

SECTION 3

Administrative Policies and Guidelines

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Policy Guidance Delegation of Nursing Tasks to Unlicensed Personnel Virginia Department of Health

1. Definitions

"Delegation" means the authorization by a registered nurse to an unlicensed person to perform selected nursing tasks and procedures.

"Supervision" means guidance or direction of a delegated nursing task or procedure by a qualified, registered nurse who receives compensation, who provides periodic observation and evaluation of the performance of the task and who is accessible to the unlicensed person.

"Unlicensed person" means an appropriately trained individual, regardless of title, who receives compensation, who functions in a complementary or assistive role to the registered nurse in providing direct patient care or carrying out common nursing tasks and procedures, and who is responsible and accountable for the performance of such tasks and procedures. With the exception of certified nurse aides, this shall not include anyone licensed or certified by a health regulatory board who is practicing within his recognized scope of practice.

The "entity responsible for client care" is defined as the local health district.

"Professional nursing" means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing; or in the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing requires specialized education, judgment and skill based upon knowledge and application of principles from the biological, physical, social and behavioral sciences.

2. Criteria for Delegation:

There must be a plan for delegation adopted by the district responsible for the client care. This district plan must contain the following:

- ◆ An assessment of the client population to be served;
- ◆ An analysis and identification of nursing care needs and priorities;
- ◆ Organizational standards to provide for sufficient supervision that ensure safe nursing care of the needs of the clients in their specific settings;
- ◆ Communication of the district delegation plan to staff;

- ◆ Identification of the educational and training requirements for unlicensed persons and documentation of their competencies.
3. The following are a list of tasks that may be delegated by a public health nurse to an unlicensed person in the Virginia Department of Health. This list is not inclusive of all tasks that may be delegated, but are examples of such tasks. Each district will have a local list of tasks that a public health nurse may delegate to an unlicensed person.
 4. In all cases, the public health nurse will make the following assessment prior to delegating any nursing task to an unlicensed person:

The delegating nurse shall assess the clinical status and stability of the client's condition, shall determine the type, complexity and frequency of the nursing care needed and shall delegate only those tasks which:

- ◆ Do not require independent nursing judgment;
- ◆ Do not require complex observations or critical decisions with respect to the nursing task;
- ◆ Frequently reoccur in the routine care of the client or group of clients;
- ◆ Do not require repeated performance of nursing assessments;
- ◆ Utilize a standard procedure in which the tasks can be performed according to exact, unchanging directions; and
- ◆ Have predictable results and for which the consequences of performing the task improperly are minimal and not life threatening.

The delegating nurse shall also assess the training, skills and experience of the unlicensed person and shall verify the competency of the unlicensed person in order to determine which tasks are appropriate for the unlicensed person and the method of supervision required.

5. The delegating nurse shall determine the method and frequency of supervision based on factors to include, but not be limited to:
 - ◆ The stability and condition of the client;
 - ◆ The experience and competency of the unlicensed person;
 - ◆ The nature of the tasks being delegated;
 - ◆ The proximity and availability of the registered nurse to the unlicensed person when the nursing tasks will be performed.
6. An unlicensed person may not delegate a task for which he or she is responsible to another unlicensed person. In the event that the delegating nurse is not available, the delegation shall either be terminated or delegation authority shall be transferred by the delegating nurse to another public health nurse who shall supervise all nursing tasks as stated above.

7. The delegating public health nurse must monitor the performance of delegated tasks and ensure appropriate documentation. The delegating public health nurse must evaluate client outcomes and be accessible for consultation and intervention.
8. After ongoing assessment of the client's condition or the unlicensed person's competence, the public health nurse may determine that delegation of the task is no longer appropriate.
9. Nursing tasks that shall not be delegated to an unlicensed person are:
 - ◆ Activities involving nursing assessment, problem identification, and outcome evaluation that require independent nursing judgment;
 - ◆ Counseling or teaching except for activities related to promoting independence in personal care and daily living;
 - ◆ Coordination and management of care involving collaboration, consultation, and referral;
 - ◆ Emergency and non-emergency triage; and
 - ◆ Administration of medications except as specifically permitted by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the *Code of Virginia*). The Virginia Drug Control Act cited is silent on the delegation of the administration of medication by unlicensed persons in the schools. Therefore, it is prohibited.
10. The public health nurse may teach unlicensed persons to administer medications and treatments to students in schools and may from time to time, review the procedures with the unlicensed persons to assess if more training is needed. Refer to the definition of "professional nursing" for clarification, specifically that nurses may "teach those who are or will be involved in nursing care." Teaching and supervising the instruction of an unlicensed person does not mean that the public health nurse is the delegating or the supervising nurse. If the public health nurse does not wish to be the supervising or delegating nurse, he or she should not serve on interview panels or provide input for or prepare the evaluation of the unlicensed person. If the nurse is performing the duties of a supervisor, he or she is the supervisor.
11. If a health director or nurse manager decides to allow public health nurses to delegate nursing tasks to unlicensed persons, the criteria outlined in number 2 of these guidelines must be met. The public health nurse will present a written record of how each of the criteria was met. That record should be retained in a place designated by the district. The delegating nurse must confirm that the unlicensed person has the necessary competencies for the particular task. A document outlining the training and return demonstration of these competencies should be in the public health nurse's and the unlicensed person's district personnel folder.
12. The "delegating" public health nurse retains the responsibility and accountability for the nursing care of the client.

Director's Comments:

Jeff Lake and Karen Connelly met with Robin Kurz, Assistant Attorney General, who confirmed that in those instances in schools when the principal or his designee assigns the performance of treatments to special needs students to one of his or her unlicensed staff, the school retains the responsibility of any adverse outcome, even if the procedure was taught to the unlicensed person by the public health nurse. However, if the district and the school choose to have the public health nurse be the delegating nurse, that liability transfers to the Department of Health.

Documentation that the public health nurse will delegate nursing tasks in the public schools must be retained at the district level.

Jeff Lake has made the decision to leave the question of whether or not to "delegate" at the district level. The Nursing Council concurs with that decision.

Keeping in mind that the decision as to whether to write a formal delegation plan is entirely at the district level, the Director offers the following guidance:

For those tasks that unlicensed persons normally perform in local health departments, such as phlebotomy, taking vital signs, performing simple lab tests, etc. are not necessarily considered nursing tasks only, but are commonly taught in courses for unlicensed persons, that a delegation plan is not required.

However, if a public health nurse, working in a school setting, delegates intermittent catheterization or any other special procedure to an unlicensed person, a full delegation plan should be written. This plan should be reviewed at least annually or more frequently if the delegating nurse chooses to do so.

Approved by Nursing Council 8/15/2002

DOCUMENTATION BY EXCEPTION MANUAL

The Virginia Department of Health has accepted documentation by exception as the preferred method for recording in the clinical record. A multidisciplinary team appointed by the Nursing Council in 1994 used the tools and philosophy of total quality management to design the system. The system is based on standards that define acceptable practice; minimum program requirements; and normal parameters for assessment, examination, intervention, expected patient responses and outcomes. The standards define the baseline of service for every patient served in any health department in Virginia. Forms were designed following these baselines which are used to note assessment, examination, intervention and expected patient responses in the areas indicated by using a check mark. An asterisk instead of a check indicates that the patient response was not normal, or that the provider omitted something that is required by the standard. In most cases, the asterisk indicates the reader should look somewhere else for clarification. No entry indicates "not required by the standard" and does not require further documentation. This system has been approved by VDH's Assistant Attorney General.

References : VDH Internal Web, <http://vdhweb/nursing/except.asp>.

Limits on Confidentiality for Minors Choosing “Do Not Contact” Status

VDH Policy Number 2003-4 June 24, 2003

“Do Not Contact” (DNC) status governs the method by which patients are billed and contacted. This status is used to provide an additional level of confidential services to patients upon their request.

1. Minors who are seen as DNC patients must be informed of the advantages of involving their parents or guardian in the minors’ medical care. (Note: in the rest of this document, “parent” should be read to mean “parent or guardian or other person authorized to consent to treatment of minors pursuant to 54.1-2969.”) VDH employees should also inquire about the reasons DNC status is requested to help the minor determine if those reasons are valid. The advantages of parental involvement include:
 - a. Parents may be the sole source of important medical history.
 - b. Parents may be able to help the minor by asking questions and exploring options, as well as providing better decision making.
 - c. Parents may be able to put the minor’s situation in a broader context, again leading to better decision making.
 - d. If the parents find out from a source, other than the minor, that the minor received confidential services, the minor’s relationship with the parents may be compromised.
2. When parents ask if their minor child is receiving care at the health department or if they want to review or obtain a copy of the minor’s medical record, they should be told

that if VDH can verify that they are the parents (see below), their questions will be answered and they can have access to the record, unless the minor received services under Title X (see exception below). It should be mentioned that the minor may have responsibly sought medical care. Also, obtaining information without the minor's consent might make their relationship more difficult. Parents should also be informed that VDH believes it is appropriate and prudent to notify the minor before releasing information and this will also give the minor the chance inform their parents directly. The encounter should be used to assist both the minor and parent in strengthening the family relationship. Through such a discussion it may be possible to identify and address concerns, possibly eliminating the need to confirm clinic attendance or to release the record.

3. Parent relationships are most easily verified by questioning the minor. If that is not possible, documentary evidence such as a birth certificate, school records, or similar documentation must be provided. The documents need to confirm both the identity of the requester and his or her relationship to the minor patient.

4. If the parent can verify his or her relationship to the patient and requests to view the record, he or she should be informed that they have that right. And, although the minor does not have to give his or her permission for the parent to see the record, VDH employees are expected to verify that agency records release policies are being followed appropriately and to verify that no new information is available that might modify or prohibit release. VDH can take up to 5 days to complete verification, but must balance the need to take that much time against the expressed needs of the parents.

5. Providing medical record information, or confirming or denying a patient's attendance at clinic, cannot be provided over the phone as the caller's identity cannot be established, but parents can be told what documents to bring with them to establish the parental relationship if they want to see the record. It must be made clear that providing such guidance does not confirm that the minor has attended a VDH clinic or that VDH has a medical record for the minor.

6. If the parents are separated or divorced, both parents have access to the minor's records, but only the custodial parent (in addition to the minor) can authorize release of the record to others.

7. It is reasonable to delay release of medical records to the parents to give the minor the chance to let us know if they are at risk because their home environment has become destabilized in terms of violence, abuse, or neglect; or to survey the staff for such information. However, any such delay must take place within the 5-day verification period discussed in paragraph 4. In cases where VDH staff become aware of such information on any minor DNC patient, the chart should be flagged when the information is obtained. Do not rely on a last minute poll of staff to identify patients at risk as a result of a medical record release. When the release of flagged records, or records otherwise identified as belonging to a patient at risk, is requested, the district director must be contacted immediately. In such cases, the district must consult with the Deputy

Commissioner for CHS or Public Health Programs. When evidence of violence, abuse, or neglect is discovered, a Child Protective Services referral is indicated.

8. Minors who are deemed adults for consenting to medical or health services under §54.1-2969 (E) of the Code of Virginia must be advised that the law does not reduce their parents' rights to access the minors' medical records, except in the case of family planning services provided under Title X. The law states that:

E. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;
3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in §37.1-203;
4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance; or
5. The release of medical records related to subdivisions 1 and 2.

This law does not convey any confidentiality rights and E.5 does not remove the parental right of access, it simply allows the minor to authorize release to those other than the parents. Also, §32.1-36.1 does not restrict parent's rights to HIV results.

9. VDH extends confidentiality for the purposes of completing the lawful medical and health care services under §54.1-2969 (E) by granting DNC status. This confidentiality is limited and conditional. When the services exceed the reasonable expected limits of the purposes listed above, the ability of the minor to continue to consent is questionable and confidentiality may not be safely maintained. Examples could include a pap smear needing follow-up and the patient refusing to keep her appointments, pap smear testing leading to a cervical biopsy, positive HIV test results, and hypertension or other chronic diseases diagnosed for the first time. The DNC patient must be notified that, under conditions such as these, parental involvement may be required. Every reasonable effort must be made to inform the minor before disclosing anything to the parents in order to give the minor the chance to let his or her parents know or to give the minor the chance to let us know if his or her home environment has become destabilized in terms of violence, abuse, or neglect.

10. This policy does not apply to substance abuse records. Minors have a federal right of privacy granted in 45 C.F.R. 2.14. If a minor had only received substance abuse treatment (an extremely unlikely event for the health department), VDH cannot confirm the minor has received services or that VDH has a medical record for the minor.

11. **EXCEPTION:** All patients, including minors, receiving any services funded by Title X are entitled to confidentiality and the parents of minors cannot access their minor

children's records unless the minor agrees. This confidentiality also includes not confirming clinic attendance. When minors receive services funded by Title X and services funded from other sources (i.e. family planning visits and separate STD visits), the medical record should be organized such that services received under Title X could be excluded from release to the parents.

Workplace Safety

National Institute for Occupational Safety and Health (NIOSH) was established by the Occupational Safety and Health Act of 1970, which also established the Occupational Safety and Health Administration (OSHA). Although NIOSH and OSHA were created by the same act of Congress, they are two distinct agencies with separate responsibilities. NIOSH is in the U.S. Department of Health and Human Services and is a research agency. OSHA is in the U.S. Department of Labor and is responsible for creating and enforcing workplace safety and health regulations. NIOSH and OSHA often work together toward the common goal of protecting worker safety and health.

References :

National Institute for Occupational Safety and Health, Retrieved December 20, 2002 from <http://www.cdc.gov/niosh/healthpg.html>

U.S. Department of Labor, Retrieved December 20, 2002 from <http://www.osha.gov/>

CASE MANAGEMENT

Case management may be defined and practiced in a variety of ways and settings. The American Nurses Association defines case management as a system of health care delivery designed to facilitate achievements of expected patient outcomes within an appropriate length of time, with goals of quality care, decreased fragmentation, enhanced quality of life, the efficient use of resources, and cost containment. (Ling 2002. p. 1) The Case Management Society of America defines case management as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. (Ling 2002. p. 1) Case management is the provision of services in a coordinated culturally sensitive approach through client assessment, referral, monitoring, facilitation, and follow up on utilization of needed services, according to the Healthy Start Division of Perinatal Systems and Women's Health. (October 2002) The Center for Medicare and Medicaid Services (2002, p. 1) defines case management as a process used by a doctor, nurse, or other health professional to manage health care, and the case manager makes sure that individuals get the needed services, and tracks utilization of facilities and resources.

In 1992 the Virginia Department of Health (VDH) published a Case Management Manual and included elements from the definitions above in its definitions. The VDH Case Management Manual (1992, p. 6) notes that case management is a practice performed by professionals with varying backgrounds to facilitate the delivery of coordinated, comprehensive, efficient, and appropriated service to individuals and families. Three modes are mentioned in the manual for the case management process/system. Programs offering case management will select the model appropriated for their clients/target population and health care network, and community resources/services. (Balingit 2001)

A case management model and process determines caseload size, assessment, services, and referrals. (VDH 1992, p. 14) An assessment of the client's needs determine their risk level, appropriate services and referrals. (VDH 1992, p. 21) The VDH Case Management Manual (1992, p. 17-18) describes "Tiers" used to identify risk level, duration, and intensity of services. Use the risk screening tool, standards of care, and documentation identified in the Documentation by Exception Records System Manual. The service plans in the VDH Case Management Manual is the protocol to guide Case Managers and Care Coordinators actions, interventions, follow up, and evaluation of the individual and/or family participating in health department services. Health Care Professionals are to follow up on the risk screening, complete a comprehensive assessment, and make appropriated referrals. (ANA 1994, p. 5) Case management based on local health districts' discretion.

References :

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Balingit, R. (2001). The American Institute of Outcome Case Management. Case Management Challenges in Population-Based Care. Retrieved November 22, 2002, from <http://www.aiocm.c.../Case%20Management%20Challenges%20in%20Pobulation%20Bas ed%20Care.htm>

Centers for Medicare & Medicaid Services. (2002). Glossary. Retrieved November 27, 2002, from <http://cms.hhs.gov/glossary/default.asp?Letter=C&Language=English>

Flarey, D. L., & Blancett, S.S. (1966). Handbook of Nursing Case Management. Gaithersburn, Md.: Aspen Publishing Co.

U.S. Department of Health & Human Services (HRSA). (2002). Interconceptional Care For High Risk Women and Infants. 2002 Healthy Start Grantee Meeting, Baltimore, Maryland 6-9 October 2002. HRSA Maternal and Child Health Bureau: Healthy Start Division of Perinatal Systems and Women's Health. Learned Information.

JAMA. (1999). The Value of Targeted Case Management During Transitional Care. Retrieved November 22, 2002, from <http://jama.ama-assn.org/issues/v281n7/ffull/jed90002.html>

Ling, C. (2002). Case Management Basics. Retrieved November 22, 2002, from <http://nurse.cyberchalk.com/nurse.course/nurseweek/nw2210/course.htm>

Virginia Department of Health (VDH). (1992). Case Management Manual. Richmond, Virginia: VDH.

Requirements for Fee Adjustments

** You must pay for services at the time of the visit and **MUST** bring **Proof of Income** (see the list below, **one or more can apply to you**). If you do not bring proof, you can pay **Full Fee** OR be rescheduled. All Proof of Income will be verified. Fees for some services may be adjusted according to income by providing one of the following:

1. WORK? Paycheck stubs from the past three pay periods.
2. NO PAY STUBS? A letter on company letterhead, signed by the supervisor, and phone number given, that states date of employment, the gross and net pay for the past 3 paydays and how many hours worked; OR the most recent **filed** federal income tax return; OR all W-2 withholding forms (from each job held) from the previous year.
3. MARRIED? Income verification for your husband and yourself if you work.
4. YOU and/or YOUR HUSBAND NOT WORKING? Termination letter that states the last day of work and a letter from the person who is supporting you.
5. NOT MARRIED, and not working - Signed letter from the person who is supporting you that includes phone number, relationship to you and how long they plan to support you.
6. GETTING UNEMPLOYMENT? Bring a letter from the Virginia Employment Commission and forms approving/denying unemployment or workers' compensation.
7. GETTING CHILD SUPPORT? Bring the court order showing how much you get in child support.
8. HAVE INSURANCE? BRING THE CARD. If card says "PCP" or "HMO", it should tell you where to go for care. If you come here you will have to pay the FULL FEE. Other types of insurance? Bring the card and proof of income. You are responsible for the co-pay and the cost of the visit.
9. A written statement from Social Services.
10. Provide documentation of SSI or Disability.
11. Medicaid cardholders are eligible for medical services. Medicaid care must be presented at each visit.
12. For information call the health department in your community.

References : 12 VAC 30-20-10 et seq. Administration of Medical Assistance Services

Department of Medical Assistance Services (DMAS)

DMAS oversees Medicaid and Family Access to Medical Insurance Security (FAMIS). FAMIS provides health benefits for children who are uninsured, but who are not eligible for Medicaid. Medicaid is an assistance program that helps pay for medical care. To be eligible for Medicaid you must have limited income and resources, and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children and people with disabilities. Any newborn whose mother is a Medicaid enrollee in the Contractor's plan on his or her date of birth shall be deemed an enrollee of that plan for three months. The newborn's continued enrollment with the Contractor is not contingent upon the mother's enrollment. For more information, contact Virginia Department of Medical Assistance Services at 804-786-4231, website www.dmas.state.va.us.

The Virginia Medicaid Handbook provides information on eligibility, services, how to apply for assistance, and co-payments. Some Medicaid recipients must pay a small amount for services; this is called a co-payment. Medicaid is not an insurance plan, but an entitlement program funded by the state and federal governments. The handbook is a useful tool that contains most of what you would like to know about the program. Medicaid rules change and there are many circumstances that affect eligibility. Apply for Medicaid at a local Department of Social Services office. Local Department of Social Services offices take applications and make eligibility decisions. DMAS pays the physicians, hospitals, pharmacies or other medical services providers for care and services received by Medicaid-eligible individuals. DMAS administers three managed care programs, specific to geographic location. They are MEDALLION, Options and MEDALLION II. Virginia has two children's health insurance programs that provide health insurance to children under age 19 years; they are Medicaid and FAMIS. FAMIS provides health benefits for children who are uninsured, but who are not eligible for Medicaid.

Virginia's Administrative Code 12VAC30-50-310 describes emergency services for aliens. "No payment shall be made for medical assistance furnished to qualified aliens who entered the United States on or after August 22, 1996, who are eligible for Medicaid for five years after their entry, and nonqualified aliens, including illegal aliens and legal nonimmigrants who are otherwise eligible, unless such services are necessary for the treatment of an emergency medical condition of the alien."

CLIA

The Clinical Laboratory Improvement Act (CLIA) was established as a guideline for laboratories to follow. The Centers for Medicare and Medicaid Services regulate all laboratory testing (except research) performed on humans in the U.S. through CLIA. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

INSTITUTIONAL REVIEW BOARD (IRB)

One of the many ways the Virginia Department of Health (VDH) serves the public and fulfills its mission is through research. Research is defined in federal regulations as a systematic investigation designed to develop or contribute to generalizable knowledge. Periodically VDH conducts research that involves human subjects. VDH considers the protection of human subjects as important as the methodology, research findings, or any other component of the research project.

VDH has developed policies and procedures to ensure that the rights and welfare of human subjects involved in research are protected and consistent with both state (12 VAC 5-20-10) and federal (45 CFR Part 46) regulations. The Office for Human Research Protections (OHRP), under the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Health, is responsible for ensuring the safety and welfare of people who participate in HHS-sponsored research. Policies, guidelines and regulations from OHRP, including the ethical principles found in the Belmont Report, provided the framework for the development of the state regulations, and provide the structure for VDH review and approval of human subjects research.

A major component of the process for ensuring the protection of the rights and welfare of human subjects involved in VDH research is the Institutional Review Board (IRB), also known as the research review committee. Research protocols must be either approved or granted an exemption by the IRB before human subjects can begin participation. The IRB also conducts continuing review of each approved protocol at least annually. The IRB may modify, suspend or terminate approval of research that has been associated with serious harm to subjects or is not being conducted in accord with the IRB's decisions, stipulations, and requirements.

In general, any research that is conducted by VDH, by outside investigators in collaboration with VDH, or by outside investigators using VDH data, is subject to review and approval by the VDH Institutional Review Board (IRB). For specific information, consult the VDH IRB Guidelines and Procedures for Obtaining Review, which can be found in its entirety on the VDH internal web at <http://vdhweb/irb/irb.htm>. If you have any questions or need assistance, contact:

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