ALTERNATIVE CARE FACILITIES

The H.O.P.E. Service Delivery Model

Through the incorporation of Medicaid waiver programs, Colorado has provided an alternative to institutionalization for elders and persons with disabilities by offering health care services in deinstitutionalized community settings. Alternative Care Facilities (ACF's), or assisted living residences that are Medicaid certified, are residential care settings that provide twenty-four hour protective oversight, daily living skills assistance, personal care services, and homemaker services in a community-based environment. The ACF program in Colorado has adopted a single philosophy of service delivery to insure quality-based, effective, person-centered care within the community that complies with the Centers for Medicare and Medicaid (CMS) goals for homelike, person-centered home and community-based services.

The philosophy of care, or H.O.P.E, is a health care service delivery model that supports elders and persons with disabilities in maintaining or improving individual potential in a non-institutional, community integrated environment. It combines strengths-based social work theory with long term care culture change initiatives. The delivery model balances individual rights of self-determination and person-centered health care with individual strengths and functional capacity levels in a health care setting that is safe.

The goal of the H.O.P.E. model is to assist individuals in reaching their highest functioning level while supporting their role in the community. It achieves this by ascertaining and reinforcing individual strengths while simultaneously identifying individual needs and adapting care to meet identified strengths and needs. The ACF facilitates this process and recognizes that *the individual desires a place to live that is both home and community*. Additionally, the ACF provides services in a less costly, highly effective environment when compared to the traditional institutional environment. The model represents service delivery that is **H**omelike, **O**rganic, **P**erson-Centered, and **E**ffective.

The H.O.P.E. Model

Homelike:

The ACF fosters a sense of home and community through staff interaction, the physical environment, social milieu, organizational structure, house rules, and care plan. Each individual is treated with dignity and respect and communicated to in a genuine manner that facilitates trust. All staff members are involved in organizational decisions and house rules are formulated in collaboration with ACF residents. The physical environment supports a positive social milieu and consists of common areas where residents can entertain guests, have privacy in bedrooms, have access to unrestricted areas, be involved in everyday activities (mealtimes, recreational activities, and leisure

activities), enjoy outdoor spaces, have access to the community, and make choices about their care and life.

The ACF conducts regular house meetings that are staff **or** resident facilitated to discuss house rules, problem-solve issues that arise within the facility (such as disruptive behaviors or house rules that limit individual freedom), and arrive at consensus regarding rules and issues. The care plan is formulated in conjunction with single entry point case management agencies and community supports, including community mental health centers, family members, non-profit organizations, and other agencies involved in resident care.

Organic:

Each ACF has a unique mix of residents who present with varying functional levels, capacities, strengths, and needs. To address the diverse clientele, the ACF consistently evaluates its residents and tailors the social and physical environment to accentuate individual and group strengths while still attending to individual and group functional and capacity levels. Since the delivered care is *adaptable*, the ACF is in a constant state of change—care changes, activities change, house rules change—as residents change and individual strengths and needs change.

To capture the changes, the ACF works in collaboration with the long term care case management agency, community supports, indigenous supports, and family members to develop a comprehensive, holistic care plan. Every "need" is addressed, whether it relates to transportation, medical, vocational, financial, therapy or budgeting needs through a service goal, even if the service that meets the individual's need is NOT a waiver service. The individual is not simply included in the service plan development; the individual directs the process with support, if needed.

Person-Centered:

The ACF delivers person-centered care by utilizing a comprehensive, individualized, "whole person" approach to addressing medical, social, mental, cultural, or other aspects important to supporting individual functional autonomy and community membership. Individual preferences—personal care activities, dining, community engagement, recreation or leisure—are encouraged and supported.

However, the ACF recognizes that individual preferences may have a negative impact on the health and welfare of individuals, ACF group members, or the community. To address this challenge, staff empowers individuals to make positive life choices that enhance individual well-being, support individual potential, promote community integration, and insure group safety.

Empowerment entails treating individuals with dignity and respect, promoting individual strengths, and educating individuals on the consequences of everyday decisions. Individual empowerment diminishes the possibility of "enabling" or creating an

unhealthy dependency of the individual on the health care system. To generate this health care dynamic, intervention begins at the point in which an individual lacks potential or capacity.

Effective:

Staff members are encouraged to familiarize themselves with each individual resident through consistent and on-going interaction in order to *identify changes in condition and provide early intervention to situations that may precipitate a lower level of functioning*. When changes in individual functional level are noted, strengths and needs are reassessed and new service planning is initiated. The service planning involves collaboration between the ACF, singe-entry point case manager, other community supports and family. It focuses on increasing individual strengths and supports to reduce susceptibility to nursing home placement, hospitalization or other crisis.

As the ACF works to maintain or improve functional levels of individuals, it also acknowledges the reality of progressive disorders, and therefore, the importance of quality of life for these and all individuals. It strives to accept and understand each individual and facilitates the individual's role within the ACF and community, thereby giving each individual a sense of value, meaning, and most importantly, *hope.*

Comparison Model

To demonstrate how the H.O.P.E. model can be applied to ACF's, 25 domains of care were identified and compared. (Please note that each ACF resident mix is unique.)

Comparison of Traditional ALR and H.O.P.E. Model

DOMAIN	TRADITIONAL ALR MODEL	NEW ACF "HOPE" MODEL
Size	Per DPHE/ALR Regulation	Preference for smaller facilities that are modeled after the "Green House" nursing facility prototype
Philosophy	Medical model emphasizing functional care needs, supervision, safety, security, social and recreational programming, and medication assistance	"Homelike/Person-Centered" model emphasizing comprehensive care needs (medical, functional, social, mental, etc.) that support client functional capacity and individual preferences in a homelike environment that is safe

DOMAIN	TRADITIONAL ALR MODEL	NEW ACF "HOPE" MODEL
Organization/ Staffing Model	Administrator controls most decisions; Inconsistent staffing levels and training	Administrator involves staff members in organizational decisions; Sufficient staff to attend to client needs; Professionally trained staff; Regular professional staff development
Decision Making	All house rules made by ALR administrator and adhered to despite needed changes and individual requests for exceptions	House rules that support individual freedom, community integration, and do not pose harm to the client, house residents, staff or others; Individual requests formulated via consultation with the individual with respect to the individual's ability to make independent decisions and the affect of the decision on staff/residents; Weekly ACF house forums to reach consensus on decisions that affect the group
Privacy	Limited areas for entertaining guests; Some private bedrooms; Private phone	Common area where clients can entertain guests; Preference for private bedrooms; Private phones (cell phone taken to private area)
Access to Spaces	Space belongs to the facility; Larger ACF's have regulations restricting access to certain areas; i.e. food preparation and laundry	Space considered clients' "home"; Preference that clients have access to all areas
Outdoor Space	Limited and difficult for clients to access and enjoy	Outdoor space that encourages and facilitates client access (evenly graded yard, sidewalks, pathways) and enjoyment; i.e., shady areas, flowers, bird feeders, gardens, water features, comfortable areas to sit

DOMAIN	TRADITIONAL ALR MODEL	NEW ACF "HOPE" MODEL
Living Areas	Can be located at the end of a corridor and some distance from the bedrooms; "Institutional"	Preference for common living areas that are located outside of bedrooms; Living areas have an inviting, comfortable atmosphere
Mealtimes	Limited ability for clients to be involved in meal planning, preparation, and/or setting/decorating of dining areas	Given individual level of capacity, ability to make decisions and freedom of choice, clients are involved in meal planning, preparation, and setting/decorating of dining areas
Dining Area	Lacks ambiance (excess lighting, lack of table decoration, large seating arrangements, assigned seats, room temperature uncomfortable)	Dining area has ambiance and is comfortable; Mealtimes are pleasant; Conversation is encouraged among staff and clients and between clients
Bedroom Area	No privacy when shared; Can lack personal décor; Can lack adequate lighting or window treatments to restrict lighting; Noisy	When bedrooms are shared, there is privacy (decorative screen); Client is able to personalize bedroom space; Client has own lamp and adequate reading light; Window treatments darken room at night; Bedroom area is quiet
Activity Levels	Activity levels fail to stimulate interests and maintain physical/mental/social functioning levels	Based on client functional level and capacity, activities stimulate interests and maintain physical/mental/social functioning levels
Staffing	Staff often have designated work areas and stay in the work areas during work hours	Staff interact with clients (in a genuine manner) and facilitate trust while maintaining a professional client/staff relationship
Community/ Family Members	Limited ability to support/participate in client's residential experience	Community and family members have ability to participate in client's residential experience

DOMAIN	TRADITIONAL ALR MODEL	NEW ACF "HOPE" MODEL
Care Plan	Care plan is completed in isolation of other organizations delivering services to clients; Seldom involves community supports	Care plan is a collaborative process with parties involved in client's care; Care plan includes community, family, indigenous, and private/non-profit services that are providing support
Leisure Activities	Often limited to sedentary activities (watching T.V. or reading); Offer limited activities	A variety of activities are available to accommodate personal needs, capacity, and interests of clients (such as, T.V., radio, reading, Wii Sports/Fitness, board games, card games, sport balls, hand electronic games, crafts, knitting, computer, lawn tennis, croquet, Nerf basketball, hand puzzles, …)
Recreational Activities	Often lacks client involvement and planning; Activities do not occur in community	Regular meetings with clients to arrange, facilitate, plan, or offer a variety of recreational activities (eating out, library trips, local school events, free day at the zoo, walk in the park, picnic in the backyard,…)
Personal Choices	House rules and regulations prohibit client from achieving positive personal growth	Given individual level of capacity, ability to make decisions and freedom of choice, clients are offered choices
Personal Care	Designated times for bathing and personal care without care for client preference	Given individual level of capacity, ability to make decisions, freedom of choice (and presenting behaviors; i.e. client refuses to bathe), client is allowed to choose times for bathing and personal care tasks
House Forum	House discussions are staff-facilitated, not meaningful, and irregular	Weekly house discussions (staff or client facilitated) with genuine consideration for client input and requests

DOMAIN	TRADITIONAL ALR MODEL	NEW ACF "HOPE" MODEL
Client Empowerment	Lack of client empowerment; Staff perception that client is helpless or sick	Clients are properly assessed for strengths and weaknesses; Intervention starts at the point where client lacks capacity; Client is encouraged/prompted to independently complete as many ADL's/personal care tasks in which they are capable; Client-strengths are identified and reinforced; There is an understanding that a client may "choose" something that is not in the best interest of the client and there is an intervention for how to empower the client to make better choices
Community Integration	Clients have little access to community; "Community" events are held within the facility	Client is encouraged to "be" within the community; Access to the community is facilitated by the ACF (phone call/client prompt to call transporting services, phone call to community volunteers who may be able to transport/include clients in community events)
Client Potential Respected	Difficulty juggling individual choice vs. client potential	Given a situation where a client is making an individual choice, staff helps the client discern whether the choice is conducive to the client maintaining/reaching his or her potential; If not, staff are able to prompt client in making choices more conducive to maintaining/reaching his or her potential
Guest vs. Home	Client treated like a guest	ACF is a client's home
Respect and Dignity	Client is treated with dignity and respect	Client is treated with dignity and respect through staff tone, manner, gestures, actions, and all other interactions