

Executive Dialogue

The Pathologist's Role in Value-based Care



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Pathologists are playing an important role in the successful transition from volume to value, focusing on outcomes and the patient experience, as well as eliminating unnecessary costs. By partnering with other clinicians and staying abreast of the most recent advances in diagnostics, pathologists can ensure that patients receive the appropriate test at the right time with an accurate diagnosis. Health Forum convened a panel of pathologists and hospital executives in July in San Diego to discuss how pathologists continue to provide and demonstrate value for patients in their institutions and across the care continuum. Health Forum thanks the College of American Pathologists for sponsoring this event.





MODERATOR (Bob Kehoe, Health Forum): What role should pathologists play in educating clinicians about the efficacy and cost of common tests as well as scientific advances? How can organizations systematize partnerships with pathologists and clinicians to ensure that the right test is ordered for the right patient?

ROBERT WYLLIE, M.D. (Cleveland Clinic): We've worked hard to incorporate the pathology [department] into trying to reduce the variability of care at the Cleveland Clinic. We use a model in a program called Care Paths, in which we

take an episode of care, something like chronic obstructive pulmonary disease or liver transplant, and we ask pathologists to give us their opinion about what tests should be done and when. We ask them not only to look at the utility of the test from a positive and negative value, but also to look at the efficacy of the test in terms of finance and how to limit testing to produce the highest value.

RICHARD FRIEDBERG, M.D. (Baystate Medical Center): One of the big challenges I see within health care is that it's becoming more technical and scientific. We need greater education at the point of care to familiarize clinicians, patients and families on the new science. Until we get there, we're seeing a rapid expansion of inappropriate testing. That's where the pathologist can play an important role. It's important that pathologists are involved in educating everyone who will be using these tests — not just physicians, but also physician assistants and advanced nurse practitioners, etc. It's going to be an interesting challenge for us moving forward. At Baystate, we're focused on the appropriateness of utilization. We're not just looking at who is placing the order, but also at what they want to do with the information. Is it actually providing the information they want and need?

MODERATOR: Michael, how would we systematize something like this so it is not just one-on-one conversations and relationships that are built around this type of issue? How do we make sure it is communicated throughout the system?

MICHAEL MISIALEK, M.D. (Newton-Wellesley Hospital): At Newton-Wellesley Hospital, we've taken the approach of collaborating with our clinical colleagues and attending their regular meetings. We present to entire primary care groups about utilization and tests that are commonly ordered that may be unnecessary; and then, we discuss how to make better ordering decisions. We've



We've worked hard to incorporate the pathology [department] into trying to reduce the variability of care at the Cleveland Clinic.
Robert Wyllie, M.D.

also partnered with our specialist colleagues and work with them on an institutional-wide basis to look at costs and utilization, and we do some communication and teaching one on one.

GAIL VANCE, M.D. (Indiana University): We've done something similar at Indiana University, not so much in the provider community as within the institution. We meet with our clinical colleagues to educate them on new biomarkers and explain the testing.

GARY PROCOP, M.D. (Cleveland Clinic): We educate and continue to educate, despite studies that have shown the limited impact of education. We've had success with hardwiring some of these interventions into our electronic health record. For example, we have limited the molecular genetic test to only those individuals who use them routinely in their practices. In the future, we will be able to manage the utilization within that group. We aren't yet at that stage, but just limiting who can order the tests has eliminated accidental orders, which we know happens.

BERT THURLO-WALSH, R.N. (Newton-Wellesley Hospital): When our pathologists meet with clinicians, we report key findings to the patient steering committee. The benefit is having multidisciplinary teams present, which includes the residency program. Our residency director has firsthand knowledge of our efforts. We also report twice a year to the patient care assessment committee, which helps to disseminate our message more quickly.

JASON NEWMARK (Baystate Health): While we've made progress, we still have a long way to go. We still hear some referring physicians say, 'I don't want Dr. X from downstairs telling me what to order. I'm upstairs treating patients and I will order what I think is right.' Sometimes physicians just don't want to hear what the pathologist has to say. Our employed physicians are more eager, and we are hardwiring ordering protocols, bundles and order sets. For our external physicians, it's more difficult because we are trying to earn their referral business.

We've had great success with our blood utilization-management initiative. By showing our surgeons data on the cost of using extra blood and blood products, we were able to reduce

overutilization significantly. We need to share more data with our physicians to get the results we want.

MODERATOR: That's a great segue to the next topic, which is how you use the data that you collect? How do you leverage data?

WYLLIE: We've become more aggressive in our efforts. We used clinical decision support systems within our EHR to implement a hard-stop program for pathology and laboratory medicine a few years ago. It won't allow clinicians to order a test that's not clinically indicated, or if it has already been done that day. We started out focusing on 10 tests and then moved up to 40. Over time, we've gradually added more tests to the system and we currently have about 1,300 tests that clinicians cannot order same day. Our chief of staff has been supportive. After we instituted that program, we started extending hard stops to things like *Clostridium difficile*, so the tests cannot be ordered on consecutive days. We've seen a significant reduction in ordering unnecessary tests through the hard-stop program.

PROCOP: We receive a monthly report on how many times these interventions occur, and how many times the provider calls the laboratory to override it. From that, we are able to calculate cost avoidance. We've decreased costs and increased efficiency because we're not having people doing things that are deemed unnecessary by our medical staff. It's also enhanced patient satisfaction. Nobody likes to get stuck by a needle more than they should.

VANCE: Who is involved in making these clinical decisions?

PROCOP: Dr. Wyllie oversees medical and clinical operations. We basically had to sell the idea up the chain of command. Initially, we started with a few physicians and then expanded it to the entire medical staff. We then built it up until we included all of the tests on the test menu that meet our criteria. It was a joint effort among medical operations, pathology and our physicians.

FRIEDBERG: Is this for inpatient visits only?

PROCOP: No, this is for everyone. However, the



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Richard Friedberg,
M.D.

issue of duplicates doesn't really arise that frequently on the outpatient side. When we did a fast-track, continuous improvement initiative, we found that most of the duplicate orders were coming from multiple physicians who were treating the same patient.

FRIEDBERG: Do you have a system in the laboratory to store a week's worth of specimens to avoid multiple blood draws?

PROCOP: Yes, we archive specimens for seven days and there is automatic retrieval if someone orders a test.

VANCE: That sounds like a phenomenal program on the inpatient side. We've done some work for the outpatient side. In Indiana, we have the Indiana Health Information Exchange, and within that, a program called Docs 4 Docs. All clinical results enter the system and when a physician pulls up a patient record, he or she will see all of the test results for that patient. It only goes so far, though. There is another regional health information exchange in Indiana, but it doesn't interface. We frequently run into these technology obstacles.

FRIEDBERG: These aren't new ideas. Clinical decision support was tested in the '90s, but the market wasn't ready. Now, the environment is different and there's more financing for these types of programs.

THURLO-WALSH: In Massachusetts, we are doing something similar to the Indiana initiative. The initiative is called the Massachusetts Health Information Highway (The HIway). It's our health information exchange. Organizations have to opt out of the program. Theoretically, the data should be shareable. It's a little limited now as to what we can see outside of our system.

MISIALEK: Within our organization, we've placed pathologists on all relevant hospital committees so they're really part of the fabric of the hospital. They are on the patient safety steering committee, the cancer committee and attend various interdepartmental specialty conferences. They bring data to the table, share it with experts and vet it in the appropriate forum.

Our pathologists participate in root-cause analysis whenever there is a problem, either a

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patient experience or an outcomes issue, which involves the laboratory. Pathologists are instrumental in the root-cause analysis, and meeting with family members, if possible, and in driving satisfaction at the patient level.

FRIEDBERG: Some of the toughest data for us to collect is financial. There are many moving parts, particularly around the reallocation of overhead. It makes it difficult to get the real financial data.

NEWMARK: We have financial people dedicated to our laboratory team to help us run reports. Will a new test help with turnaround time? Will it help to support one of our service lines? It's important to understand what the numbers are actually telling us and what the actual costs are. That information creates a tremendous amount of competence for the laboratory. It helps to gain support from senior executives and that, in turn, garners support for all the things we want to do. As we link it to clinical data, that becomes a huge opportunity. We've found our physicians to be receptive to data. When we show them the numbers and suggest they order fewer tests, they are responsive. They want that information.

VANCE: That's critical. Presenting that information is critical to building a partnership to manage health care costs.

NEWMARK: Also, it helps on my end. Is it even worth our seeing that provider? They're costing us so much money, but we're doing an OK job. A lot of people are asking for this now. They're finding out who we are and what they can bring to the table.

MODERATOR: Outside of the data part of this equation, how do you engage senior leadership on the aspect of driving performance improvement?

FRIEDBERG: We are fortunate to have a strong level of support from our executive team. That's not always the case. And, in some organizations, you see the laboratory services being sold off for short-term gains.

MISIALEK: At Newton-Wellesley Hospital, we offer a program that really equips the physicians with the skills. Bert can describe what the program is and I can add how it has been useful.

THURLO-WALSH: It's called the Clinical Process Improvement Leadership Program (CPIP) and is a six-month interprofessional team-based program for physicians, nurses, other clinicians and administrators. The program seeks to develop skills and competencies to support the provision of high-quality care, while maintaining focus on the efficient use of clinical resources. Each team works to solve a clinical problem within its environment. Previous projects have focused on lab turn-around time and blood utilization, for example. It works well from a leadership perspective outside of the data to move the dial on many things.

Pathology has good visibility throughout the organization. I attend the chairs' council meetings. When an issue with the laboratory comes up, pathologists join the chief medical officer to meet with patients and their families to discuss the lab reports.

PROTOP: Engagement with physicians and other clinicians is critical. To build support, it's better to avoid telling clinicians that they are doing something wrong. The more effective approach is to show them how they can do their work better. Everyone is engaged and the end product is better for the patient.

MISIALEK: The lessons that come out of these projects go beyond just the problem that is being addressed. The metrics become integrated into the quality program. They may become a new dashboard measure that is discussed indefinitely. More importantly, it breeds and creates a culture of process improvement.

FRIEDBERG: It's important to build on your successes. Our senior executives appreciate what we're doing because they know our track record. When we raise an issue, it's taken seriously because they know we take our work very seriously.

VANCE: They take you seriously because you are coming to the table with solutions, and not just problems.

MODERATOR: Let's talk about metrics. What are the key metrics that pathology can provide to bolster value-based care? What are the specific types of indicators and numbers that you're looking at with your teams?



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Michael Misialek, M.D.

KEY FINDINGS

Pathologists can play a significant role in educating clinicians, patients and families about the efficacy of new tests and appropriate utilization.



As hospitals and health systems shift toward population health management, the pathologist can play a critical role by addressing the underutilization of tests by patients with chronic conditions.

Sharing clinical and financial metrics with physicians and other clinicians on inappropriate test ordering not only eliminates unnecessary costs, but enhances patient satisfaction.

PROTOP: On all of our reports, we look at the number of unnecessary tests that have been stopped, the value and the costs saved. It's difficult to calculate things like patient satisfaction when it's a little piece in a complex puzzle. Those are the things that we can gather relatively easily.

FRIEDBERG: Many organizations struggle with blood utilization, but it's one of the easier items to track.

MODERATOR: Dr. Wyllie, from a CMO perspective, what sorts of issues do you look at when you review the metrics and how do you ensure that they're disseminated to all of the various players who are part of this equation?

WYLLIE: We're a very data-driven organization. As we develop the care path, we look at compliance. Are physicians following the care path's recommendations for imaging and pathology? If we find physicians who deviate from the care path, we have a conversation to determine why. It's really a way to drive out variability. There's

enough variability in the system that we don't have to be perfect in terms of deciding on a way to manage a condition. We just have to decide on the way to measure the outcome, to see how we're doing.

MODERATOR: Does that ultimately get you to where you want to be? Does talking with the people involved generally yield the results you're looking for or are there other things you have to do?

WYLLIE: We know who's ordering tests because of the sign-in to the EHRs. We can talk to that individual, whether on staff or resident, another type of trainee or independent licensed provider. We talk to him or her and explain why we feel the test is not appropriate. In terms of genetic testing, it has a profound effect on our residents and staff in regard to being ahead of the curve and at the cutting edge of the specialty. We tell them, 'If you want to practice cutting-edge medicine, you need to order these tests for these particular patients.' The physicians don't necessarily know about utilization or the efficacy behind them.



Will a new test help turnaround time? Will it help to support one of our service lines? It's important to understand what the numbers are actually telling us and what the actual costs are. Jason Newmark

PROCOP: One of the most successful non-EHR interventions we've done was to hire a laboratory-based genetics counselor. She knows the physicians who tend to order these tests regularly and, if anything gets through the system, she will review it before the test is administered. She's been very successful and essentially paid for herself within her first two months of work. Since 2012, she's cleared about \$1.2 million in cost savings. We did a review of 154 interventions. When she talked to a provider about a particular test, more than half the time the provider decided not to order the test. The focus is on ordering the right test for the patient, and not just focusing on the cheapest test for the patient.

MISIALEK: We've done something similar at Newton-Wellesley, but we've tasked the pathologists to take on that role, working with their laboratory supervisors. We've brought the billing department into the process, which interacts with the pathologist who screens esoteric or expensive tests and talks with the providers about those orders. In most instances, the providers weren't aware of the cost of the tests and ordered them out of caution.

NEWMARK: In the imaging world, physicians need higher authorization for ordering the bigger scans. We can obviously influence our employed physicians a bit easier than our non-employed group. With our non-employed physicians, we often don't find out until a specimen has arrived that the test required preauthorization. We're then left to decide whether to run the test or not.

FRIEDBERG: In radiology, you don't do the test.

MISIALEK: The challenge is that not running the test directly impacts the patient experience because the patient has to come back and be stuck again, and there is a delay in diagnosis. It hurts the system.

NEWMARK: This is an area of great opportunity. We have to build relationships with physicians and build trust. It's easier with electronic order entry. But for clinicians who aren't on staff, it becomes more of a challenge.

VANCE: You're absolutely right. We have to be viewed as a trusted broker. It's particularly important now since we have private labs mar-

keting directly to physicians. They are marketing tests such as BRCA1 and 2, along with gene testing. The physicians think that they are doing a good thing for their patients by ordering them but, in reality, the tests aren't necessary.

THURLO-WALSH: The onus is on pathologists to make sure that expensive tests are appropriate. Many appoint genetic counselors; we have them in maternal medicine and oncology. Have the counselors onboard those clinicians before the pathologist even makes a determination that this is the right test.

VANCE: Our genetic counselor works with both our employed and independent physicians. That helps a great deal.

MODERATOR: Let's shift the conversation a little and talk about patients and their families. How do pathologists, working in partnership with other clinicians, demonstrate value to patients and families?

VANCE: Well, in many states, it's not allowed — pathologists are not allowed to talk directly to patients. It's something that we advocate; allowing pathologists direct contact with patients. And I think it will increase more in the future as patients choose to assume more responsibility regarding decisions about their own medical care. Patients want to understand the language, and they want to understand their pathology report.

FRIEDBERG: I receive calls from patients because, as the medical director of the reference lab, my name is on all of the reports. I may not be the physician who signs off on the case, but my name is on the top of the form. It causes confusion and physicians become upset because they don't understand why I'm involved. But, in the end, we are in the middle of it. Some patients have been very appreciative, especially if there has been some sort of mix-up or error. We have to show the patient the controls we have in place to avoid and minimize these errors.

MISIALEK: We now offer patients the opportunity to come in and review their slides with a pathologist. We started with patients who had breast cancer. The same day they come in to meet with their radiologist, oncologist, surgeon,

radiation oncologist and nursing staff, they're given the opportunity to go to the lab and review the slides with the pathologist who made the diagnosis, so we can go line by line through the report and describe to them the disease process. We've received a great deal of feedback and the experience has been very positive. Patients come out of the discussion more engaged and empowered. They understand their diseases. They understand the specifics. They know the right questions to ask. Our role is not to guide them toward one treatment or another, but simply to empower them with more information about their diagnosis.

FRIEDBERG: Patients are fascinated with science. They're invariably fascinated when they find somebody who can actually talk both medicine and science. That's one of the big advantages that we have in pathology. We're one of the few who speak both languages.

PROCOP: Mike, that's a great approach. It's a great opportunity for patients. I'm sure all of the pathologists have had the same experience of having a friend with a cancer diagnosis come to you and ask, 'Can you please explain this report?' Most patients don't have a friend who is a pathologist or a physician who could help.

MISIALEK: We've received great support from our clinical colleagues on this as well. We vetted it with them before we began and other specialties have gotten wind of it. Our urologists have approached us with the possibility of having patients with prostate cancer come in to do the same. The only problem is, at some point, demand may outweigh capacity. But that's a good problem to have.

NEWMARK: Is anyone here using OpenNotes? We had someone from Partners present to the quality council at Baystate about OpenNotes. It sounds great. Basically, whatever the physicians are reporting in the health record, the patient is able to see in his or her chart. It's changing the way physicians are writing their reports. They are making them friendly for the end user.

MODERATOR: It becomes more of a true patient consult.

NEWMARK: That's correct. It helps patients to

follow their care guidelines and take the medications they're supposed to take. When physicians sit in the room and say, 'You have cancer,' they don't hear anything else. It helps to go back and read the notes.

FRIEDBERG: That raises a great point, and that is creating a patient-friendly pathology report. I would like to see us have another line or two in our reports that explains our findings at a sixth-grade or eighth-grade educational level. We tend to put the very technical stuff in our reports and it is confusing to patients. That's a conversation we should start having as a profession. In Massachusetts, patients have access to their health records through patient portals and they will see their reports. It's something we need to think about.

MODERATOR: Let's expand this and talk a little bit about the continuum of care and specifically how pathologists participate in population health management. How do you see your roles and how do you again move that goal forward if the organization is really focused on population health?

VANCE: We're doing a couple things and this is where telemedicine is coming into play again. We have a largely rural state. Outside of Indianapolis, Fort Wayne, South Bend and Evansville, everything is rural. We provide telemedicine services to a hospital in the southern part of the state. Digital pathology can work really well that way, as can patient communication.

FRIEDBERG: Last year, we opened the University of Massachusetts Medical School-Baystate. It's the second campus of the University of Massachusetts Medical School, and it offers a track called PURCH (Population-based Urban and Rural Community Health). The fascinating thing about this is that we're going to be dealing with people who are coming to medical school on a population health track. The first class starts in 2017. We're having numerous discussions on the role of pathology. Pathology is precision, personalized medicine. It's the antithesis of population-based care. So, we are working to determine how pathology plays into the broader discussion. We need to think this one through very carefully.

VANCE: There is a different subset of population-



There are real opportunities to use laboratory data to help improve population health management.
Gary Procop, M.D.

based medicine and population health. With telehealth, we can get medical services to people who don't necessarily have access within their communities.

PROCOP: There's tremendous opportunity for pathologists in the area of population health. Until now, much of the discussion has been around overutilization of tests, but now it's going to shift to underutilization, making sure all patients receive the tests they need. We can work with various patient populations, such as those with type 2 diabetes. If a patient has a high A1C, when can you reach out to them if they don't follow up with their provider in a certain amount of time? There are real opportunities to use laboratory data to help improve population health management.

MISIALEK: I agree with that. One of the best tools to harness data is an effective lab information system and EHR. Pathologists have been instrumental in implementing these systems and validating, testing and tracking the data.

FRIEDBERG: One of the challenges that remains is the lack of a national patient identifier. If you really want to get population health to work, it is the only way to follow the individual as he or she crosses between different systems.

NEWMARK: Informatics is taking all that information and making it usable. But one of the challenges we have is time. We need to allow pathologists time to focus on these interventions, or dedicate positions to do that. There are some pathology departments that have dedicated informatics teams. That's a struggle we have at Baystate, giving pathologists enough time to focus on the metrics. We want to let them do that because the return on investment is going to be unbelievable.

MODERATOR: What are some ways pathologists are working outside the laboratory to ensure the delivery of high-quality care?

FRIEDBERG: Pathology as a field has long had a focus on quality. The inspection process of the College of American Pathologists predates the Joint Commission. Proficiency testing has been in place since the early '60s, if not earlier. We have to be precise, or it could result in a bad

patient safety issue. Quality and patient safety are linked to everything we do.

VANCE: Quality is our goal. We have to preserve lab medicine to provide advocacy for reimbursement, and accuracy in our testing. That's what it is about.

PROCOP: We continue to focus on precision and utilization, how we prep specimens. One area of focus is reducing false positives. A false positive kicks off a great deal of activity. Patients will need follow-up visits and testing. They may have to get a radiologic scan. There is a direct link to patient safety and quality in some of the pre-analytic initiatives.

MODERATOR: What are some of the innovations you're seeing in the field of pathology that are changing the way pathologists work and impact patient care?

VANCE: Informatics, certainly, is changing how we work. It's revolutionizing the field. We'll be using more molecular testing, which is state-of-the-art.

FRIEDBERG: Patient care is really driven by the diagnosis and the laboratory testing. The science of pathology is exploding in a weird and wonderful way.

NEWMARK: We have an innovation center where we bring in different startups and big companies from around the country to brainstorm and test new innovations. We've been approached by a couple organizations in the pathology space. One area that excites me is the digitization of pathology along the lines of what happened in radiology. How will that work in pathology? We'll still need someone to prep a slide, but how do we take an image and transmit that? All of a sudden it globalizes all the work. That changes everything. I'm very excited by the possibilities.

PROCOP: This is really what we do in our day jobs. We vet these innovations and make sure the results are clinically relevant. In my area, microbiology, the biggest innovation has been the introduction of mass spectrometry for identification of microorganisms. We're identifying microorganisms that are causing life-threatening infections in patients in minutes for pennies. The



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Gail Vance, M.D.

process used to take days at a much higher cost.

MODERATOR: Are you facing any challenges in terms of finding and retaining talent in the area of informatics? How are you dealing with it?

NEWMARK: It's not just an issue of getting the talent, but how we pay for it as well. We have to work closely with administration to get buy-in. There are many competing needs that are equally important. It's up to us to educate senior leaders on the importance of these developments.

MODERATOR: You essentially have to build a business case, correct?

NEWMARK: Yes. We are fortunate, at this table, to have good visibility within our organizations. We have seats at the table. But I often wonder whether pathologists are at the table in smaller hospitals. We're a large organization, and we have big outreach programs, but smaller hospitals may not.

There is some education that needs to take place to help pathologists have these discussions with senior leadership. They are intelligent people; they're scientists. We need to help them build their leadership skills so that they can build relationships and be proactive. You almost have to be bullish about getting a seat at the table.

VANCE: I have some experience in rural health and, in my experience, the pathologist often plays a role in the clinical leadership of the organization. The reason behind that is because they are hospital-based. They don't come and go. They're there.

THURLO-WALSH: We are fortunate at Newton-Wellesley to have a high-level of engagement with senior leadership. We're part of the discussion on budgeting and capital requests, building the business case. We're actively involved.

PROCOP: It's important to discuss the next generation of pathologists. They're going to be different from the generation that liked it better behind the microscope. We all love being behind the microscope. I know I still do. As we well know, the Accreditation Council for Graduate Medical Education came out with a number of competencies a few years ago that talked about systems-

based practice, communication, practice-based learning and improvement. That's what we're teaching our residents. I tell my resident, 'You're going to leave here a really good pathologist. If you want to be great, you have to know how to communicate with your colleagues. You have to be involved at the systems level.' We are teaching those competencies. In a sense, we are rounding out the pathologists. They're going to be more interactive with administration in the future and with their clinical colleagues. I have high hopes.

VANCE: I do, as well. As informatics becomes embedded in our specialty, the new generation will be much more comfortable with that. And they are not afraid to challenge someone. There's a great deal of hope for the next generation.

THURLO-WALSH: We have a transition-year program, and many of our residents go into anesthesia, radiology and dermatology. One thing we are doing is offering them a month-long quality and safety elective and they work 40-hour weeks. Several have chosen to work with pathology as their elective. They are still going into anesthesia or radiology, but they're leaving with a good understanding about pathology and what it is that we do. It's key to their development. It's focusing on precision and providing high-quality care. It's about administering the right test at the right time to get the right diagnosis for the patient.



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Bert Thurlo-Walsh,
R.N.

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THANKS

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