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Healthcare Provider – Scope of Practice Part III
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The Spring, 2013 conversation about scope of practice continued in the fall of 2015. And, 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 adequate examined. It has been obvious that the efforts by the hospitals and particularly their consultants to change the function of RNs, 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.

Before the comment about LVNs is misunderstood, le me affirm that, LVNs have made a major contribution to SETMA in our clinics. Working with healthcare providers in the ambulatory setting in direct collaboration, LVNs contributions are outstanding. In many other settings, also, the LVN program provides important and valuable healthcare colleagues. In the hospital, working as a semi-independent member of the healthcare team, LVNs' appropriate scope of practice is too narrow to warrant that role.

The following are issues not being adequately discussed in the Scope of Practice discussion about RNs in the hospital who are working with physicians.

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, paint 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.

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.

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 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.

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.