HOMECARE UNIVERSITY

519 C Street, NE, Washington, DC 20002 • 202/547-3576 • 202/547-4322 fax

Margaret J. Cushman, *Dean and Chief Executive Officer*

About Home Care University

Mission

Home Care University is conceived to create and promote excellence in home care and hospice research, education and credentialing; for the advancement of home care and the betterment of society. Home Care University will act as principle steward to uphold and promote the values, standards, and essence of home care's rich heritage.

In carrying out this mission, Home Care University (HCU) will uphold the values of leadership through service; ethics in business; life-long learning; promotion of health, independence and peaceful death; and caring.

As a nonprofit 501(c)(3) affiliate of the National Association for Home Care, HCU will focus its efforts on furthering the following purposes of NAHC:

1. Sponsor research, gather, and disseminate home care and hospice data

2. Foster, develop, and promote high standards of patient care in home care and hospice services; and for home care agencies and their staff.

3. Disseminate information to the media and the general public to promote the acceptance of home care and hospice services and to support family/informal caregivers

4. Initiate, sponsor, and promote educational programs

5. Promote independence and contribution by potential home care clients, thereby shattering the myth that dependence is a necessary state for the aged, disabled and infirm.

Description

Home Care University is a nonprofit organization with three core endeavors: research, education, and credentialing. Home Care University (HCU) will begin with research and credentialing activities transferred from the National Association for Home Care and expand them. It will build a new education component, reference capacity, public awareness, and values enrichment.

The initial target beneficiaries of this endeavor are the 30,000 home care organizations in the United States, with primary focus on NAHC members. Future customers may include other health care organizations, international home care organizations, researchers, policy makers, and consumers.

Goals

The **overall** goal of Home Care University is to provide a state of the art center of excellence for research, credentialing, and learning; and to promote the values, standards, and essence of caring, including hospice and home care.

The goal in the area of **research** is to promote research in the field of home care and hospice, disseminate research findings, and eventually conduct research. Research areas include policy, clinical, health services (delivery, management, financing, etc.), business, market, and opinion polls. The research center will be the preeminent source for home care related research.

The goal in the area of **education** is to provide leading edge learning opportunities on caring, including home care and hospices. Education programs will include traditional teaching formats, audio tape, video tape, satellite TV programs, CD-ROM programs, on-line programs via NAHC's web page, telephone audio conferences, and written materials/publications. Curricula will be developed for in-depth preparation of home care and hospice personnel.

The goal of **credentialing** is to develop standards and recognize qualified individuals and home care organizations. Current programs include: home care aide certification, home care and hospice executive certification, and accreditation of home care aide organizations. Financial manager certification is the first expansion in this area.

In addition to the three specific areas of development, Home Care University will engage in overarching and support activities to further its mission. These activities will center on increasing the accessibility of historical and current home care **reference materials**; and, enhancing and promulgating **values.**

Strategy

The basic strategy will be to provide the highest quality products and services for a reasonable price, using advanced technology. Strategic partners will be sought to leverage resources and obtain expertise where needed. Potential strategic partners include universities, home care agencies, hospices, institutions and companies. Examples are: Rosalyn Carter Institute, IBM, National Council of Senior Citizens, The Creative Thinking Association.

Staffing

Executive
Margaret J. Cushman, MSN, RN, CHCE, Dean & CEO
E-mail: mjc@nahc.org

Patty Esensee, Administrative Assistant

Research
VP for Research
Position open

Education
Margaret J. Cushman (see above)

Marcie Barnette, MSN, RN, Director of Education and Credentialing
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Brent Miller, BS, Senior Education Associate
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Craig Kelly, BA, Education Associate
E-mail: ck@nahc.org

Credentialing
Marcie Barnette (see above)

Scot Walker, Administrative Secretary

Key Objectives

RESEARCH:

- Develop and conduct policy, pure and market research for home care and hospice issues.
- Develop and disseminate home care and hospice data and analyses.
- Monitor and promote research related to hospice and home care services.

EDUCATION:

- Develop and provide quality educational programs and products that are responsive to NAHC member needs.
- Develop educational materials to support the credentialing program.
- Collaborate with universities and other institutions for the enhancement of home care and hospice educational opportunities.
- Develop other distance learning programs, using methods such as CD-ROM and the Internet.

CREDENTIALING

- Provide certification programs for qualified home care and hospice personnel.
- Provide an accreditation program for home care aide organizations.
- Foster, develop and promote high standards of patient care in home care and hospice services, for agencies and for staff.

REFERENCE:

- Facilitate access to home care and hospice literature.
- Collect and preserve home care and hospice historical information.

VALUES:

- Continue the Fellows Program for Hospice and Home Care.
- Promote community health principles, especially the independence and contribution by potential home care clients and family centered care.
- Develop and/or promote standards of conduct for home care and hospice professionals and home care aides.
- Disseminate information to the media and the general public to promote the acceptance of home care and hospice services and to support family and informal caregivers.

HOME CARE AIDE
ASSOCIATION OF AMERICA
An Affiliate of the National Association for Home Care

Expanding Roles:

Delegating Tasks to Home Care Aides

THE HOME CARE AIDE ASSOCIATION OF AMERICA IS AN AFFILIATE OF THE NATIONAL ASSOCIATION FOR HOME CARE, LOCATED AT 228 7TH STREET, SE, WASHINGTON, DC 20003-4306

HOME CARE AIDE
ASSOCIATION OF AMERICA

Expanding Roles: Delegating Tasks to Home Care Aides

Should HCAs be permitted to administer medication? Adjust an IV flow rate? Monitor oxygen? Change a colostomy bag? Provide decubitus care? Change a simple dressing? Across the country HCAs are providing these services and performing other tasks that traditionally have been considered within the scope of nursing practice.

Fueled by an aging population, hasty patient discharges, and an increasingly cost-focused health care environment, the home care industry has grown rapidly. Most notable of these trends, however, is the continued and projected growth in the number of paraprofessionals. The US Department of Labor projections indicate a growth rate of more than 100% in two home care paraprofessional positions. HCAs who perform a variety of housekeeping tasks for home care patients, will increase from 179,000 positions in 1994 to 391,000 in 2005 (a 119% increase). HCAs who provide personal and physical care, will see an increase from 420,000 in 1994 to 848,000 in 2005 (a 102% increase).

As the HCA ranks have expanded, so have their roles. The role of the paraprofessional caregiver has grown in some settings beyond the assistive realm into areas of significantly more independence. It is no longer unusual for HCAs to provide dressing and simple wound care, routine catheter care and irrigation, and administration of medication. These tasks are all being delegated to HCAs in many states. The expanding scope of tasks for HCAs raises challenges and dilemmas for home care agencies, nurses, HCAs, and home care recipients.

Agencies are under great pressure to have aides provide care beyond basic activities of daily living (ADLs). As resources to pay for health care services shrink and costs increase, health care providers, insurers, and government entities seek less-expensive means to provide care. And people with disabilities have pushed for a more liberal and less medical view of the scope of work that can safely be provided by paraprofessional caregivers.

EXPANDING ROLES

For the past year the Home Care Aide Association of America (HCAAA), an affiliate of the National Association for Home Care (NAHC), has examined issues related to HCAs' expanding role and scope of practice. In response to numerous requests for guidance from members, HCAAA's Supervision and Delegation Task

The National Association for Home Care (NAHC) established the Home Care Aide Association of America (HCAAA) in 1990 to provide a forum for the discussion of issues related to the work of paraprofessionals in home care. Home care aide (HCA) is one of the fastest growing occupations in the country. As the HCA ranks have expanded, so have their roles. HCAAA has examined closely issues related to the expanding role and scope of task of HCAs in an effort to provide guidance to its members.

This issue analysis is designed to assist agencies in examining the myriad issues related to expanding the tasks of the HCAs, responding to requests from managed care companies, and addressing state or federal legislative initiatives. Despite urging from some agencies for a concrete list of acceptable HCA tasks, HCAAA has concluded that the broad and diverse range of practices at the state and agency level, the diversity in client needs and conditions, and variations in individual aides' abilities make it impractical to present a list of activities that can be delegated. HCAAA believes that an agency's decision to permit delegation of tasks to aides should be based on assessment of a number of variables, including existing laws and regulations, the complexity of client needs and stability, and the training and clinical competence of the HCA.

Force, comprised of home care nurses and administrators, examined delegation issues to develop a position on suitable tasks for appropriately trained HCAs.

HCAAA found that policies and practices governing HCA duties are changing rapidly. The US Department of Health and Human Services provided funding for research on supervision and delegation. State Nurse Practice Acts are being revised to expand tasks that nurses may delegate to aides. Home care agencies report pressure from payor sources to expand the tasks HCAs currently provide. Home care agencies are forming coalitions to develop consensus on what is and is not appropriate. People with disabilities are seeking ways to expand the tasks that can be delegated as well as supervisory and training requirements.

Delegation of tasks to HCAs is governed primarily by state Nurse Practice Acts. These laws vary by state: some have fairly strict requirements while others are broadly drawn, leaving much to the discretion of registered nurses. Although some states have developed or are developing training and competency standards for aides, few rules and regulations provide a solid framework for agencies.

In 1995 HCAAA surveyed NAHC members to assess current agency practices in delegating tasks to HCAs that are traditionally considered beyond the aides' scope of tasks. The survey sought information in a broad range of clinical areas from monitoring to medication administration and invasive procedures.

More than half of respondents indicated that HCAs in their state or region were being assigned nontraditional tasks. More than 70% expected funding sources—primarily managed care companies—to request HCAs to perform nontraditional tasks. Most respondents believed expansion of tasks was appropriate for HCAs *with appropriate training*.

HCAAA has concluded that the broad and diverse range of practices at the state and agency level, the diversity in client needs and conditions, and variations in individual aides' abilities make it impractical to define a list of activities that can be delegated. There is insufficient information to draw hard conclusions about ideal approaches and little information about the consequences.

EXAMINING THE ISSUES

Two research reports have examined the implications of more extensive delegation of nursing tasks to unlicensed paraprofessionals and have reached similar conclusions.

"Liability Issues Affecting Consumer Directed Personal Assistance Services," published in 1995 by the World Institute on Disability and the American Bar Association Commission on Legal Problems of the Elderly, closely examines 50 state nurse practice acts and delegations practices in many states. The report states:

Under nurse delegation, our experience is insufficient to draw any hard and fast conclusions about optimum approaches, legal ramifications. Existing law is quite varied and vague...If any one theme has been consistent in home and community-based services, it is the reality that one size does not fit all. Detailed standards and procedures that must be applied to all consumers easily miss that reality.

A report published by the Public Policy Institute of the American Association of Retired Persons (1995) examines a range of delegation issues. The report, "Delegation of Nursing Activities: Implications for Patterns of Long-Term Care," was written under contract by the University of Minnesota's National Long-Term Care Resource Center. The report reviews nurse practice statutes, related regulations, and customary professional practices to examine the circumstances by which nurses can and do delegate nursing tasks to unlicensed people. The goal of the report was to explore nurses' potential for playing an enhanced role as teachers and delegators of care to unlicensed persons. The report includes a case study of opinions about nurse delegation.

In support of nurse delegation, the following statements were made: "Delegation offers a way for nurses to assist patients to live in the settings of their choice because of general cost lowering"; "Delegation promotes equity between people with families (...give free care outside of nurse delegation prohibitions) and those who do not have families"; "Delegation offers nurses greater opportunities for leadership and use of their skills."

Views in opposition to expanded delegation included fears that "permission to delegate would glide into requirements to delegate"; concerns that "nurses' education about the why, how, and what of delegation was insufficient"; skepticism about the claims to efficiency made by proponents of delegation; liability concerns; concerns about risks of poor quality care.

The report concludes that nurse delegation is a feasible and promising approach to providing cost-effective, long-term care in community-based settings, including group residential settings.

IMPLICATIONS FOR AGENCIES

The home care industry is in a unique position in that it routinely

teaches family members, friends, and neighbors to perform sophisticated and complex tasks to promote client independence. At the same time, agencies employ paraprofessional caregivers whose training and supervision become the agency's direct responsibility and liability. Some agencies are in contractual arrangements whereby another entity actually employs a paraprofessional caregiver with whom the agency staff works. Agencies must consider that they may be held liable for actions taken by aides who are inadequately trained or supervised. Within the context of delegation there are two directions of liability which agencies must understand and consider.

Under the doctrine of *respondeat superior* the agency is responsible for all the actions its employees take. Accordingly, negligence by an aide in the performance of delegated tasks leads to liability for the agency. The nurse who has delegated the responsibilities retains liability for the performance of the aide. This could mean personal professional liability. Liability in both of these instances can mean direct financial consequences as well as loss of license. As well, individual nurses whom the agency employs must consider the impact of inappropriate delegation, or improperly performed tasks, on their own licensure status.

Most Nurse Practice Acts are broad in their definition of what constitutes the practice of nursing, leaving nurses uncertain of the standards they must meet. Nurses make critical delegation decisions that must be consistent with safe and effective nursing practice. As the nurses making these decisions will necessarily consider the appropriate training of aides, agencies must consider whether nurses have the skill to delegate.

A recent paper by the National Council of State Boards of Nursing (NCSBN), "Delegation: Concepts and Decision-Making Process," provides practical guidelines to direct the process for making decisions about delegation. NCSBN includes Five Rights of Delegation to facilitate decisions about delegation:

- Right Task—one that is delegable for a specific patient

- Right Circumstances—appropriate patient setting, available resources, and other relevant factors considered

- Right Person—delegating the right task to the right person to be performed on the right person

- Right Direction/Communication—clear concise description of the tasks, including their objectives, limits, and expectations

- Right Supervision—appropriate monitoring, evaluation, intervention, as needed, and feedback.

The paper lists a number of premises as the basis for delegation. The first is: "All decisions related to delegation of nursing tasks must be based on the fundamental principle of protection of the health, safety, and welfare of the public."

Reimbursement issues are another concern for the home care agencies. Often reimbursement is inadequate to cover the cost of essential training and supervision. Rates paid to home care agencies under Medicaid are often below the cost of providing care, which forces some home care agencies to subsidize patients. As the scope of tasks for aides expands, more extensive and costly training will be required. This cost will place an added burden on agencies. In addition, payors are demanding more for less, placing home care providers in a difficult situation.

DIFFICULT DECISIONS

Clearly, for home care agencies the primary concern is and must be the safety and well-being of the care recipient. However, every day home care agency staff must make difficult decisions concerning aide tasks with little guidance and under increased pressure for aides to do more. Established standards are minimal and are complicated by conflict among industry standards, federal and state governments, the nursing community, advocates, and people with disabilities, each of whom claims responsibility for determining appropriate standards in different circumstances.

Although some agencies and communities have developed and operationalized lists of tasks that can and cannot be provided by aides, the HCAAA Advisory Board has opted not to create such a list. This paper was developed to help agencies examine issues related to expanding the tasks of the aides employed by the agency, responding to requests from managed care companies, and addressing state or federal legislative initiatives.

HCAAA believes that an agency's decisions to permit delegation of specific tasks to specific aides should be based on assessment of a number of variables, including existing laws and regulations, the complexity of client needs and stability, and the training and clinical competence of the home care aide.

•States should establish a registry of positive findings of criminal history.

•Laws should provide a process to permit applicants to request a waiver of the prohibition against employment, which permits consideration of mitigating circumstances (such as age at which the crime was committed, circumstances surrounding the crime, character references, other evidence that the applicant does not pose a threat to the health and safety of patients, etc.) or request a fingerprint check where mistaken identity may be a consideration; laws should specify agency requirements during the investigation process and after the waiver process.

HCAAA recommends home care agencies be involved with their state legislatures in developing criminal background check legislation.

BEYOND CRIMINAL HISTORY

No matter how effective, the criminal background check cannot substitute for normal, prudent personnel practices that any responsible employer would undertake to establish the appropriateness, safety, and suitability of an applicant. Good human resources practices will include a written application completed prior to an interview, a comprehensive in-person interview, and a thorough check of all references. The agency should have every reasonable confidence that the worker can provide quality care and is not a threat to patient safety. Criminal background checks cannot substitute for careful selection, worker training, competency testing, and supervision, which are also critical components to ensure the safety of home care consumers.

Criminal background checks cannot be relied on as the sole method of keeping consumers safe. NAHC has a long history and solid track record of proactive efforts to combat fraud and abuse in home care. These efforts are broad and far reaching and necessarily go beyond criminal background checks. NAHC has developed policies for member agencies, conducted extensive educational efforts to help consumers make informed decisions, and encouraged Congress, federal agencies, and state legislatures to mandate quality assurance standards in home care.

The growth in home care has been accompanied by both a proliferation of agencies and an increase in the number of independent providers, workers who provide care independent of agencies. Rarely are these workers subject to any training, competency testing, or professional supervision. The influx of workers into home care who are not subject to standards or screening has necessarily heightened concerns about consumer safety. Although federal regulations should never be so cumbersome as to pose a barrier to care, basic standards of care must be established to ensure minimum levels of safety for the consumer, the caregiver, and the community. A 1995 report by the National Long Term Care Resource Center states, "Federal and state governments have continuing responsibilities for establishing and enforcing the conditions under which programs can be innovative, responsive to consumer preferences, and encouraged to exceed minimum standards."

BLUEPRINTS FOR ACTION

The *1997 Legislative Blueprints for Action* of both HCAAA and NAHC include a series of recommendations for federal action to protect consumers, listed below.

•Federal requirements for worker screening should be strengthened to include federally funded criminal background checks for all home visiting staff. An organized system for criminal background checks should be developed, which is reasonable in cost and will provide up-to-date information in a timely manner.

•Congress should require states to make available to the public registries listing home care workers who have been deemed qualified to provide home care services or those who have been found in violation of the law or safety standards.

•Quality assurance standards should be required in all federally and state-funded long-term care programs. Such standards should include minimum standards of training, testing, supervision, and practice in the delivery of in-home services. Quality and safety standards should apply regardless of consumer, provider, or payor.

•Training programs should be approved by the state or by a state or federally approved accrediting organization.

•Congress should require states to establish mechanisms for resolving problems that arise between consumers and independent providers. Congress should increase funding for adult protection programs and mandate that state elder abuse reporting laws include immunity from prosecution for persons reporting incidence of abuse.

•Congress should retain the elder abuse ombudsman functions of the Older Americans Act in reauthorization.

•Congress should establish a commission to investigate elder abuse and to make recommendations for increasing penalties.

As the demand for quality home care increases, it is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse cannot be tolerated in any form. The care environment must be safe for both patients and caregivers and be free of abuse, fear of abuse, neglect, exploitation, and inappropriate care. Criminal background checks are an important component of ensuring consumer safety—but only one component.

HOME CARE AIDE
ASSOCIATION OF AMERICA
An Affiliate of the National Association for Home Care

Criminal Background Checks for Home Care Workers

May 1997

THE HOME CARE AIDE ASSOCIATION OF AMERICA IS AN AFFILIATE OF THE NATIONAL ASSOCIATION FOR HOME CARE, LOCATED AT 228 7TH STREET, SE, WASHINGTON, DC 20003-4306

HOME CARE AIDE
ASSOCIATION OF AMERICA

The Home Care Aide Association of America is an affiliate of the National Association for Home Care, located at 228 7th Street, SE, Washington, DC 20002-5809.

Criminal Background Checks for Home Care Workers

On March 10, 1997, the Health Care Financing Administration (HCFA) published proposed rules in the *Federal Register* that would have a profound effect on the delivery of home care services. One of the most significant is a provision that would require home health agencies to conduct criminal background checks of home care aides as a condition of employment. This proposed rule would give the force of federal law to a practice that many home care agencies already have adopted. It reflects a growing trend at the state level of background checks of caregivers.

A recent spate of media attention has focused on the unacceptable, but isolated, cases of abuse of home care clients, fueling consumer anxiety and industry concern about the need for better consumer protections. Although any fraud or abuse is totally unacceptable, it's important to note that cases of consumer abuse in home care are very rare. The overwhelming majority of home care workers are honest and perform their duties with compassion and integrity. Likewise, the vast majority of home care agencies provide reputable, legitimate quality care.

Home care providers are often in a position to identify elder abuse committed by others. In fact, congressional testimony by the General Accounting Office (GAO) in 1991 regarding elder abuse indicated "...a high level of public and professional awareness was the most effective weapon for identifying elder abuse; inhome services was considered the most effective factor for both prevention and treatment of elder abuse." However, as in any growing industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients.

BACKGROUND CHECKS ON THE RISE

There is no doubt that interest in criminal background checks for home care workers is on the rise. A recent GAO report, "Some States Apply Criminal Background Checks to Home Care Workers" identifies the myriad factors that have fueled the interest:

- the increasing size and obvious vulnerability of the population in need of home care services,
- the challenges the home care setting poses for worker supervision,
- the rapid expansion of the home care industry,
- the unrelenting demand for home care services in the face of worker shortages,
- the low wages typically available to paraprofessional workers serving a largely low- or fixed-income population,
- the diffuse responsibility for worker selection, and
- the anecdotal reports of abuses by home care workers with criminal history.

The GAO report provides the first comprehensive look at state policies and practices on criminal background checks in home care. It covers three areas: federal or state requirements for licensure, registration, or certification that apply to home care workers and organizations; the extent to which states have used registries or similar mechanisms for screening; and state requirements for criminal background checks. GAO found that "formal safeguards for home care consumers vary widely across political jurisdictions, public programs, and types of providers; and in some instances few safeguards exist."

GAO cites three key results of its evaluations. Few states have licensure requirements for the category of workers "variously known as home health aides, personal care aides, personal care attendants, or homemakers" who provide 70% –80% of long-term care. Although federal law requires states to maintain a registry for nursing home aides, only about a quarter have incorporated home care workers or have developed a separate registry for home care workers. Finally, slightly more than a quarter of the states require criminal background checks on some types of workers, although the checks are generally limited to a state's own criminal records. States that require criminal background checks may access Federal Bureau of Investigation data; however, most do not, citing the cost as prohibitive.

Of great concern is the finding that even states that regulate some home care services may not prohibit advertisement of similar-sounding services by organizations that are not licensed, registered, or certified. "In 45 states, companion, housekeeping and homemaker, or shopping services may be legally advertised by organizations that are not licensed or certified."

GAO also mentions the impact of consumer-directed care: "states are adopting policies that encourage or require aged and disabled beneficiaries to take direct responsibility for hiring and supervising their home care workers who are paid with state or federal funds." GAO also states that "anecdotal reports of abuses by a small number of home care workers with criminal history have raised the issue of whether and how such workers should be screened for criminal background."

After a review of the report, HCFA noted, "While we agree with and support efforts designed to eliminate fraud and abuse and increase quality of care, we are unconvinced that there is enough consensus on the mechanisms [that] should be employed to address these concerns. Consequently, we believe states should be given the flexibility to determine how best to address these issues."

However, HCFA's proposed changes to the Medicare Conditions of Participation (*Federal Register*, 3/10/97) would require home health agencies to conduct criminal background checks of home care aides as a condition of employment. Should these proposed rules become final, they will carry the force of federal law and state legislatures may be compelled to implement criminal background check statutes or establish systems for criminal background checks.

RECOMMENDATIONS

The Home Care Aide Association of America (HCAAA) has analyzed state criminal background laws to assess the feasibility and potential impact on home care agencies, patients, and employees.

It is HCAAA's position that an ideal criminal background law must ensure that patients are well protected and that the rights of providers, employees, and applicants are protected as well. Although the trend seems to be toward background checks for home care aides only, HCAAA and NAHC recommend that laws cover all home visiting staff. There is currently no consistent, systematic mechanism in place through which other home visiting staff are checked. It is in the best interest of consumers of home care services for all home visiting staff to be well screened.

An organized system for criminal background checks should be developed that is reasonable in cost and will provide up-to-date information in a timely manner. The development of such a system will require adequate funding by both the federal and state governments.

As states develop criminal background laws, HCAAA recommends that the following policy issues be addressed:

- Criminal background checks should be national—at a minimum, statewide; fingerprint analysis provides the most promising approach.
- Laws should specify who can conduct the background check (for example, can agencies hire private firms?).
- Fees charged cannot exceed the cost; laws/regulations should permit agencies to pay the fees or require job applicants to pay.
- Employees hired before the implementation date should be exempt from criminal background check requirements.
- Agencies should be permitted to hire workers on a temporary basis pending results of a check; laws should protect agencies that hire workers in good faith on a conditional basis prior to background check return.
- Laws/regulations should establish a reasonable time frame for the return of the check (preferably within 21 days).
- Agencies should be required to inform applicants of intent to conduct a background check and obtain a consent form to permit access to criminal history records.
- Laws/regulations should specify responsibility for compliance with background check requirements for contract workers and independent providers; confidentiality requirements (for example, can agencies report results of a criminal background report in a reference?).
- State laws should specify which crimes prohibit an applicant from being hired on a permanent basis. Notification of the results of a positive criminal history report should be made to both the agency and the applicant for the protection of all parties.

The Home Care Aide Association of America (HCAAA) was established in 1990 by the National Association for Home Care (NAHC) to provide a forum for the discussion of issues related to the work of paraprofessionals in home care. Home care aide is one of the fastest growing occupations in the country.

The Health Care Financing Administration recently proposed a rule requiring criminal background checks for all home care aides as a condition of employment. The purpose of the rule is to safeguard against the potential for abuse in home care, but is it the only solution? And should it be limited to just home care aides?

HCAAA analyzed state criminal background laws to assess the potential impact on home care agencies, patients and employees. It is HCAAA's position that an ideal criminal background law must ensure that patients are well protected and that the rights of providers, employees, and job applicants are protected as well. Although the trend is toward background checks for home care aides only, HCAAA recommends that laws cover all home visiting staff. There is currently no consistent mechanism through which other home visiting staff are checked.

HOME CARE AIDE ASSOCIATION OF AMERICA ISSUE ANALYSIS
MAY 1997

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Home Care Aide Certification Program

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NATIONAL ASSOCIATION
FOR HOME CARE
228 Seventh Street, SE
Washington, DC 20003-4306

HOMECARE

Contents:

Home Care Aide Certification Program

Information Package

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2.) List of items to submit for ordering tests
   A.) Local test site contract
   B.) Roster lists people who will be taking exam
   C.) Skills Demonstration Checklist
   D.) Proctor Application

3.) Summary of Test Site Guidelines

4.) Home Care University Certification Program for HCA

5.) Table of Contents *Model Curriculum and Teaching Guide*

6.) A Comparative Summary: OBRA-87 and Foundation Standards

7.) NAHC Catalog of Home Care Aide Resources

HOMECARE UNIVERSITY

Home Care Aide National Certification Program
Fact Sheet

The Home Care Aide National Certification Program is composed of three competency-based elements:

- TRAINING: Seventy-five hours based on the *Model Curriculum and Teaching Guide for the Instruction of the Home Care Aide*
- SKILLS DEMONSTRATION: A comprehensive checklist with performance behaviors, administered by a registered nurse
- WRITTEN EXAMINATION: Administered through Home Care University

The National Certification Program has provided training and testing for home care aides since 1990. The program is designed to establish a national standard for preparation of home care aides. This program offers significant benefits to consumers, providers and payers.

THE CONSUMER
- Benefits from a higher standard of care
- Receives assurance that caregivers have met basic standards for training and competency
- Has access to a national registry of certified home care aides

THE HOME CARE AIDE
- Receives a national identity through certification as a paraprofessional
- Has increased self-confidence through obtaining a credential that documents individual skills and training

THE HOME CARE AGENCY
- Has access to a reasonable and responsible national standard
- Can use this program as a marketing tool
- Can use the program as a cost-effective mechanism for meeting the OBRA requirements

For information, contact the Home Care Aide Certification Program at (202) 547-3576

HOMECARE UNIVERSITY

April 27, 1999

Dear Test Site Administrator:

Please submit all of the following items when you request your next order of home care aide tests:

- ☐ Local Test Site Contract, *(Item One)*
- ☐ A check made payable to Home Care University for $32 x the number of tests to be given,
- ☐ A roster of home care aides registered for the exam, *(Item Two)*
- ☐ Summary Documentation for Skills Demonstration Checklist, *(Item Three),* and
- ☐ A proctor application. *(Item Four)*

As soon as I receive the five items in your request, I will send the testing material by 2-day UPS directly to your proctor. I will also include a UPS pre-paid mailing envelope addressed to me.

When your proctor returns the testing materials to me, I will send you a letter of confirmation listing the students who failed and passed the exam along with certificates and wallet cards for those students who passed.

Thank you in advance for following this new procedure. If you have any questions, please feel free to call me at (202) 547-3576.

Sincerely,

Scot Walker
Test Administrator

Enclosure: Packet of blank HCA test request forms

HOMECARE UNIVERSITY

Local Test Site Contract

The following person will be Home Care University's contact for the administration of exams:

Name _____
Employer _____
Address _____
_____
Telephone (work) _____ Fax _____

Name and title of person to whom exam results should be sent, *if different from that of above contact person* _____

Date of exam _____ Number of exams _____
Location of test site _____

(1) Is the room well lit and well ventilated? _____ yes _____ no
(2) Do you expect that the room will be quiet on the day of the exam? _____yes _____ no
(3) Are there restrooms in the building? _____ yes _____ no

Proctor's name _____
Proctor's address _____
Proctor's phone number _____

I affirm that all the above information is true. I agree to abide by the guidelines established by Home Care University for home care and I understand that failure to comply with these guidelines may result in the termination of my agency as an authorized test site.

_____ _____
Signature of contact person Date

_____ _____
Signature of agency administrator (if different from above) Date

Item One

HOMECARE UNIVERSITY

ROSTER OF HOME CARE AIDES REGISTERED FOR THE EXAM

The participants listed below have had a minimum of 75 hours of training based on the *Model Curriculum and Teaching Guide* or a comparable curriculum on file with Home Care University. If participants received training elsewhere, enclose a certificate noting the number of hours

THIS LIST WILL BE USED TO MAKE CERTIFICATES.
LEASE TYPE OR PRINT PARTICIPANTS NAMES CLEARLY.

Participant's Name	Social Security No.	Nurse Observing Skills	Nurse's License Number

I affirm that the students listed above have completed a 75-hour course based on the model curriculum.
Name _____ Signature _____
Institution/Agency _____ Title _____ Date _____

Item Two

Summary Documentation for Skills Demonstration Checklists

Name _____ Social Security Number _____

Checklist Number	Personal Care Skill	Where Observed (check one) Home	Lab	Observer Signature Classification	Date
1A	Temperature	☐	☐		
1B	Pulse and Respiration	☐	☐		
2	Bed Bath	☐	☐		
3	Sponge, Tub, or Shower Bath	☐	☐		
4A	Shampoo in Bed	☐	☐		
4B	Shampoo at Sink or in Tub	☐	☐		
5A	Nail Care	☐	☐		
5B	Skin Care	☐	☐		
5C	Backrub	☐	☐		
6	Oral Hygiene	☐	☐		
7A	Urinal	☐	☐		
7B	Bedpan	☐	☐		
8A	Transfer Techniques	☐	☐		
8B	Ambulation	☐	☐		
9A	Range of Motion Exercises	☐	☐		
9B	Positioning	☐	☐		
10	Make Occupied Bed	☐	☐		

Supervisor/Observer Name *(please print clearly)* _____

RN License Number _____ Signature _____

Homemaker-Home Care Aide's Agency/Organization _____

Agency/Organization Address _____

Item Three

HOMECARE UNIVERSITY

National Certification Program for Home Health Aides

PROCTOR APPLICATION

(Please fill-out a new application for each new proctor. If you use a previously approved proctor, submit a copy of his/her application with your contract)

Proctor's Name _____
Address _____
(No P.O. Boxes) _____
Daytime Phone _____
Employed by: _____
From (date) _____ Through (date) _____

List three business or professional references. Include a phone number for each.

1. _____
2. _____
3. _____

Are you 18 years of age or older? _____ Yes _____ No

Are you employed by or working under contract for any of the agencies participating in this exam, or are you a relative of an employee of any participating agency? _____ Yes _____ No

PROCTOR SECURITY AGREEMENT: I understand that I am responsible for the security of all test materials and I guarantee the confidentiality of said materials. I understand the responsibilities of proctoring this exam and I agree to follow the instructions explicitly. I affirm that the answers I have given to the questions above are true.

_____ _____
Signature of proctor applicant Date

AGENCY ADMINISTRATOR SECURITY AGREEMENT: I affirm that the person proctoring this exam is not employed by or working under contract for my agency, and is not a relative of anyone employed by my agency. I understand that the exam may only be taken by home care aides, and no other members of my staff are eligible for testing.

_____ _____
Signature of agency administrator Date

Item Four

SUMMARY OF TEST SITE GUIDELINES

National Certification Program for Home Care Aides

The following three components of the National Certification Program must be successfully completed before a certificate will be issued:

1. A 75-hour training program based on the *Model Curriculum and Teaching Guide for the Instruction of the Home Health Aide* (see the enclosed publication list), or a comparable curriculum.

2. The skills demonstration checklist (see enclosed publication list). The yellow summary sheet is mailed to the test administrator at Home Care University.

3. A written examination designed and administered by Home Care University. The written examination tests the home care aides' knowledge of essential information needed to properly perform his/her job.

Arranging Local Sites for Administration of the Written Examination

Written exams for groups of three or more aides may be arranged by home care agencies or training schools. The organization arranging for the test site must submit the following:

1. Local Test Site Contract -- to arrange a local exam.

2. Payment -- in US funds by certified check, company check, or money order -- payable to Home Care University. The fee is $32 per home care aide to be tested. There are no refunds and no credit is given for unused tests.

3. Roster of Home Care Aides Registered for the Exam. The exam is open only to home care aides. The testing of anyone other than a home care aide-- i.e., the agency director, an RN, etc. -- may result in the disqualification of all home care aides tested by that agency.

4. Skills Demonstration Checklists.

5. Proctor Application -- a proctor cannot be employed by the hiring agency or be a relative of any agency staff or individual seeking certification.

Note: Please keep the enclosed original forms on file, completing a photocopy of the form each time you want to schedule a written exam.

Forms and payment must be received by Home Care University at least ten working days before the scheduled examination date.

Mail Requests to: Scot Walker, Test Administrator
Home Care University
228 Seventh Street, S.E.
Washington, DC 20003
(202) 547-3576

HomeCare University is an affiliate of The National Association for Home Care

National Association for Home Care Certification Program for Home Health Aides

The National Certification Program is based on the Model Curriculum and Teaching Guide for the Instruction of the Home Care Aide that was developed in 1978 with the support of the U.S. Public Health Service. In 1987 the Model Curriculum was revised with the assistance of the Administration on Aging. At the same time training standards from the Model Curriculum were adopted as part of the Omnibus Budget Reconciliation Act (OBRA-87). These requirements are now codified in the Health Care Financing Administration (HCFA) Code of Federal Regulations, 484.36 Condition of participation: Home health aide services.

Sections of the Model Curriculum that address the subject areas required in a home health aide training program under Code of Federal Regulations 484.36 (a) are:

(i) Communications skills. Section II

(ii) Observation, reporting, and documentation of patient status and the care of services furnished. Section I

(iii) Reading and recording temperature, pulse and respiration. Section IV

(iv) Basic infection control procedures. Section III

(v) Basic elements of body function and changes in body function and changes in body function that must be reported to an aide's supervisor. Section IV

(vi) Maintenance of a clean, safe and healthy environment. Section III

(vii) Recognizing emergencies and knowledge of emergency procedures. Section IV

(viii) The physical, emotional, and developmental characteristics of the populations served by the home health agency including the need for respect for the patient, his or her privacy, and his or her property. Section I & II

(ix) Appropriate and safe techniques in personal hygiene and grooming that include: bed bath; sponge, tub or shower bath; shampoo in sink; tub or bed; nail and skin care; oral hygiene; toileting and elimination. Section IV

(x) Safe transfer techniques and ambulation. Section IV

(xi) Normal range of motion and positioning. Section IV

(xii) Adequate nutrition and fluid intake. Section III

(xiii) Any other task that the home health agency may choose to have the home health aide perform. Section II

The number of questions on the Written Examination from each section of The Model Curriculum are:

SECTION I Orientation to Homemaker-Home Health Aide Services (6)
- Unit A Why Homemaker-Home Health Aide Services?
- Unit B The Role of the Homemaker-Health Aide
- Unit C How Agencies Make Services Available to Clients and Families

SECTION II Understanding and Working with Various Client Populations (9)
- Unit A Communication
- Unit B Understanding Basic Human Needs
- Unit C Understanding and Working with Children
- Unit D Understanding and Working with Older Clients
- Unit E Understanding and Working with Clients who are Ill
- Unit F Understanding and Working with Clients with Disabilities
- Unit G Mental Health and Mental Illness
- Unit H Understanding Dying and Death

SECTION III Practical Knowledge and Skills in Home Management (9)
- Unit A Maintaining a Clean, Safe and Healthy Environment
- Unit B Food and Nutrition
- Unit C Managing Time, Energy, Money and Other Resources
- Unit D Home Maintenance when Disease is Present

SECTION IV Practical Knowledge and Skills in Personal Care (26)
- Unit A Body Systems, Disorders and Diseases
- Unit B Observing Body Functions
- Unit C Care of the Client in Bed
- Unit D Care of the Client Not Confined to Bed
- Unit E Observations about Medications
- Unit F Rehabilitation
- Unit G Health and Emergency Procedures

Table of Contents

Section II *19 hours*
Understanding and Working with Various Client Populations

A Comparative Summary

of Federal OBRA Regulations and National Association for Home Care Certification Program for Home Health Aides

HCA Cert.

	OBRA-87	National Association for Home Care
Training	Not required if competence is demonstrated.	As of 1991, training comparable to National Homecaring Council's *Model Curriculum* is required.
Hours	Seventy-five hours, at least sixteen of which is supervised practical skills training. Training does not necessarily have to be done with a client, and may be done using a mannequin. It may be done in the classroom or lab setting. At least sixteen hours of classroom training must occur before the practical skills training.	Seventy-five hours, at least sixteen in supervised field practice, and the remainder in a classroom or lab setting. Field practice must be under direct supervision and must be performed during actual service to individuals and families. At least thirty-eight hours of instruction precedes the practical skills training section.
Instructor	Training must be under the general supervision of an RN with at least two years of experience, including at least one year in home care. The general supervision can be in the form of direct training or overall management of the entire program.	An advisory committee should plan and oversee the program and recommend changes to meet the needs of the employees and the community at large. In addition, a coordinator has overall responsibility for the course. The coordinator should be knowledgeable about the home health aide's (HHAs) role and services. To comply with OBRA, the course must be under the general supervision of an RN with at least two years experience, including at least one year in the provision of home care.
Content	• Communication skills. • Observing, reporting, and documenting patient status and care or service given. • Reading and recording temperature, pulse, and respiration. • Basic infection control procedures. • Basic elements of body functioning and changes in body function that must be reported to a supervisor. • Maintenance of a clean, safe, healthy environment. • Recognizing emergencies and knowledge of emergency procedures. • Physical, emotional, and developmental needs of and ways to work with populations served, including the need for respect for the patient, and respect for his or her privacy and property. • Appropriate and safe techniques in personal hygiene and grooming that include bed bath; sponge, tub or shower bath; shampoo in sink, tub, or bath; nail and skin care; oral hygiene; toileting and elimination. • Safe transfer techniques and ambulation. • Normal range of motion and positioning. • Adequate nutrition and fluid intake. • Any other task that the home health agency may choose to have the employee perform.	All areas mentioned in the OBRA training requirements listed at left, plus items listed below in this column. • Orientation to HHA services, including clients' rights. • Understanding and working with various client populations, i.e., children, older clients, clients who are ill, and clients who have disabilities. • Mental health and mental illness. • Understanding of death and dying. • Managing resources in the home. • Understanding of AIDS. • Observations about medications. • Simple procedures such as cold applications, warm applications, weighing a client, caring for clients with colostomies. • Field practice (practicum) of 15 hours in client homes.

REQUIRE 75 HRS OF TRAINING

OBRA-87 National Association for Home Care

Competency Evaluation	Competence must be demonstrated in selected basic skill and knowledge areas.	Competence in the baic skills and knowledge required by home health aides (HHAs) must be demonstrated in two ways:
By Direct Observation (Skills)	HHAs must demonstrate competence in the areas listed below while under the direct observation of an RN who has at least two years of experience, at least one of which was spent in home care. • Reading and recording temperature, pulse and respiration. • Personal hygiene and grooming that include bed bath; sponge, tub, or shower bath; nail and skin care; oral hygiene; and toileting and elimination. • Safe transfer techniques and ambulation. • Normal range of motion and positioning. (Skills must be demonstrated on a human being. A mannequin may not be used.) • No standardized method of documenting performance is offered or required by OBRA.	HHAs must demonstrate competence in all the areas listed in the OBRA-87 competence evaluation requirements (column at left), plus an additional skill listed in this column. This skill must also be done under the direct supervision of an RN with at least two years of experience, at least one of which was spent in home care. • Change linens on an occupied bed. A standardized skills observation checklist is provided for the RN and for the employee's personnel file. The checklist was designed by experts in the home health care and testing fields, and has been field tested.
Competency Evaluation of Basic Knowledge	HHAs must also demonstrate competence in the following areas: • Observation, reporting, and documentation of patient status and care or service given. • Basic infection control procedures. • Basic elements of body functioning and changes in body function that must be reported to the supervisor. • Maintenance of a clean, safe, and healthy environment. • Recognizing emergencies and knowledge of emergency procedures. • Physical, emotional, and developmental needs of and ways to work with populations served, including the need for respect for the patient, the patient's privacy, and property. • Adequate nutrition and fluid intake. • Any other task the home care agency may choose to have the employee perform. Method may be written, oral, or by direct observation.	The HHA must pass a standardized written examination developed by the National Association for Home Care The written examination includes 50 multiple choice questions developed by a national committee with industry input, and it covers all competency areas required by OBRA (see column at left). • A controlled setting is required to ensure examination security. • The exam is based on an appropriate reading level and is non-discriminatory.
Duration	If a HHA has not worked for 24 consecutive months, re-testing of competence is required. Yearly evaluations are required, and HHAs must complete 12 hours of inservice per calendar year. Topics must be appropriate to the job.	If a HHA has not worked for 24 consecutive months, re-testing of competence is required. Yearly evaluations are required, and HHAs must complete 12 hours of inservice per calendar year. Topics must be appropriate to the job.
Outcomes	Minimum compliance with the law will assure HHAs are qualified to provide services to Medicare clients.	Exceeds the requirements of law. In addition to assuring compliance, the program • gives HHAs a national credential and identity. • benefits the consumer by setting a national standard. • benefits the industry by setting a higher and more appropriate standard than is required by law. • is supported by the resources and credibility of the National Association for Home Care. • establishes a national registry of home health aides. • begins the development of a career path for HHAs. • is cost effective. • is federally valid agency to agency and state to state. • avoids the need for retraining and retesting. • establishes a base that can be augmented by specialized training programs.

Home Care University

hereby certifies that

Ima Sample

123-45-6789

has successfully completed 75 hours of training, a written examination and skills demonstration examination, and is thereby deemed competent to work as a Home Health Aide in a Medicare-certified agency, as specified in federal OBRA regulation.

Margaret J. Cushman, Dean and Chief Executive Officer

Val J. Halamandaris, Board Chair

HOMECARE UNIVERSITY

ISSUED BY HOME CARE UNIVERSITY 228 SEVENTH STREET WASHINGTON, DC 20003 202/547-3576
HOME CARE UNIVERSITY IS AN AFFILIATE OF THE NATIONAL ASSOCIATION FOR HOME CARE
NON-TRANSFERRABLE. VOID IF ALTERED

HOMECARE UNIVERSITY

Accreditation Program for Home Care Aide Services

Introduction

The Accreditation Program for home care aide services and private duty nursing services, now under the administration of Home Care University, has a rich and significant history that began when the National Council for Homemaker Services established a set of basic standards in 1965. The Council anticipated rapid growth of homemaker/home health aide services that would be administered under a variety of auspices such as voluntary, public and proprietary. In 1970, the Council developed a process to measure agencies' conformity with the basic standards. Thus the first voluntary accreditation to monitor adherence to basic standards for homemaker/home care aide services was developed.

The following chronology attests to the program's merit as the country's oldest accrediting body for paraprofessional home care services.

1965 - The National Council established a set of standards to accredit agencies.

1969 - The National Council amended the standards.

1970 - The National Council for Homemaker Services began a process to measure agencies' conformity with the standards established by the National Council.

1972 - The first three programs evaluated through review of the self study material were approved.

1976 - In response to requests from the field and to strengthen the credibility of the program, the Council developed the approval process further to include a site visit for programs that wished to apply for accreditation.

1988 - The Council moved to an accreditation-only option. Approval for Companies already in the program remained valid for the remainder of the company's current cycle but each company had to apply for accreditation at the beginning of its next cycle. The Council's Accreditation Program became a part of the Foundation for Hospice and Home Care and was administered through this organization. The Foundation was at that time a non-profit affiliate of the National Association for Home Care.

1994 - The Council began the process of adapting the national standards for Home Care Aide services to private duty nursing services.

1995 - The national standards for Home Care Aide Services were adapted to address the needs of agencies providing extended hourly care by licensed nurses or home care aides to patients in their homes. The new accreditation option for private duty nursing services became available thirty years after the first national standards for home care aide services were developed.

1998 - The accreditation for home care aide services and private duty nursing services became part of the credentialing program of Home Care University, an affiliate of the National Association for Home Care.

Benefits of Accreditation through Home Care University

- The process of completing the detailed self-evaluation provides an excellent management tool and a strategic planning opportunity for your agency.
- The accreditation serves as a symbol of excellence to consumers and can be used in marketing and community education efforts.
- Your voluntary accreditation may be recognized by funding sources and referral sources as an added commitment to quality.
- Your agency will be listed in the *Directory of Accredited Services*, which can be distributed to consumers of home care.
- The annual fee structure is competitive, with NAHC provider members receiving discounted accreditation fee rates.
- Your rate of employee retention may benefit from the improved morale associated with training and working in a quality agency.

Questions and answers concerning steps to accreditation of home care aide services:

Who May Apply?

A company, operating under any auspice, may apply for accreditation of its home care aide services provided it meets the following criteria:

- Has employed home care aides for at least one year,
- Has been in operation for at least one year, and
- Has handled a minimum of twenty-five cases.

How Does a Company Apply?

The company completes an application form and sends it to Home Care University along with one year's fee for accreditation based on the current schedule. The Self Study and other material will be mailed to you in response.

What Happens after the Application is Returned?

When the completed application and fee are returned, Home Care University sends the company two copies of the Self Study and the questionnaires to be completed by the consumers and community agencies. The company completes an analysis of its home care aide services using the Self Study materials. The company requests consumers to complete questionnaires about the home care aide services. The agencies and consumers send the completed questionnaires directly to Home Care University.

When the completed Self Study is returned to Home Care University, it is reviewed by two trained peer reviewers.

Next, a site visit is arranged in order to assess the company's compliance with the home care aide services standards. The site visit for accreditation involves an overview of the entire home care aide services, including visits to clients and interviews with administrative and clinical staff.

The costs of the site visit for an accreditation application are charged to the applicant. Costs are generally for two nights' lodging, meals, and travel for two visitors. Following the site visit, the reviewers submit their reports, which are then reviewed by the Accreditation Commission.

The Accreditation Commission's decision on an application can be: (a) for accreditation, (b) for provisional status, indicating the company has excellent potential for bringing itself into compliance with all the standards and will be given accreditation when it does (this may involve an additional site visit if deemed necessary by the Accreditation Commission), or, (c) for denial of accreditation. In all cases, the Commission makes recommendations to the company.

The company pays an annual fee during its review period and after accreditation.

What Happens After Accreditation?

To maintain its accredited status, a company submits an Interim Report the year following its accreditation, describing changes in the company's operation since the last accreditation. The report also addresses progress made on recommendations from the last accreditation report.

Three years after the initial accreditation, the full process for accreditation with a site visit takes place again.

A company with an accredited program may use the accreditation program logo, display the certificate of accreditation, and be listed in the *Directory of Accredited Services.*

* * * * *

If you have not already initiated the subject of applying for accreditation with your board through the official channels of your company, we suggest you place it on the agenda of your next meeting to prepare the way for your application.

Introduction

Home care is the most rapidly expanding segment of the American health care system. There are now well over 14,000 home care agencies in the country and thousands of less formally organized systems for the delivery of necessary in-home services to the ill and infirm. Slightly more than half of the formally organized agencies (at least 6,200) provide services under Medicare and accordingly are required to meet minimal Federal standards.

Because Federal standards are limited in scope and application and state regulations are similarly limited, the National HomeCaring Council developed the basic standards attached. The National HomeCaring Council was established in 1962 "to promote homemaker services of high quality by standard setting, consultation, and research." The Council quickly gained credibility and, within five years, was cited as the national standard setting body for paraprofessionals in the *Federal Register*.

The standard established by the Council cover all aspects of the operation of a Home Care Aide service. From the beginning, however, these standards have emphasized training and focused on the consumer. For that reason, Standard V. which states it is essential that every Home Care Aide shall have received training for every task they are asked to perform for a client, is considered to be particularly important.

In 1971, the National HomeCaring Council developed an accreditation process to complement and extend the impact of these standards. Five years later, with the assistance of the U.S. Public Health Service, the Council began the process of establishing *A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide*. The curriculum has been the industry standard since it was first published in 1978.

In 1986, the National HomeCaring Council began operating as a division of the Foundation for Hospice and Homecare. In January, 1997 the Foundation merged with the National Association for Home Care (NAHC). NAHC then administered the Home Care Aide Services Accreditation Program, as well as the National Certification Program for Home Care Aides.

In May 1998, NAHC established Home Care University as a new affiliate. The Accreditation for Home Care Aide Services and Private Duty Services are administered by the Credentialing program of Home Care University. Certification for Home Care Aides and the professional certification for Home Care and Hospice Executives are also administered by Home Care University.

For more information, contact the Credentialing program, Home Care University, 228 Seventh Street, SE, Washington, DC 20003. Phone (202) 547-3576 or FAX (202) 547-4322.

Home Care Aide Services Accreditation Program

Interpretation of Standards

Home Care University
228 Seventh Street, SE
Washington, DC 20003

HomeCare University is an affiliate of The National Association for Home Care

I. There shall be a legally-constituted authority responsible for governance and performance.

I-1 The governing authority shall be responsible for the following:

I-2.1 establishing policy;

I-2.2 the ultimate quality of patient care

I-2.2.1 as exercised through the formulation of quality assessment and professional advisory committees, both of which shall include consumer representatives;

I-2.3 delegation of the authority and responsibility for overall agency administration;

I-2.4 assessment and evaluation of community needs and demographic data as they relate to the Home Care Aide program;

I-2.5 establishment and implementation of a conflict of interest policy for board members, staff and volunteers;

I-2.6 overall financial oversight including formal adoption or approval of the annual budget (see Standard III-2.1); and

I-2.7 adherence to its bylaws or comparable documents.

I-3 The agency shall have written bylaws or comparable documents which specify the following:

I-3.1 titles of officers;

I-3.2 number of board members necessary to constitute a quorum;

I-3.3 minimum number of board meetings per year; and

I-3.4 process for amendment.

I-4 The board and its committees are required to have written and signed minutes for all meetings.

II. There shall be compliance with legislation which relates to prohibition of discriminatory practices.

II-1 There shall be no discrimination because of race, color, religion, gender, national origin, age or handicap in the provision of service.

II-2 There shall be no discrimination because of race, color, religion, gender, national origin, age or handicap with respect to terms, conditions or privileges of employment, except as permitted as a bona fide occupational qualification.

III. There shall be responsible fiscal management.

III.1 Assumption of the responsibility for planning and provision of financial support will vary according to the auspices of the agency:

III-1.1 in the *governmental agency*, responsibility is vested with the board of directors and/or the owners;

III-1.2 in the *non-governmental agency*, the final responsibility is vested with the board of directors and/or the owners;

III-1.3 for *non-governmental agencies*, there shall be a committee of the board, charged with general oversight of fiscal matter;

III-1.4 for *non-governmental agencies*, an annual independent audited statement that meets the American Institute of Certified Public Accountants (AICPA) standards is necessary which, not-withstanding any qualifications in the auditor's opinion letter, reflects responsible fiscal management;

III-1.5 for *non-governmental agencies*, there shall be a liaison between the governing body and the agency's independent auditor.

III-2 The agency shall carry out its fiscal planning though the preparation of an annual budget (planned expenditures and expected income) for the service.

III-2.1.1 Each category of expenditure shall be itemized.[1]

III-2.1.2 There shall be a written plan for developing, reviewing, and modifying the budget.

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[1] Price Waterhouse & Company, *Introduction to Financial Management for Homemaker-Home Aide Agencies* (New York: National HomeCaring Council), 1978.

III-2.1.3 Those responsible for administering the Home Care Aide program shall be involved in the development and monitoring of the budget.

III-2.2 Monthly records of revenues and expenditures shall be maintained.

III-2.3 Income and expense reports and balance sheets shall be prepared in accordance with generally accepted accounting principles.

III-3 There shall be long-range financial planning, which includes formulation of alternate plans to facilitate an orderly transition if a major contract or source of funding were lost.

III-4 Each year the agency shall compute the cost of the direct service hour, based on the total dollar expenditure for the service over the preceding fiscal year.[2] This practice enables an agency to review profit and loss for the previous year and establish projections for the current year.

III-5 The agency shall acquire and maintain such insurance as is required by law or necessary to protect against liability claims.

IV. There shall be responsible personnel management including:

A. Recruitment, selection, retention and termination of all personnel; and

B. Written personnel policies, job descriptions and wage scales established for each job category.

Section A

IVA-1 The employment application form and recruitment process shall be consistent with Standard II-2.

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[2] Eugene B. Shinn, *Handbook for Computing the Cost of an Hour of Direct Homemaker-Home Health Aide Service* (New York: National HomeCaring Council), 1984. The handbook gives an excellent method of computing the unit cost. If the agency does not use the handbook to compute cost, it should at least use the following formula: divide total number of in-home service hours by total expenses of the home care Aide Service to get the cost per direct service hour. An in-home or direct service hour is defined as the time a Home Care Aide spends in the home providing direct service to the client and time spent, if specified in the plan of care, on errands on behalf of the client or in transporting clients. *This publication can be obtained from The National Association for Home Care, Accreditation Program, 228 Seventh Street, NE, Washington, DC 20002.*

Home Care aide

IVA-2 Procedures for the selection and employment of all personnel shall include the following:

IVA-2.1 an initial personal interview (or interviews);

IVA-2.2 requirement of and follow up on employment and personal references;

IVA-2.3 a criminal record check, where allowed under state law, and a check of the state Home Care Aide's registry (where applicable);

IVA-2.4 evidence of the applicant's ability to follow instructions and prepare any required written reports;

IVA-2.5 a pre-service health examination to insure that the applicant can meet basic physical demands of the job and that his/her health status does not endanger the client; and

IVA-2.6 a written evaluation at least by the end of the first six months of employment based on the on-the-job evaluations.

IVA-3 The agency shall conduct, whenever possible, an exit interview of any terminating employee(s) in which the reason(s) for separation is (are) discussed; and the agency shall maintain a record of such interview(s) for a period of at least three years.

Section B

IVB-1 Personnel policies shall address the following:

IVB-1.1 hours of employment;

IVB-1.2 benefits;

IVB-1.3 promotion criteria;

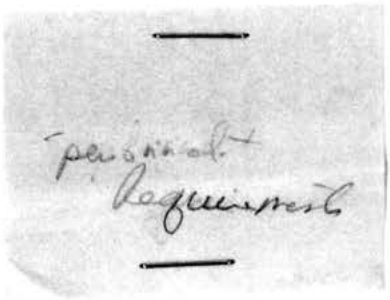
IVB-1.4 evaluation standards;

IVB-1.5 disciplinary procedures;

IVB-1.6 appeal or grievance process;

IVB-1.7 termination of employment;

IVB-1.8 leaves and absences;



IVB-1.9 wage increases;

IVB-1.10 standards for conduct on the job;

IVB-1.11 orientation and training requirements; and

IVB-1.12 substance abuse testing and counseling.

IVB-2 The agency shall have and implement a policy in accordance with state health department requirements which insures that Home Care Aides are free of reportable infectious communicable diseases.

IVB-3 There shall be regular review of the personnel policies and all job descriptions by a committee appointed by the governing authority at least every three years.

IVB-3.1 The review date shall appear on the personnel policies and job descriptions.

IVB-4 There shall be a written wage scale.

IVB-4.1 Wage scale shall be in conformity with applicable minimum wage laws.

IVB-4.2 Each employee shall receive a copy of the wage scale for his/her job category at the time of employment and when it is revised.

IVB-5 Overtime shall be compensated in conformance with applicable laws.

IVB-6 Travel time between job sites shall be treated as compensable time in conformance with applicable laws.

IVB-7 Training required during the period of employment shall be compensated in conformance with applicable laws.

IVB-8 The agency shall assume the employer's responsibility for:

IVB-8.1 social security payments;

IVB-8.2 worker's compensation;

IVB-8.3 unemployment insurance; and for

IVB-8.4 withholding required federal, state, and local taxes.

IVB-9 There shall be a written job description for:

IVB-9.1 each job category for all staff positions which are part of the service;

IVB-9.2 each job category for all volunteer positions which are part of the service.

IVB-10 Job descriptions for each job category shall include:

IVB-10.1 a job title;

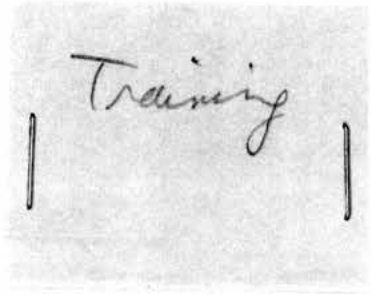
IVB10.2 delineation of job responsibilities;

IVB-10.3 education qualifications;

IVB-10.4 experience requirements;

IVB-10.5 intra-staff reporting relationships; and

IVB-10.6 essential functions of each job in the workplace.



IVB-11 Job descriptions of personnel providing services in the home shall be reviewed at least every three years by a professional advisory committee or other similar committee composed of at least three professional knowledgeable about the job requirements.

IVB-12 All field personnel shall carry documentation that clearly identifies them, by name and job title, as representatives of the agency.

V. Every Home Care Aide shall have received training for each task to be performed for the client.

V-1 Basic generic training, equivalent in content and depth to that listed in V-5, shall consist of classroom and supervised skills training and shall be conducted by qualified instructors, as identified in the *Model Curriculum*.[3]

V-1.1 At least 59 hours of the basic generic training shall be conducted in the classroom and laboratory settings.

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[3] *A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide*, developed by the National HomeCaring Council, published by the Foundation for Hospice and Homecare (Dept. of Health and Human Services Publication No. HAS 80-5508). This manual or one with similar content shall be used.

V-2 A Home Care Aide 1 trainee shall have received 16 hours of basic generic training before providing any service in the home and an additional 24 hours within the first six months of employment. The content of the first 16 hours shall be selected from content areas I, II (A&B), III (A&D), IV (G) listed in Standard V-5, and shall include ethics, confidentiality in patient care, and universal precautions. The additional 24 hours shall include Units C, D, E, F, G, and H from Section II, Units B & C (except modified diets) from Section III and 2.5 hours of practicum.

V-3 A Home Care Aide II trainee shall have completed 40 hours of basic generic training before providing personal care and an additional 20 hours of training within the first six months of assignment include information on modified diets from Unit B, Section IV, and 2.5 hours of practicum as listed under Standard V-5.

V-4 All Home Care Aide II and III trainees shall have received a minimum of 60 hours of basic generic training by the end of the first six months of employment, and no Home Care Aide shall be given an assignment for which adequate training has not been provided. Seventy-five hours of basic generic training shall be provided to Home Care Aides providing medically directed care (Home Care Aide III). The additional fifteen hours must be given within the first six months of assignment as a Home Care Aide III and should include Units E, F, & G from Section IV and Section V.

V-5 A variety of instructional methods shall be used in the generic training. Methods shall include lecture, class discussion, demonstrations and return demonstrations. Content [4]shall include but is not limited to the following:

I. *Orientation to Home Care Aide Services*
   - A. Why Home Care Aide Services?
   - B. Role of the Home Care Aide
   - C. How Agencies Makes Services Available to Clients & Families

II. *Understanding and Working With Various Client Populations*
   - A. Communication
   - B. Understanding Basic Human Needs
   - C. Understanding & Working with Children
   - D. Understanding & Working with Older Clients
   - E. Understanding & Working with Clients who are Ill
   - F. Understanding & Working with Clients with Disabilities
   - G. Mental Health & Mental Illness
   - H. Understanding Dying & Death

[4] The content listed is taken from the *Model Curriculum* Table of Contents.

III. *Practical Knowledge and Skill in Home Management*

A. Maintaining a Clean, Safe & Healthy Environment
B. Food & Nutrition
C. Managing Time, Energy, Money & Other Resources
D. Home Maintenance when Disease is Present (Infectious Disease & Infection Control)

IV. *Practical knowledge and Skills in Personal Care*

A. Body Systems, Disorders & Diseases
B. Observing Body Functions
C. Care of the Client in Bed
D. Care of Client Not Confined to Bed
E. Observations About Medications
F. Rehabilitation
G. Health & Emergency Procedures

V. Practicum

V-6 There shall be an evaluation through an examination and demonstration of the competence of the persons who have completed the basic training course.

V-7 There shall be a regularly scheduled program of ongoing in-service training for Home Care Aides to build upon the basic generic training.

V-7.1 Each Home Care Aide I shall complete six hours of in-service training annually; each Home Care Aide II shall complete 10 hours if in-service training annually; and each Home Care Aide III shall complete 12 hours of in-service training annually, preferably at intervals.

V-8 A Home Care Aide placed in a case needing specialized care, which is not covered in the basic generic training shall receive specialized training. Specialized care cases may include those which require high tech, hospice, or protective services for children and adults, or those in which the client has AIDS, Alzheimer's Disease, mental retardation, developmental disabilities or is a high-risk infant. The training shall be appropriate to the case and to the paraprofessional level. Persons regularly assigned to specialized care cases shall receive training as defined by specialized curricula developed or approved by the Home Care University.

V-9 Home Care Aides may be exempted from specific areas of basic generic training provided they have written documentation to show training equivalent in content and depth to that in *A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide*. The written documentation shall include a course outline, number of hours of training, qualifications of the

instructor(s) of the training, and a record of the Home Care Aide's attendance. However, it is required that:

V-9.1 competence shall be provided through examination and demonstration documented by the agency and placed in the personnel file; and

V-9.2 an orientation to the agency shall be provided, which shall include ethics, legal requirements, confidentiality in patient care, and universal precautions.

V-10 If a certificate is issued to the Home Care Aide upon completion of the basic generic training, it shall state that the person is qualified to work in an agency as a Home Care Aide under professional supervision. The date of certification shall be recorded and a copy of the certificate shall be placed in the personnel file.

V-11 All requirements of this standard shall be clearly documented for each Home Care Aide and placed in the personnel file.

VI. There shall be written eligibility criteria for service and written procedures for referral to other resources.

VI-1 Criteria of eligibility for the service shall be stated clearly, including reference to such factors as:

VI-1.1 age groups (if applicable based on funding requirements);

VI-1.2 geographical area;

VI-1.3 income (if applicable based on funding requirements);

VI-1.4 hours of service (including policy about 8 to 24-hour service and weekend service);

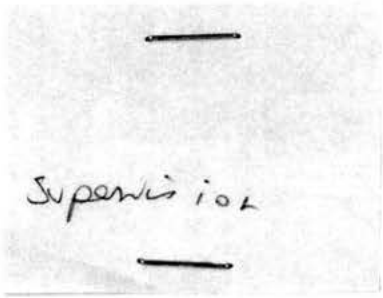
VI-1.5 social and health needs;

VI-1.6 crisis or emergency services;

VI-1.7 referral sources; and

VI-1.8 funding sources.

VI-2 Eligibility criteria which apply to the service shall be available to:



VI-2.1 individuals applying for the service;

VI-2.2 community professionals; and

VI-2.3 organizations.

VI-3 Criteria shall be developed and provided in writing to staff of the agency, enabling staff to determine the priority with which individuals and/or families shall be served when the service available cannot meet the total immediate demand.

VI-4 The agency is responsible for assisting persons who are ineligible or who become ineligible for the services(s) to obtain needed services, if available, in their community.

VII. There shall be supervision of the Home Care Aide service which shall ensure safe, effective, and appropriate care to each individual or family served.

VII-1 The individual providing supervision shall have at least a bachelor's (or higher level) degree in social work, home economics, or a related human services field, or in a rehabilitation therapy discipline and/or be licensed as a registered nurse or social worker.

VII-2 If the personal care tasks to be performed by the Home Care Aide are physician-ordered and part of a medical plan, the in-home supervisor shall occur at least every two months, and more often if the client's condition warrants.

VII-3 An initial assessment by a qualified professional shall be done in the home prior to the beginning of service.

VII-3.1 The initial assessment of the needs of the client for specific home care assistance shall include:

VII-3.1.1 discussion with the client and family or significant others;

VII-3.1.2 observation of the client and the home environment; and

VII-3.1.3 consultation with the client's physician, other agencies and/or professionals involved with the client, as indicated to achieve a full understanding of the client's physical, emotional and environmental problems.

VII-4 On the basis of the above assessment, a written plan of care shall be prepared which shall include:

VII-4.1 outcome goals;

VII-4.2 the specific tasks to be performed by the Home Care Aide;

VII-4.3 the frequency and probable duration of the Home Care Aide assistance;

VII-4.4 the frequency and method of supervision, if it is an exception to agency policy;

VII-4.5 plans for utilization of other needed services provided by the agency or by other community resources; and

VII-4.6 signature of client or client representative.

VII-5 The supervision shall include reassessment by a qualified professional of the needs of the client through home visits and revisions of the plan of care to meet the changing conditions of the client. The frequency of reassessment visits shall be reflective of the needs of the client but shall be at least every three months.

VII-5.1 When reassessment indicates termination of service, there shall be discussions to prepare the client for termination and referrals to continuing supportive services shall be made if needed.

VII-5.2 Telephone or personal contact with the client shall take place at least monthly and shall be documented by the supervisor or a designated representative.

VII-6 A record shall be kept on each client which shall include:

VII-6.1 the initial assessment and all reassessments, which shall include descriptions of the physical, mental, social, and environmental conditions of the client;

VII-6.2 all required physician orders and diagnoses;

VII-6.3 information from other professionals and agencies involved;

VII-6.4 plans of care including termination of service;

VII-6.5 observations and report from Home Care Aides of care given on each visit;

VII-6.6 documentation of conformance with clients' rights procedure; and

VII-6.7 referrals for other services.

VII-7 The supervision shall include observation, evaluation and support of the Home Care Aide through home visits, phone contacts and office interviews.

VII-7.1 The first home visit with the Home Care Aide shall occur within the first two weeks of service in order to ensure that the Home Care Aide understands all tasks to be performed, including emotional support to the client, and is capable of performing these tasks.

VII-7.2 Telephone or personal contacts with the Home Care Aide shall be at least monthly, and shall be documented by the supervisor.

VII-7.3 For the purpose of supervision, the Home Care Aide shall be observed in at least one home at least every two months.

VII-7.4 The supervisor or another professional shall be available for consultation or emergency help at all time during the placement of the Home Care Aide.

VII-7.5 The supervisor's observations of the Home Care Aide's performance, need for additional training, and readiness to accept additional responsibilities shall be documented. These ongoing reports shall be the basis for a formal annual written evaluation, which should be discussed directly with and signed by the Home Care Aide. The Home Care Aide's comments, identification of problems, and preferences for future work should also be included.

VII-8 If supervision is coming from more than one source there shall be a written plan for a documentation of coordination.[5]

VII-8.1 When there is supervision from two agencies, criteria for supervision shall be in writing.

VII-9 Assessment, reassessment, plan of care, supervision of personal care, and termination of a case may not be delegated; they shall be provided by a qualified professional as cited in Standard VII-1. Some supervisory functions may be delegated to a field counselor, an experienced Home Care Aide III, a licensed

[5] In current home care practice, the tasks involved in assessment and supervision of the client (case management) and supervision of the Home Care Aide (service management) may be divided between two professionals or even two agencies. All of the above requirements for supervision should be met regardless of the pattern of service delivery.

practical nurse, or a person with an Associate of Arts (or higher degree) in a human services or other closely related field.

VII-9.1 Supervision of non-medically-related personal care may be delegated to a licensed practical nurse.

VIII. There shall be evaluation of all aspects of the service.

VIII-1 The Home Care Aide service shall be evaluated yearly in relation to:

VIII-1.1 the agency's purpose; and

VIII-1.2 community needs.

VIII-2 An outcome of the evaluation shall be written short and long-term goals.

VIII-3 An in-depth self-study shall be undertaken at least every three years.

VIII-3.1 All levels of staff and board members shall be involved in the evaluation process.

VIII-3.2 Input from consumers who have recently used or are using the service shall also be obtained during the in-depth study.

VIII-3.3 There shall be an ongoing channel for expression of satisfaction or dissatisfaction with the service by each user of the service. A summary of the results shall be included in the evaluation.

VIII-3.4 A review or summary of formal client grievances shall be a part of the evaluation.

IX. There shall be ongoing interpretation of the service to the community.

IX-1 The availability, scope and purpose of the service shall be interpreted to the community through the use of:

IX-1.1 the distribution of written materials;

IX-1.2 local information and referral service and at least two of the following:

IX-1.2.1 participation in community meetings;

IX-1.2.2 other pertinent avenues of interpretation and communication (newspaper articles, yellow pages, public service announcements, etc.); and

IX-1.2.3 an annual report of the agency, including a report on the service, prepared and made available to the community.

IX-2 An annual report shall include the following:

IX-2.1 statistics on services rendered;

IX-2.2 a summary of program information; and

IX-2.3 at a minimum, a statement that reads "an audit for the year of ____ has been performed by _____in accordance with generally accepted accounting principles."

X. There shall be a written statement of clients' rights and clear evidence that it is fully implemented.

X-1 The clients' rights statement shall include rights to the following:

X-1.1 receive considerate and respectful care in the home at all times, and have property treated with respect;

X-1.2 participate in the development of the plan of care, and receive an explanation of any services proposed and of any alternative services that may be available (see Standard VII);

X-1.3 receive a copy of the plan of care as defined in Standard VII-4;

X-1.4 receive the name of the supervisor and the agency phone number;

X-1.5 refuse medication and treatment, counseling, or other service without fear of reprisal or discrimination;

X-1.6 be fully informed of the consequences of all aspects of care, unless medically contraindicated, including the possible results of refusal of medical treatment, counseling or other services;

X-1.7 privacy and confidentiality about one's health, social and financial circumstances and about what takes place in the home;

X-1.8 know that all communications and records will be treated confidentially;

X-1.9 expect that all home care personnel, within the limits set by the plan of care, will respond in good faith to the client's requests for assistance in the home;

X-1.10 receive information on the agency's policies and procedures including information charges, qualifications and supervision of personnel, and on discontinuation of service;

X-1.11 request a change of caregiver;

X-1.12 participate in the plan for discontinuation of service;

X-1.13 have access, upon request, to all bills for service regardless of whether they are paid for out-of-pocket or through other sources of payment;

X-1.14 receive regular supervision of the Home Care Aide, and if medically related personal care is needed, the supervision shall be performed by a registered nurse;

X-1.15 receive a clear explanation of which services and equipment provided by the agency are covered by third-party reimbursement and which will be paid for by the client, and of the charges which will be incurred;

X-1.16 receive a clear explanation of the process for voicing grievances about care, treatment, or discontinuation of service;

X-1.17 appeal agency decisions regarding care, following grievance procedures;

X-1.18 know that the agency maintains liability insurance coverage;

X-1.19 be given in writing the name and contact number of an official or owner of the agency and the state home health hotline or ombudsman number, if such a service exists; and

X-1.20 receive the services of a translator, if needed.

X-2 The following shall constitute evidence of implementation of clients' right procedures:

X-2.1 documents that show that the governing board has adopted a statement of clients' rights and grievance procedures;

X-2.2 the agency's written clients' rights statement;

X-2.3 distribution of a copy of the clients' rights statement to each client;

X-2.4 documentation that each client has received a written copy of the clients' rights statement;

X-2.5 the agency's written grievance procedure which shall include:

X-2.5.1 delineation of the steps in the procedure;

X-2.5.2 time lines for response from the agency and appeal by the client to the next step;

X-2.5.3 procedure for appeal beyond the supervisory level of direct service staff; and

X-2.5.4 assignment of final responsibility for internal resolution of grievance to the governing authority of the agency.

X-2.6 provision of clear explanation to clients about which services and equipment provided by the agency are covered by third-party reimbursement and which will be paid for by the client, and about the charges which will be incurred; and

X-2.7 written notification to the client of the state home health hotline or ombudsman number, if such a service exists.

XI. There shall be a written policy and procedure of responsible safety management in the care environment:

A. To insure the well-being of the patient ;
B. To insure the well-being of the caregiver(s); and
C. To be prepared in cases of emergencies in the home.

XI-1 The safety management policy shall include and address the following areas:

XI-1.1 patient safety;

XI-1.2 caregiver safety (in, around, to and from the worksite);

XI-1.3 violence in the workplace;

XI-1.4 accident prevention in the home/worksite;

XI-1.5 hazardous materials (i.e. household cleaners, pesticides);

XI-1.6 fire safety;

XI-1.7 safety regarding the use of any medial equipment; and

XI-1.8 infection control (OSHA standards).

Section A

XIA-1 The agency shall have a written case assessment policy that identifies safety concerns in the care environment.

XIA-2 The plan of care shall address the safety issues that have been identified in the care environment.

XIA-3 The agency shall maintain an ongoing system for reporting and reviewing accidents in the care environment.

Section B

XIB-1 The Home Care Aide pre-service training shall include a component on safety in the care environment.

XIB-2 The agency shall conduct at least one in-service meeting on safety annually.

XIB-3 The agency shall have a patient education component of the safety program.

Section C

XIC-1The agency shall have policies and procedures to deal with emergencies in the home.

Home Care University
Accreditation Program
For Home Care Aides
1999 Fee Schedule

Total Home Care Aide Salaries for 1998	**NAHC Member Annual Fee**	**Non-Member Annual Fee**
Group 1: Over $3,000,000	$3,000	$4,500
Group 2: $1,000,000-$3,000,000	$2,500	$3,750
Group 3: $500,000-$999,999	$2,000	$3,000
Group 4: $300,000-$499,999	$1,500	$2,250
Group 5: Under $300,000	$900	$1,200

- The application fee is non-refundable. Checks should be made payable to Home Care University, and should be mailed to Home Care University Accreditation Program, 228 Seventh Street, SE, Washington, DC 20003-4306.

- The accreditation cycle is three years. There is an interim report filed mid-cycle. The accreditation fee is paid in annual installments commencing with the date of application.

- The above fees exclude actual site-visitation costs of the peer reviewers (travel and lodging for two peer reviewers).

Note: New Jersey agencies have an additional site visitation cost for (1) reviewer for the annual Medicaid site visit.

Please record the following:

The agency's gross Home Care Aide Salaries for 1998 $ _____
Annual Fee (see chart above) $ _____
Annual Fee Enclosed $ _____

_____
Name and Title of Executive Director, or Individual Accepting Accreditation Information

_____
Signature Date

_____
Name of Agency

_____
Street Address

_____
City State Zip

Home Care University
APPLICATION FOR ACCREDITATION
Home Care Aide Services

Type or Print Name of Agency

Street Address

City State Zip

Telephone Number Fax Number

Has employed home care aides for at least one year and believes itself ready to apply for accreditation by Home Care University.

Full name of Executive Director or authorized official signing for the agency

Title

Signature

Date

Please type or print the name and title of person receiving materials, if different from above.

Name

Title

Home Care Aide Services Accreditation Program
Home Care University
228 Seventh Street, SE
Washington, DC 20003

HOMECARE UNIVERSITY

Accreditation Program for Private Duty Nursing and Home Care Aide Services

Introduction

The Accreditation Program for private duty nursing services and home care aide services, now under the administration of Home Care University, has a rich and significant history that began when the National Council for Homemaker Services established a set of basic standards in 1965. The Council anticipated rapid growth of homemaker/home health aide services that would be administered under a variety of auspices such as voluntary, public and proprietary. In 1970, the Council developed a process to measure agencies' conformity with the basic standards. Thus the first voluntary accreditation to monitor adherence to basic standards for homemaker/home care aide services was developed.

The following chronology attests to the program's merit as the country's oldest accrediting body for paraprofessional home care services.

1965 - The National Council established a set of standards to accredit agencies.

1969 - The National Council amended the standards.

1970 - The National Council for Homemaker Services began a process to measure agencies' conformity with the standards established by the National Council.

1972 - The first three programs evaluated through review of the self study material were approved.

1976 - In response to requests from the field and to strengthen the credibility of the program, the Council developed the approval process further to include a site visit for programs that wished to apply for accreditation.

1988 - The Council moved to an accreditation-only option. Approval for Companies already in the program remained valid for the remainder of the company's current cycle but each company had to apply for accreditation at the beginning of its next cycle. The Council's Accreditation Program became a part of the Foundation for Hospice and Home Care and was administered through this organization. The Foundation was at that time a non-profit affiliate of the National Association for Home Care.

1994 - The Council began the process of adapting the national standards for Home Care Aide services to private duty nursing services.

1995 - The national standards for Home Care Aide Services were adapted to address the needs of agencies providing extended hourly care by licensed nurses or home care aides to patients in their

homes. The new accreditation option for private duty nursing services became available thirty years after the first national standards for home care aide services were developed.

1998 - The accreditation for home care aide services and private duty nursing services became part of the credentialing program of Home Care University, an affiliate of the National Association for Home Care.

Benefits of Accreditation through Home Care University

- The process of completing the detailed self-evaluation provides an excellent management tool and a strategic planning opportunity for your agency.
- The accreditation serves as a symbol of excellence to consumers and can be used in marketing and community education efforts.
- Your voluntary accreditation may be recognized by funding sources and referral sources as an added commitment to quality.
- Your agency will be listed in the *Directory of Accredited Services*, which can be distributed to consumers of home care.
- The annual fee structure is competitive, with NAHC provider members receiving discounted accreditation fee rates.
- Your rate of employee retention may benefit from the improved morale associated with training and working in a quality agency.

Questions and answers concerning steps to accreditation of private duty nursing services:

Who May Apply?

A company, operating under any auspice, may apply for accreditation of its private duty nursing services provided it meets the following criteria:

- Has employed private duty nursing personnel for at least one year,
- Has been in operation for at least one year,
- Has at least two current private duty nursing cases,
- Has employed qualified professional personnel who assess client need and establish a plan of care for at least half of the caseload of individuals and families served, and
- Provides private duty nursing to beneficiaries within a fifty-mile radius of the company.

How Does a Company Apply?

The company completes an application form and sends it to Home Care University along with one year's fee for accreditation based on the current schedule. The Self Study and other material will be mailed to you in response.

What Happens after the Application is Returned?

When the completed application and fee are returned, Home Care University sends the company two copies of the Self Study and the questionnaires to be completed by the consumers and community agencies.

The company completes an analysis of its private duty nursing services using the Self Study materials. The company requests consumers to complete questionnaires about the private duty nursing services. The agencies and consumers send the completed questionnaires directly to Home Care University.

When the completed Self Study is returned to Home Care University, it is reviewed by two trained peer reviewers.

Next, a site visit is arranged in order to assess the company's compliance with the private duty nursing services standards. The site visit for accreditation involves an overview of the entire private duty nursing services, including visits to clients and interviews with administrative and clinical staff.

The costs of the site visit for an accreditation application are charged to the applicant. Costs are generally for two nights' lodging, meals, and travel for two visitors. Following the site visit, the reviewers submit their reports, which are then reviewed by the Accreditation Commission.

The Accreditation Commission's decision on an application can be: (a) for accreditation, (b) for provisional status, indicating the company has excellent potential for bringing itself into compliance with all the standards and will be given accreditation when it does (this may involve an additional site visit if deemed necessary by the Accreditation Commission), or, (c) for denial of accreditation. In all cases, the Commission makes recommendations to the company.

The company pays an annual fee during its review period and after accreditation.

What Happens After Accreditation?

To maintain its accredited status, a company submits an Interim Report the year following its accreditation, describing changes in the company's operation since the last accreditation. The report also addresses progress made on recommendations from the last accreditation report.

Three years after the initial accreditation, the full process for accreditation with a site visit takes place again.

A company with an accredited program may use the accreditation program logo, display the certificate of accreditation, and be listed in the *Directory of Accredited Services*.

* * * * *

If you have not already initiated the subject of applying for accreditation with your board through the official channels of your company, we suggest you place it on the agenda of your next meeting to prepare the way for your application.

Private Duty Nursing Interpretation of Standards

Home Care University
228 Seventh Street, SE
Washington, DC 20003

Home Care University is an affiliate of The National Association for Home Care

Accreditation Program for Home Care Aide and Private Duty Nursing Services

Introduction

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Benefits of Private Duty Nursing Service Accreditation through Home Care University

- The process of completing the detailed self-evaluation provides an excellent management tool and a strategic planning opportunity for your agency.
- The accreditation serves as a symbol of excellence to consumers and can be used in marketing and community education efforts.
- Your voluntary accreditation may be recognized by funding sources and referral sources as an added commitment to quality.
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- Has been in operation for at least one year,
- Has at least two current private duty nursing cases,
- Has employed qualified professional personnel who assess client need and establish a plan of care for at least half of the individuals and/or families served. The remainder may be accomplished through contract, and
- Provides private duty nursing services to beneficiaries within a fifty-mile radius of the company.

How Does a Company Apply?

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When the completed Self Study is returned to Home Care University, it is reviewed by two trained peer reviewers, one of whom is an RN.

Next, a site visit is arranged in order to assess the company's compliance with the Private Duty Nursing Standards. The site visit for accreditation involves an overview of the entire private duty nursing service, including visits to clients and interviews with administrative and clinical staff.

The costs of the site visit for an accreditation application are charged to the applicant. Costs are generally for two nights' lodging, meals, and travel for two visitors. Following the site visit, the reviewers submit their reports, which are then reviewed by the Accreditation Commission.

The Accreditation Commission's decision on an application can be: (a) for accreditation, (b) for provisional status, indicating the company has excellent potential for bringing itself into compliance with all the standards and will be given accreditation when it does (this may involve an additional site visit if deemed necessary by the Accreditation Commission), or, (c) for denial of accreditation. In all cases, the Commission makes recommendations to the company.

The company pays an annual fee during its review period and after accreditation.

What Happens After Accreditation?

To maintain its accredited status, a company submits an Interim Report the year following its accreditation, describing changes in the company's operation since the last accreditation. The report also addresses progress made on recommendations from the last accreditation report.

Three years after the initial accreditation, the full process for accreditation with a site visit takes place again.

A company with an accredited program may use the accreditation program logo, display the certificate of accreditation, and be listed in the *Directory of Accredited Services*.

* * * * *

If you have not already initiated the subject of applying for accreditation with your board through the official channels of your company, we suggest you place it on the agenda of your next meeting to prepare the way for your application.

ACCREDITATION STANDARDS FOR PRIVATE DUTY NURSING SERVICES

I. There shall be a legally-constituted authority responsible for governance and performance.

I-1 The company shall have the necessary legal authority to operate.

I-2 The governing authority shall be responsible for the following:

I-2.1 establishing policy;

I-2.2 the ultimate quality of patient care:

I-2.2.1 as exercised through the formulation of quality assessment and professional advisory committees, both of which shall include consumer representatives;

I-2.3 delegation of the authority and responsibility for overall company administration;

I-2.4 assessment and evaluation of community needs and demographic data as they relate to the private duty nursing program;

I-2.5 establishment and implementation of a conflict of interest policy for board members, staff and volunteers;

I-2.6 overall financial oversight including formal adoption or approval of the annual budget (see Standard III-2.1); and

I-2.7 adherence to its bylaws or comparable documents.

I-3 The company shall have written bylaws or comparable documents which specify the following:

I-3.1 titles of officers;

I-3.2 number of board members necessary to constitute a quorum;

I-3.3 minimum number of board meetings per year; and

I-3.4 process for amendment.

I-4 The board and its committees are required to have written and signed minutes for all meetings.

II. There shall be compliance with legislation, which relates to prohibition of discriminatory practices.

II-1 There shall be no discrimination because of race, color, religion, gender, national origin, age or handicap in the provision of service.

II-2 There shall be no discrimination because of race, color, religion, gender, national origin, age or handicap with respect to terms, conditions or privileges of employment, except as permitted as a bona fide occupational qualification.

III. There shall be responsible fiscal management.

III.1 Assumption of the responsibility for planning and provision of financial support will vary according to the auspices of the company:

III-1.1 in the *governmental company*, responsibility is vested in the appropriate legislative body;

III-1.2 in the *non-governmental company*, the final responsibility is vested with the board of directors and/or the owners;

III-1.3 for *non-governmental agencies*, there shall be a committee of the board, charged with general oversight of fiscal matter;

III-1.4 for *non-governmental agencies*, an annual independent audited statement that meets the American Institute of Certified Public Accountants (AICPA) standards is necessary which, not-withstanding any qualifications in the auditor's opinion letter, reflects responsible fiscal management;

III-1.5 for *non-governmental agencies*, there shall be a liaison between the governing body and the company's independent auditor.

III-2 Adequate financial records shall be maintained.

III-2.1 The company shall carry out its fiscal planning through the preparation of an annual budget (planned expenditures and expected income) for the service.

III-2.1.1 Each category of expenditure shall be itemized.

III-2.1.2 There shall be a written plan for developing, reviewing, and modifying the budget.

Private Duty

III 2.1.3 Those responsible for administering the Private Duty Nursing program shall be involved in the development and monitoring of the budget.

III-2.2 Monthly records of revenues and expenditures shall be maintained.

III-2.3 Income and expense reports and balance sheets shall be prepared in accordance with generally accepted accounting principles.

III-3 The company shall acquire and maintain such insurance as is required by law or necessary to protect against liability claims.

IV. There shall be responsible personnel management including:

A. Recruitment, selection, retention and termination of all personnel; and

B. Written personnel policies, job descriptions and wage scales established for each job category.

Section A

IVA-1 The employment application form and recruitment process shall be consistent with Standard II-2.

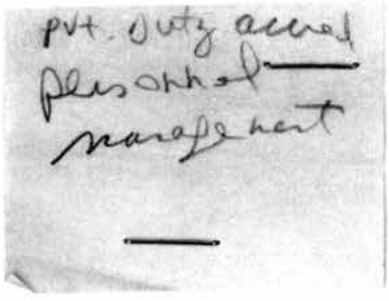
IVA-2 Procedures for the selection and employment of all personnel shall include the following:

IVA-2.1 an initial personal interview (or interviews);

IVA-2.2 requirement of and follow up on employment and personal references;

IVA-2.3 a criminal record check, where allowed under state law, and a check of the state Nursing Registry (where applicable);

IVA-2.4 proof of a post-offer, pre-service health examination to insure that the applicant can meet basic physical demands of the job and that his/her health status does not endanger the client;



IVA-2.5 proof of a written evaluation at least by the end of the first six months of employment based on the on-the-job evaluations; and

IVA-2.6 a requirement for validation and documentation of current nursing license.

IVA-3 The company shall conduct, whenever possible, an exit interview of any terminating employee(s) in which the reason(s) for separation is (are) discussed; and the company shall maintain a record of such interview(s) for a period of at least three years.

IVA.4 The administrator of the nursing program shall possess the qualifications required by appropriate state law.

IVA.5 The nursing service supervisor shall be a registered professional nurse, with one year of home care experience and progressive responsibility in nursing.

IVA.6 Each private duty nurse shall meet the state requirement for continuing education or have a minimum of eight hours training annually.

Section B

IVB-1 Personnel policies shall address the following:

IVB-1.1 hours of employment;

IVB-1.2 benefits;

IVB-1.3 promotion criteria;

IVB-1.4 evaluation standards;

IVB-1.5 disciplinary procedures;

IVB-1.6 appeal or grievance process;

IVB-1.7 termination of employment;

IVB-1.8 leaves and absences;

IVB-1.9 wage increases;

IVB-1.10 standards for conduct on the job;

IVB-1.11 orientation and training requirements; and

IVB-1.12 substance abuse testing and counseling.

IVB-2 The company shall have and implement a policy in accordance with state health department requirements which insures that home care workers are free of reportable infectious communicable diseases.

IVB-3 There shall be regular review of the personnel policies and all job descriptions by a committee appointed by the governing authority at least every three years.

IVB-3.1 The review date shall appear on the personnel policies and job descriptions.

IVB-4 There shall be a written pay scale.

IVB-4.1 Wage scale shall be in conformity with applicable minimum wage laws and hour laws.

IVB-4.2 Each employee shall receive a copy of the pay scale for his/her job category at the time of employment and when it is revised.

IVB-5 Overtime shall be compensated in conformance with applicable laws.

IVB-6 The company shall assume the employer's responsibility for:

IVB-6.1 social security payments;

IVB 6-2 worker's compensation;

IVB 6.3 unemployment insurance; and for

IVB 6.4 withholding required federal, state, and local taxes.

IVB-7 There shall be a written job description for each job category for all staff positions, which are part of the service.

IVB-8 Job descriptions for each job category shall include:

IVB-8.1 a job title;

IVB-8.2 delineation of job essential duties;

IVB-8.3 educational qualifications;

IVB-8.4 experience requirements;

IVB 8.5 intra-staff reporting relationships; and

IVB 8.6 essential functions of each job in the workplace.

IVB-9 Job descriptions of personnel providing services in the home shall be reviewed at least every three years by a professional advisory committee or other similar committee composed of at least three professionals knowledgeable about the job requirements.

IVB-10 All field personnel shall carry documentation that clearly identifies them, by name and job title, as representatives of the company.

V. There shall be professional case management services for all individuals and families served.

V-1 All clients receiving skilled care shall be under medical supervision.

V-2 The individual providing case management shall be a registered professional nurse.

V-3 An initial assessment by a qualified RN professional shall be done in the home prior to the beginning of service.

V-3.1 The initial assessment of the needs of the client for specific home care assistance shall include:

V-3.1.1 discussion with the client and family significant others;

V-3.1.2 observation of the client in the home environment;

V-3.1.3 consultation with the client's physician, other agencies and/or professionals involved with the client, as indicated, to achieve a full understanding of the client's physical, emotional and environmental problems; and

V-3.1.4 a physician's prescribed plan of treatment.

V-4 On the basis of the initial assessment, a written nursing plan of care shall be prepared, which shall include:

V-4.1 outcome goals;

V-4.2 the specific tasks to be performed by the nurse;

V-4.3 the frequency and probable duration of the nursing assistance;

V-4.4 the frequency and method of supervision, if it is an exception to company policy (see Standard VII-2);

V-4.5 plans for utilization of other needed services provided by the company or by other community resources; and

V-4.6 signature of client or client representative.

V-5 The supervision shall include reassessment of the needs of the client through home visits and revisions of the plan of care to meet the changing conditions of the client. The frequency of reassessment visits shall be reflective of the needs of the client but shall be at least every three months.

V-5.1 When reassessment indicates termination of service, there shall be discussions to prepare the client for termination, and referrals to continuing supportive services shall be made, if needed.

V-5.2 Someone other than the home care nurse should discuss the service with the client or a family member at times other than the reassessment home visit to determine that ongoing service is satisfactory.

V-6 A comprehensive record shall be kept on each client, and this record shall include together:

V-6.1 the initial assessment and all reassessments, which shall include descriptions of the physical, mental, social and environmental conditions of the client;

V-6.2 all required physician orders and diagnoses;

V-6.3 information from other professional and agencies involved;

V-6.4 nursing plans of care, including termination of service;

V-6.5 observations and reports from nurses of care given on each visit;

V-6.6 documentation of conformance with clients' rights procedure;

V-6.7 documentation of informed consent;

V-6.8 referrals for other services;

V-6.9 documentation of compliance with federal regulations requiring health care providers to discuss advance directives with clients; and

V-6.10 medication administration documentation.

VI. There shall be written eligibility criteria for service and written procedures for referral to other resources.

VI-1 Criteria of eligibility for the service shall be stated clearly, including reference to such factors as:

VI-1.1 age groups (if applicable based on funding requirements);

VI-1.2 geographical area;

VI-1.3 income (if applicable based on funding requirements);

VI-1.4 hours of service (including policy about 8 to 24-hour service and weekend service);

VI-1.5 social and health needs;

VI-1.6 crisis or emergency services;

VI-1.7 referral sources; and

VI-1.8 funding sources.

VI-2 Eligibility criteria which apply to the service shall be available to:

VI-2.1 individuals applying for the service;

VI-2.2 community professionals; and

VI-2.3 organizations.

VI-3 Criteria shall be developed and provided in writing to staff of the company, enabling staff to determine the priority with which individuals and/or families shall be served when the service available cannot meet the total immediate demand.

VI-4 The company is responsible for assisting persons who are ineligible or who become ineligible for the services(s) to obtain needed services, if available, in their community.

VII. There shall be professional registered nurse supervision to ensure safe, effective, and appropriate care to each individual or family served.

VII-1 There shall be frequent supervision of newly hired nursing personnel who have one year's experience, on initial assignments at least once every two weeks during the first two months of employment.

VII-2 There shall be RN supervision of nursing personnel in the client's home at least every 30 days.

VII-3 The nursing supervisor shall do initial and annual performance reviews of nursing personnel. The review should be signed and dated by the supervisor and the employee.

VIII. There shall be evaluation of all aspects of the service.

VIII-1 The service shall be evaluated yearly in relation to:

VIII-1.1 the quality of care;

VIII-1.2 patient satisfaction;

VIII-1.3 effective administration; and

VIII-1.4 compliance with regulatory standards.

VIII-2 An in-depth self-study shall be undertaken at least every three years.

VIII-2.1 all levels of staff and board members shall be involved in the evaluation process.

VIII-2.2 input from consumers who have recently used or are using the service shall also be obtained during the in-depth study.

VIII-2.3 there shall be an ongoing channel for expression of satisfaction or dissatisfaction with the service by each user of the service. A summary of the results shall be included in the evaluation.

VIII-2.4 a review or summary of formal client grievances shall be a part of the evaluation.

VIII-3 The company shall have a policy for measuring clinical outcomes.

IX. There shall be ongoing interpretation of the service to the community.

IX-1 The availability, scope and purpose of the service shall be interpreted to the community through the use of:

IX-1.1 the distribution of written materials;

IX-1.2 local information and referral service and at least two of the following:

IX-1.2.1 participation in community meetings;

IX-1.2.2 other pertinent avenues of interpretation and communication (newspaper articles, yellow pages, public service announcements, etc.); and

IX-1.2.3 an annual report of the company, including a report on the service, prepared and made available to the community.

IX-2 An annual report shall include the following:

IX-2.1 statistics on services rendered;

IX-2.2 a summary of program information; and

IX-2.3 at a minimum, a statement that reads "an audit for the year of ____ has been performed by _____in accordance with generally accepted accounting principles."

X. There shall be a written statement of clients' rights and clear evidence that it is fully implemented.

X-1 The clients' rights statement shall include rights to the following:

X-1.1 receive considerate and respectful care in the home at all times, and have property treated with respect;

X-1.2 participate in the development of the plan of care, and receive an explanation of any services proposed and of any alternative services that may be available (see Standard VII);

X-1.3 receive a copy of the plan of care;

X-1.4 receive the name of the supervisor and the company phone number;

X-1.5 refuse medication and treatment, counseling, or other service without fear of reprisal or discrimination;

X-1.6 be fully informed of the consequences of all aspects of care, unless medically contraindicated, including the possible results of refusal of medical treatment, counseling or other services;

X-1.7 privacy and confidentiality about one's health, social and financial circumstances and about what takes place in the home;

X-1.8 know that all communications and records will be treated confidentially;

X-1.9 expect that all home care personnel, within the limits set by the plan of care, will respond in good faith to the client's requests for assistance in the home;

X-1.10 receive information on the company's policies and procedures including information charges, qualifications and supervision of personnel, and on discontinuation of service;

X-1.11 request a change of caregiver;

X-1.12 participate in the plan for discontinuation of service;

X-1.13 have access, upon request, to all bills for service regardless of whether they are paid for out-of-pocket or through other sources of payment;

X-1.14 receive regular supervision of all home care personnel;

X-1.15 receive a clear explanation of which services and equipment provided by the company are covered by third-party reimbursement and which will be paid for by the client, and of the charges which will be incurred;

X-1.16 receive a clear explanation of the process for voicing grievances about care, treatment, or discontinuation of service;

X-1.17 appeal company decisions regarding care, following grievance procedures;

X-1.18 know that the company maintains liability insurance coverage;

X-1.19 be given in writing the name and contact number of an official or owner of the company and the state home health hotline or ombudsman number, if such a service exists; and

X-1.20 receive the services of a translator, if needed.

X-2 The following shall constitute evidence of implementation of clients' right procedures:

X-2.1 documents that show that the governing board has adopted a statement of clients' rights and grievance procedures;

X-2.2 the company's written clients' rights statement;

X-2.3 distribution of a copy of the clients' rights statement to each client;

X-2.4 documentation that each client has received a written copy of the clients' rights statement;

X-2.5 the company's written grievance procedure which shall include the following:

X-2.5.1 delineation of the steps in the procedure;

X-2.5.2 time lines for response from the company and appeal by the client to the next step;

X-2.5.3 procedure for appeal beyond the supervisory level of direct service staff; and

X-2.5.4 assignment of final responsibility for internal resolution of grievance to the governing authority of the company.

X-2.6 provision of clear explanation to clients about which services and equipment provided by the company are covered by third-party reimbursement and which will be paid for by the client, and about the charges which will be incurred; and

X-2.7 written notification to the client of the state home health hotline or ombudsman number, if such a service exists.

XI. There shall be a written policy and procedure of responsible safety management in the care environment:

A. To insure the well-being of the patient;
B. To insure the well-being of the caregiver(s); and
C. To be prepared in cases of emergencies in the home.

XI-1 The safety management policy shall include and address the following areas:

XI-1.1 patient safety;

XI-1.2 caregiver safety (in, around, to and from the worksite);

XI-1.3 violence in the workplace;

XI-1.4 accident prevention in the home/worksite;

XI-1.5 hazardous materials (i.e. household cleaners, pesticides);

XI-1.6 fire safety;

XI-1.7 safety regarding the use of any medial equipment; and

XI-1.8 infection control (OSHA standards).

Section A

XIA-1 The company shall have a written case assessment policy that identifies safety concerns in the care environment.

XIA-2 The plan of care shall address the safety issues that have been identified in the care environment.

XIA-3 The company shall maintain an ongoing system for reporting and reviewing accidents in the care environment.

Section B

XIB-1 The Private Duty Nursing pre-service training shall include a component on safety in the care environment.

XIB-2 The company shall conduct at least one in-service meeting on safety annually.

XIB-3 The company shall have a patient education component of the safety program.

Section C

XIC-1The company shall have policies and procedures to deal with emergencies in the home.

HOME CARE UNIVERSITY

Application for Accreditation
Private Duty Nursing Services

Name of Agency/Organization

Street Address

City State Zip

Phone FAX E-mail

- This company meets the criteria for accreditation application:
- Has employed private duty nursing personnel for at least one year;
- Has been in operation for at least one year;
- Has at least two current private duty nursing cases;
- Has employed qualified professional personnel who assess client need and establish a plan of care for at least half of the individuals and/or families served; and
- Provides private duty nursing services to beneficiaries within a fifty-mile radius of the company.

Print full name of Executive Director or Authorized official signing for the Company

Title

Signature

Date

Please print the name of person to whom information and/or materials should be sent, if different from above.

D:\PDN\Application for Accreditation

Home Care University
Accreditation Program
For Private Duty Nursing Services
1999 Annual Fee

Please calculate your annual fee based on the formula below and mail this form, with your check, to the address listed below. Checks should be made payable to Home Care University. Payment of the annual fee is required for participation in the Accreditation Program.

Total Private Duty Nursing Hours for Previous Year	**NAHC Member Annual Fee**	**Non Member Annual Fee**
Group 1 (15,000+ hours)	$2,000.00	$3,000.00
Group 2 (Between 10,000 and 14,999 hours)	$1,600.00	$2,400.00
Group 3 (Between 6,500 and 9,999 hours)	$1,250.00	$1,875.00
Group 4 (Less than 6,500 hours)	$ 800.00	$1,200.00

PLEASE RETURN THIS FORM WITH PAYMENT

State the total private duty nursing hours for 1998 _____

Annual Fee (see chart above) $ _____

ANNUAL FEE ENCLOSED $ _____

Name and Title of Person to Whom Accreditation Program Information Should be Sent

Agency Name _____

Street _____ City _____ State ____ Zip _____

Phone _____ FAX _____ E-mail _____

Home Care University
228 Seventh Street, SE
Washington, DC 20003

D:\Annual Fee 1999

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