COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: The Honorable Benjamin J. Lambert, III
Chairman
Joint Subcommittee Studying Lead-Poisoning Prevention

FROM: Jane H. Woods
Secretary of Health and Human Resources

DATE: October 26, 2004

RE: **Response of the Task Force on Delegation of EPSDT (SJR 43)**

As requested by Senate Joint Resolution 43, we are submitting the final report of the task force on delegation to registered nurses of screening and testing in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Pursuant to the resolution, a task force was established to examine the issues and assist the Joint Subcommittee Studying Lead-Poisoning Prevention in its work. The task force consisted of representatives from several agencies within this Secretariat, as well as the Department of Education, pediatricians who care for Medicaid patients, advocacy groups and professional associations. The task force was organized by and the final report prepared by the Department of Health Professions.

In its final report, the task force concluded that certain screening and testing components of EPSDT, including blood-level testing, can be safely delegated to registered nurses, but the comprehensive physical examinations are not within their scope of practice and should not be delegated. Such examinations should only be performed by licensed health care practitioners who have specialized training in the physical assessment and diagnosis of the pediatric population. Delegation of the physical examination portions of EPSDT to a registered nurse would not result in cost savings to Medicaid but could result in the long-term costs of failure to provide early detection and intervention.

We appreciate the opportunity to participate in the work of the Joint Subcommittee on Lead Poisoning Prevention and trust that the information presented in the attached report will be helpful in its deliberations.

Secretary of Health and Human Resources
Department of Health Professions

Study of Delegation of EPSDT Screening to Nurses Pursuant to SJR 43 (2004)

Background and Authority

Senate Joint Resolution 43, patroned by Senator Benjamin J. Lambert, III and passed by the 2004 Session of the General Assembly, authorized continuation of the Joint Subcommittee Studying Lead-Poisoning Prevention. To assist the joint subcommittee in its work, the Secretary of Health and Human Resources was requested to establish a task force to examine issues, relating to the delegation to registered nurses of screening and testing pursuant to the Medicaid program known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). In conducting its study, the Secretary's task force must (i) review the EPSDT protocols; (ii) identify the screening and testing tasks that could presently be delegated to registered nurses; (iii) identify any screening and testing tasks that would require additional training to be delegated to registered nurses; (iv) evaluate any quality of care issues relating to delegation to a registered nurse by a physician or nurse practitioner; (v) evaluate any costs/reimbursement issues relating to delegation to a registered nurse by a physician or nurse practitioner; (vi) evaluate supervision issues relating to delegation to a registered nurse by a physician or nurse practitioner; (vii) consider the advantages or benefits and disadvantages or disincentives to physicians and nurse practitioners of authorization to delegate EPSDT screening and testing to registered nurses; and (viii) consider whether any cost savings can be realized for delegation to a registered nurse of EPSDT screening and testing.

As stated in the resolution, the Joint Subcommittee on Abatement of Lead-Based Paint was established in 1993 by Senate Joint Resolution No. 245 to ensure that the Commonwealth would be eligible to obtain federal housing grant funding in 1994. Study of lead-based paint abatement was continued from 1993 to 1998, with primary focus on the continued monitoring and support for the federal grant. In1999, the joint subcommittee evolved to focus on the broader issue of lead-poisoning prevention, which encompasses many issues, such as lead-based paint abatement.

In the 2003 General Assembly, Delegate Crittenden introduced HB2477 as a recommendation from the Joint Subcommittee. As introduced, the bill would have provided an exemption in the Medical Practice Act (§ 54.1-2901) to allow physicians to delegate to a registered nurse the physical examination of children, provided the examination was conducted in accordance with a written protocol and the registered nurse had completed a training program that complied with guidelines of the Board of Nursing. The legislation was opposed by a number of organizations and agencies on the basis of concerns about lowering the standard of care for children. Registered nurses are not trained to perform *medical* examinations, and this measure would have resulted in an assessment and diagnosis of a child without being seen by a physician. In response to the concerns expressed, an amendment in the nature of a substitute was introduced and ultimately passed that provides the following exemption in the Medical Practice Act: "*Any*

physician of medicine or osteopathy or nurse practitioner from delegating to a registered nurse under his supervision the screening and testing of children for elevated blood-lead levels when such testing is conducted (i) in accordance with a written protocol between the physician or nurse practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be conducted at the direction of a physician or nurse practitioner." Therefore, the law currently permits screening and testing of children for elevated blood-lead levels by registered nurses.

Senate Joint Resolution No. 356 (2003) continued the study of lead-poisoning prevention to (i) cooperate with the executive agencies in the implementation of an expanded data-sharing initiative; (ii) seek ways to assist state agencies in the delivery of lead-poisoning prevention services in as cost-effective or cost-neutral way as may be possible; (iii) support and contribute, in any way feasible and appropriate, to the Department of Health's efforts to maintain federal support for the Lead-Safe Virginia program; (iv) support the implementation of the Department of Housing and Community Development's federal grant in any way necessary and appropriate for a legislative group; and (v) continue to strive for ways to educate and encourage parents, particularly those individuals living in housing with lead risks, in the prevention of lead poisoning of their children.

Among the recommendations made by the Joint Subcommittee was the establishment of two task forces to assist in its work - one to examine issues relating to delegation of screening and testing of Medicaid children to registered nurses, and the second to work on collaboration on blood-lead testing issues between the Division of Consolidated Laboratory Services within the Secretariat of Administration and the Secretary of Health and Human Resources.

The Secretary of Health and Human Resources is required to present the findings and recommendations of the task force on delegation no later than November 30, 2004, and a summary of the presentation will be included in the final report of the subcommittee.

Study Task Force of the Virginia Board of Health Professions:

In response to the request for establishment of a task force to study issues relating to delegation of screening and testing to nurses, Secretary Jane Woods appointed a task force with representatives from the professions of medicine and nursing, including pediatricians, school nurses, pediatric nurses and nurse practitioners. Advocacy groups represented include Voices for Virginia's Children, CHIP of Virginia, the Virginia Nurses Association, the Medical Society of Virginia, the Virginia Council of Nurse Practitioners, the Virginia Association of Health Plans, and the Virginia Academy of Family Physicians. State agencies represented on the task force include the Department of Health Professions (DHP), the Department of Medical Assistance (DMAS) Services, the Department of Health (VDH), the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and the Department of Education (DOE).

Staffing for the Task Force was provided by Elaine J. Yeatts, Senior Policy Analyst and Susan Rosen, Deputy Executive Director of the Board of Nursing within the Department of Health Professions.

Specific Assignment for the Task Force by SJR 43

(i) Review the EPSDT protocols;

The Task Force on Delegation of Early Prevention Screening Diagnosis and Treatment accomplished its review by a presentation to the group on EPSDT presented by Chris Owens of the Department of Medical Assistance Services on August 10, 2004. The Task Force was also provided with copies of the providers' manual on EPSDT with instructions on screening, testing, informing and referring and copies of the forms and schedules used for EPSDT. In the discussion of the program, the Task Force reviewed the purpose, guidelines, eligibility, and periodicity schedule for preventive screening and testing.

EPSDT requires:

1. A comprehensive health and developmental history, including assessment of both physical and mental health development;
2. A comprehensive unclothed physical examination;
3. Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
4. Laboratory tests, (including blood level assessment; appropriate for age and risk factors), and
5. Health education, including anticipatory guidance.
6. Provision or coordination of medically necessary treatment. Treatment is any medically necessary treatment service required to correct or ameliorate defects and physical and mental illnesses and conditions discovered during a screening examination. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS as medically necessary.

EPSDT is available to children eligible for Medicaid and is provided by private practitioners (physicians and mid-level providers such as family or pediatric nurse practitioners), Federally Qualified Health Centers, Rural Health Clinics, local health departments, school based clinics, and other DMAS-approved clinics.

Currently, most pediatric patients on Medicaid receive EPSDT through Medicaid managed care organizations. Therefore, only 17 of the 35 health districts now provide EPSDT, and most provide only a few preschool physicals for indigent children. While local health departments typically do not follow children from infancy as in the past, blood lead levels are routinely provided for patients who meet the one of the criteria for lead screening.

(ii) Identify the screening and testing tasks that could presently be delegated to registered nurses;

Most screening and testing required by the EPSDT assessment can presently be delegated to appropriately trained registered nurses, except the comprehensive unclothed physical

examination that must be performed by a physician or nurse practitioner. The screening and testing tasks that can presently be delegated to registered nurses are those that do not involve independent judgment or diagnosis to include:

- Obtaining a comprehensive health/developmental/behavorial history including documentation of growth measurements
- Providing health education/anticipatory guidance
- Screening or administration of immunizations
- Age-appropriate screening and testing including those for sickle cell, anemia, lead toxicity, hemoglobin, urinalysis, and tuberculosis exposure
- Objective vision and hearing screening

In practice, the delegation of screening and testing by registered nurses varies from setting to setting, depending of the organization of services being provided and the availability of licensed personnel to perform those services. At the Pediatric Ambulatory Care at Virginia Commonwealth University, registered nurses coordinate the lead-screening efforts, perform some of the anticipatory guidance and teaching, and discuss immunizations and obtain signatures for consent during well-child physicals. In most settings, the nurse may draw blood for screening lead levels but the actual testing must be performed at a CLIA compliant laboratory, so testing is performed off-site. In many clinics, both public and private, the availability of registered nurses is limited or non-existent, so delegation of additional tasks would be both impractical and non-productive.

While the objective visual and hearing screening may be performed by a nurse, the comprehensive visual and hearing examination and the dental screen should done by an appropriately licensed physician or other health care practitioner. In addition, the Virginia Department of Health (VDH) has taken the position that nurses may not do Pap Smears in their clinics, as it is believed that visualization of the cervix is critical in diagnosing certain disease conditions.

(iii) Identify any screening and testing tasks that would require additional training to be delegated to registered nurses;

Tasks that are outside the scope of practice of a registered nurse include the performance of a physical examination, diagnosis and treatment. Registered nurses are educated in a variety of programs, ranging from a diploma or an associate program to a four-year baccalaureate degree. Baccalaureate programs usually have an undergraduate physical assessment course that focuses on nursing assessment and does not include forming medical diagnoses, which is not within the scope of practice of a RN. At a minimum, the RN would need to take a graduate level health assessment course which includes physical diagnosis in order to conduct the physical examination that is central to EPSDT. Even with an additional course, the registered nurse would lack some of the comprehensive knowledge and training of a physician or nurse practitioner to detect and diagnosis childhood conditions and illnesses. Diagnosis and treatment are clearly the practice of medicine and not within the scope of practice or training of a registered nurse. Therefore, in the opinion of the Task Force on EPSDT, delegation to a nurse of the unclothed physical with any subsequent diagnosis and treatment is inappropriate – even with

additional training, unless that training is that of a nurse practitioner with a family or pediatric specialty.

While certain screening and testing tasks have been identified as delegable to nurses, there are some, such as developmental/behavioral assessment, that are more difficult and do require additional training. Since the educational preparation of registered nurses varies from a diploma or associate program to a bachelor's degree, nurses may require additional training to ensure that they have the necessary skills to screen for substance abuse, mental health concerns, developmental delay, family violence and environmental risks. If a facility uses the Denver II for initial developmental screening, training in its administration should be provided by a child development specialist. However, the facility may allow a nurse to substitute the questionnaire developed by a School Nurse Consultant at VDH, to assess if the child is developmentally appropriate for his age group. *Bright Futures*, published by the Health Resources and Services Administration of the federal Department of Health and Human Services, can be used a reference to assist the nurse in differentiating between what might be delayed development in contrast to a child who may be slow in one area of motor, speech or other intellectual components. *Bright Futures,* which serves as a guide for practitioners in anticipatory guidance for parents, indicates when appropriate referrals to specialist should be made.

Individual nurses may also need to acquire additional knowledge and skills through academic courses or in-service training to perform such tasks as the administration of immunizations or to screen for neonatal, sickle cell, lead toxicity, or anemia. In addition, it is recommended that staff involved in EPSDT screening and testing activities receive routine training in how to collect samples, administer tests, communicate with patients, identify health concerns and provide patient education. The Virginia Department of Health (VDH) is collaborating with the Department of Medical Assistance Services (DMAS) and the Virginia Chapter of the American Academy of Pediatrics to develop a web-based training curriculum to promote the use of *Bright Futures Guidelines* for pediatric care. VDH has contracted with Virginia Commonwealth University and the Medical College of Virginia to develop the training with the curriculum divided into five modules that may be completed at the convenience of the participant. The curriculum will be linked to other web-based training programs, including a Lead Screening module currently under development by VDH. Training participants will receive continuing education credit upon completion of the course.

(iv) **Evaluate any quality of care issues relating to delegation to a registered nurse by a physician or nurse practitioner;**

There should be no quality of care issues related to the delegated of screening and testing tasks if the registered nurse is appropriately trained and supervised. Delegation of the health/development/behavorial history and the provision of health education/anticipatory guidance to a specifically-trained registered nurse may favorably impact the quality of care, because these tasks are consistent with the patient care orientation of a nurse. Nurses may also be able to take the time to complete a thorough screening or assessment.

Quality of care is more likely assured if the screening components of EPSDT are provided by a nurse, but the physician or nurse practitioner performs the physical examination. In that situation, mistakes in communication or conditions that have been overlooked by the nurse should be caught in the course of the examination. Thus, there is an appropriate check and

balance in the continuum of care. If the routine physical examination in EPSDT was delegated, there would be a lack of continuity with the primary care provider (physician or nurse practitioner), who would not have familiarity with the child in order to detect subtly changes in their status or properly care for them when they are sick.

It is unlikely that a registered nurse could obtain the competency in a complete physical exam, including such things as heart murmurs, abdominal and pelvic masses, unusual diseases or conditions, and all the other conditions of pediatric practice through a short training session, when nurse practitioners and physicians spend years learning these examination techniques. There would be little value added if a registered nurse with minimal competency replaced a physician or nurse practitioner in conducting the physical examination, if some percentage of misdiagnosis or failure of diagnosis of pediatric conditions could be expected.

Regardless of insurance status, children in Virginia are entitled to quality of care. Were the statutes to be changed to allow examination, diagnosis and treatment by a registered nurse of children who are eligible for EPSDT, those children would receive care from a provider with less knowledge and training than that of a physician or nurse practitioner; and it is certainly possible that the quality would be secondary.

(v) Evaluate any costs/reimbursement issues relating to delegation to a registered nurse by a physician or nurse practitioner;

Medicaid does not reimburse registered nurses, so costs/reimbursement would be cost-neutral. While delegation of screening and testing of most EPSDT tasks to registered nurses is current practice in most health care facilities and offices, billing for their services must be through the supervising physician or nurse practitioner at the rate of that practitioner. Under Medicaid, a nurse practitioner with a specialty in family practice or pediatrics is allowed to bill at the same rate as a physician. Therefore, there are no costs/reimbursement issues relating to delegation to a registered nurse.

In a managed care system, the screening for exposure or risk of exposure to lead is part of the physical assessment, and payment coverage would therefore be available as paid through billing and would be included in any payment provided to a provider, on a preventive and diagnostic basis. Specific blood testing for lead exposure is a covered benefit, where determined to be necessary by the attending physician. Payment coverage is available when provided through contracted network providers, when so ordered by the attending provider or when accessing a member's available Out of Network Benefits when ordered by the attending provider.

(vi) Evaluate supervision issues relating to delegation to a registered nurse by a physician or nurse practitioner;

In the current EPSDT programs, where registered nurses are available to conduct health and developmental screenings, offer health education and anticipatory guidance, and review records to coordinate immunizations, they work closely with physicians or nurse practitioners in sharing information and following up on necessary referrals. Registered nurses do not function as independent practitioners but work jointly with licensed physicians or nurse practitioners as a part of the medical team – with the physician ultimately responsible for the patient. In each setting where initial screening and testing is delegated to a registered nurse, there should be a

process for follow-up and evaluation of any abnormalities or questionable findings discovered by the nurse.

Even nurse practitioners, who have completed a graduate education, and medical residents, who have graduated from medical school, must be supervised by a physician. Nurse practitioners may examine and diagnosis, but they work under a written protocol with a supervising physician and must have patient charts periodically reviewed. Medical residents must have an attending physician re-examine a patient for supervisory and billing purposes. It is certainly necessary for RN's, with less training and education, to be supervised in order to assure that they perform EPSDT activities or tasks competently and within the scope of their practice.

Because nurses are not directly reimbursed by DMAS and because nurses must be supervised by physicians, cost savings being realized by allowing the provision of these services by nurses is highly unlikely. Nurses do not have prescriptive, diagnostic or treatment authority; the level of physician supervision and involvement would not be reduced.

(vii) Consider the advantages or benefits and disadvantages or disincentives to physicians and nurse practitioners of authorization to delegate EPSDT screening and testing to registered nurses;

There are advantages to delegating many of these services to the registered nurse, and many have already been delegated to them for continuity sake, such as lead screening, tracking, follow-up, referral to Lead Safe Richmond, etc. Results and responses are communicated to the covering physicians and documented in the patient charts.

Disadvantages, though, are that there typically are not enough RN's in clinics operated by the health departments or medical centers to take on additional responsibilities. Currently, it is difficult to get the tasks completed that are the responsibility of the RN in a timely manner, and patients are already waiting for long periods of time during their well-check appointments. The wait time would increase significantly if the RN had to take on these other lengthy exams/assessments/screens, as well as triage, immunizations, and treatments required by the sick patients, such as admissions to the hospital or Emergency Department. In most private practices where children are seen under managed care, RN's are typically not available at all.

(viii) Consider whether any cost savings can be realized for delegation to a registered nurse of EPSDT screening and testing.

Since delegation of screening and testing of most EPSDT tasks to registered nurses is current practice in most health care facilities and offices, there are no costs savings to be realized.

If delegation to an RN were to be extended to include the physical examination and the comprehensive vision and hearing examination and if it became possible to reimburse the RN directly for services, there may be cost savings for delegation. In the short term, the reimbursement for a registered nurse physical may be lower than an examination provided by a physician or nurse practitioner. However, there would likely be long term costs of missed opportunities to prevent significant, expensive conditions that may be overlooked by the registered nurse, but would have been detected by a physician or a nurse practitioner. In

addition, any savings realized would likely be offset by increased costs for training and salaries for nurses.

Delegation of EPSDT in other states

A survey was sent from the Virginia Department of Education to the State School Nurse Consultant Group inquiring about delegation of EPSDT to registered nurses. Of the states that responded, Kentucky, Georgia, Texas, Kansas and Florida reported that school nurses and other nurses who are RN's with special training or credentialing are permitted to do the EPSDT examinations. Florida commented that "because so many of the children are in HMO's that there is little call for EPSDT screening for health departments."

The Texas Health Steps Pediatric Assessment Training Program is a special training that qualifies registered nurses and licensed physician assistants to perform THSteps medical checkups, which is the Texas version of the Medicaid EPSDT program in Virginia.. The training program is administered by the Texas Nurses Association.

The training consists of participants attending a three day (24 hours) course which covers the didactic portions, including all components of a pediatric physical assessment, nutritional assessment and anticipatory guidance. The participants are provided with a comprehensive manual covering history taking and physical assessment and a separate manual covering Developmental Assessment and Anticipatory Guidance. This is followed by a 24-hour preceptorship with a physician actively involved in providing pediatric health care, or a pediatric or family nurse practitioner. The training participant must complete health screenings on six different age groups plus an additional five health screenings on any age child during this preceptorship. The preceptorship must be completed within three months of completing the didactic portion. The preceptor must attest that he/she has personally observed the training participant has completed these eleven screenings exams.

While there are different models for EPSDT-style programs, the task force believes that the physical examination required by EPSDT is a comprehensive, in-depth examination and must be performed by an examiner with sufficient competency to critically discern normal from abnormal. Twenty-four hours of training and experience doing comprehensive physicals on eleven children is inadequate to prepare a RN to recognize the myriad of abnormal physical findings potentially present in the high risk population on which the EPSDT focuses.

Recommendation of the Task Force

After reviewing the screening and testing services provided under EPSDT, the task force concluded that most are within the scope of practice of and are currently being performed by registered nurses. If registered nurses are available in schools, public health clinics or private practice settings, they are well suited to give information about the program and, in many cases, to actually provide the services. Nurses are trained to provide nursing care within parameters consistent with their education, skill-level and current competence, so nurses who perform screening and testing under EPSDT would have pediatric experience and qualifications.

While certain screening and testing components of EPSDT, including blood-level testing, can be safely delegated to registered nurses, the comprehensive physical examinations are not within

their scope of practice and should not be delegated. Such examinations should only be performed by licensed health care practitioners (doctors of medicine or osteopathy, nurse practitioners, or physician assistants), who have specialized training in the physical assessment and diagnosis of the pediatric population. Delegation of the physical examination portions of EPSDT to a registered nurse would not result in cost savings to Medicaid but could result in the long-term costs of failure to provide early detection and intervention.

While there may be a need for additional education of parents and better communication with providers, the delegation of EPSDT physical examinations to registered nurses is not recommended and would not result in cost savings or a better quality of care for children served by Medicaid.