Volume VI, Number 11 Monday, August 9, 1999

Quest - SBCL Merger Expected Within Two Weeks!
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From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE BUSINESS INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs / COOs / CFOs / PATHOLOGISTs

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Commentary & Opinion by...

R. Lewis Dark

Founder & Publisher

How Hospital Lab Directors Fail Their Employees

EVERY NOW AND THEN I WANT TO TAKE some segment of the laboratory industry to task for things they ought to be doing. Today it will be hospital laboratory directors.

Virtually every hospital lab administrator in the United States will tell you that they are concerned about the job stability and welfare of their lab employees. Yet, in hospital lab after hospital lab, we hear news of radical restructuring and cost-cutting that painfully chops lab employees off the payroll.

It is my observation that many hospital lab administrators who profess concern about protecting their employees' jobs, are actually guilty of inaction which directly leads to downsizing and a reduction in the number of laboratory employees. Why do I say this? Because hospital lab administrators have some power to prevent lay offs. The management strategy and required tools to accomplish this have been publicized in the lab industry trade press for ten years. A steady stream of hospital lab administrators continues to take the podium at various lab meetings to share their successes at making their own hospital labs "lay off proof."

It's a simple management strategy: take any hospital laboratory serving an inpatient population and figure out ways to increase the volume of specimens flowing into it. The most obvious source of specimens is from physician offices in the surrounding campus. Because these physicians admit patients to the hospital, most have a positive motive to support their community hospital.

If hospital laboratory administrators had been willing 1) to take some risk to sell an outreach program to administration; 2) to invest some personal initiative into creating a lab outreach program; and 3) to provide leadership for the laboratory to succeed in that effort, then it is my contention that a large number of hospital labs would not have endured sizeable staff lay offs during recent years. The reason is inarguable. More specimens allow unused capacity and existing staff to be more productive. It lowers the hospital's average cost per test. Revenue from outreach specimens can also make the hospital lab a profit center.

Now that I have taken hospital laboratory administrators to task, I would like to challenge them. Look for successful examples of hospital laboratory outreach programs, study them and put the best management ideas to work in your own hospital laboratory! See if you can make your own hospital laboratory "lay off proof," for all the *right* reasons! TDR

West Hills Hospital Lab Hits Outreach Home Run

More specimens from docs' offices leads to improved lab productivity and profits

CEO SUMMARY: Popular wisdom says that California's man-aged care market is a financial disaster for clinical labo-orato-ries. Yet here's an exciting story about a community hospital that launched a brand-new laboratory outreach program in 1997 and found solid success. During the last two years, specimen volume is up, profits are increasing, and the labo-ratory is adding additional value to the hospital.

SITTING IN A LITTLE CORNER of Los Angeles' San Fernando Valley, **West Hills Hospital and Medical Center**, a 236-bed community hospital, is an unlikely candidate for a thriving laboratory outreach program.

Yet, during the last 24 months, it launched a daring laboratory testing outreach program into California's highly competitive managed care marketplace. The numbers tell the tale.

Billable tests from outreach testing have climbed to 7,000 per month. Net revenues from outreach testing reached $550,000 for year-to-date by June 1999. Hospital officials confirm that the outreach testing program runs in the black.

What is truly unique about the West Hills Hospital and Medical Center (WHHMC) story is its total dependence on outsourcing for the functions of sales, marketing, courier, client services, billing, collections, and draw station management.

"I had a new hospital CEO who challenged me to do this," said Joseph McCauley, Laboratory Director at WHHMC. "Upon arriving in 1997, he directed the lab to accomplish three things. First, control costs. Second, improve the lab's turnaround time. Three, add additional value in how the lab supports the hospital.

"He also made it clear that these goals were achievable and I would be responsible," recalled McCauley. "To hit these goals, we both agreed that WHHMC would have to create its first-ever outreach laboratory testing program."

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Despite 25 years of service at the WHHMC laboratory, McCauley was not threatened by the change. "This is survival," he declared. "As lab director, I have to take action if I want to provide stability and a future for both myself and the 50-some employees of our lab."

Need To Change

McCauley had already recognized the need to change the laboratory in order to survive. WHHMC is owned by **Columbia/ HCA Healthcare Corporation**. McCauley was part of a task force to evaluate lab regionalization among Columbia's California hospitals.

"I recognized the opportunity for our laboratory to do more," noted McCauley. "We've always had the latest and best of analyzers. We operate a second and third shift, essentially to do stat tests for inpatients. So there was unused capacity in this laboratory, just like at most other hospital labs.

"My hospital's business plan identified specific goals for the laboratory," he continued. "We determined that outreach specimens would generate the benefits and revenues we sought."

McCauley realized that the true measure of success would be for his lab to increase its value to the hospital. "Our motive in developing outreach business was to improve services to our inpatients and offer enhanced benefits to our physician staff and referring doctors," explained McCauley.

Four Objectives Identified

"Four discrete objectives were identified" he added. "One, fully utilize staffing on second and third shifts. Two, fully utilize equipment during every 24-hour cycle. Three, perform tests every 24 hours instead of several times per week. Four, generate additional revenue for the hospital."

Outsourcing as a way to create the outreach program was born of necessity. "My CEO wouldn't allow me to hire more FTEs," commented McCauley. "But he did authorize funding for the outreach program.

"Further, he was aware of a company in Southern California which provided contract services for hospital laboratory outreach programs," added McCauley. "That is how I got the idea to contract out the functions of sales, marketing, courier, and billing.

"We avoided the 'must build it ourselves' syndrome," he noted. "We are experts in laboratory medicine and hospital lab operations. But we are not experts in such sophisticated commercial lab business skills as sales, pricing, client service, billing, and collections.

"So we enlisted experts to help us us get started the right way," McCauley stated. "Experts knew exactly what we needed. They were a cost-effective way to rapidly launch our laboratory outreach program."

Advance Survey Of Clients

Before start-up, McCauley and his team did a survey of their potential physician-clients. "Commercial labs know how to be customer-friendly," observed McCauley. "In contrast, hospital labs focus on inpatient needs. They generally don't respond well to requests for individualized service.

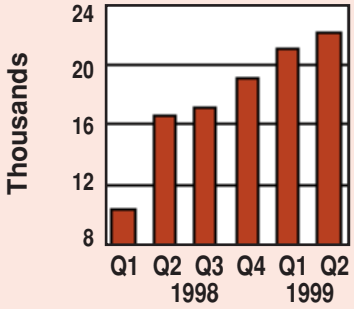
"For West Hills to succeed, we understood that we would have to meet the needs of the office-based physician," he said. "Our survey told us they wanted easy registration of patients. We had to offer better turnaround times than competing labs. Our prices needed to be competitive. The physicians also emphasized that responsiveness to their requests was an important factor.

"We were in a position to offer these things." recalled McCauley. "For example, turnaround time was easy. We have staff working throughout the day and offer that service already. The **Meditech**

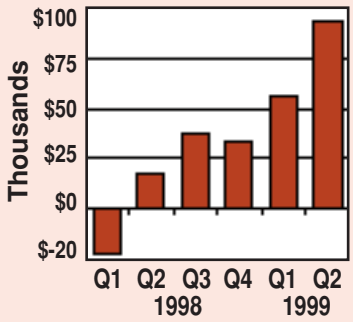
Hospital Lab Outreach Grows Steadily

Regular growth in both the number of billable tests and the net revenue at West Hills Hospital and Medical Center's laboratory outreach program demonstrates the success that community hospitals can have by offering laboratory testing to physician offices in the nearby area.

Qrtrly Outreach Billable Tests



Qrtrly Outreach Net Revenue



information system at our hospital was already linked into physician offices. Thus, doctors would be able to access inpatient *and* outpatient lab test results for their patients. Competing labs cannot match this feature."

By using outsourcing arrangements, McCauley was able to speedily move his outreach program to market. "We got help in budgeting, setting test prices, and designing the operational logistics, such as courier routes, draw station needs, billing, collection, requisition design, and test reporting," he said.

"Initially, our outsourcing company provided four sales people," stated McCauley. "These sales reps worked a 20-mile radius from our hospital. Once we picked up business from within this geography, we stabilized at 1.5 sales reps in the field."

One interesting aspect of this outreach program is that WHHMC will not sign managed care contracts. "We avoid performing lab tests for insurers that offer inadequate reimbursement," explained McCauley. "Therefore, our clients refer us only specimens for patients who have fee-for-service or Medicare coverage. Our clients send their remaining lab specimens to the major commercial laboratories as directed by the payer."

WHHMC does participate in a few PPO arrangements. About 45% of its outreach business is Medicare. According to McCauley, physicians are willing to split specimens between his hospital lab and the commercial laboratories because of their affinity to the hospital and the added service they get from the hospital lab.

"Turnaround time is one example of how we can offer a service advantage. The increased volume of specimens allows us to run more tests on a daily basis," noted McCauley. "I actually have doctors who now walk up to me in the hall of the hospital and say 'It's incredible. None of the hospitals around this community can provide me the type of lab services that I get here!' Better yet, they tell that to my hospital CEO."

WHHMC uses **NTI Florida** as its outsourcing vendor. Through a subsidiary called **United WestLab, Inc.**, NTI provides sales and marketing, courier services, client services, billing and collections, draw station management, and some specimen processing.

Cost-Plus Arrangement

"They have about 10 FTEs devoted to our contract," noted McCauley. "For NTI's total package of services, we pay about $45,000 per month. It's a cost-plus arrangement, so they don't share in the revenues."

Requisitions for physician office accounts include United WestLab's name underneath the WHHMC name. "This allows us to identify patients involved in the outreach program," explained McCauley. "As these patients are entered into the hospital's computer systems, their requisitions are zeroed out and transferred to United WestLab for billing and collections.

"Reimbursement checks come directly to the hospital," he continued. "We use a single provider number and, from day one, the system has been easy to audit and manage."

Since the outreach program's inception, the volume of monthly billable tests has climbed by more than 28%. "To handle this extra volume, we added one FTE to the graveyard shift on weekdays, giving us two on that shift," noted McCauley. "This allowed us to mop up all the work and have reports ready by 5:00 a.m. the next morning."

West Hills Hospital seems to have had a relatively smooth start-up with its outsourced lab outreach program. "Bringing in experts who knew how to operate a commercial lab business helped us avoid a lot of mistakes," said McCauley. "But I did things like review every single bill that went out during the first six months. I was determined that our team would get it right and that our clients would always get top service.

"Probably the biggest surprise we got were problems within the laboratory itself," recalled McCauley. "For example, some of the lab staff began to gripe about the additional work. That was frustrating, because we were expending all this effort to help them keep their jobs and avoid the type of layoffs so frequently seen at hospital labs these days.

"The other surprise was the length of time it took for collections to hit the door," he added. "It was probably six months before a regular flow of checks began arriving. I was also surprised that net revenue has averaged only about 60% of gross billings."

Overall, McCauley rates the outreach program as a solid success. "First, our outreach program is delivering a monthly flow of profits to the hospital. Second, we now offer faster TAT for an expanded menu of tests, both to inpatients and outpatients. In particular, our physicians appreciate this benefit to clinical practices.

Outstanding Doctor Loyalty

"Third, doctor loyalty and support is outstanding," he continued. "We definitely see a difference in physician referral patterns which favor our hospital. Fourth, the outreach program has become a vehicle for offering other hospital services, such as MRI. Our sales and customer service people take advantage of opportunities to present these services to our clients.

"In closing, I would like to say that this laboratory outreach sales program has really helped us change our entire laboratory organization for the better," declared McCauley. "Not only is our staff excited and proud, but our physician clients definitely appreciate the expanded services we now provide." TDR

For further information, contact Joseph McCauley at 818-676-4123.

Outsourcing Lab Outreach Leads to Better Service

Community hospital demonstrates that lab outreach remains a viable strategy

CEO SUMMARY: Many hospital laboratories continue to endure non-stop cutbacks to staffing and funding. The success of the recently instituted laboratory testing outreach program at West Hills Hospital and Medical Center validates that the market continues to reward labs willing to offer added-value services. These are the laboratories which will emerge as winners in tomorrow's managed healthcare marketplace.

HOSPITAL LABORATORY MANAGERS throughout North America face an identical challenge: how to lower testing costs while simultaneously increasing lab services and testing capability.

At **West Hills Hospital and Medical Center** (WHHMC) in West Hills, California, Laboratory Director Joseph McCauley and his hospital CEO used a time-proven formula to solve this problem: increase the volume of specimens processed by the lab.

Internally Financed Program

Two factors make their story unique. First, as a single community hospital operation, they were willing to launch an internally financed laboratory outreach program. Few hospitals around the United States have been willing to do the identical thing.

Second, these executives agreed that their business project would be best served by retaining the services of outside experts. This would avoid the unnecessary expense incurred when laboratory managers try to master the sophisticated skills of finance, strategic marketing, sales, billing, etc. Further, using outside experts to develop and launch the business plan accelerates implementation by a huge factor.

In less than 24 months from start-up, specimens from the outreach program now generate 28% of the monthly billable tests performed by the WHHMC laboratory. As a result, the lab is beginning to see a regular decline in the average cost per test.

WHHMC's experience can teach other hospital laboratory administrators and directors some valuable lessons about today's market.

Lesson One: Things can happen quickly. This hospital CEO made a commitment, then supported the lab director's efforts to introduce the concept into the market on a fast-track basis.

Lesson Two: Don't reinvent the wheel. As McCauley notes on page 3, he and his team are experts in laboratory testing and inpatient operations. They are not experts in finance, sales, strategic marketing, and commercial laboratory expertise. They retained specialists in these areas and listened to their advice.

Lesson 4: Physicians want their laboratory to be responsive to their practice needs. McCauley recognized this requirement. He and his team surveyed potential clients—before launching the program. They then designed their outreach program to meet the lab testing needs of office-based physicians.

Lesson 5: Managed care contracts are not *essential for lab outreach success.* This is one of the most interesting aspects of the West Hills story. WHHMC has physicians splitting specimens so it gets only their fee-for-service and Medicare work. Commercial lab competitors get the capitated and highly-discounted testing, as determined by the patient's insurer.

Lesson 6: Hospital inpatient testing benefits from the outreach specimens. WHHMC now offers daily results on tests which it formerly could only do a couple of times per week. This improves the clinical services within the hospital. Further, because of the LIS system, doctors can access both inpatient and outpatient lab test results from their office.

Lesson 7: An effective outreach program builds valuable bridges between physicians and the hospital. As McCauley noted, WHHMC recognizes a different, and more positive, patient referral pattern from doctors who use their lab versus doctors who don't.

Lesson eight: Employment stability and opportunity in the hospital lab is enhanced by an effective laboratory outreach program. Although WHHMC averages 50% occupancy with its 260 beds, its laboratory staff is fully utilized. The combination of inpatient testing and growing outpatient testing guarantees the productivity of the lab staff and its value to the hospital.

THE DARK REPORT believes that the lab outreach program at West Hills Hospital and Medical Center validates our prediction that labs which are closest to the point-of-care have the best opportunity to survive and thrive, but only if they are willing to integrate their services within the greater healthcare community.

Hospital-based laboratories are ideally situated at the point-of-care. They have an inherent advantage over commercial laboratory competitors. However, that advantage means little until progressive lab directors like Joe McCauley make the commitment to put their hospital into the laboratory outreach business! TDR

For further information, contact Joseph McCauley at 818-676-4123.

Hospital CEO Likes Benefits From Lab Outreach Program

"Our doctors love the services they get from the laboratory," said Jim Sherman, CEO at West Hills Hospital and Medical Center. "I hear compliments about everything from better turnaround time and personalized service to instant reporting."

West Hill's laboratory outreach program has generated recognizable benefits in a number of ways. "For most hospitals, the laboratory is a fixed cost," noted Sherman. "But our outreach program now brings in more specimens. This increased flow of specimens is helping us to both reduce lab costs and offer improved testing services to our doctors and patients."

Sherman intends to use this asset to the benefit of West Hills Hospital and Medical Center. "Because the laboratory is in regular contact with physician offices, we plan to use it as an outreach tool for other hospital services," he stated. "We believe it is a good way to educate the physician com-munity about the hospital and its resources."

Sherman recommends that other hospital CEOs explore the benefits of launching a laboratory outreach program. "Where appropriate, this type of laboratory

Story Update

California Assesses Fines After Needle Reuse by SBCL Employee

ONE CHAPTER HAS CONCLUDED in the story about the phlebotomist who was discovered last March to be reusing butterfly needles in Palo Alto, California.

California's **Department of Health Services** (DHS) fined **SmithKline Beecham Clinical Laboratories** (SBCL) a total of $102,00 for its part in the episode. SBCL's license could have been revoked or suspended.

Phlebotomist Elaine Georgi, while an employee of SBCL, has admitted that she reused needles to draw patients in February 1999. Evidence indicates she may have started this practice as early as August 1998. *(See TDR, April 26, 1999; June 7, 1999.)*

Authorities publicly downplayed the risk of exposure to HIV and hepatitis as a result of Ms. Georgi's actions. But a number of lawsuits were filed. At least one plaintiff now claims to have contracted hepatitis C as a consequence of having her blood drawn by Ms. Georgi at SBCL's Palo Alto draw site.

Fine Against SBCL

Formal legal action is still pending against Elaine Georgi. Meanwhile, the Department of Health Services' fine against SBCL apparently resolves the lab's involvement in this matter.

For laboratory administrators throughout the country, this issue has highlighted the risks of offering phlebotomy services to the public. When the story broke on April 15, it focused unwelcome national media attention on SBCL.

SBCL received a Statement of Deficiencies from DHS at its Dublin, California laboratory on May 12, 1999. SBCL responded with a Plan of Correction on May 26, 1999.

DHS assessed a $50,000 fine for SBCL's failure to properly manage the phlebotomist. This is based on the phlebotomist's admission that she reused needles on five to ten patients in February 1999.

Mixing Or Mislabeling

Another $40,000 fine was assessed for failure to insure specimen integrity. This was based on four instances where Elaine Georgi mixed serum specimens from two patients and/or mislabeled specimens.

Two $6,000 fines were assessed for failure to adhere to a quality control procedure at the Palo Alto site and failure of the laboratory director to ensure that "phlebotomists hired on a temporary bases were qualified and competent."

Laboratory executives and pathologists should consider this a wake-up call to review their own laboratory's crises management plan. Every clinical laboratory is vulnerable to the actions of a rogue employee.

As SBCL discovered, any laboratory can find itself in the middle of public controversy at the most unexpected moment. In such an event, a well-designed crises management plan is essential to restore public confidence in that laboratory's competence, safety, and professionalism. TDR

IS THIS POPULAR WISDOM THAT PROVED FALSE?

Ten Myths of Lab Management That Led Clin Lab Industry Astray

Part One of a Special Series

CEO SUMMARY: One of our most popular series ever was the "13 Perilous Parallels" of laboratory management. This four-part story appeared in 1996 and chronicled similar manage-ment strategies used by various national laboratories during the ten years leading up to 1996. It was a revealing look at how commercial lab executives tended to copy each other's failed strategies and generally ended up with the same failed results. THE DARK REPORT now takes a fresh look at ideas which continue to shape the thinking of both hospital lab and commercial laboratory executives. With just a little tongue in cheek, we offer our "Ten Myths of Laboratory Management." These are widely-accepted axioms of lab management that surely misguide more than a few laboratory executives in their decisions. Unfortunately, the consequences are not always pos-itive for laboratories, their employees, and their customers.

EVERY INDUSTRY HAS ITS LORE and legends which shape the decisions made daily by its managers and executives. The laboratory industry is no exception.

Yet, how often do executives question the lore and legends which consciously and unconsciously influence their decisions? Probably not often enough. Consequently, they may be basing important decisions on collective or popular wisdom which is actually wrong.

That is why it's time for the clinical laboratory industry to recognize and debate the truth about the management precepts which seem to frame the thinking of so many managers and executives.

THE DARK REPORT believes it has identified ten management myths which continue to lead laboratory managers astray. In this first installment, we take a detailed look at the first three myths.

Original Facts Often Distorted

We use the word "myth" for a reason. Myths frequently are based in truth. But the original facts often become distorted as the story is retold time and time again. That seems to happen a lot in the clinical laboratory business.

Our motive in presenting these myths is to provoke thoughtful discussion. Yes, myths have their roots in truth. But is the original truth relevant in today's healthcare marketplace? Laboratorians should not be building business strategies around destructive or false management precepts.

One way to recognize these management myths in your own laboratory is to listen during meetings and conversations with co-workers. Management myths tend to be offered in defense of a position, without supporting documentation. The advocate who repeats a management myth is relying on the fact that it is "popular wisdom" and thus should not be challenged.

That is actually a lazy defense. For, as you will read, many of the popular wisdoms bandied about during meetings are actually based on false information, outdated circumstances, or just plain bad management thinking!

It's amazing how long bad advice can remain credible. Hopefully this series of articles in THE DARK REPORT will cause our clients and readers to rethink their own opinions about these management subjects.

More importantly, in declaring these common lab management precepts to be myths, we hope that laboratorians everywhere can root out bad management practices and replace them with effective management thinking.

Without further ado, here is the beginning of our list. Despite our numbering system, these ten management myths are not presented in order of priority.

MANAGEMENT MYTH #1

Lowest cost per test gives a laboratory unbeatable competitive advantage.

FOR MANY YEARS, IT WAS A SHIBBOLETH among commercial laboratory executives that the laboratory with the lowest cost per test in a market would hold an unbeatable advantage over its lab competitors.

Thus, achieving the lowest cost per test became a persistent goal for ambitious laboratories. After all, here was a management myth that said, "if my lab could become the lowest cost producer, it would achieve market dominance."

Therefore, if low cost per test equals market dominance, then the proper business strategy for an ambitious laboratory was to

create huge laboratories which tested high volumes of specimens. This was true for two reasons.

First, because fixed costs within a laboratory represent as much as 80% of total total costs, high volumes of specimens would serve to drive down the average cost per test.

Laboratory Industry's Ten Biggest Myths

Here are the first five management myths on our list. Upcoming installments will review each in depth:

1. **Lowest cost per test gives a laboratory an unbeatable competitive advantage.**
2. **Bidding for additional specimens using marginal cost pricing is a viable business strategy.**
3. **Getting a managed care contract guarantees that pull-through business will follow.**
4. **Lab automation is an automatic way to access cost savings.**
5. **The best way to cut costs in the**

Myths 6-10: To be featured in future installments.

Second, if a laboratory company could deliver high volumes of tests, it could negotiate more favorable prices for instruments, reagents, and service agreements. This would further lower its cost per test.

Add up both results, and a laboratory which succeeded in building high-volume testing centers could achieve the lowest cost per test. But, did having the lowest cost per test actually make that lucky laboratory the dominant competitor in the markets it served?

If this management myth was true, then we would see an unquestionably dominant laboratory in city after city. Whichever laboratory boasted the lowest cost per test (based on high test volumes) would have emerged as king of the mountain in that region.

For example, in California, **Unilab Corporation** operated laboratories in the state which were acclaimed as having some of the lowest costs per test during the 1995-1998 period.

Yet, despite this cost advantage, it lost several hundred million dollars during those years and did not eliminate such competitors as **Laboratory Corporation of America** or **SmithKline Beecham Clinical Laboratories** from the marketplace.

Maintain Viable Operations

A similar example can be made for New York City and Long Island. All the national laboratories operate high volume routine and esoteric testing centers within a reasonable distance from New York City. Yet, the Big Apple remains an intensely competitive marketplace and independent laboratories continue to maintain viable operations in competition with the three blood brothers.

City after city provides similar examples. Independent laboratories continue to offer stiff competition to national labs, even though their average cost per test is higher than that of the national labs.

So how did this management myth come into being? THE DARK REPORT believes it originated in the fee-for-service system of the 1980s. Two things contributed to the creation of this myth.

First, the advent of sophisticated and increasingly automated test instruments made it much easier to create a laboratory that could test tens of thousands of specimens per night.

Second, fee-for-service reimbursement placed a non-discounted "retail" price on individual tests. If, for example, a 12-test chemistry panel was reimbursed at $20, then the amount of profit earned by the laboratory was directly proportional to its cost per test.

If a cost per test was $10, then a $20 chem panel would generate $10 in profit for the lab. But if the cost per test was only $5, then the lab could earn $15 on the same test.

Here then, was the rational economic incentive for lab executives to drive cost per test down to its lowest possible level. In the fee-for-service world, every penny shaved off the cost per test was an extra penny of profit for the laboratory.

Acquisition Frenzy

It was this combination of economics which fueled the laboratory acquisition frenzy of the late 1980s and early 1990s. Buy someone else's laboratory. Consolidate their specimens into your lab and lower your cost per test. That increases your profit on *all* specimens reimbursed by fee-for-service plans.

This type of business strategy was rational for that type of healthcare system. Commercial laboratories booked record profits during those years and were the darlings of the investment community.

But all was never well with the lab industry's client service performance. When lab A bought lab B and consolidated its specimens into the core lab, it often lost 10%, 20%, 50% or more of those acquired client accounts within 12 months. Because profits were ample even after such levels of client turnover, no one paid much attention to this phenomena.

That is why the management myth that says "lowest cost per test equals unbeatable competitive advantage" is misleading. It is rooted in the fee-for-service economics of the 1980s.

Competitive success in the lab industry remains linked to the level of service provided by a laboratory to its physician clients. Physicians, and even many managed care plans, will take a higher cost per test if they perceive that the laboratory services that come with it are superior to competing laboratories.

MANAGEMENT MYTH #2

Bidding for additional specimens using marginal cost pricing is a viable business strategy.

IT IS LOGICAL TO FOLLOW management myth number one with our management myth number two. Probably the most crippling financial decision ever made by laboratory executives during the early 1990s was their willingness to bid for managed care contracts using a marginal cost pricing scheme.

Why did lab executives believe this was a good strategy at the time? Because their laboratories had excess capacity. At the enterprise level, it seemed like a sensible thing to bid for specimens currently going to a competitor by pricing that work based on the direct cost of testing.

If the contract was won, the incremental work would fill up unused lab capacity and help lower the overall cost per test for all specimens in the laboratory. Further, it was believed there was the opportunity to get pull-through business as a result of getting that managed care contract. *(For more on this, see Management Myth #3).*

Crushing Financial Pain

Time alone has proved that bidding for additional specimens to fill the unused capacity of laboratory *is not* a viable business strategy! During the past five years, all classes of laboratories, from national labs to independents to hospital labs, have endured crushing financial pain from the managed care reimbursement levels established by laboratory testing bidders in the late 1980s and early 1990s.

It should be added that one factor compounded the already bad decision to use marginal cost pricing to acquire managed care contracts during these years. THE DARK REPORT was first to identify and describe how lab industry

overcapacity was responsible for causing below-cost bidding strategies.

In every city, there was much more laboratory capacity than there were specimens to fill that capacity. Thus, again at the enterprise level, it was rational for lab executives to decide to bid for specimens currently tested at competing laboratories by using a "below marginal cost" pricing scheme.

Utilize Laboratory Capacity

Capturing these additional specimens could contribute to better utilization of the laboratory's capacity. Pull-through specimens at fee-for-service reimbursement would hopefully generate enough income so that the lab could at least recover costs on the full mix of incremental tests.

How far below the marginal cost of testing were labs willing to bid? An example from the editor's experience at **Nichols Institute** provides a perfect example. At the beginning of 1994, a two-year contract covering 5,000 lives came up for renewal in Southern California. Since the Nichols lab already had the contract, actual utilization data was available. The IPA indicated it wanted to move the contract from fee-for-service to capitation.

Remarkable Difference

When Nichols ran the numbers, the revenue difference was remarkable. Under fee-for-service, Nichols had averaged $3.80 per member per month (PMPM). The IPA was looking for a 60¢ cap rate. Whereas this lab testing contract had generated $230,000 in fee-for-service reimbursement during 1993, at a 60¢ cap rate, it would generate only $36,000 for all of 1994.

This example illustrates how much money laboratories denied themselves when they deliberately bid for these contracts using a below-cost strategy. As if the 60¢ example was not enough, Nichols Institute lost a contract that same year when Unilab bid 22¢ PMPM.

Has the lab industry learned its lesson? Not totally. THE DARK REPORT is aware of a recent contract in the Northwest where a well-known laboratory bid 17¢ PMPM to get the work! Folks with knowledge about existing exclusive national HMO lab contracts say that the national labs which won them gave away significant price concessions for the privilege of exclusive provider status.

For these reasons, Management Myth #2 remains alive and well, flourishing despite an almost ten-year history that should have taught laboratory executives otherwise.

MANAGEMENT MYTH #3

Getting a managed care contract guarantees that pull-through business will follow.

THIS IS ONE OF OUR FAVORITE laboratory industry management myths. It was probably foisted onto administration by sales reps who wanted easy entree to the doctors's offices.

Myth #3 is closely linked to Myth #2. It was a common belief among laboratory industry executives that, by winning the big managed care contract in the area, doctors would be more inclined to use their lab for 100% of their testing.

It was believed that the lab's preferred relationship with the managed care plan would mean something. It was also believed that no doctor would want to disrupt his office by sending specimens to more than one clinical laboratory. *(See Management Myth #4.)*

There are still laboratory executives who believe that, if their lab can get the managed care contract, doctors involved in that insurance plan will refer them the Medicare and fee-for-service specimens as well.

That is wishful thinking. In its travels, THE DARK REPORT regularly queries the sales and marketing managers who

participated in bidding and working these managed care contracts throughout the 1990s.

Seldom do any of these lab sales veterans admit that winning the managed care contract actually caused all the docs to immediately steer their fee-for-service work to the winning laboratory.

To the contrary, most relate a far different experience. Once a managed care contract was won, it took six to nine months of diligent sales effort to capture the fee-for-service work from a portion of the physician offices. Typically, we are told that the winning lab never got more than between 5% and 20% of potential pull-through, even after that kind of intensive sales effort.

Were there pull-through successes? Certainly. But they seem noteworthy precisely because they happened so seldom. In the real world, winning the managed care contract did not unleash a flood of pull-through work for the lucky laboratory. To the contrary, it had to spend months, lots of money, and expend lots of sales effort to capture only meager amounts of the potential pull-through testing business.

Common Thread

These first three management myths for the lab industry are definitely linked. The common thread among them is that filling unused laboratory capacity with more specimens would be beneficial.

In other words, just to have a flow of increased specimens would trigger a variety of benefits for the lucky laboratory. Obviously, the actual experience of the collective laboratory industry during the 1990s demonstrates that the wisdom in these precepts was misleading at best, and financially corrosive at worst.

The more challenging question is whether current managers in your own laboratory still use these management myths to justify their position on various management options under consideration. The 17¢ cap rate recently bid in the Northwest proves there are still lab executives who continue to use these strategies in today's laboratory marketplace.

As reimbursement for laboratory testing continues to decline below even today's levels, it becomes imperative that laboratory administrators and pathologists make well-informed decisions about their laboratory's direction.

The margin for error continues to shrink. If a laboratory administrator bets on the wrong business strategy, the result is now a rapid descent into bankruptcy or acquisition of the lab by financially stronger hands.

Do these first three management myths teach us any lessons? Certainly the one important lesson which jumps out is that there is no substitute for offering a client top quality service.

Cutting draw stations, eliminating stat labs, and reducing client service people may reduce cost in the short term, but it certainly encourages clients to take their testing business to a better-performing laboratory in the long run. TDR

(For further information, contact Robert Michel at 503-699-0616.)

Have You Got Other Myths?

Each issue of THE DARK REPORT always contains collective wisdom and experiences from clients and readers throughout the country.

Readers are invited to contribute their own management myths about the laboratory industry. Contributions can be sent directly via: email–labletter@aol.com or fax–503.699.0969.

These management myths should represent the popular wisdom and current thinking of most laboratorians, whether accurate or not.

The Dark Index

Quest Diagnostics and LabCorp Face an Evolving Marketplace

Companies emphasizing different strategies to rebuild financial stability, generate profits

TWO OF THE THREE BLOOD BROTHERS reported continued improvement in their financial condition as second quarter earnings reports were made public.

This news, however, was overshadowed by speculation about the failure of **Quest Diagnostics Incorporated** to consummate its purchase of **SmithKline Beecham Clinical Laboratories** (SBCL) during the month of July.

Quest Diagnostics and **Laboratory Corporation of America** both released second quarter earnings. **SmithKline Beecham, PLC** did not disclose the performance of its laboratory unit for second quarter 1999, noting that its sale (to Quest) was imminent.

At LabCorp, there was an increase in both specimen volume and revenue per accession. Quarterly revenues were $429.5 million, with operating income of $42.1 million. Compared to second quarter 1998, this was an increase of 6.7% and 5.7%, respectively.

Sales Efforts Having Impact

LabCorp reported that prices increased 2.3% and specimen volume grew by 4.4% for the quarter. These numbers demonstrate that the company's sales efforts are having some impact in the marketplace.

According to LabCorp President and CEO Thomas P. Mac Mahon, growth in specialty testing was a major factor in the sales and revenue performance of LabCorp.

In contrast to LabCorp's 4.4% growth in specimen volume for the quarter, Quest Diagnostics saw specimen volume decline by 3.9%, while average revenue per requisition jumped a hefty 7.6% over second quarter 1998.

Using The 80/20 Rule

As noted earlier in THE DARK REPORT, Quest Diagnostics has aggressively used the 80/20 Rule to purge money-losing accounts in recent years. (*See TDR, June 2, 1997.*) Consequently, it is making more money while testing fewer specimens.

Quest Diagnostics reported sales of $394.0 million and operating income of $24.5 million. It is consolidating the revenues and expenses of its QuestNet lab network management service into total corporate results. Thus, third party test costs are included in this number.

QuestNet's primary contract is with **Oxford Health Plans, Inc.**, a major managed care player in the Northeast. *(See TDR, January 11, 1999.)* Quest Diagnostics has a strong market presence in the states served by Oxford.

With every quarter, effects from the distinct business strategies followed by Quest Diagnostics and LabCorp become more apparent. Each company has a different management challenge driving its particular market strategy.

LabCorp's most pressing need is to generate cash flow to service its sizeable debt burden and make dividend payments to preferred stockholders. For that reason, it is assertively pursuing new

Quest Diagnostics Announces That SBCL Acquisition To Close Within Next Two Weeks

As this issue of THE DARK REPORT went to press today, Quest Diagnostics Incorporated announced that it had come to terms with SmithKline Beecham, PLC (SB) on its pending acquisition of SmithKline Beecham Clinical Laboratories (SBCL).

In a press released dated August 9, Quest Diagnostics' Chairman and CEO Kenneth W. Freeman declared "now that all contracts have been finalized, we are planning an orderly closing."

Quest Diagnostics believes the transaction will occur within two weeks. This would mean a closing between now and August 23.

It was disagreement over terms of access by SB to Quest's laboratory data which kept both companies from finalizing the acquisition on July 2, as originally scheduled. That negotiating point was resolved by the a new side agreement between both companies.

SmithKline Beecham, PLC has been granted "certain non-exclusive rights" to use Quest's proprietary laboratory information database. SB will also form a company to sell healthcare information products through channels such as the Internet. Quest Diagnostics will hold a minority interest in this company.

With this announcement, it appears that Quest Diagnostics will finally claim its prize. Once it takes title to SBCL, it faces a daunting task to integrate the two laboratory companies into a common management culture without negative impact on clients of the two companies.

sales volume. At the same time, LabCorp wants to move test prices upwards as much as possible. Both strategies work to increase cash flow and operating profits for the company.

Seeks Profitable Business

In contrast to LabCorp, Quest Diagnostics has a relatively clean balance sheet, with modest debt. Quest Diagnostics seeks to increase operating profits and net earnings. Thus, it is focusing on "profitable" business.

That means Quest Diagnostics evaluates each new account based on whether or not it meets specific profit targets. The company is not interested in new accounts where the cost to service that account does not leave a sufficient profit margin for Quest.

Like LabCorp, Quest Diagnostics is also pushing for higher prices. This difference in corporate business strategies explains why revenues are up at both companies, but LabCorp's specimen volume is growing while Quest's specimen volume is shrinking.

Hospital laboratory administrators and competing laboratories see the impact of these different corporate strategies in their regional markets. On one hand, the three national laboratories have achieved a financial stability unseen during the last five years. The extreme "crises management" mind set of earlier years has faded into the background, replaced by a focus on positive, growth-oriented business planning.

However, this increased stability does not mean that national laboratories will become the competitive steamrollers they were during the first half of the 1990s. None of the three

national laboratories has the capability, nor the clout, to enter a regional market and push out competing laboratories they way they did for many years.

For example, as mentioned earlier, LabCorp is burdened with debt and preferred stock. Interest payments and preferred dividends siphon off considerable cash each quarter. It also doesn't have much net worth or cash.

Prevent Consolidation

These facts prevent LabCorp's management from consolidating redundant laboratory facilities. It continues to operate a national system of laboratories made up of individual sites from the pre-merger **National Health Laboratories** and **Roche Biomedical Laboratories**.

Billing and collections continues to be a major management priority at LabCorp. The separate billing systems have never been fully integrated and standardized. Since 1995, this situation has created a number of problems. Among them, LabCorp is hindered from offering a more sophisticated data management package to managed care companies.

These and other reasons have caused LabCorp to focus its growth strategy on better sales and marketing of clinical testing, hospital alliances, and development of specialty testing. Specialty assays, such as viral load testing, seem to be the fastest-growing and most profitable result of this strategy to date.

Specific Market Segments

At Quest Diagnostics, the possible acquisition of SBCL has dominated management's attention since early in the year. But ongoing business development priorities continue. In contrast to LabCorp's emphasis on boosting both specimen volume and pricing, Quest Diagnostics has targeted specific market segments for growth.

Clients and readers of THE DARK REPORT are familiar with the Quest/**Premier** alliance. *(See TDR, May 26 and June 15, 1998.)* This is a long-term initiative that will take several years to produce significant revenues and profits. But it is consistent with Quest's stated intention to develop close partnerships with hospital systems.

Quest Diagnostics' relationship with University of **Pittsburgh Medical Center** and **John Hopkins University Medical Center** are other examples of this alliance strategy. Because each is a center of influence, Quest hopes these partnerships lead to a worthwhile market position over time.

Meanwhile, even as LabCorp, Quest Diagnostics, and SBCL work to increase their market share, hospital laboratory outreach programs and regional commercial laboratory competitors are steadily capturing profitable chunks of local markets.

Lab Outreach Successes

Few hospital laboratory administrators comprehend the widespread successes that hospital lab outreach programs are achieving. The experience of **West Hills Hospital and Medical Center** (*See pages 2-7*) in California is a prime example. Hospital laboratories which launch a professionally designed and managed outreach program are enjoying much success in cities around the United States.

This growing movement towards hospital laboratory outreach programs is a competitive dynamic that national laboratories find unfamiliar—and unpleasant to compete against.

Whether or not the merger occurs between Quest Diagnostics and SBCL, the national labs are finding tougher competition in city after city now, as both hospital labs and independent labs learn more effective ways to sell their services to office-based physicians. **TDR**

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

Contrast the double digit premium increases demanded by HMOs for 1999 and 2000 with the recent Medicare announcement. Medicare will add 1.1% to hospital payments for overnight stays as this year's inflation adjustment. With annual inflation under 2%, it certainly causes one to wonder what HMOs really do with their premium dollars.

It seems to be resurrection time for ex-**National Health Laboratory** (NHL) executives. First, Tim Brodnick surfaced at **American Medical Labs** in Chantilly, Virginia. Next, Bert Koch joined **Dynacare Inc.** in Dallas, Texas. The latest ex-NHL exec to land a plum position may be Bob Whalen. Grapevine chatter says Whalen is slated to become the new President of **Unilab Corporation** in Tarzana, California later this year. **Kelso & Company** is purchasing Unilab and intends to take it private. *(See TDR, June 7, 1999.)* Sources say Whalen would become its President and Unilab's current CEO, David Weavil, will assume a different role at the lab.

PULSED-LIGHT CAN INACTIVATE VIRUSES IN BLOOD PRODUCTS

Maxwell Technologies, Inc. of San Diego, California announced that its pulsed-light technology inactivates viruses that can contaminate blood products and biopharmaceuticals. It works on blood plasma products, but not whole blood. The white pulsed-light process has "inactivated every virus we have tested it against without the assistance of chemicals or any other treatment," said Tom Horgan, Maxwell's CEO. Further testing is needed to identify whether or not there are aftereffects on relevant proteins or other molecules. The technology is at least two years away from commercialization.

Laboratory executives and pathologists should make the effort to get a copy of the upcoming August issue of *CAP Today*. It features a story on the current status of total laboratory automation (TLA) and includes some fascinating comments by individuals very close to the truths about TLA. It does what *CAP Today* does best—offer statements and observations by the entire spectrum of experts on the subject. A careful reading of the "safe" statements quoted in the article hint at a very different perspective on TLA's effectiveness to date than publicly declared by its most ardent advocates.

ADD TO...TLA

CAP Today's TLA story provides useful insights into the experience and capabilities of upcoming TLA technology. To add spice to the public debate, THE DARK REPORT hopes to follow up *CAP Today* with its own survey of TLA advocates and operators. The question is: who will talk candidly on the public record? Stay tuned, because it's sure to be informative!

Dynacare, Inc. officially announced the creation of a strategic laboratory partnership with the **University Health System, Inc.** of Knoxville, Tennessee. The partnership will operate the lab at the **University of Tennessee Medical Center** and intends to launch an outreach sales program into East Tennessee, Virginia, and Kentucky.

That's all the insider intelligence for this report. Look for the next briefing on Monday, August 30, 1999

THE DARK REPORT

UPCOMING...

- *Industry Experts Take a Fresh Look at Total Laboratory Automation (TLA).*
- *Surprising New Managed Care Contract Strategies Boost Hospital Laboratories.*
- *Pathology PPMs Dead in Today's Market as Regional Consolidation Gathers Steam.*
- *Point-of-Care Technology Moves Forward and Prepares to Transform Clinical Labs.*