PERFORMANCE CONTRACTING FOR DAY ADULT PROGRAMS FOR THE MENTALLY RETARDED: A CONCEPT PAPER

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by

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INTRODUCTION

Performance contracting is a variation of service contracting under the following general conditions: a county seeks to buy a service and/or result for a client with the benefit to that client specified, a provider agrees to provide the service/benefit/result, and a reimbursement value is attached to that outcome. It differs from traditional contracting for MR services in that the service per se is not usually purchased, but rather the specified result of that service is.

A major feature of performance contracting is that it requires the assessment or measurement of the attainment of desired client outcomes. Performance contracting as envisioned in this paper is environmentally-based: that is, it measures client performance in the natural environment. It is tied to a set of guiding principles whereby specific objectives are developed for clients, all of which revolve around providing the client with the least restrictive possible environment within which to live and work and the maximal amount of integration in the community where he/she lives .

An effective model for performance contracting depends upon the collection of a body of data which allows "tracking" the base rates for achieving different outcomes and costs of achieving them. Because no such data presently exist, we envision that implementation of a performance contracting model in Minnesota will involve a trial period of contracting for "outcomes" in which payment is essentially the same as is is now but data are collected about the costs incurred in achieving those outcomes for various types of clients.

This paper explores the feasibility of performance contracting for day adult programs for mentally retarded persons in Minnesota.

The two sections of this paper address two separate questions:

> What are the potential advantages of performance contracting over the present system of service contracting?
>
> What are the specifications necessary for a model performance contract which would allow for a fair test of whether these potential advantages would in fact result?

PART I. POTENTIAL ADVANTAGES OF PERFORMANCE CONTRACTING

The successful implementation of any new model will depend greatly upon its acceptance by a body of "constituents" affected by the changes it brings.

The MnDaca/McKnight Project hired Rainbow Research, Inc. to explore the potential benefits of a performance contracting model, design the specifications for that model, and develop a plan for a field test. Working with an Advisory Committee representing a broad spectrum of interests in MR services, and interviewing a number of service providers and purchasers, we have identified the following constituencies which are likely to benefit from performance contracting: clients and client families, taxpayers, service providers, and county purchasers of services. We also believe that the model will be beneficial in the broad perspective of the service delivery system as a whole.

PERSPECTIVE: THE SERVICE DELIVERY SYSTEM

In the past decade, the basic philosophy underlying delivery of services to mentally retarded persons, especially adults, has changed dramatically and has also brought about rapid changes in the nature of services. A new set of principles now generally accepted have resulted in a convergence of basic structural changes in all areas of services.

The overall principle has been defined and elaborated at great length, but we like the following standard from the Minnesota Department of Welfare's Rule 185: "to provide the client with a normal existence. If this is not possible, to provide the person with the alternative which is least restrictive. This includes making available to the client patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society."

Performance contracting is ideally suited to this principle of "least restrictive environment", because it seeks to measure results rather than "units of service". Is the client living, working, recreating in the least restrictive environment? This question supersedes such questions as: has the client received X hours of training in toileting/dressing/motor skills, etc.?

Environmentally-defined "outcomes" are also easily and simply measurable by comparison with developmental skills.

Finally, a performance contracting system ties provider livelihoods directly to achievement of client success, creating new rewards and incentives for successful outcomes.

BENEFITS TO CLIENTS AND CLIENT FAMILIES

The system of performance contracting which we are recommending is targeted directly at achieving results with immediate benefits to clients and client families, in the realm of greater independence for clients and increased participation and integration in the community. While it it possible to develop "care" outcomes such as provision of food and shelter, as opposed to "change" outcomes involving increased client competence or movement within the service system, it seems likely from our preliminary research that "change" objectives can be developed for most clients, even many clients diagnosed as severely retarded.

The presumption we are making is that people with developmental disabilities should be able to share and participate in the society around them, to "do as many things as possible the way most of us do them" (in the words of Lou Valenta)--work, have a good home, utilize the resources of our community, have a network of friends and family to provide support.

And because the traditional service delivery system for the mentally retarded has by and large not focused on this kind of "change" objective, we have heard from many sources that that "change" objectives can be developed for virtually all clients presently served within the system.

In addition, the system we are proposing includes the needs and preferences of the client and the parent or guardian in the process of developing specific objectives, by conducting an "ecological assessment" of client functioning-in both present and future environments and prioritizing objectives to maximize functioning within those environments .

BENEFITS TO TAXPAYERS

Maintaining mentally retarded people in state hospitals and large group homes where their life choices and their participation in community life is limited creates a large tax burden. The costs of most community-based services are significantly lower than the costs of institutionalization.

Furthermore, achieving "outcome" objectives for clients will in most cases serve the taxpaying community as well as

the client, by making him/her more employable or by enabling him/her to utilize existing community facilities and resources. Even where costs of creating results are high, the results themselves should ultimately reduce the social costs of maintaining separate facilities for developmentally disabled persons.

In Minnesota, performance contracting will be required as of July 1, 1984, for those clients judged eligible for "waivered services", an array of alternatives to large residential facilities. We have heard some fears expressed that clients who are moved into less restrictive residential settings will "fail" and possibly require a period of expensive hospitalization to "stabilize".

It is certainly true that performance contracting requires a careful analysis and screening of the client and directing objectives toward movement incurs a greater risk of failure. However, by restricting a field test to adult day services which are received by most mentally retarded adults except residents of state hospitals we can minimize the risk while at the same time beginning to collect a body of data about success rates. Eventually it should be possible to predict with greater accuracy what kinds of outcomes can successfully be achieved for a variety of clients, and to expand the range of services covered in performance contracts.

BENEFITS TO PROVIDERS

In Minnesota the provider is probably the strongest link in the system of MR services, the most likely to be familiar with clients and their needs and to advocate for those needs with case managers and families. Providers are also responding rapidly to changes in the theory of service delivery; the three county providers of day services we interviewed are all in the process of change from the old model (based on child development) to a new one based on age-appropriate functioning in natural environments.

Performance contracting will in some measure balance the control over the services delivered to clients because it will strengthen the role of the case manager in determining client needs and purchasing benefits which will meet those needs.

The providers we talked to all expressed concern about a "provider-controlled" system, and indicated that they normally involve a client advocate in the development of a program plan.

We sensed that providers believe that they are doing a good job, but would be happy to have a system in which they

could prove that they are doing a good job.

Performance contracting would have the following advantages for providers over the present system:

Expectations would be clearly defined, and successful results clearly measurable. The net result for providers who are doing a good job would be recognition for their accomplishments.

Providers could potentially profit from the performance contracting model we envision. The present system offers virtually no financial incentives for doing a good job.

New kinds of services, or specialties, could be developed by providers in response to the needs of a performance model, such as "assessment centers" to identify client objectives or resource centers which provide support to clients in the process of integration into "normal" community and vocational activities .

Flat per diem rates restrict the potential to explore new kinds of programming. If outcomes are purchased, the provider has more latitude within which to operate and can be more creative in developing ways of meeting objectives .

For example, teaching skills in small classes or on a one-to-one basis in the developmental learning center may be less effective than taking the client or a group of clients to the natural environment in which those skills are needed and finding ways for the clients to function successfully in that environment. Some providers envision a developmental learning center of the future where almost nobody is there, because clients are all out "practicing" skills, working at jobs, etc. and staff are providing or creating the support systems necessary for them to do that. The performance contract gives providers the freedom to spend less time on delivering "units of service" which may have little or no practical value to the client. Of course, the contract must also include safeguards against abuse and a system of monitoring.

BENEFITS TO THE COUNTY CASEWORKERS (PURCHASERS)

The performance contract is a powerful tool for the county case manager to insure that the needs of clients are being met, and that services which are purchased are being directed toward outcomes. The case manager has more "ownership" in the process than at present, where providers essentially determine what a client's needs are and how to

meet them.

On the other hand, performance contracting places a greater burden and responsibility on the case manager. For a performance model to work, there must be some clear benefit to the case manager and this is not necessarily implicit in the concept of performance contracting.

We've heard that the average case manager is burdened by a heavy caseload and a lot of paperwork, does not have the time to get to know the client well, and in many cases lacks the level of skill and education which the provider has. If performance contracting is to work effectively, the case manager must be the key, the advocate on the client's behalf who purchases the benefits most necessary and appropriate within the principle of providing the "least restrictive environment".

Recognition and reward for good work are necessary to produce good case managers. This implies an overall set of statewide principles: what are the characteristics of a good case manager? what kind of training should they have?

While the solution to this problem is outside the scope of a field test of a model performance contract, we are suggesting that counties with an interest in field-testing a performance contracting model provide training to their case managers, and that those case managers be given some recognition for participating in a "model" program.

SUMMARY

In sum, we believe that the potential benefits of a performance contracting model are great enough to implement a field test trial. The model could be a tool whereby adult clients achieve movement into less restrictive environmental domains, and a means for providers and purchasers alike to gain recognition for their accomplishments. It is ideally suited for development and measurement of "ecological" objectives aimed at integration of mentally retarded clients into the natural environments of the community where they live. It offers potential savings to taxpayers and profits to providers. Properly implemented, it would increase flexibility and accountability of providers and control of county purchasers over client outcomes.

The principal drawbacks of performance contracting in the present system derive from a lack of knowledge about what good performance means, for purchasers and providers alike. The field test we envision would address these drawbacks by allowing a period of one to two years in which data would be collected before payments would be tied to outcomes.

PART II.
SPECIFICATIONS NEEDED TO GUIDE THE DESIGN OF A MODEL PERFORMANCE CONTRACT

Rainbow Research, in concert with the Advisory Committee appointed by the MnDaca/McKnight Project, has developed a list of specifications needed to guide the design of the model performance contract. This is NOT an outline of a model contract but can be considered comparable to a blueprint for such a contract. We are also not suggesting the format or sequencing for the contract here, but are rather approaching the question of what needs to be covered in a sequence of questions which need to be addressed before a contract can be designed. For example, it is necessary to define the scope of goals, objectives and measures of attainment to be covered by the contract before proceeding to such questions as how outcomes will be purchased.

1.0 PROVISION OF OUTCOMES

In this section we'll want to set the scope and parameters of the model performance contract. This includes the variety of goals, objectives and measures of attainment that are permitted, as well as the types of clients and types of services. The first area, then, is to demarcate the territory to be included for modeling in this contract.

1.1 Types of goals covered by this procurement (outcome goals and process goals)

The goals or principles suggested in this section are consistent with the policies of the Minnesota Department of Public Welfare (DPW) and with the changes in programs presently being undertaken by many providers. They are based on materials from the Dakota County Developmental Learning Center and a brief survey of recent literature, especially the work of Lou Brown of the University of Wisconsin.

There need to be specs about what specific goals are targeted for this system of contracting.

We suggest that overall principles and goals guiding the development of specific objectives should include:

The principle of least restrictive environment: objectives developed for the the client should be directed toward functioning in the least

restrictive (most normal) environment possible in each of the following "domains": vocational, domestic living, leisure/recreation and community.

The principle of "ultimate functioning": where developmental skills are taught to the client, those skills should be functional, age-appropriate, and directed toward maximal participation in his/her natural present and future environments.

The principle of ecological inventory: skills should be prioritized according to individual clients' needs and preferences within the above ecological domains. The client's present activities should be inventoried for the purpose of defining the skills necessary to function within actual present environments and possible future environments. Highest priority should be given to skills with multiple and long-range applications and to functional skills necessary for participation in the least restrictive environments.

The principle of partial participation: where it is impossible to teach a developmental skill considered necessary to function in a normal environment, a variety of adaptations should be explored which will enable participation in that environment: adaptations of teaching materials, provision of adaptive devices, adaptations of skills sequences and/or rules, and adaptations of the physical and social environments themselves.

The principle of generic (community) services: wherever possible, the services and resources provided to clients should be those already existing within the community and the client should be provided with the support systems necessary to participate in those services.

1.2 Types of clients covered by this procurement

There need to be specs about what specific types of clients are targeted and how the contract will address different levels of needs/desired outcomes.

There should be recognition of the difference between "cared-for" clients and "changing" clients. It should be possible (although unusual) to contract only for specific "care" services for some clients. We suggest that, as in the DPW contracting for waivered services, three types of outcomes could be purchased, or any combination of

the three, for a given client: provision of "care" (i.e., food, medical care, physical therapy), provision of an adaptive skill or set of skills (i.e., learning to use public transportation), or movement within the system (i.e., placement in competitive community employment).

The contract should identify differences in difficulty of achieving outcome objectives requiring "care" and objectives requiring "change". Purchase of "care" outcomes need not require measures of accomplishment, but some means should be established to determine that clients have not been abused, nor have needs been neglected. The contract should specify the safeguards in terms of monitoring and compliance appropriate to each type of outcome which is purchased.

1.3 Types of services covered by this procurement

These specifications are designed to be used only for day adult programs. In cases where Individual Program Plans are developed jointly between residential and day providers, the contract shall clearly specify the responsibilities of the day program provider.

1.4 Types of objectives, and measures of objectives, covered by this procurement

There need to be specs concerning the level of specificity allowed in choice of objectives and measures.

All individual objectives should be chosen from the four "domains" (vocational, domestic living, community, and recreation/leisure) and should relate directly to the client's natural environment, both present and future.

Objectives in the domestic domain should enable clients to function in the least restrictive domestic environment, and assist to create such environments.

Objectives in the vocational domain should enable clients to participate in vocational activities as much as possible, to earn a living or contribute toward their own support.

Objectives in the community domain should enable clients to function in a wide variety of general community environments--public transportation, shopping centers, restaurants, streets, hospitals, public and private agencies, etc.--and with

non-handicapped persons in those environments.

Objectives in the recreation/leisure domain should enable clients to manage and occupy free time appropriately and in a wide variety of heterogeneous environments.

Another domain sometimes separately defined, the "interaction-with-non-handicapped persons" domain, can be subsumed under the other domains where such skills or environmental adaptations are necessary to achieve the desired client outcome.

We are proposing to compile a list of outcome objectives within each domain area in the next phase of this project. This list will be a typology, probably hierarchical, of all the possible "outcomes" which might be anticipated for clients, ranging from "most restrictive" (such as a day "work activity" program without pay) to "least restrictive" (such as competitive community employment at minimum wage). The case manager should choose appropriate objectives for each client from this list to be incorporated into the performance contract.

The case manager should conduct an assessment to identify client objectives within the four "domains" prior to finding a provider. These objectives will become part of the client's Individual Service Plan. The case manager may either conduct this assessment personally, using the available information about the client, or may contract with a provider to conduct an assessment.

We suggest that these objectives should be arrived at through an "ecological inventory" process to insure an appropriate outcome for the client's level of functioning consistent with the "principle, of ultimate functioning". They should also be tied directly to the skills and adaptations necessary to perform in environments and sub-environments identified in the ecological assessment, to assure choices consistent with the principle of "generic" services.

We also suggest that the most effective way to identify objectives which are functional and appropriate for a given client is to contract separately for an "assessment" for each client, prior to developing the Individual Service Plan.

Upon completion of the Individual Service Plan, the case manager should select a provider through the process described in Section 3.1.

2.0 UNIT OF PURCHASE

In this section we want to make clear just what is being purchased: "change" outcomes or "process" outcomes, for individuals or for a percentage of a group, etc.

We recommend that during the first phase of the field test period, outcomes which warrant payment be identified and costs of achieving those outcomes be tracked and paid for. Providers can thereby establish track records for achievement of individual outcomes, and for overall success rates with all clients over a specified time period.

During the second phase of the field test, we suggest that a system of payment for outcomes should be tested.

2.1 What kinds of performance (and service) warrant payment?

There need to be specs declaring the events or outcomes for which providers get paid.

We suggest that during the second phase of the field test period:

Per diem rates for clients should gradually be replaced by rates appropriate to different types of clients and types of desired outcomes.

The contract should specify a fixed base rate for achievement of individual outcomes.

The contract should also include incentives or bonuses for high overall group success rates and for maintenance of outcomes (i.e., lack of regressions) over prescribed time periods.

A percentage of operations support should be guaranteed to the provider, and the remainder of the agreed-upon cost be paid upon achievement of the desired outcomes or results within the time period specified by the contract. This system of payment should be followed regardless of the type of result (provision of care, change in the client, or movement within the system).

Partial payment for partial outcomes (for individuals and for groups) should be permitted and provided for in the contract.

Once a client has reached the desired maximal level of functioning, "maintenance" at that level should be an appropriate outcome which may be contracted for payment.

3.0 CHOICE OF CLIENT OBJECTIVES

While the first two sections set the stage, this one would govern how objectives are chosen (from the set permissible) for a given client, or group of clients.

3.1 How specific objectives are developed for a client (including different roles, time periods)

There need to be specs about how specific objectives are developed for a client or group of clients (how needs assessments are done).

Objectives should be identified by the case manager and integrated into the Individual Service Plan prior to contracting for a provider.

These objectives should be demonstrably appropriate for an individual client in terms of the overall principles and goals outlined in Section 1.1 above.

The case manager should utilize all available information in assessing client needs and developing the client's Individual Service Plan, including DPW's Waivered Services Screening Document, and an ecological inventory if available. (Copies of these documents are attached to this report.) The case manager should also meet with the client and client family/guardian or a client advocate in developing the Individual Service Plan.

The case manager should be trained and thoroughly familiar with the method of ecological inventory, and should select from the list of domain-based objectives to be developed in the next phase of this project, which will be consistent with that method.

We have suggested in Section 1.4 that the case manager may wish to contract for an assessment prior to developing the Individual Service Plan to insure that the choice of objectives meets the principles in Section 1.1.

We suggest that this "assessment contract" be limited to a maximum of 30 days and is most appropriately done by someone other than a potential provider of the outcomes in the performance contract. The sole purpose of the assessment is to develop client-appropriate objectives and measures to be made part of the performance contract.

We suggest that the assessment should take the form

of an ecological inventory process and should include the following steps:

Identify the relevant curricular domains;

Determine the environments in which the client is functioning or might function in the future within each domain;

Divide the environments in each domain into sub-environments;

Delineate the activities that occur in each sub-environment;

Delineate the specific skills (or environmental adapations) needed in order for the person to participate in as many of the activities as possible;

Prioritize skills and activities according to client preference, caregiver/guardian preference, and the principles and goals outlined in Section 1.1 above. (See "Activity Selection Checklist" attached to this report with the sample ecological inventory.)

After developing the objectives for an individual client, the case manager should distribute a "Request for Proposal" (RFP), a public invitation to providers to bid on a contract to achieve those objectives. In some cases the RFP may be developed for a group of clients with similar objectives.

After a provider has been selected, specific objectives developed by the provider in an Individual Program Plan should be directly related to the Individual Service Plan developed by the case manager.

There need to be specs about time periods established for achieving desired outcomes and reporting performance/outcome data.

The initial ecological assessment and development of an Individual Service Plan should not take longer than 30 days.

Upon selection of a provider, an Individual Program Plan should be developed within 30 days and a time period within which the provider expects to accomplish each objective should be specified in

the Individual Program Plan and in the performance contract.

Clients should be re-assessed quarterly to measure progress toward objectives. Quarterly reports to providers should indicate whether objectives established for that quarter have been achieved. A new Individual Program Plan should be developed annually. This system of re-assessment and reporting is similar to what most providers do now, and meets guidelines established by DPW.

3.2 How objectives are re-established

There need to be specs about how new objectives will be determined upon achievement of contractual objectives.

The ecological inventory is a suitable instrument for periodic re-assessment of client needs as well as the initial assessment. In an ecological assessment, the parent/care provider and the client are asked what activities are high preference for instruction in both present and future environments (i.e., the next three years). The case manager (or the provider doing the assessment) then prioritizes the activities. As the highest priority activities are successfully achieved, the case manager can look to activities of the next priority.

The ecological inventory should be taken again annually for *every* client, or at the point where all client objectives have been achieved (whichever comes first), and at that time client needs should be re-assessed.

3.3 Group objectives, individual, or both

There need to be specs about whether objectives are developed for an individual client or a group of clients.

Specific objectives for individuals which are part of the Individual Program Plan must be developed on an individual basis, as a result of an ecological inventory.

Case managers may find after development of Individual Service Plans for a group of clients that many of the objectives are the same. They may at this point create an RFP for a group of clients with such objectives as "secure competitive employment in a community setting" (vocational) or

"use public transportation to utilize community resources and facilities" (community), and providers may bid for a group contract.

Should case managers discover, in first phase of the field test, that they are unable to find providers equipped to achieve the desired outcome objective, records should be kept of the desired objective as well as the objective actually contracted for as a means of documenting the need for additional kinds of services.

3.4 Independence of specific service

There need to be specs about whether outcome objectives and measures of those outcomes imply, prescribe or relate to specific services.

Outcome objectives and measures which reflect achievement of those outcomes should not normally "prescribe" particular services in a way that disallows innovative methods designed to achieve outcomes. Particularly, the "principle of partial participation" allows the provider flexibility to create a variety of adaptations in the client's environment in order to achieve objectives.

In some cases, to be specified in the contract, objectives and measures could reflect both a service and an outcome. For example, where program services can be classified in terms of achievement or progress levels (such as a work program defined by five successive levels of productivity), progress could be identified and measured by movement to a new level.

3.5 Mix of outcome and process objectives

There need to be specs governing the mix of "outcome" (change in a client, movement within the system) and "process" (care) objectives developed.

It should be possible to develop some "outcome" objectives for virtually all clients, and case managers should be encouraged to do so.

In certain cases it may also be necessary to contract for provision of "care" services (at least on an interim basis), as for example when the client cannot feed or clothe him/herself or needs special medical care. The contract should clearly specify that this kind of objective warrants payment even though no "outcome" is achieved.

4.0 ASSESSMENT OF CLIENT OBJECTIVES

Given a contracted subset of objectives, and a permissible set of measurement procedures, how shall the objectives for a given client or group of clients be assessed?

4.1 How outcome measures reflect attainment

There need to be specs about how outcome measures reflect objective attainment.

Measures should be able to detect whether desired outcomes are actually achieved within a defined limit of measurement error.

Measures have to be conceptually different enough to identify different outcomes.

Outcome measures should be reliable and valid indicators of objective attainment.

Outcome measures for individual clients:

The most appropriate measures for the "domain"-based objectives developed for individual clients will be "samples" of behavior (demonstration of skill) to be observed in the "outcome" setting (performance in environment). In some cases it may be possible to take measures in the "training" setting if the behavior is not specific to an environment.

In the next phase of this project, outcome measures for all contractual objectives will be designed. The outcome measure to be taken for each objective should be specified in the performance contract and the Individual Program, Plan .

A goal of the field test should be to develop a standard instrument for measurement of domain-based outcomes, which can be normed on types of clients and types of outcomes.

Outcome measures of overall group success:

We suggest that the outcome measures developed during the next phase of this project be used during the field test period to assess client functioning at intake and at the annual re-assessment, and also to assess group change.

The outcome measures should become part of a data-collection instrument which provides information about "types of clients".

4.2 Standard measures, individual, or both

There need to be specs about whether measures are standard or individually defined or some combination of both.

Measures should provide standardized data about achievement of outcomes by types of clients (as in insurance rate-setting), including data about age, sex, IQ, level of retardation, residential placement and current status in the four domain areas.

Measures should also be useful to assess achievement of individually appropriate client outcomes.

Specific objectives should have specific measures attached to them. For example, an objective in the recreation/leisure domain might be for the client to participate in the activities of a senior citizens center in her neighborhood. The measure could be a periodic report from the center on the client's participation.

4.3 Frequency of assessment

There should be specs about how frequently outcome measures are taken.

Measures should be taken as often as necessary to confirm objective attainment. Measures should be taken at the end of the time period specified in the contract for attainment of the objective, and earlier if the provider believes that the objective has been attained.

After an objective has been attained, there should be a tracking system which provides for follow-up of long-range achievement of outcomes at periods to be specified in the contract, up to one year.

5.0 DETERMINATION OF PAY

This section will specify how the performance of the provider will be related to payment. Much of the data necessary to relate performance and payment will need to be collected during the first phase of the field test.

5.1 Relation to achievement

There need to be specs about how pay rates are related to achievement of outcomes.

There must be a clear formula relating pay and outcome.

This formula should be developed gradually by tracking costs and outcomes by type of client across all providers.
During the first phase of the field test, a system for tracking costs and outcomes should be developed, and providers should not be expected to assume the risk of loss in achieving a given outcome.
During the second phase, a system linking payments and outcomes will be developed and tested.

5.2 Determination of rates

There need to be specs about how pay rates are determined for different types of clients, and for different outcomes.

There should be a price for. achieving each identified objective for each type of client. This price should be determined during the first phase of the field test, by examining data collected about costs of achieving objectives by categories of clients.

Cost-containment should be considered in examining base rate data collected during the first phase of the field test. While the performance contracting model should offer incentives for profit when desirable outcomes are achieved, the overall costs of performance contracting should not exceed present costs.

5.3 Unit of pay

There need to be specs about whether payment is based on achievement of results on a per client basis, or on relative accomplishment of objectives for a group of

clients.

There should be a price specified in the contract, to be paid each time an objective is achieved with an individual client

There should be a bonus specified in the contract for achieving each objective with X percent of each type of client annually.

5.4 Events releasing payment

The events releasing payment should be specified in the contract.

We suggest that payment for achievement of individual objectives be released each time that evidence is presented (as was specified in the contract) that an objective or a group of objectives has been satisfactorily achieved.

5.5 Control for influential factors

There need to be specs about how pay rates "control for" factors that influence outcome rates (such as difficulty level).

During the first phase of the field test, data should be collected toward creation of standard predictors of difficulty level. The combined data obtained from data-collection instrument designed for the field test and the Waivered Service Screening Document should be examined at the end of this phase for indications of predictive validity.

6.0 CLIENT RECORDKEEPING

Recordkeeping will have to support a number of functions: the determination of performance and therefore payment; the establishment of base levels of performance against which expectations and therefore payment are made; the development of a data base that will support comparability and aggregation across clients and programs. Both case managers and providers will need to keep records.

6.1 Data to be collected on individuals

There need to be specs about the data to be collected by case managers.

Data collected by case managers should include: age, sex, IQ, level of retardation, residential placement, current status in the four domain areas, and desired outcome objectives in those areas. Where case managers are unable to find a provider to achieve desired outcomes, records should be kept of the objectives actually contracted for as well as the desired objectives.

There need to be specs about the data to be collected and recorded on individuals by providers.

Individual data collected must by usable by puchasers in the development of standardized measurement systems for dollar prices for outcomes for individuals of the same type. Therefore, providers participating in the field test must agree to standard procedures for data collection, to be developed prior to the first phase of the field test.

Standard reports must be completed for each individual for whom the provider has contracted, and these reports should indicate individual conditions so as to "flag" both problems and success stories.

6.2 Unit of analysis and reporting

There need to be specs about the level of aggregation in analysis and reporting: individual or program or actuarial subgroup or agency?

Data should be reported by each provider on each individual client on the set of measures prescribed in the contract.

Aggregate data on standard measures should also be required of providers on an annual basis. The information contained in the aggregate reports will be identified prior to the first phase of the field test.

During the field test period, data collected from providers should be aggregated to compile actuarial subtables by types of clients and outcomes, and by geographic area.

6.3 How data are to be aggregated

There need to be specs about how data are to be collected and aggregated by providers.

"Aggregate" data collected by providers should be comparable so that individual providers will establish comparable track records. The contract should specify what data are required in aggregate form from each provider.

6.4 Data privacy vs. access

The contract should guarantee confidentiality of individual client data and should be in accordance with state and federal regulations. Aggregate data may be used to create actuarial tables and may be made public.

7.0 METHOD OF PAYMENT

Given the groundrules for determining the amount of pay, some specs are needed to govern the manner, context, and consequences of payment.

7.1 Use of profits

There need to be specs governing the use of profits

The performance contracting model should create financial incentives for providers. We suggest that all profits and risks should accrue to providers once payment is tied to outcomes.

We also suggest that a percentage of providers' retained profits specified in the contract should be alloted for program improvement.

7.2 Link to records

There need to be specs about the link between records/evidence and payment.

Payment provisions should be linked to provider records of accomplishment at regular intervals. The contract might specify that providers would provide monthly records of all individual outcomes achieved during that period, thereby releasing payment, and that aggregate data required for bonus payments be submitted at other regular intervals (such as quarterly and annually).

There should be assurances for verification of results at the time of payment, according to the measures specified in the contract.

7.3 Allocation among multiple providers

There need to be specs about how payment gets claimed by multiple providers (who achieved the outcome?)

There should be a way to allocate payment to the "rightful" provider. With the changes underway in the service delivery system, notably joint program plans being developed between residential and day providers and the advent of waivered services, questions may arise about who actually achieved a given outcome.

Providers should be asked to bid on a package or cluster of correlated outcomes and should be paid

only for those outcomes which were bid upon

7.4 Frequency of payment

There need to be specs about how often payments are made.

The portion of the base payment necessary to cover operating costs should be made to the provider at regular intervals during the contract period.

Additional payments should be made on achievement of specified outcomes at specified periods. We suggest monthly or quarterly payments for achievement of individual objectives, and annual payments for long-term achievement and group success rates.

8.0 QUALITY CONTROL

No matter what is being purchased, provisions for quality and accountability have to be written in. With the increased flexibility performance contracting offers providers in achieving results and the increasing independence being sought clients, questions about safeguards for client protection assume new importance and present difficulties in monitoring not as easily surmounted as when clients were grouped together in large institutional settings.

8.1 Restrictions on methods

There need to be specs about restrictions placed on methods of achieving outcomes (i.e., "minimum standards" for services provided).

There must be safeguards against abuse, mistreatment, bad practice. We suggest that providers be in compliance with the Standards for Services for Developmentally Disabled Individuals published by the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (AC MRDD).

Particularly for those clients requiring a substantial amount of care, "process packages" (e.g., to insure client protection) should be included in the contract.

A monitoring system should be established prior to the first phase of the field test and procedures for compliance should be specified in the contract.

8.2 Qualifications of providers

There need to be specs about assuring good, or required, practice (i.e., qualifications of providers, licensing issues related to quality of care)

Providers must meet existing licensing standards, and we also suggest that they meet the standards of AC MRDD referred to above.

Providers must carry all necessary insurance and comply with all necessary DPW regulations and statutory obligations. The contract should specify which regulations and statutes are applicable to providers.

Providers must demonstrate that personnel policies, policies for physical maintenance of facilities,

and other policies meet DPW standards and other state requirements.

8.3 Limitations on responsibility

There need to be specs governing the limitations on care responsibility of each of the contractual parties.

Providers should assume responsibility for the health and safety of clients while providing programs and services, except as specified in the contract. Exceptions might include situations where the client is placed in a community job, recreational program, uses public transportation, etc. after an period of support and adjustment with the provider present.

8.4 Provisions for termination/modification

There need to be specs about provisions for termination and modification of the contract.

The contract should include provisions for termination by either party.

The contract should allow for modifications in the event that either party determines that contractual provisions are not commensurate with client needs, or present hazards to the health or safety of the client.

8.5 Intake/referral

There need to be specs about how a client is referred to a provider and the intake process.

The case manager will develop an Individual Service Plan for each client according to the procedures outlined in Section 3.1 above.

The case manager will solicit provider bids on a per client basis and/or on a group of similar clients through an RFP process to be developed prior to implementing the first phase of the field test.

The case manager will determine which provider is selected.

Upon selection of a provider, an Individual Program

Plan will be developed within 30 days of intake. The plan should be directed toward achieving the outcome objectives identified in the Individual Service Plan, and should be directed related to the ecological inventory.

There need to be specs about how an Individual Program Plan is developed for a client within the provider setting and how it is related to the case manager's Individual Service Plan.

The Individual Program Plan will be developed within 30 days of intake and will be based upon the ecological inventory and the objectives stated in the Individual Service Plan. We suggest that this plan be approved jointly by an Interdisciplinary Team, to include at least: the case manager, the provider, the client, the client family/care provider and a client advocate.

8.6 Relations with other providers

There need to be specs about relations with other providers and respective responsibilities.

Ideally, a joint Individual Program Plan would be developed for all providers responsible for a client, with respective responsibilities identified.

If there is no joint plan, the responsibilities of the provider under the performance contract for day adult programs should be clearly spelled out and differentiated from the responsibilities of other providers.

8.7 Program improvement

There need to be specs about how program improvement is allowed for and encouraged in the contract.

There should be an incentive for program improvement (addressing previous problems, and creating new methods for solutions). Within the minimum standards set to protect client health and safety, the contract should permit provider flexibility and discretion in meeting outcome objectives.

The contract should allow data to be used to improve individual treatment plans, and the agency's program delivery.

A percentage of retained profits should be channeled for program improvement.

9.0 ROLES UNDER THE CONTRACT

This would spell out the roles and responsibilities of the different parties and stakeholders to the contract.

9.1 Role of each party in fulfilling the contract

There need to be specs about the role of each of the contractual parties in fulfilling the contract

The contract should be a valid legal document, and should clearly specify the role of the provider, the purchaser, other providers concerned with the client, and the parent or legal guardian in the areas of determination of needs; choice of client objectives and program plans; data collection and assessment of outcomes; recordkeeping and reporting; determination of pay and methods of payment; insuring quality control; and monitoring and compliance.

9.2 How objectives will be re-negotiated

There need to be specs about how new contracts will be negotiated upon achievement of contractual objectives.

The contract will establish a time frame for achievement of objectives. The contract should also specify procedures for re-negotiation at the end of that period, or when all objectives have been achieved, whichever comes first.

The case manager should create a new Individual Service Plan at least annually and require a new Individual Program Plan at the time. However, a new public RFP process should not be required where providers have achieved satisfactory outcomes in the initial contract, unless the provider can no longer meet the needs of the client.

There need to be specs about how performance/outcome data will be used in re-negotiating the contract

Data collected and reported by providers should be used by the case manager in determining the new Individual Service Plan.

10.0 MONITORING/COMPLIANCE

This would spell out the procedures for contract review, and the consequences of doing well or badly.

10.1 Procedures for review

There need to be specs which spell out procedures for review.

The review process should be clearly defined in terms of what to look for, by whom, how often, and consequences. Prior to the first phase of the field test, a review process should be created with input from a selection of providers and county representatives.

The review process should be useful for the education of case managers.

The review process should be useful for the development of standardized outcome measures.

10.2 Penalties and incentives

There need to be specs about the penalties and/or incentives (such as technical assistance) if aggregate goals are not met by a provider.

Aggregate success rates for achievement of individual outcome objectives should be compiled and reviewed annually. Where providers fail to meet a substantial proportion of these objectives, a sequential process should be specified in the contract: first, incentives for improvement such as obtaining technical assistance, and second, a sequence of penalties such as special monitoring, financial penalties and termination.

Especially during the field test of the performance contracting model, every effort should be made to assist providers to improve performance before penalties are imposed.

ATTACHMENT A

APPENDIX D

DEPARTMENT OF PUBLIC WELFARE

WAIVERED SERVICES SCREENING DOCUMENT

THIS FORM PREPARED BY DEPT OF WELFARE

SCREENING INFORMATION

☐ PRIVACY ACT EXPLAINED?

WAIVER TYPE	ACTION TYPE	ACTION DATE	SCREENING LOCATION	COUNTY OF SERVICE	COUNTY OF RESIDENCE	COUNTY OF FIN RESP	PRESENT AT SCREENING						
							CLIENT	FAMILY	OTHERS				
1	2	3	4	5	6	7	8	9	10	11	12	13	14

BASIC CASE INFORMATION

CASE NUMBER	CLIENT NAME	BIRTH DATE	SEX	MAR.	LIV ARR	CASE STATUS
15	16	17	18	19	20	21

MA ID NUMBER	MA ELIG	REFRD DATE	REFRD BY	WARD OF COMM	EMPLOYEE NUMBER	CASE MANAGER
22	23	24	25	26	27	28

PRI PROBLEM	SECONDARY PROBLEMS			PRI DIAG	SEC DIAG	TERT DIAG	EMPLOYEE NUMBER	SECONDARY WORKER
29	30	31	32	33	34	35	36	37

CLIENT ASSESSMENT

BEHAVIOR

	FREQ		INTY
...rious to self	38	45	
...rious to others	39	46	
...structive of Property	40	47	
...aks Rules & Laws	41	48	
...otional Disturbance	42	49	
...turbed Orientation-People	43	50	
...turbed Orientation-Objects	44	51	

...le Determined MR 52 ☐ IS M.R. 53 ☐

SUPPORT SERVICES

	RCVG		PLAN
...time Medical Services	71	89	
...cialized Medical Services	72	90	
...cialized Dental Services	73	91	
...sical Therapy	74	92	
...cupational Therapy	75	93	
...ech Therapy	76	94	
...ntal Health Services	77	95	
...ning for Family	78	96	
...cial Transportation	79	97	
...cial Recreation	80	98	
...al Guardian	81	99	
...servator	82	100	
...al Aid Service	83	101	
...Instrumental Advocate	84	102	
...Expressive Advocate	85	103	
...havior Management	86	104	
...Respite Service	87	105	
...ernite Respite Service	88	106	

GENERAL FUNCTION

Level of Function	54	
Medical Needs	55	
Vision Function	56	
Personal Mobility	57	
Communication	58	
Hearing Function	59	
Toileting	60	
Seizure	61	
Cerebral Palsy	62	
Self Preservation	63	

Level of Supervision 107 ☐

AT TIME OF SCREENING

Residential Setting	108	
Day Setting	109	

RES/DAY SERVICES

	Care		Training	
Self Care	110		120	
Personal Hygiene	111		121	
Personal Mobility	112		122	
Community Transportation	113		123	
Socialization	114		124	
Communication	115		125	
Leisure and Recreation	116		126	
Money Management	117		127	
Community Living	118		128	
Household Management	119		129	
Infant Level Stimulation			130	
Vocational-Prevocational			131	

SIGNATURES

Case Manager 144 _____ Date 145 _____

RSS # 148 ☐

QMRP 146 _____ Date 147 _____

NOTES:

DPW-2658 (4-84) PZ-02658-01

SCREENING RESULTS

RISK STATUS	TEAM CHOICE	CLIENT CHOICE	FAMILY CHOICE	FINAL ACTION	RECOM RES
132	133	134	135	136	137

SERVICE PLAN

CURRENT SERVICE	139	
TEAM CHOICE	140	
CLIENT CHOICE	141	
Funded by UWA Waiver	142	
NOT Funded by UWA Waiver	143	

CODE VALUES FOR THE WAIVERED SERVICES SCREENING DOCUMENT

BLOCK NO SCREENING INFORMATION

1 WAIVER TYPE
- 1 - MR/DIVERSION
- 2 - MR/CONVERSION
- 3 - ELDERLY DIVERSION
- 4 - ELDERLY CONVERSION

2 ACTION TYPE
- A - SCREENING SCHEDULED GATHERING INFO
- B - INITIAL SCREENING WAS DONE
- C - AN ANNUAL SCREENING WAS DONE
- D - REENTRY
- E - SERVICE PLAN CHANGED
- F - A MISCELLANEOUS SCREENING WAS DONE
- M - EXIT DEATH
- N - EXIT ICF/SNF PLACEMENT INCREASED RISK
- O - EXIT ICF/SNF PLACEMENT CLIENT CHOICE
- P - EXIT NO LONGER AT RISK
- Q - EXIT CLIENT CHOICE OTHER
- R - EXIT PERMANENT MOVE FROM STATE
- S - EXIT NO LONGER FINANCIALLY ELIGIBLE
- T - EXIT OTHER REASON

3 ACTION DATE
- THIS CONTAINS THE DATE OF THE ACTION TAKEN IN BLOCK # 2 (MMDDYY)

4 SCREENING LOCATION
- 01 - CLIENT'S RESIDENCE
- 02 - RELATIVE'S HOME
- 03 - ACUTE CARE FACILITY
- 04 - BOARDING CARE HOME
- 05 - NURSING HOME
- 06 - COUNTY OFFICES
- 07 - COMMUNITY ICF/MR
- 08 - STATE HOSPITAL
- 99 - OTHER

5 COUNTY OF SERVICE
- 01 THRU 99 SEE CSIS CODE BOOK FOR DESCRIPTIVE VALUES

6 COUNTY OF RESIDENCE
- 01 THRU 99 SEE CSIS CODE BOOK FOR DESCRIPTIVE VALUES

7 COUNTY OF FINANCIAL RESPONSIBILITY
- 01 THRU 87

8 CLIENT PRESENT AT SCREENING
- Y - CLIENT WAS PRESENT
- N - CLIENT WAS NOT PRESENT

9 FAMILY PRESENT AT SCREENING
- Y - A FAMILY MEMBER OR GUARDIAN WAS PRESENT
- N - A FAMILY MEMBER OR GUARDIAN WAS NOT PRESENT

10 - 14 OTHERS PRESENT AT SCREENING
- SW - SOCIAL WORKER COUNTY WELFARE
- PN - PUBLIC HEALTH NURSE
- RS - REGIONAL SERVICE SPECIALIST
- QM - QUALIFIED MENTAL RETARDATION PROFESSIONAL
- AP - ATTENDING PHYSICIAN
- CP - CONSULTING PHYSICIAN
- AD - ADVOCATE
- ZZ - OTHER

15 CASE NUMBER
- COUNTY CASE IDENTIFICATION NUMBER

16 CLIENT NAME
- NAME OF CLIENT BEING SCREENED

17 BIRTH DATE
- BIRTH DATE OF THE CLIENT IN THE FORM MMDDCCYY
- MM-MONTH D-DAY C-CENTURY Y-YEAR

18 SEX
- M - MALE
- F - FEMALE
- U - UNKNOWN

19 MARITAL STATUS
- 1 - SINGLE
- 2 - DIVORCED
- 3 - WIDOW (ER)
- 4 - MARRIED (LIVING WITH SPOUSE)
- 5 - MARRIED (SEPARATED WITHOUT LEGAL ACTION)
- 6 - LEGALLY SEPARATED
- 7 - MARRIED BUT VOLUNTARILY SEPARATED (NURSING HOME ETC)
- 8 - UNKNOWN

20 LIVING ARRANGEMENT
- SEE CSIS CODE BOOK

21 CASE STATUS
- 02 - ACCEPTED FOR ASSESSMENT
- 04 - OPEN CASE
- 32 - SERVICES COMPLETED NO FURTHER SERVICE NECESSARY
- 33 - SERVICES COMPLETED REFERRED ELSEWHERE
- 36 - DECEASED
- 37 - MOVED
- 39 - ENTERED HOSPITAL/NURSING HOME
- 45 - TRANSFERRED TO ANOTHER COUNTY

22 MA ID NUMBER
- MEDICAL ASSISTANCE NUMBER OF CLIENT

23 MA ELIGIBILITY
- 1 - CURRENTLY MA ELIGIBLE
- 2 - MA ELIGIBLE IN 180 DAYS
- 9 - NOT MA ELIGIBLE

24 REFERRED DATE
- DATE CLIENT WAS REFERRED FOR SCREENING FORMAT IS MMDDYY

25 REFERRED BY
- 01 - MENTAL HEALTH
- 02 - PUBLIC HEALTH NURSING
- 03 - SOCIAL SERVICES
- 04 - INCOME MAINTENANCE
- 31 - ATTORNEY
- 32 - PHYSICIAN
- 33 - PSYCHIATRIST
- 34 - DENTIST
- 35 - CLERGY
- 36 - NURSE
- 37 - PSYCHOLOGIST
- 38 - SOCIAL WORKER
- 39 - OTHER PROFESSIONAL
- 41 - CLINIC
- 42 - HOSPITALS
- 43 - CRIPPLED CHILDREN'S SERVICE
- 44 - NURSING HOMES
- 45 - STATE HOSPITAL
- 46 - VETERANS HOSPITAL
- 47 - ICF MR FACILITY
- 49 - OTHER HEALTH AGENCY
- 91 - SELF
- 92 - FAMILY
- 93 - RELATIVE
- 94 - FRIEND
- 95 - NEIGHBOR
- 99 - OTHER

26 WARD OF COMMISSIONER
- Y - IS A WARD
- N - IS NOT A WARD

27 CASE MANAGER NUMBER
- COUNTY ASSIGNED EMPLOYEE NUMBER

28 CASE MANAGER NUMBER
- NAME OF CASE MANAGER

33 - 35 DIAGNOSIS
- ICD-9 CODES

36 SECONDARY WORKER NUMBER
- COUNTY ASSIGNED EMPLOYEE NUMBER

37 SECONDARY WORKER NAME
- NAME OF SECONDARY WORKER

38 - 44 BEHAVIOR - FREQUENCY
- 1 = NOT A PROBLEM
- 2 = LESS THAN ONCE PER YEAR
- 3 = MORE THAN ONE /YEAR LESS THAN ONE/MONTH
- 4 = MORE THAN ONE/MONTH LESS THAN ONE/WEEK
- 5 = MORE THAN ONE/WEEK LESS THAN ONE/DAY
- 6 = MORE THAN ONE/DAY LESS THAN ONE/HOUR
- 7 = MORE THAN ONCE PER HOUR
- 8 = CONSTANTLY

45 - 51 BEHAVIOR - INTENSITY
- 1 = DOES NOT DO THIS OR IS NOT A PROBLEM
- 2 = NUISANCE BUT DOES NOT INTERFERE
- 3 = INTERFERES WITH OWN PROGRAM ONLY
- 4 = DISRUPTS MORE THAN ONE BUT NOT WHOLE GROUP
- 5 = DISRUPTS WHOLE GROUP
- 6 = DISRUPTS AN ENTIRE CENTER OR FACILITY PROGRAM
- 7 = NEEDS IMMEDIATE MEDICAL ATTENTION TO PREVENT HARM

52 DATE DETERMINED MR
- DATE COUNTY DETERMINED CLIENT WAS MENTALLY RETARDED
- FORMAT DDMMYY

53 IS MR
- Y = CLIENT IS MR
- N = CLIENT IS NOT MR
- U = UNKNOWN

54 LEVEL OF FUNCTION
- 0 = UNKNOWN
- 1 = NOT MENTALLY RETARDED
- 2 = BORDER LINE OR ABOVE
- 4 = MILDLY RETARDED
- 6 = MODERATLY RETARDED
- 8 = SEVERELY RETARDED
- 9 = PROFOUNDLY RETARDED

55 MEDICAL NEEDS
- 0 = UNKNOWN
- 1 = NO SERIOUS MEDICAL NEEDS
- 4 = NEEDS REGULAR VISITS FROM NURSE OR TO DOCTOR
- 6 = NURSE ON SITE DAILY BUT NOT CONSTANTLY
- 9 = NEEDS MEDICAL PERSONNEL ON SITE AT ALL TIMES

56 VISION FUNCTION
- 0 = UNKNOWN
- 1 = NO VISION IMPAIRMENT
- 4 = DIFFICULTY AT LEVEL OF PRINT
- 6 = DIFFICULTY WITH OBSTACLES
- 9 = NO USEFUL VISION

BLOCK NO

57 PERSONAL MOBILITY
- 0 UNKNOWN
- 1 NO MOBILITY IMPAIRMENT
- 3 MOVES ABOUT WITH ASSISTANCE
- 5 MOVES ABOUT WITH DEVICE
- 7 UP IN CHAIR ONLY
- 9 COMPLETELY BEDRIDDEN

58 COMMUNICATION
- 0 UNKNOWN
- 1 NO COMMUNICATION IMPAIRMENT
- 3 SPEECH IS DIFFICULT TO UNDERSTAND
- 5 USES SIGN LANGUAGE
- 7 USES GESTURES AND/OR SOME SIGNS
- 9 NO FUNCTIONAL COMMUNICATION

59 HEARING FUNCTION
- 0 UNKNOWN
- 1 NO HEARING IMPAIRMENT
- 2 FULL HEARING WITH HEARING AID
- 4 DIFFICULTY AT LEVEL OF CONVERSATION
- 6 DIFFICULTY WITH ALARM SOUNDS
- 8 ONLY HEARS VERY LOUD SOUNDS
- 9 NO USEFUL HEARING

60 TOILETING
- 0 UNKNOWN
- 1 HAS FULL CONTROL
- 3 OCCASIONAL LOSS OF CONTROL
- 5 LOSS OF CONTROL MOST NIGHTS
- 7 INCONTINENT OR FREQ LOSS OF CONTROL
- 9 NO CONTROL

61 SEIZURE
- 0 UNKNOWN
- 1 NO HISTORY OF SEIZURES
- 3 SEIZURES CURRENTLY CONTROLLED
- 5 MINOR SEIZURES 1 TO 10 PER MONTH
- 7 MAJOR SEIZURES 1 TO 10 PER YEAR
- 9 MAJOR SEIZURES MORE THAN 10 PER YEAR

62 CEREBRAL PALSY STATUS
- 0 UNKNOWN
- 1 NO MANIFESTATIONS OF CP
- 4 CP WITH MINOR FUNCTIONAL IMPAIRMENT
- 6 CP NEEDS SELF SPEECH INTELLIGIBLE
- 9 CP IS TED OR SPEECH UNINTELLIGIBLE

63 SELF PRESERVATION
- Y CLIENT IS CAPABLE OF SELF PRESERVATION
- N CLIENT IS NOT CAPABLE OF SELF PRESERVATION
- U UNKNOWN

71 RR SUPPORT SERVICES RECEIVING
- Y IS RECEIVING THE SERVICE
- N IS NOT RECEIVING THE SERVICE
- U UNKNOWN

89 106 SUPPORT SERVICES PLANNED
- Y IS RECEIVING THE SERVICE
- N IS NOT RECEIVING THE SERVICE
- U UNKNOWN

107 LEVEL OF SUPERVISION
- 1 FULLY INDEPENDENT
- 3 SEMI INDEPENDENT
- 5 MODERATE SUPERVISION
- 7 SUBSTANTIAL SUPERVISION
- 9 INTENSIVE SUPERVISION

108 RESIDENTIAL SETTING AT SCREENING
- 01 WITH NATURAL OR ADOPTIVE FAMILY
- 02 IN LONG TERM FOSTER CARE
- 03 WITH RELATIVES NOT IMMEDIATE FAMILY
- 04 IN OWN HOME OR APT FULLY INDEPENDENT
- 05 OWN HOME / APT SUPV LESS THAN 24 HOURS
- 06 OUT OF HOME SUPV LESS THAN 24 HOURS
- 07 OUT OF HOME SUPV 24 HOURS
- 08 SKILLED NURSING FACILITY
- 09 STATE HOSPITAL
- 10 ICI
- 11 COMMUNITY ICF/MR
- 99 OTHER

109 DAY PROGRAM SETTING AT SCREENING
- 01 PRESCHOOL PROGRAM HOME BASED
- 02 PRESCHOOL PROGRAM CENTER BASED
- 03 ELEMENTARY SCHOOL PROGRAM
- 04 SECONDARY SCHOOL PROGRAM
- 05 POST SCHOOL TRANSITIONAL PROGRAM
- 06 ADULT DAY HABILITATION PROGRAM
- 07 LONG TERM WORK ACTIVITY
- 08 LONG TERM SHELTERED EMPLOYMENT
- 09 PROTECTED WORK STATION IN INDUSTRY
- 10 COMPETITIVE EMPLOYMENT FULL OR PART TIME
- 11 RETIREMENT PROGRAM
- 99 OTHER

110 119 RES/DAY SERVICES CARE LEVEL
- P PHYSICAL ASSIST
- S SUPERV & CONTROL
- M MONITORING
- I INDEPENDENT OR APPROPRIATE TO AGE

120 131 RES/DAY SERVICES TRAINING LEVEL
- M MANUAL GUIDANCE
- D DEMONSTRATION
- V VERBAL
- N DOES NOT NEED TRAINING IN THIS AREA

132 RISK STATUS
- 1 ICF/MR
- 2 IC/I
- 3 ICI /R
- 4 SNF
- 8 AT RISK BUT NOT ELIGIBLE
- 9 NOT AT RISK

133 136 SCREENING RESULTS
- 01 REMAIN AT HOME WITH SERVICES
- 02 REMAIN AT HOME WITHOUT SERVICES
- 03 PLACEMENT IN COMMUNITY
- 04 PLACEMENT IN BOARDING CARE HOME (ICF-II)
- 05 PLACEMENT IN NURSING HOME (ICF-I)
- 06 PLACEMENT IN NURSING HOME (SNF)
- 10 PLACEMENT IN ICF MR
- 97 NO SERVICES DESIRED / CLIENT REFUSED
- 98 UNDECIDED
- 99 OTHER

137 RECOMMENDED RESIDENTIAL SETTING
- 01 WITH NATURAL OR ADOPTIVE FAMILY
- 02 IN LONG TERM FOSTER CARE
- 03 WITH RELATIVES NOT IMMEDIATE FAMILY
- 04 IN OWN HOME OR APT FULLY INDEPENDENT
- 05 OWN HOME / APT SUPV LESS THAN 24 HOURS
- 06 OUT OF HOME SUPV LESS THAN 24 HOURS
- 07 OUT OF HOME SUPV 24 HOURS
- 08 SKILLED NURSING FACILITY
- 09 STATE HOSPITAL
- 10 ICI
- 11 COMMUNITY ICF/MR
- 99 OTHER

138 RECOMMENDED DAY PROGRAM
- 01 PRESCHOOL PROGRAM HOME BASED
- 02 PRESCHOOL PROGRAM CENTER BASED
- 03 ELEMENTARY SCHOOL PROGRAM
- 04 SECONDARY SCHOOL PROGRAM
- 05 POST SCHOOL TRANSITIONAL PROGRAM
- 06 ADULT DAY HABILITATION PROGRAM
- 07 LONG TERM WORK ACTIVITY
- 08 LONG TERM SHELTERED EMPLOYMENT
- 09 PROTECTED WORK STATION IN INDUSTRY
- 10 COMPETITIVE EMPLOYMENT FULL OR PART TIME
- 11 RETIREMENT PROGRAM
- 99 OTHER

139 143 SERVICE PLAN
- 01 CASE MANAGEMENT
- 02 HOMEMAKER
- 03 RESPITE CARE
- 04 SKILLED NURSING
- 50 ADULT DAY PROGRAM
- 51 HOME HEALTH AID
- 52 PERSONAL CARE SERVICES
- 53 ADULT FOSTER CARE
- 54 CHILD FOSTER CARE
- 55 MEALS/CONGREGATE DINING
- 56 TRANSPORTATION
- 57 DEAF/BLIND/DISABLED SERVICES
- 58 FRIENDLY VISITOR/SENIOR COMPANION
- 71 DAY HABILITATION
- 72 CHILD-SLA
- 73 ADULT-SLA
- 74 IN-HOME FAMILY SUPPORT
- 75 MINOR PHYSICAL ADAPT
- 91 STATE HOSPITAL
- 92 COMMUNITY
- 93 ICF
- 94 SNS
- 99 NO SERVICES PROVIDED

148 RSS NUMBER
- STATE ASSIGNED RSS NUMBER

Development Learning Center

WORKSHEET 1 (Before Interview)

7

ECOLOGICAL ASSESSMENT

COVER SHEET

CLIENT _____ DATE OF BIRTH _____

RESIDENCE _____ PHONE _____
street

_____ CONTACT PERSON _____
city state zip code

PARENT'S NAME _____ PHONE _____

PARENT'S RESIDENCE _____
street city state zip code

INTERVIEW DATE _____ TIME _____ PLACE _____

INTERVIEWER _____

ADDITIONAL ASSESSMENTS OF BASIC FUNCTIONS:

ASSESSMENT	PERSON RESPONSIBLE	STATUS

DIRECTIONS TO PLACE OF INTERVIEW:

ATTACHMENT B

WORKSHEET 2 (Before Interview)

IMMEDIATE NEIGHBORHOOD INVENTORY

CLIENT ..... DATE .....

ENVIRONMENT	ADDRESS/LOCATION	NOTES

GENERAL NOTES/REMINDERS:

PARENT/CARE PROVIDER INTERVIEW TOPICS

CLIENT _____ PROGRAM _____

1. What _____ likes is:

2. What _____ dislikes is:

3. What are _____ strengths?

4. What are _____ needs?

5. Please list any behaviors that bother you or others:

What do you (or others) do when this happens?

How would you like to see it change?

6. Does _____ take any responsibility for household chores?
   If so, what?

   What is their reaction to them?

7. Would you like to see _____ working?
   If so, what kinds of jobs would you like _____ to do?

   Are there any jobs you would object to?

8. What questions do you need answers to?

9. What would you like help with?

10. What would you like to see happen now?

WORKSHEET 3, PAGE 3 (During Interview)

Describe how _____ behaves in each of the following areas (only if appropriate for the particular client

Eating:

Communication: (receptive)

Communication: (expressive)

Toileting:

Mobility:

Socially (Getting along with others):

Are there any MEDICAL CONSIDERATIONS? Please describe:

Describe the specific places that you take _____ in the community. What happens?

Specific Places	What happens

If appropriate, describe how _____gets along with brother(s) and sister(s).

WORKSHEET 3, PAGE 4 (During Interview)

What things are important to you or other family members regarding _____ that we have not talked about yet (venting)?

Additional Notes:

WORKSHEET 4

CLIENT INTERVIEW

1. What do you want to learn?

2. What don't you want to learn?

3. What do you like to do?

4. What don't you like to do?

5. What jobs do you want to do?

6. What jobs don't you like?

WORKSHEET 5 (During Interview)

WEEKDAY SCHEDULE

CLIENT .....

List information about time the client is at home.

ENVIR.	SUB-ENVIR.	ACTIVITY	APPROX. TIME	C-A APP?	DESCRIPTION OF CLIENTS PERFORMANCE IN ACTIVITY	PREF. H.M.L	COMMENTS

WORKSHEET 5, PAGE ____ (During Interview)

WEEKDAY SCHEDULE, continued

ENVIR.	SUB-ENVIR.	ACTIVITY	APPROX. TIME	C-A APP?	DESCRIPTION OF CLIENTS PERFORMANCE IN ACTIVITY	PREF. H,M,L	COMMENTS

WORKSHEET 6 (During Interview

ADDITIONAL WEEKDAY ACTIVITIES

CLIENT _____

List any activities that occur throughout the week (M-F), but not on a daily basis.

ENVIR.	SUB-ENVIR.	ACTIVITY	APPROX. TIME	C-A APP?	DESCRIPTION OF CLIENT'S PERFORMANCE IN ACTIVITY	PREF. H,M,L	COMMENTS

WORKSHEET 7 (During Interview)

WEEKEND ACTIVITIES

Weekend activities that occur regularly:

ENVIR.	SUB-ENVIR.	ACTIVITY	APPROX. TIME	C-A APP?	DESCRIPTION OF CLIENT'S PERFORMANCE IN ACTIVITY	PREF. H,M,L	COMMENTS

WORKSHEET 8 (During Interview)

FUTURE ACTIVITIES AND ENVIRONMENT

CLIENT _____

List the activities that you would like to be doing these three years from now in each of the following areas (above dotted line). Where would these activities take place? (below dotted line). INTERVIEWER: USE YOUR INFORMATION FROM COMMUNITY INVENTORY FILE AND CLIENT'S IMMEDIATE NEIGHBORHOOD INVENTORY TO ASSIST PARENTS/CARE PROVIDERS.

After completing list, have Caregivers rank high, middle, or low preference for each activity. Put the rating in the column next to the activity. Determine if the activity and environments are chronological age appropriate. (Yes or No)

DOMESTIC	PREF. H,M,L	RECREATIONAL/ LEISURE	PREF. H,M,L	GENERAL COMMUNITY	PREF. H,M,L	INTERACTION NON-HANDICAP	PREF. H,M,L	VOCATIONAL	PREF. H,M,L

WORKSHEET 9 (During Interview)

SUMMARY OF INTERVIEW

CLIENT _____

Summarize activities from Worksheets 3,4,5 and 6 that PARENTS/CARE PROVIDERS HAVE INDICATED AS HIGH PREFERENCE ACTIVITIES FOR INSTRUCTION. Are they still high priorities: do they need to delete or add activities? Use the space below (ACTIVITIES: PRESENT ENVIRONMENTS) to record summary and responses.

Summarize activities from Worksheet 7 that parents/care providers have indicated as high preference activities for instruction. Do they need to delete or add activities/environments? Use the space below (ACTIVITIES: FUTURE ENVIRONMENTS?)to record summary and responses.

ACTIVITIES: PRESENT ENVIRONMENT
(Worksheets 3-6)

High Preference Activity	Notes

ACTIVITIES: FUTURE ENVIRONMENTS
(Worksheet 7)

High Preference Activity	Notes

WORKSHEET 10 (After Interview)

FUTURE CONTACTS

Note additional important comments made by parents/care providers during summary or closing of interview.

Other possible SIGNIFICANT INDIVIDUALS to contact:

Name: _____ Relation: _____ Permission granted: _____

Address: _____ Telephone: _____

_____

Name: _____ Relation: _____ Permission granted: _____

Address: _____ Phone: _____

_____

Next contact with parents/care providers regarding goals and objectives will be:

Date: _____ By Phone? _____ yes _____ no

Time: _____ If not by phone, location of contact: _____

Specific Notes for Next contact: _____

_____

ADDITIONAL WORKSHEET

INTERVIEW WITH OTHER SIGNIFICANT INDIVIDUAL

CLIENT .....

Use this worksheet when interviewing individuals besides parents/care providers. Make sure release of information is on file.

SIGNIFICANT OTHER ..... RELATION .....

QUESTIONS/POINTS TO MAKE (Complete Before Interview)	RESPONSES/COMMENTS BY SIGNIFICANT OTHER

ACTIVITY SELECTION CHECKLIST

NORMALIZATION: A concern for selecting activities that have social validity and will facilitate normalized domestic living, leisure, vocational and community integration, as well as provide opportunities for movement toward increasingly complex interactions.

1. *AGE-APPROPRIATENESS*. Is the activity something a nonhandicapped peer would do and/or enjoy? Yes No
2. *INTEGRATION*. Does the activity occur in criterion environments which include the presence and involvement of nonhandicapped persons? Yes No
3. *ACCEPTABILITY/ATTRACTABILITY*. Is the activity considered acceptable/desirable by nonhandicapped persons who are likely to be present in the specific environment? Yes No
4. *FLEXIBILITY*. Can the activity be accessed by the individual alone as well as in a group? Yes No
5. *DEGREE OF SUPERVISION*. Can the activity be used with little to no caregiver supervision without major modifications? Yes No
6. *LONGITUDINAL APPLICATION*. Is use of the activity appropriate across the lifespan, particularly for the adolescent and adult? Yes No
7. *CAREGIVER PREFERENCES*. Is the activity valued by caregivers? Yes No
8. *MULTIPLE APPLICATIONS*. Is the activity useful for a variety of current/and/or future environments? (Including seasonal considerations?) Yes No

Normalization Area of Concern Score: _____ 8

INDIVIDUALIZATION: Concern related to meeting the unique needs and interests of the individual learner.

1. *SKILL LEVEL FLEXIBILITY*. Can the activity accomodate low-to high-entry skill levels without major modifications? Yes No

2. *PARTICIPATION ACCESS*. Can the activity be accessed independently or through minimal use of partial participation, preferably involving persons available in the natural environment? Yes No

3. *PROSTHETIC CAPABILITIES*. Can the activity be adapted to varying handicapping conditions (sensory, motor, behavior) through normalized means? Yes No

4. *LEARNER PREFERENCES*. Is the activity something of interest to the learner that s/he would enjoy doing or be willing to do in order to access other benefits? Yes No

5. *SKILL LEVEL DEVELOPMENT*. Does the activity provide an opportunity to develop one or more critical skills? Yes No

6. *PERSONAL DEVELOPMENT*. Will the activity enhance personal development (e.g., physical benefits)? Yes No

Individualization Area of Concern Score: _____
6

ENVIRONMENTAL: Concerns related to logistical and physical components of activities in current and future environment.

1. *AVAILABILITY*. Is the activity likely to be available, both now and in the future, in the environments the learner can access? Yes No

2. *LONGIVITY*. Is the activity likely to remain available for reasonable period of time (e.g., for materials: likely to last without need for major repair or parts replacement for at least a year?) Yes No

3. *SAFETY*. Is the activity safe, within normalized "risk taking" limits (e.g., would not pose a serious/unacceptable risk for the learner and others in the environment?) Yes No

4. *NOXIOUSNESS*. Is the activity not likely to be overly noxious (noisy, space consuming, distracting) to others in the learner's environment. Yes No

5. *EXPENSE*. Can the activity be accessed at reasonable cost? (e.g., materials are priced reasonably or have multiple uses, transportation costs reasonable, etc.) Yes No

6. *MINIMAL INFERENCE*. Can the activity be programmed effectively (for performance in criterion environments) through available/feasible instructional opportunties? Yes No

Environment Area of Concern Score: _____
6