Chapter 16

The Roles of and Competency Requirements for Paraprofessionals

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The U.S. Department of Labor (2014) suggests that studies have found that home care is frequently more effective than care in a nursing home or hospital. Therefore, the elderly are increasingly choosing home care, which is a more personal experience and normally a less expensive option for the client. More often than not, home care services include assistance with basic personal care, companionship, and routine homemaking tasks, because these services help with the normal activities of daily life.

According to the National Association for Home Care and Hospice’s Basic Statistics About Home Care report (2010), the U.S. Department of Labor indicates there are more paraprofessionals in home care than in any other discipline, and they are second only to registered nurses in the category of single Medicare services employee. The U.S. Bureau of Labor Statistics (2014) also reports that employment of these paraprofessionals is projected to grow 49% between 2012 and 2022 (580,800 new jobs), which is much faster than the average for all occupations. This is due to the baby-boomer generation reaching old age and the fact that as people age they generally encounter health or mobility problems, which require them to seek assistance with daily tasks.

POSITION TITLE

The paraprofessional home care worker is referred to by several different titles including homemaker, home health aide (HHA), personal care assistant, caregiver, companion, and personal attendant. In reaction to this confusion, in 1993 the Home Care Aide Association of America (a subsidiary organization of the National Association for Home Care and Hospice) adopted the title home care aide (HCA) in the National Uniformity for Paraprofessional Title, Qualifications, and Supervision paper (1993). This document set forth the title, level of preparation, responsibilities, and supervision required for the paraprofessional classification of HCA.

THE HOME CARE AIDE JOB

The HCA is a paraprofessional worker who provides direct care to people in need of care or assistance at home. He or she is a core member of the home care team and often cooperates with other professionals, including registered nurses, therapists, and social workers. HCAs’ work helps to make it possible for the frail elderly, chronically ill, and disabled to stay at home with dignity and a sense of independence; the terminally ill to remain in the comfort of their home surrounded by family; the acutely ill person to convalesce at home; and families with children to stay together during times of crisis, stress, or illness.
The HCA’s daily routine often varies. HCAs work with a number of different clients, each job lasting from an hour or two to perhaps all day. Hours are typically during the weekdays; however, visits may include weekends or evenings depending on the needs of the client. Aides are responsible for getting to the client’s home and regularly spend a portion of their workday traveling from one client to another. Home surroundings differ, as do the clients, with some homes being neat and pleasant whereas others are untidy and distressing; clients can be friendly, cooperative, angry, abusive, depressed, or otherwise difficult. Therefore, the HCA should have a desire to help people and be responsible, flexible, compassionate, emotionally stable, and cheerful. The HCA should also be tactful, honest, and discreet because he or she works in private homes. HCAs must be physically capable of doing the work, be in good health free of any communicable disease, and have a complete physical examination including mandated tests such as those for tuberculosis. A criminal background check is now required for employment in many states.

**Level of Care**

HCAs give some of the most essential and private care centered on the personal and critical human needs of daily life. This includes assistance with activities of daily living (ADLs) in the client’s own home, which involves help with getting into and out of bed, transferring to chair or wheelchair, ambulation, toileting, bathing (bed, tub, or shower), feeding, dressing and grooming (shaving, shampooing and combing hair, and skin and mouth care). Tasks also include instrumental activities of daily living (IADLs), such as planning and preparing meals (including special diets), light housekeeping of the client’s living area, laundry and linen changes, shopping (food or pharmacy), and accompanying the client to doctors’ appointments or the hospital. When permissible by the nurse practice act, additional special tasks such as changing bandages, nail care, or catheter care may be delegated to the HCA, with proper training, at the discretion and under direct supervision of the registered nurse. HCAs also provide psychological and social support and companionship to a client, which helps to lessen the effects of loneliness and isolation and improves convalescence. Moreover, HCAs may help families with children by teaching and assisting with child rearing and housekeeping.

The tasks to be carried out by the HCA are subject to the client’s need for assistance based on a professional assessment of the client’s physical, cognitive, and functional status; home circumstances; and other supports in place. This assessment should include at least the client’s impairment level, his or her capacity to perform self-care, how the client performs routine household activities, and the condition of the home including safety, family make-up, and ongoing supports.

The level of care by the HCA can range from companion and homemaker services only to medically necessary personal care services. The companion level of service is focused on IADLs and excludes personal care. This companion level is for clients who are well or with a stable health or physical condition that is not expected to change in the near future and are capable of managing their care. Medically necessary personal care services are provided under medical supervision for clients whose health and physical condition are impacted by a recent illness, or the complication or deterioration of a chronic condition or acute illness. These clients are not able to perform ADLs/IADLs alone, and because of their physical or mental condition lack the capacity to comply with care plans. An intermediate level of care includes help for those clients with stable long-term chronic or physical conditions or disabilities that are in need of assistance with ADLs and IADLs on a recurring basis and are willing and able to comply with care plans.

Regardless of the level of care, the HCA must receive thorough instructions for each client’s care and a written plan of care prepared by the assessing professional. This care plan must detail the time and date of when to visit the client, what tasks are to be performed, the goal of the care, and safety concerns. HCAs are to keep records of the care performed and the clients’ condition and report any changes in the client’s progress or situation to the supervisor or case.
manager. In all cases, the purpose of the HCA is to assist with care whenever feasible, but directly furnish care when necessary, in order to support the independence of the client.

Supervision

HCAs generally work on their own, but always under professional supervision. According to the Medicare Conditions of Participation (CoPs), the HHA must be supervised in the home no less than every 2 weeks if the patient is receiving skilled care, and no less frequently than every 60 days if the patient is not receiving skilled services. For services other than Medicare, standards for supervision vary. In many cases the state may impose supervision requirements for Medicaid services, but may not have any supervision requirements for companion or nonpersonal care home care services. However, the National Uniformity for Paraprofessionals Title, Qualifications, and Supervision paper (Home Care Aide Association of America, 1993) stipulates supervision requirements for all levels of care by the HCA, including both companion and personal care services, to be at least once every 60 days in the home of the client.

TRAINING

For many years there was no recognized standard for training of HCAs in the United States. In response to this lack of uniformity, the National Council for Homemaker–Home Health Aides Services developed and published a homemaker–home health aide training manual in 1967. That evolved into the Model Curriculum and Teaching Guide for the Instruction of Homemaker–Home Health Aides, first published in 1978 (U.S. Department of Health and Human Services, 1978) and became the basis for the Medicare CoPs for HHA training.

The Medicare CoPs for HHA service in Subsection 484.36 (a), Standard: Home Health Aide Training—(1) Content and Duration of Training (1989), require the training program to address certain subject areas through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervised practical training. Additionally, Medicare CoP regulations require verification of competency for the HCA, and HCAs must receive at least 12 hours of annual in-service training. Thus, the Medicare CoPs established the first federal standards for training of the HCA. According to the Paraprofessional Healthcare Institute (2013), 34 states and the District of Columbia require only the federal standard of 75 hours of training; 16 states require more than the 75 hours of training, with 6 of these states requiring 120 or more hours of training for the HCA services under federal and state auspices. Ten states require some form of certification, either Certified Nurse Aide or Certified Home Health Aide. Despite these federal or state training standards, in some states there is no training requirement for companion or nonpersonal care level of service. Therefore, the National Uniformity for Paraprofessionals Title, Qualifications, and Supervision paper (Home Care Aide Association of America, 1993) specifies that the companion level of HCA must receive a total of 40 hours of training.

ACCREDITATION

In anticipation of a future rapid growth in home care services, and the added fragmentation that would bring to the industry, in 1965 the National Council for Homemaker–Home Health Aide Services set about to establish the first national set of standards for HCA services. The first three programs were approved in April 1972, and in June 1980 the Council moved to a more comprehensive accreditation process that included a site visit. In 1967 the Council was cited in the Federal Register as the national standard-setting body for paraprofessionals. Today there are several national accreditation programs available to HCA organizations, some of which are based on these original initial basic national standards. These include the Community Health Accreditation Program (CHAP), the Accreditation Commission for Health Care (ACHC), The Joint Commission Home Care Accreditation, and the National Institute for Home Care Accreditation (NIHCA).

Accreditation serves to protect the consumer, community, and payers by enabling safe, competent, responsible care from an organization.
that maintains a certain level of integrity and accountability. The accreditation process accomplishes this by setting organizational and service delivery standards that over time produce high quality, dependable care.

In addition to consumer protection, the underlying philosophy of accreditation is to help the organization to achieve excellence and minimize the numerous risks associated with providing home care services. In short, accreditation provides a much-needed guide for the consumer to assess the quality of the provider and the capability of the caregiver, and the organization to demonstrate its administrative and clinical competence to potential funding organizations or government agencies.

CONCLUSION

It would be impossible to have an effective home care delivery system without the HCA level of care. It is the HCA who spends the greatest amount of time and builds the closest relationship with the client and provides the most intimate care, which is so essential to the client’s safety, comfort, and sense of well-being. It is the information gathered as a result of this familiarity, frequent contact, and regular observation that is critical to shaping the best care outcome for the client. Although other skilled care is extremely important to the client’s recovery and overall health, it is the HCA who brings the client the dignity and security needed to feel confident while staying at home.

REFERENCES


