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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 95 LCM-95

Date: August 16, 1995

Division: Health and Long Term Care

TO: Local District Commissioners

SUBJECT: Standards for the Use and Approval of Shared Aide Programs: Proposed Administrative Directive

ATTACHMENTS: Proposed ADM, Personal Care Services: Standards for the Use and Approval of Shared Aide Programs (Available on-line)

Section 86-b of Chapter 81 of the Laws of 1995 directs the Department to develop standards for use by the social services districts in providing shared aide services in the personal care services program. The standards, contained in the attached proposed ADM, were developed in consultation with an advisory group which included representatives from social services districts, providers, labor organizations and client advocacy groups. Districts must use these standards in conjunction with 92 ADM-4 until a consolidated administrative directive is released by the Department later this year.

The Department will continue to discuss the standards for shared aide services with the advisory group and will revise the standards, as necessary, based upon the recommendations of the advisory group, consistent with Chapter 81.

These standards establish guidelines, including criteria to be considered by districts, for determining the appropriateness of shared aide services for clients in receipt of, or authorized for, personal care services. They establish the guidelines to be considered in making decisions on the use of the shared aide model in districts and in making decisions concerning the appropriateness of such a model for the clients served in a district. These standards should not be construed as strict rules, nor rigidly enforced without regard to the facts and circumstances of the district's implementation of its shared aide program, and of the

individual client being considered for shared aide services. As such, these standards should not be employed to determine strictly the districts' conduct of their shared aide programs, nor to determine strictly if or when shared aide services are appropriate for a client; rather, they merely require that certain considerations be taken into account by the districts in making determinations concerning the implementation of a shared aide program and in the determination of a client's appropriateness for shared aide services. Thus, these standards are not intended to dictate the results of the district's action in establishing a shared aide program or in authorizing shared aide services for a client.

Districts with comments, questions or suggestions concerning these standards should contact George Fleury at (800) 343-8859, extension 3-8269 or direct at (518) 473-8269 or 89A807 or Fred Waite at (800) 343-8859, extension 3-5490 or direct at (518) 473-5490 or 0LT150. Questions concerning this transmittal should be directed to Richard D. Alexander at (800) 343-8859, extension 3-5506 or direct at (518) 473-5506 or DMA037.

Richard T. Cody
Deputy Commissioner
Health and Long Term Care

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: PROPOSED

DIVISION: Medical Assistance

TO: Commissioners of Social Services

DATE:

SUBJECT: Personal Care Services: Standards for the Use and Approval of Shared Aide Programs

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SUGGESTED DISTRIBUTION:
- Medical Assistance Staff
- Adult Services Staff
- Long Term Care/CASA Coordinators
- Staff Development Coordinators
- County Attorneys
- Fair Hearing Staff

CONTACT PERSON:

General: Fred Waite, 1-800-343-8859 extension 3-5490 Fax (518) 486-4112

Reimbursement/Rates: Rosemary Contompasis, 1-800-343-8859 extension 3-5609 Fax (518) 486-4112

ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
80 ADM-9		505.14	367-g		91 ADM-42
92 ADM-4		505.33	367-k(2)		91 LCM-37
92 ADM-49					92 LCM-70

I. PURPOSE

The purpose of this administrative directive is to provide districts with shared aide standards and guidelines, explain the requirements of Social Services Law Section 367-g, as amended by Section 86-b of Chapter 81 of the Laws of 1995 regarding standards for the use and approval of shared aide services, and the requirement that each shared aide authorization be properly encoded.

II. BACKGROUND

Use of a shared aide model of service delivery has proven to be an efficient and cost effective method for the provision of personal care services. Districts were directed by 92 ADM-4 to establish a shared aide services program as part of the district's personal care services or to receive an exemption from establishing a shared aide program. Section 367-k(2)(a)(iii) of the Social Services Law requires that the assessment process for personal care services determine whether a client's functional needs and living and working arrangements can be appropriately and more cost effectively maintained through the use of shared aide services. If the district determines that shared aide services are appropriate and could be delivered more cost effectively than traditional personal care services, then the district must incorporate the use of shared aide services in the development of the client's plan of care. Requirements for the provision of personal care services are found in Department regulation 18 NYCRR 505.14. Requirements specific to shared aide services as part of personal care services are found in Sections 505.14(a) and (k) of the Department's regulations for personal care services.

Currently, all 58 local social services districts have developed and implemented Shared Aide Programs or received an exemption from developing, and implementing a Shared Aide Program. Programs in many districts are fully implemented, while in some districts expansion of the program continues. Cluster care, cooperative care, or team care are other terms for this type of program.

III. PROGRAM IMPLICATIONS

Chapter 81 requires that standards be established for the use and approval of shared aide services. The legislation specifically calls for standards in the following areas:

- Utilization of Shared Aide Services as Part of Personal Care Services

- Supervision and Safety of Clients

- o Shared Aide Services and Meeting the Functional Needs of Clients
- o Selection and Operation of Shared Aide Sites
- o Education, Outreach and Communication

Current and future shared aide program operations will be guided by the standards established in this directive to ensure that high quality shared aide services are delivered appropriately and safely.

These standards establish guidelines, including criteria to be considered by districts, for determining the appropriateness of shared aide services for clients in receipt of, or authorized for, personal care services. They establish the guidelines to be considered in making decisions on the use of the shared aide model in districts and in making decisions concerning the appropriateness of such a model for the clients served in a district. These standards should not be construed as strict rules, nor rigidly enforced without regard to the facts and circumstances of the district's implementation of its shared aide program, and of the individual client being considered for shared aide services. As such, these standards should not be employed to determine strictly the districts' conduct of their shared aide programs, nor to determine strictly if or when shared aide services are appropriate for a client; rather, they merely require that certain considerations be taken into account by the districts in making determinations concerning the implementation of a shared aide program and in the determination of a client's appropriateness for shared aide services. Thus, these standards are not intended to dictate the results of the district's action in establishing a shared aide program or in authorizing shared aide services for a client.

IV. REQUIRED ACTION

Social services districts must assure that shared aide programs, inclusive of existing program operations and future expansion of program operations, meet Department standards for the use and approval of shared aide services. Standards for the use and approval of shared aide services are discussed in Section IV. B. of this directive.

A. Definition of Shared Aide

Shared aide means a method of providing personal care services under which a social services district authorizes one or more nutritional and environmental support functions, personal care functions, or health-related tasks for multiple personal care services clients who reside in close proximity to each other in a designated geographic area, such as an apartment building, senior citizen housing complex, or who reside in a neighborhood or along a common designated route. A home care worker completes the authorized functions or related tasks by making short visits to each client. A home care worker may make multiple visits to one client during the day; a worker may also perform functions and tasks, such as shopping or doing laundry, for multiple clients simultaneously.

Under a shared aide model, service delivery is task oriented, not time oriented. The client receives personal care services according to assessed needs, but the home care worker does not remain in the client's home for a predetermined block of time to deliver the functions and tasks in the client's plan of care. Assigned tasks are completed and the home care worker moves on to the next client. The home care worker may return to a client during the course of his/her work day to complete other tasks on the client's plan of care.

Shared aide services, as a part of personal care services, are subject to Department regulation 18 NYCRR 505.14 for the provision of personal care services. Additional requirements and guidelines for the use and approval of shared aide services are contained in this directive.

B. Standards for the Use and Approval of Shared Aide Services

1. Utilization of Shared Aide Services as Part of Personal Care Services

Shared aide services provided as part of personal care services must be provided according to a plan of care. A plan of care must be based on a comprehensive assessment that the client has a medical condition, disability or impairment that necessitates assistance with personal care services tasks and warrants the use of the service.

a. The Assessment/Authorization Process

In general, the requirements, processes and procedures for establishing a plan of care and authorizing personal care services under a shared aide model are the same as those under a non-shared aide services delivery model. A physician's order must be obtained, social, nursing, and fiscal assessments completed, a plan of care developed, written (fair hearing) notices sent (social services districts must continue to use the fair hearing notices attached to 92 ADM-4), and authorizations prepared for each eligible client. The provision of services must be essential to the maintenance of the client's health and safety.

The authorization of shared aide services in combination with other models of service delivery and/or home care services (such as PERS, home health aide services, traditional one-on-one aide service etc.) is permissible. All services being provided should be indicated on the plan of care.

b. Individual Plans of Care

Department regulation and policy, (18 NYCRR 505.14 and 80

ADM-9), require that the authorization of personal care services be based on a comprehensive assessment of the client's needs. One of the end products of the individual comprehensive assessment is the individual plan of care.

An individual plan of care must include the tasks to be performed, the manner in which tasks are to be performed, and the frequency and/or timing of task performance. Scheduling of tasks should be discussed with the client at the time the individual plan of care is developed. Determinations made by the assessing nurse regarding tasks, and performance of the task (i.e. frequency, timing, and/or manner of performance) should be clearly delineated on the plan of care from information regarding client preferences in scheduling of tasks.

Each shared aide client's assessed need for assistance with tasks which must be performed at specific times (referred to in this directive as "time specific tasks") and clients' preferences for scheduling tasks which do not have to be performed at specific times (referred to in this directive as "time-discretionary tasks") become very important in developing the composite plan of care and a viable worker schedule for performance of the tasks in the composite plan of care.

As a part of the personal care services assessment/authorization process, an individual plan of care is subject to regulatory requirements concerning service provision. The plan of care must be medically appropriate, meet the functional needs of the client for home care tasks, and be reasonably expected to maintain the health and safety of the client. Changes in the individual plan of care, such as the removal of a particular task or the alteration of the timing of "time specific tasks" must be based on a comprehensive assessment meeting the criteria found in Department regulation 505.14(b). Changes in individual plans of care necessitate a review of the composite plan of care and site work schedule with changes being made in each as appropriate.

c. Composite Plans of Care for Shared Aide Sites

In a shared aide program each individual plan of care must be incorporated into a composite plan of care identifying the tasks to be performed, the manner in which tasks are performed, and the frequency and/or timing of task performance needed by all shared aide recipients in the shared aide program site. Composite plans of care must be developed by the supervising nurse(s).

d. Site Work Schedules

Site work schedules for the home care workers are developed from the composite plan of care and must include all of the tasks listed on each client's individual plan of care. When developing the site work schedule, time specific tasks should be scheduled first. For example: assistance with administration of an oral medication every four hours would have priority in the scheduling process. Time-discretionary tasks, such as laundry, shopping, may then be added to the overall schedule according to client preference. Linking of tasks which "go together", such as bathing and grooming, is desirable in scheduling but may not always be possible.

Scheduling adjustments may be necessary initially to resolve time conflicts between clients for performance of tasks. Ongoing scheduling may require more frequent adjustments because of scheduling breakdowns when a client requires performance of a single task on a weekly basis or because of client movement in and out of the shared aide cluster or changes in client needs. For example: a client may drop out of the cluster temporarily because of a hospitalization, thereby changing the size of the cluster and the task distribution within a particular day. If a client becomes ill and requires more assistance while in the shared aide program, priority will need to be given to that client and time-discretionary tasks needed by other clients in the program rescheduled. Some districts establish a maximum number of days after which the total hours assigned to the composite plan of care is formally readjusted through the completion of revised prior approval requests.

Any changes in the site work schedule either as a result of an assessment/reassessment per Department regulation 505.14(b) or as the result of site management decisions to ensure cost efficient delivery of services must ensure that services will continue to be provided in accordance with individual plans of care.

Development of worker schedules is often delegated to the participating provider agency or agencies. However, in some shared aide programs, the case manager is involved in this activity. When first implementing shared aide services at a site, weekly meetings involving the case manager, nurse supervisor, provider agency site coordinator or liaison, and the home care workers may be beneficial for reviewing the individual client plans of care and making adjustments in the scheduling of tasks as needed. As experience is gained, frequency of meetings can often be reduced.

e. Completion of the Prior Approval Request (DSS-2832-H) or Equivalent)

Proper encoding must be employed when preparing shared aide authorizations. All prior approvals authorizing shared aide services must be completed using the appropriate shared aide rate codes.

Personal care services rate codes may be found in 91 LCM-37. These rate codes enable prior approval and billing for services delivered under a shared aide model in hourly or quarter hour units.

For authorization and payment, MMIS will only recognize a prior approval for personal care services based on an hour or a fractional hour as the unit of services. Therefore, although clients receive services on a task oriented basis under a shared aide model, the prior approval request (DSS-2832-H or equivalent) must reflect hours.

Some social services districts have written specifications for converting tasks into an equivalent amount of hours for MMIS prior approval and provider billing purposes. Most districts, however, currently operate shared aide programs by estimating an amount of hours which will be needed to perform the tasks included in each client's plan of care. The estimated amount is often greater than the actual amount of time which might be needed to perform a particular task and therefore includes some hours which can be "banked" or used to make temporary adjustments in the composite plan of care. Sometimes the amount may include a block of hours for tasks such as shopping and laundry performed for multiple clients with the hours divided equally among all the clients or allocated to a single client for one week and the other client or clients involved the following week or weeks. Either practice is acceptable provided that the number of hours that the district has prior approved for a specific client will be sufficient to meet his or her needs for assistance with all of the personal care services tasks included in the plan of care.

For billing purposes, home care workers must continue to keep a record of the time actually spent in providing personal care services to each client in the shared aide program. Existing record systems (electronic time keeping systems or manually completed time cards or logs) can be used or be modified to record daily, multiple visits.

f. Reimbursement

Rates for shared aide services are set in the same fashion as rates for personal care services.

2. Supervision and Safety of Clients

a. Maintaining Health and Safety

Maintaining the health and safety of clients is of paramount importance as decisions are made regarding the provision of home care services. Statute and regulation regarding home care services (including personal care services regardless of the delivery model employed) require that provision of services occurs only when the comprehensive assessment indicates that the provision of services can maintain the health and safety of the client. Home care services may not be provided if such provision will jeopardize the health and safety of the client.

Application of this requirement is especially critical when considering the authorization of home care services for clients whose comprehensive assessment indicates a need for continuous supervision of the client and/or monitoring of the client's health and safety. A combination of home care services may be required to adequately meet client needs for supervision and monitoring, and maintain the client's health and safety.

b. Supervision of the Client and/or Monitoring of the Client's Health and Safety

The shared aide model of service delivery does not lend itself to the supervision of non-self directing clients or monitoring of clients' health and safety. Shared aide services require that the aide complete specific tasks and then move on to the next client. The supervision of non-self directing clients or monitoring of client's health and safety frequently requires the continuous presence of the aide, and effectively precludes the aide from moving on to another recipient. The utilization of shared aide services to continuously supervise or monitor a client is not appropriate.

Clients having a need for continuous supervision and/or monitoring of their health and safety must have that need met by an appropriate means for which the client qualifies. For example: the utilization of PERS for qualified self directing clients in need of continuous monitoring, or the utilization of traditional one-on-one aide service for qualified non-self directing clients in need of continuous supervision. The use of an informal

support such as a relative, or friend, or an outside agency to supervise or monitor a client should be explored and utilized wherever possible.

A client having his/her need for continuous supervision and/or monitoring met by an appropriate means may still be appropriate for and receive shared aide services for the performance of tasks listed on the plan of care. For example: a qualified self directing client in receipt of PERS may receive shared aide services to accomplish the remaining tasks on his/her plan of care; or, a non-self directing client in receipt of traditional one-on-one aide service may receive shared aide services to accomplish tasks done outside of the home such as shopping, or laundry. A client receiving traditional one-on-one aide service may receive shared aide services in the home if a second aide is required for the performance of a task, such as a client whose care requires a two person transfer.

The practice of having a shared aide periodically visit a client to monitor his/her health and safety, or supervise the client is not included as a permissible task in the Personal Care Services Scope of Tasks. Periodic visits to "check" on a client should not be substituted for an appropriate method of monitoring a client's health and safety, or supervising non-self directing clients for those clients with assessed needs for continuous supervision of the client and/or monitoring of the client's health and safety.

c. Use of Periodic Visits and Fragile Clients

Situations involving fragile individuals do occur in which a periodic "check" on a client is desirable, serving as a protective measure that can provide an advance warning on changes which may occur in a client's medical condition. For example: A client is recently discharged from a hospital. The client is medically stable, self-directing, not in need of continuous supervision and/or safety monitoring, but is weak or fragile, still in the process of regaining his/her strength. The assessing nurse determines that there is no need for on-going skilled nursing services to evaluate the client's medical condition on a daily basis. However, the assessing nurse would like to have the aide make periodic contact with the client, as a safety precaution and to facilitate communication with the client on his/her status. On the recommendation of the assessing nurse, those responsible for the site work schedule may schedule the performance of the tasks on the client's plan of care in such a way as to provide periodic visits to the client. In the same fashion

situations in which the supervising nurse perceives a need for periodic contact with a particular client as a safety precaution, the site work schedule may be revised to accommodate periodic visits to the client.

Assessing and supervisory nurses should consider the use of periodic visits as a safety precaution only when the use of a periodic visit will not jeopardize the health and safety of the client.

3. Shared Aide Services and Meeting the Functional Needs of Clients

As previously stated in section IV. A. of this directive, shared aide services as part of personal care services are subject to the requirements for the authorization of personal care services. Various aspects of current personal care services policy and procedure concerning medical appropriateness of the service, maintaining the health and safety of clients, and meeting the functional needs of clients have been included previously in sections IV.B.1. and IV.B.2. of this directive to properly establish standards in regards to the utilization of shared aide services as part of personal care services and the supervision and safety of clients, respectively. However, characteristics unique to the shared aide model of services delivery necessitate additional clarification of the application of program requirements when applied to shared aide services. The standards presented below contain this clarification and must be applied to the provision of shared aide service.

Districts may authorize shared aide services only when the comprehensive assessment indicates that provision of services is appropriate because all of the following standards have been satisfied.

Shared aide services are medically appropriate for the client.

Shared aide services do not jeopardize the health and safety of the client.

Shared aide services can maintain the functional needs and living and working arrangements of the client.

Shared aide services ensure the quality of the client's care.

Shared aide services ensures the cost-effective delivery of necessary services.

a. Medically Appropriate

For the provision of shared aide services to be medically appropriate shared aide services must be medically necessary, and social services district must reasonably expect that the client's health and safety will be maintained by the provision of services. To be medically necessary, tasks to be performed by the shared aide must correlate to needs stemming from the client's medical condition. District expectations that the provision of services can maintain the health and safety of the client must be guided by Department regulation and policy concerning health and safety for personal care services, and the standards contained in this directive regarding issues of health and safety.

b. Health and Safety of the Client

As required by 18 NYCRR 505.14 and previously cited in this directive in section IV.B.2.a., provision of shared aide services is appropriate only when districts reasonably expect the client's health and safety can be maintained by the provision of the service. The provision of shared aide services must not in any way jeopardize the health or safety of the client.

c. Maintaining the Functional Needs and Living and Working Arrangements of the Client

Shared aide services authorizations and service delivery are task based. Home care tasks necessary to maintaining the functional needs of a client that must be done continuously, or frequently, and/or at unscheduled times are not easily incorporated into the shared aide model of service delivery. Such tasks require the continuous or frequent presence of the aide. An example already discussed at length in section IV.B.2. of this directive is the task of continuous supervision and/or monitoring. Other tasks, including but not limited to assistance with toileting, walking, transferring, and feeding, may not be appropriate for the shared aide model of service delivery if the client's medical condition requires performance of the task frequently and/or at unpredictable intervals.

In determining the appropriateness of the utilization of shared aide services to accomplish a particular task for a client, nurse assessors and nurse supervisors should consider the client's medical condition and the requirements that the condition imposes on the performance of the task. Further, consideration should be given to the potential effects the performance of the task may have on the work schedule of the aide.

d. Ensuring the Quality of the Client's Care

Quality of care is subject to many factors. These factors can be separated into two categories, quality of the work force and quality of delivery.

(1) Quality of Work Force

The quality of the work force is ensured through proper training and supervision. Current Department regulation and policy require that aides be appropriately trained as they enter employment with a personal care services provider agency, receive 3 hours of in-service training semiannually, and receive on-the-job training when necessary. Personal care aides are supervised on each case for which they provide services by a qualified registered nurse. Additionally, each aide is evaluated for his/her overall job performance by the provider agency's professional nursing staff. The shared aide services work force is subject to these same requirements.

For the traditional one-on-one aide model of service delivery, current regulation provides adequate mechanisms for ensuring quality of care. A traditional aide, appropriately trained and properly supervised, needs little else but the direction of the client to deliver a high quality of care. The nature of shared aide services delivery requires additional standards for ensuring the quality of care as related to service delivery.

(2) Quality of Delivery

The task-based nature of shared aide services is central to the cost efficiency of shared aide services. Cost efficiency is maximized by the continuous movement of the aide from task to task as each task is completed. District casemanagers, supervising nurses and other provider agency staff involved in the management of a shared site are well aware of this aspect of shared aide service. However, district case managers, supervising nurses and other provider agency staff involved in the management of a shared aide site must also consider the impact of the task based methodology on the quality of services being delivered.

The delivery of a high quality of care under shared aide model of service delivery is dependent on the coordinated efforts of the clients, personal care aides and those individuals responsible for the

composite plan of care and site work schedule. Development of an appropriate site work schedule from the composite plan of care is the key to ensuring the delivery of quality care.

Under a shared aide model of service delivery the direction of the individual plan of care is now a shared responsibility between the client and those individuals responsible for the composite plan of care and site work schedule. The client retains control of directing the aide within the home, task by task, but shares control of scheduling of tasks with the individuals responsible for the oversight of the composite plan of care and site work schedule.

Staff responsible for the development of shared aide site composite plans of care and site work schedules must consider the following in the development of the composite plan of care and site work schedule:

Appropriate timing of the performance of tasks

Adequate staffing in relation to the work load

Continuity and stability in delivery

Proper timing of the performance of a task can be critical to the maintenance of a high quality of care. The importance of timing may be related to the nature of the task. For example: The task of serving breakfast should occur in the morning. Or the importance of timing may be related to the medical condition of a particular client. For example: A client needs to be reminded to take medication at a specific time of day.

While cost efficiency is central to the utilization of shared aide services and aides should be sure to move on to the next task after completing a task, aides should also be directed to complete each task thoroughly and properly. Staffing resources at the site must be sufficient to perform the site work schedule both efficiently and thoroughly.

(3) Continuity and Stability in Delivery

One of the advantages of the shared aide model of services delivery is its ability to provide continuity and stability of services delivery. The team approach used by the shared aide model can be effectively used to provide continuity and stability, and thus ensure the quality of care. Clients need not have essential services disrupted

by the absence of a single aide as can occur with traditional one-on-one aide services, or be faced with a substitute aide they do not know and who does not know them. The team approach enables on site staff to adjust to such occurrences, and continue to provide essential services. To ensure that the quality of care is maintained the team approach should be maximized. Aide staff should become acquainted with clients at the site, and the composite plan of care.

e. Ensuring Cost-effective Delivery of Necessary Services

Social Services Law Section 367-k(2)(b), Department personal care services regulation 18 NYCRR 505.14 (b) and policy stated in 92 ADM-49, Fiscal Assessment and Management of Personal Care Services requires that a fiscal assessment be completed for each personal care services client. Fiscal assessment includes a required review of the use of shared aide services as an efficiency. When the district determines through the fiscal assessment process contained in 92 ADM-49 that shared aide can appropriately and more cost-effectively serve the client, the district must use shared aide services. If shared aide services are not appropriate or not more cost-effective for a specific client, it cannot be used.

4. Selection and Operation of Shared Aide Sites

a. Location of Clients

Geographic areas in which the density of clients receiving traditional personal care services is high are likely areas in which potential sites for shared aide programs will be found. Typically, such high density areas encompass high-rise public housing complexes and single or multi-level senior housing developments with contiguous or free-standing units. If high-rise or multi-level sites are very large, possibilities may exist for grouping or clustering of clients by floor.

There are no minimum requirements for size of a shared aide group or cluster. Shared aide programs have begun with as few as two or three clients and as many as forty clients in a single group. However, districts should keep in mind that one of the goals of shared aide services is to provide services as cost efficiently as possible. Districts and providers when reviewing potential shared aide sites or clusters of clients should consider the impact of site size on cost efficiency.

In some of the smaller shared aide programs, the inclusion of clients receiving home care services under

varying reimbursement sources has made development of a cluster feasible. For example: programs have included clients receiving personal care services under Medical Assistance (MA), home health aide services under Medicare, and homemaker services under the Expanded In Home Services for the Elderly Program (EISEP). Shared aide programs can also be effectively combined with personal emergency response services (PERS) to further improve efficiency of services delivery and can be implemented in Long Term Home Health Care Programs (LTHHCPs) and for certain services provided by certified home health agencies (CHHAs). However, individuals receiving services through other programs and/or reimbursement sources are subject to the requirements of those programs and/or reimbursement sources and not subject to this directive.

There are no limitations on the types of sites which may be selected; consideration can be given to other settings where clusters of clients can be identified. Neighborhoods adjacent to housing complexes or developments or other geographical areas may also be potential sites. Regional clusters cutting across county lines offer relatively unexplored alternatives which may be feasible in some parts of the state.

Another type of shared aide site which may be selected is a "route" shared aide site. This type of site consists of a route along which PCS recipients reside and for whom all or part of their PCS care services may be more efficiently provided under a shared aide model of service delivery. A route shared aide site may extend for a considerable distance and may not necessarily be contained in a small geographic area. When considering a particular route for development as a shared aide site consideration should be given to the route site's ability to retain the inherent cost efficiency of shared aide model of service delivery. Cost efficiency may be lost if excessive amounts of time are spent traveling from one client to another. Routes with excessive distances between clients or with work schedules requiring frequent "doubling back" by the aide to revisit clients may not be appropriate for development as a shared aide site. Development of a proposed composite plan of care and work schedule is recommended to assist districts in determining if the operation of the route site is more efficient than providing services in the traditional one-on-one model of services delivery.

b. Impact of Site Selection on Staff

In addition to the consideration of geographic and demographic factors related to the efficient delivery of services in site selection addressed above, social

services districts and providers of home care services must consider geographic appropriateness in relation to staffing when selecting sites for share aide programs. Specifically, consideration must be given to the impact of site selection on the staff who will be assigned to work at a shared aide site.

As indicated in the definition of shared aide services in section IV.A. of this directive, shared aides make multiple visits and serve multiple clients, thus moving within the shared aide site frequently. A site such as a housing complex with a high density of traditional PCS recipients may also have geographic areas within the site that are known to contain habitually unsafe situations. The existence of such situations to which a shared aide worker may be exposed during the completion of a composite plan of care work schedule may require that adjustments be made to the work schedule in order to avoid an unsafe situation, or require the disqualification of the site as a shared aide site. Unsafe situations include but are not limited to; frequent illegal drug related activity in public access ways of a site, or poorly maintained building equipment, such as elevators, or stairs habitually in disrepair.

When considering a "route" shared aide site consideration must also be given to the mode of worker transportation both in terms of availability and safety.

A determination that a particular site is not suitable for the provision of shared aide services due to safety issues does not automatically prohibit the provision of traditional personal care services in that area. Determinations regarding the appropriateness of traditional personal care services in situations involving health and safety issues are subject to current Department regulation and policy for personal care services regarding health and safety.

c. Input of Staff

Districts and providers of home care services must consult with home care staff, both professional and paraprofessional, and any employee organization representing such staff with respect to the management and operation of a shared aide site. Methods for consulting with site staff may include, but are not limited to regularly scheduled meetings between site staff, provider agency administrative staff, and district staff, and/or the use of a senior aides to report site staff concerns to provider agency and district administrative staff.

5. Client Education, Outreach and Communication

Client education, outreach, and communication refers to district and or provider agency efforts to inform and communicate with clients about shared aide services. It includes but is not limited to, the use of informational pamphlets and materials, and meetings with clients to educate clients on the nature of the shared aide model of service delivery, and meeting with clients to discuss specific client concerns regarding the utilization of shared aide services. Educating clients to the nature of shared aide services and the subsequent feedback from those clients prior to receipt of services is crucial to the successful implementation. Client feedback and communication after the receipt of services is crucial to the ongoing operation of a shared aide services program. Recipient education and outreach can facilitate a smooth transition in either situation for clients for whom receipt of shared aide services is a new experience. Experience has shown that clients who have been educated regarding the advantages to be gained through the shared aide model of service delivery and who have had opportunity to discuss their questions and concerns with district and provider staff are less likely to request a Fair Hearing to formally object to inclusion in a shared aide program.

The type of information needed may vary with the client's experience with personal care services. New applicants lacking previous experience of either traditional one-on-one aide services or shared aide services may be more accepting of the shared aide model of services delivery. Clients accustomed to receiving personal care services in blocks of time may have difficulty accepting or adjusting to a shared aide services delivery model. Clients may perceive that services are being reduced. They may fear loss of home care workers with whom they are familiar and have long-term relationships. They may view services as being less "personable" because down time interludes where clients and aides socialize often connected with services delivery under a non-shared aide model are absent. In order to provide an avenue to address client concerns and fears districts and provider agencies should provide clients with the name and phone numbers of district staff and provider agency staff to whom clients can address their concerns.

District plans for client education, outreach and education must be sensitive to the primary language of the district's clients.

District Plans for Client Education, Outreach, and Communication

Social services districts must have a plan for providing information to educate clients about shared aide services. A variety of written materials have been used

for this purpose including specially designed letters and brochures. Staff from the social services district, the agency providing nursing supervision, and the provider agency or agencies participating in the program have conducted resident meetings at identified sites to explain the program and respond to concerns. Case managers have also made multiple visits to each client's home, frequently in cooperation with staff from the provider agency which will be participating in the program and the supervising nurse, if from a different agency, to discuss the program and address client apprehensions.

Written materials, oral presentations, and individual client conferences have often emphasized several of the program benefits, such as, elimination of waiting lists, diminution of services breakdowns, improvements in continuity of services to clients, and reduction of worker turnover and absenteeism due to increased worker job satisfaction. Other client benefits include the ability of the shared aide program to more quickly respond to emergencies and temporary changes in the client's needs, the ability of the program to get services more rapidly in place for a client being discharged from the hospital, and the capability of providing periodic contact with a fragile client who needs "checking on" at various times throughout the day or evening.

Written materials, oral presentations, and individual client conferences about a shared aide program should emphasize that clients will receive assistance with all of the tasks required to meet their needs for services, and that they will receive a written notice of the tasks with which the aide will be assisting. This is especially important in a transitional situation where clients have been receiving services under a non-shared aide services delivery model and will be transitioned to a shared aide model. Client resistance has <u>not</u> been a significant barrier to implementation of shared aide programs, particularly if sites have been carefully chosen and sufficient time has been allotted during the development stage for the educational efforts needed.

Additionally, social services districts plans for providing information to consumers and their representatives concerning shared aide services must include a description of the procedure to be followed by recipients of shared aide services to express concerns regarding services they receive. The description should include the name and phone number of the contact person(s) to whom concerns may be addressed, and a description of the required written notice clients must

receive and the fair hearing process available to them if they disagree with the services authorized. It is suggested that the primary contact be either the supervising nurse, or casemanager. Additional contacts for specific functions, such as the name and number of the individual responsible for the site work schedule, may be included in the information provided to recipients, as appropriate.

C. Encoding of Shared Aide Services Authorizations

Section 92(2) of Chapter 81 of the Laws of 1995 requires accurate encoding of recipient information. Shared aide rate codes must be utilized by districts when authorizing shared aide services. Shared aide rate codes are listed and described in in section V of this directive.

V. SYSTEMS IMPLICATIONS

Shared aide services rate codes are:

Rate Code	Description
2501	PCA I, Shared Aide; Basic Rate, Hourly
2502	PCA II, Shared Aide; Basic Rate, Hourly
2507	PCA I, Shared Aide; Basic Rate, Quarter Hour
2508	PCA II, Shared Aide; Basic Rate, Quarter Hour

The quarter hour rate codes have been established to facilitate billing through MMIS for personal care services provided under a shared aide model.

VI. EFFECTIVE DATES

Standards for the use and approval of shared aide will be effective _____.

_____
Deputy Commissioner