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Amy Townsed, MD -- Scope of Practice Issues Not Being Discussed

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Dear Dr. Townsend

As I have continued to think about the hospital meetings over the "scope of practice" of Registered Nurses, it occurs to me that the following considerations have not been part of the discussion. It has been obvious that the efforts by the hospitals and particularly their consultants, while ostensibly directed toward "quality and safety" for patients, have, except in the most egregious cases, such as the employment of LVNs by physicians for work in the hospital, have had the effect of stifling healthcare innovation and denying ,or rejecting the advancements we have made in the past twenty years.

The following are issues not being discussed:

1. Healthcare is no longer the function of a single healthcare provider, but at its best is the product of an active, integrated and collaborative team. While there are external limitations on team integration, most of which will be eliminated over the next twenty years, we must not allow the clock to be turned back. The reality is that the solo physician, operating in isolation, not as the leader of a team but as the only member of the team, cannot provide the level of services needed for excellence in today's healthcare delivery. The contribution of each team member must be recognized, embraced and valued by the entire system. Not to do so is to emasculate the power of the team which synergistically increases the capacity of each member of the team. Much of what is discussed in "compliance" meetings in hospitals is directed toward denying the value of the team and eliminating the contribution of the team to the exclusive province of the physician.

   A criticism of healthcare in Southeast Texas has been leveled by a consulting firm who opined, "We have never seen a place where more work is done by employees other than physicians." This is considered a negative by the consultants and they have raised the alarm that CMS, HHS, ONC, OMB, OIG, or some other overseer is going to bring the hammer down. Quickly, we would say that there are excesses which have been identified, but the too-broad-a-stroke canvass, as painted place all innovation and experimentation into the same corner. This has created the imagination that the only way to do something is the way it has always been done which has always been the mantra of those who are opposed to change until that change is forced upon them. What the consultant sees as

a deficient in Southeast Texas may be the birth pangs of innovative and creative advancements in care.

2. Pertinent to number one is that in current healthcare rarely is a healthcare encounter an isolated, *de novo* event. The power of electronic patient records and electronic patient management means that in the ideal and most progressive environment, a continuity-of-care record is almost always available. This means that each new patient encounter is built upon past encounters. Ignoring this reality means that hospital administrators are practicing 20th Century medicine, and in some cases 19th Century medicine, where even in the healthcare providers office, there was no dynamic interaction between a previous encounter and the current one. Very few personal healthcare needs, even acute ones, are experienced in isolation from the patients' medical history and the past medical record. When, with EMR, the patient's complete medical record is available at every point of service, it empowers the entire health care team to actively participate in the patient's care. Making decisions as if the current record has to be totally, newly created at each encounter, without reference to the past record, will lead to unusual and regressive decisions by administrators.

3. Resistance to the driving forces of change ignores what is described in ***The Innovator's Prescription: A Disruptive Solution for Health Care*** By Clayton M. Christensen. The impact of this work was in no small measure due to his description of the "levels of medicine," which are:

   - "when precise diagnoses isn't possible…***intuitive medicine***, where highly trained and expensive professionals solve medical problems through intuitive experimentation and pattern recognition." (XXII) (emphasis in original)
   - "As patterns become clearer, care evolves into the realm of evidence-based medicine, or ***empirical medicine*** – where data are amassed to show that certain ways of treating patients are, on average, better than others." (XXII) (emphasis in original)
   - Only when diseases are diagnosed precisely…can therapy that is predictably effective ...be developed and standardized. We term this domain ***precision medicine***."

   Christensen goes on to say, ""Hospitals and physicians' practices have long defended themselves under the banner, 'For the good of the patient.'" He asks the following questions:

   - "…do we really need to leave *all* care in the realm of intuitive medicine?"
   - Much technology has moved past this pint, and health-care business models need to catch up.
   - "….reports from Institute of Medicine – *Crossing the Quality Chasm* and *To Err is Huma*n – shattered the myth that ever-escalating cost was the price Americans must pay o have the high-quality care that only full-service hospitals staffed by the best doctors can provide."

   These ideas have led SETMA to create tools to capture the best of intuitive and empirical medicine and to deploy algorithms and treatment guidelines in an environment of precision medicine. (see the following link for some of these tools: http://www.jameslhollymd.com/epm-tools/) There is no place where this idea has been better deployed than in SETMA's Hospital Order Set Tool (see http://www.jameslhollymd.com/EPM-Tools/pdfs/admission-orders-tutorial.pdf. With this tool, whether the orders are being written by a primary care physicians, a specialist, a sub-specialist, a tertiary specialist, a nurse practitioner, a physician assistance or a registered nurse, the knowledge, skill and expertise brought to bear on the order set is the same. In addition, Clinical Decision Support Tools expand the use of precise medicine in the hospital as well as ambulatory medicine settings. Armed with web portals, health information exchanges and a dynamic team communicating via secure texting, iPhones and other technological advances, it brings precise medicine to the forefront of

medicine. At the same time, the "new" system preserves the best of the "old" systems as physicians are always readily and immediately available for the events where true intuitive medicine is required.

4. **Transitions of Care, Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan, Care Coordination Care Coaching Call Post Discharge** – As we focus totally upon whether RNs are "over stepping their bounds," we ignore critical issues such as whether or not care transition documents (http://www.jameslhollymd.com/epm-tools/hospital-care-summary-and-post- hospital-plan-of-care-and-treatment-plan-tutorial) are being prepared which improve patient safety and quality of care. The only way to effect decreases in readmission rates is with excellent transitions of care (http://www.jameslhollymd.com/epm-tools/Tutorial-Care-Transition)and care coordination (see: http://www.jameslhollymd.com/epm-tools/transition-of-care-management-code-tutorial) SETMA's patients get a medication reconciliation upon admission to the hospital, upon discharge from the hospital, during their care coaching call the day after discharge (see: http://www.jameslhollymd.com/epm- tools/Tutorial-Hospital-Follow-up-Call) and at their follow-up office visit within five days of discharge. SETMA is deploying a Chronic Care Management program as defined by CMS which will further facilitate the quality and safety of the care we give. All of these functions are performed by a team, acting compliantly with all applicable licensure and regulatory requirements but all using innovative and transformation methods and tools.

Seminal Events

SETMA's "peculiar" perspective on these issues is defined by four seminal events which occurred in May of 1999. Before the word "peculiar" is misunderstood, it must be defined. In our use of the term it means "unique, special, one of a kind." The following history and explanation will help.

Without doubt, in 1995, the first step in forming what is now SETMA was the adoption of a team approach to patient care. (see http://www.jameslhollymd.com/About-SETMA/pdfs/the-setma-team-and-the- setma-culture.pdf) That team focus will be the central part of the story when the history of SETMA is written. The second critical decision was the EMR. But, in SETMA's history, May, 1999 will always be central. In the first week of May, 1999, only 100 days after SETMA first used the EMR, these seminal events took place. They defined and directed SETMA's future.

The first event took place the first week of May, 1999, when SETMA's CEO announced that the EHR was too hard and too expensive if all we gained was the ability to document a patient encounter electronically. When we began, it took a provider five minutes to create a chart note. Our CEO concluded EHR was only "worth it," if we leveraged electronics to improve care for each patient; to eliminate errors which were dangerous to the health of our patients; and, if we could develop electronic functionalities for improving the health and the care of our patients and of population groups. This was our transition from EMR to electronic patient management (EPM).

We also recognized that healthcare costs were out of control and that EPM could help decrease that cost while improving care. Therefore, we began designing disease-management and population-health tools, which included "follow-up documents," allowing SETMA providers to summarize patients' healthcare goals with personalized steps of action through which to meet those goals. We transformed our vision from how many x-rays and lab tests were done and how many patients were seen, to measurable standards of excellence of care and to actions for the reducing of the cost of care. We learned that **excellence and expensive are not synonyms**. In ten years, these steps would lead us to begin public

reporting by provider name on over three hundred quality metrics (http://www.jameslhollymd.com/public- reporting/public-reports-by-type).

The second event was that from Peter Senge's *The Fifth Discipline*, we defined the principles which guided our development of an EHR and which defined the steps of SETMA's transformation from an EMR to EPM (http://www.jameslhollymd.com/EPM-Tools/pdfs/designing-an-emr.pdf). These principles would also be the foundation of SETMA's morphing into a patient-centered medical home (PC-MH). The principles were to:

1. Pursue Electronic Patient Management rather than Electronic Patient Records
2. Bring to every patient encounter what is known, not what a particular provider knows
3. Make it easier to do "it" right than not to do it at all
4. Continually challenge providers to improve their performance
5. Infuse new knowledge and decision-making tools throughout an organization instantly
6. Promote continuity of care with patient education, information and plans of care
7. Enlist patients as partners and collaborators in their own health improvement
8. Evaluate the care of patients and populations of patients longitudinally
9. Audit provider performance based on endorsed quality measurement sets
10. Integrate electronic tools in an intuitive fashion giving patients the benefit of expert knowledge about specific conditions

In 2009, we would discover that these principles are essentially the principles of PC-MH and that the past ten years had prepared SETMA to formally become a PC-MH. Between 2009 and 2014, SETMA became accredited as a medical home by NCQA, AAAHC, URAC and The Joint Commission and in doing this, SETMA became the only practice in America to do so.

Cortez - Fahrenheit 451 - Maginot Line

The third seminal event was the preparation of a philosophical base for our future; written in May, 1999 and published in booklet form in October, 1999, this blueprint was entitled, More Than a Transcription Service: Revolutionizing the Practice of Medicine With Electronic Health Records which Evolves into Electronic Patient Management". This booklet was distributed to our practice and our community. It became our declaration that we were going to succeed at this process at any cost and at any effort. Like Cortez, who scuttled his ships on his expedition to Mexico so that there was no turning back, this booklet was SETMA's public declaration that there was no going back. We were going to succeed. Our charge to ourselves was and our counsel to others is, "Don't give up!" The key to success is the willingness to fail successfully. Every story of success is filled with times of failure but every story is also characterized by the relentlessness of starting over again and again and again until you master the task. When we started our IT project, we told people about what we were doing. We called that our "Cortez Project". Like Cortez, we scuttled our ships; there was no going back. We had to succeed.

There were other "named" initiatives in SETMA's history in addition to the ***Cortez declaration***. There was the ***Fahrenheit 451 Initiative*** (the kindling point of paper) where we recognized and declared that paper was too expensive and too hard for record keeping and for transformation of healthcare. While we did not burn books, we set our sights on getting rid of paper in our practice.

There was also the ***Maginot Line Initiative***. Like the fixed fortifications built by the French after World War I, as an obstacle to invasion by Germany and which were fortifications were defeated by

the ability of mechanized war-machines to "go around the line," when confronted by a seemingly insurmountable obstacle to our successful transformation, SETMA went around the obstacles. 1

As we began defining and developing critical supports required for success in Performance Improvement, we found them to be:

1. Care where the same data base is being used at ALL points of care.
2. A robust EHR to accomplish the above.
3. A robust business-intelligence analytics system, which allows for real-time data analysis at the point of care.
4. A laser printer in every examination room so that personalized evaluational, educational and engagement materials could be provided to every patient at every encounter, with the patient's personal health data displayed and analyzed for individual goal setting and decision making.
5. Quality metric tracking, auditing and statistical analysis.
6. Public Reporting of quality metric performance by provider name.
7. Quality Improvement initiatives based on tracking, auditing and analysis of metrics.
8. Shared vision among all providers, support staff and administrators - a personal passion for excellence -- which creates its own internalized, sustainable energy for the work of healthcare transformation.
9. Celebratory culture which does not compete with others but continually improves the organization's own performance, using others as motivation but not as a standard.
10. Monthly peer-review sessions with all providers, to review provider performance and to provide education in the use of electronic tools.
11. Adequate financial support for the infrastructure of transformation.
12. Respect of the personal value of others and the caring for people as individuals.
13. An active Department of Care Coordination and a hospital-care support team which is in the hospital twenty-four hours a day, seven days a week.
14. Aggressive end-of-life counseling with all patients over fifty, and active employment of hospice in the care of patients when appropriate.

The fourth seminal event was that we determined to adopt a celebratory attitude toward our progress in EMR. In May, 1999, my cofounding partner was lamenting that we were not crawling yet with our use of the EMR. I agreed and asked him, "When your son first turned over in bed, did you lament that he could not walk, or did you celebrate this first milestone of muscular coordination of turning over in bed?" He smiled and I said, "We may not be crawling yet, but we have begun. If in a year, we are doing only what we are currently doing, I will join your lamentation, but today I am celebrating that we have begun." SETMA's celebratory spirit has allowed us to focus on the future through many lamentable circumstances and has allowed us to press forward through many disappointments. Focusing on our successes kept us moving forward and the cumulative effect was always success.

If these issues are not part of the current discussion of how hospital care in Southeast Texas is delivered, then we will be like the response I received when I agreed to speak to the Medicaid HIE Advisory Committee next month. One of the leaders responded to the power point for my presentation:

> "Looking at the presentation I am concerned that this system is not truly an EMR by meaningful use standards but possible a custom patient centered medical home solution. That isn't saying it is not a good system but is was an almost 7 figure investment. They indicated that they set out to: 'Pursue Electronic Patient Management rather than Electronic Patient Records. '

> "I think whoever is presenting on the topic of positive EMR adoption needs to be talking about the use of an EMR that is Certified by ONC and that the party speaking has met Meaningful Use Stage 1. Is that what the system they use is and have the meet MU?"

This narrow thinking is what has held healthcare innovation and transformation back for decades. This view was dispelled by the committee learning that SETMA has been paid for Meaningful Use I and that we will report for Meaningful Use II – all of which we comply with – in 2016. We use a certified EMR and we are accredited by all four agencies with standards for Patient-Centered Medical Home.

A different view of our EMR and our use of it was expressed by the Joint Commission after their accreditation site visit and by the Robert Wood Johnson Foundation after a three-day site-visit as SETMA said:

The Joint Commission Accreditation for Ambulatory Care and PC-MH Conclusion about SETMA

Both the surveyors and one of the executives at The Joint Commission commented about the philosophical foundation of SETMA's work. Wednesday afternoon (March 5, 2014) I called my executive contact at The Joint Commission. He said **"I was just talking to one of my colleagues and showing him SETMA's notebook which was prepared in response to The Joint Commission's Standards and Requirements Chapter Seven on leadership." The executive said, "Look at this; everything they do is founded upon a philosophical foundation. They know 'what they are doing,' but more importantly, they know why they are doing it.** (emphasis added)'" SETMA is not the result of random efforts but of innovations and advances which are consistent with a structured set of ideals, principles and goals. (the Joint Commission asked permission to post our Leadership Book on their website as an example to others.)

It is helpful that The Joint Commission recognized this and commented upon it. It is one of the strengths of SETMA and it is one of the principle guides to SETMA's development history, i.e., what caused SETMA to become what it is.

Robert Wood Johnson Foundation LEAP Study conducted by the MacColl Institute

The fifth area of uniqueness of SETMA identified by the RWJF team was a surprise to them; it was SETMA's IT Department. The RWJF team felt that SETMA has approached healthcare transformation differently than anyone they have seen. **They related that uniqueness to the decision we made in 1999 to morph from the pursuit of "electronic patient records" to the pursuit of "electronic patient management." They were surprised to see how centrally and essentially electronics are positioned into SETMA and how all other things are driven by the power of electronics. They marveled at the wedding of the technology of IT with clinical excellence and knowledge. The communication and integration of the healthcare team through the power of IT is novel, they concluded.**(emphasis added)

The danger, if discussions about hospital-based nurses' scope of practice continues as an extension of the 19th or 20th Centuries, as it presently is structured, is that in the short term, narrow compliance standards will be met but in the long term Southeast Texas will continue to fall behind those who are innovating and transforming healthcare.

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