Supply price hikes now as common as shortages

April 2022—*Staffing, supply chain, and significant supply price increases. Two continuing problems and one new. When Compass Group members met online March 1 with* CAP TODAY *publisher Bob McGonnagle, that trio of issues took center stage. Here's 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.

Dwayne Breining, I want to get your initial reaction to a COVID-related transaction. It was announced that GeneDx has been acquired by one of the COVID startups, Sema4. Do you have any news about that?

Dwayne Breining, MD, executive director, Northwell Health Laboratories, New York: We know Sema4 has done a lot regarding COVID but they also do cytogenetics and other genetics testing. They started as a laboratory in New York City and had done work with Mount Sinai. They've since moved to Connecticut and are setting themselves up as a freestanding enterprise with a lot of talent behind it. They've been especially good at comparative genomic hybridization and esoteric things like that. We'll see what develops, but it's a significant consolidation in the marketplace for that type of testing.

Gauld

Lori Gauld, are staffing challenges more severe since the last time we got together?

Lori Gauld, executive director of pathology and laboratory medicine, Medical University of South Carolina: Staffing is about the same. We are struggling with wages. In our area, Target wages went up to $24 an hour, and we're starting phlebotomists at $14 an hour. There are many challenges with working in a centralized downtown facility, among them the cost of parking. Systemwide we're trying to address the wage gaps, and we're using unique mechanisms, including a position that is essentially bachelor's or master's educated. It requires a lot more training and teaching basic lab skills. In terms of turnover, we've started to level off.

And COVID is not the crisis it once was?

Lori Gauld (MUSC): Correct. COVID is down again, and we've been able to deploy more antigen testing throughout the state. This has helped in terms of being able to manage in-lab testing.

Dan Ingemansen, what are your staffing challenges?

Dan Ingemansen, senior director, Sanford Health, Sioux Falls, SD: Staffing remains a challenge. Over the past two months or so we have seen an improvement in our ability to fill open positions. At the same time, we are filling positions with different qualifications, work levels, and skills. The staffing shortages have forced us to look differently at responsibilities and focus our medical laboratory scientists or medical laboratory technicians on testing activities and pull them away from the more routine responsibilities that a four-year biological science person or administrative staff can take on. This has forced us to re-look at the responsibilities of who does what moving forward.

Is there a promise in that of even greater yield than you are currently realizing?

Dan Ingemansen (Sanford Health): Absolutely. I think we're going to be leaner and more efficient moving forward. For example, historically our infectious disease departments were completely staffed by technologists. We pulled the plating responsibilities and preanalytics from our technologists and brought in lab assistants to do that work,

which we had not done in the past. I think our technical staff appreciated those changes because they're able to read plates all day instead of doing setup.

Dr. McHardy

Ian McHardy, can you talk about your situation in California with regard to inflation and supply chain?
Ian McHardy, PhD, D(ABMM), director, microbiology, molecular, and immunology laboratory, Scripps Health, San Diego: We have very high gas prices in California, but I think we're experiencing the same inflation shocks in contracts and sticker prices that everybody else is in the laboratory arena. We are again in the phase of suffering through supply chain shortages that are arising from places in China and other manufacturing centers that shut down during the Omicron surge or are continuing to shut down. We are facing shortages for elements like cuvettes for chemistry analyzers.

Winnie Carino, would you like to add anything?
Winnie Carino, MA, CLS, MT(ASCP), director of laboratory services, Scripps Health, San Diego: I'm seeing the most shortages with butterfly needles and Vacutainer tubes, specifically the lithium heparins and EDTAs. We're working with alternative suppliers and possible alternative materials, but it's not easy because they have to be the same materials we used when we validated our analyzers.

Brownell

Karen Brownell, are you also seeing supply chain disruption, despite the COVID relief on the frontline?
Karen Brownell, AVP, laboratory services, Intermountain Healthcare: We're concerned about the Vacutainer situation, too, but we have been lucky in that our supply chain has done well in its demand planning. So we are holding status quo. We've looked for other vendors. We've also instructed our clinicians about not doing repeat testing if not warranted; for example, don't do rainbow draws in the emergency department. We've talked to them about what they can do to help us conserve resources. We're not at urgent status yet, but we're watching it.

Mick Runnoe, can you comment on what's going on at ACL Laboratories?
Mick Runnoe, VP of Laboratory Operations, ACL Laboratories, West Allis, Wis.: I find it interesting that while our central lab high-throughput PCR testing has declined as our positivity rate declined, the rapid PCR testing at our hospitals in our urgent care clinics has sustained—there's still a need for rapid PCR testing at the point of care.

The good news is we've been able to achieve some volume of reagent for those tests. The avenues of inventory have opened up and we are able to keep some in the warehouse rather than distribute everything we get every week.

We're seeing similar issues with tubes and needles, and we went to a variety of suppliers to try to bring those inventories back up and we've been fairly successful.

We haven't had to stop doing testing or stop using any particular device. But we have experienced "I only have

enough to last me until Monday" or ". . . until tomorrow." As a large system, we're able to share supplies across locations and state lines, so that helps us.

The challenges around staffing have lessened a little. The number of open positions is now less than the number we're filling; we're catching up to where we were. But we've also expanded our internal phlebotomy program, and we have a histology program that we've expanded into our Illinois region. Those are helping fill our roles as well.

You're a big system; you represent a lot of patients and test volume. Did you notice the Labcorp and Ascension news? Because there are a lot of Ascension hospitals in the territory you share in Wisconsin and Illinois.
Mick Runnoe (ACL Laboratories): We have Ascension partners in our market in Wisconsin. My supervisors at the hospital laboratories have been getting phone calls from Ascension laboratory professionals seeking information about the jobs we have available. I imagine anytime there's a large takeover of that nature, the team members, bench folks, and even supervisors get a little nervous about how long their job will last. We have seen some of that. And that helps us a little with our open positions.

Darlene Cloutier, what's your reaction to what we've been discussing?
Darlene Cloutier, MSM, MT(ASCP), HP, director of laboratory operations, Baystate Health, Springfield, Mass.: It feels like I get a notification from our purchasing department every day that we have to find a substitute product for something. We've been able to manage and find an alternative supply, but it's concerning to the lab staff because they worry about the need to revalidate.

COVID lab testing volumes are down at Baystate, and at this time there's a significant shift to point-of-care testing. There's also a movement to discontinue preprocedure testing at Baystate unless the patient requires an overnight stay in the hospital. That will eliminate even more of the testing in the labs.

In terms of the mergers and acquisitions, we are aware of the more recent activity. We haven't heard about any recent efforts specific to Baystate, but it's not like we don't expect that conversation to be revisted at some time in the future.

Are you experiencing the problems of general consumer inflation as it's affecting your staff?
Darlene Cloutier (Baystate): Yes, general consumer inflation is affecting everyone's lives. We are feeling the impact of inflation with our supply costs. I was recently made aware of significant price increases on one of our contract renewals. In this case we had no option to negotiate pricing.

Julie Hess, what is your reaction to the consolidation news in the in vitro diagnostics and laboratory world?
Julie Hess, VP, laboratory services, AdventHealth, Orlando, Fla.: Whenever I hear about Labcorp or Quest coming into a hospital system, it gives me a quiver of fear because it feels so disconnected from what we in clinical labs feel are the foundation points—being connected to our stakeholders, the physicians, making sure it feels like there's a patient at the end of every result. I don't always get the sense of those things being important when it is outside the hospital or health care system.

I don't know what to expect from that news, but so far AdventHealth is holding strong. We have enough on our plate with our own plans for growth and development.

What is going on with staffing?
Julie Hess (AdventHealth): That's part of the stability we're reaching for. We had a media announcement in our local area that AdventHealth University has launched a medical laboratory science program. We plan to start accepting students this fall. That is with the Southern Association of Colleges and Schools Commission on Colleges' approval of our accreditation requests, so all that paperwork has been filed. We're eager to have those students and plans start this fall. We also have affiliation agreements with a number of other schools, universities, and state colleges. We're trying to be robust in our connection with students at each of those locations because that's our future, our pipeline. We have to get the word out.

Frank Beylo, tell us about supply chain or staffing at Inova.
Frank Beylo, BS, MT(ASCP), director, operations and technology, Inova Health Systems, Falls Church, Va.: We're having supply chain issues with tubes. We've received some from consulting groups we work with, and we're validating those now.

We've been able to hire some medical technologists recently. We have four people from our histology program who will be graduating in a couple months for our second round. We started a phlebotomy school this past Monday with eight candidates we are training, and our medical technologist program continues to attract a number of people. We have eight in the class this year.

We're looking at different and better ways to do more with fewer people. We've implemented our automation line over the past few months and rolled out new chemistry, coagulation, and other platforms across the system, in the midst of everything else.

Comment briefly for us on the announcements of mergers and acquisitions.
Frank Beylo (Inova): I share the same sentiment as Julie. There's something to be said for having the laboratory support your health care system.

On another topic, I was wondering if anyone has added the gender of X for admissions and, if so, how reference ranges were established.

Dr. Breining (Northwell): This has been on our radar in the New York metropolitan area. We haven't launched anything yet because it's within a few small clinical areas that it's an active issue. We're doing those things offline for the moment, but we're developing a framework and watching as the data accumulates. We've mapped out that eventually there will probably be five genders—cis male, cis female, trans male, trans female, and X, or indeterminate—and they will have different reference ranges. The reference ranges in some cases are dependent on where someone is in the hormonal therapy process. So that will always be taken into account on the clinical side, and it is maybe good reason to leave reference ranges out of the picture in some cases too, if people are going to be in process. There's still a lot to be developed. It is a rapidly advancing puzzle to solve.

Lauren Anthony, what are you doing for transgender lab values at Allina?
Lauren Anthony, MD, system laboratory medical director, Allina Health, Minneapolis: Epic had software changes, so we had a project to address that. As a first step, we took every test that had gender-specific reference ranges and determined which ones did not need abnormal flagging for a critical result. For those we put all the reference ranges in a comment. For something like estrogen, we put all ranges in a comment, and providers can interpret or extrapolate from those ranges based on the particular clinical situation.

If there is a sex assigned at birth entered in the chart, we have any gender-specific reference ranges firing off that. These are tests that require abnormal flagging. But often the sex assigned at birth will be blank, and if it's blank, the reference range fires off the legal sex, which in Minnesota can be different than sex assigned at birth. For insurance, you have to have the legal sex, so that's usually in the EHR. In the case where legal sex is missing, we developed rules to default to the more restrictive reference range. We educated around this so that providers are aware of the impact on flagging. But it's complicated and evolving. We came up with what we thought was medically appropriate, knowing it would evolve with more information and experience.


Dr. Anthony

As for supply chain problems, can you comment on some of the tubes being sold that may be illegal or

have questionable provenance?
Dr. Anthony (Allina): My question is, Why are we all being so good at problem-solving and not escalating this to the FDA and other authorities? We're meeting with the FDA and saying this is a real issue. Rather than buying things underground, how about getting EUA for this?

There are distributors, and we have documentation of this, that are going to China and buying tubes there that were approved to be sold only in China. Sometimes they claim they're made by BD in China. But if you go outside of FDA, you lose safeguards for patients, you lose the accountability these companies must have to be able to sell their products in the United States. A lot of them are sending FDA registration certificates, which doesn't mean their products are FDA approved. The FDA says on its website that if it is not on the list, it can't be legally sold in the U.S. The FDA has to force these companies to go through the EUA process.

If distributors are diverting supplies to import outside the normal channels, there is no accountability for standardization, good manufacturing practices, recalls, or that they will be consistent with future supplies. The FDA issued an EUA for blue-top tubes made in the U.K., but that's not adequate—it's all tubes. Start talking to major suppliers about other countries where they're making tubes and what we can do to get those tubes approved here.


Schofield

Stan Schofield, let's return to the topic of inflation and what effects it may be having.
Stan Schofield, president, NorDx, and senior VP, MaineHealth: One company is cutting and canceling plated media agreements around the country due to the inflationary nature of the manufacturing and lack of plastics. I received reports of several systems' worth of contracts being canceled under the force majeure clauses in the contracts, and the company is renegotiating them at 75 percent increases. That's going to shake everybody's tree. There are no alternative brand capacities, and there is no plated media capacity because other companies can't get the plastic plates either. And with the price of oil hitting $107 a barrel today, that's going to be a huge factor.

What are the vendors telling you when you question this? Is it really force majeure and it's that simple?
Stan Schofield (NorDx): It's not that simple, but there's no alternative. They're cutting you off or you're going to have to pay. I made a lot of phone calls to senior executives who said they were caught flat-footed by the company's actions. These are competitors, and they said, "Let me get back to you," and the next day they have no manufacturing capacity and overnight they have a 50 percent increase in requests for new orders. The company surprised everybody. And plan B doesn't exist now.

A long time ago people would prepare their own media, but I would venture to say there's not a system on this call that would be prepared to do that with any kind of volume, much less having the hands because it's labor-intensive work.
Stan Schofield (NorDx): Just looking for blood agar plates—you know what a steak costs at the grocery store now. When they cut the steaks in the slaughterhouse, the blood has been sold in the past to media companies and others. With COVID everybody thinned their herds because the demand for consumer meat was somewhat limited. Now the sizes of herds are down—and dollars and labor are up—and that's where the source of blood was for blood agar plates. The company canceling the agreements says it's quadrupled in the last six months as a raw material. And you're right, if I had the space, the plastic, and the media, I still don't have anybody to pour the media or the refrigerators to store it.

Dan Ingemansen, would you like to make a comment?

Dan Ingemansen (Sanford Health): Beyond the clinical side, has anybody else seen significant spikes in consumable aggregate pricing?

Stan Schofield (NorDx): Anything that's not under a direct existing contract, they're raising 10 to 15 percent on every order. With direct contracts for one, two, or three years, like we had with media, they're starting to break contracts. Anything that's not under a major diagnostic company today, like a three- or five-year contract, is going to be at risk. I don't know if major companies will break the three- or five-year contract deals, but they could come back to you and raise your service costs and they could, on the consumables, make an adjustment for plastics. They all make money based on the consumables. Even under a three- to five-year contract, they have flexibility on annual adjustments.

Dan Ingemansen (Sanford Health): Contracts are holding true on the laboratory reagents and consumables. We're seeing exponential additional cost on general lab supplies, whether that be chemical wipes, tubes, needles. We function on a formulary, but the second you jump out of that formulary and go to a nonnegotiated rate, we will have to pay market.

Stan, how is inflation affecting staff?
Stan Schofield (NorDx): They're saying, "Hey, what about me?" And it's in the context of the contract nurses at $200 an hour. We talk about people leaving their positions and going here and there—there are agencies focused on targeting histotechnologists in the labs to do three- and six-month assignments somewhere else for $60 to $70 an hour. We are still having problems getting phlebotomists at $18 to $20 an hour to take a job and pay to train them, with benefits.

The last compounding factor is it's very hard to get affordable housing. It has gone crazy the past three years. Everybody we talked to said their rents are going up $200 to $500 a month. I think it's a prelude to even more difficulty with entry-level staff personnel at traditional compensation levels in the $15 an hour range. That's history. We're going to start seeing $20 to $25 as common, though nobody can afford it.