# Digging deep to drive recruitment and retention

March 2023—*All in on staff retention and solving staff shortages, some made worse temporarily by weather. That's where laboratories were when Compass Group members told* CAP TODAY *publisher Bob McGonnagle in their Feb. 7 call where hospitals and labs were aiming their efforts. From safety huddles and stay interviews to arranging for overnight stays and incentives, the work to remain sufficiently staffed continues.*

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

**Eric Carbonneau, where is TriCore's focus at this time early in the year?**
*Eric Carbonneau, MS, MLS(ASCP), chief operating officer, TriCore Reference Laboratories, Albuquerque:* TriCore is focusing this year on staffing, thinking of new ways to recruit staff, getting new laboratorians into the field. With our different deployments—we talked in the past about our mobile units going out and doing COVID collections—we're focusing on how we can make our physician partners' and patients' lives easier.

Dr. Henricks

**Wally Henricks, what is top of mind for you in your department?**
*Walter Henricks, MD, vice chair, Pathology and Laboratory Medicine Institute, and laboratory director, Cleveland Clinic:* We're beginning to finalize and implement our priorities; we go through an OKR [objectives and key results] process. Even more of a focus this year for the organization are serious safety events and how they apply in the laboratory. Our institution is further expanding our use of the Cleveland Clinic Improvement Model for continuous improvement. We're finding new ways to apply that in our department. Across our laboratories we're doubling down on waste reduction in service of efficiency and cost savings as a first priority.

Another priority is employee recruitment and retention. Working with human resources, we're offering new, aggressive retention packages and implementing stay interviews, where we interview people about what's working well and what's not at all levels. Let's not hear what's going wrong only after someone leaves; let's see if it might be correctable. We're using employee engagement surveys too.

**As you all have reported to us, the nursing shortage directly affects phlebotomists and phlebotomy service and specimen collection. Are you seeing an impact there at the Clinic?**
*Dr. Henricks (Cleveland Clinic):* Yes. Determining where and when inpatient phlebotomy is covered by nurses versus lab phlebotomy service is more of a problem because of shortages in both groups. That can lead to some new tensions, but we're working through it. Our smaller hospitals tend to have less room to flex. Lab phlebotomy does not draw in ICUs, nurses do, so we don't have acute pressure there.

**John Waugh, give us a comment on the staffing shortage at Henry Ford.**
*John Waugh, MS, MLS(ASCP), system VP, pathology and laboratory medicine, Henry Ford Health System, Detroit:* Staffing shortages in nursing are the most precarious because surgical cases can't go and patients can't be moved quickly out of the ED and into inpatient units.

One strategy being used is stay interviews, as Wally mentioned. There is an effort to look purposefully at onboarding to further reduce turnover trends that are still seen. There are multiple check-in meetings throughout so people can feel a better sense of belonging and build trust with their new leader, which we hope will improve retention and engagement.

Waugh

**A friend who ran a laboratory used to tell me it takes at least two years for a medical laboratory scientist to begin to contribute in a significant way in a clinical laboratory. They come in well trained but there's a lot to learn. Do you have a time frame for when people begin to optimally produce results?**

*John Waugh (Henry Ford):* People get thrown in the deep end much quicker these days, and two years is probably long. People have a greater ability to cross-train. There are more workstations, there is more complexity. People walk from four or five instruments, all of which have different middleware, different interfaces, in one shift. From the instrument user standpoint, they are complex and the middleware is a rules engine that keeps track of hundreds of scenarios. It would be like asking travel agents to keep airline schedules in their head. We rely incredibly on middleware in chemistry, hematology, immunochemistry, and microbiology. People are in the deep end faster and in two years they're going to be rock stars.

Wong

**Dhobie Wong, tell us what Sutter is focusing on this year.**

*Dhobie Wong, MBA, MLS(ASCP), CLS, VP of laboratory services, Sutter Health, Sacramento, Calif.:* Our focus for this year is looking at ways to grow. An imperative from our new CEO is growth and access. With that we anticipate laboratory volume to grow as well.

We're also contending with staffing challenges and trying to think outside the box. We have a training program for medical laboratory scientists and medical laboratory technicians. One approach we're looking at is doing a skills mix optimization, where for positions that traditionally would be MLSs or clinical laboratory scientists, we would incorporate MLTs into areas such as core lab, chemistry, hematology, and blood bank.

Another approach we're exploring is creating a pool to draw from for CLSs, phlebotomists, and laboratory assistants. Historically each hospital would have its own staffing pool, so we're looking to create a regional staffing pool to draw from. We're also looking at our outpatient and inpatient; we have silos where we don't intermingle with acute and foundation settings, so we're trying to break down those barriers to see if we can create pools of staff that we can share wherever the need is between those areas.

**Tony Bull, tell us about staffing at MUSC.**

*Tony Bull, system administrative officer, Pathology and Laboratory Medicine Integrated Center of Clinical Excellence, Medical University of South Carolina:* It's severe. We're feeling it the most with cytotechnologists, histotechnologists, phlebotomists. The past two days our morning rounds have been completed later than I would like to admit. The goal is to have them done by 6 or 7 am. Our cytotechnologist team is holding it together but they are working so hard. They're in on weekends to stay caught up. We don't have enough of them to be able to meet all service demands, and it continues to be a concern.

We are excited about an apprenticeship program we're doing with a technical college in town. We have a job category for four-year science graduates who want to work in the laboratory. Through a state grant with the local

technical college, we are offering classes and on-the-job experience for those employees. It's no cost to them and they will be able to get licensed in a couple years. We have 10 students enrolled. But there's no light at the end of the staffing tunnel yet.

**Milt Datta, can you share the news from Minneapolis?**
*Milton Datta, MD, chair of pathology, Abbott Northwestern Hospital, Allina Health, Minneapolis:* The threat of a nursing strike going into the end of December pushed everybody to the negotiation table. The bottom line is it allowed us to get things done and all sides to walk away with a contract with our nurses that made everybody feel good. It's been a huge bonus for us to be able to move forward with this and keep building.

We're trying to figure out a solution for laboratory staffing. We have a new centralized laboratory staff that is unionized, so those contract negotiations continue. The results from the completed nurses' union contract gives us hope that we will end up with a positive solution.

We've pushed a safety huddle system across Allina, where we are getting together every day, talking, and taking any issues up the chain to leaders. For example, in the laboratory it starts in the morning with specific areas of the lab, like microbiology, then goes up to the laboratory leadership, then across to the entire health care system leadership with other hospitals and areas reporting in. As things get escalated, we can get significant problems in front of senior leaders and accelerate solutions.

Last year we saw the value of the safety huddle process during a stressful time. We had a crisis situation staffing phlebotomists during nights and evenings at our main hospital, Abbott Northwestern, in particular when we could not retain staff to do phlebotomy draws, which delayed lab results. It was raised up through the safety huddle by providers, first at a provider huddle, then the hospitalwide huddle, and by 10:30 am it was at the health care systemwide safety huddle with the CEO. She called in the vice president of HR, who worked with the vice president and director of laboratories, and said, What can we do to make this work? By the end of the day, we had a streamlined hiring process. We had positions posted and additional resources to sign phlebotomists as soon as possible. I'm the pathology physician lead on the provider huddles and since we were able to rapidly hire more staff, I have not heard any phlebotomy-related issues in months. When I check on the evening staff to see how they're doing as they come in, they say they're doing well.

Having transparency across the system so people know the issues in the laboratory and where we are hurting staffing-wise has had a positive impact. They hear about the nurses; they don't hear about the laboratory staff. Because we've done this, there are huge benefits by having the providers helping and advocating for us.

Kleckler

**Wendy Kleckler from ACL, tell us about the recent consolidation with Atrium.**
*Wendy Kleckler, VP of Business Development, ACL Laboratories, West Allis, Wis.:* We're now known as Advocate Health Midwest in the Illinois and Wisconsin markets, and our teammates are Advocate Health of the Southeast, which includes our Floyd, Navicent, Charlotte, and Wake Forest facilities. It kicked off the first week of January after the announcement was closed. We're just beginning the good work that will bring forward state-of-the-art laboratories.

**The challenges at ACL must be similar to what you hear from your colleagues at Advocate Southeast.**
*Wendy Kleckler (ACL Laboratories):* The issue is recruiting and retention and finding candidates, and even when we find them it takes a year to two to get them up to speed. Unfortunately at Advocate Midwest we have had to close

some of our ambulatory clinic lab sites on days we are short-staffed. Those sites are the first to close if we are short-staffed. In the Illinois ambulatory market for phlebotomy we're doing okay. We're targeting social media and trying to recruit via LinkedIn, videos—how do we get that generation to join our workforce, especially for phlebotomy, where less education is required and we can train them? That's a big focus for us and will be for years to come as it becomes harder to find medical technologists.

**Dwayne Breining, I understand you're considering switching to an HPV first algorithm at Northwell for cervical cancer screening in women.**

*Dwayne Breining, MD, executive director, Northwell Health Laboratories, New York:* It comes to mind as we talk about cytotechnologist staffing problems, which I think we're all facing. Ironically, this threat of an HPV testing algorithm is one reason a lot of people looking forward wonder what kind of career cytotechnology will be in the future. We've been talking about this for at least 10 years, but it seems the evidence base in Europe and elsewhere has reached the point where we know that all cervical cancer essentially is related to HPV. With the accuracy we now have with HPV testing, it would be a legitimate practice, from a clinical effectiveness perspective, to switch to an HPV first algorithm and require a traditional cervical smear review in pathology only if HPV is present. We're all wondering when the sea change will happen, when it will shift.

**Where are you in that process?**

*Dr. Breining (Northwell):* We're still in the talking phase, as we have been for the past 10 years, and monitoring the evidence. I'm a gynecological pathologist and cytopathologist by training, so I've been watching this my entire career. The evidence base has been there for a while, but practice, regulatory, and medicolegal patterns are creating the obstacles. But it would be a solution to the workload problem, which is mandated by law—you only look at *X* amount of slides per day.

We're hearing from some of our contacts and in conversations that one of the academic programs in another city is flirting with making this move. We've talked about if a few of us could jump through the door at the same time, it would make more sense in terms of reestablishing the standard-of-practice paradigm. We work hand in hand with the public health arm in New York City, which has also expressed interest in going down this road if we can make it happen effectively.

**Pete Dysert, do you have a strategy on the HPV first algorithm?**

*Peter Dysert, MD, chief, Department of Pathology, Baylor Scott & White Health, Dallas:* We're keeping a watchful and somewhat hopeful eye that the door will open, and when opened we can use that as a frontline standard of care.

Dr. Dysert

**What else is top of mind for you at Baylor Scott and White?**

*Dr. Dysert (Baylor Scott & White):* Last week in Dallas we had three days of a pretty significant ice storm, and the news went from reporting to telling everybody to stay home. Businesses, schools, and other infrastructure are seemingly more willing to shut down, and that creates challenges for our dedicated workforce to show up. Realizing there is a new paradigm, we're trying to get in front of it and develop a roster of people whose family circumstances and other things would allow them to be part of our emergency staffing resources—people who can stay if we can secure a place in the hospital or in the area for them to stay and provide a compensation structure that would reward them. We'd be incentivizing them to go against what everybody else is doing under these circumstances, which is staying home.

We try to have 20 phlebotomists starting collections at about 2 am and finishing by 6:30 am, because we use the information for bed capacity and control. In this circumstance, a few phlebotomists were able to work because we found places for them to stay in the hospital. Nurses had to drop back to drawing blood, which resulted in a lot of issues for us. We're trying to gain ideas from organizations in hurricane states, for example, which have thought about this and have proactively created a roster of people whose family circumstances, et cetera, allow them to work, and they don't rely solely on dedication but instead incentivize and provide for employees. If they chose to stay in the hospital, we'd have a place for them to shower and sleep. That's top of mind because we struggled last week and relied on a small group of people who went above and beyond. I'd like to hear if that's an issue for others and if there are suggestions.

**Does anyone have thoughts on taking care of staff onsite to help get through tricky days?**
*Dr. Breining (Northwell):* We're impacted a couple of times a year by a blizzard or other weather situation, and we get down to a vital level of staffing. We have rules that go into place, like you can't leave your station until your replacement comes in. We order in food for the whole staff whenever we're trapped by a blizzard. We have people in administration and staff with large SUVs, four-wheel-drive vehicles, who will do aggressive carpooling to get the necessary people in. We've received help from local and state police and people who run the plows and our own logistics team when push comes to shove, but we make the point that it's vital infrastructure. We've been lucky that they'll usually come to the table when we ask them.

**Autumn Farmer, tell us how things have been going at Bon Secours.**
*Autumn Farmer, MHA, chief laboratory officer, Bon Secours Mercy Health, Cincinnati:* Our staffing is good for the first time in a long time. Our vacancy rate is at four percent, which is the lowest I remember it being. We're focused now on how to keep the people we have. This year we're rolling out an education program for our supervisors, managers, and directors to get them in the mode of doing check-ins. We're focusing on communicating and building teams this quarter and next. Business acumen is third quarter, and the last is strategic leadership. We do a good job of teaching people how to be technologists after they come out of school, but we don't always do a great job of teaching them how to be leaders, especially in a hospital system. That's our focus now.

**Lee Bridges, can you share what's going on from your perspective?**
*C. Lee Bridges, MD, regional medical director, Bon Secours Mercy Health, Richmond, Va.:* One of our biggest challenges, even during COVID and as COVID is seemingly winding down, has been dealing with supply chain issues. We haven't had a severe blood shortage this year like last year, but we had a brief period of O positive and O negative blood shortages. Most recently we've been dealing with a short supply of high-sensitivity troponin reagents from one vendor. Sometimes we feel like magicians, trying to create tests where they don't exist and moving supply around the different markets in Bon Secours Mercy Health. I'm grateful we have so many folks in our supply chain who have been working behind the scenes and taking the lead in getting the greatly needed supplies. It seems like as soon as we wrap up one supply chain issue, another pops up. I don't recall that happening with this frequency prior to the pandemic.