The World of Travel Nursing

With Rex Hartman

Episode 54

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Jim (00:01):

Welcome to The Healthcare Leadership Experience Radio Show. This show, hosted by Lisa Miller and Jim Cagliostro, brings you insights from both the business and clinical sides of healthcare.

Lisa Miller, CEO and founder of VIE Healthcare Consulting and managing director at SpendMend, has established herself as a recognized leader in healthcare operational performance improvement, and, with her team, has generated over $1 billion in financial improvements for VIE's clients since 1999. Lisa loves to think differently, and collaborates with healthcare leaders and their teams to solve challenges and create new innovative approaches that directly impact the business and clinical side of healthcare.

As a registered nurse since 2007, Jim Cagliostro has worked in critical care, perioperative services and outpatient settings at nationally recognized medical facilities across three states. His passion for the patient, along with his experience in a variety of healthcare settings, gives him a unique perspective on how to enhance the patient experience and workplace culture for any health system — big or small.

On this show, you will hear from innovators and leaders from within healthcare and across multiple industries. We will bring you relevant and trending topics in healthcare that include strategy, finance, patient experience, innovation, leadership, communication, marketing, and much, much more.

Jim (01:28):

Hi, this is Jim Cagliostro and you're listening to the Healthcare Leadership Experience Radio Show. Today's guest is Rex Hartman. He's a travel nurse. He's been a nurse a while. He's going to tell us a little bit more about himself, and we're excited today to learn about the world of travel nursing — at least his world and his experience with travel nursing. So Rex, welcome and thanks for joining us.

Rex (01:49):

Hey, thanks, Jim. It's good to be on the podcast here, and I really appreciate the opportunity to talk about my experience, both in the field before travel nursing, and then what I've experienced after.

Jim (01:59):

Great. Just as a little intro here, even before 2020, discussions of a nationwide nursing shortage were common. I remember actually in nursing school, in the mid-2000s, when I went through school, these were discussions about a nationwide nursing shortage, and as a direct result of COVID-19, that shortage has only worsened. There was a survey from the AACN in September of 2021 where 92% of respondents said that the pandemic had depleted nurses at their hospitals and that careers were being shortened because of it, and then 66% said they were considering leaving the profession altogether because of their COVID-19 experiences. So I know those numbers don't surprise you, Rex, but they're simply to share with our listeners, to convey to our listeners the gravity of the issue, especially over the last few years.

Jim (02:45):

So one is that there was already a problem of a shortage of nurses, and then COVID-19 made that shortage a much greater issue, especially for hospitals that were losing nurses who were simply burnt out. So that brings us to our conversation today: how hospitals are addressing this need for nurses, and specifically, one of those ways is through travel nursing. The demand for travel nursing, like we just mentioned, exploded in 2020. Just for our listeners, I'm pretty sure most people know, but travel nurses, they're registered nurses who work in short-term roles at hospitals, clinics, other

healthcare facilities, pretty much around the world. It's not a new phenomenon, but it really exploded. And they work on short-term contracts. I'd like to hear your background.

Would you mind just sharing your journey, your education, your experience, prior to getting into this world of travel nursing, and then ultimately what led to that decision to jump into travel nursing?

Rex (03:37):

Yeah, I mean, to summarize it all... No, I suppose there's a couple other factors I'll throw out there for nursing shortages now and upcoming. But my story, I was a mid-20-something college dropout, and I wound up applying for jobs everywhere, and some friend of mine had a mother who worked at a hospital, and she said, "Oh, just be a patient care associate." So that's what I applied for. And they said, "Oh, you seem like you can put up with a lot of whatever, people telling you what to do." So I became a PCA, and ultimately, I stayed as a PCA and that was my first healthcare experience. And ultimately, I was trained as a monitor tech, and I spent 11 years of the first portion of my healthcare career as a PCA in monitor tech.

(04:22):

So that's what I did until, I suppose, later in my twenties, I realized I should eventually try to make something of myself. I decided to start going to nursing. And I know some people's nursing stories start with, "Uh, I had this really wonderful, compassionate nurse in my life, and they really influenced me, and so I desired to be just like them." I wish I had a story like that, but mine's, "I seem to be okay with doing all this, so I'm going to continue doing it."

Jim (04:48):

Hey, that works. Any way we can get you in there, right?

Rex (04:51):

Yeah. But I really enjoy taking care of people. And that's, I think, the reason I have stayed in healthcare and not jumped industry, not looked for ways to branch out. I enjoy taking care of people, doing a good job for them. And

later in my career, I understand the role of that advocacy thing that people talk about in nursing school, but you don't really get to live out in your life sometimes. But identifying where there's problems and finding a way to make sure that people get their needs met, that's a really big portion of it.

Anyways, so around that time I was going through other life changes. Ultimately, I started nursing school while I was living in New Jersey but ended up completing at the community college down here in Broward County, Florida, graduated in a couple years and started right away in an ICU. So all my years of working as a PCA on a telemetry floor, I decided that I would really appreciate the opportunity to take care of people who are in a vulnerable position, and I think critically-ill people fit that bill.

Jim (05:51):

That's great.

Rex (05:52):

Throughout school, I realized pediatrics...not my cup of tea, so the adult ICU is where I started. I spent two and a half years there, and then due to several managerial changes, I was looking for a change, and so I ended up in interventional radiology. So from interventional radiology, the hospital I worked at also trained you how to do PICC lines. So that's an extra skill I picked up along the way. And ultimately, I stayed in interventional radiology, just picking up overtime here and there at sister hospitals of the system I worked in, until the pandemic hit.

Rex (06:24):

And when COVID-19 hit, about a month in in South Florida, when we started seeing cases, out of nowhere, my hospital administration came to me and said, "Oh, by the way, starting tomorrow, you're going back full-time to the ICU to take full assignments." That was just a little bit of a shock. It would be as if anyone working in a clinical area all of a sudden said, "You're going back to another clinical area without any forewarning or discussion." A little heavy-handedness wasn't really appreciated, but understanding the situation, that's exactly what I did.

Rex (06:57):

For about a month and a half, ICU was full. Everyone was freaking out a little bit. If we can all remember back those two years ago, the PPE shortage and all the other types of mask shortages where we started re-wearing PPE and everything like that, we clinically started to do things that we knew were no-nos and boo-boos, but a lot of things happened across the nation where infectious disease protocols that had been set up and established for over that decade that I've been in healthcare, well, now we're re-wearing and sanitizing our PPE because there's a shortage, and I can't help but wonder how much of that created other issues for our population.

Jim (07:34):

Well, Rex, I don't know if I shared with you, but my wife, I think she had an N95 mask for about two weeks. She was pretty proud of herself.

Rex (07:42):

That didn't disintegrate between them.

Jim (07:44):

Yeah, right. Right.

Rex (07:45):

And from that period of time, if you're working in full-time ICU or somewhere in the hospital, even if you're in ancillary services, you're in surgical services, departments are getting shut down. Workflow is being stopped. And then you hear the travelers coming in by the droves. You see them, and they're like, "Hey, where are you from?" Maybe you've never met... I had never really met or worked with travel nurses until they came to the ICU. And they started to tell me, "This is what I do. This is how I work. This is how I structure my entire life."

Rex (08:15):

And man, if that didn't sound, first of all, a whole lot more interesting, as far as the variety of labor you can get into, the different clinical areas you can

travel to and different hospitals, different regions if you're into that, but also we can't underscore enough: there was crazy amounts of money being thrown around for travel nurses in 2020. And I'm not saying that I'm not a loyal person to my community, but if you want to pay me to do the same job about four or five times more, I'm hard-pressed to say no, especially if I know I'm not breaking any laws to get it.

Jim (08:48):

Right. Right.

Rex (08:49):

So I mean, that time in the ICU, getting twisted around by the hospital system and ultimately finding out that there were other opportunities, is really what helped me transition to the travel nursing role which I'm still at today.

Jim (09:03):

Sure. So then I do want to ask you, was that a conversation with your wife? I don't know if we talked about this, but were all your kids born at that time when you had started? I forget how old your kids are. Was that a difficult decision in terms of how it's going to impact your family lives?

Rex (09:17):

Well, absolutely it was, because at the time, I was working 4 days a week, 10-hour shifts, and then picking up another fifth day every single week and then picking up additional on-call time to make up for all the income, because we decided as our family structure, my wife was going to stay home, not work, raise and homeschool our children, and I was going to be this whole provider. So I think that's one of the direct things that when there's an opportunity for more money to fund that type of lifestyle, that was a huge motivating factor.

Rex (09:52):

But because our youngest was three, they were 3, 5 and 6 at the time I started traveling, that was difficult, because I made the decision that

wherever I go, they're going to come with me too. And whatever extra income that it's going to take to bring them with me, I still get to have the benefit of being with my family more, over working 5, 6 days a week and really never seeing them. So that was a huge motivating factor. After I did the math, after I sat down and thought about all the life-structure changes and even picking up everyone and traveling to a new place, I would see them more because I wouldn't be working those extra days of overtime just to make ends meet.

Jim (10:32):

Sure. That's huge, and you bring out a good point and all I've talked of other people who have done the travel nursing, and it's difficult to say no to that type of money. And also the fact that you're bringing up: you'd be able to spend more time with your family and all it meant was traveling. And so as long as your wife's on board with that, that's a great experience.

Jim (10:49):

So I do want to get into your thoughts on why hospitals, why health systems are choosing to use travel-nurse agencies. Why not just simply double their internal efforts on recruiting and bringing in nurses into their system? Any thoughts on that? Any insight that you can give on that, why hospitals are going to travel-nurse route rather than doubling their efforts on their own hiring?

Rex (11:11):

Well, that's a complex question. I have a lot of opinion. I ask a lot of questions too, and I know directors of nursing and other people in upper administration that have a variety of answers, but let me circle back first. I want to answer your question and I'm not trying to politician you, but I want to circle back to a couple of the things that you first mentioned about why there's a shortage, and I think that'll springboard into why I think there's maybe some needs that aren't being met inside the facility.

Jim (11:39):

Sure.

Rex (11:39):

A couple of additional factors that you didn't mention is that we have an aged nurse population, and this isn't just in nursing. This actually spans, I think, almost every major industry in the nation right now. As the Baby Boomer generation retires, multiple people have not only noted, but shown, that the birth rate in most industrialized countries are declining. So there's an immediate discrepancy between the consumers of healthcare and the providers of healthcare, and that's going to be fully realized when most of the Baby Boomers reach that 75-85 age window. And a lot of them are still working right now, but they're in their last few years, and many of them pre-emptively retired due to COVID.

Rex (12:27):

So we had a huge retirement and we have a coming retirement of all of these Baby Boomer aged nurses who were the primary teachers of people like myself, experienced seasoned nurses. They were a career nurse. They were there 30 years, or plus, even, some might say. And that can't be overstated, that when you have such a high proportion of your employees in that age category, ready to move on, it's going to hit really hard. And not only that; they're immediately turning the coin and they're going to be consumer of healthcare. So they're retiring and immediately, within the next 5, 10 years, they're going to be needing some type of nursing or healthcare situation.

Rex (13:07):

Beyond that, and this is just going back to 2016. When I entered nursing, the state of social media and opportunities for income, or let's say not even social media, but opportunities for, let's say, influencer-category income were little to none. That has actually changed. If you're a young person coming out of high school, looking at college or tech school or whatever across the panel, you actually stand a pretty good chance to find a way to earn money without going to nursing school or going to get any type of college degree, if you wanted to directly go into business.

Jim (13:44):

I see what you're saying.

Rex (13:44):

Or if you wanted to try to support yourself on YouTube by customizing trucks, to give an example, there's such a higher level of stratification in the last 6 to 8 years of how people can earn money, and the problem is... I'll use it for an example. If I had the opportunity to work for Walmart now, what the hospital was paying for a PCA, I would have worked at Walmart, but the hospital was paying more. And I think this is one of the factors that comes into the shortage.

The shortage that's coming up is because there are other industries that young people can get into that can outpace both growth and income than nursing income. It's good in a way, because you have a portion of people who won't chase the money, but then it's bad in a way, because it's hard to get new talent: people who might be really good nurses, but now they're somewhere else.

Rex (14:33):

And when it comes to the hospital portion, though, it's complicated. By the nature of our profession, you can't just let anyone in. We know this, right? Even though they graduate past the NCLEX, they could still be an antisocial person or not very attentive to detail or not really have a good safety concept when it comes to taking care of people. Very difficult to say what more they could be doing, except for offering more money to some people. But I don't even know that that's a viable solution, because that's what the travelers are getting now. We're getting more money. They still have this shortage.

Rex (15:05):

So I think all these other factors stack up and have this mass effect of too many people needing and too many hospitals not being able to replace their nursing staff, especially people who are just leaving the industry because they simply don't want to be there any more. I wish I had more on what to do, except that raising salaries is one solution. But how viable long-term is that solution? Because then everybody's healthcare price goes up coupled in with that.

Jim (15:35):

Right. Well, that's some great insight, Rex. I really appreciate it. That's definitely a different take than I've heard before, but it makes sense.

So if you're just tuning in, you're listening to The Healthcare Leadership Experience Radio Show, and I'm your host, Jim Cagliostro. This show is sponsored by VIE Healthcare Consulting, a SpendMend company, which provides leading-edge financial and operational consulting for hospitals, healthcare institutions and other providers of patient care.

Since 1999, VIE has been a recognized leader in healthcare costs, hospital purchase services, healthcare benchmarking, supply chain management and performance improvement. You can learn more about VIE Healthcare Consulting at viehealthcare.com.

Okay, Rex. I guess, do you see hospitals continuing to use travel nurses long term?

Rex (16:23):

I think that one of the parts of the questions I didn't answer just a minute ago was the fact that hospitals need travelers because inexperienced nurses need time to understand whatever clinical area they're being put into.

Jim (16:38):

Yes.

Rex (16:39):

Though you are a nurse, every single clinical area... And I'm in procedural work predominantly now, but even if I were take someone who typically works in a med surg or telemetry floor and put them into an ICU, there's tons of new equipment, considerations, medications and things that they're now having to use on a routine basis that just takes time. So where the traveler comes in, they've been there, they've done that, hopefully, and they will just pop right into the situation as an experienced person, and with very little updating, be able to function, maybe while you bring someone else, a new hire, up to speed for 3 months. A typical traveler contract is 13 weeks, which is 3 months in change. That's the ideal situation in which a hospital system uses a traveler.

Rex (17:23):

Where we're at now, people have left the industry, they're retiring, and healthcare needs are in general growing. So where we're at now, we have this limbo where there's thousands.... I think every major agency advertises that there's 18,000 to 21,000 open spots in the country. And while that doesn't sound like that many as far as a profession, remember there are very few people who are willing to travel as a nurse. We're grounded. We have families. Not everyone's willing like I am to pick up the family and hop over the country for 3 months. So because of that, you run into a price war. And with COVID, when there was federal money pouring in to assist with COVID emergency stuff, it wasn't that big of a deal for hospitals. But now that that's gone, the hospitals are eating the bill. So prices are coming down, which they have to, but now we're working into, how do I meet my continual short-staffing need with experienced people?

Rex (18:20):

Well, I can give you a couple examples. There's HCA, which is also known as HealthTrust, and I know of a couple other examples, which I can't necessarily completely demonstrate this, but many people are buying agencies. By people, I mean hospital systems are buying agencies to staff themselves, and they are paying the people who are agency workers a higher wage, like a traveler would make. And they will even sometimes contract them at a higher rate than their normal staff, but not such a high rate as maybe an outside traveler would make. And they will use these staffing agencies to shore up their semi-long-term needs, if I can make that a term.

Jim (19:02):

Got you.

Rex (19:03):

So it's a tactic that people are employing, and there are many people who are travelers like myself, that hospitals, they no longer really heavily enforce that radius rule. If you're not familiar with that, it's rules that facilities set that you can't travel within a certain distance, but what they will say... They need the staff members, right? They will say, "Well, we'll give a local person a slightly lower rate than we would give an away person." So I don't know if

that's discouraging enough to get people to come back to work full-time, but those are a couple tactics that hospitals are using to try to shore up their semi-long-term needs for experienced staffing.

Jim (19:41):

Well, Rex, I've also heard... I know there's a major health system in the Northeast that actually launched their own in-house travel staffing. So whether it's purchasing or partnering with, or even creating their own in-house travel staffing agency, I guess my follow-up question to that would be, how are they able to offer the higher pay? Is it because they're not providing the benefits, the retirement, all that stuff? How are they able to offer that if it's the same hospital system paying basically the same employee who just switched over to become a travel nurse? Does that make sense?

Rex (20:12):

Right. And a lot of them... I'm going to guess as speculation, right? I haven't done enough personal research to go out there and measure all these agencies empirically. But I do know that there's one I work for now, they don't offer benefits. There's no health benefits associated. There's no retirement, no pensions, no nothing. And so it's bare bones, just work for money, but they're passing on the savings to the worker. And I have to say, in the last 20 years of history in corporate America, corporate America started breaking up with their employees much sooner than the employees caught wise and started breaking up with corporate America.

Rex (20:49):

Other things happening in other industries, it's called the Great Resignation. People in our age category, between that 30 to 45 to 50 area, are shuffling around every major industry in business, in healthcare, because corporate America has cut out pensions. The price of their benefits is increasing almost to the same price that you can buy them for if you go through the open enrollment marketplace. So if that's going to be the case, my retirement... Not to bring the government into things, but it drives a few of the things that happen. The Social Security is anticipated to run out of money in my lifetime. So if I can't rely on Social Security, I can't rely on a

pension, I can't rely on things, all I can rely on is my ability to get the money, well, that's what I got to do.

Rex (21:36):

So I'm perfectly okay accepting the fact that I'm not going to get X, Y, Z health benefits, retirement benefit from the employer, because I'm getting the money. And I'm trying to do what's responsible: pay off my debts, save up money, invest money for the future. And I think many people in our age category are fighting that same mental fight. We need the money because we're not going to get the other stuff like maybe another generation did.

Rex (22:02):

So I think that drives a lot of the people to these agencies, because that's the only place they're going to get the money that they can take care of themselves. No, I'm not saying everyone uses money wisely, but at least they have the opportunity now for the higher wage, and they do. They cut benefit. My agency right now doesn't offer any health insurance, and I'm okay with that, because I go through the marketplace to buy my health insurance so I can change from agency to agency and I'm not dependent upon my employer any more for the benefits.

Jim (22:29):

It gives you a little more control in terms of... And you just have to weigh the benefits, weigh the risk, and say, like you're sharing, you made that decision, that it just makes more sense to go this route.

Jim (22:39):

So, Rex, I'm going to throw one more question out to you before we finish up here, and that would be: maybe on the reverse side of it, maybe from a hospital's perspective, what risks, if any, would you say are inherent in bringing in travel nurses? Is it the frequent turnover? Is it bringing someone from another state, that there's challenges in terms of different policies? I mean, have you personally seen that or experienced it? What warnings would you give to hospital leaders, in terms of when you're bringing in travel nurses? What are some things just to be aware of, some inherent risks?

Rex (23:13):

Right. Two things I'll say. Number one is my personal perspective. Now, I'm not here to indict every hospital system that ever existed about certain things, but I will say that sometimes you run into a problem with prioritization in the healthcare system, meaning whatever your staff gets penalized over, they will prioritize. So if the hospital administration is penalizing people over not updating their whiteboards, then that's what their nurses are going to prioritize.

Jim (23:45):

Makes sense. Yeah.

Rex (23:46):

Right. That's what I would do too. And that's what I did do when I worked full-time. And this is actually the reason I point it out, is because the people we work for, which are the people lying in the beds, the people who are getting the procedures, the people who are receiving the healthcare, they think our number-one priority is to take care of them. And I recognize this discrepancy between a lot of the bureaucratic things that have to happen, because the hospital has to please the government because Jacob comes in and says X, Y, Z, I get that.

Jim (24:15):

Right. There's certain standards that need to be met in order to continue operating.

Rex (24:18):

Exactly. But because I personally could care less if my whiteboard's not updated if I have not done what's right for my patient first... Because my priorities are to the person I'm taking care of. Again, I enjoy it. I have felt the liberty of, as a travel nurse, when I come into a system, they're not concerned with me abiding by every single one of their bureaucratic details, as long as I'm prioritizing their standards of practice and as long as I'm conducting myself according to the Nursing Practice Act of whatever state it's in. They really just care that I do a good job and that I'm following their

standards of practice. If my whiteboard's not updated, to use that as an example, they don't care, nor will they penalize me. And I would say anyone who did try to penalize me for doing something minute that's not directly related to patient care, as a traveler, I simply would probably not work for them over the long run, because my priorities are to take care of a patient.

Jim (25:14):

That's something I really haven't thought about before, but in a sense, it seems like when you bring travel nurses in, it really does force us as a healthcare industry to get back to the basics of why are we in healthcare? I love that, Rex.

Rex (25:27):

Thank you.

Jim (25:27):

Go ahead.

Rex (25:28):

You asked me, have I seen anything that's a risk or liability? Absolutely, and most of it was actually during 2020 and 2021 when I was working in ICU more as a traveler versus procedural work. And working in the ICU, the travelers had a very... Not all. Again, everyone who travels as a different individual. You have to judge them based on who they are, how they do what they do. But I, coming into the situation, have this very moral and personal burden to do my best for every person I possibly can. Not everyone's like that, and many people are potentially accidentally overdosing their patients or maybe not assessing them correctly. And then before the hospital system could ever catch wise, their two-to-four-week contract is already up. They've made their thousands and they're off to the wind.

Rex (26:14):

So does this introduce liability? Yes, it definitely does. And how do hospitals vet that? Well, there's legislation being kicked around in various states

about capping pay for travelers, which I don't think is the right way. But I think, let's say for the compact licensed nurses, adopting educational standards or standards of practice beyond state lines might be the answer. That people have some type of overseeing standard of practice or authority. And I hate to say authority, because that just means another bureaucracy, but they have some ability to regulate or maybe get some type of certification that allows this person to verifiably have some type of skillset.

Jim (26:58):

Sure. Sure. Rex, I love the insights that you shared. Some things I haven't thought about, or at least I haven't thought about it in that way. So thank you so much for being on the show today, and thank you to our listeners who spent time with us today.

If you have any questions about VIE Healthcare Consulting, a SpendMend company, or if you want to reach out to me or Lisa Miller, you can find us on LinkedIn.

We at VIE love helping hospitals save money and enhance the patient experience, and we're hoping that the episode today gave you some new insights or ideas to consider and to even use in your career and in your own healthcare organization. Rex, thank you for being with us today.

Rex (27:33):

Thank you.

Jim (27:35):

If you have any questions about VIE Healthcare Consulting, a SpendMend company, or if you want to reach out to me or Lisa Miller, you can find us both on LinkedIn. We at VIE love helping hospitals save money and enhance the patient experience, and we're hoping that today's episode gave you some new insights or ideas to consider and use in your career and healthcare organization.

MEET JIM CAGLIOSTRO

"Healthcare in this country is very complex. We cannot succeed or move forward unless we are willing to work together to achieve better patient outcomes."

James joined VIE Healthcare Consulting in 2018 and brings to the role over a decade of critical care nursing experience at highly regarded medical facilities across three states. During that time, he observed both the 'good and bad' of hospital operations in a number of regions, giving him a unique insight and understanding which he brings to our clients. That insight means he prioritizes patient care.

He has observed for himself and throughout his career that hard work makes a tangible difference in the lives of patients. While at Stanford, he was extensively involved in training staff on patient care with Ventricular Assist Devices and Total Artificial Hearts, which reinforced the importance of education and preparation in order to excel.

It is this, coupled with his experience at the bedside in reputable facilities, that has prepared him to be flexible and work on a 'patient first' basis. Underpinning that drive for meeting patient needs is an understanding of the critical requirements for clear and direct communication within and between healthcare organizations.

James has a BSc in Nursing from Messiah College and a Master's in Health Education from Penn State. He also has 7 years of critical care experience at Hershey Medical Center (PA) and Stanford Hospital & Clinics (CA) and 3 years of PACU/perioperative/surgery center experience in NJ.

MEET REX HARTMAN

Rex Hartman, RN, Travel Nurse specializing in Critical Care, Interventional Radiology, Cath Lab, and Vascular Access.