Materials for the Unlicensed Assistive Personnel (UAP) Task Force Forum

June, 1998
~~Decision~~
draft

The Continuum of Care: A Regulatory Perspective
DRAFT - June 1998

I Introduction

The intent of this paper is to clarify the legal authority and accountability for care provision by licensed nurses and assistive personnel along a continuum based on the client's physical and cognitive abilities. (See Continuum of Care: A Regulatory Perspective Table, page 4). This information should provide state boards of nursing and other regulatory agencies with a framework for policy-making decisions related to the provision of care which is inclusive of, but not limited to, nursing delegation. Based on Dorothea Orem's *Self-Care Deficit Theory of Nursing* (Eben, J., Gashi, N., Hayes, S., Marriner-Tomey, A., Nation, M. & Nordmeyer, S., 1994), this document describes the roles of clients, licensed nurses, and assistive personnel along the continuum of care from when the client is fully competent and independent in self-care to when the client is fully dependent on others for care.

II. Background

Advances in research and technology have contributed to a rapidly growing older population whose needs for health-related care are greater than any other segment of our population. These advances have also improved the capability of individuals of all ages with health impairments and disabilities to function more independently. With the information explosion of the past quarter-century, consumers are not only more knowledgeable about health care but also much more involved in both choosing and directing the care they wish to receive (Gragnola, C. & Stone, E., 1997). Many consumers directly access the services of licensed nurses for health-related education, support and consultation. Assistive personnel are often independently hired by consumers to assist them in a wide range of activities from daily living, to childbirth, to health maintenance or wellness promotion. When clients are significantly health impaired and unable or incompetent to make care decisions, the nurse is often the care manager and assistive personnel carry out direct nursing care activities through the delegation process.

Since the decade of the 1980s, the increased utilization of assistive personnel within health care delivery systems has been the focus of much attention among state boards of nursing as well as other regulatory bodies, professional organizations and consumer advocacy groups. Cost containment measures, along with federal legislation requiring training of nurse aides in nursing homes and certified home health agencies, have also raised awareness on a variety of assistive personnel issues. These issues include not only the training of assistive personnel, but also the parameters of their role in providing patient care, and the appropriate staffing mix in a variety of health and non-health care settings. Who provides the training, defines the training requirements, and credentials assistive personnel who have met the necessary requirements are questions for state regulatory bodies to answer.

Boards of nursing have been challenged to clarify the relationship between the licensed nurse and assistive personnel in relation to the client's status. Issues that boards are being asked to address include:

(1) authority - i.e., the source of the power to act (Webster, 1981);
(2) delegation - i.e., transferring to a competent individual authority to perform a selected nursing task in a selected situation (Hansten & Washburn, 1994); and
(3) accountability - i.e., being responsible or answerable for actions or inactions of self and others (NCSBN, 1995).

Common questions related to authority and accountability in client situations include:

1. Who is directing care? - the client or the nurse?
2. Who is a client surrogate?
3. What is the nurse's agreement with the client? i.e., to provide education and support? provide consultation? provide care coordination or direct all care? (Accountability will be based on the agreement between client and nurse within permissible limits of the Nurse Practice Act).
4. What is the line of authority with assistive personnel? i.e., who is directing care and to whom is the assistive person answerable and accountable?

5. What are the legal limitations related to the client-care situation? These include limitations set by occupational licensing laws, and other applicable state and federal statutes (agency licensure, civil and criminal).
6. With whom is the client contracting for care? What are the terms of that contract?
7. When does the Board of Nursing have jurisdiction over unsafe practices?

III - The Continuum Of Care: Client Health Status and Roles of Nurse and Assistive Personnel

The lines of authority and accountability between the nurse and assistive personnel are based in part on the extent to which a client functions independently and is competent to direct his/her own care. It is also based on the client's contract for care. Inherent in the understanding of the continuum of care are specific principles which help define the interface between the client, nurse and assistive personnel. These principles also may be utilized for policy development.

Principles which apply across the continuum are:

1. The client's health status influences who initiates, who provides and who is accountable for the provision of care.
2. Care decisions may be made by the client or client surrogate. (A surrogate is an individual appointed to act on the client's behalf).
3. Care may be provided by licensed nurses and/or assistive personnel.
4. In non-health care systems, the care is directed by the client or client surrogate.
5. Assistive personnel may function across the continuum of care.
6. The licensed nurse is not accountable for care decisions when a client contracts independently with assistive personnel.
7. The licensed nurse determines and is accountable for the appropriateness of delegated *nursing* activities (NCSBN, 1995).
8. The licensed nurse is ultimately responsible and accountable for the management and provision of *nursing* care (NCSBN, 1995).
9. Values and experiences of clients and licensed nurses influence decision making.
10. Boards of Nursing have accountability and authority for the regulation of *nursing* practice.

There are three major points along the continuum to consider in terms of the interface between the client, the nurse and assistive personnel. These points are identified by the client's health status as independent, partially dependent and fully dependent.

Independent Status - A client with or without a health impairment who has the ability for self care.
The client at this level may initiate, accept and direct health-related interventions. Such interventions may be provided by licensed nurses or assistive personnel to the extent that the actions of assistive personnel do not constitute the practice of nursing. For the client without an identified health impairment, interventions may include general education and support to promote wellness, health maintenance and disease prevention. For the client with an identified health impairment, the nurse may also provide consultation, initiated by the client or nurse, to support and maintain the client's independent status.

Partially Dependent Status - A client with self care deficits who needs assistance in activities of daily living (ADLs) and/or health maintenance activities.
The nurse's primary responsibilities for partially dependent clients may be described as care coordination. Such responsibilities may include consultation, needs assessment, providing education, support and other direct care activities, on-going evaluation of the care provided by self and others, as well as teaching and validating the competencies of assistive personnel who perform care activities. Whether the client or the nurse directs the care will depend upon the degree of self-care deficit and the level of monitoring and interventions required by health professionals. Assistive personnel may be directed by the client or authorized to perform care through the nursing delegation process.

Fully Dependent Status – A client whose responsibility for care has been transferred to licensed health professionals within a healthcare system.
This client may or may not be competent or capable of participating in self-care. The nurse is accountable for the overall management of nursing care. When assistive personnel are utilized, they are authorized to perform care through the delegation process (refer to Delegation Resources available through the National Council for further description of the components of the delegation decision-making process).

Summary

The Continuum of Care: A Regulatory Perspective outlines the roles of the licensed nurse and assistive personnel in relation to client health status and ability to direct own care. Because Boards of Nursing and other state regulatory agencies are mandated to protect the public, it is critical that these agencies clearly define the lines of authority and accountability among licensed nurses, assistive personnel and clients to whom care is provided.

References

Eben, J., Gashti, N., Hayes, S., Marriner-Tomey, A., Nation, M. & Nordmeyer, S. *Self-care deficit theory of nursing.* In A. Marriner-Tomey, (1994). *Nursing theorists and their work (3rd ed.).* St. Louis, MO: Mosby-Year Book, Inc.

Grignola, C. & Stone, E. *Considering the future of health care workforce regulation.* SanFrancisco: UCSF.

Hansten, R. & Washburn, M. (1994). *Clinical delegation skills: A handbook for nurses.* Gaithersburg, MD. Aspen Publications.

National Council of State Boards of Nursing. (1995). *Delegation concepts and decision-making process.* Chicago: NCSBN.

Webster's New Collegiate Dictionary. (1981). Springfield, MA: G&C Merriam Company.

The Continuum of Care: A Regulatory Perspective

*Roles of the Licensed Nurse** and Assistive Personnel (AP) in Relation to the Client*

	Independent		*Partially Dependent*		*Fully Dependent*
Client Health Status (Includes physical and cognitive abilities)	No identified health impairment or self-care deficit	With identified health impairment or self-care deficit	Assistance needed in ADLs and/or health maintenance activities, client has self-care deficit *Client maintains most self-care responsibilities*	Client has sufficient degree of self-care deficit to require frequent monitoring and direct interventions by health care professionals *Client maintains some self-care responsibilities*	Responsibility for care transferred to licensed health care professional within health care delivery system
Primary Roles for the Licensed Nurse**	General Education and Support to promote wellness, health maintenance and disease prevention as requested by client **Client initiates*	Care Consultation related to health impairment, includes education and support to maintain client independence *Client or nurse initiates*	Care Coordination Nursing activities include: • consultation • needs assessment • teaching care provider to perform care activities • providing education, support and other direct care • monitoring client status • ongoing review of care provision *Client or nurse initiates/directs*	Care Coordination Nursing activities include all previous activities plus: • directing nursing care, including assignment and delegation of activities *Nurse directs*	Total Care Management Includes direct care, assignment and delegation responsibilities within health care system; care provided by both licensed nurses and AP (delegated activities) *Nurse directs*
Assistive Personnel (AP) Role	May participate in client directed or requested activities *AP accountable to client*		May be directed by client or authorized to perform care through nursing delegation process *AP accountable to client or nurse*	Authorized to perform care through nursing delegation process *AP accountable to nurse*	Authorized to perform care through nursing delegation process *AP accountable to nurse*
Types of Settings for Care (Examples)	Independent Living, Home, Ambulatory Care, Employment/Social/Public Meeting Places		Home, Residential Care Facilities, Assisted Living, Day Care, Mental Retardation/Developmental Disabled Homes, Sheltered Workshops, Schools, Ambulatory Care		Hospitals, Nursing Homes, Other Long Term Care Settings

* Client or client surrogate

** States have varying degrees of authority for LPN's

Revised June 1998

GEORGETOWN UNIVERSITY

Judith Feder
Dean of Public Policy
Georgetown Public Policy Institute

January 7, 2002

Lex Frieden
Senior Vice President
The Institute for Rehabilitation and Research
1333 Moursund
Houston, TX 77030

Dear Lex:

Thank you for your participation on the Advisory Committee for the Georgetown University Long-Term Care Project. We have received twenty long-term care financing proposals and look forward to discussing them with you at the upcoming meeting. Attached you will find the agenda for the meeting, a summary of the proposals received, and a copy of the letter sent out to solicit proposals.

As a reminder, the next Advisory Committee meeting will be held on Friday, January 11, 2002. The meeting will be held at the Monarch Hotel, 2401 M Street, NW in Washington DC. The meeting will begin at 9:00 am and end by 3:00 pm. A continental breakfast will be available at 8:30 am and lunch will be provided. If you have any questions regarding the location of the meeting or if your travel plans have changed, please call Theresa Jordan at 202-687-0880.

The primary goal of the meeting is to get your advice on the long-term care financing options to be analyzed. Prior to discussing the proposed options, Lisa Alecxih, from The Lewin Group, will help us examine the financing of long-term care under current arrangements. She will also discuss with us key assumptions that will be used in the analysis of the proposed financing options.

If you have any questions or concerns about the enclosed documents or upcoming meeting, please contact Robert Friedland at 202-687-0881 or via e-mail at rbf4@georgetown.edu.

We are looking forward to this meeting as well as continuing to work with you over the course of the project.

Sincerely yours,

Judith Feder
Dean of Public Policy
Georgetown Public Policy Institute

Sheila Burke
Adjunct Professor
Georgetown Public Policy Institute
Undersecretary for American Museums
Smithsonian Institution

Mailing Address:
Georgetown Public Policy Institute
3600 N Street NW Suite 200 Washington DC 20007-2670
202-687-9186 FAX: 202-687-5544

Advisory Committee Meeting
Long-Term Care Project

Monarch Hotel
2401 M Street, NW
Washington DC

(202) 429-2400

January 11, 2002

8:30 am	Continental breakfast available
9:00 am	**Call to order: Goals of the day and update on the project** Susan Dentzer, Advisory Committee Chair; The NewsHour Sheila Burke; Smithsonian Institution Judy Feder; Georgetown University
9:30 am	**Financing long-term care in the future under current law arrangements** Lisa Alecxih; The Lewin Group
10:00 am	**An alternative future of financing long-term care: Choosing a set of policy options** Judy Feder; Georgetown University
Noon	Working Lunch
1:30 pm	**Key Assumptions of the Long-Term Care Financing Model** Lisa Alecxih; The Lewin Group
2:30 pm	**Next Steps and Closing** Susan Dentzer, Advisory Committee Chair; The NewsHour

NOTE

The attached summary includes 2 additional proposals received after the summary was e-mailed to you on Friday January 4, 2002.

One of the two new proposals has been added to the "combined private and public approaches" category and the other has been added to the "expand public coverage" category.

Georgetown University
Long-Term Care Project

Long-Term Care Financing Options
January 7, 2002

In response to our request for proposals for financing options, we received 20 proposals. We have reviewed those proposals and identified nine across a range of approaches that we feel are the most worthy of analysis. We have also identified five proposals that are very interesting and that either could be added to, or substituted for, the nine others. In addition there were six proposals we feel should not be considered. The reasons are mixed. Some were just not as well developed or offered fewer lessons. Others, however, were difficult or impossible to model in the Lewin Long-Term Care Financing Model.

To indicate our ranking:

- ● **Preferred proposal**
- ○ Alternative proposal
- ▪ Not preferred

To help us focus on the range of proposals we have organized the 20 proposals received into three categories:

I. Expand private insurance for long-term care (8 proposals)

II. Combine private and public approaches (7 proposals)

III. Expand public coverage of long-term care (5 proposals)

This document also includes a list of who submitted proposals and a table summarizing the 20 proposals.

I. Expand private insurance for long-term care

Eight proposals focused on expanding private insurance coverage for long-term care. Each is quite different. Several proposals develop new products either through new ways of bundling LTCI with other insurance policies or tying LTCI to other forms of wealth accumulation. Others would increase incentives to purchase LTCI using various approaches.

- **Redesign life annuities (such as retirement plans) so that they pay higher amounts if a person is disabled. Adding a disability increment to annuities may improve the efficiency of the annuity market and give people alternatives for converting their savings into retirement income and long-term care protection. (Mark Warshawsky).**
- Develop a wider array of products by bundling LTCI with other types of insurance (such as disability insurance, life insurance, or annuities). Also consider bundling LTCI with a group of "preferred" providers. (Don Charsky and Kathy O'Connell).
- Encourage the purchase of LTCI through a product tied to contributions made to a deferred savings plan (e.g., 401(K) plan). Dollars put into the savings plan would accumulate at a guaranteed rate (below market rate) but would enable the participant the option of purchasing a LTCI policy at a later date at a reduced premium (partially financed by the accumulation of the earnings on reserves above the minimum guarantee). (G. Lawrence Atkins).
- Create a new LTCI product that is financed using home-equity. That is, bundle LTCI with a reverse mortgage. (Mark Merlis).
- *Encourage the use of modestly priced Continuing Care Retirement Communities to provide and finance long-term care. (John Nyman).*
- *Encourage people to purchase LTCI by making access to Medicaid more difficult. However, help those with modest assets by providing a line of credit (privately administered, backed by government re-insurance) against all of their assets for long-term care needs. These efforts are intended to institutionalize the principle that long-term care is a personal responsibility for which everyone should plan early and save, invest, or insure. (Stephen Moses).*
- *Market Medicare-approved LTCI policies through Medicare (analogous to the role the Office of Personal Management makes in offering heath insurance choices to federal workers and retirees) starting at age 50. (John Cutler, Lisa Shulman, and Mark Litow).*
- *Promote coordination between private health plans with community based long-term care. (Walter Leutz).*

II. Combine private and public approaches

Seven proposals offer a combination of private and public mechanisms. Given the interesting variation in these approaches, we consider most of them worthy of analysis.

- **Subsidize the purchase of LTCI using vouchers. Those electing to accept the vouchers would forego the opportunity to apply for assistance from Medicaid. The vouchers would be based on the expected or average value of Medicaid spending for long-term care and thus the subsidy would not cost any more than otherwise would have been spent by Medicaid. (Mark Pauly).**
- **Encourage the purchase of LTCI that provides partial asset protection when applying for assistance through Medicaid (i.e., an expansion of the RWJF Partnership Program to all states) and encourage saving for long-term care through tax-advantaged long-term care accounts. (Michael O' Grady and Gail Wilensky).**
- **Give Medicare beneficiaries the option of trading the current Medicare Part B home health benefit for a combination of private pre-approved LTCI and a Medicare long-term care catastrophic benefit. Premium for private insurance would be subsidized for beneficiaries with low-income or disabilities. (Jeanne Lambrew and Anne Tumlinson).**
- **Provide catastrophic social insurance for long-term care services up to an amount based on level of disability after a substantial waiting period (e.g., two or three years). Encourage purchase of private LTCI to cover the waiting period. Also, enhance and standardize Medicaid benefits nationwide. (Christine Bishop).**
- **Mandate savings (via a payroll tax) during working years for either LTCI or long-term care services. At age 65, a person would have the choice of using the accumulated savings to purchase a LTCI policy or the savings could be retained to be used for long-term care expenses. Low-income workers might have their savings subsidized with federal and state funds. (James Knickman).**
- **Mandate long-term care coverage either through insurance or a competing new Medicaid program. Fundamentally restructure Medicaid eligibility for long-term care (eliminate the means testing) and the rules governing private insurance but require everyone, age 55 and older, to purchase either access to Medicaid or private insurance. In effect, Medicaid and private policies would compete with one another. Premiums would be collected through the tax system, but allowed to accumulate and move from insurer to insurer. (Len Burman and Richard Johnson).**
- *Use Social Security Benefits to finance long-term care. Although not fully developed, the idea is to allow for a trade-off of less Social Security benefits in exchange for financing either public coverage or the purchase of long-term care insurance or both. Proposal would also encourage purchase of private LTCI by promoting new products linking LTCI with life insurance or annuities. (Yung-Ping Chen).*

III. Expand public coverage of long-term care

Five proposals focus on expanding public coverage for long-term care. Two call for expansions through Medicaid and two calls for complete federal financing of needed long-term care, and the fourth calls for directing new public resources to caregivers.

- **Enable Medicare beneficiaries with assets below $75,000 and incomes at or below 200% of poverty (as well as "medically needy") to be covered by Medicaid for long-term care (home and community based care and nursing home care). This part of Medicaid would be required for all states and completely federally funded. For individuals with income or assets above these thresholds, states would have the option of covering them with an enhanced federal match (FMAP + 15%). In addition, states could charge premiums for those with incomes above 250% of poverty. (Barbara Cooper).**
- **Universal federally financed state-administered long-term care financing program. People using institutional care would pay for food and lodging portion of costs. Financed by taxes and copayments based on sliding scale that would depend on income and assets. (Rachel Boaz).**
- *Combine Medicare funding and the Medicaid component of long-term care into one funding stream to cover both the acute care and long-term care needs of the Medicare long-term care population. Perhaps allow those not on Medicare and Medicaid eligible the opportunity to buy-in to the new system. (Richard Besdine and Vincent Mor).*
- *Enable Medicare beneficiaries with incomes up to 300% of poverty access to Medicaid home and community based care. This would be required and federally financed at existing federal matching rates. Medicare beneficiaries with higher incomes could gain access to home and community based care through buy-ins. (Marty Lynch, Carol Estes, and Mauro Hernandez).*
- *Provide vouchers for home and community based supportive services (including home health, home aide, and adult day services) to family caregivers. Eligibility based on care recipient having substantial level of disability and caregiver income below certain thresholds. Vouchers financed by combined state and federal funds. (Shelley White-Means).*

Proposal Participants

G. Lawrence Atkins
Health Policy Analysis

Richard Besdine
Brown University

Christine E. Bishop
Brandeis University

Rachel F. Boaz
The City University of New York

Len Burman
The Urban Institute

Don Charsky
LifePlans, Inc.

Yung-Ping Chen
University of Massachusetts, Boston

John Cutler
US Office of Personnel Management

Carroll Estes
Institute for Health and Aging/UCSF

Mauro Hernandez
LifeLong Medical Center

Richard Johnson
The Urban Institute

James R. Knickman
The Robert Wood Johnson Foundation

Jeanne Lambrew
George Washington University

Walter Leutz
Brandeis University

Mark Litow
Milliman USA

Marty Lynch
LifeLong Medicare Center

Vincent Mor
Brown University

John A. Nyman
University of Minnesota

Kathy O'Connell
Corporate Marketing, LifePlans, Inc.

Michael J. O'Grady
Center for Health Affairs

Mark Pauly
University of Pennsylvania

Lisa Shulman
University of Maryland

Anne Tumlinson
Health Strategies Consultancy, LLC

Gail R. Wilensky
Center for Health Affairs

Mark J. Warshawsky
NBER/Columbia University

Proposed Long-Term Care Financing Options

Preferred proposals	Alternative proposals	Not preferred
	Expand Private Insurance	
Design life annuities to include a disability payment.	Bundle LTCI with other insurance	Market Medicare approved LTCI policies
	Create new deferred savings plan tied to LTCI	Tighten access to Medicaid to encourage LTCI purchase
	New LTCI product financed through a home-equity reverse mortgage	Encourage LTCI tied to CCRCs
		Promote LTC coordination
	Combine Private and Public Approaches	
Provide a voucher for LTCI in lieu of Medicaid.		Cut Social Security to finance LTC and promote public and private coverage
Encourage LTCI through tie to Medicaid and tax advantaged LTC savings accounts		
Encourage LTCI tied to a Medicare option foregoing Part B home health care		
Public catastrophic LTC coverage and encourage private insurance for waiting period		
Mandate saving for either LTCI or LTC. Public subsidy of savings for low-income workers		
Mandate long-term care coverage with competing public and private options		
	Expand Public Coverage	
Expand Medicaid eligibility for LTC coverage	Expand Medicaid eligibility for home and community based LTC	Provide vouchers for caregivers
Universal publicly financed LTC coverage	Integrate Medicaid and Medicare coverage for LTC	

October 10, 2001

Dear Colleague:

We are directing a project to promote the discussion of policy initiatives to improve financing for long-term care (a description of the project is attached). As part of the project, which is sponsored by the Robert Wood Johnson Foundation, we will be commissioning authors to develop specific policy options that would establish savings or risk-spreading strategies for financing long-term care. We are writing to explore your interest in developing such a policy option for this project.

At this stage, we are soliciting brief 1-2 page descriptions of policy options. We anticipate selecting about 10 proposed policy options that we will commission authors to fully develop—that is, to prepare a paper (about 15-25 pages, double-spaced) laying out the strategy in detail and discussing its objectives, strengths, and limitations. It will then be our task to estimate and compare the effects of proposals with respect to a number of consequences, including the number of people with insurance coverage, public and private costs, out-of-pocket expenses, and the distribution of those expenses across people in different income and age groups. This will be done, in large part, using a micro-simulation model developed by the Lewin Group explicitly to evaluate long-term care financing options. A synthesis of the analysis will be prepared to compare the policy options. The goal of this effort is not to choose or recommend a specific policy option—rather, it is to encourage creative development of policy options, explore a range of approaches, and analyze their differing strengths and limitations.

Our interest in options is based on the premise that achieving effective protection against long-term care costs arising from home and community based services as well as institutional care will require public policy intervention. Historically, discussion of that intervention has focused on the public or private nature of the risk-spreading mechanism—for example, how much to build on a private insurance, a social insurance, or a public assistance approach. This is, of course, an important choice. But placing any approach—or a combination of approaches—on the nation's policy agenda requires specification of the form it could take and of practical strategies for putting it into effect.

Our hope is to generate a range of fairly detailed policy options that vary on at least two fundamental dimensions:

- **What people get:** A policy to provide financial protection to people who need long-term care services must specify the form in which the "insurance" or "covered benefit" is provided—for example, payment for a defined set of services; a voucher toward the purchase of services (or insurance premium); or cash to use as recipients see fit. It must also specify the types of services and level of expenditures to which the insurance or benefit applies—for example, the scope of coverage of supportive services and alternative living arrangements. Attention is needed to the way these mechanisms might operate and the policy measures necessary to implement them effectively.

- **How resources are acquired and risks spread**: A policy to provide financial protection must also specify its financing mechanism. Broadly speaking, that means specifying the premiums, taxes, or savings instruments the policy would encourage or require and the public or private mechanisms through which benefits would be paid. Authors must consider whether and how to distribute financing responsibilities across generations, and how to address the financing of current and future long-term care needs.

Proposals to address these design challenges need not purport to be perfect. On the contrary, we are interested in having authors assess both their strategies' strengths and limitations. Specifically, we are interested in understanding the scope of an author's intended impact (ranging from incremental to comprehensive), which population(s) would be assisted (and which left out) and why, and expectations for the role of existing long-term care programs (most importantly, Medicaid). Although we are interested in strategies that would apply to people with long-term care needs, regardless of age, we recognize that different strategies may be appropriate for different segments of the population. We are therefore open to proposals that focus solely on the population above or below specific ages.

If you are interested in responding to this request, we would appreciate a 1-2 page outline of the strategy you propose by November 16, 2001. The final set of policy options to commission will be chosen, in consultation with our advisory committee, to reflect a broad array of options.

We will pay $7,500 for each commissioned policy option. We expect to commission specific policy options in February 2002. First drafts of the options will be expected in May 2002. We will work with you through July 2002 to ensure that the draft is sufficient to undertake an evaluation of the proposal. Detailed analysis of the options, using the Lewin Group's simulation model, will begin in July and should be completed by January 2003. Following that, authors will have until June 2003 to revise their final papers if they wish. Authors may, but do not have to, incorporate the simulation results in their final papers. Authors' final write-ups of their policy options will be distributed through our project. Authors will receive full credit for their designs in our work. It is our hope that authors will participate in a conference at which alternative proposals will be discussed in Washington, D.C., in approximately November 2003.

We hope this sounds interesting to you and that you would like to submit a brief description of a policy option. Please feel free to share this letter with your colleagues. If you have any questions or would like to discuss the possibility of submitting a proposal, please contact Judy Feder at 202-687-0880.

Sincerely,

Judith Feder
Dean of Public Policy
Georgetown Public Policy Institute

Sheila Burke
Adjunct Professor
Georgetown Public Policy Institute,
Undersecretary for American Museums
Smithsonian Institution

Enclosure

From Sally Johnson 8/22/00

NORTH CAROLINA BOARD OF NURSING
BOX 2129, RALEIGH, NORTH CAROLINA 27602

To: John Dalrymple

AUG 2[illegible]

Here are the final materials related to the Continuum of Care - which I downloaded from the National Council's website. See the webpage reference on the Diagram page. You may want to share the website address with your colleagues at the National level.

Hope this is what you want. It was good to see you @ the LTC Roundtable - Keep up all your good work.

final Published Version

RECEIVED
JUN 26 2001

Document Originally Attached to Following Page

6-30-01

Richard,

Thanks for being so helpful.

Next a similar paragraph for Lexington. Let me know if he does not get it.

John Dalrymple

NATIONAL COUNCIL

National Council
of State Boards of Nursing, Inc.

676 North St. Clair Street
Suite 550
Chicago, Illinois 60611-2921

312 787.6555
FAX 312 787.6898

The Continuum of Care: A Regulatory Perspective
A Resource Paper for Regulatory Agencies
October 1998

Authors: *National Council's Unlicensed Assistive Personnel (UAP) Task Force*

I. Introduction

The intent of this paper is to clarify the legal authority and accountability for care provision by licensed nurses and assistive personnel along a continuum based on the client's physical and cognitive abilities. (See The Continuum of Care Framework in the "Delegation and UAP Issues" section of the National Council's Web site at _____). This information should provide state boards of nursing and other regulatory agencies with a framework for policy-making decisions related to the provision of care which is inclusive of, but not limited to, nursing delegation. Based on Dorothea Orem's *Self-Care Deficit Theory of Nursing* (Eben, J., Gashti, N., Hayes, S., Marriner-Tomey, A., Nation, M. & Nordmeyer, S., 1994), this document describes the roles of clients, licensed nurses (registered nurses and licensed practical/vocational nurses), and assistive personnel along the continuum of care from when the client is fully competent and independent in self-care to when the client is fully dependent on others for care.

II. Background

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Since the decade of the 1980s, the increased utilization of assistive personnel within health care delivery systems has been the focus of much attention among state boards of nursing as well as other regulatory bodies, professional organizations and consumer advocacy groups. Cost containment measures, along with federal legislation requiring training of nurse aides in nursing homes and certified home health agencies, have also raised awareness on a variety of assistive personnel issues. These issues include not only the training of assistive personnel, but also the parameters of their role in providing patient care and the appropriate staffing mix in a variety of health and non-health care settings. Who provides the training, defines the training requirements and credentials assistive personnel who have met the necessary requirements are questions for state regulatory bodies to answer.

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(1) authority - i.e., the source of the power to act (Webster, 1981);
(2) delegation - i.e., transferring to a competent individual authority to perform a selected nursing task in a selected situation (Hansten & Washburn, 1994); term is defined differently among states; and
(3) accountability - i.e., being responsible or answerable for actions or inactions of self and others (NCSBN, 1995).

Common questions related to authority and accountability in client situations include:

1. Who is directing care? - the client or the nurse?
2. Who is a client surrogate?
3. What is the nurse's agreement with the client? e.g., to provide education and support? provide consultation? provide care coordination or direct all care? (Accountability will be based on the agreement between client and nurse within permissible limits of the Nursing Practice Act).
4. What is the line of authority with assistive personnel? i.e., who is directing care and to whom is the assistive person answerable and accountable?
5. What are the legal limitations related to the client-care situation? These include limitations set by occupational licensing laws and other applicable state and federal statutes (agency licensure, civil and criminal).
6. With whom is the client contracting for care? What are the terms of that contract?
7. When does the board of nursing have jurisdiction over unsafe practices?

III. The Continuum of Care: Client Health Status and Roles of Nurse and Assistive Personnel

The lines of authority and accountability between the nurse and assistive personnel are based in part on the extent to which a client functions independently and is competent to direct his/her own care. It is also based on the client's contract for care. Inherent in the understanding of the continuum of care are specific principles which help define the interface between the client, nurse and assistive personnel. These principles also may be utilized for policy development.

Principles which apply across the continuum are:

1. The client's health status influences who initiates, who provides and who is accountable for the provision of care.
2. Care decisions may be made by the client or client surrogate. (A surrogate is an individual appointed to act on the client's behalf.)
3. Care may be provided by licensed nurses and/or assistive personnel.
4. In non-health care systems, the care is directed by the client or client surrogate.
5. Assistive personnel may function across the continuum of care.
6. The licensed nurse is not accountable for care decisions when a client contracts independently with assistive personnel.
7. The licensed nurse determines and is accountable for the appropriateness of delegated *nursing* activities (NCSBN, 1995).
8. The licensed nurse is ultimately responsible and accountable for the management and provision of nursing care (NCSBN, 1995).
9. Values and experiences of clients and licensed nurses influence decision-making.
10. Boards of nursing have accountability and authority for the regulation of *nursing* practice.

There are three major points along the continuum of care to consider in terms of the interface between the client, the nurse and assistive personnel. These points are identified by the client's health status as independent, partially dependent and fully dependent.

Independent Status - A client with or without a health impairment who has the ability for self care. The client at this level may initiate, accept and direct health-related interventions. Such interventions may be provided by licensed nurses or assistive personnel to the extent that the actions of assistive personnel do not constitute the practice of nursing. For the client without an identified health impairment, interventions may include general education and support to promote wellness, health maintenance and disease prevention. For the client with an identified health impairment, the nurse may also provide consultation, initiated by the client or nurse, to support and maintain the client's independent status.

Partially Dependent Status - A client with self-care deficits who needs assistance in activities of daily living (ADLs) and/or health maintenance activities. The nurse's primary responsibilities for partially dependent clients may be described as care coordination. Such responsibilities may include consultation, needs assessment, providing education, support and other direct care activities; ongoing evaluation of the care provided by self and others; and teaching and validating the competencies of assistive personnel who perform care activities. Whether the client or the nurse directs the care will depend upon the degree of self-care deficit and the level of monitoring and interventions required by health professionals. Assistive personnel may be directed by the client or authorized to perform care through the nursing delegation process.

Fully Dependent Status - A client whose responsibility for care has been transferred to licensed health professionals within a health care system. This client may or may not be competent or capable of participating in self care. The nurse is accountable for the overall management of nursing care. When assistive personnel are utilized, they are authorized to perform care through the delegation process (refer to Delegation Resources available via _____ for further description of the components of the delegation decision-making process).

Summary
The Continuum of Care: A Regulatory Perspective outlines the roles of the licensed nurse and assistive personnel in relation to client health status and ability to direct own care. Because boards of nursing and other state regulatory agencies are mandated to protect the public, it is critical that these agencies clearly define the lines of authority and accountability among licensed nurses, assistive personnel and clients to whom care is provided.

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The Continuum of Care Framework

*Roles of the Licensed Nurse** and Assistive Personnel (AP) in Relation to the Client*

	Independent		*Partially Dependent*		*Fully Dependent*
Client Health Status (Includes physical and cognitive abilities)	No identified health impairment or self-care deficit	With identified health impairment or self-care deficit	Assistance needed in ADLs and/or health maintenance activities; client has self-care deficit	Client has sufficient degree of self-care deficit to require frequent monitoring and direct interventions by health care professionals	Responsibility for care transferred to licensed health care professional within health care delivery system
			Client maintains most self-care responsibilities	*Client maintains some self-care responsibilities*	
Primary Roles for the Licensed Nurse**	General Education and Support to promote wellness, health maintenance and disease prevention as requested by client	Care Consultation related to health impairment, includes education and support to maintain client independence	Care Coordination Nursing activities include: • consultation • needs assessment • teaching care provider to perform care activities • providing education, support and other direct care • monitoring client status • ongoing review of care provision	Care Coordination Nursing activities include all previous activities plus: • directing nursing care, including assignment and delegation of activities	Total Care Management Includes direct care, assignment and delegation responsibilities within health care system; care provided by both licensed nurses and AP (delegated activities)
	**Client initiates*	*Client or nurse initiates*	*Client or nurse initiates/directs*	*Nurse directs*	*Nurse directs*
Assistive Personnel (AP) Role	May participate in client directed or requested activities		May be directed by client or authorized to perform care through nursing delegation process	Authorized to perform care through nursing delegation process	Authorized to perform care through nursing delegation process
	AP accountable to client		*AP accountable to client or nurse*	*AP accountable to nurse*	*AP accountable to nurse*
Types of Settings for Care (Examples)	Independent Living, Home, Ambulatory Care, Employment/Social/Public Meeting Places		Home, Residential Care Facilities, Assisted Living, Day Care, Mental Retardation/Developmental Disabled Homes, Sheltered Workshops, Schools, Ambulatory Care		Hospitals, Nursing Homes, Other Long Term Care Settings

* Client or client surrogate

** States have varying degrees of authority for LPN's

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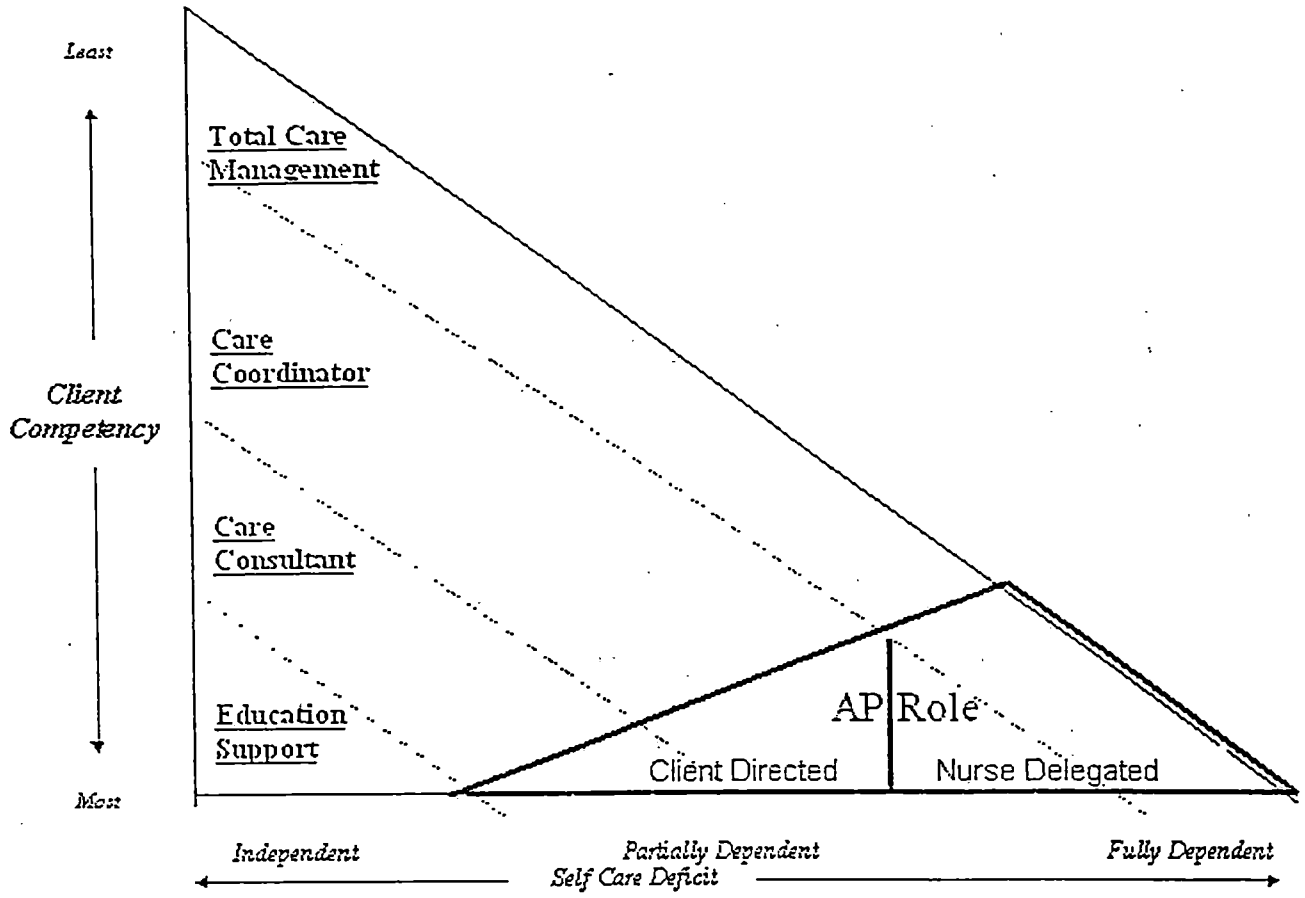
Diagram to Illustrate Roles of Nurses and AP *At Different Points of Client Competence/Self Care Continuum*



A Visual Model of the Continuum of Care Table

The above diagram provides a visual model of the Continuum of Care table that describes the roles of the licensed nurse and assistive personnel (AP) based on variances in client need. The axis for this diagram reflect client competency and client self-care status.

The original concept for the categories of the licensed nurse's roles shown in this diagram is based on Dorothea Orem's nursing system theory. The task force began with her supportive-educative, partially compensatory and wholly compensatory systems, then further defined nursing education and support to include a consultation role. Reflecting

today's health care environment of integrated health care and multiple settings for health care, the partially compensatory system is called care coordination. Wholly compensatory care is called total care management, and would be provided for those clients unable to control their movement and position, have greatly diminished response to stimuli and who are incompetent to make care decision.

Assistive personnel (AP) may be used across the continuum of care. The AP role is represented by a triangle outlined by a heavy dark line and falls within the nurse's role. The vertical heavy dark line that bisects the AP role delineates those care situations which are client directed from those where the activities must be delegated by the nurse. The purpose of developing this diagram was to assist in identifying those situations when a client can effectively self-direct care activities, and to distinguish from those where nurse delegation is needed.

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