



Models for Success in Clinical Lab Outreach

This is the first article in a three-part series on laboratory outreach. Successive articles will discuss solutions to outreach challenges and long-term planning strategies.

Until the mid-1960s, hospital laboratories operated using a basic billing process of test performance, direct billing to insurance companies or patients according to a fee schedule, and direct payment from those entities. Hospital laboratories were largely insular, servicing primarily hospital inpatients, emergency room patients, and some outpatients; few true hospital laboratory outreach programs existed. However, with the introduction of Medicare and Medicaid in 1965, the insured population of Americans over 65 nearly doubled, leading to a need for increased utilization of all medical services, including laboratory testing.

The Role of Medicaid and Medicare

Within a few years of the introduction of Medicaid and Medicare, many facilities began to view outpatient laboratory testing as having the potential to generate profit, thereby serving as a catalyst for the outreach testing industry. Independent labs sprung up across the country, marketing directly to physician offices and charging discounted rates that often were subsequently inflated by physicians and billed to the patient or the patient's insurance company for a profit. As a result, throughout the 1970s, Medicare expenditures increased significantly.¹

During the 1980s, several important changes helped reduce the burden on Medicare, including:

- ▶ Elimination of physician office markup billing.
- ▶ Implementation of the prospective payment system (PPS) based on diagnosis related groups (DRGs) for Medicare inpatient reimbursement. Medicare expenses under this new system became reimbursed on a predetermined, cost-per-case basis for a diagnosis established largely at the time of the patient's admission.
- ▶ Introduction of the Medicare Clinical Laboratory Fee Schedule. This new bundled payment system, combined with reduced reimbursement via a fixed fee schedule, caused many hospital laboratories to become cost, rather than profit centers, particularly with regard to inpatient testing performed for Medicare patients.

Much of the history of clinical laboratory operations during the last 50 years can be described as a reaction to the development of Medicare and Medicaid, as well as to the regulatory bodies established to oversee the administration of these programs.²

The Private Insurance Perspective

The US government was not the only entity looking to curb escalating lab test costs in the 1980s; the private insurance industry formulated its own cost-containment strategies, which led to the increase in managed care organizations (MCOs) during this period. These organizations carefully directed the use of services, particularly costly ones, during inpatient admissions. The net result was a decline in inpatient testing, as well as in hospital admissions and lengths of stay.³ Consequently, within several years, laboratory test volumes decreased significantly, yet the hospital laboratory still was needed to provide testing for inpatients and to operate 24 hours per day, 365 days per year with attendant levels of staff, technology, equipment, and supplies, even though capacity was not fully utilized.

Greater test volumes help maximize capacity within the laboratory, meaning that laboratory fixed costs can be spread over a larger volume of testing, ultimately decreasing the cost per test.

The Advent of Outreach

As hospital admissions and lengths of stay declined, outpatient visits increased at a similar rate. As mentioned, the trend toward increased outpatient care brought about the development of outreach programs. Today, successful laboratory outreach programs provide benefits for every party involved. Greater test volumes help maximize capacity within the laboratory, meaning that laboratory fixed costs can be spread over a larger volume of testing, ultimately decreasing the cost per test. Larger test volumes also provide the opportunity to broaden the in-house test menu and



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reduce testing referrals. Local physicians and providers benefit through enhanced service levels and expanded test offerings, and patients benefit from the provision of community-based medicine, supported by an integrated medical record across the continuum of care.

Elements for Outreach Success

The best laboratory outreach programs establish effective business, operational, and service infrastructures that support all participants in the program, including hospital administration, clinical providers, outreach customers, patients, and the laboratory itself.

TABLE 1
Sources of Outreach Assistance

External Courier Services

Courier Express	www.courierexpress.net
Medical Courier Elite	www.medicalcourier.com
Medspeed	www.medspeed.com

Connectivity Software to Interface with Physician Offices

Atlas Medical	atlasmedical.com
CareEvolve	www.careevolve.com
Lifepoint Informatics	www.lifepoint.com

Billing Services

APS Medical Billing	apsmedbill.com
ARx/XIFIN	www.xifin.com
Kellison and Company	www.kellison.com
Laboratory Billing Solutions	www.laboratorybilling.com
McKesson/PSA	www.psabilling.com
RCM Medical Billing	www.rcmmmedicalbilling.com
Telcor	www.telcor.com

Test Catalog Providers

ARUP Laboratories	www.aruplab.com
Mayo Medical Laboratories	www.mayomedicallaboratories.com

Lab Outreach Consultants

Applied Management Systems	www.aboutams.com
Chi Laboratory Solutions	www.chisolutionsinc.com
LabMetrics	www.labmetrics.com
Mayo Medical Laboratories	www.mayomedicallaboratories.com
Nichols Management Group	www.nicholsmanagementgroup.com

The average outreach customer requires comprehensive and accurate test results, but to excel in the crowded outreach market, the laboratory must deliver results with sufficient quality, speed, and service to impact customer satisfaction. When asked to name the most important laboratory service elements, medical providers almost uniformly cite quality (technical accuracy) and turnaround time first, followed closely by customer service (ie, telephone responsiveness, problem resolution, and consultative support) and patient convenience (ie, phlebotomy experience, billing, and laboratory cost).

Business Infrastructure

The tenets of a strong outreach business infrastructure include finance, contracting, and information technology support (see **TABLE 1**). Billing, pricing, health plan contracting, financial reporting (eg, demonstrating profitability), and results delivery mechanisms are the areas that require the most frequent collaboration with other departments in the institution. Because of the integrated nature of outreach programs, the hospital administration's support is necessary to ensure the initiative is aligned appropriately with other institutional strategies.

Operational Infrastructure

The outreach operational infrastructure must enable the integration of specimens collected in outpatient settings into the inpatient workflow of the laboratory. Unique to an outreach program, specimens may be collected in a variety of locations, including provider offices, long-term care facilities, laboratory-managed patient service centers, and institutionally-managed outpatient centers. Similarly, they may be collected by a variety of medical professionals who may be employed by the customer or the laboratory. Regardless, the laboratory must provide mechanisms for test ordering (electronic or manual), specimen collection, and specimen transportation from the point of collection to the laboratory (typically a courier service.) Upon receipt, the specimens must be registered, labeled, and processed in a manner that supports efficient integration into the routine workflow of the testing departments of the laboratory.

Service Infrastructure

A complete outreach program provides customer- and patient-focused service, as each interaction a customer or patient has with a laboratory employee creates an impression of that laboratory. This means all laboratory staff members—including sales and customer service representatives, phlebotomy and registration staff, couriers, and anyone who answers the telephone—are responsible for creating positive interactions and relationships with customers and patients to ensure the program's long-term success.

Health Care Industry Changes and Transition

When the Patient Protection and Affordable Care Act (PPACA) was

signed into law in 2010, it accelerated the need for change in our nation's health care system. Like the passage of Medicare/Medicaid in 1965, the PPACA spurred an influx of newly insured patients in need of care. Now, the difference is that fee-for-service is a thing of the past. Care coordination and population health management are the new buzz terms, and hospitals are being "held financially accountable for meeting cost and outcomes goals."⁴ To achieve these goals, hospitals are integrating and forming large multihospital health systems. In addition to expanding patient referral networks, these health systems are purchasing, or becoming tightly affiliated with, the practices of physicians and mid-level practitioners.

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For laboratory outreach programs within these health systems, the providers that were once external customers are now affiliated providers within the system, meaning that former outreach becomes inreach. Furthermore, many health systems require their providers to use the ancillary services provided by the system. Doing so strengthens the relationship between providers and the laboratory, and the laboratory outreach program realizes volume growth. It is important to recognize that even when a health system requires such a relationship, this idea of a family business cannot be taken for granted. The laboratory still must provide a competitive level of service and convenience.

Keep in mind that integration models differ from system to system, and not all health systems require that owned or affiliated providers use the laboratory or other hospital-based ancillary services. In these cases, the providers retain discretion over where their laboratory testing is performed, and the laboratory outreach program must compete against commercial laboratories for that business. Further, due to restrictive health plan contracts, the laboratory outreach program may not be able to provide a cost-competitive service for the patient. Although the provider may prefer that a patient have testing performed within the hospital laboratory outreach, the patient may not be able to afford the out-of-pocket expense and may opt to use a commercial laboratory alternative. It is not uncommon for a health system-owned provider to use several different laboratories, even if their prefer-

ence is to use their own laboratory. (*Parts 2 and 3 of this series will address these challenges in greater detail.*)

Conclusion

More than 50 years have passed since clinical laboratories began performing outreach testing and, in that time, the landscape of health care provision has changed dramatically. Regardless of the future direction of health care in the US, outreach laboratory testing remains a viable and necessary strategy. A hospital-based laboratory outreach program can provide a mechanism to secure additional testing, which helps maximize departmental capacity and lowers overall unit cost, among other benefits. When test results are integrated into the patient's medical record, the laboratory also becomes integral to the patient's complete continuum of care. ■

Part 2 of this series will focus on competition, consumerism, market disruption, administrative support, and benchmarking.

References

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4. Kutscher B. Making physicians pay off. *Mod Healthc.* 2014 Feb 22;44(8):12-13, 16. <http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986>.



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