Manager’s Moment
Test Utilization and How It Relates to Healthcare Reform

With all of the changes that relate to Healthcare Reform, the Affordable Care Act (ACA) signed into law in 2010, will result in significant changes to our entire healthcare system. Two items play a major part: 1) health insurance reform and 2) payment models based on the improvement of healthcare performance while reducing costs.

Statistics show that at least 70% of all medical decisions are based on diagnostic laboratory tests but most of us are unsure of how the ACA will affect our own laboratories. However, the expectation will be that reimbursements will continue to decline making it more important than ever to stream-line testing. What steps can laboratories take to enhance the patient care experience, increase laboratory efficiency while decreasing costs and assist the providers in ordering the right test at the right time?

Have you questioned ordering practices after the testing has been completed and found them to be medically unnecessary? One example may be multiple CBC with Diff orders within a 24 hour period. Could a CBC only (without diff) or Hemoglobin/Hematocrit provide the necessary information? What tests are being ordered too frequently? Test utilization is a great place to start. Look for opportunities that produce patient-care focused testing by evaluating your current test menu searching for over-utilized tests, and offering information to providers when they are searching for the “correct” test to assist with the proper diagnosis. Labs will be challenged to be the key player in the collaboration between the provider and laboratory to ensure the right test is being performed at the right time. As more expensive genetic tests become available (currently the fastest growth area, estimated at 15-25%\(^1\)), it is important to find ways to offer real-time ordering assistance to providers. What capabilities can the EMR (Electronic Medical Record) systems provide for offering ordering assistance? Can your system offer “alerts” or other “soft stops” to guide the ordering process? Algorithms are another great tool to offer providers when searching for the correct test. Could they be an addition to your EMR?

These questions and more will be the challenge to work through for offering helpful tools to the providers and patients we serve.  

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Rice started a Blood Management Program in 2014 as a result of studies showing overall improved patient outcomes when blood transfusions are decreased. Gathering the required data proved to be a challenge as most data collected was done using a very manual process. However, with the help of our hospital IT department, we were able to build reports to gain knowledge from our own data. We followed this with necessary education pieces for our ordering providers using catchy slogans offered by the American Red Cross: “Why give 2 when 1 will do?” and “7 the new 9”. We voluntarily enrolled in a Blood Bank utilization reporting group that meets periodically via the web. Dr. Kent Donelan and Dr. Lee Cafferty have been our physician champions and proponents to the medical staff, while Joel Halbritter, Rice Lab Technical Manager has been the key player in gathering and reporting the data to this group. We receive monthly status reports that show our progress. Since January 2016, we have increased the incidents of giving one unit before checking the patient’s hemoglobin by almost 20%. This has resulted in a decrease of transfused units which equates to better patient outcomes and a monetary savings. Be on the look-out for ways that your lab can be a vital player in our ever changing lab world!

Have a wonderful holiday season and Thank You for your continued support! You and your business are all very important to us!

Karen Samuelson, MLS (ASCP) CM
Director of Laboratory Services

1 2016 Mayo Clinic Utilization Management Program, “Utilization Management Background”, Curt Hanson, MD, Mayo Clinic Dr. Kent Donelan has been our physician champion. He is our proponent to the medical staff.

Retirement: When you stop living to work and start working to live!

~Author Unknown

Farewell, I Will Miss My Rice Family!

With mixed feelings, I write my final column for the newsletter. As editor of Reachout, I saw it grow in content and in circulation. When I began working at Rice, outreach didn’t exist. Through the hard work of Junell Petersen and John Thon, the outreach concept was born and matured. I was privileged and thankful to them for being able to become a traveling active part of it in 1995. I was “recruited” to maintain the “Lab Manual for Nursing Personnel” and assist in the revisions for the Outreach Test Catalog which evolved into the current Electronic Test Catalog. I was asked to take over as Quality Assurance Officer for the clinical lab which now includes Path QA and MPC workload statistics. In 1996, with the statement “It is part of client outreach” I started DOT breath alcohol training and DOT urine drug collection training. Being involved with so many worthwhile projects kept me busy, gave me an education that one can only gain by expanding horizons, and enabled me to interact with so many clients and colleagues. These experiences will stay with me forever. I turn these tasks over to the capable hands of Rae Jean Bulthuis and Melissa Bergeson.

I enjoyed each and every task, each and every visit, each and every colleague! Retirement is an adventure to anticipate, and as I take all that you have given me, thank you for having been such a part of me for 24 years! Thank you so much, my Rice Family!

Steph

Rice Laboratory’s donation this past fall was presented to Ridgewater Technical College – Campus Ministry Center. The campus food shelf county outlet was discontinued due to staffing and funding shortages. The Campus Ministry Center exists to serve the Students and Staff of Ridgewater College. They are located across the street from the college and offer a wide variety of activities and programming.
Flu season is upon us. It is the time of year when one scurries to the employee health office to get the flu vaccine both to prevent potential illness and to avoid whatever public shaming tactic has been created to encourage vaccination compliance. Just kidding…like various highly acclaimed pet-training programs, only positive reinforcement is used!

Influenza or the ‘flu’ is a contagious respiratory viral infection that affects the nose, throat and lungs. It affects people of all ages and infection varies greatly in severity ranging from a mild illness to severe illness with complications including death. Typically, young children, pregnant women and older individuals (>65 years old) are at the greatest risk for severe illness. Eighty to 90% of flu-related deaths occur in patients >65-year-old. One of the most effective ways of preventing influenza infection is by vaccination.

The flu vaccine is a killed or an attenuated (weakened) live version of the virus that can’t cause infection in humans but can trick the body into thinking it is infected so the immune system produces antibodies against the influenza virus. Though there are innumerable types of influenza viruses that are constantly changing and mutating, the vaccine is only made up of 3 or 4 types of influenza viruses. The types of influenza viruses that compose the vaccine of determined by infection experts from the World Health Organization the prior year. They use epidemiologic surveillance data to provide their best guess at which types of influenza will spread cause the most disease the following year. Then they select vaccine viruses that are similar to those selected viruses predicted to spread. Sometimes the antigenic match between the produced vaccine virus and the actual virus isn’t close enough. In this case, the antibodies that the vaccine encouraged patients to produce are not effected in fighting off the actual flu virus. Unfortunately, if this happens another batch of vaccine cannot be manufactured for the current year as it takes approximately 6 month to make a large quantity of vaccine.

There are a few things that have changed regarding the flu vaccine this year. First, the intranasal flu vaccine (FluMist) which is a live, attenuated vaccine is not recommended this year. Data from the last few years has shown that it does not appear to be as effective as the injectable form. The reason for this is currently unknown. There is also a new vaccine available for people over the age of 65. Fluvax contains a standard amount of antigen, but also contains an additive called MF59 that produces a more robust immune response than the regular flu vaccine. An older high-dose vaccine (Fluzone) that also produces a stronger immune response is also still available. These immune boosting features are important in older people because as humans age, our immune systems become less vigorous.

Lastly, recommendations for people with egg allergies receiving the flu vaccine have changed. Since most vaccines are made by growing inactivated virus in chicken eggs, there was always a concern that people with egg allergies would be at risk for developing an allergic reaction to the vaccine. However, studies have shown that severe egg allergies caused by the flu vaccine are unlikely and the CDC is no longer recommending that people with egg allergies be observed for thirty minutes after vaccination. The CDC now recommends that the presence of a health care provider in a medical setting is only necessary during vaccination for those with a severe egg allergy (not hives). Alternatively, there is a recombinant, trivalent, injectable vaccine that is egg-free (Flublok) because it is not made using chicken eggs.

If you if you haven’t gotten your flu vaccine already, it’s not too late. There are still a few candies left in the bowl. Now go get yourself a treat. Good Dog.

Leah Dvorak, MD
Minnesota Pathologists Chartered

"Now go get yourself a treat. Good Dog!"
Calibration verification (cal ver) is defined by CLIA as testing materials of known concentration in the same manner as patient specimens to assure the test system is accurately measuring samples throughout the reportable range. I have received many questions on this lately so am doing a quick review of the facts.

1) Calibration verification is NOT needed for manual tests, microscopic procedures, coagulation testing, qualitative tests, microbiology, or automated hematology analyzers.

2) Calibration verification IS needed for all other non-waived analytes. Some commonly missed analytes include microalbumin testing on the DCA or Afinion and non-waived testing on the Triage analyzer (D-dimer).

3) Chemistry testing that includes a three-point calibration that spans the low, mid, and high end of the reportable range does not need additional calibration verification.

4) Performing quality control using three levels of chemistry controls qualifies as cal ver ONLY if they are run more than once each day and they span the entire reportable range.

5) There is no requirement for specific calibration material, in some cases previously analyzed or proficiency testing material could be used for calibration verification but make sure that they span the entire reportable range. You can also dilute a high patient analyte and it would be acceptable if it covers the reportable range of that analyte.

6) CLIA only requires three levels for calibration verification: low and high ends of the reportable range and something mid-range. More levels are certainly acceptable but not required as long as the three levels demonstrate linearity and verify the upper and lower ends of the reportable range.

7) CLIA requires calibration verification every six months or as required by the instrument manufacturer. It is always better to err on the side of doing the cal ver sooner rather than too late.

On another subject, many of you already know that Stephanie Sjoberg is retiring in January 2017. I would like to thank her for all her help through the past years with consulting visits and all the times she stepped in to help. We all wish Steph a very happy and relaxing retirement!
Histology/Cytology/Microbiology/Molecular Relocate– Second Floor Lab

On July 18 moving crews assembled and relocated Histo and Cyto labs to the second floor above the main core clinical lab. Aside from a few minor mishaps, the move went smoothly. Microbiology and molecular followed on July 25, again with few unexpected glitches. There was no “downtime” nor any significant delay in processing!

As with any relocation, some “taken for granted” tasks and actions had to be reassessed and changed to accommodate the distance. A dumbwaiter was installed to allow easy transport of materials and samples between the floors. (No, we are not allowed to transport staff! ) Use of Harvest messaging became a necessary tool in communication! In some respects we are still tweaking processes.

The space is light filled—“windows” are such an added bonus! Being so much more spacious, it is amazing how we had crammed it all into the old areas, and how those new spaces filled!

“We Adjusted Our Sails!“

On November 21, we hosted an open house for hospital staff. They had a self guided tour of the space and cookies!

“"The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails."
- William Arthur Ward

Electronic Only:
Do you wish to receive REACHOUT? Please submit your email address to: rjb@rice.willmar.mn.us
Staff Development—Client Services 3

In mid-August, the Client Services 3 position was created with the purpose to streamline and aid in the process of sending out and receiving case materials for various reasons. Pat Mikkelson MLS (ASCP) and Kristi Bobzien MLT (ASCP) were named as our CS3 techs. The pathology send-outs include referral testing, case material patient referrals and expert consultations. Requests for common referral testing include: Immunohistochemical (IHC)/special stains, molecular/genetic testing, flow cytometry, renal biopsy, muscle/nerve biopsies and other pertinent testing deemed necessary to the interpretations. Case material may also be requested by the patient to be delivered to another healthcare organization or provider. Expert consultations occur when our pathologists want to consult with another pathologist at another institution to obtain their expert opinion on a case. The majority of referral testing and expert consultations go to Mayo Medical Laboratories, but other laboratories are also used dependent on the case source and location of the expert or specialist in that area of care.

The duties and organization of the CS3 tasks are a job description in process. As needs of the department are determined or develop, the job will change to accommodate that demand.

Rice Laboratory TEST CHANGES

Please Refer to Rice Lab/Mayo electronic test catalog for ordering specifics. http://ricelab.testcatalog.org/catalogs/114/edit  The EPIC LAB02 codes are now in the catalog. Changes are in bold print below.

Anion Gap: Effective 12/6/2016 the NEW reference range will be 10-17

MMRV– Immune Status Profile: Measles (Rubeola) Ab, IgG – 86765, Mumps Ab, IgG – 86735, Rubella Ab, IgG – 86762, Varicella-zoster Ab, IgG - 86787 Processed M/W/F, Specimen Required- 0.5 mL serum, refrigerated

MENINGITIS/ENCEPHALITIS CSF PANEL: BioFire Film Array™ Specimen required: 0.5 mL (0.3 mL minimum) CSF, refrigerated.

Mayo Test Code Changes, Effective Date:
Aug 23
MYASTHENIA GRAVIS (MG) EVALUATION, ADULT (MGA1)
Aug 23 - MGETH/83372 Myasthenia Gravis (MG) Evaluation, Thymoma (MGT1)
Aug 23 - NMOCS Obsolete: NEUROMYELITIS OPTICA (NMO)/AQUAPORIN-4 -IGG FLUORESCENCE ACTIVATED CELL SORTING (FACS) ASSAY, SERUM (NMOFS)
Sept 1 - PRENATAL ZIKA AND DENGUE VIRUS PANEL, IgM, SERUM (MZIKP):  CPT: PMZIK-86790, PMDEN-86790, Specimen Required— 3.0 mL Serum, refrigerated. Processed M/T/W/Th
Sept 6- NTX-TELOPEPTIDE, URINE (NTXPR ), Specimen Required: 4.0 mL second morning void, Frozen
Sept 15 - ZIKA VIRUS REAL-TIME RT-PCR, SERUM (FZIKS), Specimen required— 2.0 mL Serum, Refrigerated. CPT-87798, Processed Mon-Sat.
Sept 15- ZIKA VIRUS REAL-TIME RT-PCR, URINE (FZIKU), Specimen Required— 2.0 mL Urine, Refrigerated. CPT-87798, Processed Mon-Sat.
Sept 16- CERULOPLASMIN (FCERU)
Oct 26 - TICK-BORNE PANEL, MOLECULAR DETECTION, PCR, BLOOD (TKPNL), Specimen required: 1.0 mL EDTA whole blood, refrigerated CPT 87798 x6, Processed Mon-Sat
Nov 3- THYROID-STIMULATING IMMUNOGLOBULIN (TSI), SERUM, Transport temp change– Frozen

Staff Development—Client Services 3

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<th>Year</th>
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Our lab Christmas Party was held December 2 at the Willmar KEC. We enjoyed a delicious buffet meal, games, prize drawings and bowling and of course, socializing outside the workplace!

Cellophane Ball Game—each team member took turns at unwrapping the ball. Gloves were a must! Any unwrapped surprises were the property of the unwrapper!
The American Red Cross has a critical need for blood and platelet donations now and throughout the holiday season. While people gather with family and friends to celebrate the holidays, patients may spend them in a hospital room and need blood and platelets. The need for blood doesn’t break for the holidays – it is constant. But right now, blood and platelets are being sent to hospitals as fast as they are received. With many regular donors traveling or busy for the holidays, new and repeat donors are critically needed to build and maintain a sufficient supply. To encourage donations, all those who come to donate Dec. 22, 2016, through Jan. 8, 2017, will receive a long-sleeved Red Cross T-shirt, while supplies last.

“Many of us celebrate this time of year with loved ones, but patients may spend the holidays and ring in the new year from a hospital room,” said Sue Thesenga of the Red Cross North Central Blood Services Region. “Blood and platelet donors can bring joy to patients and their families by giving blood or platelets to help ensure patients receive the lifesaving treatments they need.”

Donors of all blood types are urged to make an appointment to give as soon as possible by downloading the Blood Donor App, visiting redcrossblood.org or calling 1-800-RED CROSS. Donors are encouraged to make appointments and complete the RapidPass online health history questionnaire at redcrossblood.org/rapidpass to save time when donating.

“The need for blood doesn’t break for the holidays – it is constant.”