Lab staff shortage calls for speed, money, and more

August 2021—*From critical to worse is how two Compass Group members described the lab labor shortage on July 6 when the group spoke with CAP TODAY publisher Bob McGonnagle in another of their monthly virtual meetings. "Things imploded. We're struggling in every area," said one. Others have similar stories and shared what they're doing in response. "We now have a full-court press," said another.*

That and more—surprise billing, laboratory-developed tests—were what they and McGonnagle talked about. Here is what they had to say.

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

The Biden administration is putting out the first regulatory guidance about surprise medical billing, which is a concern to all and particularly those who have active independent pathology groups. From the looks of it, the intention from a regulatory basis is to make it virtually impossible to have any differential for out-of-network fees or ancillary services, and that could be harmful to those who are outside of systems. Steve Carroll, what have you heard?
Steven Carroll, MD, PhD, chair, Department of Pathology and Laboratory Medicine, Medical University of South Carolina: It is definitely hitting our radar here, and it's causing a lot of concern. Our financial people are worried about how it will impact us, although the scenarios in which they think it's going to impact us are a bit vague.

How serious could this be?
Dr. Carroll (MUSC): They don't know exactly how serious it's going to be. We're sort of in the midst of a transition state. We recently purchased four new hospitals. We are about to close a deal to purchase four more, and we're going to provide pathology services there. The shape that will take is yet to be determined, and that's why they can't give me anything definitive about how they think it's going to impact us. The caution and concern are probably merited, but what form the damage will take isn't clear yet.

Stan Schofield, are you seeing anything at NorDx?
Stan Schofield, president, NorDx, and senior VP, MaineHealth: There is community and public awareness and complaints are being filed, but there's not yet what I would call a critical mass around here to get people excited or terribly concerned about surprise billing or secondary billing. Nobody wants it, and the legislature just adjourned, and they didn't address anything around surprise medical billing. They're still working on transparency issues.

As COVID-19 ebbs, what worries are returning?
Stan Schofield (MaineHealth): It's still about staffing. For 10 years, staffing has been kind of sensitive. The past two years it has been a critical situation, and now it's like a meltdown. Long-term people are hanging it up and saying, "I'm done." We're going to come up with a major wage package next month.

Janet Durham, are you dealing with the same in the Chicago area and Wisconsin?
Janet Durham, MD, medical director, Wisconsin operations, ACL Laboratories, and president, Great Lakes Pathologists, West Allis, Wis.: Yes, it's a struggle. More people are deciding they want to retire, and for others it's a question of which facility they are going to work for and where they can get the better wage.

Sterling Bennett, MD, MS, senior medical director, pathology and laboratory medicine, Intermountain Healthcare, Salt Lake City: The labor shortage seems to be affecting nearly every industry. We're seeing sign-on bonuses for fast-food restaurants, a raise in pay if you refer someone to work at McDonald's. Everybody's dealing with it, and health care systems in general have been slow to respond to the marketplace. It could take us a while to catch up relative to other industries to which our frontline, on-the-job-trained employees could go.

We all realize there are no magic bullets for this one. The wage increases that Stan referred to will be a big piece of change.
Stan Schofield (MaineHealth): It's tough to face and tough to afford. We have PAMA cuts coming down in January

again, at least at the moment, and if you look over the past six years, we're down almost 50 percent in revenue. And in the last two years or three years we're up 20 percent for technical staff raises and retentions. And it's not going to change. People are not coming into the field, and those who are coming in aren't staying long because they can go out and become a consultant or work for Epic and make a lot more money.

Most of you have your main campuses, your main hospitals with hundreds of beds, and you also have smaller hospitals, clinics, doctors' offices, staffed emergency departments, et cetera. When you have such a mix of centers of testing, and then a labor shortage on top of it, do you worry about consistency in lab testing quality? Sterling Bennett, I know Intermountain can be quite far-flung in Utah.

Dr. Bennett (Intermountain): Yes, and the size and complexity of the facilities vary dramatically. We have hospitals with fewer than 20 beds, for example, and in terms of concerns about the quality of the testing, the smaller facilities probably have more consistency right now than the larger facilities in that people have chosen to go to the small communities because they want to live there. They want that lifestyle. The turnover is much lower than in our urban centers where we do have more concern about the turnover we're seeing and the proportion of employees who've been on the job for a short time. Experience matters.

Bull

Tony Bull, you're in incredible competition for good people. Tell us about your labor situation in Orlando now.

Tony Bull, executive director, AdventHealth, Orlando, Fla.: It tracks with what everyone else is sharing, and adding complication for us is that we're transitioning now to Epic and our rate of retirements has gone up quite a bit. And our turnover rate has never been higher than it is right now for our nonlicensed employees—laboratory assistants and others. That can be competition from other industries, other factors we're all reading about, but that's been a real challenge. And I'd even say it's new hires where we're seeing the highest turnover—people who've come into this field and then leave for something else. We brought in a group of lab techs from the Philippines and so far it's going well, but that's an indication of how hard we're having to work to find qualified people.

How do you respond to my earlier question about maintaining consistent quality across a diverse, distributed network of testing, where you have expertise in critical areas and central laboratories, pathology, advanced infectious disease, and then you're all over the place with clinics, doctors' offices, et cetera? Do you worry about consistency of quality?

Tony Bull (AdventHealth): In terms of our laboratories, I don't worry. The quality in the laboratories is consistently high. We communicate and work with each other, so if there's expertise at one place that is needed at another, we do a good job of sharing information. I do worry a little about physician offices and some of the other service locations, and in a lot of ways it's sort of like herding cats. You have people who aren't familiar with all the processes—they don't do it as frequently—so there's more opportunity for problems with those sites. We just have to remain vigilant. It takes a lot of work.

Cindi Starkey, give us a report from Tulsa.

Cindi Starkey, MD, PhD, medical director, hematopathology, Pathology Laboratory Associates, Regional Medical Laboratory, Tulsa, Okla.: We've had a struggle with the labor force as well, and I agree that the turnover is both people opting to retire now—particularly with the pandemic, if they reach that age, they say, "This is too much. We're done. We're going to go ahead and retire," rather than continue—and then the new hires, who will be onboarded, trained, get bonuses, and jump to another facility. We see a lot of moving around to other facilities in

our neighborhood.

Dr. Starkey

What is Regional Medical's experience with worries about consistency of quality testing regardless of site?

Dr. Starkey (Regional Medical): There isn't much concern about inconsistencies in quality among our laboratories. We oversee a lot of it. We do have a lot of inexperienced new technicians, but we have a safety net with all of our systems in that staff can forward questions to the more experienced centers and our core laboratories, and that seems to help a lot.

Darlene Cloutier, what is Baystate's experience?

Darlene Cloutier, MSM, MT(ASCP), HP, director of laboratory operations, Baystate Health, Springfield, Mass.: We have the same challenges, and off-shift help is an extreme challenge for us, because we either have people working on the night shift who can go to another facility where they can work on a day or evening shift, so they leave the organization, or people who will move to another shift within our organization. And with regard to growth, we are definitely challenged in our more manual laboratories like our histology section, where retaining and recruiting PAs and histotechs has been difficult. To support growth, you need to have the staff in place.

I'm told that wherever Amazon puts up one of its distribution centers, the labor is taken from the surrounding businesses, and I'm assuming that may take some people out of health care as well.

Darlene Cloutier (Baystate): Yes, especially the lab assistant or phlebotomy level candidates.

Dan Ingemansen, have you experienced this?

Dan Ingemansen, senior director, Sanford Health, Sioux Falls, SD: We serve the Upper Midwest, and they're establishing two distribution centers—one in Fargo, North Dakota, and another in Sioux Falls, South Dakota. Each facility will bring about 1,000 jobs per community. Across the board we're going to compete for employees in an already difficult labor environment.

Greg Sossaman, what is your staffing situation in New Orleans?

Gregory Sossaman, MD, system chairman and service line leader, pathology and laboratory medicine, Ochsner Health, New Orleans:

I like Stan's description: It went from critical to meltdown over the past year. We were focused on COVID, we devoted so many resources to molecular testing, and although we didn't take our eye off the ball, it seems to have happened quickly. Things imploded. We're struggling in every area. We're seeing exactly the same things others have reported—acute-on-chronic exacerbation.

Dr. Anthony

Laboratory-developed test regulation has raised its head again, and it looks as if there might be increased scrutiny. Lauren Anthony, can you comment on this development?

Lauren Anthony, MD, system laboratory medical director, Allina Health, Minneapolis: I know there are unintended consequences from this, but I, for one, would welcome LDT regulation because of the unproven and low-value LDT tests that some of the commercial laboratories are putting out there and marketing directly to clinicians and to patients. Some of these tests encroach on our nonprofit health systems because they're marketed in ways that increase demand. They take up time and resources to address, to educate around, and to explain that the test doesn't add a significant value or that it's unproven.

Many of these end up being self-pay tests, and even if they're self-pay and performed for recreational purposes, they end up encroaching on the health care system because patients want follow-up tests for a supposed abnormality that was found. Some of these places don't provide the infrastructure to support their testing. They rely on the infrastructure of health care systems to draw their samples and provide them with a never-ending stream of specimens for which they don't have to provide resources. Generally, commercial labs that perform tests with proven value will send a phlebotomist to a patient's home and provide that service. Most labs offering self-pay tests say, "Take this to your doctor" and expect them to sign off on it and provide collection and processing services.

So they create expectations. They add unnecessary testing, and they invariably end up encroaching on our resources. I tell clinicians that when patients bring in these things, they can make the laboratory the bad person, and we'll address it. We do have policies.

Sterling Bennett, tell us a little more about laboratory-developed tests and how you look at them at Intermountain right now.
Dr. Bennett (Intermountain): LDTs take a few different shapes for us. Some are what we usually think of as an LDT, where you take ingredients from scratch and develop a test that fills a need in the marketplace or in the health care arena that we cannot get elsewhere. That's the minority of what falls under the LDT umbrella for us. Most of these are variations of what the FDA has approved, where we're looking at different specimen types or extending the stability times or other such things. Whether the LDT regulations end up being helpful or harmful depends on what they ultimately try to regulate. If they go after tests of the type that Lauren Anthony described, ones that have low or unproven clinical utility, and the regulations require demonstration of clinical utility before the tests are marketed, the regulations could be helpful. But if they take another form, where any modification of an FDA-approved assay now has to go through seven layers of bureaucracy, that would worry us.

Tesoriero

Compass Group members have always strived to offer solutions to problems. So I would like to return to the labor problem. Does anyone have an innovative solution or a success story about how you're dealing with the problem of staffing in the laboratory?
Richard Tesoriero, VP of business and operational performance, Northwell Health Laboratories, New York: Most recently we did a market-based survey of salaries—we needed to know where we were in the marketplace. Our goal was not to be at the highest percentile and certainly not at the lowest, but we were surprised to see we were below the 50th percentile for other systems in this marketplace. So we pushed ourselves to the 75th percentile and took that increase in June. It's tough to float those salary increases, as Stan said, and it was substantial. Even in the support areas—accessioning, phlebotomy—the rates were below the 75th percentile, which was surprising because we thought we were aggressive. So salaries are changing significantly.

Would anyone else like to comment on their efforts to deal with staffing problems?
Dan Ingemansen (Sanford): Our leadership team is focused on establishing an environment in which people want

to stay. Beyond that, it's collaborating with all the departments that help with the onboarding process; everyone is accountable to their piece. It used to be apply for a job and you'd hear back in a week. We now have a full-court press. If an application comes in, we work with HR to not only engage with that candidate but also to work through the process as fast as possible. We know applicants are applying for multiple jobs. There's a lot of opportunity and it makes us act quicker on any type of interest we may see.

Tell us more about how you're working with Human Resources.
Dan Ingemansen (Sanford): Our HR department became a system service department several years ago and implemented a single software recently. We have dedicated recruiters representing the entire system who are able to talk with candidates. They know the characteristics and qualifications we're looking for in the laboratory. The only variable is hours and facility. When they have a candidate, it's a full-court press to review the applicant and get an offer out as soon as possible, if applicable.

That must give you a leg up in a tough market.
Dan Ingemansen (Sanford): We're not perfect but I think we're doing a better job. We learned through the pandemic, as we were looking to the agencies to provide staff, that if the agency contacts you about a candidate, you have hours not days to respond and get an offer out.

Janet Durham, do you have a staffing solution to share?
Dr. Durham (ACL): We've had a histology school for years, but what we're trying to do for anatomic pathology now is to have a sort of continuous funnel of having people who are laboratory assistants, and who know something about the lab, be the candidates who are applying to our histology school. And for the first time we will have two different cohorts every six months, a new group so that we have a more continuous flow, because, as Darlene shared, when you're trying to get new work, the limiting factor is having the histotechs to be able to perform that work. So we're hoping that is successful for us this year.

Richard Tesoriero, would you say that the difficulties with histotechnologists is on a par with the difficulty with medical technologists?
Richard Tesoriero (Northwell): It's probably more difficult with a smaller pool.

Dan Ingemansen, what is your solution for histotechnologists?
Dan Ingemansen (Sanford): We have a program in which we can take a four-year-degreed science major and surround the person with the right curriculum. After a year, the person becomes eligible for certification. That program has worked out well.

Johan Otter, can you comment on staffing issues on the West Coast?
Johan Otter, DPT, assistant VP, Scripps Health, San Diego: We have 10 openings for histotechnologists. It's not easy because it's not the highest-paying position and our cost of living is high. We are in a competitive environment. We're hiring away from our other labs in town right now, and we had one start and quit two weeks later because they couldn't keep up with the pace of work. It's been challenging.

Dr. Otter

IVD people always say they have a lot more automation they can bring to labs to help alleviate labor shortages, and they've largely done a wonderful job with labor-saving automation. But I'm wondering if we're at the end of the trail there or close to the end of the trail. What are your thoughts?
Dr. Otter (Scripps): It depends on what you can afford automationwise as well. Having just gone through a

cyberattack, I can tell you automation is one thing. You still need to have people do a lot of the work, and especially at the lower end of the pay scale. Automation often takes people out on the lower end of the pay scale, but you still need to transport your specimens and you still need people to accession your specimens. You may have automation, but in particular in anatomic pathology, that doesn't always work that well. It's a two-edged sword, and I would say it can go either way.

Stan Schofield, can't IVD folks help solve some labor problems beyond providing automation? That is, should they be able to offer packages of machines and technicians? Would that help?
Stan Schofield (MaineHealth): The idea is perfect, but by the time they would mark it up, it wouldn't be affordable. And they can't find the people now to begin with. So, yes, we're kind of getting to the end with automation, unless you have more scope and scale and a critical mass.

Look at microbiology, for example. We're a good-size microbiology lab, but it's not enough to have a decent return on an investment of $3 million or $4 million worth of capital, which is nothing compared to some of the systems. The chemistry, immunoassay, hematology lines are all okay, but we still don't have integration of full robotics. That would help. The last big area is microbiology, and there are not many choices and those choices are really expensive. So, going forward, the justification for that is almost whether you want the service, because I can't get the bodies.

Having IVD companies hook up equipment and people is a great concept, but I don't think they'll ever do it. And you know what that's called? Quest and Labcorp. Our instruments and our people, and we own you now.