THE CORE AND CLUSTER SERVICE DELIVERY SYSTEM

PROVIDING AN ARRAY OF SERVICES TO PERSONS WITH MENTAL RETARDATION - THE CORE AND CLUSTER SERVICE DELIVERY SYSTEM

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I. CORE-CLUSTER SERVICE DELIVERY SYSTEM

CORE-CLUSTER SERVICE DELIVERY SYSTEM

Definition: Core-Cluster Service Delivery System

The core-cluster is a dynamic service delivery system which systematically provides a best-fit match between the individual's needs and the community's resources in an effort directed at normalizing the environments in which persons with mental deficiency live. It is grounded upon the belief that all people have the right to reside within the community and is organized around individual clients and their families. The delivery of services in a core-cluster system begins with a thorough evaluation of the client and only then determines the unique residential services required for community living. The core-cluster service delivery system consists of a network or "cluster" of residences which are programmatically and administratively linked to a "hub" or "core" residence. The integrated core-cluster system should be viewed as the basic organizational unit of a full array of services providing individualized environments and other support service for persons with mental deficiency and their families. Each cluster consists of a single core residence and several alternative residences. The array of services is age appropriate with children served in separate clusters from adults. Administratively, the core-cluster service delivery system is affiliated with a larger organization.

Objective of Core-Cluster Service Delivery System

1. To obtain or provide for services at the local level so that persons with mental retardation can live in their communities.

2. To provide residential services which are age appropriate and culturally normative.

3. To obtain or provide an array of services which will meet the needs of persons with mental retardation throughout life.

4. To promote the development of services for persons with mental retardation whenever possible using resources and settings available to all citizens.

5. To increase the skills of persons with mental retardation so they may participate in and contribute to the community.

6. To support and assist families in meeting the needs of their family members with mental retardation.

7. To provide staff with the resources necessary (within fiscal constraints) to fulfill their responsibility.

8. To provide a service delivery system that is consistent with TDMHMR's goals.

II. ESTABLISHING THE CORE

ESTABLISHING THE CORE

Core: Physical Structure

A core residence is simply an existing home (usually three bedrooms) that employs 4-6 full-time residential staff. One of the bedrooms in the core residence will always be available as a respite bed for people in the alternative residences. Two of the core's beds are for evaluation; the third is for respite. The core residence is not a long term home for its residents. It is simply a short term (1-3 months) residence to allow functional evaluation of the person's needs.

Core: Staffing

The managerial staff of a core-cluster service delivery system consists of a unit manager responsible for administration of the core-cluster system, and two assistant managers. The core residence has an assistant manager responsible for its functions, while the alternative residences which cluster about the core are run by an assistant manager.

The full-time staff of a mature core (see the Glossary in Appendix A) is 4-6 trained professionals who work shifts . An example of a typical shift pattern can be found in the Core-Cluster Integration section of this paper. The staffing pattern breaks down to the following functions:

1 - cluster manager

1- assistant manager responsible for the core

1 - assistant manager responsible for the alternative residences

4-6 - full-time direct resident associates or home teachers

Core: Functions

The core staff performs five major functions:

1. Functional evaluation profile
2. Program administration
3. Client and staff training
4. Respite
5. Monitoring

Functional Evaluation Profile

Before being admitted to the core residence, the individual will have had a comprehensive Diagnosis and Evaluation as part of the parent agencies eligibility for service criteria. However, the traditional D & E is not the type of evaluation referred to here. It is not a functional residential evaluation. The residential evaluation of the client which takes place in the core may be viewed as an elaboration of the initial D & E which may have recommended that the client be referred to the core-cluster for services. The purpose of the core's evaluation is to develop a comprehensive functional profile of the client that enables staff to determine the nature and quantity of services the individual requires in order to live as normally as possible within the community. A functional profile then is not a clinical, medical, psychological or social evaluation; rather it represents an ecologically valid assessment of the individual's needs. Ecologically valid refers to a prescriptive match between the client's needs as determined by an assessment made in an environment similar to the one in which he/she will live and the resources and services available in the community.

A major focus of the core-cluster is ensuring the fit between the individual's needs and the service delivery system is optimum for the client. In order to ensure an optimal fit, the assessment of the client should be performed in an environment that models his/her future home. Since there is considerable literature documenting the relationship of behavior to environment, it is vital to the client-service fit that the client's behavior be accurately profiled. There are many reasons to believe that the profile will not be accurate unless the individual is assessed within an environment that resembles the one in which he/she will eventually reside. The accuracy of the assessment not only requires that the physical environment be similar but also that the flow of the day's activities be similar. In situations where the individual enters the core residence from an environment which is very different from the one in which he/she will reside in the future, the value of behavioral assessments performed prior to residency in the core are questionable, i.e., the behavioral instruments which are part of the D & E, as well as verbal reports or nurse's notes, etc. For example, the AAMD adaptive behavior scale is a formal assessment instrument that is highly similar in intent to what the client profile attempts to measure. However, utilization of the adaptive behavior scale in an environment dissimilar in both physical structure and in the flow of daily activities from that where the individual will eventually reside, results in an assessment which may greatly exaggerate individual deficits and abilities, resulting in a profile inappropriate for the prescriptive allocation of community resources.

The adaptive behavior scale as well as most behaviorally based assessment devices, measures "chunks" of behavior (assesses eating one day, toileting the next, etc.) which are disassociated from, or not incorporated into the flow of a typical day. A functional evaluation requires that the individual's behavior

have the same flow to it that it will possess when he/she is moved into a alternative residence. That is, a functional assessment requires that the individual's ecology be a viable component of the assessment design. Such a concern increases the likelihood that the profile will generalize to the alternative residence thereby giving the evaluation ecological validity.

The individual's one to three month residence within the core allows time for core staff to develop an accurate client profile. Simultaneously, the three month residency also functions to allow the cluster manager to recruit, screen, train and hire the staff of the alternative residence where the individual will live. The selection of alternative residence staff is done after the core staff and the client's family have jointly determined the individual's needs and translated these into an individual habilitation plan that structures the interacting between client and staff. Thus, forthcoming from the profile is information that determines the kind of staff needed by the individual. For example, an individual who requires medical support may live with a registered nurse while someone who requires only supervision may share a home with a displaced homemaker. In the final analysis, both the nature of the cluster residence and the kind of staff required are determined by the development of an ecologically valid client profile.

For the most part the training of alternative residence staff should take place in the core residence. The functional evaluation process which occurs at the core becomes the vehicle for training alternative residence staff on how to care for the client with whom they will reside. By the time the client is ready to move to the new residence, the alternative residence staff will have been

working with him/her for some time, thereby facilitating the transition from core to alternative residence. The Core to Cluster Decision Flow Chart in Appendix A diagrams some of the functions of the functional evaluation of the client.

Structure of Functional Evaluation Profile

The evaluation profile will assess the type of services needed by the client (medical, educational, social skill development, behavioral, etc.). It will also identify all client and/or family concerns (religious, cultural, etc.) that might impact on the kind of services used. Emanating from the client profile will be a determination of service providers (physicians, dentists, psychologists, merchants, public school, alternative residence staff, etc.). The need for prosthetic devices, equipment, and architectural modifications of the alternative residence should be part of the profile.

The core staff, as previously described, consists of four-six full-time staff members, none of whom represent the various disciplines, traditionally associated with the diagnosis and evaluation of persons with mental deficiency, i.e., physicians, psychologists, rehabilitation specialists. Although such professionals would not be required for the development of the profile they may be needed in order to provide information valuable to the translation of the profile into an IHP. If such a need arises, then services should be secured through a consultation process. The core-cluster system is based upon a set of principles that includes a concern for the utilization of resources already available in the community. Inherent to this principle is the need for core staff to obtain professional services through the community on an as-needed basis rather than hiring professionals as full-time staff for the core.

A draft of the Functional Evaluation Profile is in Appendix A. The profile, as a functional evaluation of the client, represents a systematic view of how well the client functions in his/her every day setting which is defined, as not only a physical environment but also as a sequence of events, which in their rhythmic reoccurrence, structure the typical day. The profile itself is organized around a typical day. Within this organization, and paralleling the typical day, are certain activity structures which reoccur with an expected frequency. These daily structures are key points with regard to assessing clients' ability to function on their own, or for the staff, to gain insight into not only the clients' need for services, but also, at what time during the day such services would be required.

Although the overall nature of each person's day varies in accordance with a number of variables, most days are characterized by a somewhat routine format; the person gets up in the morning, dresses, eats breakfast and then does something. Getting up in the morning in being a structure of the normal day is also a structure of the Functional Evaluation Profile. The nature of the specific activities engaged in by people after breakfast are variable, i.e., someone may go to school, another to work, while someone else goes to a sheltered workshop, weekends and holidays may be even more varied. Thus, the profile in anticipating the routine daily structure, i.e., awakening, lunch, dinner, toileting, sleeping, etc., assesses the client's <u>ability to function</u> in relation to the structural activities characterizing the routine day. However, the typical day in containing nonstructured time periods i.e., the period between breakfast and lunch on a Saturday where the individual is free to do what he/she so desires, requires that the individual be capable of entertaining himself/herself with an activity that is engaged in on his/her own initiative.

Thus, the profile in recognizing the unstructured components of a typical day assesses the client's ability to function in these unstructured periods (called free time on the profile). However since these free times are unstructured and therefore somewhat specific to the individual, the profile in attempting to assess these free times does so by way of looking at what the client does not do. That is, on the profile where the free time categories are found (these are part of the morning, afternoon and evening structure of the typical day) the evaluator records those behaviors which the client produces when left on his/her own and is without a structured activity organized by staff. When given free time, does the client spend it doing nothing; performing stereotyped behaviors watching TV, or what? If the behavior engaged in is deemed appropriate, i.e., sewing clothes or watching TV then staff assistance is not required because the client functions appropriately in unstructured situations. However, if the client spends all the free time producing stereotyped behaviors, then staff assistance may be required. The intensity of such assistance is a staff judgment based on the severity of the clients' inappropriate behavior during these unstructured periods.

Column 1 on the. Functional Evaluation Profile contains a list of activities ordered in the sequence they would normally take place within any given 24-hour period. This progression through the day as found in the Daily Activities column, demonstrates that the main concern of a functional evaluation is to determine both the assistance and resources required by a client to live each day as fully as possible.

The Staff Assistance column indicates for each behavior whether the client requires any assistance (Yes-No), and the degree of assistance required,

(High-Medium-Low) if assistance is needed. This column allows the administration to make data based estimates concerning resource utilization relative to client needs.

The third column, Service/Resource describes the kind of resources required by the client. Again, the value of this column is found in management's concern for the type of alternative residence and staff that will be required by the individual.

The Reason column contains a specific notation with regard to the precise nature of the problem. For example, a client may need a moderate degree of staff assistance in getting up in the morning. Now, if this client were to live independently while working in the community, not getting up may be a real problem, so more specific information as to the nature of this problem may be required. This client may not set his alarm clock the night before, or he may have it too far from the bed, or turned down too low to respond to it in the morning. Thus, the Reason column describes the specific area of intervention that may be required by the client's functional deficit, and as such, this information may be important when staff begin to develop the IHP. When the IHP process begins, staff can look to the activity column to find the functional deficit area, then turn to the specific reasons as to why the client has a deficit and from the description, develop a prioritized strategy for training, if training is deemed necessary. However, it must be kept in mind that the core-cluster is hot a training program. Its principle purpose is to provide services to people with mental retardation, if one of these services is training that is fine.

Since the client is expected to be in a day program, school, workshop, or

whatever is appropriate, formulation of the IHP process should be shared with participants from the other services (other than the core) the client receives. Formulation of the IHP may also require active participation on the part of the consultants who may be called in to provide a specialized assessment for the client.

The need for consultants would be documented in the Service/Resource column of the Functional Evaluation Profile, while determination of this need would result from the functional evaluation itself (if not already part of the initial D & E). For example, a client who has physical difficulty getting out of bed, bathing, etc. may require, in addition to personal care service, physical therapy in the morning to alleviated stiffness in the muscles and help prevent atrophy. The Service/Resource column would list the need for those services, while the Reason column would specify the problem.

It is important to keep in mind that the essence of a functional evaluation of the client is the concern for ecological validity. The reification of this concern begins with a delineation of the event rhythm of a typical day (the Activity column). Following this, the principle concern of the assessment is the client's ability to function within these event-categories (grooming, meal preparation, etc.). If the client is unable to do so, the first concern becomes what services are required to enable appropriate functioning. This question may be answered with a training program but this manner of response is not paramount but secondary to the staff providing the services to allow appropriate functioning i.e., personal care. The inability of a particular client to function within any event-category may result from severe behavioral problems, a physical disability

(blindness) or from simply not possessing the necessary skills. The reason for the client's inappropriate response to the event-category then becomes the basis for determination of the need for consultants. This need emanates from a functional description of the client's ability to meet the demands of daily life.

in the selection of both the alternative residence and its staff, information obtained from the functional assessment of the client is incorporated with data obtained from a structured interview conducted by the assistant manager of the alternative residence with the client's family. The results of this interview is recorded in the Family Agreement form in Appendix A. The conceptual basis underlying the Family Agreement interview involves a concern, on the part of the core-cluster administration, that the family realize they still have a responsibility for the care of their family member. The core-cluster service delivery system's intention is not to supplant the family, rather, the family, in the form of an agreement, should be encouraged to continue to actively participate in the life of the family member. The nature of this participation can be varied, from the suggestion of clothing and grooming styles to weekend visitations and two-week vacations for the family member each year.

However, the function of the Family Agreement in the core-cluster service delivery system is much more than a statement of principle. The Family Agreement can prove to be very efficacious with regard to the support services the core offers the alternative residences. If the family takes the family member home on weekends, then the cluster staff for that client receives respite without core involvement. The client's family should be responsible for some, if not all of the client's clothing and grooming aids. The purchase of such items as agreed to by the family relieves some of the financial

responsibility from the service delivery system. The agreement can also prove beneficial to the cluster residence by negotiating with the family for provision of some of the transportation that might be required by the client for trips to the family physician for example. Perusal of the Family Agreement form point out additional responsibilities that could be assumed by the family that not only ease the alternative residence's responsibilities but also to ensure continued family participation in the life of the family member residing in an alternative residence.

The final form found in Appendix A is Factors to be Considered in Developing Cluster Residences. The functions of this form are two-fold. First, the structure of the form itself is meant as a reminder that the client's needs are the basis for selecting appropriate staff. Therefore, potential staff should be systematically evaluated by management with regard to their ability to meet the needs of the client. Thus the form's second function which is to systematically interface relevant client variables with those of the potential staff. For example, does the couple who have applied to be resident associates have a home that meets the client's need for housing, i.e., is their house barrier free in order to accommodate a wheelchair? Do they have any difficulties with allowing an adult client drink alcohol in the home? The client, for example, may need to live in a residence without small children or pets, does the couple's family situation meet these needs? The Factors to be Considered in Developing Cluster Residences is a draft of a form that attempts to systematically relate client need and staff characteristics in an effort directed at providing a best fit match between client and alternative residence staff.

ADMINISTRATION

The core-cluster unit manager is responsible for the management of the entire core-cluster. The manager is responsible for all staff in the core-cluster service delivery system. Management is responsible for the operation of the alternative residences in a manner that facilitates a prescriptive fit between client and residential services provided. The manager is responsible for the alternative residences meeting the objectives of the core-cluster while ensuring that the accomplishment of these objectives occurs in a manner congruent with the underlying service delivery principles which are in Appendix B.

There are several management functions that appear to be somewhat specific to a dynamic service delivery system such as the core-cluster. Several of these functions are listed in Appendix C. Those functions listed in Appendix C are scaled from most specific to the core-cluster to least specific and therefore more general with regard to managerial concern. As becomes apparent from a careful reading of Appendix C, a central concern of management is on maintaining the identity and integrity of the core-cluster service delivery system. Without proper management this system can quickly become liable to the "dumping" criticisms that have plagued community placement in the mental health field. For example, recruitment of the appropriate residential staff is essential if the model is to remain dynamic with regard to its ability to serve a wide range of clients. If staff are inappropriately matched with clients, then those clients may not reside in an environment that is both nurturing and normalized. Their needs may not be met and they may physically and socially atrophy. If management chooses an improper location for an alternative residence, the client may be isolated from the community and as such, cut off from those resources required for the continued maintenance of his/her well being. In order to

maintain the integrity of the core-cluster service delivery system, management must continuously be concerned with ensuring that those variables which constitute the model's identity (Appendix C) be in place and functional within the system.

In addition to the unit manager of the core-cluster, there is an assistant manager of the core residence who has the following duties and responsibilities:

1. Policy and procedure development and implementation for the core.
2. Supervision of core staff.
3. Scheduling of core staff.
4. Ensure appropriateness and timeliness of functional evaluations
5. Participate in the family agreement negotiations
6. Participate in IHP process
7. Coordinate with alternative residences assistant manager regular staff training.
8. Liaison with alternative residences assistant manager regarding client transition to residence.
9. Coordinate with alternative assistant manager with regard to respite coverage by core staff and emergency back-up.
10. Work directly with core residence clients as back-up resident associate.
11. Coordinate client transportation.

Appendix D provides a time-line breakdown of some of the general concerns of core-cluster management. These three charts furnish the manager with routine concerns that arise as a result of managing a core-cluster service delivery system.

CORE TRAINING

The training function of the core falls into two major domains, programmatic training for clients and staff training.

Client training is not itself a major function of the core. However, the core in its attempt to model the environment in which the client will eventually live may begin a training program that directly follows from the client profile. The aim of client training within the core is to initiate a process that will be transferred to the cluster residence where the client will reside. As part of the functional evaluation profile, special problems or needs will be documented. If for example, a client has a severe behavior problem requiring behavior management, the appropriate consultants may be obtained to work with the client while he/she is still in the core. However, the client's transfer to an alternative residence is not contingent upon resolution of the problem. The core facility does not function as a special training unit with explicit behavioral entry and exit criteria. The client will be placed in an alternative residence as soon as the profile has been developed, an alternative residence found and staff properly trained. If any training is initiated in the core residence, it will be continued by the staff of the alternative residence.

Part of the services provided the client while in the core will be participation in a public school program workshop, day program, or employment, whichever is appropriate. Although such activities begin while the client is in the core they continue without interruption as the client is transferred from the core to an alternative residence.

Staff training is a principle function of the core. Before staff can begin working with clients they must complete basic orientation and training. In light of the emphasis on individual needs within the core-cluster system, the focus of training for resident associates is on meeting the needs of the client with whom they will work and/or live.

Resident associates are recruited only after management has obtained sufficient information with regard to the needs of the client. Once hired, staff can train with the client with whom they will reside while the client is still in the core. In this way the resident associates will come to understand both the special needs of their client as well as how to best handle those needs. In addition, the interaction between the cluster staff, core staff and the client while at the core furnishes the basis for a mutual bonding between the three parties. Since one function of the core is to provide respite and emergency services, the establishment of a mutual bond facilitates any interactions between the resident associates and client in such a manner that any transitions in service delivery (whether due to the need for respite or emergency services) have as little disruption as possible for both client and staff.

Although the emphasis of staff training is on meeting the individual needs of the client, certain general information is required. Therefore, each core-cluster should have a basic curriculum that provides information and skills relevant to the field of mental retardation. This curriculum establishes a general knowledge base which will allow staff to then develop skills specific to the client with whom they will work in an alternative residence.

The basic training curriculum should be competency based and include the following:

History of mental deficiency

Value-based training

Normalization

Developmental model

Role of parents

Organizational structure

Legal rights of persons with mental deficiency

Assessment of behavior

Strategies for handling severe behavior problems

Coal setting

Writing behavior objectives

Strategies for integrating the person with server disabilities into the community

Task analysis skills

Understanding of Individual Habilitation Plan

Sensory-motor skill training

Personal care skill training

Awareness of social and sexual aspects of life

How to position, turn and transfer the bedfast

How to lift clients properly

How to protect oneself from an angry client

Medication training

First aid, CPR, Hemlich method, etc.

Proper nutrition

Stress management techniques

Core-cluster management should develop a set of guidelines which aids in determining the competency of staff with regard to appropriately caring for the client. Management should also develop a timetable and plan for on-going training of resident associates in order to assure that proper care continues to be provided. For example, skills such as CPR or the Hemlich maneuver are vital for proper care yet may require semi-annual training to ensure that staff is not only competent with such procedures but feels comfortable enough with them to employ the techniques in the necessary situation without prolonged hesitation.

CORE RESPITE CARE

The core residence is a source of both routine and emergency respite for the cluster. The core respite capability should have the flexibility to become operational on short notice. The core must also be capable of providing various levels of respite, i.e., from a few hours to two weeks while cluster staff vacation.

The core's need to be flexible with regard to its support function emanates from many concerns. For example, full-time care of a person who is nonambulatory may be very stressful for the staff. In order to minimize burn-out thus ensuring continuity of individualized care for the client, cluster staff should be encouraged to vacation for two weeks a year. This suggests, aside from scheduling concerns on the part of management, a need for a two week respite wherein core staff would provide services to the cluster client. Arrangement must be made where either core staff go into the client's residence for two weeks, the client stays at the core, or previously trained backup staff (who may work full-time but rotate throughout the cluster) provide the required support services. Since the core staff have previously worked with all the

clients currently residing within the cluster, minimal preparation on the part of staff will be required thereby providing the service delivery system with a certain flexibility.

In situations where resident associates require respite for a few hours in order to go out, they may hire a "substitute" at their own expense. In situation where resident associates require routine respite services (several hours during each weekday for example) the resident associates may hire someone; however, in such cases the core-cluster manager or alternative residence assistant manager should interview the prospective "substitute" to ascertain his/her qualifications.

In consideration of the range of possibilities that might create a need on the part of alternative residence staff for respite care, it becomes apparent that the core-cluster manager must establish policy with regard to the amount of respite that will be provided by the core staff to each alternative residence. For example, the alternative residence contracts (see Establishing the Cluster section) will contain a specific agreement with regard to respite services. The contract will contain a provision for routine respite such as two weekends a month (or the equivalent) and two weeks vacation per year, while establishing a limit on the amount of respite service provided each cluster residence each year (forty days for example).

The core residence will be available for respite even on an emergency basis because one bed in the three bedroom home should be kept empty for just this purpose. However, a possibility can be envisioned where the demand for respite beds goes beyond the core's physical ability to supply them (the core

may have two beds occupied by clients being evaluated and the third bed may already have a respite client). Under such circumstances the flexibility of the service delivery system is paramount. If the core cannot furnish a bed, then staff may have to go to the client's residence. Preferably such respite care will be supplied by a core staff member, however, the core-cluster manager may have to use previously trained backup staff. Each core-cluster manager will have to develop policy to handle such situations.

MONITORING

Systematic monitoring of the cluster residences is vital to the effective delivery of services as structured by the core-cluster system. As previously described, if clients are placed in residences without a continuous regard for their quality of life, the core-cluster quickly loses the effectiveness which gives it its identity. If services are not monitored to ascertain their effectiveness, costs borne by the core-cluster system are no longer efficient expenditures. Client monitoring maintains a continued concern for the prescriptive fit of resources to client needs. (See "Core-Cluster Integration" section for a discussion of client monitoring.) Administrative monitoring retains overall responsibility and accountability for the well-being of the client and the well-being of the service delivery system.

Client records provide the data for concluding certain actions have occurred that are critical to the health and safety of the client and the quality of services being delivered. The client record is maintained in two sections: 1) the master record, which remains at the affiliated agency, and 2) the residential record, which remains with the client.

Documents contained in the master record will include:

- Intake data
- Professional evaluations
- Client evaluation profile
- Service referral documents
- Correspondence
- Copy of the Individual Program Plan and monthly review
- Copy of the family agreement and any consent forms
- Copy of the residential placement contract
- Copy of any other service agreements or contracts

The residential record remains with the client. It is established in the core residence and follows the client to the alternate residential placement. Documents maintained in this record will include:

- Medical data/emergency care data
- Seizure record
- Unusual incident reports
- Medication administration record
- Copy of the residential contract
- Training data, if applicable to contract
- Health care notes
- Daily observation notes including unusual or special events
- Record of specific services provided

Administrative monitoring of the service delivery system requires a comprehensive review on a regular basis of certain documents and practices maintained in the system. A general list of areas for review includes:

- the implementation of a comprehensive set of policies and procedures for the core and cluster
- Audit trails for client funds
- Audit trails for billing and reimbursement of services provided to each client
- Staff training and development (schedules and types of training provided)

Because this service delivery system is founded on a particular set of values and principles (see Appendix B, "Service Delivery Principles"), an administrative audit may need to include a periodic self-examination by the system. Examples of questions that will need to be asked includes:

- Is each client receiving generic services wherever possible?
- Are services supporting the family unit rather than supplanting it?
- Have all clients who were placed in alternate residential placements been evaluated in the core residence?
- Is each client monitored with a frequency that ensures services remain appropriate to meet the client's needs?
- Are service providers on contract with the agency accomplishing what they are being paid to accomplish?
- When a client must move to a new residential setting (even for crisis or respite care), are adequate measures taken to make this transition a comfortable, not abrupt, one for the client?

Are alternate residence staff and clients' families provided an opportunity regularly to renegotiate their contracts with the core and cluster?

Do all staff receive sufficient training to be effective in their job performance?

III. ESTABLISHING THE ALTERNATIVE RESIDENCES

ESTABLISHING THE ALTERNATIVE RESIDENCES

Definition: Alternative Residence

A cluster residence is not a pre-defined structure that is the same for all clients. In this sense a cluster residence is not so much a thing as it is a dynamic concept identifying a mechanism of service delivery. Alternative residences are not stereotyped living arrangements but a multitude of possible ways to provide residential services. Alternative residences are to be found in any architectural environment, including houses, apartments, condominiums, townhouses, etc. The common thread running through all alternative residences is one of principle, that is, the services that are to be delivered to each client must be based on the client's needs. Therefore, alternative residences as physical structures are chosen on the basis of their ability to meet the needs of clients. This is why the alternative residence and its staff are selected after the core residence has developed the functional evaluation profile.

Alternative Residence: Physical Structure

Any dwelling can be a potential alternative residence. The physical structure of the alternative residence is determined by the needs of the client. If a client is nonambulatory and weighs 200 pounds, the alternative residence should probably be a single story home or a ground floor apartment. However, if the client possesses no mobility problems then a two-story home may be an ideal residence for the client. The physical structure of the residence is not, in itself, the determining factor with regard to it qualifying as an alternative residence. Rather, what is vital is the client's needs in relation to the physical structure of the residence, for it is this relationship that determines whether the residence should be considered an alternative residence for a particular

client. An alternative residence is a living arrangement other than the core residence where one to three clients reside with varying degrees of support.

Although the actual physical structure of the alternative residence is dependent upon the client, all alternative residences must be physically safe. Appendix E provides a guide for evaluating the physical integrity of an alternative residence.

Alternative Residence: Staffing

As previously discussed, resident associates are chosen only after the functional evaluation profile has yielded sufficient information to determine what characteristics the staff should have for individual clients. Therefore, the selection of staff should not be a pre-ordained process but must wait upon the client's profile to develop. In addition to the individual alternative residence staff, there is an assistant manager who is in charge of the alternative residences just as there is an assistant manager who is responsible for the core residence. The chief responsibility of the alternative residences' assistant manager is the coordination of resource allocation across the various alternative residences in order to maintain the fit between service delivery and client. The alternative residences' assistant manager should also work closely with core residence assistant manager in order to ensure that staff are appropriate to client needs as well as to the alternative residences themselves. Coordination within the cluster between the alternative residences and core is vital if the core is to do an efficient job of providing support and respite services to the alternative residences. Coordination is especially important if alternative residences are to be successfully identified and maintained.

Some of the duties and responsibilities of the alternative residences assistant manager are:

1. Scheduling coverage for client need/emergency coverage
   - if resident associate quits on short notice
   - if resident associate stops serving client
   - death, injury, illness to resident associate
   - emergency in resident associates immediate family
   - scheduling time off as specified in contract
2. Resolving problems concerning day-to-day client activities.
3. Policy and procedure development for alternative residences.
4. Monitoring of alternative residences to ascertain compliance with core-cluster objectives.
5. Day-to-day financial tracking of expenses.
6. Development of alternative residences in conjunction with unit manager, core assistant manager and case manager.
7. Participation in IHP development and program review in conjunction with unit manager, core assistant manager and case manager.
8. Coordination of client transportation.
9. Coordinate with core assistant manager for regular staff training.
10. Coordinate with core assistant manager client's transition from core to alternative residence.
11. Participate, as required, as emergency backup resident associate.
12. Participation in staff recruitment.

The core-cluster model represents a dynamic service delivery system which, in a sense, artistically fits services to client needs. Dynamic signifies the system's ability to modify resource allocation in relation to client need. Therefore, the

number of staff required by each alternative residence is not fixed at the outset, but determined by the client profile. For example, if a client's alternative residence is with his/her parents, in their home, no staff may be required, although respite care may be involved. Or, the family may require some support to deal with their child's behavior problem. Under such circumstances, a staff person, experienced in behavior modification, may need to stop by their house for several hours a week. This potential service situation suggests the need for resident associates that may work several different alternative residences or be employed only part-time on a contract basis.

At possibly the opposite end of the service delivery continuum from the above example is the person with profound disability, both mental and physical. Placement of this client may require a single story residence, barrier free and a family (or staff) where the husband is not only healthy, and capable of lifting the client, but around to do so. This combination may be difficult to find. In this setting a full-time resident associate may have to be on duty during the day while the husband is away at work. If the client is in a day program, the need for staff during the day will be reduced. However, the client may require physical therapy, indicating that a consultant may have to visit the alternative residence several times a week. Under such circumstances, there are essentially three and one-half staff members serving in the nonambulatory person with profound mental deficiency. Thus, the number of staff required by any alternative residence is determined by the client's need.

As with the number of staff required by any alternative residence, the matter of whether the staff live with the client or "visit" him periodically is dependent

on the client himself. When the client possesses sufficient living skills to live by himself (or with another client as a roommate) then no staff may be required other than supervision once a week or so. Whereas, clients with many or severe disabilities may require two 24-hour live-in staff.

The characteristics of the staff, like previous concerns for number of staff and living arrangements, cannot be pre-selected, but must rely on the client profile for determination. Whether live-in staff need to be at the alternative residence all day or only part of the day cannot be determined independently of the client and the type of services received, i.e., attends day program. The same is true for cultural and religious characteristics. Only by knowing the client as individual i.e., does he/she smoke, go to church, drink, date, read, toilet trained, self-abuse, etc., can appropriate resident associates be selected. In many ways the process of staffing the cluster can be made more efficient if the characteristics of prospective staff are systematically related to the client's characteristics. The form in Appendix A, Factors to be Considered in Developing Cluster Residences, attempts to do this.

Alternative Residence Functions and Services

Functions	Services
Client Care	Personal Care Homemaker/Health Care
Client Training	Habilitation In-Home Training
Client Support	Transportation Case Management
Modeling	Integration into Daily Living Activities

Although four functions of an alternative residence can be discerned, they are not mutually exclusive but are actually somewhat overlapping in that each function, to some degree relies upon the others in impacting the client. For example, staff cannot adequately care for the client without modeling a particular behavior that would, at some point, be the first step in appropriate behavioral changes in the client. So the functions of an alternative residence are really four identifiable points on a continuum of care directed at providing a normalized environment for the individual with mental retardation.

The association of services with alternative residence functions depicted above, is principally for managers who are concerned with coordinating the Functional Evaluation Profile with alternative residence functions. The purpose of which is to obtain a ready accounting of the kind and quantity of services provided each client in the cluster.

Client care is the foremost function of the cluster which must provide those services that guarantee the health and safety of the client. These can range from assisting with washing and toileting to calling the client's physician. As is true for all the functions of the alternative residence, staff's role in client care is determined by the IHP, which in turn is based on the Functional Evaluation Profile. Therefore, resident associates of individuals with profound retardation may need to be intimately involved with all levels of care, from toileting to feeding. While more self-sufficient clients may require minimal intervention except in instances of actual physical illness.

Client care is a function that requires the utilization of at least two alternative residence services, personal care and homemaker/health care services. Personal

care refers to services provided by staff in assisting the client in the areas of toileting, grooming, feeding, ambulation, dressing, etc. Homemaker/Health Care Services refers to services that provide a minor physical modification of the residence such as making it barrier free for the nonambulatory client. Also included is laundry services, meal planning and preparation, shopping, housecleaning, etc.

Client training is concerned with the client developing those skills that will increase the quality of life and lead towards independent living. Since the client's needs are determined by the client himself (as revealed by the functional evaluation profile) there is no common set of training areas for the alternative residences, rather each client's training needs will, for the most part, be unique.

Depending upon the individual client, alternative residence staff may have to train the client in those basic skill areas that also fall in the client care range of service delivery. Again, it should be kept in mind that alternative residence functions are not mutually exclusive, but overlap considerably. If, for example, an alternative residence is home for an individual who is profoundly retarded, then his/her training needs may be quite high. This possible scenario suggests that it would be a practical impossibility to immediately train the client on all deficiencies in the area of client care. The IHP would prioritize specific training needs as to which should be worked on first. Therefore, some of the staff's time would be accounted for by the personal care function while some time would be accounted for by the training function although both functions may very well involve client behaviors falling with the same domain, i.e., personal care.

Client training also includes areas of specialized training from consulting professionals such as a psychologist working with self-abusive problems or a speech therapist for correcting a speech deficiency.

Of concern for the client support function would be the amount of case management services necessary for coordinating the community's resources in a manner that efficiently links client need to community services. Variability in the amount of case management service required by a particular client is directly related to the individual client's needs. Clients with severe disabilities may require a high frequency of case management services in order to obtain all the professional assistance required by the person, whereas, clients who are mildly disabled may require only low frequency case management services because of the client's degree of self-sufficiency.

The modeling function of the alternative residence refers to the influence of a normalized environment on developing appropriate behavior in individuals exposed to such environments. There is a considerable literature documenting the effect of no-trial learning (imitation) on behavior. Essentially, no-trial learning refers to the ability of individuals to modify their behavior as a result of imitating the behavior of significant other. Normalized environments, are by definition, places where appropriate behavior occurs at a high frequency. Within the core-cluster system clients reside with a resident associate in a normalized residence, implying that clients will be continuously exposed to appropriate behavior. By watching others perform the typical and routine tasks of daily life, clients, regardless of their ability level, cannot help but to learn from the resident associates, independent of any training. In addition, the client training function of the alternative residence will be facilitated by the

impact the staff's behavior (as a model) holds for the client.

The power a model holds for modifying behavior is virtually unquestioned in developmental and social psychology. A good deal of adaptive behavior occurs incidentally, that is, without specific training. The individual, when residing within the same environment as the model (simply a significant other) "picks-up" the behavioral skills successfully employed by the model who is constantly solving problems of various magnitudes which constantly appear in the environment. Incidental learning is facilitated by the fact that people have a natural tendency to imitate. This tendency is certainly not limited to nonhandicapped individuals but is a general phenomena characteristic of all people.

Alternative Residence Contract

Resident associates should be employed on a contractural basis. The final form of the contract must be tailored to the specific alternative residence staff since resident associates will perform differential functions at varying intensities in accordance with the needs of the clients served. Although contracts will be unique to each resident associate, there are points of uniformity across all such contracts. Several of the specific items that need to be contractually agreed upon are presented below.

1. Contract should be written specifically for the staff who will work with a particular client.
2. Contract should specify services to be provided by staff and the frequency of those services. The basis for this specificity should be the Functional Evaluation Profile and the Individual Habilitation Plan.

3. Contract should specify amount of staff time required by client from full-time 24-hour care to minimal supervision.
4. Contract should specify amount of training staff will require and the need for on-going training.
5. Contract should address the staffs willingness to take an additional client into their home.
6. Contract should address obligations on the part of core-cluster management with regard to property damage resulting from client.
7. Contract should specify who transports the client to required services as well as any reimbursement concerns for mileage and vehicle depreciation.
8. Contract should specify the core-clusters obligations for the installation of any time-saving appliances to the alternative residence.
9. Contract should specify any architectural modifications to the alternative residence in order to facilitate client movement.
10. Contract should address the need for consultants, core-staff, and backup staff to enter alternative residence at various times during the day.
11. Contract should address the need for monitoring agencies to have access to alternative residence.
12. Contract should establish an agreed upon monitoring policy.
13. Contract should address the alternative residence staffs obligation to provide and maintain the physical structure of the residence in order to ensure the client's safety.
14. Contract should specify a respite care policy with regard to routine days off, vacation days off, emergency time off and spontaneous time off. A ceiling on respite days should be agreed to.

15. Contract should address the possibility that required staff time may be reduced as the client increases his independent living skills.
16. Contract should establish a set salary for staff.
17. Contract should be of a fixed duration, possibly for one year. Included in the contract might be a clause that allows either party to cancel the contract during the first thirty days of the client's residence in the alternative residence without need to show cause.
18. Contract should address the rights of the client's parents with regard to visitation, taking their child for trips, finances, etc.
19. Contract should clearly specify the liability of each party to the contract.
20. Contract should address issues of insurability (addressed on next page).

ISSUES REGARDING INSURABILITY

The issue of insurability requires clear understanding between the core-cluster administration and residence associates. For that reason the alternative residence contract must address those kinds of insurance the residence associates will need before assuming responsibility for a client. If the client will be residing in the residence associate's home, a home-owner liability policy is required of the residence associate. If the residence associate will be transporting the client at any time, the residence associate will need to present evidence of adequate vehicle insurance. When a client presents special needs in his care and supervision, e.g., behavioral problems, lifting and transporting needs, or health conditions that may place the residence associate's well being at risk, the resident associate will need to present evidence of adequate health insurance coverage.

When a client resides in his natural home or in his own apartment, issues of insurability are the client's responsibility. However, when the core-cluster assumes responsibility for the placement of a client, the core-cluster also assumes a liability for the client. An insurance company in California has been located which may provide agencies with an insurance policy capable of meeting the liability needs of the agency. The policy can provide coverage of one million dollars for each residence associate, any others in his household, and anyone entering the household to provide client services. A rider covers client-incurred damage - both bodily and property damage - up to one million dollars aggregate for the client. Currently, costs for this coverage are $55 per year per client. Specific information is available from Insurance Programming Associates in Los Angeles, 1-800-423-9733.

Variables Affecting Agency-Resident Associates Salary Assignment

The contract between the agency and resident associates will determine the resident associates' salaries. Some variables that should be considered before salary determination are listed below.

Staff-Client

- Hours per week
- Education level
- Pertinent experience
- IHP requirements (amount of supervision, personal care needs, etc.)
- Transportation requirements

Residence Provisions

- Who provides residence
- Architectural adaptations
- Depreciation
- Client wear and tear on household furnishing and structure
- Excess utility consumption
- Special location

Agency Provisions

- Insurance/hospitalization
- Retirement
- Holidays
- Vacations
- Sick
- Special benefits

IV. CORE-CLUSTER INTEGRATION

CORE-CLUSTER INTEGRATION

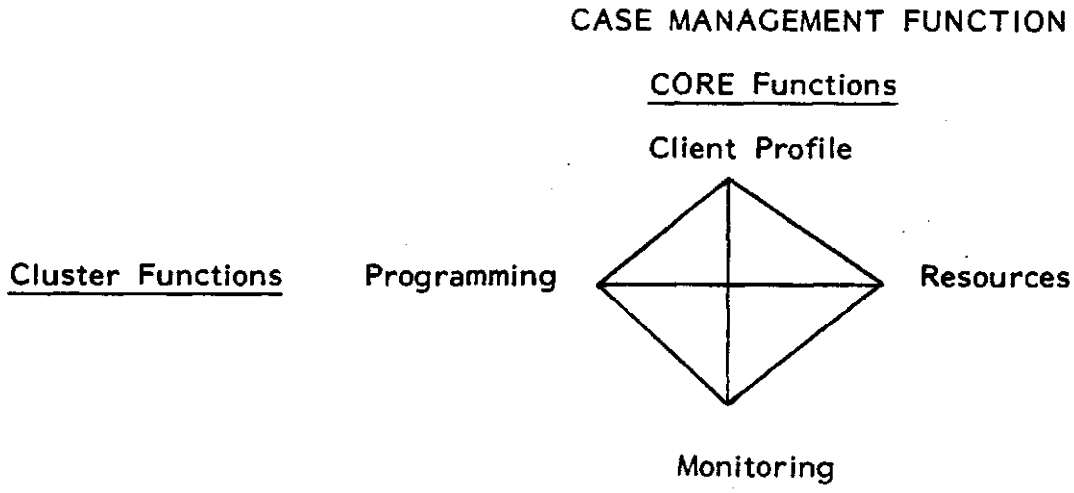
For the core-cluster to deliver services systematically, core functions must be integrated with alternative residence functions. The integration process begins with the client's short stay in the core residence. A major outcome of the core evaluation process is the Functional Evaluation Profile. The information contained in this assessment becomes the basis for selecting the appropriate staff and residence. The alternative residence is functionally integrated with the core residence by virtue of their programmatic relationship which is mandated by the requirement that programming and training provided clients be tailored by the individual's need. The Functional Evaluation Profile precedes development of the IHP, residence selection, staff selection and resource allocation for each client. Therefore, the Functional Evaluation Profile functions as a vehicle of integration between the core and alternative residences.

A second avenue for linkage between the system's two components is respite services. The alternative residences' reliance on the core for scheduled respite and particularly emergency respite, strongly recommends that coordination between the two components occur. In a mature core-cluster there may be as many as 15-20 alternative residences all requiring respite service. Coordination of respite care with cluster demand requires a knowledge of how the clients are adapting to their residences, how they are progressing on their IHP, etc., in order to be able to maintain continuity in the client's lives. Effective coordination of respite services also presupposes a working knowledge of the resources that are available at any point in time and throughout the year.

A third modality of interaction between core and cluster is found in the administrative function. Although resource coordination and allocation must wait

upon the collection of appropriate client information as determined by the Functional Evaluation Profile, the coordination of client needs and resident associates mandates that the core-cluster manager work closely with the two assistant managers (core and alternative procedures). Thus, the administrative structure requires core and cluster integration if there are to be assurances that staff and resources are, in reality, matched with client needs and at the same time not overburdening the capabilities of the service delivery system.

A system of service delivery implies that each component interacts with the others for the good of the whole. There are many areas for interaction in addition to the three already mentioned. Transportation, consultation, monitoring, a mutual concern for parents, etc., all require interaction between the core and cluster in order to effectively deliver services to clients. The case management function of the core is necessary for managing the interaction between service delivery and the client's response to this intervention. The match between services and client is best made by staff who have access to both the client as an individual in need of services and the available resources. The case manager facilitates the systematic interaction between core and cluster by coordinating services to fit client need.



Case management is an essential integratory function systematically linking core to cluster. The case manager, in order to systematically link available resources in the client's best interest, requires knowledge of the client's evaluation profile. Resources cannot be appropriately allocated without a knowledge of the profile. Since the case manager links services, a continuing knowledge of the client's progress while in the residence is mandatory. As the client changes with time, so too will his/her needs. As such change occurs, the case manager monitors this change in order to modulate service delivery in an effort to stay in tune with the client as an evolving person.

One way clients change is through both the training and modeling functions of the alternative residence. This suggests that concern for change in the client places the case manager in the unique position to monitor these functions of the alternative residence. Information obtained from the monitoring function of the case manager is feedback, capable of modifying the IHP, thereby allowing it to more appropriately reflect the current state of the client. Since resource allocation is based on client need as reflected in the IHP, modification of the IHP may be correlated with modifications in the nature of service delivered to the individual client. When viewed in this way, case management is essential to the integration of the core and cluster into a functional service delivery system.

Case Management Integration of Core and Cluster

Core-Cluster Function	Case Management Function
Profile	- Familiar with client - Determine client needs in resources
Resources	- Determine community resources - Coordinate and fit service delivery to client

Case Management Integration of Core and Cluster (cont'd.)

Core-Cluster Function	Case Management Function
Programming	- Familiar with programming activity to determine client change in response to training/modeling
Monitoring	- Modify resource allocation in response to feedback
	- Provide feedback to administrative staff in monitoring of cluster services and modification of IHP

Adult Core Simulation *

Days	Client Movement	Client Characteristics	Resources**
1	Client #1 enters core	Mild disability	Single story, 3 bedroom, 1 manager, 2 assistant managers 6 resident associates 1 case manager
21	Client #2 enters core	Moderate disability Moderate behavior problem	
30	Client #1 moves to cluster		
33	Client #3 enters core	Moderate disability	
81	Client #2 moves to cluster		
83	Client #3 moves to cluster		
84	Client #4 enters core	Profound disability non-ambulatory special diet	Consultants: physical therapist, speech therapist, dietitian
87	Client #5 enters core	Mild disability	
127	Client #5 moves to cluster		
130	Client #6 enters core	Moderate disability	
174	Client #4 moves to cluster		
177*	Client #7 enters core	Severe disability Severe behavior problem Visually impaired	Consultants: Psychologist Occupational Therapist (vision)
190	Client #6 moves to cluster		
193	Client #8 enters core	Moderate disability Deaf	Consultants: Speech Therapist, Vocational Therapist
267	Client #7 moves to cluster		
270	Client #9 enters core	Mild disability	
283	Client #8 moves to cluster		
286	Client #10 enters core	Mild Disability	

Days	Client Movement	Client Characteristics	Resources
15	Clients #9 & 10 move to cluster		
318	Client #11 enters core	Severe disability Skilled nursing care	Consultants: Physician, Physical Therapist
320	Client #12 enters core	Mild disability Severe behavior problem	Consultants: Psychologist, Vocational Therapist
375	Client #12 moves to cluster		
378	Client #13 enters core	Moderate disability	
415	Client #13 moves to cluster		
418	Client #14 enters core	Mild disability	
438	Client #11 moves to cluster		
441	Client #15 enters core	Moderate disability	

'Resources column contains only those resources considered to be special and limited only to certain clients. All clients would require case management and supervision, for example.

**See Resource Allocation Continuum in Appendix F.

Adult Alternative Residence Simulation

Days	Client Movement	Setting/Staff	Services
30	Client #1 enters residence	Living alone in apt.	Homemaker/Health Care
81	Client #2 enters residence	Living with couple (with older child)	Respite Homemaker/Health Care Consultation: Psychologist
83	Client #3 enters residence	Share apt. with/staff	Respite
127	Client #5 enters residence	Shares apt. with #1	
174	Client #4 enters residence	Shares apt. with 2 staff	Respite Homemaker/Health Care Personal Care Training Consultant: Physical Therapist
190	Client #6 enters residence	Lives with parents	Respite Homemaker/Health Care
267	Client #7 enters residence*	Shares house with Client #4	Consultants: Psychology Occupational Therapist
283	Client #8 enters residence	Living with couple (teaches at school for deaf)	Respite Homemaker/Health Care
315	Clients #9 & 10 enter residence	Share apartment	
375	Client #12 enters residence	Shares apt. with 1 staff	Respite Homemaker/Health Care Consultant Psychologist
415	Client #13 enters residence	Lives with couple	Respite
438	Client #11 enters residence	Shares apt. with couple (one of whom is RN)	Respite Personal Care Homemaker/Health Care Training
528	Client #14 enters residence	Lives with widow	Respite

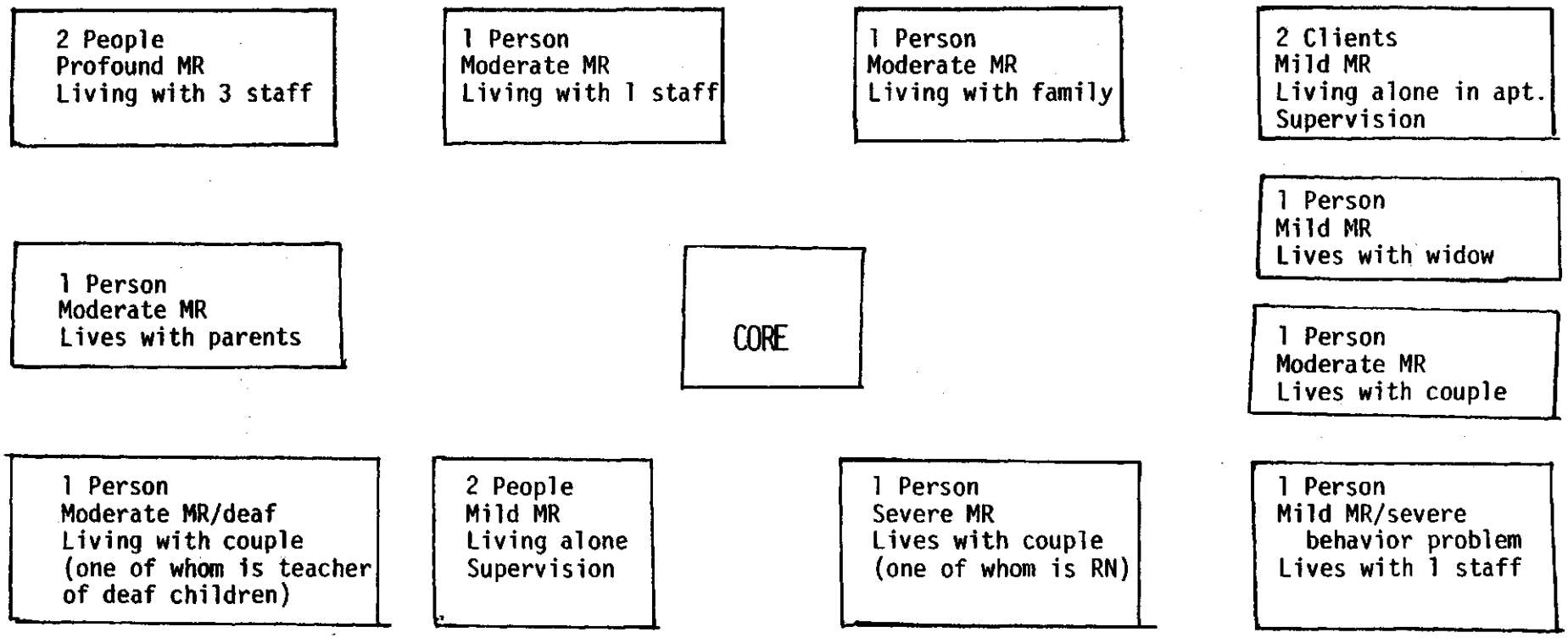
*When Client #7 leaves core he/she resides with Client #4 and additional staff added to residence.

EXAMPLE OF ADULT CORE RESIDENCE STAFFING PATTERN*

SHIFT	DAYS						
	M	T	W	TH	F	SAT	SUN
8-4	Day Program	Day Program	Day Program	Day Program	Day Program	RA #4 #5	RA #4 #5
4-12	RA #1 #2	RA #1 #2	RA #1 #2	RA #1 #2	RA #1 #2	RA #4 #5	RA #4 #5
12-8	RA #3	RA #3	RA #3	RA #3	RA #3	RA #6	RA #6

* With six full time resident associates (RA). RA's #1, #2, #3 work full time during the week. RA's #4, #5 each work four shifts on weekends. RA #6 works two shifts on weekends. Therefore, between RA's #4, #5, #6 there are five full work days available for respite and back-up. In addition, the core assistant manager can back up the resident associates as needed.

ADULT CORE-CLUSTER SIMULATION



V. APPENDICES

APPENDICES

Appendix A

Glossary

Functional Evaluation Profile

Core to Cluster Decision Flow Matrix

Family Agreement

Factors to be Considered in Developing Cluster Residences

Appendix *B*

Service Delivery Principles

Appendix C

Managerial Concerns in the Core-Cluster Delivery System

Appendix D

Manager's Planning Sheets

Appendix E

Guidelines for Physical Integrity and Safety of Cluster Residence

Appendix F

Resource Allocation Continuum

APPENDIX A

CLOSSARY

Alternative Residence - The client's residence upon leaving the core. The residence can be any architectural structure; apartment, house, natural home, etc., but cannot contain more than three clients. The number of resident associates staffing any alternative residence is determined by client need.

Cluster - The systematic functional interdependence of the core with a number of alternative residences. Although the number of clients receiving services from a cluster is not fixed, "mature" core may have between 30 and 40 clients with half of them living in alternative residence with staff (resident associates). Clusters can be for adults or children.

Core - A three bedroom residence with staff of 4-6 resident associates. The core has several functions ranging from the performance of a functional evaluation of the client to the provision of emergency respite. The client's length of stay in the core should not be longer than 90 days.

Ecological Validity - A qualifying condition that indicates that an assessment is concerned with the environments influence on the client's behavior. The Functional Evaluation Profile has ecological validity because it is an assessment that is based on the event rhythm of the typical day in an environment that models the environment in which the client will reside.

Functional Evaluation Profile - An ecologically valid assessment of the client's ability to perform the behaviors required for independent living. The purpose

of a functional evaluation is to determine the kind and intensity of resources required by the client.

Home Teacher - A term for the staff of a children's cluster including both core staff and alternative residence staff.

Resident Associate - A term for the staff of an adult cluster including both core staff and alternative residence staff.

APPENDIX A

FUNCTIONAL EVALUATION PROFILE

WORKING DRAFT

Activity	Staff Assistance[1] Yes H	Yes M	Yes L	No	Service/Resource	Reason
Early Morning						
Waking[2]						
Toileting						
Bathing						
Toothbrushing						
Grooming						
Dressing/Appearance[3]						
Timeliness[4]						
Relating[5]						
Other						
_____						
_____						
_____						

[1]H=high, M=medium, L=low

[2]Does client get up when alarm goes off, or does he require physical assistance?

[3]Does client choose appropriate clothing for work, for season? Does client have and use dressing skills?

[4]Does client perform morning routine within an appropriate amount of time, i.e., will he/she be late for work?

[5]Does client get along with others, is there communication and tolerance of delay, etc.?

FUNCTIONAL [redacted] .UATION PROFILE

WORKING DRAFT

Activity	Staff Assistance: Yes H	Yes M	Yes L	No	Service/Resource	Reason
Breakfast						
Menu						
Preparation						
Utensils						
Neatness						
Clean-up						
Relatedness						
Other						
_____						
_____						
_____						
Mid-Morning						
Preparation						
Relatedness						
Transportation						
Free Time						

FUNCTIONAL [redacted]'LUATION PROFILE

WORKING DRAFT

Activity	Staff Assistance: Yes H	Yes M	Yes L	No	Service/Resource	Reason
Lunch						
Location[6]						
Menu						
Preparation						
Neatness						
Clean-up						
Relatedness						
Timeliness						
Other						
_____						
_____						
_____						
Mid-Afternoon						
Leisure						
Recreation						
Hobbies						
Relatedness						

[6]Does client eat out on his own; if so, does he eat appropriately (menu); does he require supervision?

FUNCTIONAL [redacted] .UATION PROFILE

WORKING DRAFT

Activity	Staff Assistance: Yes H	Yes M	Yes L	No	Service/Resource	Reason
Free Time						
Appearance[7]						
Dinner						
Location						
Menu						
Preparation						
Neatness						
Clean-up						
Relatedness						
Timeliness						
Other						
_____						
_____						
_____						
Evening						
Relatedness						

[7]Does client appear dirty by late noon or unkempt?

FUNCTIONAL [redacted] UATION PROFILE

WORKING DRAFT

Activity	Staff Assistance: Yes H	Yes M	Yes L	No	Service/Resource	Reason
Free Time						
Laundry						
Housekeeping						
Manage money[8]						
Grocery shopping						
Care for Personal Possessions						
Medication						
Use of telephone						
Understanding of Emergencies[9]						
Bed						
Toileting						
Bathing						
Grooming						
Preparation for next morning						
Relating						

[8]Is client able to pay bills, do checking, etc.?

[9]Does client understand what to do in an emergency?

FUNCTIONAL[redacted]LUATION PROFILE

WORKING DRAFT

Activity	Staff Assistance: Yes H	Yes M	Yes L	No	Service/Resource	Reason
Sleeping						
Toileting[10]						
Sleeping through night						

[10]Does client wet bed; if not, does client awaken and go to bathroom?

APPENDIX A

CORE TO CLUSTER DECISION FLOW CHART

Specialized Resources

Consultants

Client Evaluation Profile

Residence
- With Family
- With Staff
- Location
- Architectural Modification
- Transportation to Resource

Staffing
- Full-time Supervision
- Part-time Supervision
- Periodic Supervision
- Training
- Appropriateness

Programming
- Resource Allocation
- Resource Intensity
- IHP
- Prosthetics

APPENDIX A

Visitation Responsibility

How frequently will family visit client?

How many days a month will client spend in family's home?

Will family be taking client on vacations?

Will family spend holidays with client?

Transportation Responsibility

Will family take client on a regular basis , i.e., to work, school, recreational activity, church?

Will family take client to appointments?

Financial Responsibility

Will family pay for or provide any of the client's clothing?

Will family pay for visits to the beauty parlor or barbershop-

Will family pay for or provide any of the client's personal items?

Will family pay for or provide any special equipment the client might require?

Will family provide client with money for special events on a regular basis?

Appendix A

Factors to be Considered in Developing Cluster Residences

MATCHING CLIENT NEEDS WITH STAFF'S RESOURCES

FACTORS[1]	CLIENT	STAFF
Residence/Home		
Access		
Ground		
Two-Story		
Barriers		
Special Modifications[2]		
Type		
Apartment		
House		
Duplex		
Other		
Size (sq. ft.)		
Neighborhood/Location		
School		
Work		
Transportation		
Recreation		
Culture		
Roommates[3]		
Religious Preference & Attendance		
Leisure Preferences		
Smoking		
Alcohol		
Social Relationships[4]		
Medical/Dental Needs[5]		
OTHER		

[1] Determined by client's preference or parents where appropriate and functional evaluation profile.

[2] Would client's needs require the home to have special equipment such as dishwasher, special bed, and is staff's home structurally amenable to this modification.

[3] Roommates refers to clients ability to get along with other children/other clients.

[4] Is there a concern for male/female socializing for client or on part of the staff.

[5] Client's needs in these areas and staff's ability to care for such needs at home and with regard to transportation.

WORKING DRAFT

Personnel/Staff [1]

Sex

Age

Marital Status

Relevant Experience

Relevant Health Factors

Staff's Physical Size [2]

Staff's Occupation

SES [3]

Personal Habits and Needs

Clothing

Hair Style

1 Questions in this section refer to staff
2 Type of work and hours involved
3 Determined by client's preference or parents where appropriate
4 Style, price, purchaser, quantity

APPENDIX B

Service Delivery Principles

1. The client comes first.
2. The environments of core-cluster residents should be normalized.
3. Services are selected and systematically organized in accord with the client's needs.
4. Services are to be used as needed and should be selected from those "generically" available to the community.
5. The core-cluster should serve clients regardless of the severity of the disability.
6. The core-cluster should use ordinary houses in ordinary residential neighborhoods.
7. Houses used as alternative living residences should blend into the neighborhood.
8. Cluster homes should be dispersed throughout the larger community affording their residents the opportunity to participate in the community.
9. Cluster homes should be accessible to a variety of stores and other community facilities providing access to a typical range of community services.
10. The number of clients in any single residence should be as small as possible with not more than three in the core residence and three in the cluster homes.
11. Attention should be given to teaching clients those skills necessary to enable them to participate in the life of the community.
12. Services and staff should be coordinated allowing for the increased likelihood that the client's experience will be one of continuity.

APPENDIX C

Managerial Concerns in the Core-Cluster Service Delivery System

1. Budgeting in dynamic service delivery system
2. Staff recruitment
3. Contracting with staff
4. Determining location of residences
5. Integration between core services and cluster services
6. Client recruitment
7. Ensuring appropriate balance in core-cluster resource utilization (keeping client mix) (staff coverage)
8. Liaison between core-cluster and affiliated agency
9. Provide orientation and on-going inservice training
10. Oversee development and implementation of policies and procedures
11. Supervision of core and alternative residence assistant managers
12. Review report of unusual incidents
13. Conduct client abuse investigations

MANAGERS PLANNING SHEET I/FREQUENCY – SIX MONTHS OR MORE – Prepared Every 6 Months

Residential Area: _____

	Admission/ Anniv. Date	Physical Exam	Dental Exam	Psycho-logical Exam	Parent/ Agency Contract		New Employee Orientation	Proba-tionary Eval.	Annual Eval.	Annual Contracts	Birthdays	Lease Renewal	Fire Exting-uisher Check	Inventory Control Check	
Frequency		1/yr	1/yr	1/3 yrs	1/yr		1	1	1/yr	1/yr	1/yr	Varies	1/6 mos	1/6 mos	
CLIENTS															
			S A M P L E				F O R M A T								
STAFF															
RESIDENCES															

Appendix D

MANAGERS PLANNING SHEET II/FREQUENCY – DAILY TO SIX MONTHS – Prepared Monthly

Residential Area: _____

CLIENTS/CONSUMERS	Frequency
Association for Retarded Citizens Mtgs.	1/2 Months
Client PTA Mtgs., Scouts, etc.	
Attendance Records (Due 20th with time cards)	1/Month
Medication Records (Due 14th with time cards)	1/Month
Fire Drill Reports	1/Month
STAFF	
Cluster Staff Meeting	1/Week
Staff In-Service Training	1/Month
PASS/Normalization	
Physical Health	
Behavior Analysis – Programming	
Staff Time Cards (Due 14th & 29th)	2/Month
Area Meeting – Department	1/Week
Staffing Schedules:	1/Month
Vacation	
Holidays	
Sick Days	
Mileage Reports (Due 5th of the month)	1/Month
Managers Meetings – Division	1/2 Months
Additions/Deletions to Inventory List	1/Month
RESIDENCE	1/Week
Medication Charts	
Daily Log	
Sanitation – Hygiene	
Maintenance Requests	
Purchase Requests: Clothing, Furnishing, Personal Items	
Incident Report Forms	
Change of Status Forms	
Residence Budget	
Client Finance Records	
Activities – Program Charts	
IPP Objectives Review	
Fire Drill Reports	
Height & Weight Records	
Food Supplies – Menu Reviews	
Aversive Consequence Requests/Reviews	
Dr./Dentist/Psychologist/Speech Therapist/or other needs	
Check Inventory – Furnishing, appliances	
Employee Disciplinary Action	

SAMPLE FORMAT

Appendix D

MANAGERS PLANNING SHEET III/FREQUENCY – PERIODIC – UNANTICIPATED EVENTS – Prepared Monthly

Residential Area: _____

	ICFMR Evaluation	ACMR/DD Evaluation	Welfare	Fire Marshal	EEOC	PASS Evaluation	Affirmative Action	Wage & Hour	Maintenance	Tours				
CLIENTS		SAMPLE				FORMAT								
STAFF														
RESIDENCES														

Appendix D

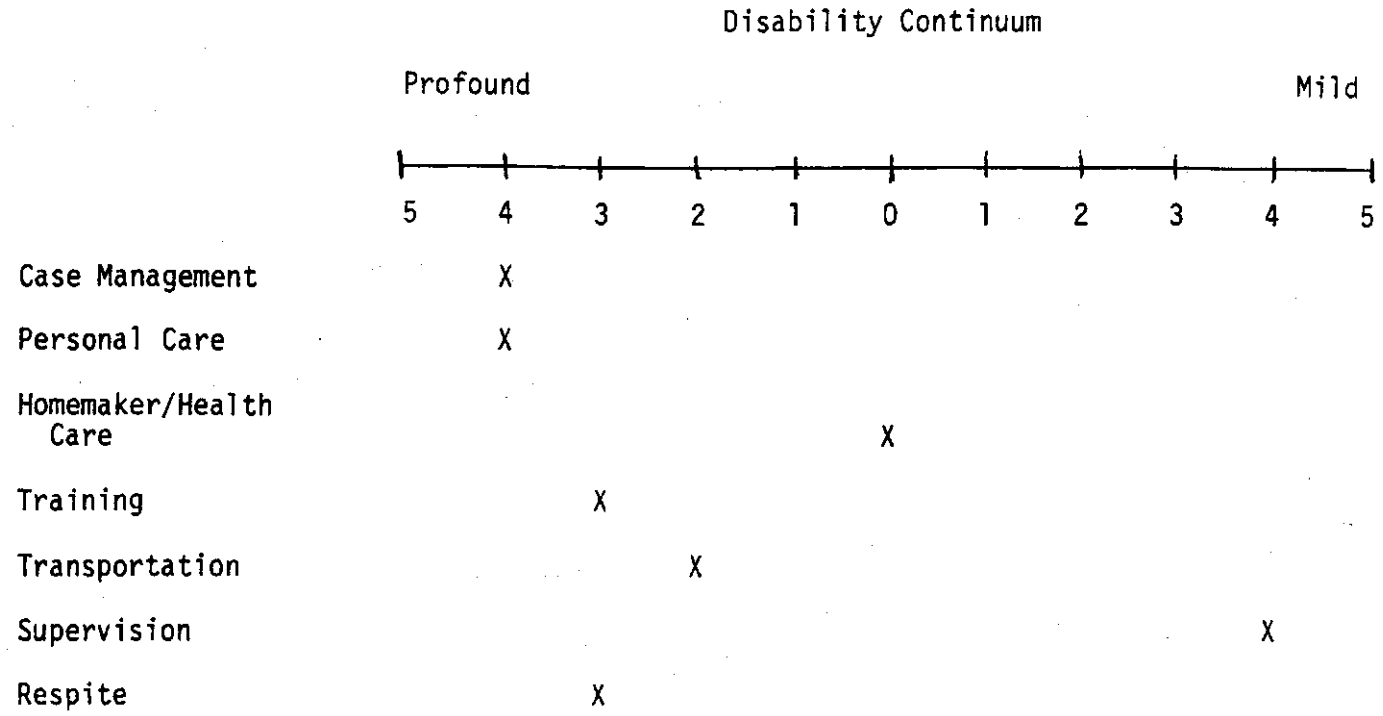
APPENDIX E

Guidelines for Physical Integrity and Safety of Cluster Residence

1. Be safe and of substantial construction and comply with applicable state and local laws relating to location, zoning, plumbing and sanitation.
2. Be adequately lighted by natural or artificial light including each hall, stairway and bathroom.
3. Have approved water supply.
4. Have ample supply of hot and cold running water.
5. Have adequate ventilation in all areas used by residents. There must be an exterior window in each resident's room which can be opened.
6. No resident shall reside separately in mobile home, detached building or rooms or other enclosures, or in basements not constructed as sleeping quarters. Approved basements must have an outside door.
7. The heating system must maintain an even temperature.
8. Telephone service must be available and accessible to residents.
9. All exterior grounds including sidewalks, steps, porch, ramps and fences must be in good repair.
10. The residence's walls, ceiling, floors, floor coverings, steps, windows, window coverings, doors, electrical fixtures must be in good repair.
11. There must be a fire control and evacuation plan that is practiced at least quarterly by the residents.
12. There must be an adequate number of smoke detectors for square footage of the residence.
13. All firearms and ammunition must be locked away.
14. Phone number of a hospital, ambulance service, poison control center, fire department, guardian and physician must be posted and close to the phone.

RESOURCE ALLOCATION CONTINUUM

APPENDIX F



The intent of the resource allocation continuum is to aid in the planning of both cluster size and mix (resource allocation) with regard to the relative distribution of core-cluster resources. The scale is read as follows: The zero point indicates that the particular resource (left hand column) required by two clients, one with a mild disability and the other with a profound disability, is essentially equal and therefore in balance (zero). A client with a profound disability may require considerably more case management for placement than a mild client; thus the X under the four in the far end of the profound side. The numbered continuum indicates simply and only approximately, the increased frequency of resources (case management required for example) by the profound client relative to the mildly disabled client's need for the same resource.