Salaries, schools, students—all eyes on workforce

September 2021—*SARS-CoV-2 spread and the staffing shortage drove the conversation when Compass Group members met Aug. 3 for their monthly call led by CAP TODAY publisher Bob McGonnagle.*

"Like others, we were seeing problems before COVID, but COVID seems to have kicked it into overdrive," Steven Carroll, MD, PhD, of the Medical University of South Carolina, said of the shortage. And more long term, it's time to jump-start training programs, he and others 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. Here is what they shared last month.

Stan Schofield, has MaineHealth seen breakthrough infections?
Stan Schofield, president, NorDx, and senior VP, MaineHealth: Yes, we're having breakthrough infections every day. So far we know of 20 breakthroughs in the past few weeks of employees of the system who are fully vaccinated. They're doing sequencing on this to see what's going on. Our vast majority of positives are unvaccinated people under the age of 40, 45.

Jennifer Laudadio, what's going on in Little Rock? And are you at the mandatory vaccination stage or in discussions about it?
Jennifer Laudadio, MD, professor and chair, Department of Pathology, University of Arkansas for Medical Sciences College of Medicine: Our legislature passed a rule that as a state entity we cannot mandate vaccinations, so we're not having the conversation, although they are trying to get the legislature to reconsider.

Test volumes are similar to those in January and February. We have 10 hospitalized patients currently who were vaccinated. Most of our vaccinated patients don't need ICU-level care. They tend to be older or immunosuppressed or have other underlying conditions.

Clark Day, tell us what's going on in Indianapolis.
Clark Day, VP of system laboratory services, Indiana University Health: At IU Health vaccines are mandated for 36,000 team members. The mandate went into effect in May and team members were given until September 1 to be fully vaccinated. To date, about 80 percent of IU Health team members are compliant.

In Indiana about 44 percent of our total population is vaccinated. Our health system has had a few breakthrough infections. A handful of our pathology team members have experienced the breakthrough.

Sarah Province, tell us about Orlando's situation.
Sarah Province, director of laboratory operations, AdventHealth: Testing is increasing, and our positivity rate in central Florida is 25–35 percent. For employees only we're running 15–20 percent positivity rate with over 200 employees tested each week. We do have breakthrough infections. We discontinued preop screening for specific outpatient populations, GI patients, and pediatrics in June. We're running between 700 and 800 tests a day at the Orlando campus.


Dr. Antonara

Stella Antonara, tell us about mandatory vaccinations in Columbus and breakthrough infections.
Stella Antonara, PhD, D(ABMM), medical director of microbiology, OhioHealth: It was announced today that we're going to have mandatory vaccination, and they're giving people until December. Those choosing not to be

vaccinated will require weekly testing. It's my understanding that the other health systems in central Ohio will have a similar policy.

We have seen breakthrough infections and we work with Ohio Department of Health to sequence these patients.

Steve Carroll, same question for you.
Steven Carroll, MD, PhD, chair, Department of Pathology and Laboratory Medicine, Medical University of South Carolina: We went mandatory with vaccinations almost immediately after Houston Methodist Hospital won its case. We are seeing breakthrough infections but not a large number. Yesterday's positivity rate was just shy of 20 percent and we have a lot of people coming into the hospital. Greater than 90 percent of the cases are delta.

Peter Dysert, are you seeing what your colleagues here are reporting?
Peter Dysert, MD, chief, Department of Pathology, Baylor Scott & White Health: We're seeing the same. Our inpatient census is probably about a third of what it was at peak. Almost all of our admissions now are unvaccinated, and those who are vaccinated but immunocompetent seem to have a five- to seven-day flulike illness not requiring hospitalization. Incubation time seems to be a little shorter with the delta variant, and they have high viral loads.

How worried are you that this is likely to spin out of control again?
Dr. Dysert (Baylor): Each day our census appears to be creeping up. We had been told to prepare for a peak that was roughly 25 percent of our peak in the early stages, but we're already at that number and probably will exceed it.

Dwayne Breining, what is it like now in New York and what are your predictions?
Dwayne Breining, MD, executive director, Northwell Health Laboratories: The positivity rate is about three percent, which is about twice as much as it was two weeks ago. We're above 80 percent delta variant. Almost all admissions are among the unvaccinated. In New York about 70-plus percent of the people eligible for vaccine are vaccinated, so we don't think our numbers can get all that high, but we are watching a bit of a resurgence and it is sorting right along the zip codes where the vaccine rates are the lowest.

Greg Sossaman, Louisiana is having an outbreak and has low rates of vaccination. Tell us what you're experiencing at Ochsner.
Gregory Sossaman, MD, system chairman and service line leader, pathology and laboratory medicine, Ochsner Health: Louisiana does have a low vaccination rate and a positivity rate now above 20 percent, and more than 90 percent of that is delta. We do not have a vaccine mandate. Our state attorney general told us we would be sued, and he has already sued a medical school within the state for mandating vaccines prior to their being fully approved. For those who are not vaccinated at Ochsner, which is still a significant portion of our employees, we are moving to mandatory N95 masks and weekly testing.

We've seen very few breakthrough infections, but of those we have seen the patients are all well.

Hospital beds are close to full. We put a COVID ward back in place. We're redistributing nurses and physicians, similar to what was done in the initial surge. The biggest problem is staffing. We need staff to expand the number of our ICU beds to help the local hospitals whose beds are full.

Lauren Anthony, what is Allina seeing in Minneapolis?
Lauren Anthony, MD, system laboratory medical director, Allina Health: We're seeing an uptick. We were starting to ease up on some of our pre-procedure testing, but now they're looking to halt those plans and roll back to what they were doing before when everyone was tested. We have seen breakthrough infections and the risk factors are the common ones.

We're working now on the approach to the flu season—which platform to use, because some of the best tests available for testing flu along with COVID come prebundled. They're putting multiplex cartridges together, but what do you do when you need only flu and COVID and you have a multiplex cartridge with other things on it? How

do you manage the orders for that or providing results for tests that aren't needed or weren't specifically ordered? Test utilization, billing, and so forth are the concerns.

Yes, there is a lot of concern around panels—their costs, getting reimbursed.

Anthony

Lisa Anthony, tell us what HNL Lab Medicine is experiencing.
Lisa W. Anthony, MS, MT, DLM, senior VP for strategic initiatives, HNL Lab Medicine, Lehigh Valley Health Network, Allentown, Pa.: Today our network in conjunction with two neighboring networks jointly announced mandatory vaccinations will be required for colleagues and nonemployed partners after the first COVID-19 vaccine receives full FDA approval. We will have eight weeks post-approval to comply with this mandate.

Pennsylvania is now considered to be a high transmission state but is not currently tracking breakthrough cases. HNL is, however, performing NGS and while we are not seeing significant breakthrough case numbers, all have been the delta variant.

Carbonneau

Eric Carbonneau, how are things in Albuquerque?
Eric Carbonneau, MS, MT(ASCP), director, laboratory operations, Woodward Labs and TriCore Research Institute at TriCore Reference Laboratories: A few breakthrough cases but most are minor illnesses. Our hospitalizations are mostly the unvaccinated. We are sitting at about 65 percent fully vaccinated in the 12 and over population. Our positivity rate jumped from about one percent to six percent and a majority is delta. We've also seen a spike in parainfluenza and RSV cases.

The University of New Mexico is the first public entity in the state to require vaccination to attend in person.

Dan Ingemansen, what's the situation in Sioux Falls?
Dan Ingemansen, senior director, Sanford Health: The expectation is all employees are vaccinated or obtain an exemption by November 1. Following this announcement, we had a protest last week in front of one of our medical centers, but overall we're getting support and good feedback from the communities we serve.

Next week we're going to simplify our build within Epic—we will be standardized to Cepheid's SARS-CoV-2/flu/RSV test at all of our laboratories for symptomatic patients. We will have a separate test code for SARS-CoV-2-only testing for those who may be traveling or contact tracing. Within our Cepheid order, the provider can select the analyte or analytes they're interested in. Although the analyzer will run all four targets, our team will only result the analytes ordered.

A frequent question is what to do with positive results from tests not ordered. I'm wondering what others are doing with those results.

John Waugh, what are you doing at Henry Ford?
John Waugh, MS, MT(ASCP), system VP, pathology and laboratory medicine, Henry Ford Health System: We have order sets that are together so physicians see what is in the order set when they create the order, so we're not coming back behind them and we did that intentionally. We did not want, for example, RSV orders to accompany seasonal influenza last year or COVID testing. We're billing and reporting only on what was ordered at that time.

We now have a mandatory vaccine policy and it has a September 10 date on it. We've seen our share of protests at five hospitals, and we still need about a quarter of our employee population to get vaccinated in a short period.

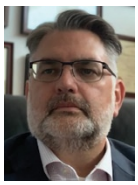
I'm watching a couple of leading indicators here: Are the employee health clinics packed with people going in there to get their vaccinations, and if they have a two-dose system are they getting in there in the next couple of weeks or so? The other leading indicator I'm watching is whether people are drawing down vacation time banks, maybe in anticipation of leaving the organization.

From the start our organization has taken the position, it's your choice, your decision. You don't have to divulge your vaccination status unless you choose to do so. There have been a lot of listening sessions—tell us what's on your mind, what your concerns are. That has helped move the needle for some, but others made up their mind early and are cemented into a position. So this is a polarized situation and not unique to Detroit.

We have stopped presurgical testing of vaccinated patients.

Let me turn now to a topic we spent time on in our call last month—staffing and the economics that get pulled into it. I'm assuming the headlines don't make a laboratory or hospital a more attractive place to go work, and I have to assume the financial incentives are still first and foremost in people's minds. Stan Schofield, is that true in your experience now?
Stan Schofield (MaineHealth): Absolutely. We just rolled out our new comp program and we're waiting to see the results. The approximations are eight to nine percent for lab medical technologists and up to 15 percent for phlebotomists. Unprecedented numbers but it's not just the lab—the entire health system rolled out more than $65 million in comp adjustments. Of 23,000 employees we have 3,700 openings at the system level, and of them more than 800 nurse openings. We're not alone in this. We're doing a big hiring blitz and having a job fair next week to promote the new wage package. For the people who left in the past three or four months, it is all about money. I can confirm that.

Is the shortage now so serious that they're saying despite the reimbursement, revenue, bottom-line conditions, we need to increase wages because if not we won't be able to pursue our mission?
Stan Schofield (MaineHealth): That's part of it. The other part is we didn't get any slack on the budget requirements. The financial requirements of the system haven't been waived, we're not getting much relief, and it will be an interesting year if PAMA comes in with a full cut. We've always been a successful, strong financial performer. We'll just have to see. We budgeted a low COVID testing volume for the year because we weren't sure. If this surge continues, it's only going to help us financially but it's not going to help us operationally with staffing.


Dr. Breining

Dwayne Breining, talk about the labor and financial issues and the pressure to continue offering service at the level you do.
Dr. Breining (Northwell): It's similar here. Even before COVID we were seeing a steady increase in the number of open positions. I think New York has an older workforce than much of the rest of the country, so it's even worse.

And there are four or five big medical systems fighting over the same labor force, so there's a bit of an arms race mentality as well. We just offered a new comp regional salary base and ideas to keep ahead, so that's going to keep spiraling.

COVID has led a lot of people to consider their work-life balance. Some of those who had extended their careers well past the time when they were eligible for retirement have rethought that. And a lot of our techs juggle two and sometimes three jobs. It's a buyers' market; they can work as much as they want. And a lot of people are considering that work-life balance and whether they want to continue doing that. It's good for them but bad for us in terms of keeping the lab running at the current rates.

Dr. Carroll

Steve Carroll, does this labor crunch sound familiar to you?
Dr. Carroll (MUSC): We have been fighting over labor for months. Like others, we were seeing problems before COVID but COVID seems to have kicked it into overdrive. And it's across the board; it's virtually every kind of position. We have shortages in microbiology and hematology. HLA was a problem; histotechnology is a major problem now. And a big part of it is salaries. We had not been paying at the level of some of our competitors so they were recruited away to community hospitals. We were paying them lower wages to do a harder job and that's not sustainable. So I had to make the case that we have to get our salaries up, and we're in the process of doing that.

The other thing long term is the pipeline. Training programs have been contracting across the country, but if we don't have people coming through those training programs, we're going to have real long-term problems. So I'm now making the pitch that we have to reinstitute many of these programs. Every time we do a CAP inspection the pathologists at the places we're inspecting ask me why we're not training these people. They have a point—we have a responsibility to do it.

The training pipeline problem seems to be a nationwide one.
Dr. Breining (Northwell): We are opening a medical technology training program with Hofstra where we opened the medical school a few years ago.

Right before COVID we had started a community outreach type of thing. We had always been involved with the high school students, but we realized by high school a lot of students have already decided to forgo math and science. So we reached out to every middle school science teacher to invite them and their students to come through our new, shiny, state-of-the art laboratory for tours. Our team was great; they had kids learning how to do point-of-care testing and other such things. It was phenomenal, well received, and then COVID hit so it was put on the shelf. We're hoping to start it up again, but with what's going on with delta, I think we're going to be waiting a few more months.

***Barron's* this weekend had a cover story on how the U.S. is going to be in for a long-term labor shortage. Is training within our own systems going to be adequate, or do we need a change in paradigm about the career, the career path, and the eventual outcome of that kind of employment?**
John Waugh (Henry Ford): We're looking at reopening our school of medical technology. It's a long road but I think it's essential, as Dr. Carroll said, that we train people in these fields. We have the capacity to do it, and we've done it before. It's challenging, but I'm not about to give up the field of pathology and laboratory medicine lightly. It's an essential resource for the health system. We started this process pre-COVID; it got stalled and I've got it back on a restart. But there are not enough qualified people coming forward, unfortunately. I don't know if that fully answers

your question, Bob, but that's some of our situation on the ground.

Waugh

That does answer my question in the following way: You can open all the medical technology schools you want to, but if the word of mouth about the profession is that you're going to be underpaid and overworked and don't have a nice career path for promotion, it might all be in vain.
John Waugh (Henry Ford): You're right, but I don't know that we have any other choice but to try. If we continue to have shortages and we hire as we're doing in some respects now—we're hiring agency people to fill positions at big premium pay, and we have an international relationship whereby students are trained offshore—the price is going to get higher.

Market adjustments are not hard—all you need is money. But there are a lot of people standing in the money line with us on this one. At the executive level of our laboratory team, I have to fight hard to make the case, and not just hope, that somebody recognizes our people.

We've spoken often about the silos and splintered groups we have in the field of pathology and laboratory medicine. We have the IVD vendors on one side. We have multiple laboratory organizations, each pursuing important agendas of their own for their own memberships. Sterling Bennett, do you think there's a need for more coalition building to help solve some of these problems like labor?
Sterling Bennett, MD, MS, senior medical director, pathology and laboratory medicine, Intermountain Healthcare: Yes, there's a need for more coalition building. It's unlikely we'll see a consolidation of the organizations because, as you said, they exist for certain reasons, but I do think they could cooperate and join in unified efforts that might help us get through the current situation.

Stan Schofield (MaineHealth): A great example of cooperation is the Compass Group, but we can't solve each other's staffing and training problems. It's going to take legislative and financial relief to make the career path financially viable against the high costs of a college education and the debt that comes with it. But hospitals and health systems don't have the money—there's just too much cost that's not being covered operationally and financially by the patients and the insurance companies and the government. It's a tough combination, and the government doesn't want to pay more because it is paying too much now. And the private insurers are tired of the cost shifting, so they're not going to do anything to raise operational expenses by higher reimbursement to pay higher salaries.

Greg Sossaman, would you like to comment on this issue?
Dr. Sossaman (Ochsner): Not to disagree with Stan, but I do wonder about the ability of the larger health systems, like the groups on this call, to partner with local community colleges or other universities for training programs. We partner with our academics group here, which established a training program for physician assistants at a local university. They saw an opportunity to talk to university students who were interested in perhaps medical or pharmacy school but probably weren't going to make it into those graduate schools and to divert them to other kinds of programs. With that in mind, we are partnering with them to help them start an MT school. Things like that are opportunities in our larger systems. We know we're going to need to make our own. So I think and hope there are other opportunities.

Looking for additional funding from the government is problematic. The advocacy that many of the large organizations like CAP do is aimed at reimbursement for physicians and other services—the clinical lab fee

schedule, for example. The educational dollar piece has been left out for many years. There's a well-known retirement cliff that we've already gone over in many areas. I know we have. I do think it would be wonderful if some of the larger organizations could come together to focus on this issue in a much larger way. A group like Compass has a lot to add to that, too, because many of our members have done the things we're looking to do. Those are creative and valuable solutions.

Sam Terese, you've done a lot to help train people to work at Alverno, and you have an eye and an ear for a lot of different systems and the overall economic problems that Stan Schofield described. Give us your impressions about the discussion we're having.

Sam Terese, president and CEO, Alverno Laboratories: We have two medical technology programs, an MLT program, and a histotech program. We're adding another medical technology program. We have programs for training biology-degreed–level people to be technologists. So we are doing as much as we can to add to the labor pool on the supply side.

On the demand side you have to ask if the lack of labor is going to drive consolidation. This is not just a laboratory question. Go across any number of industries and you'll notice that the hours are aligned to an eight-hour day, because that's all the labor we have available.

There's just not as many people, like those who had been extending their work lives into their 70s but who have now changed course because of COVID. I wonder what is going to happen on the demand side, the need to reduce and where it will be felt. My fear is that it will be felt more in rural health and we'll see accelerated closure and disparities of care based on zip code. It's a concern on where we're headed.