-dependent; in many practices what you describe is referred to as "eat what you kill". Some colleagues feel comfortable in such settings and culture … others don't	Karim E. Sirgi, M.D., MBA
Dr. Sirgi if you could address your last point on fairness further in the Q/A?	Please see my response addressing this matter, above	Karim E. Sirgi, M.D., MBA
Nice solutions, but DETAILS on how you make an algorithm? Would either presenter be willing to provide their algorithm?	Yes.	Adam J. Hoffhines, M.D., PhD