High hopes for schools as lab positions go unfilled

May 2022—*Opening and expanding schools—the path to a labor pool for labs. Compass Group members continue to move on that as they experiment with other solutions. "We're exploring every avenue to bridge the staffing gap," said Dhobie Wong of Sutter Health in a virtual roundtable with* CAP TODAY *publisher Bob McGonnagle on April 5. Here is more of what she and others said, including about digital pathology, hiring pathologists, and installing Beaker.*

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

Joe Baker, we've been talking about the staffing shortage for at least a year. You have been among many who have talked about the need to start your own school, train your own people. Where are you now in your efforts, and is your staffing situation any better?

Baker

Joseph Baker, VP of laboratory, Baylor Scott & White Health, Dallas: We've received approval to expand the medical laboratory sciences school in our central Texas region. We're expanding that student base because we get enough applicants, which has been surprising. We're hoping to expand to a couple of sites in our north Texas regions this year with the goal of expanding further in years to come. We are trying to get our phlebotomy and laboratory technologist training programs off the ground; we expect to have our first class around July. We're trying to build a foundation and hire the appropriate people to teach and train.

We're struggling with staffing. It's not just about not having qualified candidates; it's also trying to ensure people don't leave the system. We're worried about and focused on the morale and health of the team. We're cognizant of the struggles and are developing ideas and implementing actions around these areas.

Wendy Kleckler at ACL, where are you with staffing?

Kleckler

Wendy Kleckler, VP of business development, ACL Laboratories, West Allis, Wis.: Our staffing is short everywhere in the medical laboratory technician world and in phlebotomy. We have phlebotomy and histology schools, so we have the opportunity to pull those people in, but not nearly enough in terms of volume. The market is competitive, so when you raise your minimum, your neighbor raises their minimum; you have a sign-on bonus, they double your sign-on. We continue to partner with human resources and our talent teams to identify opportunities, but we're still short several hundred technicians.

Are you using staffing agencies?

Wendy Kleckler (ACL Laboratories): We have used some but your budget takes a hit. We have used them in

northern Wisconsin, where it's hard to find candidates but there are some agency staff. Otherwise we're working short, unless we can't—then we'll employ agency.

Dhobie Wong, tell us what you're doing about staffing.
Dhobie Wong, MBA, MLS(ASCP), CLS, VP of laboratory services, Sutter Health, Sacramento, Calif.: We're exploring every avenue to bridge the staffing gap. We're looking at using more medical laboratory technicians in the laboratory to bridge the duties and responsibilities from our clinical laboratory scientists team.

Even with the MLTs there's still a shortage within California, so we're looking to partner with schools or expand our teaching. We have partnered with schools for clinical laboratory scientists. We're seeing if there are ways we can optimize our unlicensed staff, like lab assistants, and what duties and responsibilities they can fill with skills-mix optimization.

We're also exploring a centralized fulfillment center, an approach widely used in nursing. Our fulfillment center provides short-term and crisis staffing solutions using a hub-and-spoke model for multiple sites. We're looking into whether it's feasible within our laboratory structure. There's groundwork to be done, trying to get operationally standardized and more alignment so it's easier to shift staff to where we have a need.

One of the main topics at the USCAP meeting was pathologist staffing. Peter Dysert, can you elaborate on where you are within Baylor Scott with the pathologist shortage and trying to hire?
Peter Dysert, MD, chief, Department of Pathology, Baylor Scott & White Health, Dallas: We're recruiting people now. We've had a number of people choose to retire, many of whom were senior and experienced pathologists. We've struggled to find candidates who would fit our academic-style practice. A lot of people are prioritizing what I would say is closer to pure private practice. With the 400-plus multidisciplinary conferences we do a year, the overhead that training residents represents seems to be a bigger challenge. We've managed to hire a couple of people, but we're still looking for people who will thrive in our academic practice environment. I've been visiting with other colleagues around the country who are in a similar situation.

Lauren Anthony, last month you told us about difficulties with the blood supply and supply chain. Has the situation improved?
Lauren Anthony, MD, system laboratory medical director, Allina Health, Minneapolis: The Red Cross told us the blood supply is stabilized. We have been monitoring it, and we still have our contingency planning. The tube supply seems to have stabilized, so we're able to resume use of some light green–topped tubes, which we had restricted. We're still having command-center meetings to monitor the supply and make sure we ease controls on the utilization gradually based on inventory. We're thinking ahead for strategy.

Sam Terese, you run an enormous enterprise at Alverno. What's top of mind for you?

Terese

Sam Terese, president and CEO, Alverno Laboratories, Indiana and Illinois: Staffing is probably our number one concern. We are spending significant dollars for agency and overtime. The numbers are quite large to cover our open positions. I think our only way out is to build our own labor pool. We're opening more schools. We have three schools active now, and we're opening a fourth in the next few months. We have an active histotechnology program to try to keep up with demand. We have rapid tech training programs in which we take people with bachelor's degrees and turn them into techs in 90 days for our automated and rapid response laboratories.

A new concern garnering attention here is inflation impact with supply chain lines. We've started digging through

our contracts to understand what kinds of consumer price/medical price index increases are built into them and what exposure to cost increase we might experience. We are getting ready for that wave of cost that will probably be coming across our desks in the next several months.

We're looking at automation investments where we wouldn't necessarily have made them in the past. We're starting to look at what the returns on investment would look like in our smaller organizations, our 200-bed hospitals, where we wouldn't consider automation in the past. There's an opportunity to stem the staffing demand from that perspective as well.

Our experience with finding pathologists is similar; we're having difficulties.

You were mentioned frequently at the USCAP meeting for your prescient adoption of digital pathology. Can you give us an update about how that's going and if it is fulfilling promises according to the schedule?
Sam Terese (Alverno): We are still rolling out a couple of sites. We got sidetracked with COVID and didn't visit a lot of locations to do that final training sign-off. We lost a little ground as we had challenges with computer chips, for example. But most of our sites are live and reading.

So far from the initial phase, which was primary screening, the immunohistochemistry and special stains, that work is moving forward and we're starting on the artificial intelligence initiatives. We're working with a couple of partners, Ibex being one of them. There's a team of pathologists and forward-thinkers who are working through initial AI deployment potentials. We hope by year-end to have something out there. So far, so good—it's doing everything we hoped it would. The only challenge is from an ROI perspective; it continues to present challenges for many. Given our centralized histology model, we have a bit of an advantage.

Greg Sossaman, tell us what you're thinking as we talk about digital pathology and the pathologist shortage.

Dr. Sossaman

Greg Sossaman, MD, system chairman and service line leader, pathology and laboratory medicine, Ochsner Health, New Orleans: We're also in the adoption phase for digital pathology. As Sam said, the ROI can be tough. We've been using it for a couple of years for educational purposes. We have a couple of scanners and are using it for scanning immunohistochemistry, some tissue types or tumors, where we require two people to look at it before we sign it out prospectively, for quality assurance. We've yet to fully adopt it but we're moving toward that.

We're on the road toward validation for primary diagnosis and I would expect that to happen in the next two months. We'll have to acquire a couple of other scanners. Then we'll see what that looks like and begin to tally the cost, what we need for the remaining infrastructure, whether we're going to see savings or efficiency gains. We agree it's the right route; it's just how long it takes us to get there.

As far as pathologists, we're having trouble recruiting in certain areas—transfusion medicine is one of them. We have a relatively younger staff, and we've been fairly stable through the public health emergencies thus far.

Do you believe digital pathology will play a big role in meeting some of your staffing demands in pathology? Is that the pot of gold at the end of the rainbow?
Dr. Sossaman (Ochsner): It will help with efficiency, particularly since we're a group that's moving toward a semi-subspecialty model where people work in several kinds of work groups, not totally subspecialized, much like at

Northwell in New York. It helps because it's easier to level load the work throughout the system. We've seen during the pandemic that it provides flexibility for people who need to be at home or find it harder to travel—different scenarios. That flexibility is what we're looking at now. I think it will eventually be the way we all migrate, but the ROI is a steep hill to get over right now.

Wally Henricks, what is preoccupying your time at the Cleveland Clinic?

Dr. Henricks

Walter Henricks, MD, vice chair, Pathology and Laboratory Medicine Institute, and laboratory director, Cleveland Clinic: We've been preoccupied with a multiyear project that came to fruition at the end of February. We implemented Beaker, AP and CP, across all of our northeast Ohio hospitals and clinics, and a new Haemonetics blood bank system.

Our biggest acute problem with staffing is vacancies in front-end specimen processing people and phlebotomists. To help with our pipeline, we have a medical laboratory scientist school and a cytotechnologist school. We recently started a school of phlebotomy. Histotechnologists are another challenge.

We've been using digital pathology for a while, but we don't use it for primary diagnosis. We do international and some domestic consultation with it. Our institute recently signed a deal with PathAI with goals of developing an extensive digital pathology image database with linked metadata and collaborating on algorithms for translational research and clinical diagnostics. There's a lot of excitement as it's getting off the ground. It's a five-year agreement.

One of the challenges with digital pathology and artificial intelligence is, what is the targeted business case? I've always been skeptical about forecasts about it because there are a lot of direct and hidden costs that must be justified. We wanted to use it for frozen sections. The challenge we run into is, who do you put on site to process the specimen, handle the gross, and dissect it if necessary, given the shortage of pathologist assistants or other qualified people to station at a remote site in a way that makes it effective to keep pathologists at home base to look at the remote frozen sections?

Will the installation of Beaker mean anything in gains to productivity and efficiency that will help with staffing problems?

Dr. Henricks (Cleveland Clinic): Staffing, I don't know yet. Front end, probably. The fact that orders and label printing are integrated with the lab system, and clinician-collected specimens are now coming with lab-ready labels—if they remember to close out the order and do it the right way—that's our big efficiency gain. Being able to track specimens across the front end into the laboratory and get more visibility, those are not only efficiency but also safety gains.

We don't know yet about the productivity. The pathologists have been slowed down but hopefully that's a learning curve. In our experience there are a lot more clicks for the pathologists to get through their cases. But again, there is a learning curve.

We're still sorting through the biggest issue of order management and whether orders are entered correctly and closed out. For anyone thinking about or in the process of implementing Beaker, I'd suggest getting that nailed down because if the collector doesn't mark a collection time or doesn't close out the order properly, it causes problems in the lab for processing the order and specimen, and you get into phone calls or specimen rejection.

One thing we're seeing is that it changes governance of the laboratory information system. I believe this is consistent with what has happened at other sites. Lab has less autonomy to run its systems, make decisions, and implement changes. It can also affect prioritization of lab projects.

Sterling Bennett, how are things at Intermountain? I'm assuming you have good news on COVID and continued bad news on staffing?

Dr. Bennett

Sterling Bennett, MD, MS, senior medical director, pathology and laboratory medicine, Intermountain Healthcare, Salt Lake City: We have low positivity COVID rates, but as of the middle of last week, our influenza A rate was about 35 percent in our urgent care centers. So it looks to our minds like the SARS-CoV-2 virus outcompeted the influenza virus for the human cellular machinery needed for viral replication, and as COVID has disappeared in our area, influenza has made a roaring comeback.

In terms of staffing, nothing has changed—no better, no worse.

Pre-pandemic what would be your normal flu infection rate for this time of year?
Dr. Bennett (Intermountain): In a typical year, flu would be on its way out. We'd be in the single-digit percent rate or even lower by this time of year.

Winnie Carino, how tight is the staffing shortage now at Scripps?
Winnie Carino, MA, CLS, MT(ASCP), director of laboratory services, Scripps Health, San Diego: Staffing is a challenge, especially with nightshift clinical laboratory scientists and for lab leaders, such as manager, supervisor, and lead. Many of our posted positions have been open for months. One of our hospital sites has an opening for a lab manager, and I've been searching for the right person for more than six months. Another challenge in staffing is in the field of LIS. It's difficult to find Epic Beaker specialists. We've tried many different avenues to find candidates, such as advertising nationally and using agencies—with little success.

On a good note, we've had a CLS training program since 2016. We were part of the San Diego Clinical Laboratory Scientist Training Consortium program in partnership with UCSD and Sharp HealthCare. In 2019 we became our own independent program licensed by the State of California Department of Health, and last week we had a visit from the National Accrediting Agency for Clinical Laboratory Sciences. We applied to get our program nationally accredited. We're doing our part with the challenge in staffing by having our own training program to help future generations of laboratorians.

The cost of living in California is working against us. We're having difficulty finding lab assistants and CLSs, especially in areas where the housing market is very expensive.

Carino

Has the nursing shortage affected your phlebotomy teams? Nurses in some places can't do the draws

anymore and hand it back to the lab, which often doesn't have a sufficient phlebotomy team to fill that gap.

Winnie Carino (Scripps): During the height of the surge, when we're short-staffed with lab assistants, we ask nurses to help us with phlebotomy. But that's what we hear back—they're short-staffed too. We all did our best to meet the needs of the patients. I feel bad because we're not able to support the entire hospital in a timely manner on certain days, especially when our own staff are sick and we have multiple openings. However, it's getting better because the census is getting better, there are fewer sick calls, and we're able to manage the volume of patients now because the surge has ended.