‘Scary situation’—lab leaders on staffing and COVID

October 2021—*Surge, supplies, staffing. Eighteen months into the pandemic, the story remains similar. Even where laboratory salaries have been bumped up or sign-on bonuses have been in place to strengthen the workforce, Compass Group members report little to no success. And on supplies: “Every week we cross our fingers and toes to see what arrives in the door, how to disperse that through the systems, and how to continually educate the physicians on appropriate use of that limited resource,” says Judy Lyzak, MD, MBA, of Alverno Laboratories.*

She and other laboratory leaders of the Compass Group met virtually Sept. 6 to share their latest. Of the confluence of problems laboratories face, one said: “I have never seen anything quite like this.”

The Compass Group is an organization of not-for-profit IDN system lab leaders who collaborate to identify and share best practices and strategies. Here’s their conversation with CAP TODAY publisher Bob McGonnagle.

Dr. Crawford

Jim Crawford, what is the COVID situation now at Northwell?
James Crawford, MD, PhD, professor and chair, Department of Pathology and Laboratory Medicine, and senior VP of laboratory services, Northwell Health, New York: The patient census is holding steady at levels well below what we had in the winter surge, and the proportion that is breakthrough is still in the minority. Of our COVID-positive hospital admissions, 80 percent are naïve patients who are not vaccinated. And with only 63 percent of New York residents fully vaccinated, we cannot remotely be complacent. There is assurance that the New York population over age 65 has a 95 percent rate of vaccination, and so the severity of illness among the elderly is not a crisis. But all of us have great uncertainty as to how things are going to go in the coming months.

Have you taken steps to revisit your supply chain, your dedicated personnel? I’ve heard of a few places that have stopped elective surgeries.
Dr. Crawford (Northwell): There is no impact on our regular portfolio of care. Our biggest concern systemwide, including in the laboratory, is our workforce. They’re tired. So we are harboring the energy of our workforce as best we can, which involves decanting COVID testing to the Pandemic Response Lab in New York City—up to a third of our approximately 8,000 tests per day, depending on volumes—to make sure we’re not overtaxing our own workforce, for which the infield shift is over. The infield’s back on base in the main automated lab. Testing supply still has to be carefully managed with respect to the cartridge-based and rapid testing. We’re harboring our cartridge and rapids in anticipation of a steady pressure cooker growth as we enter the flu season. Fortunately, our mainframe testing capacity exceeds our daily need, as we protect our workforce.

Stan Schofield, did your system make any significant changes in patient care—deferring elective surgeries or other procedures, for example, as case counts rose?
Stan Schofield, president, NorDx, and senior VP, MaineHealth: Yes, we dialed back all cardiac rehab for 12 hospitals, all elective endoscopies, and next on the agenda is elective joint replacements. And they’re redirecting and redeploying staff, nurses, because we are well on the upside of the growth curve for the delta variant. Our testing has gone from 400 to 500 a day to 1,600 to 2,000 a day, and everybody’s hustling. On top of that, Roche last week put us on reallocation and restriction on point-of-care instrument cartridges.

Ian McHardy, do you have any better news from Southern California?
Ian McHardy, PhD, D(ABMM), director, microbiology, molecular, and immunology laboratory, Scripps Health, San Diego: We’ve been experiencing a surge in cases for seven or eight weeks now, and it’s slowly starting to come

down. With school starting, we'll have to see if it remains down. Like everybody else, we are experiencing allocations for our point-of-care tests—for the Abbott and the Roche Liat. So a lot of tests are having to come back to our core lab, and nobody is happy about that turnaround time.

Despite my comments in prior months in these Compass Group discussions about having fewer staffing problems than elsewhere, that's over now. Our lab assistants in Southern California, probably for a variety of reasons, are leaving in droves, so we're short-staffed on the phlebotomy and lab assistant side and feeling that pinch now, whereas previously for some reason we were sheltered from that.

John Waugh, what is Henry Ford seeing?
John Waugh, MS, MT(ASCP), system VP, pathology and laboratory medicine, Henry Ford Health System, Detroit: We've stopped presurgical and preprocedural testing, and that has helped conserve consumable supplies. Our positive percentage has been around eight to 10 percent. The deadline for the vaccine mandate in our organization is September 10 and it has created a certain amount of instability in our workforce. Like others, we received news from Roche on an allocation, far less than our usual run rate on Liat consumable supplies.

Judy Lyzak, are things similar at Alverno?
Judy Lyzak, MD, MBA, VP of medical affairs, Alverno Laboratories, Indiana and Illinois: It's much the same as for everyone else. Our rates are going up. We reinstated preprocedure testing across the board, and those rates hover from zero percent to what we had at one site today and that was 14 percent, which is a little alarming. On average it's about one percent. We have some ICU beds left, but they are becoming reduced in number. One parent system has a vaccine mandate, and the other is in the process of putting a mandate in place, so we'll soon learn what the impact of that is going to be.

The supply situation is similar too. Every week we cross our fingers and toes to see what arrives in the door, how to disperse that through the systems, and how to continually educate the physicians on appropriate use of that limited resource.

Lauren Anthony, can you give us an update on Minneapolis?
Lauren Anthony, MD, system laboratory medical director, Allina Health, Minneapolis: We haven't had any rapid testing available at the point of care, so we're spared from those shortages since we aren't used to having it. In one sense, that might be fortunate. We had allowed antigen testing in the ED only as a screen, and if the patient needed to be admitted, they would have to confirm by PCR. At the end of June the emergency medicine physicians came to us and said, "We don't need this anymore. This isn't necessary." We decommissioned it, and two weeks later they said, "We need it back." Our data are showing about 20 percent of symptomatic patients are positive, and that does warrant bringing the test back, so we did. Overall in our system the positivity rate is about seven to eight percent. We're doing more and more tests, and our collection kits have run short, so we're having to pull people to help make those again.


Dr. Dolan

Terry Dolan, tell us about Tulsa?
Terrence Dolan, MD, president, Regional Medical Laboratory, Tulsa, Okla.: This morning our COVID-19 positive PCR test rate was running 25 percent. The hospitals are full. Breakthroughs are occurring, and the question is why. I've talked often on these calls about antibody testing because we do a lot of it here, and we have been seeing the same thing that was reported in Israel—a fairly rapid drop-off in antibody levels in those who have had COVID as well as people who have been vaccinated. The Israel study would indicate that the drop-off is even greater in the

vaccinated than in those who had COVID. That's yet to be verified by others, but the rapid drop-off in antibody level is quite remarkable, and we've documented it and others have too.

That leads us to the booster, which I'm a great believer in, because this is a virus that is a relative of influenza and every year we have to get a booster for influenza. I've predicted for a long time that COVID would follow the same course. In our view, eight months for a booster would be the upper end and we'd recommend it by then, and that's from your last dose. We believe boosters will become common, and there is data to support it.

Jim Crawford, like Terry Dolan, you've done a great deal of antibody testing. Are you seeing some of these same results as reported in the Israeli study and by Terry in this call?
Dr. Crawford (Northwell): Our lab is part of the NCI-funded Serological Sciences Network for COVID-19, and we are prospectively tracking antibody responses to primary vaccine in immunologically compromised patients, focusing on autoimmune diseases. We are also now embarking on a retrospective study with Kaiser-Permanente to examine the question on longitudinal antibody responses in the overall population. Considering that our daily testing volumes on the Roche platform are approximately 1,800 spike antibody tests per day and about 300 to 400 nucleocapsid antigen tests per day, there should be opportunity to contribute meaningful, real-world data. We also are directly involved with the National Institute of Allergy and Infectious Diseases trial on boosters, which is Pfizer, Moderna, and J&J. The goal is to enroll 200 to 400 patients who are immunocompromised—transplant, cancer, and autoimmune disease—and directly examine what happens to their booster response. So hopefully we can contribute to the U.S. effort to address these questions.

Steven Carroll, have any patient procedures at MUSC been changed or deferred?
Steven Carroll, MD, PhD, chair, Department of Pathology and Laboratory Medicine, Medical University of South Carolina: Not yet, but it's just a matter of time. Our beds are being taken up by people with COVID, and almost all are unvaccinated. Our rates are going up; in Charleston it's about nine percent. In other parts of our system it's up to 14 percent. Boosters are now front and center.

We have the same supplies problems others mentioned. Personnel, though, is really hitting my radar. Interestingly, we're having bleed-through in terms of how personnel is hurting us. The nursing shortage is creating a lot of problems, and we've been in discussions with other areas like the ED because they're asking us to provide additional phlebotomists to them so they can relieve the nurses they have. So we're now scrambling on the phlebotomist side, and we've had the same shortage in medical technologists. Things were looking good for a while. We went down. We reduced our staffing at our COVID lab to two shifts and had to go back up to three shifts because our number of tests is up again. It's hurting morale. Everyone thought we were heading out of it; now it's getting worse than it was before.

Karen Brownell, what is happening at Intermountain?
Karen Brownell, AVP, laboratory services, Intermountain Healthcare: Hospitalizations are up; ICUs are full. We have caregiver shortages in the laboratory and at the bedside. We just started to re-ramp up the preprocedure testing, so we're looking at 800 to 1,000 preprocedure tests a day. I haven't heard of large cancellations at this point, but they are looking at whether to proceed with surgeries.

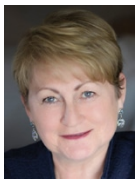
We're pretty stable with the supplies for our core PCR testing, but our difficulty now is that we need rapid tests for our caregivers. Because we're so short at the bedside and at the bench, we're trying to find a quicker way to get answers to symptomatic caregivers on whether they're positive. So we've looked at trying to do a combined strategy of some of the over-the-counter antigen kits with our PCR as confirmation, and there is a shortage of those over-the-counter kits. It's new because we haven't deployed those over-the-counter testing solutions in the past.

Julie Hess, fill us in on what's happening on the ground in Florida.
Julie Hess, executive director, laboratory services, AdventHealth, Orlando, Fla.: It feels like we're the national leader in this latest surge, and it's discouraging to see Florida in the news. We began to see elevations at the end of July, and we jumped up to about 30 percent positivity for several weeks. We are just now coming out of that.

Today we're at about 25 percent positivity with PCR. We're still seeing record numbers of orders a day. In the division of Florida I'm responsible for, about 2,100 COVID-19 PCR tests a day is the average. We also saw the shift in demand from high-capacity PCR to rapid so bed flow could be managed. For us it was Cepheid, then Liat. One positive bit to being the first to surge is we were able to stock up.

During the worst of our surge, we were in code black for about four weeks, and we had to adjust our surgical care, nursing ratios, and all kinds of things. We ended up with several hundred patients, ICU-level care, outside of our ICU walls because we ran out of beds. We're now able to open up more necessary surgical procedures, but we're still having a day-by-day review with our CMOs to make sure those surgeries are appropriate and that we have a bed to place a patient in should the bed be needed.

A lot of staff redeployment. We, too, had such a demand for support of our nursing team that they needed us to take over phlebotomy. That put a tremendous pressure on our hiring of phlebotomy staff, or even patient care techs to help extend and do staff extender models. Our hospital, after some deliberation, decided to make a significant investment in adjusting our living wage for our minimum wage staff. It just went into effect. We hope it will help us with phlebotomy recruitment in our laboratory and with our laboratory assistants.



Irons

Denise Irons, where's your level of optimism at Baystate today?
Denise Irons, director, laboratory information systems, Baystate Health, Springfield, Mass.: Compared with everybody else, we're doing quite well. We're running our 600 to 900 tests a day on two Cobas platforms. The ED has the Abbott ID Now, and they're running about 150 a day at our main ED, with probably about another 150 combined between the three community hospitals. We're also diverting a little of the work to the Panther during the week as required. So we're running about 1,000 a day on average.

No preprocedure testing has been canceled at this point, although I just got a notice about a strategy meeting, because our big problem is staffing. Our vaccine mandate goes into effect October 1, and there's still a number of people who are not getting it. So we have a big problem trying to manage what could potentially happen if those people don't come through.

Joe Baker, are things similar at Baylor?
Joseph Baker, VP of laboratory, Baylor Scott & White Health, Dallas: Yes, they are. We received notification that we're on allocation for Cepheid and Liat. We're starting to get worried about collection supplies and not just those that are COVID-related but also some of the other consumables.

We went back to doing preprocedural testing on everybody, where previously we based testing on vaccination status. We're doing around 3,000 tests a day within our system. Our positivity rate is just over 18 percent at this point, but it has plateaued over the past three weeks.

On staffing we're challenged like everyone else, specifically on the phlebotomy and technologist side. We have a vaccine mandate in our system with a due date of October 1. We've had some staff already let us know they don't plan to get it. So we've been trying to recruit for the past five to six weeks and haven't had success, even given the market adjustments we made and the sign-on bonuses. We continue to try to get agency staff. There is nothing out there, and the candidates that do come our way have not been good quality.

We're worried about the health of the team. We're giving differential pay for people who pick up extra shifts where openings are the highest. We are getting the same requests as other organizations where our nursing partners are

seeking our help; we try to help where we can because we are in it together.

Our most recent challenge is that our organization has asked the state for staffing support to help in nursing and respiratory therapy, and when the state says they have someone to send to you, you have 24 hours to say you'll accept them or not. Getting them onboarded with point-of-care testing and assuring competency is completed quickly has been challenging.

Kremitske

Diana Kremitske at Geisinger, do you have any good news for us or any special take on what you've heard?
Diana Kremitske, MS, MHA, MT(ASCP), VP, Diagnostic Medicine Institute, Geisinger, Danville, Pa.: Our story is similar. We're at about 1,400 tests per day systemwide for COVID. Our positivity rate is about 11.4 percent in the past seven days, and that is an increase from prior periods. We're worried about the workforce, as everyone else is. In our organization the vaccine mandate will be effective November 1.

We are offering a retention incentive program for certain job titles across the organization, and phlebotomists are included. This is a one-time two-year retention incentive program, so we hope to retain our current workforce. We are struggling like everyone else on the recruiting side. We still have issues with securing temporary agency techs. It's a bidding war out there. High dollar amounts are being requested for viable candidates. It's a scary situation, and workforce concerns are where my heart and head are—I'm concerned about being able to cover the workload that's not only happening now but also during a future predicted spike that's probably going to come in Pennsylvania in about mid-October. Regarding any outpatient service restrictions, at this time some cardiac rehab outpatient services have seen light restrictions.

We are being called upon to address a variety of COVID testing needs. Geisinger has a program called Life Geisinger, which provides health care services to help adults 55 and older who would otherwise be confined to a nursing home live independently in their homes. A few of those centers are considering closing because of the positivity rate in the community and we want to make sure there are no outbreaks at the centers. So we're communicating now about how to assist with any testing needs for the participants in that program.

PAMA cuts look to be reinstated with the beginning of next year. The clinical lab fee schedule and the professional fee schedule are not doing anyone any favors from what I can read in the early notes from CMS. How is that affecting the planning and the day-to-day existence as you look forward to what you might be able to expect in terms of revenue through 2022?
Diana Kremitske (Geisinger): I'm probably more concerned about getting through the logistics in the reporting side of that. That's first and foremost. We had a pretty good structure during the first reporting cycle because our lab did report for some of our operations that qualified under the criteria. But that is not at the forefront of my mind now. I'm just focused on the day to day, getting through this pandemic, and I think everything will fall into place by the time the deadline comes around next year. As far as revenue, we'll wait and see how it all shakes out and what the data are going to show.

Stan Schofield, as the pandemic worsens, can you imagine that perhaps the PAMA cuts and the PAMA reporting might be suspended for another year, or do you think it's full speed ahead?
Stan Schofield (MaineHealth): I don't think it's going to be suspended. The thought process is everything else is reopening and we're just going to plow through it. The government wants the money, needs the money, and they're looking for any opportunity. It's on the books, it's available to them, and I think they're going to do it.

We're approaching median pricing for many things. We only put 10 percent as the Medicare reduction, and the insurance companies are going to be close to that number. So at the moment, as detailed a budget process as we have here, COVID will float the boat. The longer the delta comes—and if we have a mu variant—that's going to float the boat this year for the enterprise, because the outreach regional lab business is right at cost now from the reimbursement levels. Seventy percent of our business is all hospital management and hospital operations, and that's the good news. The bad news is most of the hospitals can't afford to pay the cost increase with the new pay and comp packages. So we're juggling a lot of things now.

About the earlier comments related to phlebotomy services: We put in 15 percent increases in phlebotomy service hourly rates and adjustments, and we're not seeing an improvement. The announcement went out six weeks ago. It just comes down to you can pay a population more money, but you have to have the population to begin with, to get them hired. And we're not seeing anybody returning to the workforce.

That's grim, but not necessarily unexpected. Many people think we've exhausted the supply. If it's all tapped out, it's tapped out.
Stan Schofield (MaineHealth): It's everywhere! I took my car to the car dealership today for the prepaid maintenance warranty work. This is a high-end dealership that gives you rides or loans you cars even for an oil change. I go in there this morning. "Hi, how are you doing? We have no drivers to take you to work a mile and a half away. We have no one in the dealership who can get you there." This appointment has been on the books for three months. They called me an Uber. We're talking about one of the high-end brands and they can't get even basic drivers. I wonder where 50 million people went from the workforce.

John Waugh, I know you've studied where revenue is coming in and budgets, but also labor. What's your take on the current situation? Are you having the same problems Stan reports? In other words, we're giving more and more but there's no one to bring in?
John Waugh (Henry Ford): Yes, and it's disturbing. I think we've destabilized our workforce here in health care. I hear a lot of the same comments. We may be a little earlier on that because we moved very early on a vaccine mandate, and that kind of amplified the effects we're seeing. We have all the same issues as others; we're throwing money at temporary and critical paid staff. A lot of those are nurses, but we're seeing vaccine hesitancy in other positions like transporters, medical assistants, food services, housekeeping staff, and we're carrying out bed closures because of an inability to staff positions, though not at the hospital where I am. But it's destabilizing. All of the comments that Stan and Diana made are reflected in Detroit.

Clark Day, what are your thoughts?
Clark Day, VP of system laboratory services, Indiana University Health: We've spiked in Indiana. It's a high spike but perhaps a little narrower. Our census is high, but the trend of the increase is slowing, so an increase at a decreasing rate. We did cut elective surgeries that require an inpatient stay by 50 percent.

Our issue in this spike is not testing. We have plenty of capacity to test. But we dismantled all but one of our remote collection sites, our tents and drive-throughs, in June of this year. So this caught us a little flat-footed. We've been scrambling operationally the last two to three weeks to rebuild our patient collection infrastructure and access, all to relieve our emergency departments. They're getting overrun because patients have nowhere to go to get a test in short order.

Terry Dolan, have you ever seen anything quite like this, where all these difficult problems are coming seemingly at one time, within months or a couple of years of each other? A pandemic, a new surge, the labor issues. Now we're worried about how we're going to get paid. Do you have a reaction to that?
Dr. Dolan (Regional Medical Laboratory): I have never seen anything quite like this, and I've been at this probably longer than anyone on this call. But if you look at England and India, where they've had quite a bit of experience with the delta variant, the infections there tended to drop off all of a sudden, so I'm hoping we see the same thing. I believe it will peak and it will drop off. We need new vaccines with the variants like we do with influenza. Once that gets in production, perhaps we'll be able to stay at least close to it, maybe not ahead, but certainly manage it

far better than we are. I have guarded optimism that this pandemic will start turning around in the near future.

Are you also optimistic that we'll have a turnaround in the laboratory labor crisis?
Dr. Dolan (Regional Medical Laboratory): I've seen situations like this, though nothing to the degree where money doesn't help. I think people want to enjoy their life and their job, and we have to focus on what we need to do to make those better. The pressures all of us are under now make it difficult, but we need to look beyond the current. What is it that makes these folks happier going forward? We need to start focusing on that. I don't think the dollars are going to make a difference. Short term it's going to be difficult; it's been difficult and it will continue to be difficult. But I am an optimist—I hope not a foolish optimist—but I do believe things will start turning around soon.