Lab leaders on growth, labor, and cybersecurity

July 2021—*Revenue and growth, cybersecurity, and labor and wage pressures were on minds June 1 when Compass Group members met virtually with CAP TODAY publisher Bob McGonnagle. But perhaps no problem felt heavier than the labor shortage.*

"Everybody's scrambling to figure out how we're going to stay competitive and retain people," said Stan Schofield of MaineHealth.

"I would rather pay people who are here," said John Waugh, MS, MT(ASCP), of Henry Ford, "than pay people to come here with sign-on bonuses and then not have their loyalty, and they turn around and chomp at the next opportunity."

And Julie Hess of AdventHealth: "If I'm asked to do things for the strategy of the hospital overall, can I say yes with confidence if I'm so short on key labor?"

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

I'm going to start with questions around revenue growth and predictions for the balance of this year and going into next year. People seem to be getting pressure for guidance from the C-suite on these topics. Joe Baker, tell us what your experience has been as you're hearing more about what they want you to do in terms of forecasting growth, revenue, where the lab business will go.
Joseph Baker, VP of laboratory, Baylor Scott & White Health, Dallas: We just went through our budget processes for the upcoming fiscal year. We are assuming that COVID testing is now part of our normal daily operations and that volumes are returning to 2019 levels. We shouldn't be seeing as many variances as we saw this past year on the expense side. Our goal is to hold firm on what our expenses and revenue will be moving forward in the new fiscal year. We are looking at our growth; it is increasing. We are experiencing this on our elective surgeries and seeing more of our outpatients return. We remain diligent on being good stewards of our limited resources to maintain our expenses at a reasonable level.

Stan Schofield, what are you hearing in Maine?
Stan Schofield, president, NorDx, and senior VP, MaineHealth: They're trying to figure out what's going to happen next year. The big hospitals are full. The small hospitals are at 80 percent. The wage pressure is monstrous—the worst I've seen in my entire career. Everybody's scrambling to figure out how we're going to stay competitive and retain people. We have to balance that, and then we have regular capital. There's also strategic capital—replacing big projects like a new laundry system. Right now there's $177 million in requests and $52 million worth of money, so we're pressured in every direction. And then COVID: When it was 5,000 tests a day, we were really busy but the money was great. Now we're down to 1,000 a day. It's still pretty good, but I think it's going to drop further. There's no new offset revenues. The market's pretty tight, and we're going to face large market adjustments in wages.

The personnel problems may be as big as any we face in the laboratory. Terry Dolan, can you comment on the need for money for personnel and any other financial issues you see?
Terrence Dolan, MD, president, Regional Medical Laboratory, Tulsa, Okla.: We have moved to a quarterly moving budget in an effort to adjust to the realities of the market. I've always been a great believer in moving budgets rather than fixed budgets because that's the reality of running a business today. We are seeing wage pressures also. Our volumes have recovered to the year before the pandemic. For the month of May this year we were ahead of May two years ago, so we're coming back very strong, but we do have staffing challenges and the pay is going to be one of them. I think inflation is going to be much more of a challenge than people realize, and the question is: Will we bring inflation under control? I have no assurances at this point.

Hess

Many people have not lived in an inflationary environment. It can be very difficult. Julie Hess, you were one who had a deep concern about questions of revenue growth, new-business growth. What have your recent experiences been and what discussions are you having at AdventHealth?

Julie Hess, executive director, laboratory services, AdventHealth, Orlando, Fla.: This morning I started having conversations with the nursing leadership because they are having so much pressure to staff nurses that they are asking if we would consider moving from our nurse-collect model for our phlebotomy work to the laboratory collecting again. So I may be looking at trying to find 100 phlebotomists, and right now I have 100 open positions for them in my division. I'm not sure where they're going to come from, but, yes, I agree with the comments already made: It feels like we are in a state of inflation with wages, and keeping up with the competing demands is a real challenge.

Peter Dysert, you must be feeling some of these same pressures. What has your recent experience been as you look to the future on costs and on labor?

Peter Dysert, MD, Department of Pathology, Baylor Scott & White Health, Dallas: We're in a competitive job market in Dallas, so there are plenty of jobs available, more than there are people to fill them. Therefore we are making market adjustments. At a system level, our nursing group already got a tranche of additional payment to the tune of $50 to $60 million last year, and I've heard rumors that another round of market adjustment will be made this year.

Joseph Baker (Baylor): We just went through a market assessment and we were able to give adjustments to many of our laboratorians. We had to change all our pay grades for our medical technologists, MLTs, lab technicians, and phlebotomists, just to remain competitive in our markets. This was a significant investment from our system that got us 75 percent of the way to where we thought we needed to be within the market. When you only do this for some of your jobs, it impacts morale for those that didn't receive an adjustment. We're continuing to evaluate those other job descriptions. We expect to see positive outcomes on our recruiting efforts and our ability to retain staff.

Will laboratories be able to find increased pay for their people, more automation, more consolidation? Or are we starting to approach a hard stop, where the labor shortage is going to conflict with the laboratory mission? John Waugh, share your impressions of what you've been hearing so far on this front.

John Waugh, MS, MT(ASCP), system VP, pathology and laboratory medicine, Henry Ford Health System, Detroit: There is a lot of competition for the limited amount of market adjustment funding that's available. We're one of the organizations that works with a quarterly budget because that way we can get a near-term picture of things. We're also comparing 2021 with 2019 because 2019 was a more typical year, so we feel that if we're tracking closer to 2019 and almost pretending 2020 didn't happen, that'll give us guidance. We're back on surgical and medical cases, but we're lagging now on tertiary and quaternary cases. And there are a lot of people lining up for market adjustments, so our compensation division will be busy, but they're going to take all of their guidance based on the input for our market and from CEOs and presidents as to which positions should be lined up. I'm lobbying all of them.

Waugh

What prediction do you have in terms of how you're going to get through this immediate crisis? Do you think you'll come out on the winning end of your request, or will you still have to use stopgap measures?

John Waugh (Henry Ford): It's a little of a lot of different things. There isn't any one fix. We still have a lot of market competition for laboratory positions in Southeast Michigan, so we're all stealing from each other or trying to do so. Part of it is to try to make sure we have a workplace that's desirable, where people would want to work and spend their career. That is very important. I would rather pay people who are here rather than pay people to come here with sign-on bonuses and then not have their loyalty, and they turn around and chomp at the next opportunity.

Julie Hess, let me come back to you because you were also interested in how the laboratories at AdventHealth can grow, where they can find new sources of revenue. Tell us about your progress.

Julie Hess (AdventHealth): We're making progress on paper. We have an upcoming strategy session with our women's and children's hospital, along with our oncology services and our Center for Genomic Health. I hope to get an idea of where we can grow together as our organization focuses on what it wants to accomplish in those service lines over the next five years and what the lab needs to be prepared for. It's a great opportunity for revenue, but, again, there is concern: If I'm asked to do things for the strategy of the hospital overall, can I say yes with confidence if I'm so short on key labor?

Wally Henricks, tell us how you're dealing with the demand for growth, for more revenue, and probably more profitable activities out of the entirety of the Cleveland Clinic pathology operation.

Walter Henricks, MD, vice chair, Pathology and Laboratory Medicine Institute, and laboratory director, Cleveland Clinic: One way is to make sure we are in as lockstep as possible with new initiatives at the institution level. These are efforts for increasing the number of patients seen through new models that have emerged, whether it be figuring out how to deliver testing for remote visits and incorporating that—not that those will continue at the same pace but lessons learned—and also home collection and self-collection. These provide opportunities to expand our services while better supporting the organization's efforts to see more patients. That's probably the biggest one. That's long-term strategy, not just related to COVID.

Within the laboratory, we've looked to expand niche services—a suite of services around subspecialties within pathology, leveraging our subspecialty expertise in anatomic pathology referral base while expanding our molecular pathology testing menu and being more intentional in referring them into molecular, whether it be companion diagnostics or the adjunctive testing that goes with them.

Do you find that you're going to be looking at high-value cancer care that will put demands on subspecialty pathology, molecular laboratories, having NGS at hand, maybe in-house instead of on a reference basis? Are all these things familiar to you so far in the discussions you're having at the Cleveland Clinic?

Dr. Henricks (Cleveland Clinic): Yes, they are. We have NGS in-house, and it's challenging because there are so many targets of opportunity. Which one do you pick next for development, because these things take time to develop? It is assessing multiple factors to identify what is the combination of what's most important clinically but also highest value growth. And that's where we come back to supporting and making sure we're in step with the organization for the clinical programs, which also supports our reference testing.

Bob Carlson, this argues for a lot of investment in pathology specifically and in cancer oncology diagnostics. Will that spur additional consolidation of testing among members of the Compass Group? It also raises the specter of even bigger consolidations that might come down the road. What are your

thoughts?
Robert Carlson, MD, medical director, NorDx, MaineHealth: This is a rapidly evolving field with new markers being identified frequently. Getting consensus on what markers should be included in panels can be a challenge. Validation for laboratory-developed tests requires significant investment of time and resources and having sufficient test volume to justify the effort may support the opportunity for coopetition—arrangements with our other partners and providers.

Mirkes

Doing the esoteric cancer testing and becoming an important pillar of cancer care in a region sounds good. But at the same time, the payers have a few tricks up their sleeves, such as preauthorization of testing, perhaps inadequate reimbursement for important companion diagnostics. Linda Mirkes, what's your experience at Atrium, and what are your predictions?
Linda Mirkes, MBA, MT(ASCP), assistant VP, core laboratory and integration, Atrium Health, Charlotte, NC: I don't know if anyone can predict because we hear daily, it seems, of new payer strategies. We are at the mercy of whatever the payers decide to change on the fly. Molecular and NGS testing are currently being impacted. We're seeing some payers that won't reimburse for outpatient testing above a certain number of targets, and with inpatients—you essentially get nothing for that work. We're starting to work with our oncology providers to understand which targets, which tests really provide value so we can ensure we're putting together panels that address those needs. We are attempting to figure out the sweet spot of providing a panel with enough information versus too much or too little. We're in the investigative phase. We do have some NGS testing live, but we're continually looking at reimbursement as we talk about expanding and growing. Another challenge with NGS is getting the resources and teammates who have enough experience and who understand how to work with that technology.

You're competing with diagnostics companies, with pharma research, and with other places for this type of talent. Is that what you're finding?
Linda Mirkes (Atrium): Absolutely. We find we're competing with some of our vendors and, yes, with the pharmaceutical companies. It opens the door to a whole different level of competition. When we get someone who's good and seasoned, that is the type of person everybody's after. How do I work with my leadership to understand benchmarking when I can't get benchmark data for these highly specialized areas? We can't replace a seasoned person who leaves with a new grad. It's not a one-for-one productivity match, so we're trying to figure out benchmarking and how others are approaching it. I can only say so many times to my hiring committee, "This is very manual, highly technical. It requires highly skilled people." They kind of would like me to prove it. That's where I'm getting stuck.

So the question is how Compass Group members in medical and administrative leadership deal with these acute shortages of personnel, the need to keep productivity high, even when you have to bring new people in, the ease with which you can lose people, not only to other laboratories but to the diagnostics and pharma companies. James Crawford, what is your advice to people who have to sit in committees and try to explain why they need more money to attract and retain highly skilled people?
James Crawford, MD, PhD, professor and chair, Department of Pathology and Laboratory Medicine, and senior VP of laboratory services, Northwell Health, New York: I'll push back on your use of "acute." It's acute-on-chronic, to use a hepatology term. I mentioned at the close of last month's call that we had done a survey of our laboratory consortium members in New York, and all of us are looking at workforce shortages of comparable magnitude, which, when you spin them out over three shifts and multiple subspecialty workstations, create glaring holes. A key

starting point for our advocacy in the budget process is with the most senior hospital leadership. For hospital-based laboratory staff, doing this at the level of the hospital is critical: This is your house, and not having the laboratory adequately staffed puts your house at risk, starting and ending with patient safety. Hopefully we don't have examples of breaches in patient safety, but the threat is ever-present. Since the hospital CMOs, CEOs, and CFOs talk to each other across the network, in essence our advocacy also is across the network. The messaging is the same. We are cheek-by-jowl with our competitors in the New York region, and it starts with the fact that our own workers, a substantial minority, are working two jobs, so they already have knowledge of the price differentials between different health systems. These workers are incredibly price-sensitive. They will move for differentials that might surprise you, but move they will.

So the first part of the campaign is education of hospital and system leadership. The second is actually getting the market salary adjustments. And since it costs money with 2,200 laboratory professionals, 1,000 of whom are licensed technical personnel, that's a big budget hit. So, having in April 2021 our hospital people say, "Okay, we'll target the salary adjustments for November," that's campaign number two, which is: "No, we target it now."

The third is that there aren't people out there. The pipeline in New York is not sufficient. This is not about histotechnologist and medical technologist schools. This is about lateral recruitment. It's about recruitment from out of state, and the state of New York has high walls since it does not recognize coursework or certification from out of state. So right now is the advocacy effort to have the state tear down the walls. This is definitely one of those, "Don't let a good crisis go to waste." It's precisely COVID that has given us access to the state Assembly and the state Senate to have a new law written and, we hope, passed to create a much more lateral openness so that we're not relying on an inadequate pipeline.

But in the end, it's lack of people, which means strategy number four is you must retain your people, which means doing everything you can as a leader to advocate for a good workplace. Round. Talk with people. Small victories count a lot. Even retaining one employee who has light feet and might go somewhere else is a boost for the people who remain and are saying, "Oh my God, we're going to lose another staff member." That means you and your senior lab colleagues have to be willing to go to bat with any HR unit that's nonresponsive and non-agile, because the fourth strategy is you have to do everything you can as a leader to retain your people. You hopefully do so in a fair fashion so it's not just Whac-A-Mole, and the people who look for jobs elsewhere are the ones who get the pay raises. You have to advocate for the whole workforce.

Schofield

Stan Schofield, what kind of regulatory relief might there be, not only in a state like New York but nationally through changes in CLIA or CMS regulation? Could this be a bit of a breathing space as you deal with the labor shortage, or not?

Stan Schofield (MaineHealth): I don't think the regulatory or legislative process is going to take into account the impact of COVID and the shortages. I don't think anybody is going to water down CLIA. State licensure is hard to change or move very much. Labs are going to have to adapt and adjust. Instead of having a four-year MT(ASCP) kind of staff, we will have to move more to not just MLT-level staff but people with a bachelor's degree to be a machine operator. And I'm not being cruel or facetious—a button-pusher with basic training with the automation but not making clinical decisions. The few medical technologists we have are going to have to be expanded into the quality control and safety component more than we've done thus far.

In the past, there was talk about only having the right people doing the right work and making the right decisions, but it's been slow to be changed and almost impossible to completely go down to a stripped-down model because

you lose so much intellectual capital in doing so. I heard someone say recently if a person with 20 years of experience leaves, you can't replace them with one or two new graduates, if you can even find a graduate. Labs are going to have to supplement their workforce by being creative and growing a few of their own at less advanced technical understanding and scientific awareness and using lower-skilled people to run the automated equipment.

So you are talking about real changes in how the laboratory looks at its own workforce.
Stan Schofield (MaineHealth): Absolutely. We've all been talking about it for 10 or 15 years. A lot of us have done a lot of the pieces. Now it's hitting the wall; you have no choice.

Darlene Cloutier, would you like to comment on this labor issue?
Darlene Cloutier, MSM, MT(ASCP), HP, director of laboratory operations, Baystate Health, Springfield, Mass.: At Baystate, we're feeling the same pain. We performed a market adjustment with our team a couple of years ago for the med techs, MLTs, histotechs, and other technical staff, and recently we revised scales for the supervisor, manager, and quality positions on the team—because there was inequity and because we're challenged not only at the technical level but also at the leadership level. We are starting to look at international recruitment of ASCP-certified individuals. We're trying to get creative.

Cloutier

By and large, the laboratory's relationship with the system executives improved dramatically during the COVID crisis. For the first time, many of you felt understood and appreciated in ways you had never felt before. As we look at the declines in COVID revenue and at the demands on labor, and at the reimbursement difficulties because PAMA is sure to return in some guise, do you feel that the new rapport you have with system executives is going to stand you in good stead for these challenges? Or do you think this progress will disappear as the emergency of COVID disappears? Darlene, what are your thoughts on that?
Darlene Cloutier (Baystate): You need a crystal ball for sure, but I do feel like we have a place at the table in a different way than we ever did before. My senior leadership were with me step by step through the COVID crisis and now have gained a much greater understanding of what it takes to mount a response like we did in COVID. So I am hopeful that moving forward, because we have this greater understanding and appreciation of the work that's done in a laboratory, we will gain support.

I'll give you an example. The other day I brought to my senior leader's attention the impact we're seeing on our workforce at a state level of the expansion of the Paid Family and Medical Leave Act, an impact we're feeling in certain teams even more so than in others. I identified that when we develop our budgets, we may have to add FTEs because we're feeling the impact of so many people out of work. The organization is listening and understanding these challenges.

Mike Quigley, please share your thoughts on the labor issues.
Mike Quigley, MD, PhD, vice president, diagnostic services, and medical director, Scripps Health core laboratory, San Diego: We have a lot of biotech in our area so we're in competition with them, but sometimes we get well-trained people who leave biotech. So that can go two ways. We also set up a CLS training program and have been successful in recruiting graduates. That has been a powerful tool. So overall we are treading water with the CLS hires right now: doing okay, not going under.

Ian McHardy, do you have anything to add?
Ian McHardy, PhD, D(ABMM), director, microbiology, molecular, and immunology laboratory, Scripps Health, San

Diego: We responded to COVID surprisingly well. We probably are a bit insulated compared with much of the rest of the country in that we can recruit people from places with worse weather. Ultimately we end up making life harder for all of you, unfortunately. We were able to recruit people relatively quickly when we needed it the most, and so far we've maintained our staffing. As far as the long-term strategy goes, it's our CLS training program.

What are your thoughts on the improvement in relationships with hospital and system executives and whether it is going to be a new resource you can count on as you try to solve problems in the laboratory?

Dr. McHardy (Scripps): We have shown the value of the laboratory in the response to COVID and during the recent cyber incident that affected our system. We've developed strong relationships over the last year and a half that I think will continue into the future.

Stan, do you think this rapport with system executives is going to benefit everyone who's facing the typical kind of threat from a Labcorp or Quest, or do you think it's still going to be out there?

Stan Schofield (MaineHealth): The threat will always be out there because Quest and Labcorp are not going away and they're only going to grow by acquisition. The value of the lab has never been greater if you are a lab that delivered during COVID. You had to do the testing. You had to make a difference in what was going on in your system. Those people will have the halo effect for the next year or two. But there's a lot of external financial pressure for everybody, and no matter how good or how successful you are, hospitals are bricks and mortar, and they may have to monetize an asset to keep their bricks and mortar going. An example: We've had a tremendous success story here. We've made a lot of money for the system under COVID, but at the end of the day they're a system and they're hospitals and you're just a laboratory. As long as you're producing and doing the quality and giving the service, you're going to be fine. You fall short, you will be up on the block.

Joe Baker, what is your view on this, and how does a labor shortage play into it, because the lab could be the best lab operation in the country and yet if it doesn't have enough high-quality lab people working there, it can be difficult to defend an independent position?

Joseph Baker (Baylor): We definitely have a lot more visibility with our senior administration team because of COVID. I would agree with others that we have a seat at the table. I see it as my function, as Dr. Dysert's, and that of our other laboratory leaders within our system to maintain that going forward so we don't lose what we've gained. We're looking at strategic ways we can bring additional value to the system so we're not looked at as a commodity.

With regard to labor, we have more than 100 positions open within our system. About 60 percent of those are in the med tech, MLT, histotech arena. We're struggling to find people to come in, not so much in our metroplex area but definitely in our more rural hospital locations. We struggle significantly in the esoteric laboratories—HLA, molecular—they're a real challenge. We're offering higher sign-on bonuses than we have previously done, but it's just to compete with what our competitors are offering.

We published a couple of articles on cybersecurity recently. Hospitals have had significant outages, and we know health care could be the most vulnerable major industry to cybersecurity threats. And laboratories are front and center as suppliers of critical data. Terry Dolan, what are your thoughts about cybersecurity in the current environment?

Dr. Dolan (Regional Medical): We can't get enough of it because we are a target like any other vulnerable target, and I tell our IT staff that I want the very best available anywhere. Unfortunately, there are a lot of smart people out there who are criminals doing their best to undermine us, and the question is: Who will win in the end? I have no idea. We have fortunately been able to avoid it, but that may not be the case tomorrow. And IT specialists are hard to come by. It's going to be hard for us to keep coming up with honest people who are smart enough to keep ahead of the criminals. It'll be a continuous challenge.

Peter Dysert, you know a lot about the IT side of laboratories and pathology. If you think you have a problem with med tech labor, imagine the kind of problem you have with the highest degree of IT expertise to combat cyberattacks. How are the discussions at Baylor going on this?

Dr. Dysert (Baylor): I don't know that we are any different than anyone else, but at an industry level, it's a topic that's going to drive a new conversation for some organizations, and that is to outsource through the large consolidated technical initiatives so that the organizations have the talent and infrastructure to help them deal with the threat. The idea that an organization can take this on on its own without getting outside help is naïve, and the players in that space will get bigger and probably more sophisticated in terms of those who can protect us. It is going to mean a whole new conversation for your IT staff to look to those types of partnerships that they may not have had in the past.

How will your vendors in the laboratory play into that? Will they participate in a larger-scale enterprise on just the cybersecurity issue?
Dr. Dysert (Baylor): That question goes to Epic, since we're probably headed in that direction, and Epic as an EMR provider. The question will be asked: If you're an Epic systemwide install, what is the answer for these kinds of problems? What type of technical infrastructure, from a security and cybersecurity perspective, does a partner bring to the table that Epic cannot represent, because usually these things get in the door not through Epic per se but through email apps and other things. So you're going to need an enterprise-level consulting group that can help you figure out what type of risk you have and then manage it for you.

Wally Henricks, you have a lot of IT expertise. What are your thoughts about cybersecurity at the Cleveland Clinic and for others?
Dr. Henricks (Cleveland Clinic): We've been aggressively planning for this, and it's at the institution level on down. Every department is tasked with business continuity planning for a ransomware attack, all the way down to complete loss of network. Everybody has downtime plans, but this is a different kind of downtime. What business processes can stay, short term and longer term? How do we best coordinate support of the clinical services? Trying to function at anywhere near full scale in a complete ransomware situation is hopeless, but you have to keep people alive. How do you best do that? How do you convert to manual processes when necessary? There's a body of work being done for that, and it's been ongoing.

On the technical side, there's a different skill set—the IT people that labs often think of are those who support the LIS. They know the lab operations that the IT supports. Often med techs or others have gotten LIS training and maybe more technical training, but here we are talking about IT security specialists who know how to keep networks safe, how to manage devices, how to distribute patches and changes, and how to keep up on all of the breaking developments. It speaks to the need for what Pete Dysert said—it's an enterprise-level commitment, one that can be made at the largest stratum of the organization. It's not really an EHR vendor-specific issue. These attacks get in through insidious emails and websites. Our group has been aggressive about clamping down on where we can get to on the Internet, and I'm sure all of you have some variation on this.

What are the odds that the Cleveland Clinic will suffer a major cybersecurity breach in the next three years?
Dr. Henricks (Cleveland Clinic): I can't quote a probability. Hopefully the odds are being reduced every day, but I can tell you that we are under constant attack.

John Waugh, do you feel besieged and under attack on a regular basis at Henry Ford?
John Waugh (Henry Ford): It's on my anxiety list all the time and very high up there. The article in the April issue of CAP TODAY ["Weeks of lab turmoil follow cyberattack"] was absolutely chilling.