Making the Most of Customer Complaints

By Michael R. O’Leary, M.D., CEO

An article with the same title recently appeared in the Wall Street Journal. It quickly caught my eye since our company prides itself on our excellent customer service. We receive compliments from all sectors of our business: patients, providers, hospitals, and nursing homes, to name a few. I am not naive enough though, to believe that we do not have occasional service lapses. No one and no organization is perfect. That’s not an excuse, it is simply a fact. That is precisely the reason why it is crucial for companies to realize that the way they handle customer complaints is every bit as important as trying to provide great service in the first place. By speaking up when they have not received the service that they expected, our customers provide us with an opportunity to fix problems and restore goodwill. If they didn’t speak up, how would we know that there was a problem?

Customer complaints are a window into the customer’s perception of a company. Experts tell us that virtually all satisfied customers are silent. Many dissatisfied customers are silent as well. Studies reveal that only 1 in 10 customers who want to complain actually do. Those unsatisfied customers that don’t complain to us will complain about us to their families, friends and even strangers. They do not provide us with an opportunity to fix the problem that they see.

Service Recovery

Customers are constantly judging companies for service failures, both large and small, from bug-ridden software to a hamburger served cold. Studies have shown that customers judge the company first on how it handles the problem and then on its willingness to make sure that similar problems don’t happen in the future. Unsatisfied customers are far less forgiving of the latter. Fixing breakdowns in service, commonly referred to as “service recovery,” has an enormous impact on customer satisfaction, repeat business and ultimately on a company’s success and growth.

Customers often want to know, within a reasonable time, not only that their problem has been resolved, but how the failure occurred and what the company is doing to make sure that it doesn’t happen again. Often, a customer’s faith can be restored using this approach. Experts have noted a phenomenon known as a “recovery paradox,” in which customers can be more delighted by a skillful service recovery than they are by service that was failure-free!

However, there is a dangerous flip side to this phenomenon: customers have more tolerance for poor service than for poor service recovery. Experts warn that if a customer experiences a second failure of the same service, there is no recovery strategy that works, and in all likelihood, that customer will be lost forever. Research suggests that after a failed service recovery, what annoys and even angers customers is not that they weren’t satisfied, but that they believe the system remains unchanged and likely to fail again.

You as a Customer Service Rep!

Customer complaints are strictly the purview of customer service personnel, correct? Wrong! Everyone in our company must be involved in the receipt and resolution of complaints. While these may often be a headache, when resolved skillfully and successfully, they can lead to loyal customers.

As to how to handle a complaint first-hand, I found a clever mnemonic at an area hospital – LAST, which stands for: Listen, Apologize, Solve and Thank.

Therefore, the next time someone complains about our service, please sincerely thank them for helping to make our company better!
Hypervirulent *Clostridium difficile* Documented in Syracuse

In the March/April 2008 issue of Lablines, I reported a case of pseudomembranous colitis caused by a hypervirulent strain of *Clostridium difficile* that occurred in a patient at a Utica hospital with a fatal outcome.

At that time, no such cases of infection were documented in the Syracuse area. Regrettably, the situation has changed and this notice serves as an alert that a case of hypervirulent *C. difficile* infection has recently been documented in a hospitalized patient in Syracuse.

The isolate was confirmed as a hypervirulent strain by the New York State Department of Health. Given the extreme potential seriousness of this infectious disease process, the article that I authored previously is being published below in its entirety.

Hypervirulent *Clostridium difficile*

Reprinted from the March/April 2008 issue of Lablines

*Clostridium difficile* is the leading cause of hospital-associated diarrhea in the United States. The pathogenicity of *C. difficile* is associated with the organism’s ability to produce a cytotoxin, called toxin A, and an enterotoxin, called toxin B.

In recent years, several studies have reported that the rate and severity of *C. difficile* associated diarrheal disease is increasing. In part, this increase is thought to be due to the emergence of a more virulent strain of *C. difficile* that is capable of producing increased amount of toxins A and B.

Toxin A and toxin B production in *C. difficile* is regulated by a series of genes, called an operon or, more specifically, the Pathogenicity Locus (PaLoc). Within the PaLoc is a repressor gene which is responsible for “shutting down” or repressing the production of toxins A and B.

A mutant strain of *C. difficile* has emerged with an 18 base pair deletion in this repressor gene which prevents the organisms from shutting down the production of toxins A and B. The presence of this mutation results in the hypersecretion of toxins up to 25 to 30 times the normal amount. This hyperproduction of toxins in this mutant strain is thought to account for more serious disease with higher mortality rates (N.E.J.M. 2005 vol. 53., 2433).

About two months ago, a patient was admitted to an area hospital who died of *C. difficile* pseudomembranous colitis. Because the patient experienced such a rapid decline, her stool sample was submitted to the New York State Department of Health to determine if her disease might be due to this mutant strain. Using molecular methods, the NYSDOH confirmed that the *C. difficile* isolate responsible for this patient’s death produced both toxin A and B and also had the 18 base pair deletion in the repressor gene, called the TcdC gene.

This patient represents the first documented case of infection due to this more virulent strain of *C. difficile* in Central New York. Although treatment of *C. difficile* infection remains the same, physicians and other health care providers should be alert to the possible existence of this hypervirulent strain of *C. difficile* in our community.

KPC - The New Andromeda Strain

In 1969, the recently deceased Michael Crichton of Jurassic Park fame authored a book called *The Andromeda Strain* which told of the invasion of planet earth by a microorganism that caused fatal human infections for which there was no effective antimicrobial treatment.

Nearly 40 years later, this science fiction novel is rapidly becoming a reality as we are confronted with an ever increasing number of highly multi-drug resistant microorganisms that have new and unusual antibiotic resistance mechanisms.

Carbapenemases are one of the most recently described resistance mechanisms that hydrolyze all beta lactamase antibiotics including the carbapenem class (imipenem, ertapenem and meropenem) of antibiotics. This resistance mechanism has been called KPCs (Klebsiella Pneumoniae Carbapenemases) because they were first found in strains of *K. pneumoniae*. Since then, KPC resistance has also been documented in other members of the *Enterobacteriaceae* and *Pseudomonas aeruginosa*.

KPCs are beta lactamases but are different from other beta lactamases because of their wider spectrum of activity and ability to inactivate carbapenem antibiotics. In brief, other beta lactamases are bacterial enzymes that inactivate beta lactam antibiotics. There are well over several hundred beta lactamases that inactivate the beta lactam ring found in the penicillins and most cephalosporins.

Some beta lactamases are capable of inactivating the extended cephalosporins, such as ceftriaxone, ceftazidine, and the monobactam, aztreonam. Because these beta lactamases have an extended spectrum of activity, they are called Extended Spectrum Beta Lactamases or ESBLs. ESBLs are not the same as KPCs. Furthermore, other new beta lactamase resistance mechanisms have been recently described, such as Amp C beta
Compliance Corner
By Nancy Sniffen, Director of Billing and Compliance

Diagnostic Information

Medicare wants providers to know that they should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare may deny payment for a test even though the physician believes it is appropriate if the test does not meet Medicare’s definition of medical necessity.

National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) list specific test CPT codes that are covered, as well as the ICD-9 codes (diagnosis codes), for which Medicare will cover those tests when they are reasonable and necessary for the diagnosis or treatment of the ICD-9 codes listed.

ICD-9 codes which support medical necessity must be included on the laboratory requisition form. The diagnosis must be present on the form for the procedure to be paid. Without appropriate diagnostic information when ordering a test not only helps us operate efficiently and get paid for our services, it can also eliminate the time and expense the physician office may incur when reviewing patient files in order to respond to our requests.

NCDs (National Coverage Determinations) and LCDs (Local Coverage Determinations)

- National Coverage Determination (NCD) is a diagnostic laboratory test that is a national policy statement. It indicates which diagnoses, signs, or symptoms are payable for specific tests. A list of NCD tests and information concerning the appropriate diagnosis codes for these tests can be found online at www.cms.hhs.gov/MCD/index_section.asp?ncd.
- Local Coverage Determination (LCD): An LCD is a local policy statement by the local Medicare carrier or fiscal intermediary that indicates which diagnoses, signs, or symptoms are payable for specific tests. Effective Sept. 1, 2008, our Medicare carrier is now National Government Services. A list of LCD tests and information concerning the appropriate diagnosis codes as well as the Medicare fees for these tests can be found online at www.ngsmedicare.com/NGSMedicare/Homepage.aspx.

When ordering a test that does not meet the NCD or LCD guidelines, an Advanced Beneficiary Notice (ABN) should be obtained from the patient. The purpose of the ABN is to give the patient advance notice that Medicare may not pay for the test ordered. When payment is denied as not medically necessary, Laboratory Alliance can only bill the patient if we have received a valid ABN (signed by the patient).

Reflex Testing

Reflex testing is testing that is performed as a result of initial test results which are used to further identify significant diagnostic information required for appropriate patient care. A list of the reflex tests that are performed when appropriate is in our Directory of Services, on our website and is also located on the back of our requisitions.

Panels

Organ or disease panels will only be billed and reimbursed when all test components are medically necessary. If only some components are medically necessary, or if the physician wishes to order other tests not included in the panel, those tests should be ordered individually. A list of tests included in the American Medical Association’s acceptable panels is included on our requisition and in our Directory of Services. Medicare reimbursement amounts for these tests can be found online at www.cms.hhs.gov/ClinicalLabFeeSched/.

Medicaid reimbursement will usually be equal to, or less than, the Medicare reimbursement.

Clinical Consultation Services

Appropriate test use and ordering may be discussed with Laboratory Alliance’s CEO and Director of Laboratories, Michael R. O’Leary, MD. He may be reached by contacting our Customer Service Department at (315) 461-3008.
Urine Drug Screening: Practical Guidelines for Clinicians

By Jayne L. Healey, M.D., Assistant Director of Laboratories

The use of urine drug screens (UDSs) for commonly abused drugs (amphetamines, benzodiazepines, opiates, marijuana [THC], cocaine and phencyclidine [PCP]) has increased in the past decade.

Drug testing is frequently performed in the workplace, the military, athletics, legal situations and healthcare. Healthcare applications include treatment, compliance monitoring and cause of death. Accurate interpretation requires clinicians to be aware of the validity and reliability of the various assays.

Of the biological specimens available for testing (urine, blood, hair, saliva, sweat and nails), urine is preferred due to ease of collection and high concentration of drugs and their metabolites. Most drugs are rapidly cleared from the circulation, with only low levels found in serum. The higher concentration of drugs in urine increases the chance of detection and provides for longer detection times.

The most common initial screening method is the immunoassay. Immunoassays utilize antibodies to detect specific drugs and their metabolites. Automation of immunoassays allows for large-scale screening and rapid detection. However, the high sensitivity of immunoassays does result in some cross-reactivity, with occasional false positive results.

False-positive amphetamine screens may be seen in patients taking anorexiants, decongestants, prescription stimulants for attention deficit disorder or narcolepsy and agents used in the treatment of Parkinson disease (selegiline, deprenyl). False positive opiate screens can occur in patients taking quinolones or rifampin or in those with recent poppy seed ingestion. Antihistamines can cause false-positive results in screening tests for tricyclic antidepressants (TCAs). Screening assays for cocaine and THC are less prone to cross-reactivity and tend to have high positive predictive values.

It is important for clinicians to recognize the preliminary nature of immunoassay-based UDSs. All positive results obtained by immunoassay must be confirmed by gas chromatography-mass spectrometry (GC-MS). GC-MS is the most accurate and reliable method for detecting small quantities of specific drugs. It is, however, both time-consuming and costly. GC-MS is typically reserved for confirmation testing of screen-positive samples.

Detection time is a common question posed by clinicians. Numerous factors affect the length of time that a drug can be detected in the urine. Some of the factors influencing detection time include: pharmacokinetics, presence of metabolites, hydration status, body mass and composition, short-term versus chronic use, urine pH and time since last ingestion.

The table to the right gives general detection times for various drugs:

- Health care professionals need to be aware of the possibility of specimen adulteration, dilution and substitution. Common adulterants include drain cleaner, bleach, soap, ammonia, peroxide, lemon juice and eye drops. Commercially available products often contain glutaraldehyde, potassium nitrate, peroxide or pyridinium chlorochromate (PCC). THC assays tend to be the most sensitive to adulterants.

- Urine specimens should be shaken and observed for appearance (e.g. excessive foaming) and color. Initial temperature should be 32°C to 38°C. It may be helpful to perform a concurrent urinalysis. A pH level <3 or >11 is suspicious for contamination. Specific gravity should be between 1.002 and 1.020. Urine creatinine concentrations of <20 mg/dL are considered dilute, and those <5 mg/dL are inconsistent with human urine.

Laboratory Alliance performs routine urine drug screening by immunoassay for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates and PCP. Immunoassay screening for methadone and TCAs is also available upon request. All routine UDS positive results obtained by immunoassay screening are confirmed by GC-MS. Quantitative testing for specific drugs and their metabolites is also available upon request. Laboratory Alliance does not document chain of custody; therefore, results of urine drug testing are not applicable to legal situations. It is important for health care professionals to understand that UDSs have a limited application and do not provide information such as time since last ingestion, duration of abuse or state of intoxication. Results of UDSs must be assessed in conjunction with clinical history and physical examination in order to avoid the serious consequences associated with misinterpretation.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Detection Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>1 – 3 days</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>1 – 12 days</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>24 hrs – 3 weeks</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1 – 3 days</td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
</tr>
<tr>
<td>single use</td>
<td>1 – 3 days</td>
</tr>
<tr>
<td>chronic, light use</td>
<td>3 – 30 days</td>
</tr>
<tr>
<td>chronic, heavy use</td>
<td>up to 12 weeks</td>
</tr>
<tr>
<td>Methadone</td>
<td>1 – 3 days</td>
</tr>
<tr>
<td>Opiates</td>
<td>1 – 3 days</td>
</tr>
<tr>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td>single use</td>
<td>7 – 8 days</td>
</tr>
<tr>
<td>chronic use</td>
<td>2 – 4 wks</td>
</tr>
<tr>
<td>TCAs</td>
<td>1 – 7 days</td>
</tr>
</tbody>
</table>
Are You Ordering the Right Vitamin D Test?

By Jayne L. Healey, M.D., Assistant Director of Laboratories

The extra-skeletal benefits of vitamin D have received so much recent press that detection and treatment of vitamin D deficiency has become a public health priority.

The skin forms vitamin D3 during sunlight exposure. Vitamin D is also acquired in the diet as vitamin D2 or D3. The liver converts both forms to 25-hydroxyvitamin D \([25(OH)D]\) which the kidney converts to the biologically active form, 1,25-dihydroxyvitamin D \([1,25(OH)2D]\).

With so many circulating forms of vitamin D, many clinicians find themselves asking the question, “Which vitamin D test to order?”

Despite being the biologically active form, serum 1,25(OH)2D provides no information about vitamin D status and can be misleading if ordered in error. Serum 25(OH)D is the major circulating form and is the only metabolite necessary to assess for vitamin D deficiency or intoxication.

Although serum 25(OH)D is present in both the D2 and D3 forms, there is no established benefit to reporting separate results. The total vitamin D assay, performed by Laboratory Alliance, has 100 percent specificity for D2 and D3, yielding a total circulating 25(OH)D value.
Transportation Department Couriers Provide ’Round the Clock Service

Laboratory Alliance’s 40 couriers provide an invaluable service for the company and our customers. The hardworking staff includes the following individuals:

Above, left to right: Bill Becker, Alan Farmer, John Melfi, Sam Martino, Tony Tartaglia, Andy Paton, Bill Bartlett, Jim Hare, Jerry Dillon, Mike Lynch, Rick Russell and Dom Frijo.

Above, left to right: Tony Mastrobattisto, Dick Clark, Paul Vautrain, Bill Miller (Supervisor), Bob Fiesinger, Bill Kilburn, Mike Manfredi (Routing Coordinator), Galal Galal, Jim Donaldson and Bob Cavelli.

Above, left to right: Stan Ferris, Neil Wescott, Tom Ross, Sam Toscano, Joe Spado, Mike Galeazzi, Jean Amidon (Dispatcher) and Bonnie Waltman.

Not pictured are Gary Burns, Alex Dempster, Bill McCarthy, Charles Gronau, Clyde Birch, Bob Davenport, Pauline Arcaro, Wayne Nowakowski, Dave Weaver and Bill Mammone.
New Employees

Please welcome our new employees:

At our Operations Center
Diana Bortle, Medical Technologist
William Haahr, Laboratory Office Assistant

At our Corporate Office
Phil Crocetti, Information Systems Analyst
Matthew Vanderwerken, Information Systems Analyst

At our Rapid Response Laboratory
at Crouse Hospital
Lauri Kratz, Medical Technologist

At our Rapid Response Laboratory
at St. Joseph’s Hospital Health Center
Rebecca Wallace, Laboratory Office Assistant

Employee Anniversaries

November
5 Years
Gina Potenza
10 Years
Molly Boone
Maria Dillon
Barbara Guiffrida
Carl Huppman
Rosemary McGraw
Anne Marie Mullin
Dhirajben Patel
Diana Signore
Lonnie Stallcup
Theresa Weller

December
10 Years
Jeffrey Coyne
Nancy Flattery
Lynn Trickey

Community Outreach

Lonnie Stallcup Jr., MT, Education Services Manager, participated in the Syracuse University Internship Fair on Sept. 24.

He spoke with students about our Medical Technologist/Technician Training Program and distributed marketing brochures detailing Laboratory Alliance. As a result of his community outreach, a recent Upstate Medical graduate is being considered for employment and he established contacts with students at Onondaga Community College and SUNY Environmental Science and Forestry. Local recruitment is very important to Laboratory Alliance. Lonnie participates in many career fairs across Central New York throughout the year.

Dancing His Way to Local Fame

Submitted by Linda Bondy
Customer Service Representative

Laboratory Alliance’s own Dan Ho, Information Systems Technician, is a finalist in the Dancing with Our Stars - Syracuse competition.

Dan will be competing with other Syracuse stars in April 2009. The competition, a benefit to support the Barnes Foundation, will be held at the Oncenter.

Here’s Dan with Terry McGraw, also known as Mrs. Fix-It. The full list of competitors will be released to the media in December.
By Dru Ellen Clay, Materials Manager

Laboratory Alliance will again participate in the U.S. Marines Corp “Toys for Tots” campaign, which consists of the donation of new, unwrapped toys to children who are less fortunate. The generosity of the Laboratory Alliance staff who contribute to this campaign each year is heartwarming!

The collection boxes are located in the front lobby of our Operation’s Center and our Corporate Offices, as well as at each of our Rapid Response Laboratories. The boxes will be picked up on Thursday, Dec. 18 and brought back to our Operation’s Center for pickup by the Marines Corp.

Calendar of Events

Thursday, Dec. 4
BizEventz Fast Track 50 Awards Recognition Luncheon. Fourth annual event recognizing 50 of the fastest growing companies, Convention Center at Oncenter. Laboratory Alliance will be recognized.

Friday, Dec. 12
The Blood Banks Association of New York State Blood Bank Seminar, Laboratory Alliance Corporate Office. Laboratory Alliance is a corporate sponsor.

Saturday, Jan. 10
Laboratory Alliance Employee Holiday Party, Holiday Inn Electronics Parkway, 6 p.m.-midnight.

KPC - The New Andromeda Strain
Continued from page 2

Lactamases and the metallo-beta-lacta-mases, which further contribute to the resistance problem.

Many infections caused by ESBL-producing strains of gram-negative bacteria would normally be treated with a carbapenem, such as imipenem. However, with the emergence of the KPC resistance mechanism, the carbapenems as well as piperacillin/tazobactam are no longer effective. Furthermore, KPC producing bacteria are often resistant to the fluoroquinolones and aminoglycosides by other resistance mechanisms which greatly limits antibiotic treatment options.

Our Microbiology Department routinely screens for the presence of KPC resistance in gram-negative bacteria. To date, KPC resistance has been found in several bacterial isolates but, fortunately, the overall incidence has been extremely low. However, as with the emergence of any bacterial resistance mechanism, one can expect the incidence to increase with the passing of time.

If a KPC producing strain of bacterium is detected in one of your patient’s specimens, Laboratory Alliance will alert the physician and/or health care provider by appending a comment on the laboratory report indicating that a KPC producing strain has been isolated. The recovery of such an organism has significance not only for therapy but for its possible infection control implications as well.