Operational Inefficiencies in Healthcare

With Ryan Lee

Episode 83

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Ryan (00:00):

Studies say right now, up to 53% of nurses are considering leaving the profession in the coming years. And half of that would be devastating. So hospitals are obviously putting in place measures to try to combat this, but it's really hard. It's a deep hole to dig out of, and it's going to take a collective effort that involves every stakeholder.

Introduction (00:18):

Welcome to the Healthcare Leadership Experience Podcast, hosted by Lisa Miller and Jim Cagliostro.

Lisa is the founder of VIE Healthcare Consulting and now Managing Director at SpendMend. Lisa and her team has generated over $1 billion in financial improvements for VIE's clients since 1999.

Since 2007, Jim has been a registered nurse working in critical care, perioperative services and outpatient settings at nationally recognized medical facilities across three states.

You'll hear conversations on relevant and trending topics in healthcare and much more. Now, here's your hosts, Lisa and Jim.

Jim (00:57):

Hi, this is Jim Cagliostro and you're listening to the Healthcare Leadership Experience. Today's guest is Ryan Lee, CEO, and co-founder of HireMe Healthcare. Today we're talking about operational inefficiencies in healthcare. Welcome Ryan, and thank you for joining us today.

Ryan (01:13):

Thank you, Jim. It's a pleasure to be here.

Jim (01:15):

I always like to jump in and start by having our guests share a little bit about themselves, some of your story, your career, and how you got to where you are today, and also if you want to throw in why you enjoy what you do today.

Ryan (01:27):

Yeah, absolutely. So I followed a pretty non-linear career path, to say the least, but I'll start from the beginning. I was born in Charlotte, North Carolina, which is where HireMe Healthcare is based. I went to the University of North Carolina, very proud to be at Tar Heel. And after that I moved out to Colorado, I made a promise to my dad when I was 12 years old that said I was going to move out there after college, wanted to be a man of my word. So I did and I pursued the legal career path while I was out there. I was always told, I was born to be an attorney, which I think just means you're very argumentative and problematic, but ...

Jim (02:04):

I've been told that before too, yeah, Ryan.

Ryan (02:06):

It's a compliment if you look underneath the surface, I'd say. But I moved out there, I got a job at a law firm just working in an office while I was applying for law school and ended up unable to leave the state of Colorado despite some good offers around the country, and I went to the University of Colorado at Boulder. And when I was there, there was a huge entrepreneurial

component to it. They have a whole department dedicated to it, and I got deeply involved in startups in a lot of different ways. I mean, one of them was a party clothing company at the time. Now they're a major prescription...subscription underwear.

Jim (02:39):

Okay.

Ryan (02:40):

I'm not sure what prescription underwear would be, but it might exist.

Jim (02:45):

I'm sure it does. I'm sure it does.

Ryan (02:47):

Right. Yeah. But I was a model for them, compensated in six packs of beer and went on to become their attorney and ultimately an investor and advisor for them. It's a company called Shinesty to the listeners out there. I highly recommend you check them out. You can't go wrong. But yeah, it was a big scene and it got me really interested in startups from the business and legal side and just really in the early stage.

So I took that with me and I went and opened up my own law practice. I was doing criminal defense and entrepreneurial law, an interesting dichotomy of work and caseload if you will. But I represented startups and people accused of crimes, and it was really fulfilling. It was a lot of great work. There was never a dull day. But my passions were always to get involved in something that attacks giant problems at a deeper level to make an impact like that.

Ryan (03:42):

And one of the ways I sought to do this was based on one of my other passions, which is international affairs and just humanitarian issues. And so after about four or five years of practice, I moved overseas to Austria to pursue a master's in human rights. I wrote my thesis based on the right to health while I was there. And as part of that, they ask you to go get either an

internship or a job, and I chose a job. So I went to go work in Uganda working for a company called African Clean Energy, where we were bringing a clean cooking solution so it cooks without smoke, which is imperative for cooking indoors. And all cooking in villages is done inside huts on three stone fires. So eliminating that is a major health benefit to a large portion of the population over there. And it was really exciting.

Ryan (04:35):

My job was to figure out how to get this product into the refugee context. So they asked me to basically build a startup within a startup. Yeah. So I was there right up until the pandemic began. I came back a little earlier than planned with malaria, stuck around for a couple of months for the birth of my first daughter, still my only daughter, and that was March of 2020. She was born in April. So any plan to go back was curbed by this pandemic that we all may or may not have heard of. And from that point on, I guess I'll rewind a little bit.

Back in 2017 when I was practicing law, a childhood friend of mine, our dads were actually best friends since middle school so we've known each other well for our entire lives. I'd call him a brother. He came to me with an idea. He had been working in healthcare operations at a major healthcare facility, and he was witnessing these problems regarding hiring, particularly with regards to nurses.

Ryan (05:35):

And he saw, frankly, he blamed the timeline of corporate policies that it would take anywhere a minimum between 30 to 45 days just for a nurse to get into the door. That was about half of the national average of backfill, which back then it was 90 days. And with nurses giving two weeks' notice, this was leading to immediate and automatic staffing shortages, just on the timeline alone, let's look at that in a vacuum. And so he decides to take a pen and a pad on his spare time and draw out an application that would put all this into one place and make hiring more efficient, more effective, and just simplify the process. And that company is called HireMe Healthcare.

So I came with him as an advisor and I went with him to go vet an investor who had extensive experience building an IT startup from a garage to an exit.

And I walked away from that meeting as the co-investor. And there we had HireMe Healthcare's founders round.

Jim (06:38):

Nice.

Ryan (06:39):

Now, I stayed on as an advisor and participated helping Trey as much as I could while I was also pursuing other things overseas, got very familiar with the healthcare hiring situation, just with the technology that we were building, and worked closely with him building a beta and really getting some initial usage and really proving this concept. So when I came back from Uganda, we had proven the concept, we'd been making placements in under 30 days, nurses and healthcare executives alike had expressed interest saying, "This is a viable alternative to what we're doing. We'd be interested in seeing this." So we decided that I would join and pursue it full time.

Ryan (07:21):

And by March, 2021, we decided that it was in the best interest of the business for us to switch places and for me to take my background in early stage startups and everything I had learned in that process to build us out as a business. And we worked to build a product. And in 2022, we launched the updated product. We'd learned much from the beta, and we wanted to build something that immediately scaled because the problem was so intensive and a solution was so direly needed. Now it's hard for me not to feel like I'm preaching to the choir here, Jim. You're a nurse, you've experienced all this stuff firsthand. You know what I'm talking about?

Jim (07:58):

Well, you're spot on. You're absolutely right. And the timing, like you said, it's something that the healthcare world really ... It hit them. I mean, all of a sudden, but it's been a problem that's been building, but COVID really just put it into full swing.

Ryan (08:12):

It was just throwing gasoline on the fire. I mean, when we look back, this problem is not new. And that is important. Trey's realization of this was in 2017 after years of working in the space. And if you look back, a lot of the studies that talk about the American nursing shortage, there's extensive clinical literature on this coming from the early 2000s. I mean, it's been a problem. There's books about nursing staffing from Florence Nightingale on. I'm blanking right now on the name of that text but it's a good book worth reading, and it talks about how it's been a problem since the beginning of nursing. But like you said, COVID was that accelerant that took it from industry knowledge to the front page of the Wall Street Journal at least. So the awareness component has been one positive, if you will, to look at through all of this mess.

Jim (09:06):

Sure. Well, first of all, I'll say I didn't realize this about your background, just how wide of an experience you've had in terms of the humanitarian efforts and the international health. I mean, I'm sure that just gives you a perspective, and then the legal background. I know that that comes in handy when you're talking about an organization, a tech company like this. So if I can, maybe before we jump directly into the staffing and the hiring part because I know we're going to talk a lot about that, maybe a little more general. What are some of the most common operational inefficiencies that you've observed in hospitals today? And I would say specifically in the American healthcare system, although I know your knowledge probably goes beyond that too.

Ryan (09:45):

Yeah, I mean there's a nursing shortage in Uganda, and it's for the same reasons. This is not a uniquely American problem. However, there are studies that show that COVID and the American response was a bit, how would you say...it had a sharp lean towards an American problem. We experienced growth in the shortage far beyond, and particularly on the mental health and burnout side of it. This was a study actually looking ... This was done in 2022 in the International Journal of Nursing Studies, Nurse Studies, and it attributed

to the increase of anxiety, and they were using the GAD 7, which is a general anxiety questionnaire to determine for diagnosis purposes. And then they were using the PHQ-2 for depression to test this. So two very trustworthy components there. I'm familiar with both of them personally actually.

Ryan (10:41):

And what they found was that the increase in responsibilities, the increase in travel nursing and the decrease in resources, greatly exacerbated the mental health strain on nurses. And this is obviously a tangent into how it's become a bit more uniquely of an American problem a bit more ... We feel it a little more here than in others, but they also found that to be more common for hospital nurses, which checks out. But one of the best ways I've heard it said was speaking with a nurse manager from a major healthcare facility just the other day. It's about trying to do more and more with less and less.

Jim (11:15):

I've heard that. Yep, absolutely.

Ryan (11:17):

Yeah. And I was actually just speaking with a neurocritical care doc this morning and knowing I was coming on here, I said, "What would you say is the number one operational inefficiency in a healthcare system?" And she said, "There's too much administrative red tape put in place by too many people that don't have bedside experience." And that's not to say you don't need people with different backgrounds, it's critical to have that. But it was interesting to hear, and those are her words, not mine. But it's interesting to hear that take and these operational inefficiencies, and I am definitely way more qualified to speak to this in a nursing staffing context.

Jim (11:52):

Please.

Ryan (11:53):

So it just comes down to how much turnover there is. And that's what I mentioned earlier about the time it takes to fill a position based on the time it takes a nurse to leave a position. That just speaks towards a growing and aggregating problem there. They even have a fancy acronym to describe fill rates, the RDIRN or the Recruitment Difficulty Index.

Jim (12:18):

Okay.

Ryan (12:18):

Which is a fancy way of saying time to fill, but that's increased in recent years from the 90 days it was when HireMe was founded to 95 on average. And in certain specialties, particularly in med-surg and similar, it is upwards of 100 days, up to even 120 in certain areas, and that's way too long to find a nurse, especially with how critical it is and that there's a growing gap between the amount of responsibilities and the demand and what's there on the supply side. And this extends to a vacancy rate or this lends to a vacancy rate that right now it's at 16% a little over, which is a lot of gaps to be filled. That's a lot of nursing positions that are needed. With a vacancy rate that high, the recommended nurse to patient ratio, four to one, is almost impossible to achieve for most hospitals around the country.

Ryan (13:12):

And one interesting thing I've read that I'll mention here too is there's a study, an article about the competing interests of CNOs and CFOs here. And it's not the fault of any particular CNO or any particular CFO, but when one has the goal of making sure appropriate staffing is met and that the nurse labor force is best equipped to handle the patients coming through, while the other is primarily tailored towards making sure that financial needs are met, they see a gap in the nursing. They say we're spending 40% of our budget goes to our labor costs, and that is a huge portion of the budget, but it's there for a reason too.

Ryan (13:54):

And yeah, we can come back to this. It's very interesting. This was in a study done and it was done by the American Nursing Association, American Nurses Association, the American Organization for Nursing Leadership and the Healthcare Financial Management Association. So it's definitely one worth reading given that it brings in both sides to really talk about how this interprofessional approach where there's more overlap, more cooperation, could really help people land on the same page. Because everyone is steering towards a common goal of patient outcomes, patient satisfaction, and call it the truth, also financial success.

Jim (14:32):

Yeah. Well, you mentioned that about patient outcomes. So I guess I'd want to ask or maybe dig a little deeper into that. How do these inefficiencies that you're kind of touching on, how does it impact patient care and how does it impact overall hospital performance? We could talk about outcomes, we could talk about financial. What's your take on that? The impact that the inefficiencies have?

Ryan (14:53):

There's three main categories the way that I see it here. There's patient satisfaction for one, which with the rise of value-based care is an increasingly important metric, but the other two are patient outcomes and efficiency measures. And having safe staffing, which is also called appropriate staffing or evidence-based staffing has been shown to improve all of these components. So for patient outcomes, I mean you have anything from the frequency of cardiac arrests, a lot of it just has to do with what happens when patients are in the care of understaffed units. So an increase in cardiac arrest with subpar staffing, an increase in HAIs and hospital acquired infections, which can amount to tens of billions of dollars nationwide every year. That's a really expensive one. More instances of respiratory failure, failure to rescue becomes more common. And overall it increases inpatient mortality rates, which is the very goal of a hospital to avoid.

Jim (15:46):
Yeah.

Ryan (15:48):
And on the efficiency side, it impacts readmission rates, the length of stay, the turnover time in an operating room, the average time in the emergency department. And coming back full circle, it impacts the staff retention, which it's this vicious cycle that self-perpetuates where nurses are understaffed, working in an understaffed unit impacts mental health and wellbeing, which leads to burnout, which leads to more turnover, which leads to more understaffed units. And then it's just this cycle, it's really terrifying to look at because of what kind of an impact ... I mean we're talking about studies say right now up to 53% of nurses are considering leaving the profession in the coming years, and half of that would be devastating. So hospitals are obviously putting in place measures to try to combat this, but it's really hard. It's a deep hold to dig out of and it's going to take a collective effort that involves every stakeholder.

Jim (16:43):
That's a great point, Ryan, and I'm glad ... Everything you named there, I mean a lot of hospital leaders were thinking about the cost, the impact of these inefficiencies. It's expensive and you're losing people, the people that are necessary to provide that healthcare. And like you said, it's a cycle. It's not going to get any better unless we have interventions, unless we do something differently, unless we have interventions that improve that efficiency. And so I am glad you're kind of hitting on all those points.

In your opinion then, what are the main challenges that hospitals face? I know you've kind of mentioned some of these, but what would you say are the main challenges that hospitals face in tackling these inefficiencies? Are there any longstanding, and I'm sure the answer is yes, but maybe you could touch on this, any longstanding issues that characterize our health systems that contribute to these inefficiencies?

Ryan (17:32):

Yeah, you have to give credit where credit is due as well, because there is truly a talent shortage. That's a real thing. It's not just this burnout phase, this increase after COVID, nurses fed up with the status quo and everyone leaving in droves. We lost 100,000 plus nurses last year. It's not just that. There is an actual talent shortage here, and that comes from several things. There's a pipeline issue, for instance, education is a huge ... There's a shortage in faculty talent to train our nurses. There's way more qualified applicants for nursing schools than there are available seats in nursing schools. That's part of the recent ... A hundred million that the Biden administration just pledged to attack the nursing staffing crisis is addressing the education pipeline. So it'll be really interesting to see how that plays out. This is new as of the last, I think it was last week that this happened. So I'm still learning more and more about what all that entails and what its efficacy will actually be.

Ryan (18:30):

But there is a talent shortage and there's reasons. If you go back, I'll look to this survey done by an organization, a think tank called Health Workforce Solutions. This was in 2001 where they talk about the reasons for the American nursing shortage. And it comes down to an aging population, still more true today than it was back then. They were talking about Gen X being the primary generation in the nursing workforce, which now we're looking at Millennials, an aging nursing workforce, still the same. The average age of nurses is over 50, nationwide. They had to do a lot with the work environment. They said fewer resources and more demand. This was in 2001. None of this is new. They talked about competition and pressures in healthcare financing, which is that CNO-CFO tension right there.

Ryan (19:21):

Everyone in a healthcare environment needs more money, whether it be for research, whether it be for just resources in the hospital for updating the infrastructure. There's so many different demands on finance, and often the nurses struggle to enact changes. It's existed for a long time. The nurses don't have a loud voice. They have a CNO to speak on their behalf. They have higher ups in the C-suite advocating for them. And that is growing right now,

I have to tip my hat to a lot of hospital systems for really opening their ears and their doors to the nursing workforce. But if you're a disgruntled nurse, you're not going to be able to get a meeting with the CEO. And with the volume of staff there, it's hard to really get a meeting too with the CNO. They're aware of these challenges, but sometimes it's best as you know, who best to speak about the bedside perils of a nursing professional than the nurse themselves.

Ryan (20:18):

And again, the struggle with career development opportunities for nurses. Hospitals were not really opening it up for nurses to expand their career, to go deeper into specialties, to get advanced education, looking for advanced licensures. And also two other things that this survey referenced was a lack of diversity in the workforce. And just to give you an idea of when this was, this was a time when a lot of women began leaving the nursing workforce because it was opening up to pursue other professions. So old problems that are still present today, old problems that are a little less relevant in today's workforce, but still an issue. It's been a problem for a long time. And there's the issue of what hospitals will take, whether they take an approach based on their own internal systems towards tackling the crisis versus looking towards evidence-based and safe staffing measures, which have been proved time and time again by studies just over and over the direct impact, the correlation of the ... I mean it goes as far as causation of subpar staffing set by what these evidence-based standards are and the patient outcomes that we discussed.

Ryan (21:31):

And I guess lastly, I would just say there's an issue as the neurocritical care doc mentioned, there's just the issue of administrative red tape and that gets in the way of being willing to take innovative risks versus actual troublesome risks that could jeopardize the company. They see innovation and new technological approaches towards age-old problems in place of traditional methods. And I speak primarily to the hiring side. Call me a little biased here, but I believe technology is the answer to this solution, and I can find a lot that stand with me on that.

Jim (22:07):

Sure. Well, it's okay to be a little biased because you've seen it work. You've seen how effective it can be, and I'm glad ... That's something I don't think we do enough is looking at old studies. You mentioned this in the statistics from 2001, and like you said, it might be a little different, but we're seeing a lot of same problems. Maybe they're just manifesting themselves a little differently, but I think that's a valuable practice to do, to look back and say, okay, this was a problem 20 some years ago. How did they address it then? And maybe we can address it maybe with a similar mindset.

Jim (22:36):

But now also, like you said, we have innovation in technology today that we didn't have 20 years ago. And so we can rely on that. And I'm glad you brought up again the administrative red tape and it's a reality. And like you said before, there is a business side of healthcare. We have to acknowledge that, but the importance of people at the bedside having a voice, and a lot of that can be found in if you have leadership that has that bedside experience, and we've talked about that on previous episodes of this podcast, it's valuable. I mean, we have that business side of healthcare, but we also have to understand the bedside, the practical, the clinical side of it, that can't be forgotten in all of this.

Ryan (23:14):

Absolutely. It's understandable why certain positions are taken in the C-suite of hospital systems. It makes sense. It is a business. It requires cashflow to survive. It requires cashflow to thrive and to innovate and to grow with the changing demands of our patient pool. We're all patients in this system. I will say it's hard to discuss operational inefficiencies in healthcare hiring without mentioning travel nursing.

Jim (23:42):

Sure.

Ryan (23:44):

You were a travel nurse back when the only purpose of travel nursing was the amazing, or not the only purpose, but the real basis for travel nursing was living in various places, having an adventurous life, getting a chance to fill in where needs were at a temporary high in certain areas, be it flu season, whether you're doing it to go fill in for a flu season in St. Louis or whether you just want to live in Denver, Colorado for three months. That was the basis of travel nursing up until the pandemic really. And that's when labor costs just skyrocketed for that. And it became almost imperative for the nursing side. You're looking at people making two, three times as much as you and the hospital's paying eight times that at some points. I mean, the average cost for an hour of agency labor got up to 275 an hour during the pandemic, which is utterly insane. That would be amazing money for a nurse if the nurse saw even close to half of that.

Ryan (24:42):

But the average pay for travel nurses was still around $125 an hour versus the usual $50 an hour. I mean, so you're looking at being able to afford two and a half FTEs for the same price as a travel nurse, but why would you go take an FTE position when you can make almost three times what you're making? So it made sense for nurses to take on these roles. I knew a lot of nurses who were living in Charlotte and working in Winston-Salem, and they were technically a travel nurse, but not like when you were a travel nurse, Jim, where you moved to California to do your job. They were just driving from Charlotte to Winston two hours every day, and that made them a travel nurse and eligible for that kind of pay.

Ryan (25:26):

So that's the system we made. And obviously, I mean, our health system nationally spent $24 billion in one year just on travel labor, which sounds absurd, but when you do the math, 275 an hour spent times our workforce that shifted into travel and the hours demanded of a short-staffed healthcare system. It was quite amazing to say the very least there.

Jim (25:50):

You mentioned it earlier, sorry to cut you off, but you mentioned that the time to fill and really, I mean you simplified it great for our listeners, I think where, okay, you can give 2 weeks' notice and you'll lose a nurse, but it takes 60 days or 90 or even up to 120 days to fill that position. We were kind of set up for this situation, and unfortunately the pandemic really threw the healthcare system into it. And so what do you do? You're left with this situation where you have the agency nurses, where you have to fill those positions and it's costing the hospitals millions of dollars.

Ryan (26:24):

Absolutely. And I mean it's being done ... At the height of the pandemic, turnover got up to almost 30%. It was a little over 28. And so that's almost a third of the entire national workforce just turning over. And that doesn't include the specialties that had significantly more. We mentioned med-surg. There were points where combining a couple of specialties would go over 100% turnover ratio, which was meaning that hospitals were turning over an entire department in under a year. A lot of them would raise that with travel labor. And one of the risks of travel is just that cohesiveness in a nursing unit.

Jim (26:59):

Which is important.

Ryan (27:02):

Absolutely. I mean, in addition to just the human tension that arises when you're sitting there training someone, showing them where the gloves are above all, and then knowing that they're making three times what you are, there's just the unit cohesion that goes out the door there. But I have an example from my family. My sister was having ... She had her second child and she's a nurse herself. She was in the neural ICU for most of her career, and she witnessed two travel nurses come in. They used different scales to weigh her baby and only she would notice that because of her nursing experience. But it led to a major panic.

Ryan (27:40):

They thought that her newborn daughter had lost over 10% of her body weight, which led into triple feeding, emergency formula, immense stress. That's stress that a patient's not going to have. What's that going to do for patient satisfaction? Fortunately, they remedied the error. Would they have remedied it if she had not been able to notice that and pointed it out and say, well, maybe it was the scales and this was the next day? So hours through the sleepless night of stress later.

Jim (28:08):

Well, that's a great point. And yeah, that's not just a one-time occurrence. If it's happening there, it's definitely happening in other scenarios.

So I mean, you're really speaking well to this and to see how this problem can build. How would you say, and I know this kind of gets into more of what you do, how would you say technology plays a role in optimizing hospital operations? How technology can help improve efficiency in terms of hiring or any other area?

Ryan (28:34):

From the hiring side, it makes it more efficient, it simplifies it, and this may sound strange given that it's technology based, but it humanizes the process. And that's what HireMe Healthcare sets out to do is to humanize the process.

Jim (28:45):

I need you to just break that down for me because yeah, I want to hear. That's great.

Ryan (28:52):

Absolutely. So let's go from the nurse perspective first. So you are applying for a job, but you're applying for multiple because you want to find that right fit. So you're going to fill out a new application, your resume exists, but it has no point because you have to fill out applications for hospital systems through their system and through their portal individually each time, typing the same

information over. And I remember this, I had to do this with the United Nations. It was quite tedious. They had you do it for every single position, and it honestly deterred me from applying to a lot of positions that I think I would've been a good fit for.

Jim (29:23):

Sure.

Ryan (29:25):

So technology can play a role by offering a one-stop shop personal profile. And we're not the only ones doing this. I'm not pretending we are, but it's a great way to have all the necessary boxes that need to be checked for a specific job can be in one place, and then you get to take the quick step forward towards the human side of the process. Is this nurse a good fit? And HireMe Healthcare uses matching technology to pair nurses based on individualized nurses, individualized job descriptions, looking to find the person behind the resume, and the person, the people, the team behind the job description. It's not just quantitative. Do you have this experience? Obviously that stuff's very important, but that can be determined in seconds. I mean by having our one-stop shop personal profile, and then each customized job description, it allows hiring managers to have these candidates ranked for them just based on the check boxes and the components. And then adding in qualitative components to find out what kind of a fit someone's going to be on a particular unit.

Ryan (30:28):

It's not as simple as you're a good fit for a hospital lifestyle. Are you a good fit for the fourth floor of CMC Maine Hospital in Charlotte, North Carolina? Or are you a good fit for the eighth floor at a hospital in New Jersey where you're based? It's going to be based on the people on each unit. And as these units do stabilize a bit more, we have a little more insight to what unit culture is like. Unit culture was hard to even differentiate for a while there in the pandemic, it was just who's in for these 30 days and who's out after 90?

Jim (31:05):
It was like survival mode. Yeah.

Ryan (31:07):
Absolutely. Yeah. It was like an episode of Survivor, people just disappearing left and right. And technology allows the humanization of that process. And we're looking into the AI ML world to really heighten the capacities of these algorithms that are based on searching. Algorithms used to be used under traditional hiring methods to actually short circuit the hiring process. One of the earlier uses of AI in employment was filters on resumes where certain keywords, if you didn't hit enough buzzwords, they would never see your resume. This was one of the things that Trey saw firsthand that led him to say, "Wow. I mean, I know qualified applicants. I'm sending them through our process and they're not landing on the hiring manager's desk."

Ryan (31:52):
They were being filtered by things. And it can be something as simple as if you have your old ... We have a job opening post right now, and I'm getting people that are based in Charlotte that still have their old address on their resumes. Those resumes would never land at the feed because they put in a filter, they didn't want to pay relocation fees, for example. So they put in a filter. It has to say one of these zip codes on there.

Jim (32:12):
That's interesting. Okay.

Ryan (32:15):
Your address should not preclude you from being offered a job that you're well-qualified and that desperately needs you to be there. So technology's there to simplify, to eliminate steps. It can all be done on technology, even the interview can be done. We're building that out as part of our component where an interview can be conducted on HireMe Healthcare's platform. It should be that you filtered enough through that by the time you're sitting there talking to this person, you know good and well that they should be a

proper fit. And then you get to get into the important stuff. Then interviews are more efficient. You get to talk to people about the things that matter and find out really are they a good fit for your unit? And not filtering people out, but filtering people, funneling them in.

Jim (33:02):

Sure.

Ryan (33:03):

And that's our approach to this. And there's plenty of other ways technology can play a role, but I'm obviously best equipped to speak to HireMe Healthcare's approach in the matter.

Jim (33:14):

Well, I love that because I know at the bedside it's, "Oh, technology, great. This makes everything impersonal. This gets in the way of the human aspect of nursing." But the way you put it when you say, "Well, hold on, technology can simplify the process, it can minimize the steps that needs to be taken, it can allow more time to focus on that human aspect of, well, the interview and how do we connect and make sure someone's a good fit." I mean, it's great. I'm glad you laid it out like that because a lot of times our immediate reaction is, "Oh, technology. Well, we're really ruining the human aspect of patient care or healthcare in general." But that's a great point that you make.

Jim (33:52):

If you're just tuning in, you're listening to the Healthcare Leadership Experience, 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 purchased services, healthcare benchmarking, supply chain management, and performance improvement. You can learn more about VIE Healthcare Consulting at viehealthcare.com.

Jim (34:25):

So Ryan, if you don't mind, explain, getting into it a little bit more, what role does staffing and staff training and development play in reducing operational inefficiencies in hospitals? I know we focused on the hiring, but maybe some of that training or some other aspects of the staff training and development that can help with these inefficiencies.

Ryan (34:46):

Of course, if you can retain your staff long enough to train them well, they will be more inclined to perform better on the job, which as we mentioned, this comes back to the better staffing, leading to better patient outcomes.

Right now, it's hard to really focus on training your staff when they're turning over as quickly as they are. A lot of first year nursing students or first year grads entering the nursing workforce, they turned over some 36% I believe it was last year, and they're losing a third of grads that need the most training of all right off the bat, and that means they're going to bounce to another job. And this was another thing that Trey really experienced firsthand, and that led to the creation of HireMe Healthcare was just how little time nurses had to be trained and that they'd be trained on certain protocols within a hospital. But if you're flipping to a new hospital every 30 to 90 days, like travel nurses or disgruntled first years that have a, this isn't what I expected. They're not around long enough to endure the proper training that they need.

Ryan (35:51):

And also training comes into requiring resources, and those resources like the resources for hiring and everything else are becoming more scant, the time spent. We talked about, oncology is actually a great example of this. It's a hyper-specific practice that has a bunch of, just as they describe it, little things that make it very unique that only are necessary for oncology nursing, but they don't have the wherewithal to hire someone full-time, someone who's trying to transition into oncology. They don't have the resources to hire someone and just employ them full-time for the training necessary to become masterful in such a critical practice that has so many nuances.

Ryan (36:35):

This is true across the board that not having enough resources to train your nurses leads to subpar training. And a lot of that training focuses, as I said, on protocols and those protocols can be unique. Going back to my sister's example, the weighing protocols were just not what they were used to in that setting. Fine, talented nurses, not trained in a specific protocol of a given unit are going to make errors that are just different in that. Every hospital operates somewhat differently in certain little nuanced ways. And one of the big parts of training, I believe that is often overlooked is that resiliency training, training nurses to endure what is to come. Because even in times of less rigorous staffing shortages, which like I said, always existing these staffing shortages, but to what extent, even in times with less of that, it's a grueling, grueling job. And again, this is me preaching to the choir. You can speak very much on that. I mean, if you don't mind me flipping the script here, what was it like training in your experience, in your career path? How did you feel about that?

Jim (37:47):

Well, I have to say, as you were mentioning that, I was reminded, I'm watching some of the Women's World Cup that just finished and they were talking about having a sports psychologist for the team. And at some point, it was required that every player met with the sports psychologist on a regular basis. And then at some point it wasn't required. It was just an optional thing. And I'm trying to think back into nursing school and even the early years of nursing, there really wasn't much of an emphasis in terms of, you mentioned resiliency training. We relied heavily on our coworkers, and it was sometimes people who were like, "Okay, you are just as stressed out as I am." Or "You're having the same struggles that I'm having getting into this career of nursing, understanding how it works."

Jim (38:32):

We would really rely on those who were still young enough in their careers, maybe two or three years in where they could sit with us and say, okay, yes, this is normal. This is kind of how you work through things. This is kind of how you figure out. So it was very much, it was with your peers that we found

that support. It definitely wasn't a formalized something like resiliency training. I think that's a great thing, but it was more like a, "Hey, find your support. Find someone that you can connect with to help you through that process."

Ryan (39:01):

Right. And you mentioned sports psychologists, so I can only think of Ted Lasso. But yeah, I mean, think about relying on your team like that when they're turning over at 20, 30%. I mean, turnover's reduced since the pandemic, the ultimate, the pinnacle of the stressors has subsided slightly, but it's still 22%, and you're relying on that staff when they're flipping over all the time and you're having to have new people come in and then now you're the one that they rely on. You're like, wait, I just figured out how to be resilient in this particular operating environment. How am I supposed to coach you on it?

Jim (39:38):

Yeah. So Ryan, looking ahead now, I'm trying to think moving forward, what changes do you foresee having the greatest potential to address these inefficiencies that we're talking about? And maybe I can ask, are you seeing any of this positive change today? Maybe some of the hospitals that you work with or some of the leaders that you're working with, are you seeing them make the right moves in terms of improving efficiency?

Ryan (40:02):

You see both directions of that. There's a lot of things being done as you know, and it's a matter of which ones are more effective, which ones are actually working, and which ones are hospitals marrying to that are not carrying the results that are necessary that they desire to see. One of the most common ones, for example, just to go start in the negative direction, is asking nurses to volunteer for overtime. According to the NSI retention report, 99% of hospitals are doing this, and it's not very effective as you can imagine, especially if we look at the impact on nurse wellbeing and nurse mental health. Just asking RNs to do more is not the way to go. But a couple of things we've seen have been very effective, authorizing critical staffing pay

has worked. Nurses getting paid for what they're actually up against. There's building in-house nursing staffing pools, float pools have been very effective within to really have labor that understands your protocols on hand. That's been very effective.

Jim (41:04):

Absolutely.

Ryan (41:05):

Nurses like getting paid more, but when you really talk about what's the real trigger here, it's not "If I got paid more, I would be happy in this job." The most effective measures hands down are those that address the mental health and wellbeing of nurses. And I also see a lot of efficacy coming from those that are embracing technology. I have to tip my hat to a couple of local hospitals here for Atrium Health, and it'll be interesting to see how everything plays out with their merger with Advocate, but Atrium has an innovation department specifically focused on bringing in technology-based solutions to tackle major problems. Cone Health in the Carolinas also has a venture arm that looks to pilot technologically focused endeavors, and if it's something that they're willing to try new things. And I would say the two biggest things hospitals can do are treat their nurses well, and I mean actually taking action towards mental health.

Ryan (42:04):

Novant Health is building meditation pods, for example. I thought that was something really cool. Novant has a wellbeing department, which I really respect, and the leader of that, a man named Jonathan Fisher is both a friend and real hero of mine in this process. He's an example of someone really stepping into a role that says, "Let's look into the wellbeing." You just had someone on here the other day talking about gratitude, and it's those measures, focusing on things like that, really looking into the humanity of the people practicing by the bedside and finding ways to tackle that that really go a long way. Focusing on gratitude, on compassion, and I think we can all agree the pizza parties thing didn't work.So...

Jim (42:48):

Well, and I'm glad you mentioned that. I'm sorry to jump in, but the whole idea of a department or a position devoted to wellbeing and even the innovation department. A lot of times when the money's tight, sometimes these are the first things to be cut. It's like, "Oh, yeah, we don't necessarily need that, but to hold these things thinking long term, this is a valuable position. This is a valuable department that we need to keep. We can't just get rid of."

Ryan (43:14):

I fully agree there, and all I was ultimately leading to is that I think the two biggest solutions are mental health and technology, which conveniently are two of my biggest passions.

Jim (43:25):

I love it. That's great. Well, it's been a great conversation, Ryan, and I love what you're doing. Sharing a little bit more about HireMe Healthcare, and I want to go back to what you said and then we will close up here. But you said you had, I think early in the conversation you said you wanted to address giant problems at a deeper level, and obviously the staffing issue is a giant problem in healthcare and I believe HireMe Healthcare and other organizations like you mentioned, are addressing these at a deeper level. It's not just a quick fix, but we need to think big picture. We need to think about investing into our staff members, training, development, all these things. But I'd like to give you an opportunity if you could leave our listeners with any advice, particularly leadership lessons that you've learned or maybe that have motivated you throughout your career.

Ryan (44:12):

The first lesson I would speak to is that burnout is real and preaching to the choir as far as healthcare workers here and healthcare execs, they have daunting problems ahead of them, but burnout is something that impacts leaders in every role. Ironically, I have burned out several times in my attempt to tackle nurse burnout and self-care, these compassion, these gratitude exercises speaking to each other with vulnerability, these things can all

address the underlying causes of burnout. I mean, it's easy to say work less, but sometimes the work demand is just going to be something that cannot be overcome and that you have to buckle down and tackle these hours. Now, when these stretches like that come and it's hard, people in leadership roles are often of the mindset that they cannot take a break because what would that look like to other people? I've been yelled at by my staff for not taking enough breaks. So that's what it looks like to other people in my organization at least.

Jim (45:16):

That's a good culture to have. That's great.

Ryan (45:17):

Yeah. When I said, I'll be available on my trip to Austria, and I went for the wedding that we talked about the other week, when I said I would be available from that, I got pushback on that. They told me not to be available. Now, there's some things I just have to answer. That's the nature of a leadership role like mine, but I really did shut it off for that whole week, and I came back renewed and refreshed and ready to tackle things from the beginning. And in America, that can be kind of hard. We're not exactly known throughout the international community for our vacation and holiday time, or our paid time off, or our maternity leave, or our parent parental leave, but finding places to work for that do value those things. It's a buyer's market for people with skills and trying to find jobs these days.

Ryan (46:01):

So from a leadership perspective, make those things available or you're going to lose a lot of talent, and from the talent perspective, looking for these roles. Don't take a job that looks at the outset like they're not going to look after your mental health. Ask questions in interviews and structure it that way. I'm interviewing people for our sales roles right now, and I think they're going to be surprised to learn that what do you do to take care of your mental health is going to be a question in a 30-minute interview.

Jim (46:28):

That's a great question. That's great.

Ryan (46:30):

Yeah, I want to make sure I barely have the capacity to take care of myself and my family and my employees. I don't have time to take on new staff and become their babysitter. I need to make sure that people are doing the right thing and really looking out for themselves because the best thing you can do for other people is take care of yourself.

Jim (46:47):

Well, Ryan, some very wise words. Thank you so much. I think that's a great way to end our conversation. Thank you 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. You can also find Ryan on LinkedIn as well.

We at SpendMend 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 use in your career in your own healthcare organization.

Ryan, again, thank you so much for being on the show today.

Ryan (47:21):

Thank you for having me, Jim, and thanks to our listeners for tuning in.

Speaker (47:25):

Thanks for listening to the Healthcare Leadership Experience Podcast. We hope you've enjoyed this episode. If you're interested in learning new strategies, best practices and ideas to utilize in your career and healthcare organization, check out our website at the healthcareleadershipexperience.com. And oh yeah, don't forget to rate and review us, and be sure to join Lisa and Jim next time on the Healthcare Leadership Experience Podcast. Thanks again for listening.

MEET LISA MILLER

"It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999."

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through frontline insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.
She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book The Entrepreneurial Hospital is being published by Taylor Francis.

MEET JIM CAGLIOSTRO

Jim 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 VIE Healthcare Consulting's clients.

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MEET RYAN LEE

Ryan Lee, CEO & Co-Founder of HireMe Healthcare, navigates life with a resilient smile, embracing challenges for growth. With an adaptable perspective cultivated through education, work, and social engagement, he swiftly acclimates to new environments, innovates solutions, and collaborates across diverse individuals, balancing autonomy and teamwork. Ryan believes in leveraging each team member's uniqueness to effectively conquer obstacles, foster growth, and ignite development.

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