James L. Holly, M.D.

An Open Letter to the Medical Executive Committees of Baptist Southeast Texas Hospital and Christus St. Elizabeth Hospital

October 26, 2015

Dear Colleagues:

From the Conclusion of this Letter Below

On the basis of this discussion, I would implore the MEC of Baptist and Christus to declare that RNs cannot practice medicine in either hospital, but not to define "practicing medicine" in such a narrow and incorrect manner that RNs cannot work in collaboration with and under the direct and immediate supervision of physicians in the hospital such as:

1. Screening calls from nurses for physicians at all times
2. Communicating with the physicians for whom they are credentialed to work and relaying the response to the physician to the hospital nursing staff.
3. Functioning as a scribe to record in an electronic patient record the documented diagnoses, treatment plan, chief complaint, history of present illness, physical examination and consultation reports found in the chart. This function will be exercised in Admission History

and Physician Examinations, once the patient has been seen by the physician, in the Hospital Admission Plan of Care and Treatment Plan, and in the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (previously called "the discharge summary) – please see page six.

While we must all work to make sure that we are in compliance with all legal requirements in our work, we must not let our anxiety about those requirements stymie the creative, transformation efforts being made to improve care in Southeast Texas.

Hospitals Answer A Question Which No One is Asking

The Baptist Hospital Medical Executive Committee in official session on October 22, 2015 voted to declare that Registered Nurses (RNs) cannot practice medicine (verbal report of action). On October 29, 2015, Christus St. Elizabeth will meet to take up the same position. At a currently unscheduled time, the MEC from each hospital will meet in an extraordinary "joint session" to make sure that both hospitals have the same policy.

To my knowledge, no one is arguing that RNs should practice medicine and no one is arguing that they are allowed to practice medicine. What is happening is that out of fear of sanctions by CMS, hospital administrations are promoting draconian measures which will have the effect of stifling innovation and transformation of healthcare. The prevention of physicians to employ RNs in the hospital for legitimate "continuity of care," while avoiding abuses of nurses practicing medicine, out of a fear that someone will violate the rules, does not require the MEC's "legislating" excessively restrictive measures.

At every point that healthcare providers have been asked to change our practice patterns and workflow and when those requests made sense, we have done so. We were asked to not allow RNs to complete history and physicians until after the patient is seen by the physician and we changed, even though it did not improve the quality of care but only fulfilled an imagined standard. When we were asked to not let RNs document the chief complaint, history of present illness, we complied. Now, it is being suggested that our RNs can not even be in the hospital after hours. That doesn't make sense. It certainly is not dictated by CMS or by the Texas Nursing Board.

The following discussion is offered in an attempt to have the MECs of both hospitals not do harm while they are trying to do good.

History of the Controversy About Nurses Working for Physicians in Hospitals

For at least the past three years, there have been efforts by the Centers for Medicare and Medicaid (CMS) and by the administrations of local hospitals across the nation and in Southeast Texas to eliminate practices which do not comply with Federal and State regulations as to whom has the authority to make diagnoses, issues orders and/or to practice medicine.

In audits by CMS in 2012, concern was raised that RNs and in at least one case an Licensed Vocational Nurses (LVN) have been operating outside of their scope of practice in the:

1. Completion of hospital admission history and physical
2. Issuing of treatment orders for hospital inpatients
3. Completion of discharge summaries from the hospital

The ambulatory care setting of healthcare has benefited from LVNs who work in direct supervision of physicians and nurse practitioners, and there are places where they can function in the hospital setting but the above practice is clearly not within their scope of practice.

Other abuses have taken place, even to the extreme of licensed healthcare providers, other than credentialed physicians who have been granted privileges in the hospital, rounding on patients, completing progress notes and writing orders, sometimes even when the supervising physician is out of town. When the physician returned, those progress notes and orders have been signed as if the provider was present when they were issued. And, charges were submitted to CMS and other insurance carriers as if the services were originally provided by the physician. There were instances where this has taken place in the treatment of critical ill patients in the intensive care unit.

These abuses and the scrutiny by CMS have created an alarm among hospital administrations. Hospitals have hired consultants who have reviewed physician performance and the use of ancillary personnel in the hospital and raised an alarm about these practices. Unfortunately, in their enthusiasm for justifying their contracts and fees, these consultants have often gone further than State and Federal law require and have created anxiety and fear among administrations with the suggestion that hospitals will lose their payments and will have fines and penalties levied against them, if they do not severely limit the legitimate work of RNs.

Registered Nurses (RN) working for physicians in the hospital setting

The reality is that most physicians who employed nurses in the hospital did not employ LVNs but RNs with extensive experience in hospital work, and most physicians employed those nurses within their legal scope of practice. In their fear of sanctions by CMS, hospital administrators and their consultants have sought to impose “one-size-fits-all” limitations on the work of RNs not employed by the hospital. Over time, hospitals, led by physicians, who have assumed exclusively administrative positions, and who have ceased to practice medicine, have worked to limit the work of RNs which limitations have gone beyond the legitimate scope of practice.

The Context and Development of RNs working for Physicians in the hospital

In the 1970s, specialists, particularly cardiologists, began employing RNs to improve the transitions of care from the hospital. The RNs completed medication lists, which were handwritten with directions for use and with explanations for why the medications were being prescribed. Gradually, these RNs began completing initial patient evacuations and daily progress notes and discharge planning and instructions.

As is still the case, no charges were submitted to CMS or to other insurance companies for the work of these RNs. They were trained by the specialists and treatment guidelines were established for excellence of care and for patient safety. As long as this process was practiced by specialists no objection was raised.

Gradually, as the demand upon primary care increased and as the complexity of care increased more and more primary care physicians employed RNs in similar capacities. Again, no charges to CMS or other insurance companies were generated for the work of these nurses. The nurses' work accomplished:

1. Improving of care as to continuity, quality and immediacy
2. Improving of the quality of life of the healthcare providers as their sharing of responsibly of care allowed for excellence of care and proper rest for the providers.

The Contradictions between healthcare Reform, Innovation and Regulations

Effective collaboration between members of the healthcare team has been a hallmark of healthcare innovation, particularly in regard to patient-centered medical home. Physicians and nurses have increasingly become colleagues rather then employer/employee.

The current tension between medical practice, hospital administrators, CMS and the Texas Nursing Board is a perfect example of "a business model innovation" which has improved care, working effectively toward the Triple Aim as defined by the Institute for Healthcare Improvement (IHI), which is now being challenged because "regulators have not permitted it."

SETMA's Team Approach – Hospitals Unwittingly Attempting to Turn Back the Clock on Healthcare Transformation

SETMA's team approach to inpatient care is a success as demonstrated by the facts that our lengths of stay, quality metrics, core measures, cost of care, readmission rates, and patient satisfaction are excellent. And, it is one of the reasons why the indigent, uninsured and unassigned patients for whom we care receive the same quality of care as our private patients. I would offer the following observations about SETMA's team. SETMA has licensed and credentialed healthcare professionals who work to the top of, but not beyond their legal scope of practice as defined by each of their accreditation agencies.. As a policy issue, the prestigious and influential *Health Affairs* of January 14, 2013, published an extensive article entitled, *Primary Care Physician Shortages Could Be Eliminated Through Use Of Teams, Non-physicians, And Electronic Communication*. The goal of this transformation is to integrate teams to increase their efficiency, excellence and economy. This is what SETMA started nineteen years ago.

There is resistance to this transformation. In September 2010, the Texas Higher Education Coordinating Board was considering allowing two Texas Health Science Centers' Schools of Nursing to expand their programs to offer the Doctor of Nurse Practitioner degree. It is hard to believe, but one physician testified that nurses should be giving enemas and using bedpans rather than getting doctoral degrees. Hospital administrators and their employed physicians would

argue that they agree with our consternation at this absurd idea, without realizing that their efforts to redefine and limit the legitimate functions of RNs in the hospital is just another way of saying the same thing.

The following are three articles SETMA has published that are relevant to the role of RNs in the innovative transformation of healthcare.

- Article 3 is from 2010 and addresses the need for integrating the education and training of components of the healthcare team.
- Article 2 is from January, 2013 and is an analysis of SETMA inpatient team care. This article is the most directly relevant to scope of practice.
- Article 1 is a look at the future of team collaboration and a response to the criticism of the CMS rules on RN participation on the healthcare team.

1. The Future of Collaboration Between Physicians and Nurses
2. SETMA's Inpatient Team Based Process Analysis: The Interaction of SETMA's Hospital Care Team - Collegiality and "Electronic Huddles"
3. Re-Evaluating the Value of Members of the Healthcare Team

The Ideal Setting in Which to Deliver and Receive Healthcare

The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. In fact, that is the imperative of Medical Home. Without an active team with team consciousness and team collegiality, Medical Home is just a name which is imposed upon the current means of caring for the needs of others. And, as we have seen in the past, the lack of a team approach at every level and in every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

Why is this? Typically, it is because healthcare providers in one discipline are trained in isolation from healthcare providers of a different discipline. Oh, they are in the same buildings and often are seeing the same patients, but they rarely interact. Even their medical record documentation is often done in compartmentalized paper records, which are rarely reviewed by anyone but members of their own discipline. This is where the first benefit of technology can help resolve some of this dysfunction. Electronic health records (EHR), or electronic medical records (EMR) help because everyone uses a common data base which is being built by every other member of the team regardless of discipline. The identify of the person creating the documentation is tracked automatically the electronic patient record. While the use of EMR is not universal in academic medical centers, the growth of its use will enable the design and function of records to be more interactive between the various schools of the academic center.

And, why is that important? Principally, because more and more healthcare professionals are discovering that while their training often isolates them from other healthcare professionals, the science of their disciplines is crying for integration and communication. For instance, there was a time when physicians rarely gave much attention to the dental care of their patients, unless they had the most egregious deterioration of teeth. Today, however, in a growing number of clinical

situations, such as the care of diabetes, physicians are inquiring as to whether the patient is receiving routine dental care as evidence-based medicine is indicating that the control of disease and the well-being of patients with diabetes are improved by routine dental care. Also, as the science of medicine is proving that more and more heart disease may have an infectious component, or even causation, the avoidance of gingivitis and periodontal disease have become of concern to physicians as well as dentist.

It is my hope that the Texas Nursing Board, CMS and hospital administrators do not push back the clock and return us to the healthcare silos where teams did not exist, care was fragmented and patient safety suffered from both

Current RN Scope of Practice - Texas Nursing Board (TNB)

The Texas Nursing Practice Act (TNPA) and the official, board-endorsed *Position Statements* which expand the description of the RN Scope of Practice, leaves many questions not addressed clearly. The position statements on RNs carrying out order from CFNPs and PAs are helpful. It would be very helpful if the Board spoke officially on hospital staff nurses ability to receive orders from a hospital-credentialed RN who is employed by a physician when that order originates with a physician who is on he staff of the hospital.

The following is the Texas NPA's description of the RN's Scope of Practice:

> "The professional registered nurse is an advocate for the patient and the patient's family, and promotes safety by practicing within the NPA and the BON Rules and Regulations. The RN provides nursing services that require substantial specialized judgment and skill. The planning and delivery of professional nursing care is based on knowledge and application of the principles of biological, physical and social science as acquired by a completed course of study in an approved school of professional nursing. Unless licensed as an advanced practice registered nurse, the RN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. RNs utilize the nursing process to establish the plan of care in which nursing services are delivered to patients. The level and impact of the nursing process differs between the RN and LVN as well as between the different levels of RN education (see Table)."

The *Six-Step Decision-Making Model for Determining Nursing Scope of Practice* does not indicate that SETMA's deployment of RNs on our hospital team violates any element of the TNA.

- The verbal transition of an order from a physician via an RN to a hospital-staff RN does not represent an "act of medical diagnosis or a prescription of therapeutic or corrective measure" by an RN.
- Because we are now working in an environment at SETMA where the continuum of care patient record is available at ALL points of care, the RN's placement of the diagnoses and plan of care and orders into a formal electronic document based on documentation by a

SETMA or an ER physician's assessment and instructions, does not represent the "medical diagnosis or prescription of therapeutic or corrective measures."

- And, because the Hospital Care Summary and the Post Hospital Plan of Care and Treatment Plan (previously called the "Discharge Summary") is a product of the hospital record and of verbal and electronic huddles between the RN and the treating physician, this does not represent "medical diagnosis or prescription of therapeutic or correction measures" by the RN.

Letter from General Counsel of the Texas Board of Nursing – May 6, 2013

"The NPA's description of an RN's scope of practice, and the Six-Step Decision-Making Model for Determining Nursing Scope of practice should provide…a good understanding of the Board of Nursing's position on an RN's scope of practice….The NPA and The Board of Nursing Rules and Regulations are written broadly so that every nurse may be able to apply tem to his or her own practice setting. The Board of Nursing does not have a list of tasks that a nurse can or cannot perform, because each nurse has a different practice setting, background, knowledge base, and level of competence. Nurses must use his or her best judgment when deciding how to verify physician orders; whether they should administer a medication or perform other tasks." (Correspondence from James W. Johnson, Texas Board of Nursing, May 6, 2013 in response to April 20, 2013 Correspondence from Southeast Texas Medical Associates, http://www.jameslhollymd.com/Letters/pdfs/Texas-Board-of-Nursing.pdf)

The Texas Board of Nursing and the Texas Nursing Association do not and will not provide an advisory directory as to whether or not a certain practice is within the Scope of Practice of RNs in Texas.

The Future of Healthcare – Issues which must be addressed

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.

Little Healthcare Delivered in Isolation

Pertinent to the above 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.

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 Human - shattered the myth that ever-escalating cost was the price Americans must pay to have the high-quality care that only full-service hospitals staffed by the best doctors can provide."

Tools for Integration and Collaboration

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.

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.

Conclusion

On the basis of this discussion, I would implore, the MEC of Baptist and Christus to declare that RNs cannot practice medicine in either hospital, but not to define "practicing medicine" in such a narrow and incorrect manner that RNs cannot work in collaboration with and under the direct and immediate supervision of physicians in the hospital such as:

1. Screening calls from nurses for physicians at all times
2. Communicating with the physicians for whom they are credentialed to work and relaying the response to the physician to the hospital nursing staff.
3. Functioning as a scribe to record in an electronic patient record the documented diagnoses,

treatment plan, chief complaint, history of present illness, physical examination and consultation reports found in the chart. This function will be exercised in Admission History and Physician Examinations once the patient has been seen by the physician, in the Hospital Admission Plan of Care and Treatment Plan and in the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (previously called "the discharge summary).

While we must all work to make sure that we are in compliance with all legal requirements in our work, we must not let our anxiety about those requirements to stymie the creative, transformation efforts being made to improve care in Southeast Texas.

Sincerely yours,

James (Larry) Holly, M.D.
C.E.O. SETMA
www.jameslhollymd.com

Adjunct Professor
Family & Community Medicine
University of Texas Health Science Center
San Antonio School of Medicine

Clinical Associate Professor
Department of Internal Medicine
School of Medicine
Texas A&M Health Science Center