Achieving Maximum Gains in 4\textsuperscript{th} and 5\textsuperscript{th} Generation Multi-Hospital Laboratory Consolidations

Management Master Class—Executive War College—2011

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Overview of this Management Master Session

- Why is there a renewed interest in hospital-based laboratory consolidations?
- What’s different about laboratory consolidation or consolidation optimization today versus the 1990s?
- If you are called to the table to participate in hospital-based laboratory consolidation, what’s worth fighting for, what are the pitfalls, and what are the opportunities?
- What should the model look like in an era of major healthcare reform and why? What about the models from the 1990s?
- What are the big pockets of financial gains? How painful is it to realize them?
- What are the three elements of a consolidation business case? Why should you be concerned about them?
- What are the six major enablers in 2010s that make hospital-laboratory consolidations easier?
- What are the key elements required for maximum gains in 4th and 5th generation hospital-laboratory integrations?
Purpose of this Management Master Class

- To update managerial thinking about the best approaches to maximize integration success.

Contribution Margin

Cost Profile
Why is there a renewed interest in hospital-laboratory consolidations?  

**Expense Reduction!!!!**

<table>
<thead>
<tr>
<th>Healthcare Reform:</th>
<th>Economy:</th>
<th>New Strategic Directions:</th>
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<tbody>
<tr>
<td>Accountable Care Organizations &amp; Payment Reform</td>
<td>Growing Ranks Of Uninsured Growth In Demand--Baby Boomers Retiring &amp; Medicaid Is Expanding Federal And State Deficits</td>
<td>Patient-centric Care Outcome-based Reimbursement Physician Integration Cost Reduction Focused</td>
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1) Arkansas/St. Vincent's: Create market relevance by entering into pilot programs with payers with a focus on risk-sharing, bundled payments, medical homes, and other future skill sets.

2) Colorado/Centura: Outreach to rural communities coupled with the formation of new models of care delivery involving creative approaches of physician integration.

3) Ohio/Cleveland Clinic: Establish efficient and effective care by moving from paying for service to paying for quality.

4) California/UCLA: Patient centric care—the way to survive the perfect storm of healthcare reform.

5) Iowa/Iowa Health: Improve quality of care through innovation in delivery and cost efficiencies.

6) Florida/Florida Hospital: Tightening alignment with physicians and use the hospitalist model to improve and strengthen patient outcomes and financial results.

7) Detroit/Henry Ford: Relentless focus on seven pillars performance—people, quality, patient safety, service, growth, academics, community, and financials.

8) Florida/Orlando Health: Integrating a patient-first model of care throughout the organization.

9) Boston/Mass General: Strive for affordable care by focusing on reducing the cost of a unit of care.

10) Pennsylvania/Geisinger: Will work with a number of health care systems across the country to attempt to infuse their innovative methodology into different sociologies and markets.

11) Ohio/Summa: Playing a leading role in the development of an accountable care organization that will be launched locally and nationally, through the Premier Organization.

12) California/Scripps: Focused on successfully implementing a new horizontal co-management structure that improves patient care, cuts costs and ensures employment for staff.

Biggest Challenges

- Avoid penalties for patient infections: 41%
- Hire primary care physicians: 46%
- Avoid penalties for patient readmissions: 61%
- Obtain stimulus law funding for EHR system: 62%
- Develop integrated information systems with physicians: 65%
- Align more closely with physicians: 72%
- Reduce Operating Costs: 86%
1. Lower reimbursement,
2. RAC’s gather momentum,
3. More uncompensated care,
4. Political gridlock,
5. Uncertain fate of healthcare reform,
6. Anticipated ACO rules may open the floodgates,
7. Greater focus on experimentation,
8. States will continue to cut Medicaid spending,
9. Healthcare IT funding will start--$30 to $40 billion will be distributed to hospitals, physicians and other providers,
10. More hospital consolidations likely.

10 Key Trends for Hospitals in 2011, by Leigh Page, November 22, 2010, Becker’s Hospital Review.
Top Three Issues per the American College of Healthcare Executive--2009

1. Financial Challenges (n-393)—Specific concerns:

- Medicaid reimbursement 87%
- Bad Debt 80%
- Medicare reimbursement 78%
- Increasing cost of staff, supplies, etc. 72%
- Inadequate funding for capital improvements 64%
- Managed care payments 47%
- Other commercial insurance reimbursement 46%
- Revenue cycle management (converting AR to cash) 45%
- Emergency department 43%
- Competition from specialty hospitals 25%
- Other 10%

Press release from American College of Healthcare Executives, January 11, 2010
Top Three Issues per the American College of Healthcare Executives--2009

2. Healthcare Reform Implications (n=275)

- Reduced reimbursement as a result of:
  - Reduction in Medicare reimbursement 91%
  - “Public Option” 83%
  - Bundling payments instead of fee for service 80%
  - Tax on “Cadillac” type plans 25%
  - Other 10%

- Increased demand for services such as
  - Queues for emergency services 46%
  - Queues for preventative care like mammography 29%
  - Access to primary care 5%
  - Other 2%

- Reduced quality of care
  - Less innovation in diagnosis & treatment 40%
  - Standardized “cookbook” medical protocols 35%
  - Other 9%
Top Three Issues per the American College of Healthcare Executive--2009

3. Care for the Uninsured (n=187)

- Medicaid
  - Medicaid 91%
- Advocacy for funding
  - Advocacy for funding 79%
- Underwriting cost
  - Underwriting cost 61%
- Reaching out to all community members
  - Reaching out to all community members 34%
- Response to other hospital closures
  - Response to other hospital closures 11%
- Increasing numbers (all written-in responses)
  - Increasing numbers (all written-in responses) 6%
- Emergency department overuse
  - Emergency department overuse 5%
- Other
  - Other 3%

Press release from American College of Healthcare Executives, January 11, 2010
Laboratory Consolidations

**1990s**

- Major focus:
  1. Drive economies of scale
  2. Labor reductions
  3. Reagent savings
  4. Supply savings
  5. Benchmarking
  6. Equipment standardization
  7. Routine, non-time dependent and esoteric test transfers to core
  8. Rapid response labs
  9. Internal silo structure
  10. Reference test insourcing

**2010s**

- Major focus:
  1. Drive out waste to drive out costs
  2. Lean labor planning, retention & attrition
  3. Reagent savings
  4. Supply savings
  5. TPS and Lean management
  6. Acute care hospital menu design
  7. Esoterics transferred to core
  8. Acute care hospital laboratories—no RRLs
  9. Automated lean work cells—silos
  10. Manage utilization and referrals
  11. Standardize everything
Models – Early Adopters in the 1990s

- On-site Hospital-based core laboratory
- Off-site core laboratory
- Esoteric centers
Model for 2010s

Point-of-Care Testing: Patient Service Center, Physician Offices, Bedside, etc

Acute Care Hospital Laboratories

High-volume Automated Centers

Esoteric Core: Molecular Dx Genetics Companion diagnostics & therapeutics
If you are called to the table to participate in a laboratory consolidation, what’s worth fighting for, what are the pitfalls, and what are the opportunities?

**Fight for:**
1. The best menu for your customer base
2. Funding for Lean transformation
3. Renovation dollars

**Pitfalls:**
1. Resistance to change
2. Politics driving strategy
3. Menus based on priority of test order
4. Slow, ineffective implementation

**Opportunities:**
1. Highly organized, stable work environments
2. Ability to take on growth without adding labor
3. A bigger job with new accountabilities and responsibilities
Big Pockets of Financial Gain

Reference Testing
- Insourcing
- Contract Renegotiation

Test Utilization
- Practice Guidelines
- Referrals

Equipment & Reagents
- GPOs
- Standardization on Vendor

Labor
- Benchmarking
- Lean Labor Planning
**Case Study—Source of Integration Gains--2007**

Integration benefits account for 82% of the improvement vs. Status Quo.

- Insourced reference testing accounts for 38% of this gain.
- Supply unit cost reductions resulted from using GPO pricing (or better) and conversion to common test platforms.

<table>
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<tr>
<th>Source of Benefit</th>
<th>% Total</th>
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<tr>
<td>Amended SQ Productivity Improvements</td>
<td>18%</td>
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<tr>
<td>Integration Related</td>
<td></td>
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<tr>
<td>Insourcing of Reference Tests</td>
<td>38%</td>
</tr>
<tr>
<td>Insourced Billing of Outreach</td>
<td>3%</td>
</tr>
<tr>
<td>Efficiencies from Test Transfers</td>
<td>13%</td>
</tr>
<tr>
<td>Supplies Unit Cost Reduction</td>
<td>22%</td>
</tr>
<tr>
<td>Reference Test Contract Renegotiation</td>
<td>5%</td>
</tr>
<tr>
<td>Total Integration Benefit</td>
<td>82%</td>
</tr>
<tr>
<td>Total Gain vs. SQ</td>
<td>100%</td>
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1 determined without phase-in assumptions
Case Study: Analysis of Actual Saving Compared to SS&A Integration Plan

- Sprick, Stegall Year 1 Savings Estimate
- Actual Year 1 Savings

![Graph showing savings comparison between Sprick, Stegall Year 1 Savings Estimate and Actual Year 1 Savings. The categories include Supplies, Sendouts, Labor, Additional Support/Admin Expenses, Other, and Total First Year Savings. The savings range from negative $1,800,000 to positive $3,700,000.]
Three Elements of a Consolidation Business Case

A Savings Differential Analysis

**Current State**
- Direct Costs
- Volumes and FTEs

What are my combined baseline costs?

**Amended State**
- Benchmarking and/or Process Improvement

What is the savings potential at this step?

**Consolidated Future State**

What is the savings potential at this step?
An Incremental Approach

CURRENT STATE
- Staffing
- Test volumes
- Operating Statement

AMENDED STATUS QUO
- Staffing changes without consolidation
- Other process improvements without consolidation

FUTURE STATE
- Staffing changes with consolidation
- Consolidate tests to specific locations
- Standardization
- Insourcing
- Group Purchasing
Why Should You Be Concerned About the Three Elements?
Six Enablers for Consolidation in the 2010s

- **Information flow**—orders, results, billing, demographics; gov. dollars; meaningful use
- **Real tools** providing awesome results
- **Automating of value-adding steps**

- **EMRs**
- **Lean 6σ**
- **Automation**

- **Healthcare reform**, significant growth, bad economy, and payment reform
- **Cloud computing**, iPads and other output devices, image management, etc
- **Process mgt.**, complexity automated, smaller footprint, integrated diagnostics, web-connectivity with vendor service.

- **Disruptors**
- **Information Technology**
- **Equipment and Interfaces**
Key Strategies if You Find Yourself Leading a Consolidation Initiative in the 2010 Decade

- Become the low cost producer.
  - Savings from process improvement may far outstrip consolidation savings and lessen the pain considerably.
- Aim for cost savings in the patient care value stream, not necessarily in the laboratory silo.
- Provide the right test, at the right time, at the right place, at the right cost—patient centric care.
- Drive appropriate test utilization.
- In the area of labor, start with benchmarking and optimize with Lean labor planning tools.
- Be passionate about lowering cost while improving quality.
- Use marketplace disruptions to fuel a change environment.