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A Proposal to Solve the Emergency Department Nursing Shortage

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Physicians who have practiced Emergency Medicine for many years have experienced multiple "feast or famine" cycles relating to the adequacy of ED registered nurse staffing. With biblical precision, there have been "fat" periods during which our EDs are properly staffed, followed by "lean periods" during which nursing shortages lead directly to bed closures, long waits, poor patient satisfaction, adverse outcomes, and provider burnout.

Nursing workforce analyses from the Healthcare Resources and Services Administration (HRSA) opine that some states have a surplus of RNs while others have too few nurses. However, future nursing workforce projections vary widely and can change rapidly due to unforeseen events as occurred with the COVID-19 pandemic. Not to mention, competition among different regional health systems has increased nursing salaries and benefits but has also fostered a "revolving door" mentality in which experienced nurses will move from one hospital to another for minimal salary or benefit increases. This churn undermines hospital management's efforts to stabilize their nursing workforce and further decrements performance during periods of relative ED nursing shortages. The churn also undermines providers' abilities to build trust with their shorter-tenured nursing colleagues, impeding the development of the teamwork necessary for good EM practice.

One strategy that can help mitigate the nursing shortage would be to expand the practice scope of nonRN staff, termed "Assistive Personnel" (APs). APs include ED techs, EMTs, LPNs, scribes, and paramedics. Registered nurses can "delegate" a portion of their tasks to APs.

Although some state Nursing Practice Acts are very proscriptive regarding what can be delegated, the major nursing professional organizations have policies that permit delegation if accompanied by a series of hospital-administered operational checks and balances. These policies permit a delegation framework to be developed in each hospital, with a prohibition on delegating tasks involving clinical reasoning, nursing judgement, or critical decision-making.[i] It is estimated that only 14% of nursing work in the ED can be delegated to assistive personnel.[ii]

The paradox that occurs when considering whether to expand the roles of APs, is that although despite nursing being short-staffed, the average staff nurse, and at times, nursing leadership, often fail to unequivocally embrace an expansion of the roles of assistive personnel as a major tactic to mitigate the nursing shortage's operational effects. The reluctance to expand the practice scope of APs could be based on concerns about patient care but could also result from job security concerns or professional pride by the ED RNs.

Another reality of current ED operations is insufficient focus on maximizing the efficiency of nursing tasks. The triage process is a good example of wasted effort. Triage was initially designed to stratify the patient's chief complaints by illness severity risk in order to make a rationale decision about which patients should be seen first if there is a wait for treatment. In most settings, this simple concept has been expanded such that "triage" has become a broad term for populating the nursing database with questions on a potpourri of diverse topics. Triage data can include whether the patient has been a victim of domestic violence, has traveled to West Africa, or has been exposed to tuberculosis. We have not seen a strong push from our nursing staff for a "click reduction strategy" that would be laser-focused on maximizing nursing efficiency. This lack of incentive for hospital employees to "push the efficiency envelope" further erodes patient throughput for any given level of nurse staffing.

Since the early days of Emergency Medicine, many hospitals have outsourced the physician and PA practice in the ED to a third-party vendor. Traditionally, the physicians formed a professional corporation that was owned by a subset of physicians who worked at the hospital (or hospitals) staffed by their PC. New physicians to the practice would usually be hired initially as employees of the corporation and would have a period of time where their practice patterns and collegiality would be observed by senior partners. After a defined period, a decision would be made whether or not to offer them the opportunity to become a partner, thus permitting them to share in the practice's profits. This system, although now being disrupted by practice consolidation resulting from private equity-backed companies purchasing EM practices, has provided client hospitals with a highly professional, dedicated EM provider workforce and has given many emergency physicians stable and lucrative careers.

If the "outsource" system works for the physician group, would the establishment of a parallel system of outsourcing ED nursing lead to greater stability and greater efficiency? We believe that a scenario in which a group of senior ED nurses would incorporate an entity that would contract with the hospital to provide ED nursing services would have a salutary effect in three domains:

1. Reduced staffing costs from changing mix of RNs and APs
2. Increased nursing staff stability
3. Revenue enhancement from operational efficiencies

Reducing Costs

This plan could provide financial benefits to both the hospital and the nurses. Such benefits would occur because RNs would be incentivized to embrace a "managerial model" for ED nursing that would increase the ratio of APs to RNs. ED techs cost about 50% of what an RN costs, but it is likely that not every nursing position would be replaced by 2 techs, thereby lowering the ED's overall staffing budget but having a greater number of staff providers at the bedside. The nursing provider's contract with the hospital would have flexible minimum staffing requirements, allowing nursing leadership to creatively modify their staffing grids to produce better outcomes at a lower cost. Presumably, some of the cost savings could be returned to the hospital, and some would become nursing bonuses.

Increased staffing stability

The current "nursing churn" is costly to the hospital, which bears the financial burden of recruiting and orienting new staff. The frequent use of agency and travelers is also both costly and inefficient, as temporary staff often do not perform as well as their permanent colleagues. Nurses who have an equity stake in the staffing company will be motivated to stay put and work hard to improve care and patient satisfaction.

Increasing efficiencies

Multiple new operational efficiencies would evolve with this system. For example, nursing leadership would likely become more active in working with the hospital's IT department to simplify nursing database requirements and find ways to reduce any unnecessary clicks. Currently, there are significant redundancies between the physician and nursing documentation, not to mention the overly detailed nursing database acquisition expectations for

the low acuity, high ESI patients. In this model, nurses will be incentivized to streamline any unnecessary documentation requirement. Nursing leadership is also likely to explore the cost-benefit of ED scribes assisting with RN documentation requirements.

The nursing company would become the employer of all the RN's, ED techs, unit secretaries, nursing scribes, ED supply techs, and basically any position located in the ED which reports to the ED nursing director. Such control would allow considerable job description flexibility for focusing all ancillary positions to help off-load administrative tasks from bedside nurses. Nurses would be attracted to the group and take pride in being led both professionally and fiscally by one of their own. They would be encouraged to suggest innovative enhancements to the care model.

The hospital would be expected to financially compensate the nursing company for excessive boarding. The hospital would then become more aggressive at improving its own "back-end" functions to avoid their direct financial liability to the ED nursing staffing company for excessive boarding.

The hospital could align contractual incentives in both the nursing and physician contracts that would create increased physician-RN teamwork than in the current system. Additionally, we envision a scenario where the physician group would become a minority investor in the nursing company providing even better incentive alignment between the physicians and nurses. It is important though, that this be a minority share as one of the key elements of this plan would be that the nurses control their own finances and the destiny of their endeavor. It would be possible for this company to grow and look to provide nursing services in other venues and other types of nursing specialists other than emergency nurses.

The nurses would now wholeheartedly embrace the "managerial model" and look to delegate as much as possible to APs. As ED techs cost about ½ of what nurses make, more help for the same price should speed up throughput, thus improving patient satisfaction. Now ED nurses will be more empowered and more likely to press the hospital's IT group to work to make the ED information system more user friendly. They will push hard to remove documentation requirements that don't contribute anything to patient care or patient safety or are redundant to what the physicians and APPs are documenting.

Such significant change could be implemented with the assistance of the hospital or by obtaining a grant to allow the nurses to get legal and financial help to create their company's governing documents, create the budget templates necessary to determine how much to charge the hospital, and to determine whether any cost savings can be obtained.

The adoption of this outsourcing approach holds the potential to initiate a paradigm shift within ED nursing. By empowering nurses to take charge of their employment status and by taking only very slight personal financial risk, ED nurses have the potential to increase their earnings, improve their job satisfaction, and improve patient care and satisfaction. It is certainly worth exploring since there is no end in sight for our current staffing and throughput challenges.

The authors have no conflicts to report.

[i] National guidelines for Nursing Delegation. Joint Policy Statement of American Nurses Association/National Council of State Boards of Nursing, April 2019.

[ii] Emergency Department Management: Strauss and Meyer editors. 2014, p. 135