NOVIS NETWORKS

Dr. B was not about to wait for their office manager to inform him that yet another clinical practice was sending their pathology work elsewhere. Last year, his group lost the business from both a dermatology and a urology practice. The physicians comprising those groups no longer wanted Dr. B's general pathologists to pick and choose which cases they believed merited outside consultations. They wanted all *their specimens examined by pathologists who were fellowship trained in, and who examined exclusively dermatology and urology specimens. Now, the hematologists were thinking along the same lines.*

That consumers of health care services believe that competence is deliverable only by specialist-trained physicians should surprise no one. The specialty of Pathology is only the last to follow that trend in Medicine. Directors of pathology training programs realize this. The College of American Pathologists Residents Wiki lists fellowship programs in no less than 16 specialty pathology disciplines.[i]

Fellowship trained doctors usually wind up in the employ of large multi-specialty practices, some of which market their services to clinicians in distant communities. Often, the physician customers of these services are situated in office buildings located directly across the street from the local generalist pathology practices. Generalist pathology groups find it difficult to compete. They lack resources by which to attract specialist pathologists, or to train in those specialties, members from their own ranks. Even if they could do either, those narrowly trained physicians might soon go stale from lack of sufficient case material.

In New Hampshire, a three-member pathology practice faced this dilemma. The hematologists in their community were asking that all bone marrow and lymph node specimens be examined by fellowship-trained hematopathologists. To meet this demand, they hired Dr. Chris Chong, a hematopathologist practicing with a sizable group in the Midwest.

The logistics were simple. They licensed Dr. Chong in New Hampshire and FedExed processed specimens directly to him. Dr. Chong examined the material and issued reports electronically on the New Hampshire group's report forms. The group billed the cases just as they did for all other member's cases, and compensated Dr. Chong according to a prearranged financial agreement. Because Dr. Chong was a bona fide member of the New Hampshire group and already had his own malpractice insurance, third party billing relationships and insurance coverage were not issues.

It worked out well for both parties. The New Hampshire group retained their customers, and Dr. Chong gained a new source of cases. "It was better than doing traditional consults," recalls Dr. Chong. "I got to see a lot of case material and develop close professional relationships with the local hematologists. The group routed clinicians' calls directly to my office in the Midwest.

The customers did not get a different pathologist every time they called. They always spoke to me."

Dean Pappas, managing partner of another pathology group in the Northeast also feared losing his hematopathology business. Borrowing on the experience of his New Hampshire colleagues, he hired, Dr. Charles Abbott. Dr. Abbott is a hematopathologists employed by a group located 150 miles due west of Dr. Pappas, far beyond the competitive orbits of both practices. The relationship was a success. Dr. Pappas has since added a dermatopathologist who is a member of yet another pathology group.

Both Northeast practices might have tapped into specialty expertise by partnering formally with the larger groups. But as Dr. Pappas states, "I did not want to risk losing control of my practice." Dr. Abbott was not keen on the partnership idea either. He says, "Our group had no interest in burdening itself with the operational oversight, liability, and billing headaches that would likely result from absorbing a remote practice, and one which might possess a work ethic and culture that clashed with our own."

To be clear, these relationships were between the small pathology groups and the *specialty pathologists,* not between the small and large groups. The specialists and their parent groups had their own business relationships to which the small pathology groups were not privy.

There are no limits to the number of specialists a small group can add or to the number of small groups specialists can join. There are no significant capital expenditures so the risk to both groups for experimenting with this relationship is negligible.

Specialist pathologists are not necessarily employed by large groups. Dr. Sundram is an experienced dermatopathologist living in a physician-saturated region of the West Coast. Jobs there are hard to come by. Family obligations and the local nationwide market in dermatopathology prevent her from relocating. Says Dr. Sundram, "Virtual subcontracting allows me to live where I choose, apply my specialized skills, and pursue a lifestyle that works best for my family and me."

By adding specialist pathologists, small groups can match the value offered by large group practices, retain their customers and perhaps regain business lost previously for want of specialty expertise.

For specialist pathologists and their parent groups, the added work is a caseload windfall that fills vacant capacity, and does so without having to undertake the arduous task of establishing billing relationships with third party payers in other states. As Mick Raich, President of Vachette Pathology America's largest pathology practice management firm notes, "establishing billing relationships across state lines is no small task, if possible at all."

Obviously, virtual relationships require everyone to live with lower per-case revenues, as reimbursement checks must be shared between the practices and the specialists. But there is payback. For small groups, it comes when they need to add new or replace retiring physicians. It is far more economical for a group to pay specialists a portion of a reimbursement check than it is to pay not only a share of the reimbursement, but also benefits, retirement compensation, malpractice insurance and all the other expenses that come with installing doctors on-site.

For the large groups, payback comes with securing markets. By placing their pathologists as members of distant groups, they avoid commoditizing themselves, which often is the case when services and quality among competitors are too similar for customers to discern differences. Further, large practices can accrue corporate value by having their members acquire contracts nationwide.

Serving as reservoirs of specialty expertise, large multi-specialty groups and their trained experts can also look to support small pathology organizations by providing expertise in burgeoning technologies such as genomics, molecular diagnostics, and information management, all of which will likely be services that pathologists will one day provide. Anatomic pathology is only a starting point.

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[i] Pathology Resident Wicki, Trainees, Fellowship & Jobs, Anatomic Pathology, Anatomic Pathology (AP) Fellowship Programs by Subspecialty. Wikihttp://pathinfo.wikia.com/wiki/Anatomic_Pathology_%28AP%29_Fellowship_Programs_by_Subspecialty Accessed December 15, 2014

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