Juggling IT demands—labs, vendors open up

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Access interactive guide

Hopes, fears, frustrations, and change. In time for our annual LIS product guide, that's what CAP TODAY asked LIS companies and lab users of IT about. What we heard was talk of uncertainty, complexity, finite IT resources, the need to stay current, and, as one company president put it, "swimming with an anchor" attached. Here's what they told us.

As LIS vendors, what is your biggest frustration in the IT marketplace right now?

Susan Bollinger, sales and marketing director, Hex Laboratory Systems: Our biggest frustration is the cost and complexity of interfaces to EMRs, and the [resulting] customer sticker shock. A doctor's office only has to do one interface to one laboratory, but the laboratory may do hundreds or thousands of [interfaces to] doctors' offices, and it's expected, in most cases, to pick up the cost for the client. These aren't easy plug-and-play interfaces. They're complex; they're time-consuming. We can very cost-effectively and very easily put in an HL7 file output, yet the EMR companies insist they don't take a standard HL7 feed. They want it adjusted; they want it customized; they want it their way. I wish the EMR companies were more standardized in terms of what they took in terms of HL7, because that would make it much simpler and more cost-effective to interface.

William J. Shipley, president, Schuyler House: I've read several articles lately that have lambasted the 'evil' LIS company for charging so much for system interfaces to EMRs. This is a serious problem for us because there's a disconnect between the expectation that customers have and the reality of the world at the moment. The expectation of our customers is everyone will be connected, and it's going to happen right away, and there won't be a lot of problems. Unfortunately, while we do have health care standards, a lot of people don't follow HL7. They think they follow HL7, [but] they've invented their own way of doing HL7, which is less than productive.... For more than 100 brand names [mostly EMRs, some health information systems], we've had to make 88 versions of HL7. So I feel like we're trying to swim with an anchor tied to us. If there actually were a standard HL7, then we could meet some of our customers' expectations.

Sandra Laughlin, product manager, LabDAQ laboratory information system, CompuGroup Medical: Our biggest frustration is that our clients have all these directives: meaningful use, health care reform, HIPAA compliance, and then the whole ICD-10 implementation. I think it's more their frustration [rather than ours], and they're coming to us and saying, 'Please help us!' So we're providing our clients with information and tools that will help them get through these next few years.

A positive impact of these regulations is the meaningful use requirement to integrate the lab and EHR. This has kept our integration department very busy. But the labs are under a time crunch, so we're working through the projects with them to get the interface to their EHRs connected. It requires taking time to explain that these are complex projects; they're not something that happens overnight. It's understanding the workflow, configuring the software, loading the compendiums, and assisting with testing and validation. Each interface is often a 45- to 60-day project; these are not quick, turnkey solutions.

How would changes in the health care system benefit your lab information system business?

Wyatt

Les Wyatt, president and chief operating officer, Aspyra: Our customers are expressing fear, uncertainty, and doubt [about the future]. The government's actions, and what will change in terms of reimbursements, the potential impact of ACOs, and what that's going to mean in terms of their business—these unknowns have caused our customers to hold off, in many cases, on making capital investments. We have hundreds of thousands of dollars worth of proposals out to customers for things they need—proposals they asked for. Resolution of that uncertainty would absolutely benefit our business.

The transition to ICD-10 will definitely benefit us, even though our customers are a bit imperiled by it. We have a number of customers who have been on their current infrastructure for several years and are in very great need of doing an upgrade—not so much because of the application environment, but because of the servers, network infrastructure, and all the other pieces that provide the reliability they need to run their business. ICD-10 will force that; it will cause them to have to make their systems current so that they can, one, deploy new versions of the applications that have ICD-10, and two, have the performance characteristics that will be able to handle those new environments. It will definitely provide us with incremental business in terms of upgrades and applications.

Another big change in the market environment [that affects our company] is the consolidation of smaller labs and community hospitals into larger groups. We have a lot of community hospitals that are our customers. As they get acquired, the question becomes: Is the lab going to move to whatever HIS is used by the acquiring organization, or are they going to be allowed to keep Aspyra's CyberLAB, upgrade that, and interface to the new HIS? We've been very fortunate there; we have extremely loyal customers who see great value in CyberLAB and can make the case to their board that the lab should be independent of the new HIS and continue using CyberLAB.

Shipley (Schuyler House): It would really help our business if health care as a whole took another look at the value of clinical lab testing. We're getting more and more of a push in the clinical laboratory industry to do fewer and fewer tests. What you're doing then is eliminating the cheap part of medicine, which is the automated testing, and putting more burden on the shoulders of the expensive part, which is the doctors and other health care personnel. The way technology progresses, everything should get better, faster, cheaper. But instead, as an industry, we seem to be focusing on the physician, which is a very limited resource, as people's time gets more expensive.

And we do have a pet peeve. We're in California, and a good deal of our business is reference labs. In 2001 the state put a 180-day moratorium on applications to clinical laboratory providers. Basically, they wouldn't give out any more licenses for reference labs for six months, and every six months they've extended it. It was a major hit to our business. We've subsequently spread throughout the U.S. and some overseas, so we're a little less dependent on what happens in California, but it would improve our business if they lifted that moratorium.

Laughlin (CompuGroup Medical): One of the biggest changes coming is the treatment and payment incentive model with accountable care organizations. This payment model is focused on patient outcomes rather than fee for service. The ACOs and insurance companies are asking labs to evaluate lab data: who's ordering, what are the ordering patterns, what are the test results. Our LIS has the tools to assist in determining the ordering patterns for certain providers and to provide test results for the detection and early treatment of chronic diseases. Users can also determine which procedures were completed for a specific group of patients with the same diagnosis. They're using our LIS to assist with the analytic evaluation of data. [We benefit because] if they have only a simple LIS or none at all, they're looking to either implement or upgrade to the systems that have the tools that can help them.

As users of lab information systems, what hopes do you have for your IT systems in the next year?

Jim Kearns, vice president, information technology, ACL Laboratories: ACL is a laboratory that's co-owned by Advocate Health System [the largest in Illinois] and Aurora Health System [the largest in Wisconsin]. Everyone has to be ready for ICD-10 no later than October of 2014, so we need all of our systems to be compliant with that. We also have both of our health systems going through stage two meaningful use, [which includes] laboratory components. So the first thing we think about is, we've got to stay current with the environment and with what the government is requiring of our health systems.

The second thing that I'm hoping for our lab systems is that we can drive optimization and efficiencies into the lab and automate as much as possible to drive down our cost structure. We're co-owned by two of the leading health systems in the country, which are, in many ways, very progressive. As they get ready for accountable care, we're looking at providing the right level of testing in both systems. We're seeing volumes come down and cost pressures go up.... We want to add more and more value for the health systems that own us and the patients we serve. Value can be delivered in terms of the results we provide, so we're looking at different ways to do that. And we're trying to lower our average cost per test every year; that's our goal.

David Robb, manager, laboratory and radiology applications, Sutter Health: We have so many overlapping projects and initiatives; my hope is that we can implement all of them in the necessary time frames. It's meaningful use and ICD-10; Sutter is deploying Epic EMRs; and then there's a variety of other things. They're consolidating hospitals; they're moving into new buildings in California. So any one of these, for a single hospital, would be a major project for the year. Our group is doing dozens of these things simultaneously, and my hope is that we can do it all and coordinate it all. We know there will be bumps, challenges, and conflicts, and management will have to make priorities for different things, and some adjustments will have to be made. But our hope is that it will go smoothly.

Stephen Mikkelsen, operations director, laboratory services, Intermountain Healthcare: Intermountain has a homegrown hospital information system that has served us well for many years. But requirements for IT support have grown, and the decision was recently made that we will be moving to the Cerner platform later this year. What we hope for as we make this transition is, first of all, we want to do what's necessary to meet the meaningful use guidelines. We also want to make sure we can do the physician order entry piece, and we hope to have bidirectional interfacing so that not only can [physicians] order into our EMR, but [the system will] also allow the transmission of results back to the ordering physician. That's been a bit of a challenge for us, so we're hoping this new IT system will help us mitigate some of the challenges we've had.

We also have homegrown software for our lab intranet. Again, we're hoping there's a way or a mechanism to integrate [the intranet], which has served us so well, with the new Cerner system. Our hope is that our partnership with Cerner will help us continue to develop products that can enhance our workflow and our efficiency in the laboratory service.

Andrew Splitz, interim director of LIS for North Shore-Long Island Jewish Hospital and president and chief executive officer, S&P Consultants: At S&P, we implement LISs or we optimize [an existing] LIS. We are very much on the user side and really are the client advocate. We work constantly to assist vendors in understanding what is needed at the bench level. It's challenging enough to get the best-of-breed LISs implemented, never mind trying to deal with some of the systems that aren't fully baked yet. From the client perspective, a huge benefit would be for vendors to provide a simplified implementation but also be able to customize and use the functionality that each of the clients need. I am not a fan of the term 'best practices.' When you hear a vendor saying they are going to implement best practices, we have learned they are really saying, 'We're going to implement the standard that we know better, and you'll have to deal with it.' That's really what we're finding; the major vendors are implementing a simple and generic solution so they can get it in on time. The problem is the clients don't really have the ability to put in the bells and whistles when they need to go forward. So my hope is to be able to optimize the implementation strategy so that clients get the customization they need to function optimally.

What is the biggest fear that you, as LIS users, have for your IT system in the next year?

Ronald Workman, MD, former vice president of laboratory services at Sutter Health and sponsor of the Core Laboratory of New York project: My biggest fear for the coming year is that health system IT departments typically have a 'placeholder' date in their strategic plans for when the best-of-breed LIS is to be replaced by the EMR vendor's LIS, and nothing will be forthcoming, in terms of capabilities that create clinical value, from either the lab leadership or the LIS company that causes the CIO to alter that plan.... And my biggest fear about the LIS company is that they continue listening to laboratory and IT department leadership instead of medical leadership to formulate their plans for development. Medical leaders, including many pathologists, don't need more and faster information as much as they need to know what the information means and what to do about it. The medical need is clinical decision support, which embodies the clinical value of the system.

Kearns (ACL): Probably the biggest fear is the uncertainty. There's a lot of turmoil in the marketplace. It's being able to anticipate the changes in the marketplace...and finding the best value for the patient. It's being able to manage that and the other uncertainties that are out there with Obamacare. It's not a very clear path.

Mikkelsen

Mikkelsen (Intermountain): Our concern is that...with new requirements always tasking our IS team, every clinical service and every clinical program has a hierarchy of needs for IT support. So our biggest fear is having too many clinical programs vying for those finite IT assets, and trying to support their particular service or program; we actually experience that all the time with our laboratory's service. We're competing with other programs and other clinical services for IT assets to meet our LIS needs. Sometimes you get prioritized a little lower on the scale, and it kind of pushes things back, which keeps us from fulfilling some of the strategic growth we'd like to do.

The other fear I would share as we make this transition [to the Cerner platform] is that the things we have become so dependent on over the past several years, that have done so well for us, won't work with the new Cerner program. This would create a potential work stoppage or something we would need to work around. We have all of our SOPs online, we have an event-reporting system online, our billing system. Everything that's part of an operational laboratory, IS-wise, is going to have to integrate one way or another with the new Cerner system. And again, we don't know what will and won't work, what we'll have to keep offline and what we can integrate into the Cerner system.... Obviously, change can bring anxiety.

Robb

Robb (Sutter Health): The fear is that some of the priorities we have set now for projects will be accelerated. The meaningful use project had been set for a certain timeline; then it was needed sooner. It's hard to respond to that kind of thing, as well as other things that just come up. For instance, the AUTO12-A standard is supposed to be coming up. That means we'll have to do a systemwide upgrade, which is good; you should do those once a year. But we didn't know about that until we started seeing articles…. We're planning out to 2017—to inject that into all the other plans is awkward, especially when it only impacts the laboratory, and other people have billion dollar projects going on. The biggest fear is that the lab's priorities will not be recognized.

Splitz

Splitz (S&P): The fear in the LIS world is that we're being forced to accept LISs that may not be fully functional because it's the right financial move for the hospitals, not the lab. Nowadays, all the funding for lab systems, IT systems, and clinical systems runs through the CFO and CIO. So the big fear in the industry right now is we'll have CIOs and CFOs selecting systems that are the right financial choice for the institution but do not provide the functionality that the lab needs to have clinical patient safety [standards] met. The ownership, power, and decisionmaking have moved outside the laboratory to a level in the organization that does not understand what is done in a laboratory department.

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Questions and answers compiled by writer Jan Bowers.