New Jersey Nurse Delegation Pilot

Aides Performing Skilled Tasks for Home Care Clients

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New Jersey Nurse Delegation Pilot

- From October 2008 until February 2011, the New Jersey Department of Human Services, Division of Disability Services facilitated nurse delegation of health maintenance tasks (including medication administration) to agency-employed, certified homemaker-home health aides serving home care clients with chronic but stable health conditions in selected agencies.
- The goal of the pilot was to improve home care so that people with chronic conditions could remain at home or return from institutional settings.

The Pilot Process

- All 260 agencies supplying Medicaid PCA services were invited to apply. 33 applied, 23 were selected and 19 participated.
- Pilot staff (experienced home care nurses) provided orientation (CEUs given) to nurses at participating agencies and did outreach with nursing home discharge planners and state employees who do nursing home admission screening.
- Agency nurses identified cases with a suitable client and an aide to whom the nurse was comfortable delegating, and invited the client and aide to participate.
- If all parties wanted to participate, the nurse taught the aide the task and required the aide to demonstrate competency. The nurse monitored the situation as often as s/he wanted (at least every 60 days) and had the sole authority to delegate or rescind delegation.
- Delegation only applied to a specific client, nurse and aide, and only for the specific task(s) for which instruction and return demonstration of skill were provided.
- The New Jersey Board of Nursing granted permission for delegation of medication administration to nurses and aides participating in the pilot (currently aides are prohibited from administering medication)
- The Pilot was overseen by an Advisory Council of state stakeholders and national experts, and regular reports were given to the Board of Nursing.

Who Participated?

- 226 Medicaid PCA clients in 19 agencies
  - *65% were age 65 or older; the rest were 18-64*
  - *Around 70% were women and about half were white*
  - *Wide range of health conditions affecting physical, cognitive and emotional well-being—needed help with 3 ADLs and 7 IADLs, on average*
  - *About 1/3 lived alone*
- 186 nurses were oriented, of whom 70 delegated tasks
  - *No significant difference in experience, education or caseload between delegating and non-delegating nurses.*
- Aides were almost all women, 35% were white—from a few months to 40 years experience (median 9.5 years)

Evaluation Methods

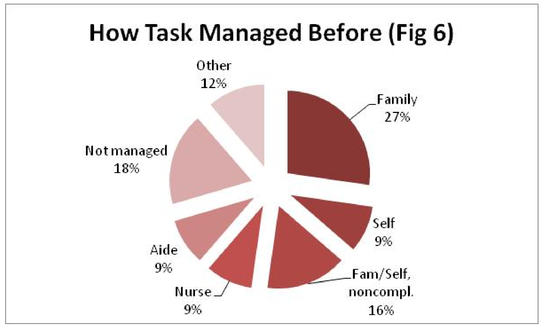
Surveys and Administrative Data: Pre- and post-implementation surveys of Nurses, Aides, Consumers and Administrators/Policymakers

Interviews: A subset of cases were selected based on region, type of delegated task, functional needs and agency variation. We attempted to interview everyone involved in the task to assess satisfaction and perceptions of quality with delegation compared with how the task was performed before.

Participation/observation: Agency orientation, Advisory Committee and Council meetings, Nurse Roundtable meetings, Pilot staff presentations to state agencies, Board of Nursing meeting

Medicaid Cost/Claim Evaluation: Done separately by Mathematica Policy Research under contract by US DHHS.

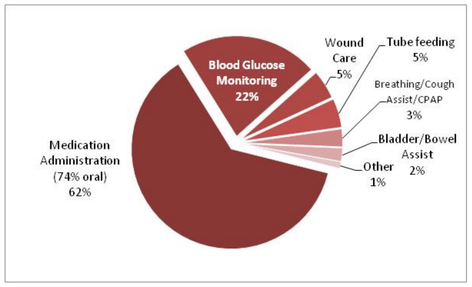
Consumer Results



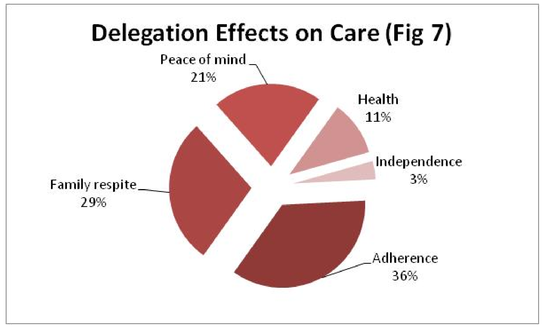
Nurse Results

- About half of delegating nurses reported positive effects on their practice from delegation; one-third reported no effects and 17 percent thought it was more work.
- Nurses who did not delegate had more concerns about the competence of the aides with whom they worked than delegating nurses did.
- Delegating nurses were willing to delegate tasks to about 40 percent of the aides with whom they worked, compared with 20 percent of aides for the nondelegating nurses.
- Delegating nurses had fewer concerns about safety but about the same level of concern about liability when compared with nondelegating nurses.
- Nurses who did not delegate thought that a lack of a backup plan for potential enrollees was the largest barrier to enrolling clients in the program.

Delegated Tasks



Consumer Results



Aide Results

- In some cases aides were already doing tasks prior to program implementation (consistent with earlier research finding that delegation brought supervision to "underground" practices).
- 76 percent of aides reported spending the same amount of time with their clients after the implementation of delegation (i.e., few increases in hours)

Delegation Benefits Aides	*Delegation Benefits Others*
• *job training for aide and I don't have to pay any money to do it* • *it benefits me because doing the medication, I can go from there and be a certified medication aide. I get experience.* • *If you are planning to make a career in the nursing field, it gives you knowledge, something more than someone who has not had the opportunity to delegate those tasks.* • *Responsibility will eventually become more money.* • *There may be potential for select aides to earn more money for being diligent and responsible in tasks performed*	• *company is receiving benefit (savings) by me doing it, but I still get my same pay and hours* [note: some agencies increased wages] • *The only benefit is to the client. Clients really need someone to administer medication. Some clients cannot reach the area where medication is. No benefit to the aide at all.*

Overall Results

- Consumers reported better quality of life and positive effects on their health, and caregivers experienced increased peace of mind and respite.
- In many cases delegated tasks were not being done at all, or not consistently, prior to the implementation of this program.
- No evidence of coercion of participants or adverse health outcomes (Rutgers, MPR, DDS). No evidence that agencies pushed service on clients who didn't need it (MPR).
- Respondents in all surveyed groups were positive about delegation (consumers were the most positive, followed by aides and then nurses and others)
- Facilitation was needed to spur enrollment and referrals. Credibility of program manager with various stakeholders was key
- Rates of illness and disability were higher among pilot participants than in the Medicaid PCA population (MPR).
- Costs were low, averaging $550/yr, slightly less than what Medicaid pays for 4 days in a nursing facility.(MPR).

Conclusions/Policy Implications

- Findings support removing the blanket prohibition on medication administration by certified homemaker-home health aides.
- The current New Jersey regulatory language allows flexibility for nurses to assess and delegate according to their professional judgment.
- Delegation as implemented by this program appears to be a low-cost, low-risk practice that holds the potential to benefit consumers, but it was not being done prior to this program despite the lack of explicit prohibition of many of the tasks, and many nurses did not feel comfortable implementing it. Facilitation of a culture change in the approach to the role of nurses and aides in home care will be necessary for this practice to catch on, in addition to removing regulatory barriers.

Acknowledgements

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