‘A struggle every day’—outpatient center decisions

July 2022—*A time of tough choices. A complex dance. This is how Compass Group members on a call with their colleagues, led by* CAP TODAY *publisher Bob McGonnagle, describe what it’s like to cover outpatient centers amid severe staff shortages.*

“We are consuming significant resources to get all our locations staffed,” one member says. Another predicts: “We will not be out of this staffing situation for 10 years.”

Here is more of what they and others talked about on June 7 as COVID positivity rates were up and monkeypox was in the news.

The Compass Group is an organization of not-for-profit IDN system laboratory leaders who collaborate to identify and share best practices and strategies.

Lauren Anthony, what is the staffing situation now in Minneapolis?
Lauren Anthony, MD, system laboratory medical director, Allina Health, Minneapolis: We are having staffing challenges, and I would be interested to know how people are managing clinician expectations and staffing shortages, especially in the ambulatory sphere, where we’re feeling the crunch. I’m trying to navigate that, maybe move to a different model for supporting our clinics. Offering complex test menus or moderate-complexity testing is less sustainable now. We have a lot of resources out there, and it’s a high-maintenance model that has become unstable because we have resignations every day.

Ingemansen

Dan Ingemansen, you have a vast network of ambulatory medical care at Sanford. How are you coping with staff shortages and complex testing when you may not have all the people you’d like to have on site?
Daniel Ingemansen, senior director, Sanford Health, Sioux Falls, SD: We still have quite a few levers we can pull to alleviate some of the concerns. Our ambulatory centers still have a deep menu of on-site testing. One action we took was pointing outside orders to specific patient service centers with dedicated phlebotomists. This has allowed our acute care centers to focus on Sanford patients.

We continue to assess the level of service we can provide considering our staffing shortages. Equally concerning are the general employee shortages. Serving as a reference lab to providers across the Midwest, we have many nonclinical employees specifically in our customer service and revenue cycle departments. For these positions we’re competing not necessarily with local hospitals but every local business.

It is a time of tough choices.

Stan Schofield, current events continue to ruin systemwide budgets—labor shortages, increased expenses, inflation. Give us a little commentary on what you’ve heard so far and particularly how it affects system budgets.
Stan Schofield, president, NorDx, and senior VP, MaineHealth: At a high level in the economics of health care, if you treated a lot of COVID patients, you lost money. Hospitals and systems make money on joint replacements, high-cost procedures, imaging, and cancer medicine. They need that; government and insurance payments do not cover all typical expenses. At the same time, we’ve had a massive increase in contract labor costs. They are out of

control. People were paying nurses in some cases $200 an hour so they could keep the doors open, or at least the lights on, because they had no other staffing—their nurses left to become travel nurses for the money. Some of that has resolved and improved but it's not over.

Every day I see headlines and get market intelligence—this health care system lost $1 billion in the first quarter, another one $870 million. It is clear to me that many health care systems are at an inflection point financially, and they are not going to be able to close this gap caused by contract labor. You cannot catch up with enough heart surgeries and joint replacements to make up a billion-dollar loss.

Having said that, many places have endowments and investment funds. Well, the stock market has crushed that too, and then you add inflationary components, the price of fuel, and the cost and availability of housing.

Laboratories are going to be challenged to remain a strategic asset. Hospitals are in trouble; they're bricks and mortar. The lab will always be a secondary consideration for patient direct care within the hospital or health system, and health systems are hospital-centric, not laboratory-centric.

My prediction is we will not be out of this staffing situation for 10 years. People said two million, three million people left the workforce. I want to know where 40 million went. You're paying people up to $30 an hour for phlebotomy and you still can't get them.

We're going to have to be creative. We have been using lower educated, experienced people to be equipment operators, device operators. We're still running schools and training phlebotomists but we can't get people to apply to the classrooms and be paid $20 an hour with benefits to be trained to be a phlebotomist. We can't use the tools we've used in the past. We're going to have to come up with different strategies or different locations.

Contract labor costs are going to be a massive disruptor to lab operations. I'm not talking about lab contract labor; I'm talking about all the contract labor the hospitals are paying for, and the lab's going to see the consequences of that.

Carbonneau

Eric Carbonneau, are you seeing the staffing problems, inflation, et cetera?
Eric Carbonneau, MS, MT(ASCP), chief operating officer, TriCore Reference Laboratories, Albuquerque: Yes. We have multiple phlebotomy programs in the state and the city, and TriCore recently started its own. We're trying to attract even more candidates. The major employers outside the health care industry are competitive with wages. We've done market adjustments in some cases to the tune of 20 percent increases to staff in order to attract folks. We're looking at benefit changes, more education, tuition stipends, those sorts of things.

We've had to close or consolidate some of our outpatient centers, depending on staffing needs. A major project for us this summer is how we can become more efficient with our patient care centers so people have access in the community but still meet our staffing needs and customers' expectations.

Mick Runnoe from ACL, would you like to comment?
Mick Runnoe, VP of Laboratory Operations, ACL Laboratories, West Allis, Wis.: Our agency staffing within the laboratory to accommodate vacancies is almost becoming unsustainable. I brought my leaders together and said we have to see significant reductions in our agency staffing. The prices are ridiculous.

Runnoe

We have many moderately complex laboratories in our ambulatory settings, especially in the Wisconsin region, and on any day I get reports that one or more of our collection centers had to close because we haven't had staff to fill those. A lot of it is due to existing vacancies and then compounded by COVID vacancies. We've had about 25 percent positivity rate in our community and 10 percent in the organization as a whole.

It's becoming difficult when you have a site that has one med tech and two phlebotomists to know whether one will show up. So we've had to make difficult decisions. It's fortunate we have good relationships with the clinical staff at ambulatory sites, and they're understanding and are dealing with the same issues we are.

We've seen an uptick in our stat courier services, because when we close a lab those physicians expect the same service level. Then you send the stat courier and pay for the additional fuel charges. It's becoming, as was said, a bit unsustainable and difficult to manage. Where are we going to be if we can't turn the table, especially with staffing vacancies?

If you're having to close collection centers, patient service centers, doesn't that create an inevitable downward spiral for a system?
Mick Runnoe (ACL Laboratories): It does. If we close one location, we leave instructions with the staff at that site for where patients can go to get collected at another location. Fortunately in the Wisconsin region, we have quite a few places where patients can get collected, but then it becomes a burden on the other site.

To be more proactive we've done away with walk-ins. We're pushing our clinicians to ask patients to call ahead to schedule or have them schedule when they write the order.

Cloutier

Darlene Cloutier, how bad or good does this discussion make you feel? How are things going at Baystate with COVID?
Darlene Cloutier, MSM, MT(ASCP), HP, director of laboratory operations, Baystate Health, Springfield, Mass.: We peaked a month ago at about 15 percent positivity. We're down to about five percent now. A month ago is when our staffing challenges spiked, too. A decision was made by the organization to allow staff who had COVID to come back in five days, but many of them could not return because they were not well enough and were still reporting symptoms. So the time away from work extended beyond five days for many.

We've tried to pull back on agency help. In place of that, we've had a series of bonus incentive programs in place to support minimum staffing levels. Many are exhausted now and they are no longer interested in the double or triple bonus incentives for working extra.

We experience a struggle every day to keep patient service centers open. Some of our satellite labs have only one tech scheduled and we are challenged to recruit for some of the remote locations, so we're using a courier system to bring the specimens to a waypoint lab in our system to get them tested. We're trying to create a float pool but

there are only so many staff to go around to try to cover all the vacancies.

We're getting to the time of year when we begin to look at budgets for next year. What are you anticipating the demands will be on you as you look at budgets?
Darlene Cloutier (Baystate): There's going to be a budget shortfall, no question. We will carefully approach the budget with a sense of projecting new revenue to avoid cuts. If we need to make reductions, where do we cut? You can't cut staff. You can look at some opportunities for non-wage expense, but in many instances we've already done this due diligence and these costs are only increasing. Every year you think this will be the worst budget season, but I think this one's going to challenge everyone in health care.

John Waugh, what are you anticipating at Henry Ford?
John Waugh, MS, MT(ASCP), system VP, pathology and laboratory medicine, Henry Ford Health System, Detroit: This is about the fourth cycle of these I've been through; 2008–2009 is a more recent one when the markets got crushed. I tell our people we're going to become a smaller organization for a time.

Nobody wants to touch staffing, but with premium pay now, staffing is probably 60 percent of our expenses that are going up. There will be a retraction of our facilities. We'll probably look at outpatient capacity and say, how much do we really need? That's the way we managed in prior times. But I also tell people there is another side to the valley. We have gone through these cycles before. This is a deep one; we'll come out of it, but it will be ugly getting through it.

Sam Terese, what are you anticipating for a budget cycle for Alverno?
Sam Terese, president and CEO, Alverno Laboratories, Indiana and Illinois: We're in a bit of a novel place. We got a little ahead of the staffing curve with the launch of some new programs. We came out of the winter months with vacancy rates around 22 percent and we've reduced it to 13 percent in several of our markets. We haven't had to close any of our patient service centers or alter service, but don't get me wrong—every day is a complex dance of moving people to get them covered.

We are consuming significant resources to get all our locations staffed. We are experiencing significant labor cost inflation pressures, and we are working aggressively to identify where we can reduce cost. We are seeing a bit of a retraction in volumes at some of our hospitals, and they are starting to look at various programs they are offering, so it's taking a little burden off the laboratory.

California seems to be a hotbed of COVID infections. Friends there who've had it said they were quite ill for up to five days but didn't need to go to a hospital. Dhobie Wong, is that the picture you're seeing at Sutter?
Dhobie Wong, MBA, MLS(ASCP), CLS, VP of laboratory services, Sutter Health, Sacramento, Calif.: Between our locations in the Valley, Sacramento area, and the Bay, we're running about a 20 percent positivity rate. Our hospitalizations are up too. Many of our employees are getting COVID despite vaccines and boosters, and on average they're out a week. They're describing symptoms of a heavy flu. We don't have information on the variant type.

Dwayne Breining, what about in New York?
Dwayne Breining, MD, executive director, Northwell Health Laboratories, New York: New York's been the opposite. We're down around seven percent overall now. We do limited genotyping using an ultra-high-throughput PCR system and we had our first couple of cases of BA.4 about three weeks ago.

Eric, what's the word from TriCore?
Eric Carbonneau (TriCore): We're still riding a small surge of COVID, running about 17 percent positivity. There is a lot of at-home testing, so we're not sure if we're capturing all the data for the state.

Greg Sossaman, tell us about monkeypox and are you seeing it in New Orleans?
Greg Sossaman, MD, system chairman and service line leader, pathology and laboratory medicine, Ochsner Health, New Orleans: I am not overly concerned about it here, and I've talked with some of my infectious disease

colleagues, who don't seem to be too excited about it. Medical Twitter has been blowing up in the past few days with concerns about it and calls for testing. I read Abbott and Roche are developing an assay, but I don't have specific information about it. The CDC has an assay for us, but we're not doing anything differently to prepare other than general awareness.

Sterling Bennett, would you like to comment on COVID in the Salt Lake City region?
Sterling Bennett, MD, MS, senior medical director, pathology and laboratory medicine, Intermountain Healthcare, Salt Lake City: We are seeing a slow uptick in cases in Utah. The testing levels are nowhere near what we saw during delta, but our total number of positives is approaching that level. We're pushing a 30 percent positivity rate overall and in urgent care. We think most of the testing is happening at home, but the people who feel surprisingly ill are being seen and tested, and about a third of them are positive. More staff members in the laboratories have returned to wearing masks.

Dr. Wilkerson

Myra Wilkerson, what's the view from Geisinger?
Myra Wilkerson, MD, chair of laboratory medicine, Geisinger, Danville, Pa.: We were up to about 20 percent positivity max. But over the past few weeks it's down and has stayed steady around 13 percent.

At the American Society of Clinical Oncology meeting, oncologists and allied people who are providers in oncology were reporting that they're having a terrible time keeping their infusion centers open, keeping up with patient demand. There are serious shortages everywhere and they're worried about that as a matter of scheduling people. Are you hearing complaints of shortages outside of the pathology space, particularly in nursing and pharmacy?
Dr. Wilkerson (Geisinger): Yes. We've had our highest employee absentee rates across the system in the past two to three weeks from the entire pandemic, and we have mandatory vaccination. Employees are out five days on average.

I assume the staffing shortage is making it even more difficult to effectively recruit in pathology and lab staff generally? In other words, the prioritization of money and time is part of the problem?
Dr. Wilkerson (Geisinger): Lab staff see all the salary reports from nursing. It's driving a lot of dissatisfaction in other groups of staff, including the laboratory. They feel like they've been working hard during the pandemic and have been the unsung heroes. We're starting to see a lot of early retirements.

Janet Durham, what is going on from your perspective in the upper Midwest?
Janet Durham, MD, medical director, Wisconsin operations, ACL Laboratories, and president, Great Lakes Pathologists, West Allis, Wis.: We've been fairly steady, around 10 percent for the system. Urgent care is higher, and knowing there is home testing, it's probably underrepresented.

We have seen staff who are COVID positive. We were talking about masking today, and I am curious what other systems are doing about masking. We know people are not wearing masks in the community, but we are still wearing masks in the hospitals and laboratory. The staff COVID positivity is resulting in a staffing issue: Once someone is positive, it's an automatic five days they won't be at work, even if they're not severe. Wearing masks prevents transmission to colleagues.

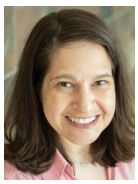
John, what is the masking requirement now at Henry Ford?
John Waugh (Henry Ford): We're still masking in the building, anytime you're in a public corridor and in the

laboratories. There are different thoughts on whether that's a good idea. But I think people have seen the impact of the uptick; we're up around 20 percent for about 10 days in a row for people who are tested. When you look at ED patients, outpatients, presurgical, preprocedural, it's our employee group that has the highest percentage of people who are testing positive.

Tony Bull, where are you with COVID?

Tony Bull, system administrative officer, Pathology and Laboratory Medicine Integrated Center of Clinical Excellence, Medical University of South Carolina: We are going to institute masking requirements this week at Medical University of South Carolina. If you're not vaccinated, you have to be masked; in clinical areas you'll need to be masked. We did away with most of those rules for several months.

We're seeing about a 20 percent positivity rate. The volume of positive tests is roughly equivalent to last summer's numbers. We're seeing some BA.4 and BA.5, which is interesting because we didn't see BA.2 until well after everyone else did. Still, this is a lower volume than we've seen before.



Dr. Laudadio

Stella Antonara at OhioHealth reports they're still masking. Same at Geisinger. Jennifer Laudadio, what's going on in Arkansas. Did you ever stop masking there?

Jennifer Laudadio, MD, professor and chair, Department of Pathology, University of Arkansas for Medical Sciences College of Medicine: We did here at UAMS. We loosened our masking policy so that if you're not interacting with patients, you don't have to wear a mask. It is optional in our laboratories.

A lot of people are missing work now because of being exposed or having symptoms. Today we have 145 people not cleared to work overall for UAMS. A lot of people are reporting allergy symptoms and I tell them they need to get tested, and they test positive. We're reinforcing the idea that if you have any symptoms you think could be COVID, please get tested. UAMS closed its additional site that it had opened for employee testing, so it is recommending an antigen test at home and then a call to student and employee health.

We haven't done a sequencing run in a couple of weeks, but on our last run we saw one BA.4 and the rest were BA.2 or BA.2-like.

On monkeypox, Roche is working with TIB Molbiol and they have assays that run on a Cobas z 480 analyzer. One is generic orthopox, one is monkeypox only, both clades. One will cover general orthopox but differentiate the West African and Congo Basin clades of monkeypox.

Have you seen monkeypox at UAMS?

Dr. Laudadio (UAMS): We had our first vesicular rash swab today to send to the health department, but I don't think it's a high level of concern for this particular patient. They did not have a travel history.