Where smart labs go when the money's gone

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August 2014—Payment rates declining. Bad debt rising. Test orders falling. Diagnostic equipment manufacturers checking in on test-volume commitments. A wrenching transition from fee-for-service care to population-based medicine. These are a few of the trends that laboratories across the country are seeing and that keep lab directors up at night, heavy lidded, checking their email, illuminated by the glow of their smartphones.

Laboratories are facing tough times, says Stanley Schofield of NorDx. "You need to use your imagination on how to do things differently, and you must have execution."

Strategies that once reliably yielded success in the laboratory business are no longer sufficient, says W. Stanley Schofield. He is president of NorDx, which operates 11 labs and 23 patient service centers and is owned by the MaineHealth system, also affiliated with four other health care organizations in the state. Schofield is cofounder and managing principal of the Compass Group, a 501(c)(6) business league whose 24 lab members represent more than 300 of the nation's most prestigious hospitals and health systems.

Labs are being called upon to simultaneously add value, cut costs, and improve the quality of the work they do, Schofield says. Moreover, the pressure is on for laboratories to show how their performance compares with that of their peers.

"Today, labs are known for, and their value is seen to be in, delivering accurate test results in a timely fashion," Schofield tells CAP TODAY. "In the future, the value of the laboratory is that it will help manage that the right test was done on the right patient for the right reason, and that the right cost will be available. And that they manage

the data, rather than just report the data. That is one of the huge transitions that labs have to go through right now, and that we are preparing for."

To succeed, Schofield told a crowd of more than 800 at this year's Executive War College, laboratories must follow five rules: add clients, keep clients, create revenue opportunities, get paid, and reduce expenses.

An essential ingredient in fulfilling these mandates is having the information to help make tough calls on purchasing, staffing, and test menus while demonstrating value to clients, payers, and C-suite decision-makers. After many years of double-digit growth (for which Schofield credits a dedicated and highly skilled staff), NorDx's recent expansion has come through the integration of new hospitals and physician practices into MaineHealth.

That stands in stark contrast to what Schofield called the "old school" methods of adding clients.

"What we used to do in outreach is have a few doctors in the neighborhood, or two or three nursing homes, and call that outreach," he said. "You worked with the providers you knew, and you'd go out and sell a few new ones."

But that well is running dry, Schofield contends, even as NorDx provides laboratory services to more than 100 nursing homes.

"Now we're doing more. We're doing integrations and standardizations. We have been a lead organization for the health system in terms of clinical integration," he said. "All these health systems come together, and they do all these contracts, and they have to prove they're clinically integrated and prove they make a difference. We in the lab are the trailblazers for that.

"So, the model we have is that we integrate the entire hospital lab. It's a total outsource—staff, equipment. It's possible to generate 15 percent total savings in the lab to the hospital. We have an emphasis. We are not just chasing tests, but providing high-quality service at the lowest possible cost point to a hospital that has not achieved that on its own."

Hospital management agreements now account for 70 percent of NorDx's business. Yet it was never a foregone conclusion that leadership at the new MaineHealth sites or affiliates, spread across the sparsely populated state, would readily agree to laboratory consolidation. It takes meaningful data on metrics, such as the cost per lab test, to make the case.

"A hospital says, 'My lab costs $2 million. You say you can come in here and run it for $1.8 million. Prove it to me.' That's where we would show them the cost per test at the core lab, and it turns out to be one-third of the cost at their hospital lab," Schofield tells CAP TODAY. "That's where this kind of information is valuable, at the administrative and financial level."

NorDx works with Applied Management Systems, a Burlington, Mass., consulting firm that, among other things, provides benchmarking services to help labs compare their performance with that of more than 1,000 other U.S. laboratories.

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"The key to calculating your cost per test, and your paid hours per billable test, is to compare it to an objective standard," says Paul D. Camara, a principal at AMS. "But the standard also has to be reflective of what the unique demands are in your particular laboratory."

In its benchmarking process, AMS accounts for elements such as whether there are training programs in place at the laboratory for pathology residents and medical technology students.

“We make adjustments to the fundamental benchmark so that it’s meaningful for your lab on the labor-productivity side and the cost-per-test side,” Camara says. “The lab can then have the confidence to look at those numbers and say, ‘How am I doing?’ It’s customized to your local lab.”

NorDx declined to share specifics from its benchmarking data with CAP TODAY readers. However, Schofield says that data on metrics such as cost per test will be “absolutely critical” in the transition to value-based medicine.

“If you have a facility that averages $15 per test, but you have another facility at $5 per test, there will be pressure to come close to that $5 throughout your organization,” Schofield says. “In population-based medicine, every time you’re doing a test, that comes out of the per-member, per-month pool, or the bundled payment, so you want to make sure it’s at the lowest possible cost factor. Why run a test at a small hospital, where it costs $40, when you could have it sent to a core lab for $5?”

Frederick V. Plapp, MD, agrees. He is a board member of the Compass Group and laboratory medical director of Saint Luke’s Regional Laboratories, part of the 10-hospital Saint Luke’s Health System in Kansas City. The system uses Truven Health’s ActionOI solution for benchmarking. Dr. Plapp says cost-per-test data were “critical” in determining which tests could be run on site at one of the system’s smaller hospitals and which should be done at the core laboratory.

Dr. Plapp

The data are equally important in deciding which tests to insource versus outsource, Dr. Plapp tells CAP TODAY. “Even though you may have the technical ability to set up a new esoteric test, we may end up sending it out if that means doing it for half the cost.”

Back at MaineHealth, Schofield tells of a recent example where having benchmarking data came in handy. A physician wanted to consolidate the microbiology lab from one hospital into another at a nearby hospital. But the move—which would have converted a microbiology department into a larger microbiology department at another hospital—also would have tripled the average cost per test to $21, compared with moving that small lab’s business to the core lab for an average cost of $8 per test. The physician did not get his wish.

These days, the conversations about centralizing laboratory operations are easier than they used to be, Schofield said in his War College talk.

“It’s a long, drawn-out process about control and fear,” he said. “But with enough fear, pain, and money in the right combinations, you can get people to change. Well, the fear is real. The money’s going away, and I’ve got to tell you, the pain that the small hospitals are facing with reimbursement cuts, long-term care facility cuts . . . the money’s gone. And the bad news is, this is only the first wave of that.

“So, in my first five or six years in Maine, you’d go talk to the little hospitals in the health system and they’d go, ‘Shoo, shoo. We don’t need you.’ Now they are lined up, saying: ‘Let’s have that discussion on how you might help us.’ Part of the model is we go in with a straight contract, cut the expenses, standardize the equipment, enhance staff performance, and the hospital does all the billing—inpatient and outpatient—and keeps that revenue.”

If adding clients is difficult, even through the route of health system laboratory consolidation, then keeping existing customers is even more critical.

“It’s hard, hard, hard to get a client,” Schofield said. “You do not want to lose them. And they’re leaving for many reasons that you cannot control today.”

Again, Schofield said, the old-school approach is no longer good enough.

“How did you keep clients in the past? You had an account rep, you’d buy them a little lunch, do an annual business review. Rah, rah. You want IT connectivity? OK, I can hook you up. I can handle your IT solutions to make these things happen. Standard stuff,” Schofield said. “If the office staff was happy, it was an account in good standing.”

Now, he said, “people want data.” The lab’s role “for today and tomorrow is going to be as the lab data management experts.” To answer the call for that kind of information, NorDx provides what it dubs a “tailored metrics program for quality and services.”

“Everyone’s demanding these kinds of information, mostly from the patient service point of view,” Schofield says. “This quality information has to be reported to the government, and to payers. And the client wants to make sure these services meet the needs of their medical staff and their patients.”

Each quarter, NorDx shares the scores for its patient-service centers on survey questions from the Agency for Healthcare Research and Quality’s Consumer Assessment of Healthcare Providers and Systems. In addition to the average score for MaineHealth, scores on phlebotomy are broken down by service center. This includes, for example, the proportion of patients who rate a facility positively on cleanliness and quietness or pain management.

But NorDx has gone beyond this to develop its own set of lab-centric patient surveys to improve quality and patient satisfaction.

“We’d get reports in the health system, and it was all about patients in the hospital. The lab would score very poorly. Well, it was about someone who comes in and sticks ’em with a needle and leaves. Sure, the experience was going to be bad,” Schofield tells CAP TODAY. “We decided we needed something for our service centers to develop those questions in a way that is lab-centric, that work in an inpatient setting and an outpatient setting.”

Each month, patient contacts are downloaded and a survey is mailed to a sampling of those patients. The survey questions are “all about their lab experience and nothing else,” Schofield says.

“It’s customized, and deals with emotional things,” he said at the War College. “It’s almost soft and fluffy to me, but that’s what the patient experience is all about.”

For example, blood draw outpatients are asked to rate the service centers on access, emotional support, information and education, physical comfort, and respect for patient preferences.

“We take this information and meet quarterly with the hospitals we manage,” Schofield says. “It’s an active process of improvement.”

That does not appear to be idle talk. At one patient service center, a survey revealed nine patient complaints about the site’s physical condition.

“It wasn’t well maintained. It was dirty. We had a lot of problems with the landlord,” Schofield says. “As soon as this survey came out . . . we immediately got out of the building. We moved somewhere else within two weeks.”
Another survey uncovered patient concerns about a loose-lipped employee whose conversations appeared to infringe on patient privacy.

“We investigated it, found it to be true, and removed the person from their position,” Schofield says.

“We’re in a report card world,” he adds. “If your patients aren’t happy, they’ll either respond by complaining or by not coming back to you. I’d rather get that feedback in a report card way, and respond to that.”

The approach to generating new laboratory revenue also needs to change, Schofield says. Old-school strategies such as adding the occasional test or participating in modest clinical trials will no longer fit the bill.

In addition to hospital management agreements, labs should be looking to maintain contracts with point-of-service insurance programs.

“You’ve got to get in there. As painful as it is, you’ll be cut out by the insurance companies due to national contracting if you don’t participate,” Schofield said at the War College.

“It’s not a new revenue opportunity for lots of money,” Schofield says. “It’s an opportunity to preserve what you have.”

Also, labs should look to aid manufacturers in their validation of methods and equipment.

“If you’ve got good quality and are a really good lab, you can do this,” he said. “With some of the cutting-edge, next-generation sequencing devices, we’ve helped with method validation. The advantages are that you get the equipment, make sure it works well, and you get a break on the pricing by putting in that sweat equity that you just can’t buy.”

Judicious adaptation of highly complex testing—KRAS and BRAF genetic mutations, for example—also should be on the menu as a revenue opportunity, Schofield said.

“These are not easy to do, but they are not so hard. This is the value that the lab presents, if the oncologist feels that getting this within a day will make a difference,” said Schofield, who four years ago was diagnosed with stage IV throat cancer that required nine months of treatment.

“Let me tell you, when somebody comes up to you and says you have cancer, your whole world falls apart,” he said. “The next thing is you go into a ball and say, ‘Help me,’ or you say, ‘I’ve got to kill it.’ If you say, ‘I’ve got to kill it,’ then you need the data. And there are people charging in there, saying, ‘We can fix this. We can help you.’ And the lab’s right there—not being blamed, but being given credit for being able to add value to the patients so they don’t have to go somewhere else or don’t have to wait a week.

“It’s a two-edged sword,” Schofield added. “You have to do it well and do it cost-effectively. You cannot just start adding these tests and say, ‘Who cares what it costs?’ It will eat you up.”

NorDx is evaluating how to proceed with next-generation sequencing. Such decisions are made with the help of “cost analytics and cost accounting,” Schofield tells CAP TODAY. “What does it really cost us to generate a result? And you compare that to four or five other labs.”

With pay rates and test volumes falling, getting paid for the work that is done takes on outsized importance. A lenient approach to collecting from clients will no longer do, Schofield says. NorDx has seen bad debt double within the past 18 months.

“We’ve had to become very firm about getting paid. In the past, you could let it slide a month or two if this was a powerful, well-known doctor and you didn’t want to rock the boat. Now everybody’s strapped for cash. There are no special favors or dispensations,” he says.

After 60 days without payment, NorDx’s collections staff start making phone calls. After 90 days, NorDx sends notices warning that lab services will be discontinued unless debts are paid.
“Then, suddenly, the checks start appearing,” Schofield says. “We don’t let things ride out very far.”

It takes NorDx an average of 44 days to collect after a sale, Schofield says. The industry benchmark is between 45

and 55 days, according to AMS' Camara. Meanwhile, AMS helps NorDx gauge how well its in-house billing and collections staff is performing on metrics such as paid hours per requisition.

Finally, when it comes to cutting costs, old-school tactics such as freezing travel, capital expenses, or hiring are no longer enough.

"Today, we have metrics daily," Schofield says. "What's the trend? What's the volume? How is the hospital doing? Did they lose a surgeon, or did a clinic close?"

Such close attention to detail helps NorDx's leadership team respond quickly to problems or prevent them altogether.

Flexible, cross-trained staff is key to a parsimonious approach when covering four or five facilities in a 20- to 30-mile area, Schofield says.

"When I was a med tech, everyone was a generalist. We're putting people back into the generalist mode. We can move staff around based on needs, coverages, vacations. A prime example is that we're integrating a hospital and changing lab systems and equipment in August. I can send staff up there who already know how to use that new equipment and system to help them. The week before they go live and the week after they go live, we'll have supplemental staff there. If things go crazy and they have a big problem, they have an expert standing right next to them."

Sometimes, however, personnel cuts are necessary. When that is the case, Schofield warns, "You can't just come in and say, 'You nine people don't work here anymore.' That's not how we operate." With help from AMS, the goal is to do the cuts in the right way.

"Even though our stock-in-trade is metrics work, we do a lot of qualitative stuff with regard to optimizing workflow and processes," AMS' Camara says. "When we're doing these types of studies for our clients, we've got this set of guiding principles in place that cannot be violated. Top among them is that quality must at least remain the same, but in the best of circumstances it should improve."

Another place to cut is in senior leadership, Schofield said. NorDx used to have 11 director positions and now has seven.

"Flatten your organization. You do not want to be standing up there like a pillar on the top of the hill when the lightning storm strikes," he said.

Meanwhile, NorDx looks for savings on nonlabor costs through the by-invitation-only Compass Group, whose leverage is used to save when negotiating for new technologies.

"There isn't a problem I can't solve by picking up a phone and calling one of my friends," Schofield said. "It's a very powerful networking group."

Standardization and integration across MaineHealth also help save on equipment, reagents, and services. Meanwhile, Schofield urges laboratory directors to beware of diagnostic equipment companies' newly aggressive approach to checking on test-volume commitments now that the heyday of ever-rising test orders has come and gone.

"The diagnostic companies are checking contracts and assessing penalties," he says. "I know lots of folks who, in the last six months, got phone calls or someone comes to visit to say, 'You're 15 percent below your commitment.' And instead of saying, 'Wink-wink, we'll work this out,' they say: 'No, you've got till the end of the quarter or we want $15,000.'"

NorDx is not signing any more such commitments, and Schofield advised his colleagues at the War College also to avoid them.

“The diagnostic companies are all going to hate me,” Schofield said. “They need to learn to do something a little different. They all want to be your partner. They all want to be your buddy and want to be your primary source. Well, they better start acting, and treating, you like it.”

Reflecting on how he has survived life-threatening throat cancer, Schofield notes that the disease “took me to death’s door, but I wouldn’t cross the threshold.

“I stayed engaged. I never missed a day of work. I never thought about dying. I only thought about living,” he says. “I called it the rattlesnake mentality.”

That fierce mental approach appears to be one that he and his team at NorDx are bringing to the challenges that threaten a laboratory’s survival.

“We’re facing really tough times, and we’re going to have to do things differently from what we’ve been trained to do,” Schofield says of the laboratory medicine community. “You need to use your imagination on how to do things differently, and you must have execution. . . . You can have the best battle plan, but when you go to battle, if you don’t do what you’re supposed to do, you will be wiped out.”

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