Healthcare Reform: Where Does the Laboratory Fit?

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Collaboration

The growth in healthcare expenditures in the United States is recognized as unsustainable. Historically, physicians have not been rewarded for quality and have not been held particularly accountable for their outcomes. But now, pathologists and laboratory professionals are in a position to lead as the healthcare industry strives to be truly efficient in a modern, lean sense.

We are in an environment where we have to do more with less. One of the key elements of healthcare reform is utilization control, and for the first time in the history of modern laboratory medicine, pathologists and medical laboratory professionals will receive incentives to collaborate with health systems to rein in test utilization.

These converging challenges coincide with an explosion in new technology to advance the field of medicine and laboratory practice, and they present entirely new challenges to the community. We are at a critical juncture where ASCP members can have an important impact.

Pathologists and laboratory professionals are being asked to consider serving as diagnostic consultants. As such, they need to step outside the laboratory to demonstrate the value of their contributions to medicine. Collaboration with all members of the multidisciplinary medical team is vital in this emerging era of medicine if we are committed to improving the delivery of patient care.

In this issue of Critical Values, authors examine the evolving role of the medical laboratory and the opportunities for pathologists and laboratory professionals to provide leadership that will improve the cost effectiveness of healthcare delivery while advancing patient outcomes. ASCP President Steven H. Kroft, MD, FASCP, offers his Top 10 list of strategies for laboratories and laboratory professionals to not only weather the approaching storm, but to thrive.

Please enjoy this issue of Critical Values and let me know your thoughts about how pathologists and laboratory professionals are poised to lead in this dynamic climate. I can be reached directly at Blair.Holladay@ascp.org.

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Facing (and Thriving in) the Future: A Top Ten List

The Relevance of Laboratories in a Changing Healthcare Landscape

New Year, New Format

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Betty Chung and Edna Garcia

ACOs and the Laboratory

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We are on the cusp of the most dramatic period of change in the way healthcare is delivered and consumed in this country in recent history. A storm is approaching and, like it or not, the laboratory is going to be right in the middle of it. The factors that will impact laboratory practice are numerous, varied, and complex, and no one has a crystal ball that can tell us what the other side of the chasm will look like. However, it is becoming increasingly clear that there are a number of things laboratories and laboratory professionals will need to do in the coming years to not just survive, but thrive. So, what are those things?

10. Be smart about your human resources.
Good laboratory professionals don’t grow on trees these days, so we need to make the most of that most precious resource: Our workforce. This means not only hiring people with good skill sets, but also giving them the means for obtaining additional critical skills. What’s more, it means matching employee skill sets with the
right jobs and providing clear pathways for advancement. Successful employees are happy employees, and happy employees make functional teams. (Tip: If you have lab managers spending their time stocking shelves, you might want to rethink your staffing model.) Finally, if you have an opportunity to help build the laboratory workforce of the future—whether by being a clinical training site, mentoring a young laboratory scientist, or helping recruit students into STEM programs and spreading the word about what a great field we have—take it and run with it.

No matter what comes down the pike, waste will no longer be an option in clinical laboratories. Through the application of lean techniques and related principles, we can cut non-value-added work out of our processes and at the same time improve quality and employee satisfaction. It’s a win-win.

8. Take charge of test utilization.
While it is counterintuitive for labs to try to reduce the amount of business they get, this is exactly what we will be asked (and rewarded) to do. Implement systems to help physicians order the right test on the right patient at the right time at the right cost. Help doctors be smarter about how they utilize resources. Own the issue. And don’t forget: WE are the experts at lab testing. Don’t let that aggressive surgeon intimidate you.

7. Take up permanent residence in the patient-centered medical home.
Plop down right in the living room, and don’t budge. The laboratory is at the center of every aspect of the practice of medicine. We are uniquely positioned to facilitate the coordination of care through robust systems of information exchange. We need to make labs as patient-centered as any other part of the healthcare system.
6. **Create true value.**
Value is defined as quality divided by cost. A fundamental principle inherent in the new models of accountable healthcare delivery is the building of systems to increase quality (and thus improve outcomes) while at the same time reducing costs. You can add only so much value to a commodity, which is why laboratory services MUST NOT be commodities. We have to add value through service, whether it’s decision support for ordering, clinical consultation, testing cascades, interpretive algorithms, computational diagnostics, or even interacting directly with patients about their laboratory results.

5. **Locate your inner informatician.**
Every single aspect of a value-added approach to laboratory medicine requires robust informatics support. Learn to generate the data you need, learn to convert that data into knowledge, learn to LOVE data. Learn to move information where it needs to go, get it there when it needs to be there, and put it in the forms in which it will be most useful. Use good data every single day on a continuous quest for greater quality and value.

4. **Get out of the lab.**
If we are a black box, we will fail. Get out into your healthcare system. Integrate, advise, advocate. Get in people’s faces. Be at every table where decisions are being made that affect the lab and that the lab can affect. Lead.

3. **Quality is not optional.**
While this is axiomatic in laboratory medicine, there may be a temptation to cut corners as pressure mounts to drive down costs. Don’t succumb to that pressure; draw a line in the sand and hold it. Live quality, breathe quality, learn to SELL quality. And don’t forget, investments in quality do, in fact, pay for themselves many times over.

2. **Never, EVER forget who our final customers are.**
We hold the power of life and death in our hands. If we’re not doing everything in our power to help sick people get well and prevent well people from getting sick, then we’re not doing our jobs. Seventy percent of medical decisions: Be a proud and faithful steward of that legacy.

1. **Don’t fight the future. Embrace it.**

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Around ASCP Journals

The American Society for Clinical Pathology (ASCP) offers information and education that can aid your practice as pathologists or laboratory professionals. Whether you read the printed journals or get your information online, the American Journal of Clinical Pathology (AJCP) and Lab Medicine provide the latest research, reports, and studies. Highlights from recent issues include:

AJCP
The November issue of AJCP contains two review articles about the pathologist’s and laboratory’s role regarding new oral anti-coagulants. These articles are part of the ongoing Pathology Consultation series produced by the Academy of Clinical Laboratory Physicians and Scientists. An article in the December issue evaluates an external quality assessment program for HIV testing instituted in Haiti. The January issue offers the first in a series of educational articles planned for 2014, along with an editorial giving an overview of the series. These articles and others can be accessed at www.ajcp.com as part of your ASCP membership.

Lab Medicine
The Fall 2013 issue of Lab Medicine offers readers an inside look at the challenges of medically monitoring crew members and performing basic clinical research during spaceflight. Currently, very few instruments are used because of technical constraints. NASA scientists Brian Crucian et al. discuss medical laboratory instruments needed aboard the International Space Station and adapting analyzers for use in spaceflight.

The Lab Medicine website (www.labmedicine.com) features articles that are not available in the printed journal. Exclusive content includes the full-length version of the 2013 Wage Survey, a podcast on Cyclospora, and a video discussing the laboratory considerations for brown recluse spider bite victims.

The website also features Lablogatory, the blog for medical laboratory professionals. Written by expert authors, topics covered on the blog include leadership, global health, pathology resident concerns, and more. If you would like to become a blogger, please contact the web editor at editor.labmed@ascp.org.
A Seat at the Table: The Future of Medical Laboratory Professionals as Collaborative Partners in Patient Treatment and Care
One of the memories I have of holidays gone by is of heading off to my grandmother’s house for dinner. She had seating for eight at the dining room table, and often there would be that many adults. Naturally, we kids were relegated to other locations, such as at a card table set up in the kitchen or with TV trays on an enclosed porch. When I was around 12, the fun of watching my younger cousins’ shenanigans had worn off. I desired to have “a seat at the big table” and to be included in adult discussions about subjects such as politics, health, weather, jobs, and football. When I made my case that I was ready for a seat at the big table, my mother counseled me that it was not likely to happen anytime soon and to be careful what I asked for, because doing so meant someone else would likely have to move away or die. Her advice was to be patient and wait; my day would come.

Deciding to pursue a degree in Medical Technology came with the realization that the profession would include little direct patient care beyond phlebotomy. Like many of my colleagues, I was fine with that. Simultaneously making a living and a difference by providing for patient needs was a noble path, even if there was limited or no direct interaction with patients. What soon became difficult to accept was the ostensible limited input into patient diagnosis and treatment. In hindsight, this view was incorrect because the input I provided was significant; it was simply conveyed through results rather than consultation. Still, decisions made in meetings attended by doctors, nurses, department directors, and administrators seldom included laboratory professionals. There were times, particularly early in my career, when thoughts about not having a seat at the big table returned.

In one of my first laboratory jobs, I was instructed not to discuss patient results of testing with anyone. Understandably, these discussions were not to occur with
patients or visitors; yet the prohibition extended even to nurses and physicians. Any question beyond “when can I expect my results” was to be referred to a supervisor or pathologist. The correlation between testing and patient diagnosis and treatment was not within the general technologist’s area of expertise. When I asked when I might have the opportunity to participate, the counsel was similar to the advice my mom had given me about the seat at the dining room table: Be patient and wait; that day would come.

Another example occurred soon after I became a Specialist in Blood Banking, when I had the opportunity to attend the facility’s transfusion committee meetings. Post-surgery single red blood cell transfusions given to adults with hemoglobins above 10 mg/dl were not unusual, and it seemed the attending physicians were quite perturbed when asked to justify why the transfusion was necessary. The blood bankers even wondered whether, in some cases, single transfusion rule questioning was avoided by transfusing two units of red cells rather than one. It was not for the blood banker to determine if the transfusion was clinically indicated—even raising the question was not our place. Having years of blood bank experience and holding a specialty did not make any of us a competent medical authority.

Opportunities to have a “seat at the big table” professionally are now becoming more abundant within our respective fields. With an ever-expanding menu of clinical laboratory tests for diagnosing and monitoring scores of diseases, emphasis on reducing healthcare costs, and calls for choosing wisely and testing right the first time, the future of healthcare is moving toward more collaboration between healthcare professionals.

The issues will become more complex and acute as the Affordable Care Act is implemented. Will laboratory professionals have a role? If not, why not? Medical Laboratory Scientists are already technical subject matter experts, know the analytical processes, run the analyzers, interact with the vendors, and troubleshoot instrumentation. Right now, an estimated 60 to 70 percent of decisions on admissions, medications, and discharges are based on laboratory data and patient-specific clinical pathologist consultations—and those numbers are on the rise. So there is an ever increasing need for laboratory scientists, particularly those with business and clinical acumen, specialties, and/or graduate degrees, to be part of the healthcare decision team.

With advancements and variations of diagnostic testing, such as the rapid development of genetic and molecular tests, the need has never been greater for harnessing laboratory professionals’ knowledge. We are certainly able to comprehend and utilize business principles such as operational efficiencies, healthcare cost control, and reimbursement as well as compliance, customer service, and clinical correlations of laboratory tests. Knowledge of clinical correlations to test results, lean concepts, and the business of healthcare will position graduates for future opportunities “off the bench.”

Physicians and other healthcare professionals directly involved in patient care are challenged to keep up with the rapid growth of new clinical information. Thus, getting advice in addition to the results from laboratories relieves the burden of acquiring further diagnostic knowledge and allows the clinicians more time to focus on disease management. Advanced informatics systems help provide this need and will go beyond the automatic computer-generated comments that are not patient-specific, and often insufficient to guide the clinician. These informatics systems need a network of experts from various subspecialties at diagnostic centers linked by data transmission systems. Professionals are able to assemble the data and apply it to medical diagnoses, thereby reducing the costs associated with healthcare delivery.

Competent laboratory professionals are well positioned to move into areas of responsibility for evaluating data about test performance and providing information for physicians. This includes making recommendations about clinical utility and lean processes to ensure tests are useful, timely, reliable, and cost effective; evaluating blood product utilization for a facility or a health system; determining the validity and utility of new clinical laboratory tests; serving as patient advocates for use of only those tests where evidence of sufficient sensitivity and specificity exists; and performing evaluations of new and complex biomarkers.

The needs and opportunities are there. Why not have seats at the big table?

Mr. Hager is Chief Executive Officer at the American Red Cross National Testing Laboratory in Portland, Ore.
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Change for the Future

As a medical student, I often felt frustrated with the inefficiencies of our healthcare system and the inability of my patients to receive the care they needed at the appropriate time. Even at that early stage in my training, the need for healthcare reform was quite clear to me. As a pathology resident, my frustrations only continue to grow. Yet, we are no longer able to stand still.

Changes are happening today as we see the beginning effects of the new healthcare laws, which were passed in hopes of stepping toward a healthier America. These new laws bring a mix of emotions among patients and providers alike. There is a significant amount of angst because of the many uncertainties about how the ever-changing healthcare landscape will evolve. Only one thing is certain: There will be change.

The Right Test for the Right Patient at the Right Time

The driving principles behind healthcare reform rest on delivering patient-centered care and improved health outcomes at a lower cost. In 2011, the United States spent $2.7 trillion on healthcare, averaging an estimated $8,680 per person. Many of the rules within the healthcare laws will require healthcare systems and laboratories to critically evaluate their practices to eliminate waste and maximize efficiency.

When evaluating total healthcare costs, the direct cost of laboratory/pathology testing is estimated to account for 4 percent ($60 billion) of that total. At a glance, laboratory testing does not seem to offer much opportunity for curtailing total healthcare spending.
However, when one considers the indirect costs of those tests, a much different picture unfolds.

Diagnostic services play a central role in everyday clinical decision making. In fact, an estimated 60 to 70 percent of medical decisions are influenced by laboratory data. Whether a test was appropriate or not, the result may lead to a subsequent chain of events that, in some cases, is unnecessary and potentially harmful to patients. As physicians and laboratory professionals who are intimately involved with all laboratory results, we must take an active role in decreasing unnecessary and overutilized tests.

We must maximize pathologists’ role in optimizing test selection and diagnostics amid ever-changing medical innovation. While we must practice in a more cost-effective manner without compromising care, it is vital that we continue to integrate new technologies into our work. If we thought test-ordering menus were complicated now, consider the increasing number of molecular tests that will only continue to expand. According to the Global Genetic Testing Market Forecast to 2015, genetic testing is predicted to grow by 26 percent annually through 2015. While these new technologies will continue to increase a physician’s ability to offer personalized/targeted care and therapies, we must also be careful to critically evaluate these new tests to adequately demonstrate their clinical utility and ability to produce meaningful, actionable results. Value must be assessed not only by looking at clinical performance and cost, but also by weighing the impact on patient care and management. Ultimately, we need to provide the right test to the right patient at the right time.

Coordinated Patient-Centered Care

In the process of providing clinicians with accurate, timely results, the laboratory and pathologists are often viewed as a commodity rather than as a value-added asset to the clinical care team. This could not be further from the truth. The role of the laboratory and pathologists does not end at a single test result, nor at the ability to optimize test utilization. We are also in a key position to lead the way to diagnostic interpretation and integration. By partnering with our clinical colleagues, we can develop tools to help optimize their time with patients. Targeted test approaches are more cost-effective than “shotgun” test ordering. Thus, care-based and disease-based testing algorithms have the capacity to improve and optimize test selection among physicians, potentially decreasing time for the ordering clinician as well as decreasing unnecessary utilization. Furthermore, through interpretive patient-specific laboratory reports, we can provide value-added information to results and assist clinical care teams in making effective care decisions to improve patient outcomes.

With intimate knowledge of laboratory tests and diagnostics, pathology and laboratory medicine are uniquely positioned to take an active role in clinical decision support systems. The laboratory information system itself contains a wealth of power and has the capability not only to provide our colleagues clinical decision support, but also to provide population-based approaches to care. This will be increasingly important as healthcare providers and systems are held accountable for the efficacy of the health care delivered to populations. Lastly, as an increasing number of individuals enter the healthcare system, physicians will need to optimize their time with patients, making such support tools vital to providing quality care.

Preparing for the Future

While the exact effects of the new healthcare laws cannot be predicted, the number of individuals within the healthcare system will dramatically increase, and laboratories will be pressured to do more with less. We must shift our approach from a volume-based to a value-based practice setting. The concepts previously mentioned are just a few among many that demonstrate the value-added care that laboratories and pathologists can provide patients and clinical care teams as we move forward in this ever-changing practice environment. We must be proactive and find innovative ways to empower clinicians to effectively provide care while also engaging patients to take control of their health.

Ultimately, no one has all the answers about healthcare reform and the changes that will unfold in the years to come. But tackling future challenges requires, or rather demands, a multifaceted collaborative approach among all stakeholders: Patients, healthcare professionals, and physicians alike. To truly make the changes in health care that our country needs, we must all work together as we forge ahead, keeping one goal in mind—the welfare of our patients.

REFERENCES


Dr. Stall is a fourth-year pathology resident at the University of Michigan, Ann Arbor, Mich.
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The Relevance of Laboratories in a Changing Healthcare Landscape

By Kelly Swails, MT(ASCP)

In today’s changing healthcare environment, laboratory professionals can’t afford complacency. Proposed Medicare reimbursement changes, the Affordable Care Act, evolving payment models, and the ever-increasing demands on healthcare services mean that the laboratory could shift from a profit center to a cost center. It’s feasible that a facility’s administration could come to see an in-house laboratory as a losing proposition, and it’s up to laboratory professionals to discourage that mindset.

Now is the time to rethink how to do business in order to keep the laboratory relevant; once the decision is made to sell laboratory services to the highest bidder, it’s too late. In order to compete in this changing marketplace, laboratories need to take an honest look at their business model and ask themselves tough questions. Are they providing the right test menu for their clientele? Are their processes as efficient as they could be? How can they add value to the services they provide? Finding the answers to these questions can strengthen a laboratory’s position with administrators.

In-House vs. Send-Out

In terms of test menus, one size does not fit all. Every clinic, hospital, and network has unique patient populations, and those patients have specific needs.

"When determining the scope of an in-house laboratory, you have to stop and think about the delivery of laboratory services," says Sue Zaleski, MA, HT(ASCP)SCT, lean management engineer in the Department of Pathology at the University of Iowa Hospitals and Clinics in Iowa City, Iowa. "What model meets the needs of the providers and the patients in the particular community of interest?"

Jack Hager, MS, MT(ASCP)SBB, CEO of the American Red Cross National Testing Laboratory in Portland, Ore., advises laboratories to “start by looking at customer service and patient needs. Oftentimes it’s a cost decision that has a customer service element.”

If, for example, your facility has a diabetic care clinic, performing glycosylated hemoglobin testing in-house would be imperative. Small rural clinics might be most profitable if they perform only stat testing, such as CBCs and chem 7 panels, and routine coagulation testing, such as PTs and aPTTs, in-house. Sending out entire departments such as microbiology, types and screens, and anatomic pathology might make sense for these clinics, because they wouldn’t have the volume to justify performing the testing in-house.

But midsized facilities, those with around 250 beds, might find that sending out a small portion of their menu fits their needs.
Ms. Zaleski. “It’s a much more cost-effective way to deliver volumes from multiple hospitals into one location,” says The advantage is the economy of scale when you pull small rather than sending it to a reference laboratory. The opportunity to establish a central location for that testing that test could be a candidate for outsourcing. It’s also an opportunity to establish a central location for that testing rather than sending it to a reference laboratory.

“Laboratories have always sent out some of their work, usually for tests where there’s not a need for a quick turnaround time,” Mr. Hager says. A midsized facility might outsource to a reference laboratory the esoteric tests that are rarely ordered by physicians, such as those for babesiosis, MERS, or Lyme disease.

In contrast, large facilities with 500-plus beds tend to look at outsourcing a bit differently.

“We have a very strong core laboratory as well as satellite laboratories that have specific functions to provide services to specific populations,” says Ms. Zaleski of her facility. “We have a NICU laboratory that’s embedded in our level four NICU and serves only those patients. We also have a critical care lab that serves the operating room and our critical care inpatient units. It all goes back to providing service.”

These laboratories, she notes, perform a limited test menu with stringent turnaround time requirements. They are designed to be near the populations they serve in order to facilitate good patient outcomes. Although this arrangement could technically be called outsourcing because the work isn’t performed in the core laboratory, these labs are part of the same overall laboratory business model in terms of budget and staff.

**Pros and Cons of Outsourcing**

The possible advantages of outsourcing a portion of the test menu include lower costs (fewer reagents to buy, analyzers to maintain, and staff to pay), simplified workflow, and less pressure on personnel. If a clinician doesn’t require the results right away—as with a PAP test, for example—that test could be a candidate for outsourcing. It’s also an opportunity to establish a central location for that testing rather than sending it to a reference laboratory.

“The advantage is the economy of scale when you pull small volumes from multiple hospitals into one location,” says Ms. Zaleski. “It’s a much more cost-effective way to deliver service. You’re concentrating the work and the skill.”

A disadvantage of outsourcing to a large reference laboratory is the potential for errors. A large reference laboratory can have multiple patients with the same name and birth date—Mary Jones, DOB 2/19/1950, for example. When that happens, it would be easy to order and perform testing on the wrong Mary Jones. Since the clinical laboratory professionals working at large reference laboratories don’t know this particular Mary Jones and are not familiar with her situation, they might not catch results that aren’t normal per se but aren’t right for that Mary Jones.

“You get to know your patients when their specimen comes to an in-house laboratory. ‘Oh, here comes Mary Jones again. We know what her results typically are,’” Mr. Hager says. “Suddenly you have a flag value that is not necessarily a critical value, but it’s abnormal for that Mary Jones. You’re far more likely to question that in-house.”

Ms. Caldwell agrees that in-house laboratory testing has a number of advantages over outsourcing an entire laboratory. “Technologists are present to answer technical questions about results,” she says. “Slide reviews are easier. There can be coordination between departments in regards to specimen integrity.”

Kim Futrell, MT(ASCP), products marketing manager for Orchard Software Corp. in Carmel, Ind., and author of the white paper, “The Value of the Lab in the New Healthcare Model,” published in July 2013 adds, “The lab has valuable clinical knowledge to offer that can be instrumental in educating clinicians.” That guidance could be missing if outsourcing became the norm.

**Look at the Whole Forest, Not Just the Trees**

Perhaps the question shouldn’t be, Do we keep this in-house or send it out? Or, Should we consolidate three microbiology departments into one? But rather: How can we provide the best value to our patients and providers? Adding value to the services provided makes it less likely that administrators will...
see the laboratory as a liability.

One way to add value is to manage the bottom line by streamlining processes. “Instead of saying, ‘We’re going to send this out,’” says Ms. Zaleski, “I think you need to look at your processes and ask, ‘How can we do this better?’ We cannot continue to do things as we have done them historically.”

Laboratories must identify waste in their systems and eliminate it, a concept commonly known as lean. If laboratory professionals make processes more efficient, they spend less time performing functions that don’t provide value. The services they provide improve bottom lines, patient care, and provider satisfaction.

Another way to add value is to change the laboratory’s mindset. “Labs have always monitored analytical and preanalytical factors in their testing processes,” says Ms. Futrell, “but healthcare reform’s shift from a volume focus to a value focus is an opportune time to branch out further into the oversight of proper test utilization.”

Tracking test ordering practices lowers costs, and laboratory professionals can advise clinicians on the best test to order for a particular malady or suggest an efficient test algorithm. For example, a facility can work with providers to determine the best tests to order when monitoring a diabetic patient. Providers follow this agreed-upon testing paradigm, thereby eliminating tests that aren’t useful or relevant. They can also go a step further and branch out into reflex testing and decision trees (if test A is positive, then the laboratory orders test B).

“Proper test utilization can be supported by implementation of test cascades and algorithms, like Mayo and other larger laboratories have already successfully incorporated,” says Ms. Futrell. “In these scenarios, the provider can order the Celiac cascade, for example, and the lab testing will follow that algorithm with subsequent testing only being performed if the previous test results indicate that it is necessary and appropriate.”

In the end, administrators will decide the fate of in-house laboratories, and those administrators will need laboratory input and data to make an educated and justifiable decision. While the argument can’t be made that sending everything to a reference laboratory is better for patient care, monetary concerns will be the driving factor in that decision. It’s up to laboratory professionals and pathologists to be advocates for the laboratory and demonstrate to administrators specific examples of how that laboratory’s services add value to the care provided.

REFERENCE


Ms. Swails is a laboratory professional and Web Editor of the Lab Medicine website.
As the United States works to transform health care through the implementation of the Affordable Care Act (ACA), much emphasis is being placed on the role of primary care physicians, hospitals, and third-party payers in improving the healthcare system. Currently, health care accounts for 17.3 percent of the U.S. gross domestic product and is projected to increase to 19.3 percent by 2019 (Figure 1). But health outcomes commensurate with the amount spent on care are not necessarily proportional. A report from American Health Insurance Plans and the Commonwealth Fund shows that “30-50 percent of healthcare expenditures are unnecessary due to inefficient, soiled, or poorly organized care” (Figure 2). Patient-centered, coordinated healthcare delivery models are at the core of addressing the fragmentation present in our current system, and the role of pathologists and laboratory professionals must evolve in order to dovetail with the three overriding goals of the ACA: Promote better care for individuals, provide better healthcare for populations, and lower per capita costs.

By Betty Chung, DO, MPH, MA, PGY-2 and Edna Garcia, MPH

Health Reform and the Future of the Workforce

The Future of the Medical Laboratory Workforce under Healthcare Reform

According to the American Society for Clinical Pathology’s (ASCP) Taskforce on Laboratory Professionals Workforce report, the enactment of the ACA will increase the demand for healthcare services, which will in turn increase the demand for appropriate laboratory tests. With approximately 7 billion to 10 billion laboratory tests performed annually, laboratory professionals are well qualified to provide recommendations for appropriate test ordering, identify prevention efforts that focus on patients most likely to benefit, and report healthcare historical trends.4,5

With the application of the new healthcare laws, Accountable Care Organizations (ACOs) are expected to grow as their inherent design—coordinating a patient’s, or a population of patients’, care among all providers in that system, and using quality metrics to determine reimbursement—aligns with the new ACA measures. For ACOs to be effective coordinators of care, they need the structural capability and systems necessary to address the changing healthcare landscape. Pathologists and laboratory professionals who staff the nation’s laboratories represent the core diagnostic side of ACOs, and the increasing significance of laboratory data in coordinated care will drive important medical decisions and population-based health outcomes (Figure 3).6

Laboratory professionals provide information that supports prevention, treatment, and management of disease. Physicians, nurses, and other healthcare providers rely on clinical laboratory data for appropriate care coordination and value-based purchasing information. The laboratory profession should then serve a central role within ACOs because they can 1) influence decreases in inappropriate or unnecessary ordering of laboratory tests; 2) improve health information technology utilization; and 3) reduce cost of care.

ACOs are commonly viewed as a way to rein in laboratory test utilization and cost, but not all healthcare facilities in the country participate in this form of coordinated care. Facilities outside of an ACO do not have the same incentive to encourage laboratory professionals to monitor tests because there is no financial penalty for not doing so. In many instances, the same tests are requested more than once for any particular patient, leading to unnecessary duplication of services and medical errors. In addition, abusive billing and contractual arrangements and practices related to patient care may occur in non-ACO facilities. Since the ACO places a degree of financial responsibility on the provider for the overall quality, cost, and care of their services, improper billing practices are more easily avoided.7

As stated in the ASCP Public Policy Statement on Fee Splitting, Markups and Related Practices (http://www.ascp.org/ISTP/Public-Policy/Level-One-Priorities), self-referral, markups, and certain inappropriate contractual agreements “can distort rational medical decisions, lead to the overutilization of health services and higher medical costs for patients and third-party payers, and cause unfair competition by freezing out competitors unwilling to engage in such practices.” The Health and Human Services Office of the Inspector General conducted a study on these practices and found that physicians with a financial interest in the clinical laboratories where they
critical values  | January 2014

Doctors ordered a test that had already been done | 23
Time spent on paperwork related to medical bills and health insurance a problem | 26
Healthcare system poorly organized | 36
Any of the above | 54

**Figure 2.** Potential healthcare waste and inefficiency. Adapted from Miles, J., Weiss, R. ARUP Laboratories. The role of laboratory medicine in accountable care organizations. http://www.aruplab.com/blog/ACO_whitepaper. Published August 2011.

refer Medicare patients order 45 percent more laboratory tests than physicians who do not have such a financial interest. Clinical laboratories that do not participate in these practices and are not part of ACOs may be forced to reduce their services, close, or consolidate, and this could lead to a decrease in vacancies for laboratory professionals. Since it is projected that the profession will need more laboratory professionals in the coming years, these practices compound the challenges facing the laboratory workforce today.

**Broad Changes for the Pathologist Workforce under Health Reform**

The emerging sentiment in health care, and one supported by the ACA, is that the patient should be at the center of the healthcare system. Access, transparency, quality of care, and coordinated care are key in this process, and the ACA includes economic incentives to direct clinical medicine toward these goals—a few of which will be discussed in this article.

It was previously estimated that about 46 million people in the United States were uninsured and that similar numbers were underinsured. With the individual mandate effective since January 2013, penalties starting in 2014 for non-compliance, and the state exchange marketplaces open since October 2013, more Americans are expected to be insured and able to access care when necessary. Additionally, many financial barriers, such as third-party payer denial based on pre-existing conditions; health insurance annual and lifetime limits; non-reimbursement policies on preventive screenings; and the Medicare prescription drug coverage gap, will be addressed or eliminated.

The ACA financial incentives are expected to shift care to coordinated care delivery models. These models, such as patient-centered medical homes and accountable care organizations, focus on infrastructure that promotes integration and continuity of care, improved access to and transmission of patient information through use of electronic health records and laboratory information systems, and improved quality of care and outcomes. These models also legitimize the patient experience as a driver for healthcare decisions. Pathologists must demonstrate that they play an indispensable role in meeting these goals and that they can practice within such systems.

With respect to compensation, the ACA hopes to usher in value-based, pay-for-performance payment models with capitated, bundled, or alternative shared reimbursement plans based on meeting quality and efficiency measures rather than traditional fee-for-service. To achieve better outcomes and cost savings, physicians and other relevant health professionals, including pathologists, will need to collaborate in interdisciplinary teams and integrate their respective expertise to order appropriate testing while decreasing those tests that are inappropriate. Additionally, incentive payments and criteria outlined in the Meaningful Use Policy endorse increased adoption and utilization of electronic health records (EHR). And pathologists, as the guardians of health data and monitors of quality improvement variables, can contribute to more efficient and comprehensive diagnostic results reporting within EHR and to outcomes-based research.

It has been estimated that about 70 percent of diagnostic and treatment decisions are based on results of clinical laboratory testing. Clinical pathologists can show their value to the primary care team as experts on the nuances, indications, and costs of such testing. Similarly, anatomic pathologists can help provide prognostic and treatment information with immunohistochemical, in situ, and/or molecular test results supplementing their morphologic diagnoses. With the recent push toward personalized medicine and digital health technology, pathologists are well poised to demonstrate their value as diagnostic experts. But this will be if, and only if, they are proactive and present in these patient care discussions.

Data collection and quality improvement initiatives such as the Physician Quality Reporting System (PQRS) and research through the Patient-Centered Outcome Research Institute seek to promote quality information reporting, best evidence practices, and, eventually, payment for performance.

PQRS was originally established as the Physician Quality Reporting Initiative (PQRI) in 2007 and was voluntary. With passage of the ACA, PQRI underwent a name change to

**Figure 3.** The value of laboratory data in driving outcomes. Adapted from Crawford, J. Leveraging the clinical laboratory in the accountable care era. http://pathology.ufl.edu/files/2012/10/2013-seapc-crawford.pdf.
PQRS and becomes mandatory starting in 2015. Eligible professionals and group practices in pathology must report data on three quality measures to receive incentive payments or payment adjustments for compliance, or they will receive penalties for non-compliance or unsatisfactory performance.

Physicians can receive a 0.5 percent bonus on all of their Medicare billing for 2013 by reporting on three out of five specialty-specific PQRS measures to the Centers for Medicare & Medicaid Services (CMS); a 1.5 percent penalty or payment adjustment will be applied in 2015 based on 2013 PQRS reporting performance. Starting in 2016, that penalty will increase to 2 percent. An additional 0.5 percent incentive payment is available to those satisfactorily reporting PQRS data and participating in the CMS-qualified American Board of Pathology maintenance of certification program more frequently than is required.14

Currently, there are five quality measures developed by the College of American Pathologists (CAP) that were approved by CMS as desirable for quality data reporting. Pathologists can choose three among these five to report: 1) breast cancer resection (measure 99) pathology reporting; 2) colon cancer resection (measure 100) pathology reporting; 3) Barrett’s esophagus (measure 249) pathology reporting; 4) radical prostatectomy (measure 250) pathology reporting; and 5) immunohistochemical HER2 evaluation for breast cancer patients.15

In the past, organizations such as ASCP and CAP lobbied for the exclusion of pathologists from CMS incentive programs such as eRx (electronic prescriptions) where it would be difficult for the profession to meet the requirements. Similarly, now that many of these programs are mandatory due to the ACA and are moving out of the incentive into the penalty phases, it is imperative that pathologists not only participate when possible, but also speak up for exclusion when the nature of the profession precludes satisfactory participation.

With healthcare reform and the expected increase in patient coverage, the healthcare landscape of the future is predicted to be dramatically different from its predecessor. Furthermore, big data and patient-accessible healthcare digital technologies are developing at a rapid pace. Therefore, pathologists must rebrand themselves as a vital contributing member of the primary care team who can help direct reliable, high-quality care while facilitating shared cost savings in this new era of health care.

REFERENCES


Dr. Chung is a resident in the Pathology Training Program at the University of Illinois Hospital and Health Sciences System in Chicago. Ms. Garcia is the Senior Manager of Scientific Engagement and Research for the American Society for Clinical Pathology in Washington, D.C.

The authors would like to thank Matthew Schulze, Director of Government Relations for the American Society for Clinical Pathology in Washington, D.C., for his assistance in the writing of this article.
Cut down on stress. Quit smoking. Save money. These are just some of the phrases uttered at the start of a new year. According to USA.gov, several of the most popular New Year’s resolutions revolve around improving overall health, and on January 1, Americans got a push in that direction as the Affordable Care Act (ACA) went to full strength at the stroke of midnight.

The depth of change that healthcare reform will bring is yet unknown, and fixing a system that is so fragmented will take more than a little time to produce better patient experiences and outcomes. But as the new healthcare paradigm moves toward lowering the cost and improving the coordination of care, accountable care organizations (ACOs) are the delivery model many expect to help drive change.

By Molly Strzelecki

ACOs and the Laboratory

New healthcare delivery models bring a raised awareness of the lab—and many opportunities
An ACO is a network of providers—physicians, hospitals, laboratories, and clinics, for example—that shares the responsibility for a defined population of patients. These populations can include patients with private insurance or Medicare; they could be healthy or have chronic illnesses. ACA reforms require that Medicare-sponsored ACOs cover at least 5,000 Medicare patients for at least three years.

Under an ACO, each patient’s care and health information is shared and coordinated throughout the provider network. In the current healthcare model, much of the care is provided in silos on an episodic basis; one doctor may not be talking with another doctor or clinic, which could result in unnecessary services and drive up costs. In an ACO, such things as duplicate testing or unnecessary hospital stays are presumably reduced or even eliminated because of the health information exchange.

ACOs also differ from the current standard in the area of reimbursements. Today’s healthcare reimbursement system uses the fee-for-service model: A physician or a lab provides an exam or test, and they are then reimbursed for it by the insurance company. ACOs, however, are moving toward a member-per-month reimbursement model, wherein the organization receives a certain amount of money per patient for a specific period of time. That money is then used to cover all of the patient’s care needs, which can include lab tests, physician office visits, and more. Currently ACOs also use a fee-for-service reimbursement model, but unlike traditional fee-for-service, under an ACO the money is reimbursed to the organization, rather than to the provider. The ACO is the entity that distributes the money to providers based on predetermined agreements with each. What’s more, to receive full reimbursements, the ACO must provide proof of outcomes.
“Some people will say that an ACO is just another term for managed care,” says Ran Whitehead, CEO and chief mission officer of PeaceHealth Laboratories, Springfield, Ore. PeaceHealth works with several ACOs in the Oregon and Washington areas, many of which are spin-offs of insurance companies the lab previously contracted with, he notes. Mr. Whitehead presented a session at the 2013 Executive War College in New Orleans on “Evolution in Support of ACOs, Integrated Care, and Region-Wide Services,” which in part discussed the laboratory’s role in an ACO. “But managed care doesn’t necessarily have the accountability for outcomes,” Mr. Whitehead says. “And part of the healthcare reform act is that there are objective quality measures an ACO has to meet. And if they don’t, they will get dinged in terms of reimbursement.”

As the U.S. ushers in a hopeful new era of healthcare, ACOs stand to be a main driver of change. Central to this healthcare delivery model is that it makes better care, rather than more care, a priority. But some clinical laboratories may encounter difficulties operating within the new paradigm.

### Balancing Act

Laboratories face two major issues with the growing number of ACOs. One trend has ACOs purchasing and managing what used to be independent and group physician practices.

“These new relationships have disrupted some of the basic service decisions on the part of physician practices. They may have previously selected reference laboratories on their own, but now may be invited or directed to send their testing inside rather than outside the health system,” says Joseph Miles, MHS, MT(ASCP), senior consultant for Outreach Development at ARUP Laboratories in Salt Lake City. Mr. Miles co-authored the white paper “The Role of Laboratory Medicine in Accountable Care Organizations,” which was published in 2011. At the 2013 G2 Intelligence Annual Laboratory Institute in Arlington, Va., he continues, there was much discussion about the fear that regional independent laboratories may be in danger of becoming extinct under ACOs.
“The reason being they are having trouble finding their niche in new scenarios,” Mr. Miles says. “Larger independent laboratories have market share captured, and hospital laboratories are stepping up to the plate and meeting the challenges of integrating and providing services at a higher level.” He adds that as new delivery models shake out, there will undoubtedly be new opportunities and new forms of competition.

The second major issue laboratories face under ACOs is whether laboratory and pathology leaders will be included in planning how the lab will function as part of the ACO.

“Laboratories and pathologists may find that if they are not part of that discussion, less attention will be paid to their value,” says Ronald Weiss, MD, MBA, FASCP, professor of Pathology at the University of Utah Department of Pathology and ARUP Laboratories, and director of Faculty Outreach for the University’s Office of Technology and Ventures Commercialization. Dr. Weiss was a co-author with Mr. Miles on the 2011 white paper. What has happened in several cases so far, he continues, is that decisions within an ACO about which services to provide and at what rate of reimbursement were made well before the laboratories were invited into the ACO relationship, or they were informed of the decisions after the fact.

“The assumptions had been made, the decisions had been made, and labs were given what was left over,” Dr. Weiss continues. “It is clearly a threat, and it’s important that pathologists, no matter what their practice setting, be a part of the discussion.”

**The Information Age**

Right now, ACOs don’t have much incentive to listen to pathology and laboratory leaders, because the lab represents such a small piece of the economic model of their system. But, Mr. Whitehead notes, ACOs are missing the fact that laboratories are such a large piece of the information model, and that information is what makes an ACO successful.

“The laboratory is an information company that just happens to do lab tests,” says Mr. Whitehead. “And that’s very different from how most laboratories are viewed in healthcare systems. Laboratories are always viewed as a cost center. Sometimes they are viewed as a revenue center. But hardly ever are they seen as an information center.”

Simply collecting the data needed for established quality measures will not make an ACO suddenly take notice of laboratories. The key will be converting those quality measures to demonstrate that performing or not performing a test leads to better patient outcomes.

“Collecting data and having a nice repository for it isn’t the end result,” says Mr. Miles. “The real end result is getting the information in the hands of the right people at the right time. Laboratory professionals are enablers in that role.”

To get that information where it needs to be, however, laboratories need to formulate ways to analyze the aggregate significance of the data, he explains.

The caveat, as Mr. Whitehead points out, is that while many laboratories have sophisticated laboratory information systems (LIS), those systems don’t always have the capability to mine collected data in a way that will be truly beneficial to an ACO.

“We’re looking at large numbers of people, and what their laboratory information is telling that ACO about the health and non-health of that population they’re responsible for,” Mr. Whitehead explains. “Laboratory leaders should be taking a serious look at how they will extract that information, and whether or not their LIS system can do that mining on its own, or if they are going to have to push it to a data warehouse that can handle big data and help them mine that information.”

On a patient level, pathologists can use the collected data to help providers fully understand the significance of the information the laboratory supplies.

Dr. Weiss notes that pathologists acting as consultants to physicians in the coordinated care leg of the ACO model represent an opportunity to “engage clinicians and help them identify what test to order and how to interpret it, particularly if it is complex—molecular diagnostic testing, for example. And then, how to put that information in the context of their particular patient and make better-informed decisions.”

He adds that by sharing clinical information and incorporating evidence-based protocols, laboratories have the potential to eliminate redundancies and inefficiencies within an ACO, thereby reducing costs.

“Early and accurate diagnosis is the most important factor in avoiding medical odysseys and the associated wasted financial resources,” Dr. Weiss says. “It is estimated by several studies that 30 percent of healthcare currently provided is unnecessary and avoidable. This represents $1 trillion to $1.5 trillion in potential annual savings to the U.S. healthcare system.”

Change to the U.S. healthcare system is imminent, and that means that laboratories must change as well.

“Laboratories need to be willing to continually improve on approaches evaluating clinical conditions and utilizing tests that lead to the best patient outcomes and reduce overall costs,” Dr. Weiss says.

And with the fresh start of a new year, there has never been a better time for laboratories to resolve to have a seat at the table and underline their essential role in patient health within new healthcare delivery models.

**REFERENCE**


Ms. Strzelecki is Senior Editor of Critical Values.
David Glenn, MASCP, MLS(ASCP)℠, is an avid pilot and former CEO of Pathology Services, PC, North Platte, Neb. Mr. Glenn sees people as a laboratory’s most important asset, and says giving them the tools to develop shared-management work teams is one way labs can better integrate healthcare reform changes.
Healthcare Reform and the Laboratory:

A Q&A with David Glenn

By Molly Strzelecki

As the former chief executive officer and lab manager of Pathology Services, PC, in North Platte, Neb., and an avid private pilot, David Glenn, MASCP, MLS(ASCP)CM, will be the first to tell you that a successful laboratory is a lot like flying a plane: Never stagnant and always in motion. With more than 40 years of experience, he has seen multiple changes within the laboratory, including new technologies and tests, modernized regulations, and improved procedural processes. In September, Mr. Glenn presented a session at ASCP’s 2013 Annual Meeting on “50 Ways to Lead Your Laboratory,” in which he addressed techniques to develop shared-management work teams to improve productivity, raise morale, and increase staff retention. And now, as 2014 brings the new healthcare reform laws, laboratories are once again poised for change. In this new environment, maintaining a well-run, well-staffed laboratory is even more crucial to success. Here, Mr. Glenn discusses how healthcare reform will affect laboratories and laboratory professionals.

Critical Values (CV): What advantages or disadvantages will laboratories encounter under healthcare reform?

David Glenn (DG): One of the advantages of the new healthcare laws is that the government is trying to cover more people with health insurance. And with more people covered, hopefully we would see more laboratory tests ordered, since that is such a vital part of evaluating and follow-up therapy with patients. So on the plus side, there will probably be more laboratory testing in the future.
On the negative side, we don’t know for sure what private insurance companies are doing. But the talk from the government is that private insurance companies are saying we’re going to have to cover more people with less money, as they cut fees for service. And that could mean that laboratories will probably be given a smaller piece of the pie for their share.

Another fearful thing is that even with new healthcare reform laws, it’s not going to be a level playing field. There are going to be some areas of the country that will get into accountable care organizations or medical homes that would possibly require caps where they only get so much for each patient in that program. And that could cut into the laboratory as well.

Recently the government has been discussing cutting laboratory reimbursement by 20 percent or more. They’re not targeting physician-office laboratories, or hospital laboratories, but rather independent laboratories. They know the independent laboratories have always been very efficient, and can be controlled a little more, as they don’t have the lobbying strength that physicians or hospitals have. If those cuts happen, small, regional reference laboratories like ours could be negatively affected.

Whether or not a 20 percent cut to these independent laboratories is feasible depends on the patient mix. Hopefully, most independent laboratories have less than 50 percent of patients who are federally funded, so that would be a cut on less than half of their business. In our case, we’re in a large rural area, and we have a large proportion of Medicare patients, so a 20 percent cut would impact us quite a bit.

On the other end, every company providing Medicare insurance is providing private insurance, such as Blue Cross Blue Shield. As a Medicare intermediary, they know exactly how much they can lower reimbursement costs and still keep business. They will make cuts, but pass the cost on through increased premiums to patients and decreased payments to those performing the work, and will probably cover less testing.

It’s a problem, and the American Society for Clinical Pathology is trying to address that, such as through the Choosing Wisely campaign. There are a number of tests that may not be necessary, and they are trying to find quality indicators and find out how we can get the right test at the right time, and pay providers for treating the whole patient, not just a fee for service, and get it covered under one payment.

CV: With more people entering the healthcare system, how would that affect diagnostic testing? Will there be a greater number of tests performed, and, if so, how will that change laboratory operations?

DG: I’m not sure it would change the way a laboratory operates. First of all, if we bring in millions of new people with healthcare coverage, they would probably need the same tests that we’re already performing on the patients currently with coverage. So it wouldn’t be a change, but an increase in volume.
Much of the screening that those patients would require we’re already doing on automated analyzers. And that’s good, because we usually have excess capacity that’s not being utilized on some of these large screening analyzers. So we would probably be able to pick up that volume with low additional cost. The incremental costs would be for extra reagents and the like. We probably wouldn’t have to go out and hire extra people in most instances, because we do have that excess capacity with automated testing equipment.

**CV:** How might healthcare reform influence hiring processes, both for in-house staff and outside vendors?

**DG:** We found out years ago, when we first established our independent reference laboratory, that people are the key to our success. I’m not talking just about laboratory professionals, but every person who ties the laboratory together to give a good impression or a bad impression when you’re in a competitive environment—the testing personnel, the billing personnel, the people on the phones. We’re competing against large national laboratories, and we have to out-service them because we can’t always compete on price alone. New healthcare reform is making the environment even more competitive.

With people as our most important asset, we can be more nimble and more responsive to customers than a larger laboratory can. But the key is that we allow our employees to have more freedom, responsibility, and authority to do their jobs. By doing that you remove a lot of different layers of administration and management supervision. Everybody in our laboratory works in teams, and the teams elect their own leaders, often co-leaders, so there is always a go-to person available. When it comes to hiring someone new for their team, they write the ads, review the resumes, select the candidates for interviews, and they’ll select who we hire. It works because it was the team’s choice to bring the person on, and they’ll work harder to help train them. And it saves us a fortune, because these teams are willing to have flexible hours, job share, or split shifts to cover the laboratory when we’re busiest. The less management you have, the better the management you have.

As a reference laboratory, we work with hospitals and clinics that need help with tests they don’t perform in their own laboratories, and we compete against the bigger laboratories for the business. We work hard to target our immediate 150-mile radius and saturate as well as we can. And with changes in healthcare laws, we have to make sure we’re as cost effective as we can be. For example, with our couriers, we need to make sure we pick good people who make our customers happy. Our customers don’t see us in the laboratory—they see our courier who drops by every day. Our couriers have to do a top-notch public relations job for us.

Ms. Strzelecki is Senior Editor of *Critical Values.*
Critical issues facing pathology and the medical laboratory profession—from the role of accountable care organizations to the workforce shortage—took center stage at ASCP 2013 Chicago.

More than 1,500 pathologists and medical laboratory professionals gathered to hear amazing speakers and attend outstanding educational programs at “Beyond the Lab,” the ASCP Annual Meeting at the Hyatt Regency Chicago, Sept. 18–21.

Chicago Mayor Rahm Emanuel introduced the keynote speaker, a former U.S. Secretary of State, and presented the Society’s inaugural STEM Student Scholarship award to a Chicago high school senior as part of ASCP’s “Building a Laboratory Workforce to Meet the Future” outreach initiative with Perspectives Charter School in Chicago.

Three general sessions underscored pivotal topics that play a central role in this evolving healthcare climate—patient-centered health care, appropriate test utilization, and how pathologists and laboratory professionals can enhance the value of their diagnostic work by using data analytics.

This year’s annual meeting offered the widest-ranging education sessions ever, according to newly installed ASCP President Steven Kroft, MD, FASCP. By joining forces with partner organizations such as the Association for Pathology Informatics and the American Pathology Foundation, 2013 ASCP Chicago was able to feature expansive sessions on pathology informatics and laboratory management, which are vital to the future of laboratory medicine.
—That’s a Wrap

000+ PROFESSIONAL LEAGUES

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80+ HOURS OF LAB MANAGEMENT LEARNING

4 MEMORABLE DAYS OF LEARNING

3 SHOW-STOPPING GENERAL SESSIONS

1 PHENOMENAL KEYNOTE SPEAKER

1 GREAT CITY OF CHICAGO
Lynnette Chakkaphak, MS, MT(ASCP), a member of the ASCP Board of Directors, checks out the Lab Management University (LMU) T-shirt during a reception for participants in LMU.

Mark Tuthill, MD, FASCP, of Henry Ford Hospital, Detroit, and a leader of the Association for Pathology Informatics, moderates a general session, “Preparing for Seismic Shifts in Pathology Informatics,” which underscored the expanding role that pathology informatics plays in personalized medicine.

Ventana was among the many exhibitors that showcased their latest products at ASCP 2013 Chicago.

John Nkengasong, PhD, (right) accepts the ASCP Patients’ Advocate Award on behalf of Thomas Frieden, MD, MPH, Director of the U.S. Centers for Disease Control and Prevention, who was recognized for the contributions he has made to advance patient care nationally and internationally.

Bruce Friedman, MD, FASCP, Emeritus Professor of Pathology, University of Michigan Medical School, talked about how technology is revolutionizing the delivery of medicine during the general session. “Preparing for Seismic Shifts in Pathology Informatics,” was developed in concert with the Association for Pathology Informatics.

Lee Hilborne, MD, MPH, DLM(ASCP)CM, FASCP, moderated a general session, “Putting Pathology and Laboratory Medicine In The Driver’s Seat for Tomorrow’s Healthcare,” which focused on appropriate test utilization and the Choosing Wisely campaign. Panelists included Elaine Jeter, MD, Medical Director of Palmetto GBA, LLC, one of Medicare’s larger insurance carriers in Columbia, S.C., and Gary Procop, MD, FASCP, Chairman of the Department of Molecular Pathology at the Cleveland Clinic, Cleveland.

Chicago Mayor Rahm Emanuel introduced Hillary Rodham Clinton, former U.S. Secretary of State and former U.S. Senator from New York, as keynote speaker at ASCP 2013 Chicago. ASCP Executive Vice President E. Blair Holladay, right, presented the former Secretary of State with the 2013 ASCP Global Humanitarian Award.

Ulysses Balis, MD, Associate Professor of Anatomic Pathology at the University of Michigan, served as a panelist in a general session, “Preparing for Seismic Shifts in Pathology Informatics,” co-sponsored by the Association for Pathology Informatics.
Choosing Wisely Initiative Expands to California

ASCP is working collaboratively with the California Society of Pathologists (CSP) to raise awareness of the Choosing Wisely campaign to reduce duplicative testing among pathologists throughout California. During CSP’s Annual Meeting in San Francisco in December, ASCP hosted a symposium, “Choosing Wisely: How California Pathologists Can Influence Appropriate Testing,” followed by a panel discussion moderated by Lee Hilborne, MD, MPH, DLM(ASCP)CM, FASCP, 2011-2012 Chair of ASCP’s Institute Advisory Committee and a past ASCP President. Additionally, an online toolkit has been developed so members can glean tips and best practices on how to reduce duplicative testing.

Laboratory tests are often ordered without performing a complete patient history and physical exam. In an accountable care organization future, this translates to increased costs for the laboratory, and potentially harmful duplicative testing for the patients. To raise awareness of this issue, ASCP joined the American Board of Internal Medicine Foundation’s Choosing Wisely campaign to help laboratories inform physicians and patients about the most appropriate tests—and how to avoid duplicative testing that could harm patients.

Introducing the New Journal App

ASCP is introducing a new Journal app for 2014, which will allow ASCP members the flexibility of receiving the Society’s periodicals on their smart phones or tablets. Members can access digital versions of AJCP, Lab Medicine, and Critical Values on the go, through most Apple and Android devices. The print versions of the periodicals will still be available.

The app is among several new benefits that ASCP is introducing during its 2014 membership renewal drive, which is currently under way. The laboratory professional community will have the opportunity to select from several membership options designed to enhance their professional development. Membership in ASCP comes with a terrific variety of benefits, including certification maintenance tools, special rates for continuing education through meetings and coursework, and the option for unlimited online CE. For details, go to www.ascp.org.

Report Tackles Workforce Strategies

ASCP has unveiled a new report, “Building a Laboratory Workforce to Meet the Future,” which was developed by the Society’s Task Force on the Laboratory Professionals Workforce in an effort to provide strategies for building a pipeline of future medical laboratory professionals. The report, which takes a multi-pronged approach to addressing the shortage, culminates a yearlong study by the task force on the issue.

Recommendations include promoting laboratory professionals as an integral part of the clinical care team; developing innovative educational programs; maintaining high standards for certification of lab professionals; and continuing to develop STEM (science, technology, engineering, and math) outreach initiatives in communities.

2013 Wage Survey Results Are In

The salary outlook for the medical laboratory profession appears to be very positive, according to the ASCP 2013 Wage Survey. Medical laboratory professionals who are certified earned on average nine percent more than individuals who are not certified. The confidential survey, administered every two years, serves as the primary source of information for academic, government, and industry labor analysts.

Results from past surveys show that laboratory medicine is a rapidly evolving field. The 2013 Wage Survey was conducted through a collaboration between ASCP’s Institute of Science, Technology, and Policy and the ASCP Board of Certification. New questions were added this year regarding licensure, training sites, wages by state, union representation, and age of respondents to examine some of the factors that affect wage and vacancy rates.

Published in the Fall 2013 issue of Lab Medicine, the ASCP Wage Survey provides current wage data for U.S.-based laboratory scientists. The survey highlights pay levels broken down by title, geography, certification, and other variables using results of an online survey that requested data from more than 10,000 laboratory managers, directors, and supervisors across the United States.
**Rallying Cry in the Capital**

The Society’s members responded en masse to an ASCP action alert, sending more than 2,200 letters in a concerted campaign to change the Centers for Medicare & Medicaid Services’ (CMS) 2014 Physician Fee Schedule (PFS) and Clinical Laboratory Fee Schedule (CLFS) Proposed Rule. The letters made their way to the agency through the ASCP e-Advocacy Center in response to several ASCP action alerts about a CMS-proposed cap on non-facility PFS payment rates. Also as a result of the ASCP action alert, members of Congress received almost 8,000 letters urging them to raise their concerns about the plan with CMS.

In addition, ASCP and the American Pathology Foundation (APF) co-authored a comment letter to CMS, voicing strong concerns about several of the proposals housed in the Proposed Rule. ASCP and APF urged CMS to withdraw a proposal to cap non-facility technical component charges for pathology (physician) services at Medicare Hospital Outpatient Prospective Payment System rates. ASCP and APF also raised concerns about a proposal to revalue the entire CLFS.

**Building a Laboratory Workforce in Côte d’Ivoire**

A distinguished team of ASCP volunteers traveled to Côte d’Ivoire in November to assist with the creation of the country’s national association of laboratory technicians. Through its participation in the President’s Emergency Plan for AIDS Relief (PEPFAR), ASCP was invited by the Ivorian government to build an association, modeled after ASCP’s organizational structure, that will be known as l’Association Ivoirienne de Biologistes Techniciens. The overarching goal is to provide support, expertise, and education for the nation’s medical laboratories that will ultimately improve the delivery of patient care.

After nearly a year of planning and negotiations with CDC-Côte d’Ivoire, the team, consisting of Lee Hilborne, MD, MPH, DLM(ASCP)℠, FASCP, Kathleen (Kay) Doyle, PhD, MASCAP, MLS(ASCP)℠, and Rae Rader, MPA, PA(ASCP)℠, will conduct their assessment visit to Abidjan in November.

Over the course of a year, the ASCP delegation will mentor their Ivorian counterparts in an array of areas such as governance, advocacy, membership, certification, and continuing education. After the initial assessment, Aji Sanneh, ASCP’s Côte d’Ivoire Country Manager, hopes to reach out to numerous ASCP members in different fields for their expertise and guidance.
ASCP staff member Lei Zhang, right, with honored guests from Mongolia, Daram Dariimaa, MD, PhD, left, and Namid Munkhtuvshin, MD, PhD.

Melissa Upton, MD, FASCP, and Doreen Ramogola-Masire, MD, at the President’s Dinner. Dr. Ramogola-Masire received the ASCP Patients’ Advocate Award during ASCP 2013 Chicago.

Brenda and William “Wes” Schreiber, MD, FASCP, during the President’s Dinner.

Cindy Johns, MSA, MASC, MLS(ASCP), SHCM, displays the 2013 ASCP Member Lifetime Achievement Award she received at the ASCP 2013 Chicago annual meeting.

Outgoing ASCP President Joel Shilling, MD, FASCP, left, is joined by the 2013–2014 ASCP President Steven Kroft, MD, FASCP, center, and ASCP Executive Vice President Dr. E. Blair Holladay.
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