Labonomics

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Labonomics

The economic challenges surrounding medical care in the United States first became evident in the 1970s and have steadily grown more serious. In essence, our medical knowledge, technology, and ability to diagnose and treat patients are rapidly expanding; but our ability to pay for this care is lagging behind. With millions of baby boomers reaching retirement, cost containment, and the judicious use of resources will be further challenged.

Passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010 increased the focus on the economics of health care for all. Even if portions of the law are eventually modified or repealed, it appears that economic change is inevitable. Instead of resisting change, we must be at the table as change agents, letting our commitment to quality and patient-centered care help direct and set future healthcare standards. And, to ensure quality, we must continue to contribute what we do best: laboratory personnel certification, advocacy, and continuing education. The quality of health care is directly affected by all three.

Laboratory professionals who understand the issues and problems must be engaged and participating when decisions that will affect the quality of our nation’s medical care are made. This issue of Critical Values is intended to help familiarize ASCP members with some of the issues we and our patients face and their ramifications. It is time to embrace change and the opportunities it offers.

In this issue, authors share their perspectives and solutions for coping with the changing landscape for pathologists and laboratory professionals in the new era of Labonomics. ASCP President C. Bruce Alexander, MD, FASCP, and ASCP Chair of the Council of Laboratory Professionals M. Sue Zaleski, MA, SCT(ASCP)HT, give readers solutions for containing costs while continuing to deliver quality care to patients. American Clinical Laboratory Association President Alan Mertz discusses how medical laboratories are being nickeled and dimed by Congress and offers solutions for fighting back. Three pathologists talk about how they have adapted to the challenge of in-office laboratories and continued to thrive. Dennis Matricardi, MS, SM(ASCP)DLM, shares advice on purchasing laboratory instrumentation, while Diana L. Kremitske, MHA, MT(ASCP), shows laboratory directors how to budget wisely.

Finally, on a personal note, I want to recognize the contributions that Ellen Sullivan has made as the Editor of Critical Values. In 2008, she had the vision, courage, and knowledge to launch this award-winning magazine for all ASCP members. I will miss Ms. Sullivan’s positive nature, genuine sincerity, and incredible talent for finding outstanding authors to write articles that helped to make each issue of Critical Values relevant and essential reading for our members. I wish her all the best in her new leadership position in the medical nonprofit world.

Please enjoy this issue of Critical Values, and let me know your views about Labonomics and what dynamic opportunities the future holds. I can be reached directly at blair.holladay@ascp.org.

Dr. Holladay is Executive Vice President of ASCP.
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In the United States, the economics of health care are complex and multilayered. The basic issues, however, are simple. The cost of caring for patients must be contained, and resources must be conserved. The challenge is how we can do this effectively and efficiently while keeping the patient front and center.

Reimbursement for Medicare physician and laboratory services remains a major concern. The U.S. government introduced the Sustainable Growth Rate (SGR) formula in 1997 to curtail Medicare expenditures on physician services. Under this formula,
actual growth in spending on physician services is compared to a cumulative target growth rate linked to gross domestic product. When actual growth exceeds that target, physician reimbursements are reduced the next year, potentially to unrealistic levels. In 2012, physicians faced a 27-percent reduction in reimbursements. To avoid this, the government opted to use the Medicare Clinical Laboratory Fee Schedule to offset cuts in the Medicare Physician Fee Schedule, thus reducing reimbursement for laboratory services instead.

Reimbursement for molecular diagnostic tests is another challenge. Molecular tests tend to be labor-intensive and costly. While reimbursement from third-party payers does not reflect the actual cost of performing these procedures, Medicare reimbursement rates are even lower. Automation could help curb costs, but this would require significant capital investment. ASCP believes molecular tests need their own Medicare codes, so that reimbursement rates will reflect their actual cost.

Two more possible sources of difficulty are direct access testing (DAT) and the proliferation of physician office laboratories (POLs). The Society’s position on this is expressed quite well in the ASCP Policy Statement on Direct Access Testing at www.ascp.org/DAT. One concern is that patients may not adequately understand their DAT results and fail to get proper medical care when needed. DAT also raises new concerns about liability. If an insurance company refuses to cover tests not ordered by physicians, reimbursement becomes an issue.
POLs can affect the U.S. healthcare bottom line by performing tests at a higher volume than hospital or reference labs. But our main concern involves quality. While these labs are covered by Clinical Laboratory Improvement Amendments regulations, POLs may be more likely to use uncertified personnel. The whole point of laboratory personnel certification is to ensure that those performing tests are likely to get quality test results. At a minimum, we recommend supervision by a certified laboratory professional. (See the ASCP Policy Statement on Personnel Standards for Laboratory Professionals at www.ascp.org/PSLP.)

**Accountable Care Organizations**

The Patient Protection and Affordable Care Act did present several ideas for reducing Medicare costs. Among them is the Accountable Care Organization (ACO). An ACO is an organization comprising diverse healthcare providers that agrees to be accountable for the quality, cost, and overall care of its assigned Medicare patients. Although ACOs can take various forms, they would typically include primary-care physicians, specialists, and ancillary healthcare providers—possibly even hospitals and clinics.

In theory, ACOs will provide a more frugal use of resources by offering fully coordinated patient-centered care designed to avoid unnecessary procedures and duplication of services. As an added incentive, they would get a share of the savings when they meet or exceed pre-determined clinical performance and per capita cost projections. However, they may also have to assume some risk if expenses exceed projected costs.

One concern involves the impact ACOs will have on smaller, independent practices that cannot offer such competitive rates. Quality measurement is another. ACOs should use nationally recognized measures to improve and document quality; but effective specialty-specific measures may not always exist. In that case, the government must allow ACOs to use or develop indicators that adequately reflect the quality of services provided. Furthermore, pathologists and certified laboratory professionals must play an integral role in ACOs to help prevent unnecessary or inappropriate testing.

**Meeting the Challenges**

Although questions about healthcare reform and its ultimate effect on laboratories remain, it is clear that pathologists and other laboratory professionals must contribute to the decision-making process. We have experience and expertise in some critical areas, including test utilization, quality improvement, technology assessment, regulatory management, medical informatics, patient-focused consultation, and compliance review. This, combined with our educational skills, would enable us to make valuable contributions to policy development and patient care.

To comment on these or other issues, or to get more involved, please email me at: President@ascp.org.

Dr. Alexander is Professor and Vice Chair of Pathology and Residency Program Director at the University of Alabama at Birmingham, Birmingham, Ala.
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Preparing for the New Laboratory Economics

Do more with less!
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The clamor of imperatives grows louder with each new budget. As a result, budgeting in the clinical laboratory is moving beyond “Budgeting 101” to encompass economic efficiencies. This means managers must now meet budget targets expressed through improved efficiencies and productivity increases achieved by reducing supply and labor costs.

Healthcare Reform Brings Economic Change

The American healthcare system is currently preparing to operate under a new kind of economics—an economics de-
fined by healthcare reform. Historically, healthcare providers subsidized losses resulting from Medicare and Medicaid by charging commercial payers premium rates, but the ability to recover costs diminishes under healthcare reform. An aging population and decreases in reimbursement by government and private programs shift the cost burden, forcing patients to assume greater responsibility for their healthcare expenses.

Another problem is the growth in patient debt. Healthcare providers accustomed to bad debt from the uninsured are now experiencing double-digit growth in debt from patients with insurance because of unpaid copayments and deductibles. There is also an expected shift in healthcare enrollment to include 25 million uninsured Americans. The combination of all of these changes will squeeze positive profit margins, forcing healthcare providers to reduce their operating costs by 10 to 15 percent.

The Challenge for Laboratory Managers

We can expect keen competition for the shrinking pool of healthcare dollars, making it essential that laboratories demonstrate leadership in this new era of healthcare economics. We must do this by embracing strategies that reduce costs, improve productivity, and enhance efficiency.

Managers can employ several strategies to get their financial picture into shape. They can evaluate their staff skill set and invest in process improvement by applying principles of Lean to reduce waste. Finally, they can evaluate existing technology and equipment to determine if capital investments in automation, middleware, and information systems are needed.

The successful implementation of these strategies in our laboratory at the University of Iowa Hospitals and Clinics in Iowa City, Iowa, has resulted in improved productivity. The introduction of the principles of Lean production prior to implementing a pre-analytical instrument in the lab resulted in a work redesign with fewer steps that reduced the specimen processing time by 10 minutes.

This created a better environment for launching our pre-analytical instrument. The new instrument, in turn, enabled us to eliminate two manual steps, which reduced both labeling errors and employee exposure to biohazards. Elimination of manual, mundane, and repetitive work improved staff morale and retention.

Applying Lean principles before and after implementation of the pre-analytical instrument produced excellent outcomes. At the same time, the implementation of middleware allowed us to create decision-making rules, make pre-selected
calculations, and use “push technology” to generate even greater efficiencies. For example, middleware greatly increased auto-verification capabilities—to 98 percent (from 45 percent) for chemistry tests and to 85 percent (from 45 percent) for automated complete blood counts. Implementation of all of these strategies ultimately increased productivity. Since 2005, laboratory volume has increased 30 percent, worked hours have dropped 11 percent, and productivity (billable tests/hours worked) has increased 47 percent.

**Effective Workforce Engagement Strategies: Right Person–Right Job**

Finding time for our medical laboratory scientists and technicians to work on Lean, middleware, and automation projects proved challenging. For example, these technical staff members were doing supply chain activities. To resolve this issue, two clerical staff positions were created out of laboratory vacancies and used to relieve technical staff of their inventory and ordering responsibilities.

Our clerks soon became highly proficient—and as their confidence grew, so did their ability to handle supplies, deal with vendors, and keep inventory levels at a minimum. The change in personnel ultimately had several benefits. We greatly reduced the amount of time technical personnel spent performing nontechnical tasks, we cut inventory levels, and we improved relationships with suppliers.

**Benchmarking Metrics Identify Best Practice Laboratories**

In today’s healthcare environment, it is not enough for managers to spearhead their budgets. They must also employ “benchmarking metrics” that can demonstrate successful implementation of strategies for continuous improvement in productivity and efficiency. Benchmarking is defined as comparing the performance of a laboratory with that of its peers. First we identify peer labs that are better performers, and then we attempt to learn from these labs and improve our own laboratory’s performance. We do this by engaging with them in best practice sharing activities such as conference calls and site visits.

Budget trends and benchmarking metrics provide valuable information about the overall health and performance of the laboratory. The laboratory manager is a coach responsible for developing winning strategies and watching the score using budget data and benchmarking metrics.

I welcome your feedback. Please send questions or comments to me at CLPchair@ascp.org.

**Notes**

1. To maximize customer value while minimizing waste—in other words, creating more value for customers with fewer resources.
2. A type of software that enhances the functionality of laboratory information systems.
3. Computer technologies that deliver information to users automatically, without the need to search for it or request it.

Ms. Zaleski is Clinical Pathology Laboratory Manager, University of Iowa Hospitals and Clinics, Iowa City, Iowa.
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I was somewhat overwhelmed when I learned that “laboratory economics” was the theme for this issue of *Critical Values*. At this point in my career, I have only a basic grasp of laboratory finances and the possible economic impact various policy changes and healthcare reform might have on the lab.

Personal economics, on the other hand, is a major concern for most pathology residents. The vast majority of medical students (86 percent) graduate with medical school debt, which averages $162,000. However, asset and liability (i.e., debt) management is not taught in medical school, and financial savvy among graduates is lacking. Accordingly, my wife (also a physician) and I met early in our residencies with a financial adviser who specializes in advising physicians. With his help, I felt I could offer a basic financial roadmap with tips that most pathology residents can reference throughout this crucial time in their lives. I have broken the information down by year.
A Financial Roadmap for Residents

First Postgraduate Year (PGY-1):

- Meet with a financial adviser.
  - Often the cost of an adviser is minimal to nil while you are in training. A good adviser understands what he or she will ultimately benefit from a long-term working relationship with you and from the referral of other physicians and colleagues.
  - Ideally this adviser should be familiar with the young physician demographic, student loan debt, and the special niches of each particular specialty.
  - Discuss retirement plans. It is never too early to save for retirement. Plus, you may qualify for favorable plans like Roth IRAs only early in your career.
- Get rid of high-interest debt first.
  - Pay off credit cards and other high-interest loans as soon as possible, before paying off student loans. According to my financial adviser, failing to do this is one of the biggest mistakes even highly educated professionals make. This concept applies throughout residency and into practice.
- Navigate your student loans.
  - Consolidate loans and minimize interest rates (if not already done).
  - Should you choose deferral or forbearance payment plans? During forbearance, interest accrues on both subsidized and unsubsidized student loans.
  - If you choose to make student loan payments during residency, look into income-based repayment plans. Try out the online calculator at: www.aamc.org/services/first/medloans/.
  - Every student loan scenario is different. Consult with your graduate medical education office, and check out the federal student aid and other resources at studentaid.ed.gov/PORTALSWebApp/students/english/index.jsp and www.aamc.org/services/first/.
- Make a budget.
  - Sticking to a budget is crucial. Kids, pets, hobbies, and other expenses must all be factored in. Fortunately, free online tools like www.mint.com can help keep track of your finances.

PGY-2 Year:

- Plan for large expenses.
  - Many residents take their Step 3 exam during this year. Costs include study materials and the certification exam, which alone costs about $750.
  - Applications for state medical licenses, often obtained before the third post-graduate year, not only take a long time but also incur fees.
- Build up your emergency fund.
  - Experts say a rainy day fund should be up to six times your gross monthly salary. If your household has two wage earners, it should be three times your household’s gross monthly salary.

PGY-3 Year:

- Budget for fellowship interviews.
  - You may travel a lot for fellowship interviews during your PGY-3 year. Needless to say, travel expenses can add up. Fortunately, they can be written off on tax returns, so save receipts.
- Manage loans.
  - Most loans go into repayment during the PGY-3 year. If you don’t choose income-based repayment plans, make sure you apply for or renew forbearance on your loans annually.

PGY-4 Year (and beyond):

- Plan for Board examinations.
  - The last year of residency generally hits the wallet hardest. The American Board of Pathology application for the certification examination, plus travel expenses to Florida to sit for the exam, are costly. Be ready to fork out at least $3,000. Depending on your program, your educational “book fund” may not cover these expenses.
- Moving expenses.
  - The cost of relocating for a fellowship can be significant. For example, getting a house ready to sell can cost a few hundred to several thousand dollars.
  - Fellowship programs do not reimburse or provide financial assistance for relocation expenses. But save your receipts because these expenses are tax-deductible.
- Job search.
  - Jobs with a large research component (50 percent, or 20 hours per week) and jobs in the public service sector will qualify you for loan forgiveness programs. Check out www.lrp.nih.gov/faq/index.aspx for more information.
  - Have a financial adviser and an attorney look over your job contract before you sign!

I hope this information will help you make a good financial plan and allow you to focus on your specialty training.

Many thanks to Ryan Keshemberg, CFP, financial adviser at North Star Resource Group in Madison, Wis., for his assistance with this column.

I welcome your feedback. Please email questions, comments, or suggestions to me at ResidentCouncil@ascp.org.

Dr. Cogbill is a fourth-year pathology resident at the Medical College of Wisconsin, Milwaukee.
The ACLA is the Washington, D.C.-based advocacy voice of the nation’s leading national, regional, esoteric, and pathology clinical laboratories. This advocacy work is always made more effective when it includes the direct involvement of the individuals who manage and operate the laboratories themselves—whether that be through letters or phone calls to their own members in the U.S. Congress or in face-to-face meetings on Capitol Hill.

Today, this role is more critical than ever.

As you know, Congress recently enacted a 2-percent cut to the Clinical Laboratory Fee Schedule (CLFS), which sets reimbursement rates for laboratories. Two percent may not sound like much, but it works out to be a massive reduction in the real world. ACLA members are concerned about the effects these cuts are likely to have on clinical labs, the people they employ, and the communities and patients they serve.

Here is how this round of cuts came about. In February, Congress passed and President Obama signed into law The Middle Class Tax Relief and Job Creation Act of 2012. The law extended payroll tax cuts for millions of working Americans, continued expiring unemployment benefits, and prevented a scheduled 27.4-percent cut in Medicare payments to physicians.

But as it turned out, very late in the negotiations, Congress decided to help pay for the cost of preventing those deep cuts in physician payments by reducing Medicare’s CLFS payment rates by 2 percent in 2013. This works out to be a reduction in clinical laboratory payments of $2.7 billion. Unfortunately, that cut came on top of previous cuts the industry has sustained. The 2010 Affordable Care Act health reform package cut CLFS payments significantly by creating a “productivity adjustment,” which applies to all healthcare providers, that is tied to growth in the U.S. economy. Additionally, Congress cut CLFS payments by an additional 1.75 percent through 2015. And in August 2011, Congress passed a deficit reduction measure that included a 2-percent across-the-board reduction to all Medicare provider payments.

When combined, Medicare reimbursement under the CLFS will be reduced by approximately 23 percent over the next 10 years. In January 2013 alone, payment rates for clinical laboratory services will be reduced by more than 5 percent. The impact of these reductions during the next five years is shown in Figure 1. A test that was reimbursed at $10 in 2010 will be paid at $9.32 in real (inflation-adjusted) dollars in 2017 and at $9.83 in 2022.
Unfortunately, all providers are still at risk for further reductions. Congress’s “fix” to the physician payment problem was only temporary and is set to expire on Dec. 31. Congress will need to pass more legislation before the end of this year to prevent another payment cut, making clinical laboratory reimbursement a possible target once again.

During the past year, ACLA led one of the most extensive advocacy campaigns in our history to prevent these and other threats to laboratory reimbursement. The good news is that ACLA was able to delay many cuts, and the organization also prevented even deeper cuts. But the bad news is that these are still much too deep. ACLA is again redoubling its efforts. The 2-percent cut occurred despite its best efforts to protect medical laboratories from further reductions in the coming months. ACLA’s membership has grown exponentially in the past few years, and today truly represents the breadth and diversity of the laboratory industry. If your laboratory does not belong to ACLA and would like to join, I encourage you to contact me directly to learn more about ACLA’s programs and benefits (amertz@acla.com or at 202.637.9466).

ACLA is undertaking a multifaceted advocacy campaign involving a significant data collection and analysis effort to educate members of Congress about the benefits laboratories bring to their districts, including thousands of jobs with wages that exceed national averages. Additionally, ACLA supports the “Results for Life” campaign, which is devoted entirely to promoting the value of laboratory services through Congressional briefings, advertising, and media outreach. The campaign is directed and supported by ACLA members as well as associate members. Find more information about it and learn how ASCP members can help out at www.labresultsforlife.org.

On behalf of ACLA members, the Association has met repeatedly with members of Congress, their staffs, and their committees to educate them about how the most recent cuts will affect labs. ACLA’s goal is twofold: first, to inoculate against future cuts, and second, to obtain support for relief from these reductions, which ultimately affect the livelihoods of medical laboratory professionals and pathologists.

While it will be difficult to reverse the laboratory cuts, particularly before the presidential elections, ACLA is constantly striving to find opportunities.

To conclude, I am asking for the help of ASCP members. Share your concerns about these cuts with Congress NOW, so that U.S. senators and representatives understand the impact of the reductions on laboratories and that prevention of further cuts is imperative for the industry. Find more information—including easy-to-use tools that will help you generate an email to your local member of Congress—at the ACLA website: www.ACLA.com.

Mr. Mertz is the President of the American Clinical Laboratory Association, headquartered in Washington, D.C.
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Spurred by an exception in the Stark Law, an anti-markup rule on diagnostic services, and the economic downturn, the landscape for medical laboratories is shifting rapidly in the United States. While medical laboratories inside hospitals flourished throughout the 20th century, in-office anatomical laboratories are springing up in the early 21st century. They are becoming mini-hospitals in their own right. Instead of pathologists at the helm, primarily urologists, gastroenterologists, and dermatologists in larger practices are driving the establishment of in-office laboratories to serve their patients.

“Pathologists and medical laboratory professionals have certainly faced many significant challenges in the last decade,” said Robert Goulart, MD, FASCP, Director of Surgical Pathology at New England Pathology Associates (NEPA), Springfield, Mass. “The growth of in-office laboratories represents a major such challenge for our specialty. Even large academic institutions are not sheltered from their effect.”

While the proliferation of in-office laboratories accounted for 8 to 9 percent of total diagnostic tests in 2011, their growth is forecasted to increase
"With the poor economic climate of the past number of years, clinical group practices are searching for opportunities for revenue enhancement," said Robert Goulart, MD, FASCP, Director of Surgical Pathology at New England Pathology Associates (NEPA), Springfield, Mass. "The process of establishing an in-office anatomic pathology laboratory represents a potential opportunity for pathologists to partner with our clinical colleagues. Sitting back and doing nothing is extremely risky. The most important issue at hand is to maintain the quality of processing and interpretation of pathology specimens, for the obvious good of our patients."
by 5 percent annually and expected to reach $2.6 billion in revenue by 2014.¹ Some rules, however, are curtailing the revenue incursions of in-office laboratories. Legally, these laboratories can process only the specimens from their own patients.

Converging circumstances have driven these changes. First, the Stark Law’s In-Office Ancillary Services Exception (IOASE) allows physicians and group practices to furnish designated health services in their offices for the convenience of their patients. Most office-based laboratories rely upon the IOASE to enable referring physicians to provide these services within their practices.

Second, the Centers for Medicare and Medicaid Services (CMS) approved an anti-markup rule on diagnostic services. Through the CMS rule, the technical component (TC) of a pathology service must be supervised by a physician, but he or she does not have to be a pathologist. On the other hand, the professional component (PC) of a pathology service has to be performed by a pathologist. Reimbursement rates differ for the two procedures: 65 percent for the TC and 35 percent for the PC. As a result, nonpathologist physicians have a financial incentive to profit on anatomic pathology services they order.

Third, a weakened economy has affected many clinicians. In many practices, demand for medical services has dropped, and the competition for patients has increased among traditional and nontraditional providers. For example, dermatology groups face increased competition from cosmetic spas and less demand to perform cosmetic surgery from consumers.²

Survival of the Fittest

Adapting to the economics and dynamics of the evolving landscape, pathologists are inventing new business models. While the adjustment may be tough, the marketplace reality demands flexibility and new strategies. “The first reaction is not to work with group practices that set up in-office laboratories because their work cuts into the traditional laboratory’s revenue,” said Al Parker, MS, Administrator of Ketchum Wood Burgert/Pathology Associates in Tallahassee, Fla. “But our business made the decision to stick it out and continue to receive the professional component fees.”

Likewise, NEPA has lost business because of in-office laboratories, according to Dr. Goulart. The nine pathologists at NEPA were determined not to discount the PC of pathology services by entering bidding wars. “That is extremely dangerous for the pathology profession as it discounts our abilities,” he said. “Pathologists have to maintain the integrity of our specialty. We have certainly undermined ourselves if our services become based on the lowest bid.”

NEPA’s strategy has been to maintain a collaborative patient-to-clinician relationship, which is most comparable to the classic hospital-owned laboratory scenario. In one instance, NEPA
Adapting to the New Environment

“Who is better able to identify and locate quality histotechnologists—urologists or pathologists?” asked Dr. Goulart rhetorically. “This service is a very advantageous component for a clinical group. Currently, clinicians have the power to legally build an in-office laboratory, but they do not have the expertise to manage it.

“With the poor economic climate of the past number of years, clinical group practices are searching for opportunities for revenue enhancement. The process of establishing an in-office anatomic pathology laboratory represents a potential opportunity for pathologists to partner with our clinical colleagues. Sitting back and doing nothing is extremely risky. The most important issue at hand is to maintain the quality of processing and interpretation of pathology specimens, for the obvious good of our patients.”

For KWIP/Pathology Associates, 5 percent of its clients made up 95 percent of its revenue, or $15 million in 2008. The business, which consists of 14 pathologists, decided to go on a weekend retreat and plan its strategy. Pathology Associates agreed to continue relationships with its four major clients rather than risk losing all of its revenue. In each case, the outcome has been different, according to Mr. Parker.

- One group practice set up an in-office laboratory and continued to use Pathology Associates for the PC of pathology services.
- A second group practice built a dermatology laboratory and hired one of the partners at Pathology Associates. However, Pathology Associates still gets paid to do some of the work because an insurance provider insists on it.
- A third client of gastroenterologists built its own laboratory and tried to negotiate a substantially lower payment for the PC of pathology services. Pathology Associates turned it down, but it receives some work at the insistence of an insurance provider.
- The fourth client asked Pathology Associates to help it set up the in-office laboratory as a partner. The relationship lasted for a year until an outside pathologist offered his services to perform the TC and PC of pathology.

For the TC and PC of pathology services, 20 percent of the clients made up 95 percent of its revenue, or $15 million in 2008. The business, which consists of 14 pathologists, decided to go on a weekend retreat and plan its strategy. Pathology Associates agreed to continue relationships with its four major clients rather than risk losing all of its revenue. In each case, the outcome has been different, according to Mr. Parker.

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developed a joint venture for 50/50 ownership with Mercy Medical Center, Springfield, Mass., called LifePath Partners LLC in 2002. Mercy Medical Center ceded 50 percent ownership of its histology and cytopathology laboratories to NEPA in exchange for increased pathology coverage. The two organizations split operating expenses based on use.

Additionally, NEPA has partnerships with two urology groups that have in-office laboratories: Urology Group of Western New England and Glazier Urology. The urology practices own their laboratories and bill for the TC of pathology services, while NEPA manages their laboratories, including the lease of its employees, education, equipment, and installation, and performs and invoices for the PC of pathology services.

Mitchell Study: Urologists’ Self-Referral of Pathology Services Inflates Utilization, Reduces Likelihood of Cancer Detection

Respected Georgetown University health economist Jean Mitchell, PhD, has provided documented evidence that urologists who profit on their referrals for anatomic pathology services overuse them in their recent study published in Health Affairs. Additionally, Dr. Mitchell found that self-referring urologists were less likely to diagnose cancer, possibly because “financial incentives prompt self-referring urologists to perform biopsy procedures on patients who are unlikely to have prostate cancer.”

The Mitchell Study examined Medicare claims for men in geographically dispersed counties of the United States to determine how the In-Office Ancillary Services Exception affected the use of surgical pathology services and cancer detection rates from their prostate biopsies. Dr. Mitchell’s research showed that urologists who build in-office laboratories order 72 percent more pathology services, or 10.3 specimens versus six specimens, compared to their nonreferring colleagues. Fewer cases of cancer were detected—21 percent through in-office laboratories compared to 35 percent for those sent to external laboratories.

The Mitchell Study confirms what many pathologists and laboratory professionals have suspected for the past decade. The Alliance for Integrity in Medicine (AIM)—comprising a broad spectrum of medical specialty, laboratory, radiation oncology, and medical imaging groups that include ASCP—lauded the publication of the Mitchell Study.

An AIM spokesperson said the study was particularly welcome because it provides independent, peer-reviewed evidence that this self-referral practice—in which urologists use their pathology laboratories to test prostate biopsies for cancer—provides no benefits to patients and is only serving to drive up Medicare costs.

“ASCP commends Dr. Mitchell on the publication of her seminal research exposing the seriously troubling business of physician self-referral of anatomic pathology services,” said ASCP President C. Bruce Alexander, MD, FASCP. “Her study adds to a wealth of evidence illustrating that self-referral may result in overutilization of costly medical services.”

The American Clinical Laboratory Association and the College of American Pathologists co-funded the study. The funding for the study had no bearing on the content of the research, which was independent.

ASCP Urges Reform of Self-Referral Law for Pathology Services

ASCP signed an Alliance for Integrity in Medicare (AIM) letter on Dec. 5, 2011, to key leaders in the U.S. Congress as part of an effort to remove pathology services from the Stark Law’s In-Office Ancillary Services Exception (IOASE). The IOASE outlines exceptions, or safe harbors, to the Stark Law’s ban on the self-referral of physician services. Removing pathology services from the exception is intended to prevent inappropriate self-referral and potentially abusive billing of pathology services.

AIM is a coalition of organizations dedicated to ending the practice of inappropriate physician self-referral in Medicare. ASCP is a founding member of the coalition. Other members of AIM representing the specialty of pathology and laboratory medicine are the American Clinical Laboratory Association and the College of American Pathologists.

An excerpt from the AIM letter states, “We believe that the ongoing misapplication of the IOASE to the Ethics in Patient Referrals Act, known as the Stark Law, results in increased spending, unnecessary overutilization of services, and could also lead to compromised patient choice and care. Since the IOASE was implemented, the Stark Law and its policy objectives have been diluted, making it possible for physicians to avoid the law’s prohibitions by structuring arrangements to meet the technical requirements, but not the intent of the exception. Evidence shows that physician self-referral leads to increased utilization of services that may not be medically necessary, poses a potential risk of harm to patients, and costs the healthcare system billions of dollars each year.” The AIM letter concludes by urging Congress to close the loophole and curtail inappropriate spending by Medicare to sustain the program for current and future beneficiaries.

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"Pathologists need to know in-office laboratories can change their businesses almost overnight and develop solutions to adjust their business model before it happens,” Mr. Parker said. Through its strategies, Pathology Associates has recouped about 59 percent, or $4.6 million, of its former revenue.

Symbiotic Relationships

Similar to NEPA, CAP Lab, based in Lansing, Mich., has formed partnerships with several local in-office laboratories by providing professional services like leasing its histologists at an hourly rate, according to James E. Richard, DO, Director at CAP Lab.

“I approach in-office laboratories like a small hospital,” Dr. Richard said. “I want to be their laboratory director and advise them about good-quality care and accreditation for their in-office laboratories. Pathologists should make it safe by performing the professional component on tissue samples and making quality diagnoses.”

One solution is for pathologists to become known as the respected authority on the laboratory business to clinicians who set up in-office laboratories, according to Dr. Richard. “Pathologists need to be problem solvers and look at the in-office laboratories from the clients’ perspective and figure what they need to best serve the patients,” he added.

Future: Daunting or Hopeful?

Dr. Goulart sees the TC versus PC issue at the root of the substantial rise of in-office laboratories. “The relative increase in TC reimbursement, coupled with the economic downturn, has created a perfect storm,” he said. “If the technical component was reimbursed at a lower relative rate, this trend would stop and likely would not have arisen in the first place.”

Other solutions would be a booming economy, changes to the Stark Law IOASE, and reversal of the CMS anti-markup rule. Alerting consumers to the higher costs and less efficient diagnoses of many in-office laboratories has begun with the recent publication of the Mitchell Study. (See p. 23.)

“Pathologists need to make the best of the situation for the benefit of our patients,” Dr. Goulart said. “The wrong thing for a pathology group is to pretend it doesn’t exist. We have to play with our hand of cards as they are currently dealt.”

References


Ms. Patterson is the Editor of Critical Values.
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Game On:
Playing the Best Hand to Buy or Lease Laboratory Instrumentation

By Dennis Matricardi, MS, SM(ASCP)DLM
Buying or leasing instrumentation in the laboratory can be a bit like playing a new game. Generally, you read the instructions before playing a game, particularly one you've never played before. Unfortunately, far too many laboratory professionals skip the instructions and jump right into playing. This often results in paying too much for equipment, or, even worse, not knowing exactly what you're getting. Here are some instructions to help you avoid these pitfalls with your next purchase or lease.

**Instruction No. 1—Prep for the big game.**

In my business, I am often asked whether it is best to buy, lease, or rent laboratory instrumentation. My answer is often, "I don't know, you tell me." Before the customer actually hangs up the phone I try to add, "I'm serious." Think about it. If you were going to buy a car or a laptop computer, you wouldn't walk in to the dealership or store and ask whether it is best for you to buy or lease. Why? Because you know the answer to that question, or, at least, you should know the answer. If you have the money to buy the car or laptop, you pay cash. If you don't have the money, and you really need or want it, you lease or finance it. The same principle applies to the laboratory.

Assess your financial status. Either the capital equipment committee approved or will approve the purchase, or there is no way the purchase will be approved. Go the capital dollars route first. Whether it is a planned purchase or an emergency purchase, it is almost always better to pay cash, just as it is with cars or laptops. Whether you have the cash or not, proceed to Instruction No. 2.

**Instruction No. 2—Roll the dice.**

At this point, you are either working with the capital equipment committee to get the money, or you're finding out there are no capital dollars. For right now, though, roll the dice and proceed as though you have the cash and don't give anyone reason to think that you do not. Shop around and do your due diligence on your instrumentation choice. Get price comparisons and use all of the resources available to you to negotiate...
Game-winning Strategies

Considering a purchase or a lease? Get your game face on and keep these tips in mind to help you negotiate the best deal.

- **Do not show your cards.** Never let the vendors know how much money you have—or don’t have—on the table.

- **Play hard and play as though you are a millionaire.** Negotiate as if you have nothing to lose. You just might win it all.

- **Keep your cards until the very end, and then use the cards left very wisely.** Wait until just the right moment to announce whether you’ll be purchasing or leasing, hopefully once you’ve negotiated the terms you want.

- **Finish strong.** Don’t let the vendor take charge of the situation. Rely on your hospital finance department to help you get the answers you need to make an informed decision.

the lowest possible price for your purchase. (Don’t look at it as anything other than a purchase.) You are off and running.

**Instruction No. 3—Play hardball.**

As you continue down the negotiation path for your purchase, you may feel as though you have to take three steps backward when you learn your capital equipment request has been denied. Maybe you hear, “The remaining money in the capital budget is going to radiology”—shocker! Despite this discouraging news, you must keep rolling the dice with a poker face. I repeat: Do not let the vendor know your intentions to buy or lease until the end of the game. Even when you see the finish line, don’t let them see you swerve from your confidence in the capital dollars to come. Having the costs broken out in detail for the purchasing scenario is the best template to figure out cost if you end up using any other method. Besides, it’s always a good tip to negotiate on things you understand. We all understand paying cash; we don’t do so well when someone throws leasing information at us.

**Instruction No. 4—Cross the finish line.**

**Scenario A—Purchase**

You are now down to the wire and ready to make the game-winning move. You have played the game diligently and focused on the prize at the finish line (getting the new piece of instrumentation for the best price). You have tried to negotiate an additional year warranty, extra training at no charge, no-charge shipping, free start-up reagents, and any and all other extras under the sun. The total cost of your instrumentation, post-warranty, and supplies/reagents are clear and easy to understand. You have got the cash and negotiated the best deal possible. Now it’s time to buy. Game over!

**Scenario B—Lease**

At the end of the game, the choice of purchasing or leasing comes down to whether or not you have the cash—not, as many laboratory professionals tell me, because you aren’t sure if it’s better to buy or lease. Many people tell me leasing is a better option for them because they can just get rid of the instrumentation if it doesn’t work out or if they change their minds. Really? If you lease a car, you will pay a penalty for early termination, and we all know how early termination works with our cell phones. Why would it be any different for laboratory equipment? It is not any easier to change equipment that is leased versus equipment that is purchased.

Leasing is only an advantage if you don’t have the cash to pay for it. Most laboratory leases last for 60 to 84 months, and the useful life of most laboratory equipment is 60 to 84 months. Whether you buy or lease, you are essentially stuck with the equipment for the same amount of time. You can shorten your lease and pay more, or you can break your lease and pay a penalty, but you cannot just walk away from a lease.
So, faced with leasing your equipment, what is your best move? When just the game-winning dice roll remains, then, and only then, do you say, “Oops ... I just found out the capital dollars are not available, and administration would like me to lease this instrumentation.”

**The Game Goes On**

Your best move when leasing is to get the finance department of the hospital involved. Do not spend too much time on a lease. Your primary goal is patient care and quality results, so take the leasing information to people who work with that sort of thing every day.

Rely on your finance department to help you decide the leasing scenario that is right for you, including:

- FMV (Fair Market Value) versus $1 Buyout. Don’t rely on the vendor for information to help you make this decision, or you’ll likely get 50 pages and 16 different leasing scenarios that will only cloud your decision and help their bottom line.

- Third party versus vendor. Most of the leases I see are through the vendor, but third-party leases can be just as good and are likely to be cheaper. Again, give this one to Finance. Do not go there!

- Reagent rentals. Doing a reagent rental really muddies the water. The possible scenarios get multiplied by 10 or more. Since you’ve already negotiated, along with Materials Management, your best pricing for your reagents when you were going to purchase your equipment, you now need to put all of that “stuff” into a reagent rental. The types and variations are another article that would likely be more like a novel. Let Finance help you.

Buying—or leasing—laboratory instrumentation can be a tough game. The most important thing to remember to play the game well is to read the instructions before you make your first move. Knowing what questions to ask and what strategies to use can help you identify significant savings and get you the equipment you want and need.

A 30-year laboratory veteran, Mr. Matricardi has had oversight for anatomical pathology, cytology, microbiology, immunology, laboratory information systems, and laboratory compliance and finance, as well as directing a hospital infection control program. He now serves as a clinical analyst with MD Buyline.
Marshaling Lab to Budget Effectively

By Diana L. Kremitske, MHA, MT(ASCP)
Preparing a sound annual operating budget for a clinical laboratory is one of the main competencies that a laboratory operations director must demonstrate. The financial health of the clinical laboratory relies on operational leaders at various levels in the chain of command who can manage a thoughtfully and accurately prepared budget. As important as it is to be focused on financial matters throughout the budget preparation process, however, maintaining a focus on what the laboratory needs to support its core strategy of raising the bar on quality and service standards to patients is central to this task.

Engaging one’s supervisory team in all phases of the budgeting process builds knowledge of operations, helps the management team stay attuned to the financial balance required to sustain and to acquire resources for operations, and instills accountability to manage by the information contained in the final, approved budget.

This article is based on my experiences working for a hospital laboratory within an integrated multi-hospital health system.

Gathering Information

To understand upcoming operational needs, a period of focused information gathering is an essential first step in the process. Both internal and external fact finding must be accomplished to derive the budgetary projections. Seeking internal and external information for the budget process takes some time, so advanced planning and connections with key contacts within the organization, such as a financial liaison, are necessities.

It’s also important to stay attuned to organizationwide projects that involve laboratory services, such as Computerized Physician Order Entry (CPOE) implementation and CPOE enhancements to lab orders. Identify what changes will occur to the lab’s strategy to improve its patient focus in the upcoming fiscal year and, therefore, what the operation needs to realize patient-centric outcomes. This kind of exploratory information is useful to project changes in expense and volume for the budget. Here are examples of broad questions that come to mind during the initial budget preparation steps.

Fact Finding—Needs of External Customers

- Is the organization opening new medical services, making changes to current medical specialties, or starting new clinical programs?
- How are clinical specialties that are supported by the lab growing or changing? What outpatient volume projections are being made by these clinical specialties?
- Are there going to be changes in the number of test-ordering providers in the organization? What are their specialties? Are their specialties low or high utilizers of laboratory services?
- How will lab test ordering patterns be affected by any new outpatient health maintenance order sets in the electronic health record?
- Are there customer-service challenges where improved turnaround time may be more reliably met by a point-of-care test option? What are the overall expenses compared to the benefits of such alternative testing options?
- Has there been significant feedback on methodologies necessitating considerations about whether a test should be continued in-house or referred out?
- Are there going to be any new client contracts or possible loss of contracts?

The answers to these questions require research. The answers may necessitate test menu changes, test volume adjustments, or consideration of different skill levels of laboratory professionals. Or perhaps it means rationalizing where a subset of testing should be performed, for example, in the core lab, distributed, co-located with a medical specialty, or sent to a reference laboratory.

Fact Finding—Internal Laboratory Needs

Assess operational changes planned within the laboratory. Some questions to ask in this area include:

- Are workstations going to be reorganized for better efficiency?
- How does the full-time equivalent (FTE) total compare against productivity?
• Is the right skill mix in place for anticipated clinical and patient service needs?
• Is new technology or replacement equipment going to be acquired that will change the operation? For budgeting purposes, how will it change the operation in terms of volume and expense?
• Are there appropriate manpower resources for planned projects?

These are just a few of many questions that arise in the budget preparation process. All questions, which depend on a laboratory’s individual situation, will aid in improving the accuracy of budgetary projections.

In addition to external and internal information gathering, a thoughtful productivity review is typically part of the operating budget preparation process. Productivity data trended monthly and compared against a reliable benchmark will assist in spotting functional areas or departments that require more in-depth analysis to determine cause(s) of unfavorable variances—over capacity or under capacity.

Over time, productivity data allows the computation of FTE needs or capacity, and is very useful in workload modeling. For example, can increases in volumes be safely absorbed or not? Of course, there can be defined pockets of expected, unfavorable productivity where patient service considerations outweigh the demonstration of favorable productivity.

### Engaging the Supervisory Team

Bringing the supervisory team together at the beginning of the budgeting process for a high-level review and discussion of considerations is helpful and will benefit the operation overall by improving understanding of how decisions to balance the budget are made in the final approval process. This preliminary session will help to organize the team’s thinking for the tasks ahead. Budget preparation tasks for each laboratory section can be appropriately assigned to team members. These tasks include determining new growth in volumes and trends in current volumes; assessing manpower needs based on productivity trends; identifying equipment that has expiring first-year warranties; and obtaining price quotations for minor equipment needs. Setting up individual meetings with the financial representative and each laboratory supervisor who is responsible for budget preparation allows for a review of budgeting details of each accounting unit under their responsibility.

### Anticipating Revenue and Test Volume

An understanding of current procedure (test) volumes and anticipated changes to volumes drives the revenue components of the budgeting equation. A laboratory operations director may consider budget volume projections in two ways: first, current, incremental growth and second, new business growth. Other intricacies of volume projections may exist depending on the organization’s financial methodologies. For example, over a course of time, volume growth may be forecasted at the organizational level. Projected inpatient hospital testing volumes is one such instance.

An important aspect of volume projections involves delineating whether volume changes will be inpatient, outpatient, or both. Inpatient and outpatient test payment methodologies are different, and understanding the differences and impact of prospective payment systems (PPS) will help you fully appreciate the revenue variables relative to volume projections. Also, an understanding of the mix of payment methodologies, whether it be PPS, fee schedule, or percent of charges, will help you appreciate the imperative to control costs and improve operating efficiencies. Budget calculations with the anticipated revenue mix should ultimately deliver a positive operating return for the laboratory. After net patient service revenue and any other sources of revenue are applied against total expenses, hitting a target, net positive contribution of the laboratory to the organization’s bottom line, is the desired outcome.
Reports from the organizational budget software package can aid in deriving incremental outpatient volume projections for the laboratory. Using trend reports and comparing fiscal years, a laboratory operations director can assess the rate of outpatient growth, positive, negative, or stagnant, drilled down to laboratory section. This data applied with previously obtained external and internal information assists in making reasonable budget assumptions about volume changes in the upcoming fiscal year.

What can be more challenging to accurately predict is new business volume growth. What proportion of the growth in new medical practices or clinical services requires laboratory procedures? Sometimes, if not most of the time, the knowledge of new business growth does not come along with detailed predictions of laboratory test utilization. Reasonable estimations may be based on historical experience, such as number of tests per requisition, established standards for laboratory testing per diagnosis(es) or treatment, and evidence-based practice.

Reports from information systems within the organization will aid in this analysis. The reliability of projections can be improved by speaking with subject matter experts who may be the pathologists-administrative partners and other relevant physician leaders or departmental administrators.

**Scrutinizing Expenses**

Expenses may be broadly categorized as salary and nonsalary. Approximately 33 percent of laboratory expenses at Geisinger Wyoming Valley Medical Center, Wilkes-Barre, Pa., are attributed to nonphysician salary and wages, plus benefits. Because this area of the budget accounts for such a high proportion of the total laboratory expenses, it deserves increased scrutiny. Human capital is the foundation of the laboratory. As a result, it is critical to ensure that all positions and FTE needs are reviewed and properly accounted for in the budget.

Other FTE position changes or additions by job title, pay rates, overtime, shift differential, bonuses, incentive payment plans, and contracted staff are generally accounted for in this area of the budget. The justification of new position additions requires at the very least an analysis of current productivity and the impact of anticipated volume or workstation changes. Staging of new FTEs for a particular month in the coming fiscal year can be done and may be appropriate for specific situations. Also, due to the workforce shortage of laboratory professionals, the recruiting time can be lengthy.

Another consideration for thorough FTE budgeting involves open positions that have been approved but not yet backfilled. Due to timing of information downloads from human resource systems into the budgeting software being used, these may need to be added to ensure approved yet open positions are retained in the final budgeted FTE total.

Roughly 25 percent of laboratory expenses at Geisinger Wyoming Valley Medical Center are attributable to supplies, which include blood product expenses. The budgeting software that Geisinger uses displays expense history in various categories with appropriate adjustments for inflationary and projected volume increases. The software allows entries of dollar or percentage changes by those responsible for budgeting in each expense account, subject to administrative review upon finalization.

Some reasons for adjusting amounts in budgeted expense accounts are to accurately reflect changes to a supplier’s agreement or contract, to account for changes in proficiency testing costs, to pay for licenses coming due, and to purchase needed minor equipment. Additionally, individual organizations may provide guidelines to help determine budgeting amount entries for other expense categories, such as continuing medical education.

When using a software program, some categories of expenses may not be automatically calculated for the upcoming fiscal year since they vary year to year. These must be tabulated and manually entered into the budget. In these cases, obtaining a file of historical invoices, by vendor, that shows frequency of payments will allow operational laboratory directors to have details at hand about the total expense and when it occurs—monthly, quarterly, or annually—to properly stage those expenses in the budget.

Expense budgeting may have additional complexities. Other classifications of expenses, such as intercompany and shared expenses, also exist but are more common in integrated, multiple-laboratory organizations.

**The End Result**

After accounting for all expenses for the upcoming year and entering projected volumes, the successful budgeting process should calculate at the end to a percent margin that is within a positive, targeted percentage range. The upcoming fiscal year’s percent margin is defined here as the contribution margin over net revenue compared to the current year annualized. The desired margin may not occur in the first roll up for all laboratory accounting units. Iterative adjustments of the major categories of expenses and outpatient volume projections may be required to reach desired financial targets.

The budget preparation process enables laboratory operations directors to get to know the laboratory operation very well and understand what it takes to afford the operating needs of the business. Then you can prepare the budget based on how your organization’s laboratory may efficiently provide for and excel at maintaining a focus on the patient.

**Acknowledgments**

I would like to thank Jeffrey Renn, Financial Liaison, Laboratory Medicine Clinical Service Line, Geisinger Health System; and John Yurko, Senior Laboratory Operations Director, Geisinger Wyoming Valley Medical Center, for their feedback on this article.

Ms. Kremitske serves as the Laboratory Operations Director, Geisinger Northeast, Wilkes-Barre, Pa. She is responsible for clinical pathology laboratory operations at Geisinger Wyoming Valley Medical Center and Geisinger South Wilkes-Barre campuses. In addition, Ms. Kremitske is a member of the ASCP Council of Laboratory Professionals and serves as the ASCP Regional Representative for the Northeast.
ASCP Announces a Stellar Keynote Roster for the 2012 Annual Meeting

The American Society for Clinical Pathology (ASCP) will present an impressive keynote speaker series at its 2012 Annual Meeting, Oct. 31–Nov. 3, in Boston. The six general session presenters understand the power of the entire laboratory team in making the right diagnosis of disease. They realize the laboratory team's diagnoses ensure that patients obtain the right treatments to restore their good health. Their stories reflect how real science has changed the lives of real patients worldwide.

The Grand Opening Session Keynote Speaker, Ashley Judd, MPA, a humanitarian, actress, and advocate for public health programs in 13 countries, kicks off the ASCP Annual Meeting on Wednesday, Oct. 31. The Thursday, Nov. 1, Keynote Speakers, Laura W. Bush, the former First Lady, and Barbara Bush, the Founder and CEO of Global Health Corps, discuss efforts to expand breast and cervical cancer treatments throughout the world.

The Scientific Address will be presented on Friday, Nov. 2, by Donald M. Berwick, MD, the former Administrator of the Centers for Medicare & Medicaid Services (CMS) and author of two groundbreaking books about improving health care. Giuliana and Bill Rancic will headline the Friday Evening Showcase with a firsthand account of how they managed Giuliana’s recent diagnosis of breast cancer and her subsequent double mastectomy. The couple star in the hit reality show “Giuliana & Bill.”

ASCP and ASC Sign MOU to Partner on Education, Scientific Discovery, and Advocacy

ASCP and the American Society of Cytopathology (ASC) signed a Memorandum of Understanding (MOU), effective April 17, 2012, to partner on education, scientific discovery, and advocacy initiatives that will mutually benefit the pathologists, cytopathologists, laboratory professionals, and cytotechnologists who belong to the Societies. This partnership will enhance their shared missions of interdisciplinary education, scientific discovery, and advocacy; leverage their respective resources and membership benefits; and create administrative efficiencies while allowing each Society to maintain its own identity and governance.

“ASCP and ASC both have long, rich legacies, and we have worked together often for the common good of our respective members,” said ASCP President C. Bruce Alexander, MD, FASCP. “This MOU formalizes and expands our collaboration to enhance patient care and to work together on state and national legislative and regulatory issues.”

ASCP Becomes Managing Partner for ADASP

ASCP and the Association of Directors of Anatomic and Surgical Pathology (ADASP) signed a Memorandum of Understanding, effective March 15, for ASCP to manage the day-to-day activities of ADASP, so its leaders can conduct business more effectively. Previously, ADASP officers and councillors
handled both administrative and strategic functions. The MOU also fosters greater collaboration on the organizations’ educational and scientific activities in support of anatomic pathology and the broader pathology community.

“Our partnership with ASCP creates new opportunities for our members to be fully engaged and focused on strategic issues,” said ADASP President Jeffrey L. Myers, MD, FASCP, A. James French Professor and Director of Divisions of Anatomic Pathology and Medical Laboratories, University of Michigan, Ann Arbor, Mich. “The MOU creates the capacity for our organization to think and do big things. We found a great partner in ASCP.”

ASCP and California Society of Pathologists Join Forces to Strengthen Advocacy, Education, and Membership

ASCP and the California Society of Pathologists (CSP) signed a Memorandum of Understanding, effective March 1, to collaborate on education, advocacy, and membership initiatives that will mutually benefit the pathologists and laboratory professionals who belong to the Societies. The MOU’s goal is for each organization to gain a better understanding of the needs of the other organization’s members to maximize advantage of their respective expertise and find and develop their synergies.

“ASCP and CSP will work together to strengthen academic training programs and advocacy for our members and the entire laboratory profession,” said ASCP President C. Bruce Alexander, MD, FASCP. “This alliance is a proactive partnership serving the profession at the state and national levels. Engaged practitioners show greater commitment to patient-centered pathology.”

ASCP and ASCO Forge Ties to Aid Cancer Patients in Kenya and Beyond

Oncologists and pathologists have to collaborate in Kenya and other developing countries to provide the right diagnoses and treatments for cancer patients. That was the insistent drum roll at the Multidisciplinary Cancer Management Course (MCMC), Feb. 15–17, in Eldoret, Kenya, presented by the American Society of Clinical Oncology (ASCO) in partnership with ASCP and the Academic Model for the Provision of Access to Health Care (AMPATH).

“To deal with the patient’s needs, pathologists and laboratory professionals must recognize the complete role of health services delivery and proactively engage clinicians,” said Dr. Blair Holladay, ASCP Executive Vice President. “We recognize laboratory diagnostics are not the sole equation; however, they are the necessary crucial element for saving lives throughout the third world.”

Pathology in Africa has not evolved like pathology in the United States or Europe. It is focused mostly on anatomic pathology, and pathologists wear several hats and usually do not run the clinical laboratories. Often, hospitals in Africa have been built without much thought about the laboratories, and they are unprepared to ramp up cancer care with an already strapped pathology department, according to Drucilla Roberts, MD, FASCP, ASCP Representative at MCMC.

“Multidisciplinary care was the main message of this significant three-day course,” said Hugo Villars, MD, FACS, a surgeon based in Tucson, Ariz., who represented ASCO and developed the MCMC in 2004. “The coordination between pathologists and oncologists was outstanding during the meeting. Pathologists are so relevant to any discussions of breast cancer, cervical cancer, and lymphoma in HIV and non-HIV patients. When tumor is the rumor, tissue is the issue.”

ASCP Collaborates to Open New TB Testing Center in Swaziland

To combat the deadly combination of HIV/AIDS and tuberculosis (TB) decimating its population, a new TB testing center opened on Jan. 26, 2012, in Mbabane, Swaziland. It is a collaboration among ASCP, the U.S. Centers for Disease Control and Prevention, the University Research Corporation, and Doctors Without Borders. The facility, with high-technology laboratory equipment, access control, and computerized laboratory to match the requirements of the World Health Organization, is housed within the five-story National Reference Laboratory.

Swaziland has the world’s most severe HIV/AIDS epidemic, affecting 26.3 percent of its adult population between 15 and 29 years old and 15 percent of children under the age of 15. Due to their weakened immune systems, HIV patients are more vulnerable to TB. Health officials estimate 50 percent of Swaziland’s HIV patients also have TB.

“Correct diagnoses for specific types of tuberculosis are critical in order to treat Swazi patients correctly and efficiently, and turn the tide on this devastating epidemic,” Dr. Holladay said. “Erecting the new TB testing facility finally allows for timely testing to assist these patients in need. Since TB—in all its forms—is highly contagious, laboratory professionals in Swaziland also have a much safer environment to conduct the tests and reverse the current paucity in testing.”

Pathologist, 71, Wins Halfway Milestone in 1,000-Mile Dog-Sled Race

At first glance, being a pathologist and running sled dogs competitively in Alaska would seem to be completely different pursuits. But Jim Lanier, MD, a retired pathologist and career-long member of the ASCP who was the first musher to reach the halfway point in this year’s Iditarod race, sees some parallels.

“For medicine in general, the training involves going without sleep—so it has that in common,” said Dr. Lanier, 71. “And my medical training and knowledge are useful when it comes to the veterinary care of the animals. I understand the physiology of dogs, and when I discuss things with vets during the race or at home, I speak their language.”

The March 2012 Iditarod, a 1,000-mile race from Anchorage to Nome, was the 15th for Dr. Lanier. This was the first time he won the GCI Dorothy Page Halfway Award for reaching the Cripple Checkpoint in the race before all the other mushers—in just four days.
Real Science. Real Life. Real Education.

As new research changes the way you approach your work and the way you deliver patient care, count on the 2012 ASCP Annual Meeting to keep you ahead of the curve. This year, you’ll discover four days of brand new and innovative learning opportunities that cover the pressing issues that impact everyone in pathology and laboratory medicine.

Calling all pathologists, lab professionals and residents!
In 2012, turn to the ASCP Annual Meeting for opportunities to improve the way you care for your patients. From learning with the other members of your own practice to connecting with colleagues and friends in the new ASCP Commons, this is the conference that unites the entire lab team to explore the future of pathology and laboratory medicine.

Register online by August 31 and SAVE!

Preview our incredible keynote speaker series!
www.ascp.org/2012AnnualMeeting
Ling Zhang of Tohoku University, Sendai, Japan, was the Grand Prize Winner of the 2012 Journal of Laboratory Automation (JALA) & Journal of Biomolecular Screening (JBS) Art of Science Contest.* This image shows a large-scale and chemically stable SERS substrate for single molecule detection. Quasi-periodic wrinkles were made by thermal contraction of pre-stretched polymer substrates. Plenty of nanogaps with various spacings, as well as an abundance of nanotips and bowtie nanoantenna structures, are obtained at the ridges of the wrinkles introduced by film shrinking. The robust substrate made by wrinkled nanoporous films contains a high number density of electromagnetic "hot spots" with a local SERS enhancement larger than 10^9.

The deadline for entries to the 2013 JALA & JBS Art of Science Contest is Aug. 31, 2012. The grand prize will be the new iPad. Runners-up receive $50 Amazon gift cards. For more details, go to www.SLAS.org.

* The image is reprinted with the permission of the Society for Laboratory Automation and Screening.
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