ADULT FAMILY HOME

ADMINISTRATOR STUDENT MANUAL

VERSION 5.2

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Tell Me More! I'm Interested

Introduction

Before you decide to become an adult family home (AFH) provider, you should consider:

- The reasons you want to become a licensed provider, and
- How you will maintain your adult family home business over time.

This profession is heavily regulated and monitored. You will be caring for individuals that may have multiple complex needs in a community setting. You are not in this alone. There are many resources available to help you be successful in owning an adult family home.

In this module we will discuss what an AFH is, as well as the roles, responsibilities, and skill sets needed to succeed in this profession. We will also explore cultural competency and introduce you to Person Centered Philosophy.

We will conclude with a self-assessment. This reflection will help you determine your readiness to become an AFH provider. You will also ask a friend or family member to assess your readiness to help you see if this is the right fit for you.

Learning Objectives

At the end of this module, you will be able to…

- Explain what an AFH is
- Describe an AFH provider's roles, responsibilities, and necessary skills
- Discuss who is seeking AFHs and how those needs can fill the AFH provider's niche
- Identify the importance of Cultural Competency, Sensitivity, and Humility
- Explain how words can have a significant impact on others
- Recall the importance of using Person Centered Philosophy

What Do You Know?

What do you know about adult family homes?

What is an Adult Family Home?

- Privately owned homes in the community
- Licensed through the State of Washington, Department of Social and Health Services (DSHS), Residential Care Services (RCS)
- Provide personal care and other support services for two to eight residents. (WAC 388-76-10030)

AFHs are neighborhood homes where staff assumes responsibility for the safety and well-being of their residents. WAC 388-76-10000

NOTE: The residents are not related by blood (includes adoption) or marriage to the AFH owner, entity representative, resident manager, or caregiver, who resides in the home.

An AFH license is not required:

- To provide care for your own relatives related by blood, adoption, or marriage in your home.
- To provide care for one person – unrelated to you – in your home.
- To care for a relative and one other person not related to you in your home.
- To provide only room and meals in exchange for rent.

The populations served by AFHs varies. Some may need minimal care for many years or others who need a great deal of care for shorter periods of time. Many residents may even be near the end of their lives or need occasional nursing care. Some AFHs offer specialized care for people with:

- Developmental Disabilities
- Mental Health Issues
- Dementia

AFHs provide a room, meals, laundry, supervision, personal care, and cognitive needs. The type of services an AFH offers depends on the skill level of the provider and their staff. The cost of care varies depending on the level of care the resident requires. Residents:

- Take an active role in their care planning
- Are encouraged to have guests
- Decorate their room with their personal belongings
- Access their community as much as they are able

AFH Resources:

Adult Family Homes – Developmental Disabilities Administration
What You Need to Know… Before Becoming a Licensed Adult Family Home Provider
AFH Information (A series of documents to help understand the basics of AFH Operations)

AFH History

The first AFH was licensed in 1989. At that time, there were 287 homes around the state. The department supported the growth of AFHs as an alternative to nursing facilities. Over time, the number of licensed AFHs has grown to almost 90 homes per year. This includes Change of Ownerships (CHOW), revocations, and new licenses.

Residential Care Services (RCS) is a division within the Aging and Long-Term Support Administration (ALTSA). They are responsible for oversight and inspection of AFHs. There was some concern in the early years that oversight was inadequate. Care needs of residents had become more medically complicated. The number of AFHs grew dramatically.

Between the years of 2004 – 2009, ALTSA reported that abuse and neglect complaints in AFHs rose 45%. This prompted the department to develop a workgroup to study the abuse and neglect issues in the AFH industry. The workgroup provided a series of recommendations that addressed deficiencies in data collection, reporting, investigation, training, and emergency response.

Legislation provided the department more licensing discretion and developed more AFH provider requirements. These requirements include items such as:

- The ability to communicate in English
- The ability to demonstrate financial solvency
- Required background checks/ fingerprinting
- Completing 1000 hours of direct caregiving prior to licensure
- Completing AFH Administrator training

Added new requirements for maintaining a safe home environment. Increased safety provisions include:

- Providing unrestricted access to resident common areas
- Widening hallway dimensions to accommodate mobility aids
- Maintaining safer outdoor areas for resident use
- Ensuring safe egress from the home
- Background checks for staff

WAC 388-76-10000 Definitions

***"Provider"** means:*

(1) Any individual who is licensed to operate an adult family home and meets the requirements of this chapter;

(2) Any corporation, partnership, limited liability company, or other entity that is licensed under this chapter to operate an adult family home and meets the requirements of this chapter; and

(3) For the following sections only, also includes an entity representative solely for the purposes of fulfilling requirements on behalf of the entity:

(a) WAC 388-76-10020(1); (b) WAC 388-76-10035(1); (c) WAC 388-76-10060; (d) WAC 388-76-10064; (e) WAC 388-76-10120; (f) WAC 388-76-10125; (g) WAC 388-76-10129; (h) WAC 388-76-10130; (i) WAC 388-76-10146(4); (j) WAC 388-76-10265; (k) WAC 388-76-10500; and (l) WAC 388-76-10505.

"The most difficult transition for new providers is going from employee to employer, from being managed to managing others, and from communicating concerns and complaints to manager(s) to fixing them yourself. When you are employed, you are paid regardless of the facility's resident census; as an AFH provider, you are responsible for ensuring you have enough income to meet all of your financial obligations."

Joseph Spada, AFH Owner and Instructor

AFH Roles, Responsibilities, and Skill Set

You need to have the character, competence, and suitability to operate an AFH. In module two, we will discuss resident rights. You must be able to protect your resident's rights over the needs of yourself and your family.

As an AFH Provider, you will:

- expand your role,
- increase your responsibilities, and
- enhance your skill set.

Roles

In your role as an AFH Provider, you:

- Provide a home where you care for individuals who may have many and/or complex needs
- Provide space for residents to create their own home environment
- Set the standard of care in your home
- May be an employer if additional staff is needed to ensure your residents needs are met day and night
- Are a role model to your staff and other AFHs
- Are an advocate and protector for your home and residents
- Are a problem solver
- Are a business owner
- Are a professional

Responsibilities

As an AFH provider, you will have a wide range of responsibilities. These include caregiving, owning a small business, and being an employer. You must have sufficient income to meet your financial obligations.

For your residents, you are responsible for their care and safety 24 hours a day, whether you are on-site or not.

You must ensure the staffing level is adequate to:

- Always meet all resident needs (24 hours a day, seven days a week)
- Evacuate all residents from the home within five minutes or less

You must ensure your residents are treated with dignity, respect, and compassion, as well as support their quality of life. Module 2 will cover more on Quality-of-Life regulations.

AFH providers must:

- Know resident rights WAC 388-76-10510 – 10616
- Prevent all forms of abuse WAC 388-76-10670 –10680
    - Abandonment
    - Verbal, sexual, physical, and mental abuse
    - Exploitation and financial exploitation
    - Neglect
    - Involuntary seclusion
- Understand the impact of using a Person-centered approach
- Provide supervision if identified as a need in their assessment
- Meet the assessed care needs and preferences of each resident including:
    - Activities of Daily Living (ADLs)
        - Personal Hygiene
        - Dressing
        - Bathing
        - Eating
        - Toileting
        - Skin And Body Care
        - Medication Assistance or Administration
        - Mobility (Walking and Transfers)
    - Instrumental Activities of Daily Living (IADLs)
        - Cooking
        - Shopping
        - House Cleaning
        - Doing Laundry
        - Working
        - Managing Personal Finances
- Ensure your residents have a variety of recreational activities specific to each resident's interests
- Knowing and staying current with applicable AFH rules (WAC 388-76 and 388-112A)
- Follow state and federal audits and inspections

You are required to carry out the management and administrative requirements in statute. RCW chapters:

- 70.128 – Adult Family Homes
- 70.129 – Long-term Resident Rights
- 74.34 – Abuse of Vulnerable Adults

You will be required to keep detailed and up to date records, including:

- Resident records per WAC 388-76-10315
- Employee records per WAC-388-76-10198
- Home records such as accounting, income tax and payroll records

Failing to know and adhere to the laws and rules for AFHs can lead to:

- Citations
- Civil fines
- Stop placement of admissions
- Conditions on the AFH license
- License suspensions
- Revocations

Skill Set

Successful AFH providers have a wide set of skills. You must:

- **Be able to plan ahead and be committed to achieving success**
  There are many reasons why some providers close their AFHs after only one or two years. Some reasons include:
  - Misjudging the challenges associated with sharing their home with others.
  - Overestimating their abilities as a provider.
  - Poor financial planning.
  - Lack of experience with operating a business.
  - Underestimating the difficulties of attracting residents.

  When a home closes, this negatively impacts residents and their families, as well as providers and their families.

- **Be literate and able to communicate in the English language**
  WAC 388-76-10130 states that providers must be "literate" and able to communicate in the English language. Literate means the ability to read and write. AFH providers come from a widely diverse background and may be literate in many different languages. For the AFH Admin training, the provider must be literate in English as well as be able to communicate in English. Providers must be able to speak English well enough to understand about the resident and their care needs, and be understood by:
  - Residents and their families
  - Medical professionals
  - Emergency medical responders (911)
  - Case managers
  - Department staff such as licensors
  - Complaint investigators
  - Long-term Care Ombudsmen
  - Pharmacists
  - Other professionals

  Providers must be able to read, understand, and meet all laws and rules related to AFHs. They must also ensure there is always staff available at the home who is capable of understanding and speaking English well enough to be able to respond appropriately to emergency situations. Staff must also be able to read, understand, and implement resident negotiated care plans that are written in English. WAC 388-76-10130

Providers need to be able to communicate with the resident in their primary language. They can communicate either through a qualified person on-site or one that is always available. They can also arrange a language line with access to translators.

- **Be comfortable using technology**

  Computer literacy skills are important when owning an AFH. A provider, at a minimum, must be able to communicate via email, perform basic word processing, and know how to use a spreadsheet. They must also perform online tasks required by the department.

  Computer literacy skills are also required to complete this training coursework such as homework and creating your AFH policies. These policies are a required part of your AFH application.

  AFH providers use their computers to amend their policies based on WAC and RCW changes. It is also critical to keep up to date on major events that impact AFHs. This may include events like the COVID pandemic or other emergencies.

- **Be able to perform basic accounting**

  Knowing basic accounting is a valuable skill that helps ensure financial stability for any business owner. As an AFH provider you must meet your financial obligations and requirements. DSHS requires "…a demonstrated history of financial solvency related to the ability to provide care and services" in multiple WACs. You will need to know how to create a basic 12-month cash flow forecast.

NOTE: Developing basic computer skills and having financial literacy cannot be stressed enough to be successful in starting your AFH business.

What is Your Niche?

A niche is doing something you are interested in, care about, or have a passion for. What are you good at? Who do you enjoy providing care for? Understanding your niche and using it to market your AFH can help with your home's financial success. Most important, your niche may help you provide a home where individuals with similar backgrounds, experiences, and cultures feel cared for and accepted.

"As you are developing your Adult Family Home, consider providing care for a specialized population of clients at your home. There are clients who have difficulties finding an Adult Family Home due to a variety of reasons: These include criminal history, HIV/AIDS diagnosis, behavioral challenges, medically complex needs, severe obesity, chronic homelessness, age, and traumatic brain injury among many other reasons. Each Adult Family Home is unique, and we encourage you to find your niche!

To care for individuals living with Dementia, Developmental Disabilities, or Significant Mental Illness, you will need to complete additional classes and be certified prior to accepting clients with these 3 diagnoses into your home."

DSHS Resource Support & Development Unit

Caring for Diverse Populations

Bariatric Care

Bariatrics is related to or specializing in the treatment of obesity. The residents that are obese often face humiliation or embarrassment because of their size. They may delay in asking for help fearing that they may break equipment, cause problems for caregiving staff or be ignored all together. Bariatric residents may require specialized equipment that is appropriate weight-rated and sized. You may also need to hire additional staff and provide specialized training.

DSHS is currently developing an eight-hour Expanded Specialty Training for Bariatric Care. This training will not be required for licensing. The goal will be to provide skills and knowledge to help care for someone needing bariatric care.

Blind, Deaf, Hard of Hearing, or Speech Disabled

The resources below provide information that can help when considering caring for an individual who is blind and/or deaf/hard of hearing:

- Office of the Deaf and Hard of Hearing
- Washington State Department of Services for the Blind
- Telecommunication Equipment Distribution Program /22-051 Telecommunication Equipment Distribution Program (wa.gov)

  The Telecommunication Equipment Distribution (TED) program provides telephone equipment to Washington residents who are deaf, hard of hearing, late-deafened, deaf-blind or who have speech disabilities so they may access and use the telephone independently. The TED program distributes several types of equipment, including amplified, braille, text, and captioned telephones.
- Telecommunications Relay Service Program

  Telecommunication Relay Service (TRS) is also known as Washington Relay. TRS permits individuals who are Deaf, Hard of Hearing or have a speech disability to use the telephone system via a teletypewriter (TTY) or other text input device. This allows them to call persons without such disabilities. TRS, operated by the Office of the Deaf and Hard of Hearing (ODHH), provides equal access to effectively communicate through specially trained relay operators. Operators help telephone callers communicate with individuals who are Deaf, Hard of Hearing, Deaf Blind, or have a speech disability.

  Calls can be made to anywhere in the world, 24 hours a day, 365 days a year with no restrictions on the number, length, or type of calls. All calls are strictly confidential, and no records of any conversations are maintained.

- Dear Provider letter #2016-015 Services to Enable Accessible Communication with People who are Deaf, Deaf-Blind, hard of Hearing, or Speech Disabled.
  This letter outlines a variety of telecommunication services available through Office of Deaf and Hard of Hearing (ODHH) that would be helpful in promoting resident rights and improved quality of life. Some of these options include:
  - Telecommunication Equipment Distribution (TED) Program
    ODHH also has contracted service providers throughout the state who can provide an outreach presentation about the TED Program (1-800-422-793).
  - Telecommunication Relay Services
  - Digital/Internet Based Captioning Telephones
  - Program Application & Resources

Challenging Behaviors

DSHS is available to support our AFH providers with multiple programs, services, and resources. If you need assistance with residents who have challenging behaviors, our RCS Behavioral Health Support Team is here to help. Referrals can be emailed to RCSBHST@dshs.wa.gov.

RCS Behavioral Health Support Team

Residents can engage in challenging behaviors for many reasons. Sometimes it's due to mental illness, traumatic brain injury or cognitive impairment. Maybe it's because they're having a hard time adjusting to a new setting, or they've decided they don't like one of your caregivers. Whatever the reason, a resident engaging in challenging behaviors can create challenges for ***you*** as the Adult Family Home provider.

If you're working with a resident who engages in challenging behaviors and you're starting to feel overwhelmed or you don't know how to respond, the Residential Care Services Behavioral Health Support Team (RCS BHST) is a great resource. The team offers a variety of services - from tailored consultation about specific residents, to broad group training for your staff. They bring a combination of extensive mental health ***and*** regulatory experience to help you get creative, while also helping you understand how to follow the regulations as you cope with a challenging resident situation.

Note that while members of the BHST work for Residential Care Services, they are ***not*** licensors or complaint investigators. The RCS BHST does not write citations. They are available regardless of funding source – meaning they can help you with state funded/Medicaid ***and*** privately funded residents. They are also available to help no matter what diagnosis a resident may have.

Dementia

According to the National Institute on Aging, "Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person's daily life and activities. These functions include memory, language skills, visual perception, problem solving, self-management, and the ability to focus and pay attention. Some people with dementia cannot control their emotions, and their personalities may change. Dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage, when the person must depend completely on others for basic activities of living."

To provide care to an individual with a dementia diagnosis, you must have:

1) successfully completed the current eight-hour DSHS developed Dementia Specialty training and
2) have it as a designation on your AFH license.

If your resident develops dementia while living in your home, you must obtain the dementia certification within 120 days and provide verification that you have completed the training (WAC 388-112A-0490).

What is dementia? - YouTube (2:18)

https://www.youtube.com/watch?v=kkvyGrOEIfA&t=8s

Developmental Disabilities

Developmental disabilities are a group of conditions. These conditions are due to an impairment in physical, learning, language, or behavior. These conditions begin in childhood and may impact day-to-day functioning. They usually last throughout a person's lifetime.

RCW 71A.10.020(5) defines a developmental disability as Intellectual Disability, Cerebral Palsy, Epilepsy, Autism or another neurological or other condition like Intellectual Disability.

The disability must:

- Have originated before your resident turned eighteen,
- Continued or can be expected to continue indefinitely, and
- Results in substantial limitations.

To provide care to an individual with a developmental disability, you must have:

- successfully completed the current eight-hour DSHS developed Developmental Disability Specialty training and
- have it as a designation on your AFH license.

Ethnic Minorities

"The term 'racial and ethnic minority groups' includes people of color with a wide variety of backgrounds and experiences. Negative experiences are common to many people within these groups, and some social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health. Social determinants of health are the conditions in the places where people live, learn, work, play, and worship that affect a wide range of health risks and outcomes."
Health Equity Considerations and Racial and Ethnic Minority Groups

HIV/AIDS

Human Immunodeficiency Virus (HIV) is a chronic illness for which there is no cure. If HIV is not treated, it can lead to acquired immunodeficiency syndrome (AIDS). People diagnosed with AIDS may need help with activities of daily living. New medications and treatments continue to be developed for those infected with HIV. Now, the lifespan of an infected person can extend for many years. (CDC)
Universal precautions were born out of understanding how infections, such as HIV work. Universal precautions are your best protection against infection. Infection control protocols are critical in AFHs.

Read this article to learn more about The Purpose of Universal Precautions.

Hospice

Hospice care is available when someone is expected to live 6 months or less. Hospice is considered the gold standard for end-of-life care. As our society becomes more comfortable discussing end-of-life related issues, hospice is often expected and sought after by families. The AFH is in a unique position to offer this type of care, allowing residents to receive end-of-life care in a home that provides a compassionate personal setting.

The goal of hospice is to provide comfort and minimize physical, emotional, and spiritual suffering. Hospice works in collaboration with AFHs. Hospice can offer 24/7 support to residents and their families. They can also support caregivers to manage the care needs during the end-of-life phase. A multidisciplinary team, including a nurse, social worker, chaplain, and at times aides and volunteers, visits the resident and provides guidance and help. Research shows that people often live longer and are more comfortable while on hospice. Unfortunately, many people wait too long for this service and residents end up in the hospital, which is distressing and upsetting for all.

The goals of hospice care are very much in line with the mission of AFHs because they strive to offer the best care possible to their residents in a home in their community.
Washington State Hospice & Palliative Care Organization - Find Care

Incarceration/Detention History

The First Step Act, signed in 2018, BOP: First Step Act Overview requires the Federal Bureau of Prisons to support inmates to relocate closer to their primary residence and consider their mental and medical health needs. As the prison population grows older, their needs are becoming increasingly difficult to manage in a prison environment. Thus, a variety of individuals with an offender history are needing the support to return to living in the community.

Before considering individuals with an offender history, make sure you are well informed of the person's:

- Criminal background,
- Any potential Department of Corrections (DOC) supervision requirements, and
- Their assessed personal care needs.

The person may be coming from a prison, jail, state hospital, or they could be currently residing in the community.

Things to consider if the person has requirements for their release:

- Has the person been given a Lesser Restrictive Order or Conditional Release Order and what are the requirements?
- Does the person need to abide by Probational Obligations and what are the requirements?
- Has the person any other legal requirements (No Contact orders, etc.) that need to be considered?

Things to consider if the person is required to register as a **Registered Sex Offender** (RSO):

- What are the guidelines in your neighborhood and/or county? The guidelines may differ from area to area.
- Consider the residents that are currently living in your home. Will they be at risk based on the offender's history?
- Can you ensure the safety of everyone involved?

It's important to consider your availability to assist the resident to appointments, to access their Community Correction Officer (CCO), and/or other probation requirements if needed.

The State Hospital Discharge & Diversion (SHDD) teams address the state hospital transition and diversion needs for Medicaid individuals who need increased staffing and service supports.

It is essential that you have all the relevant information to provide the care required with all aspects of safety in mind. The assessment needs to be thoroughly reviewed and follow up questions addressed to ensure you have accurate information. Then you will be able to determine if you can provide the care required and the individual will be a good fit in your home.

The SHDD provides **free continuing education (CE) training monthly**. Current training can be located on the State Hospital Discharge and Diversion Team website.

Incarceration Resources

- 'Model' Nursing Home For Paroled Inmates To Get Federal Funds | Connecticut Health Investigative Team (c-hit.org)
- Federal Courts Move to Release Some Western Washington Inmates Vulnerable to COVID-19 | The Daily Chronicle (chronline.com)
- Compassionate Release/Reduction of Sentence: Procedures for Implementation of 18 U.S.C. 3582(c)(A) and 4205(g) | National Institute of Corrections (nicic.gov)
- Supporting America's Aging Prisoner Population: Opportunities & Challenges for Area Agencies on Aging (usaging.org)

LGBTQ+

L – G – B – T – Q – + is an acronym for Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning. The initials may vary depending on who you are talking with, but this is the most common. The + connotes a variety of other identities and expressions such as gender identities that are non-binary and sexual orientations such as asexual. You also may hear the term "Rainbow Community" because a rainbow is a common international symbol for people who identify as LGBTQ+. The acronym that is symbolic of this community continues to grow and evolve as people feel more comfortable expressing their gender and sexual identities. As an AFH provider and community member, it is important to remember to be respectful and use terms that people prefer.

"A lot of the people who are providing care at adult family homes and senior living centers are people who have certain biases due to culture who are definitely against LGBTQ and especially the transgender folks. There are larger percentages of transgender people going back in the closet or who are not treated with respect in terms of their chosen and living gender in terms of care. That's the biggest gap that I see."

-Voices from the Town Hall

At-Risk and Underserved: LGBTQ Older Adults in Seattle/King County – Findings from Aging with Pride; October 2015

"While the U.S. census has never measured how many LGBT people live in America, reports estimate that there are currently around 3 million LGBT adults over age 50. That number is expected to grow to around 7 million by 2030." Sage – LGBT Aging

An AARP survey of LGBT adults aged 45-plus found that:

- More than 80 percent of the survey respondents said they would welcome signs or symbols that indicate a facility or service is LGBTQ-friendly.
- Many LGBTQ aging and elders are being forced back into "the closet" for the sake of physical and emotional safety and have expressed concerns as they age and seek care.
- LGBT adults would also prefer that long-term care providers be trained to handle their specific needs or that some staff identify as LGBT.
- Sexual orientation and gender identity and expression are two entirely separate aspects of human identity and providers need to have a working understanding of both.

Adapted from: LGBT Adults Fear Discrimination in Long-Term Care
Victoria Sackett, AARP, March 27, 2018

Some homes display **variations** of the Pride Flag. This all-inclusive variation is the trans and BIPOC (Black, Indigenous, and People of Color) flag.

LGBTQ Resources

- LGBTQ.wa.gov – General Information and Definitions
- Long-Term Care Equality Index
- LGBT Welcoming Toolkit for Primary Care Practices
- Facts on LBGT Aging

VIDEO Resources

Safe and Visible: Creating a Care Facility Welcoming to LGBT Seniors - YouTube - This video from LIFE Eldercare gives you actionable information on creating a welcoming, supportive environment in your AFH. Please see the information about this video below.

"Because they grew up and came of age in a time when their rights and safety were not protected and discrimination was even sanctioned by society and the government; LGBT older people on average are more likely to live in poverty and have deferred healthcare issues, and less likely to have an established support system. Many remain traumatized by the oppression they experienced over several decades. And so, despite some facilities and healthcare settings being inherently welcoming, LGBT seniors will likely remain hidden and feel some level of anxiety unless they see and hear overt signs indicating that they are safe. Care Facilities especially, are still often seen as a place of likely discrimination or abuse. In fact, a recent report shows that only 22% of LGBT people feel that an LGBT older adult can be open with the staff of a nursing home, assisted living facility, or other long–term care facility about their sexual orientation and/or gender identity."

LEI Video

Research shows that upwards of five percent of long-term care residents are members of the lesbian, gay, bisexual and/or transgender community. The Human Rights Campaign Foundation and SAGE believe that most long-term care communities want LGBTQ elders to feel welcome and get the care they need. That's why the Long-term Care Equality Index, also known as the LEI, exists. The LEI encourages and helps long-term care communities adopt policies and best practices that provide culturally competent and responsive care to LGBTQ elders.

Physical Disabilities

Individuals with a physical disability may need help with activities of daily living, need specialized equipment, or staffing for their care. Common examples may include individuals who have had a stroke, multiple amputations, muscular dystrophy, or quadriplegia (also known as tetraplegia).

Psychological/Mental Health Needs

Mental health needs are becoming more prevalent in our society as is mental illness. Mental illness is defined in the Merriam-Webster dictionary as: "any of a broad range of medical conditions (such as major depression, schizophrenia, obsessive compulsive disorder, or panic disorder) that are marked primarily by sufficient disorganization of personality, mind, or emotions to impair normal psychological functioning and cause marked distress or disability and that are typically associated with a disruption in normal thinking, feeling, mood, behavior, interpersonal interactions, or daily functioning."

To provide care to an individual with a mental health diagnosis, you must have successfully completed the current eight-hour DSHS Mental Health Specialty training and have it listed on your AFH license.

NOTE: If your resident develops a mental health condition while living in your home, you must obtain the mental health certification within 120 days and provide verification of completion (WAC 388-112A-0490). Medicaid residents may be eligible for additional mental health and behavior support under the Residential Support Waiver. You will learn more about these options in Module 9 – Getting Ready.

Living with a Mental Health Disorder (Buzz Feed - YouTube 3:16)

Religion

Washington includes people of many different spiritual and religious beliefs. People are looking for homes that are open to, respectful of their individual beliefs, and can accommodate their spiritual needs.

Traumatic Brain Injury

A Traumatic Brain Injury (TBI) may be caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Conservative estimates indicate there are nearly 145,000 individuals living with TBI-related disabilities in Washington (TBI Comprehensive State Plan - 2017).

The long-term negative effects of a TBI are significant. People with a TBI are at a greater risk of dying from seizures, accidental drug poisoning, infections, and pneumonia. The problems faced by individuals with a TBI can be long lasting requiring long term care. (Moderate to Severe Traumatic Brain Injury is a Lifelong Condition)

TBI Resources

- Traumatic Brain Injury (TBI) Resources Washington State
- Brain Injury Association of America

VIDEO: What is TBI? - YouTube (3:32 min) - Provides a basic understanding of a Traumatic Brain Injury (TBI) and includes signs, symptoms, and actions to take to support an individual with a TBI.

Veterans

Veterans need long term care for a variety of reasons that range from stroke to complex battlefield injuries. A veteran's doctor in the hospital or rehabilitation center will complete their assessment. This assessment is part of the eligibility process for Aid and Attendant services. Aid and Attendant services may help pay for their care.
Aid And Attendance Benefits And Housebound Allowance | VA.gov | Veterans Affairs

If you have questions about providing care to a Veteran, call the Washington State Department of Veteran Affairs at 800-562-2308.

Discrimination

Discrimination is treating a person or group of people differently than you would treat others.

> *No residents receiving care and services in an adult family home will be subject to discrimination on the basis of race, color, national origin, sexual orientation, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability (AFH Application, WACs 388-766-10515 and 388-76-10545).*

Cultural Identity

Cultural identity has many facets that define who we are. The ADDRESSSING model is a framework developed by Pamela Hays. It helps us recognize and understand all the pieces that make up our identity. Each of these different elements, as well as our life experiences, contributes to a complete understanding of our cultural identity. ADDRESSING stands for our:

- **A** Age/Generation
- **D** Disability status (developmental)
- **D** Disability status (acquired)
- **R** Religion/Spirituality
- **E** Ethnicity
- **S** Socioeconomic status
- **S** Sexual orientation
- **I** Indigenous heritage
- **N** National origin
- **G** Gender

> *"Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It comprises beliefs about reality, how people should interact with each other, what they 'know' about the world, and how they should respond to the social and material environments in which they find themselves."*
>
> Gilbert, Goode, and Dunne (2007)

Cultural Competency, Sensitivity, and Humility

According to the Pew Research Center, the United States has more immigrants than any other country in the world. In 2018, 40.8 million people living in the U.S. were born in another country. Most of these individuals came from China, India, Mexico, and the Philippines. Other locations include Europe, Canada, Central and South America, the Middle East/North Africa, and sub-Saharan Africa. Each year, more than 1 million immigrants arrive in the US, many of them refugees. Seattle is one of the top 20 urban areas in the US with the highest number of immigrants. (*Key findings about U.S. immigrants*)

With such a diverse aging population, we need to be aware of those who may need long-term care and consider the equity of our outlook on cultural competence, sensitivity, and humility.

What is Cultural Competence?

Cultural competence… the "process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each". – *National Association of Social Workers (2015)*

Notes:

Becoming Culturally Competent

"Cultural competence engages the development of abilities and skills to respect differences and effectively interact with individuals from different backgrounds. This involves awareness of one's biases or prejudices and is rooted in respect, validation, and openness toward differences among people. Cultural competence begins with an awareness of one's own cultural beliefs and practices, and the recognition that others believe in different truths/realities than one's own. It also implies that there is more than one way of doing the same thing in a right manner.[1]"

Cultural Sensitivity

Means being willing, and able to use respectful verbal and non-verbal methods of communication to understand people of other cultures and allows the individual to be accepted and heard.

How to Develop Cultural Sensitivity

To develop cultural sensitivity, consider the following list from the Finnish Institute for Health and Welfare when working with your residents:

- Perceiving one's own cultural background, perceptions and manners and using this as the basis for increasing one's understanding of other cultures.
- Respecting diversity.
- Showing interest in different cultures.
- Reflecting on the effect and significance of one's cultural background on oneself and personal attitudes.
- Finding the courage to encounter residents as individuals rather than representatives of certain cultures.
- Being open and patient.
- Asking residents about their habits, values, and culture instead of making assumptions and generalisations.
- Working with the assistance of interpreters when necessary.

[1] *Hermeet K. Kohli, Ruth Huber & Anna C. Faul (2010) Historical and Theoretical Development of Culturally Competent Social Work Practice, Journal of Teaching in Social Work, 30:3, 252-271, DOI: 10.1080/08841233.2010.499091*

Individuals who open AFHs come from many backgrounds and cultures. Consider cultural sensitivity when preparing meals and how you communicate with and around your residents.

It is important to note your own cultural practices when you have visitors to your home. For example, your cultural practice may be to offer food and drink or give/accept small gifts from visitors. While this gesture is greatly appreciated, certain visitors such as licensors, investigators, and social workers from the State of Washington or the Department of Social and Health Services (DSHS), are bound by state law and cannot give or receive any gifts, even food or drink.

Cultural Humility

Cultural humility is an ongoing process of self-exploration and evaluation combined with a willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are.

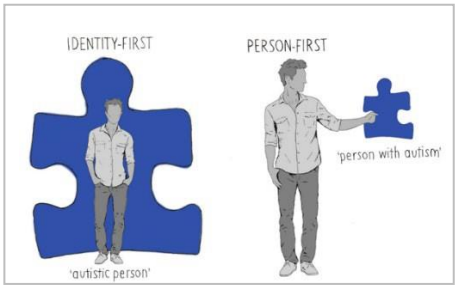
Cultural Competency, Sensitivity, and Humility Resources

- Communicating with People with Limited English Proficiency
- Cultural Competence and Elder Abuse
- Elder Mistreatment and Diverse Communities - Fact Sheets

Words are Powerful – What You Say Matters

How we use our words can make a significant impact on those around us, they can hurt; they can heal – bring joy or sorrow.

Person-First and Identity-First Language



Take the time to ask if your resident prefers **person-first** or **identity-first language**. The idea behind person-first language is to highlight the person and not the disability. For example, "a person with a disability" instead of "a disabled person".

For some, using identify-first language is preferred – "disability" and "disabled" are indicators of culture and identity. Thus, "disabled person" is an accepted term. Using identity-first language is often true for those in the Autistic and Deaf/Hard of Hearing communities. Check out this article by Emily Lada, *Why Person-First Language doesn't Always Put the Person First*

Person-First language: Person First Language Video – 1:34

Inclusive language

Inclusive language is defined as, "language that avoids the use of certain expressions or words that might be considered to exclude particular groups of people…" Dictionary, Encyclopedia and Thesaurus - The Free Dictionary

Using inclusive language is about respect. When you use inclusive language, you are choosing to respect other people's dignity and diversity.

Gender-inclusive language – use "they" instead of "he" or "she" when talking about someone whose gender is unknown or a generic "somebody".

"The language a society uses to refer to persons with disabilities shapes its beliefs and ideas about them." –The Arc

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ON YOUR OWN ACTIVITY: Talking about People with Disabilities

Answers are in the Appendix.

Exercise for talking about people with disabilities:

Set #1: Write a **P** ("**preferred**") or an **A** ("**avoid**") before the phrases and sentences below.

	Bill is disabled.		Jose is mentally ill.
	This building isn't set up for handicapped people.		Sara uses a wheelchair.
	Simon has autism.		Joan suffers from cerebral palsy.
	Frank has a disability.		Ted is a victim of a birth defect.
	Ben is visually impaired.		Tonya is a person with Down Syndrome.

Set #2: Write a **P** ("**preferred**") or an **A** ("**avoid**") before the phrases and sentences below.

	Don is mentally retarded.		I work for an autistic person.
	Carol has a communication disorder.		She has a mental illness.
	He is wheelchair-bound, so doesn't use stairs.		Being deaf is really difficult.
	She is afflicted with fragile-X syndrome.		Phillip is developmentally delayed.
	Even normal people use the automatic doors.		She is a person with cerebral palsy.

Set #3: Write a **P** ("**preferred**") or an **A** ("**avoid**") before the phrases and sentences below.

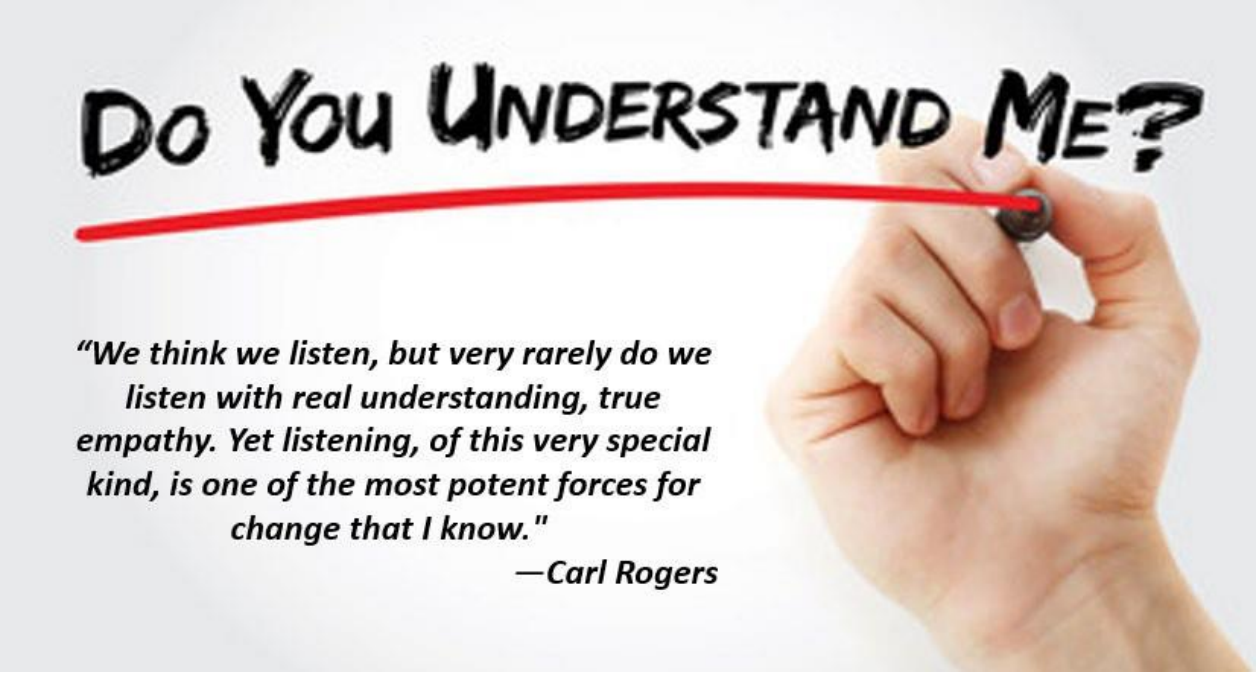
	I'm glad the disabled have so many services.		He is bipolar.
	I help someone who is hard of hearing.		Sam is a person with dementia.
	This building is very accessible for someone with a physical disability.		Joel has a disability.
	Sal is a quadriplegic.		Sue is healthy and normal.
	Kathy is an epileptic.		She is so brave even though she's handicapped.

Idioms, Industry Jargon and Acronyms

Idioms are a group of words in a fixed order that have a particular meaning that is different from the meanings of each word on its own. To "have bitten off more than you can chew" is an idiom that means you have tried to do something which is too difficult for you. Idioms don't translate well from culture to culture and can be a source of confusion and embarrassment.

Jargon refers to words that are only understood by those who are members of a group or are part of a particular profession. This is very common in health care. If you don't understand what your case manager or nurse is saying for example, be sure to ask.

Using acronyms can be confusing as well, especially if it can refer to more than one thing. An example of this is that HCA can be "Home Care Aide", or it can also represent the "Health Care Authority" that is responsible for providing Medicaid payments. If you use acronyms, be sure your staff understand them and include them in your employee handbook and orientation. Avoid using acronyms with your resident unless it is standardized and well known, such as DSHS for the Department of Social and Health Services.



Person Centered Philosophy

Person-centered describes a certain way of thinking about people and how you treat them. Every individual is equally deserving of your interest, respect, empathy, compassion, and service. Person-centered behavior reflects that.

People who care to be person-centered will get to know you. They want to learn what is important to you. They want to collaborate on solutions that meet your needs in a way that works for you. They promote your strengths, choice, direction, control, happiness, and well-being. In other words, person-centered people will learn about you, value, and support you.

Person Centered Philosophy means that you ask about your resident's values and preferences and use them to guide all parts of care and activities. The tools you use may vary based on the unique needs and choices of each person.

Implementing Person centered practices is:

- A Promise to listen
- A Promise to act on what you hear
- A Promise to be honest
- A Promise to keep asking and honoring what's important to them

Person centered planning builds upon a resident's ability and desire to engage in activities in their home and communities. It honors their preferences and choices. There are a multitude of tools and resources that can assist an AFH provider in implementing person centered care, and we will cover some of them throughout this training. Please look for continuing education opportunities to learn more about this important topic in the future.

Learning About People

A commitment to (ongoing) discovery

- A commitment to really getting to know the person.
- It is not a onetime only activity. It is not an interview. It is an ongoing informal/casual attempt to be better acquainted with them as a fellow human being.
- Who are they? What's their story? What activities do they find most meaningful? *Who* do they care for? *What* do they care for? What are their beliefs and values? What sort of daily rituals do they have (or miss having)?
- Not everyone is interested in sharing everything about themselves, so discovery (like every other concept here) is tailored to each individual's preference and personality.
- You should also commit to self-discovery. The better you know yourself, and the person you support, the better your ability to build rapport and come to mutual respect.

Discovering the *whole* person

- Is learning about, thinking about, and communicating about the person; do NOT focus on diagnoses, health issues, or inabilities.
- DO highlight strengths and abilities. This is a strength-based focus.
- We are ALL massively complex human beings with characteristics that we or others may perceive as more or less valuable. We are all collections of those attributes, and appreciate being understood as such, with a focus on those attributes about which we are most pleased.
- Use person-first language.
- Recognizing everyone's potential for growth.

Recognizing and respecting worldviews, perspectives, and attitudes

- Religious beliefs, culturally informed views, political affiliations, philosophical orientation etc.
- You will need to be aware of how your own culture, upbringing, environment, level of privilege etc. affect your own worldviews, perspectives, and attitudes.
- Now… how open are you to showing value and respect for others?

Learning what is important to/for the person

- Important *to* include things that each person cares about, is important to them
- Important *for* includes things that a person must attend to stay healthy and safe and meet the social expectations of others in ways that allow for inclusion.
- Help the person find a good (for them) balance between the two.

Learning to communicate effectively with the person

- Learn/discover how this *unique individual* communicates, both verbally and non-verbally.
- What do their words and gestures signal? When are they more, or less communicative? What level of participation do they prefer? What indicates possible irritation? What behaviors suggest they are becoming more agitated? What does that sigh suggest? Etc. How can you adapt to facilitate the best communication possible? Where is communication breaking down?

Valuing People

Affording respect and dignity

- Assuming the best of people.
- Dignity is self-respect, self-worth, and self-love.
- Respect is showing a high regard or special attention to someone.
- This may be communicated by your words and behaviors but is adjusted at a deeper level.

Recognizing the dignity of risk

- A fundamental belief that people grow and develop by making their own life decisions and learning from them (especially their mistakes). Self-determination is the ability to make choices and manage their own life. Self-determination is a fundamental right of human existence. Therefore, it is critical that people be supported in these opportunities regardless of their need for support for physical or cognitive disabilities.
- This means giving people room to make (and learn from) mistakes.

Celebrating cultural identity, diversity, and individuality

- The value and beauty of diversity. Recognize and appreciate cultural and individual differences. These differences make our world interesting and rich!
- Cultural identity and expression are something that should not be assumed. Let the person self-identify and teach you about themselves… while you listen, learn, value, and celebrate! If you were to describe "the typical American," and then apply that knowledge to what you think about someone else, they might be offended.
- Exercise cultural humility.
- If you have engaged in the discovery process (both self-discovery and discovering the person with whom you are working) you should become aware of possible differences. Learn to respect those differences that grow from the person's cultural or personal background. What has shaped their perspectives, beliefs, and values? What has shaped your own?

Supporting People

Promoting choice / direction / control

- This can include any aspect of support and services and risk-taking. This includes which services and supports they will use. This includes what, where, how much, and/or how often. The person is not obligated to participate in any service or support including formal person-centered planning processes.
- Actively help the person identify opportunities to make choices.

- Empower the person to be as independent as they are able and interested. Don't be too quick to do something for them that they can do for themselves (fixing). Be patient and give them the time they need. It feels good to handle your own business when you can.

Promoting self-determination / self-direction / autonomy / independence

- Very similar to: Choice / Directions / Control.
- The person makes decisions independently, plans for their own future, and takes responsibility for making these decisions.
- If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.
- You should presume individuals are competent and capable of making decisions for themselves (without undue influence) unless legal arrangements (e.g., guardianship) dictate otherwise. If needed, help the person with supported decision making.

Exercising power *with* rather than power *over*

- Fixing vs. Supporting.
- Power *over* is the practice of trying to "fix" people with support needs. Deciding for people how they need to solve their problems.
- Power *with* is the practice of shared responsibility and support. Providing options and decision support to individuals while respecting their right to self-determine and experience the dignity of risk.
- Inadvertently reducing choice direction or control.

Building good relationships

- Transparency
- Trust
- Respect
- Authenticity

Facilitating teamwork

- Service, care, support etc. are not something you do *for* the person…. they are something you do *with* them.
- Know the formal and informal members of the team.
- The person should choose with whom to work and how to work with them.

Tailoring your care

- How best to support the individual.
- Not enough to know, you have to act on what you know.
- What is Working / Not working.
- What have you tried, what did you learn?
- Stages of change and meeting people where they are.
- Evaluate your care practices and effectiveness… adapt.
- Level of need (how much, what kind), Level of interest, Capacity.

Advocating for the person

- Client rights
- Community inclusion
- Mandated reporting
- Discrimination from others

Person-Centered Video Resources

- What are Person Centered Practices? - YouTube (6 min)
- Michael Smull – Definitions. What is meant by person centered approaches, thinking and planning? (5.47 min)
- Sorting what is important to and for - YouTube (13 min)

Introducing Person Centered Thinking Tools

There are a multitude of tools that you can use to support Person centered philosophy. We are going to cover:

- Important To and Important For
- Rituals and Routines
- One Page Profile

Important To – Important For

The simple explanation is that "important to" is something you value, while "important for" is something you need, or that will help you in some way.

This work is all about helping people live better lives. If you can recognize and understand what makes your life good, you are better prepared to help others achieve their preferred quality of life as well.

One thing we know for sure is that it is critical for people to feel in control of their own lives. One of the ways you can tell if you have control over your life is by looking at the balance between what is Important To and Important For.

ACTIVITY: Important To – Important For

Fill in the following table with what is Important To you and Important For you. An example has been provided for you.

What's important **to** the person? What brings comfort, happiness, contentment, fulfilment, satisfaction, purpose	What is important **for** the person to be healthy, safe, and be a valued member of their community?
1. *Betty attends monthly game night with her friends* 2. 3.	*1. Betty e*ngages in personalized activities that are important to – and support – her emotional and mental well-being. 2. 3.
What else do we need to know and learn?	

Rituals and Routines

Many parts of our lives include routines or rituals. The normal things we do every day that guide us through our day and provide consistency, comfort, and control. For example, think about how you celebrate birthdays, anniversaries, or holidays. What do you do when you are sick, or grieving? These events often coincide with some sort of routine or ritual.

VIDEO: Michael Smull – The Importance of Routines: Routines - YouTube (5:45 min)

ACTIVITY: Routines

We are going to give you a chance to describe one of your routines in detail: the things that you do in the morning between when you wake up and when you are ready to start your day. We'll call this your "morning routine."

Questions that that may help you describe your morning routine:

- Are you a morning person who springs from bed ready for the day, or does it take you hitting snooze five times before you even open your eyes?
- Do you use some hot, caffeinated beverage to assist you in the process of waking up?
- Do you shower in the morning or the night before?
- Do you brush your teeth before you shower or after?

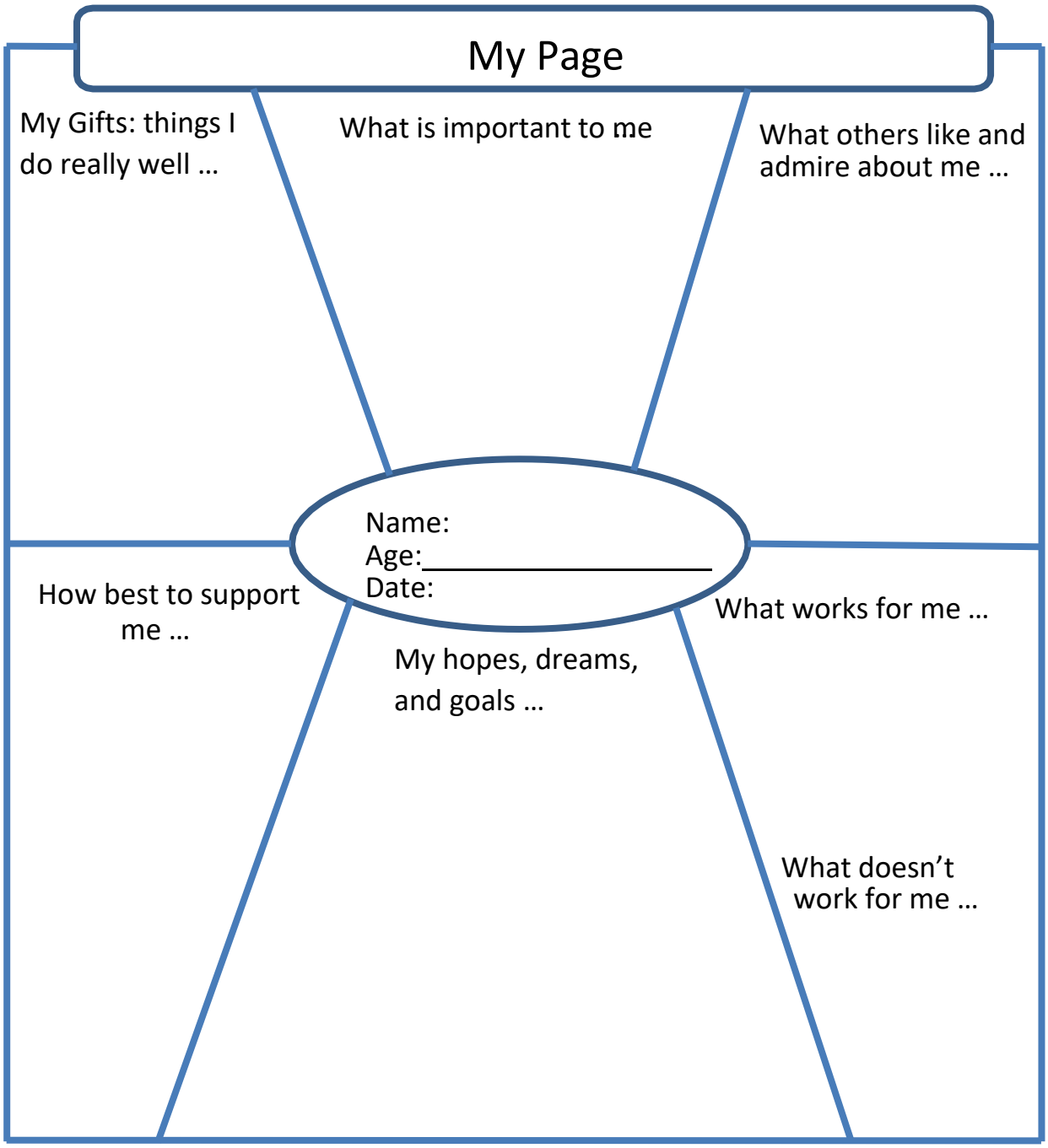
Activity Rules:

1. Others will read your routine so don't write down anything you don't want others to know about.
2. We are not interested in anything that leaves your body in the morning – you can omit that.
3. The routine should start when you get out of bed and end when you are ready for your day.
4. If you do not have a consistent routine, then write up this morning or yesterday morning.

My Morning Routine:

One Page Profile

The following Person-centered tool is the One Page Profile used by the Developmental Disabilities Administration (DDA). Review DDA's process. It is another tool you may want to consider using during care planning.



DSHS Developmental Disabilities Administration
Person Centered Planning One Page Profile 1.3 Rev. Sept 2015

My Page – A One Page Profile (instructions)

Please complete this one-page profile before you meet with your case manager for your assessment. Your case manager will review it with you before they complete your assessment and person-centered service plan. This is so your case manager can know you better and understand what is important to you.

By understanding what your goals are, your case manager can better assist you with determining how DDA paid services can help you live the life you want to live.

You can complete the one-page profile on your own or with the assistance of someone who knows you well. You may complete as much or as little of the profile as you wish. If you need extra space, you can use another piece of paper. If you want to include a picture of yourself with your one-page profile, you are welcome to do so.

You are not required to complete this profile, and if you choose not to, it will not affect your eligibility to receive a DDA assessment and paid services.

Instructions:

In the center oval write down your name, age, and the date you completed your profile.

- **My strengths, skills, and gifts.** In this space, write down the things that you are good at doing.
- **What is important to me**. In this space, write down people, places, interests, activities, things, pets … anything that is important for helping you live happily and safely.
- **What others like and admire about me**. In this space, write down what it is that other people like about you.
- **How to best support me**: In this space, write down ways that people can best help you do things when you need help. How should people communicate with you? What things are important for you for health and safety?
- **What works for me**. In this space, write down the things that help you out the most.
- **What does not work for me**. In this space, write down the things that you don't like, things that cause you to be upset, or are not good for your happiness, health, or safety.
- **My hopes, dreams, and goals**. In this space, write down your hopes and dreams and goals. This might be about where you want to live, or a job you want to have, or something you really want to do. What are your ideas for the best possible future for yourself?

DSHS Developmental Disabilities Administration
Person Centered Planning One Page Profile 1.3 Rev. Sept 2015

Additional Person-Centered Practices Resources

- The Learning Community for Person Centered Practices
- Building Capacity for Person Centered Thinking in Support of People with Developmental Disabilities

Partner Organizations

There are many organizations you will work with, often on a daily basis. Individual program roles and responsibilities will be outlined further in the manual.

Department of Social and Health Services (DSHS) - As a Department we are tied together by a single mission: to transform lives. Each administration within DSHS has a refined focus on this mission.

Washington State Department of Social and Health Services | Transforming Lives

- **Aging and Long-Term Care Administration (ALTSA**) – ALTSA's mission is to transform lives by promoting choice, independence, and safety through innovative services.
  - **Home and Community Services (HCS)** - HCS promotes, plans, develops, and provides long-term care services for persons with disabilities and the elderly who may need state funds (Medicaid) to help pay for them.
  - **Residential Care Services (RCS)** - RCS is responsible for the licensing and oversight of adult family homes and other licensed or certified facilities within the State of Washington. Their mission is to promote and protect the rights, security and well-being of individuals living in these residential settings.
    - **Complaint Resolution Unit (CRU) –** Receives reports/claims of abuse and neglect and pass the information to investigators
    - **Behavior Health Support Team (BHST) -** offering resident specific consultation and group trainings for staff in every part of the state. Whether a provider is rural or urban, nursing home or assisted living facility, adult family or supported living home, the BHST team is available to support providers who are serving

individuals with behavioral health challenges. The goal of the BHST is long-term success for individuals with behavioral challenges living in long-term and community-based settings.

- **Business Analysis and Application Unit (BAAU)** – Processes AFH applications
- **Adult Protective Services (APS)** – Investigates claims of abuse and neglect

- **Developmental Disability Administration (DDA)** – DDA strives to develop and implement public policies that will promote individual worth, self-respect, and dignity such that everyone is valued as a contributing member of the community. DDA is transforming lives by providing support and fostering partnerships that empower people to live the lives they want.

- **Behavioral Health Administration (BHA)** - transforms lives by supporting sustainable recovery, independence, and wellness. We do this through funding and supporting effective prevention and intervention services for youth and families, and treatment and recovery support for youth and adults with addiction and mental health conditions (also known as behavioral health). It operates three state psychiatric hospitals and the Office of Forensic Mental Health Services that deliver high-quality services to adults and children with complex needs.

Department of Health (DOH) - The Department of Health works with others to protect and improve the health of all people in Washington State. Our programs and services help prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions and ensure our state is prepared for emergencies. The DOH licenses, certifies, and registers all health professionals in the State of Washington which includes the Home Care Aide. Home | Washington State Department of Health

Health Care Authority (HCA) - The Washington State Health Care Authority's mission is to provide high quality health care through innovative health policies and purchasing strategies with a vision of a healthier Washington. The HCA manages the ProviderOne payment system.

Adult Family Home Council (AFHC) – Adult Family Home Council (AFHC) – The Adult Family Home Council is a mission driven member organization formed in 1993. The Council provides adult family home providers with resources and training covering all aspects of their business. The Adult Family Home Council supports regional chapters. The chapters conduct regular meetings, continuing education, and networking opportunities. The Adult Family Home Council also advocates on behalf of AFH providers with the state legislature, the Department of Social and Health Services, and as a member of the Washington State Senior Citizen's Lobby. The AFHC is the

exclusively recognized representative of adult family homes for purposes of collective bargaining. Home - Adult Family Home Council

Collective bargaining is a process of negotiations between Washington State and the Adult Family Home Council. The negotiations are primarily to set Medicaid reimbursement rates. The scope of bargaining includes economic compensation, such as the rate of subsidy and reimbursements; health and welfare benefits; professional development and training; labor-management committees; grievance procedures; and other economic matters.

Long-Term Care Foundation of Washington State – The Long-Term Care Foundation's mission is: " To improve and develop access to high-quality long-term care services through public awareness, community connections, and a well-supported long-term care workforce. " The Long-Term Care Foundation staff develop and manage the AFH Training Network to provide training, workforce development and other services to AFH operators and staff.
Home | LTCFWA (longtermcarefoundationwa.org)

Washington State Ombudsman (Ombuds) – "The Washington State Long-Term Care Ombudsman advocates for residents of nursing homes, adult family homes, and assisted living facilities. Our purpose is to protect and promote the Resident Rights guaranteed these residents under Federal and State law and regulations." (waombudsman.org)

Office of Developmental Disabilities Ombuds – "The mission of the DD Ombuds is to inform the Legislature's work to ensure safe, quality DD services and improve the lives of people with developmental disabilities."
DDOmbuds.org

Statewide Mental Health Ombuds – A Statewide Mental Health Ombuds is being developed. Under E2SHB 1086, the 10 existing regionally organized behavioral health ombuds offices will be replaced by a State Office of Behavioral Health Consumer Advocacy. Until then, the current 10 regional behavioral health ombuds across the state, will continue to advocate for persons with behavioral health issues. The regional offices are organized through Behavioral Health Administrative Service Organizations (BH-ASOs).

Assignment #1: Readiness Assessments

Are you ready? Before making the decision to become licensed as an adult family home provider, talk to other AFH providers. Ask a lot of questions. We will discuss the results of this assignment in the next class.

Due next class

- **Part One: Self-Assessment**
- **Part Two: Family or friend assessment**

Instructions:

1. Complete Part One – Self-Assessment. Answer Yes (Y), No (N), or Sometimes (S) to the questions in part one that best describes your response to each statement.

2. Ask a family member or close friend to complete Part Two; their assessment of how they see you.

3. When complete, add up your YES scores:
    a. Your score: ____
    b. Your family or friend's score: _____

    If you and/or your family/friend answered yes to **18 or more** of the questions, you may have a good understanding of the nature of the adult family home business. Write down what you believe your strengths are, where you need to improve and a few ideas on how you will improve in those areas identified.

    Strengths:
    - ○
    - ○
    - ○

    To improve:
    - ○
    - ○
    - ○

    Strategies to improve in areas identified:
    - ○
    - ○
    - ○

Readiness Assessments

AFH providers helped to develop the following assessments. The goal is to give you an idea of how you may respond to the considerable demands of running an AFH.

Part One: Self-Assessment

Circle your answer (Yes (Y), No (N), or Sometimes (S) to each question.

1.	I am patient with other people's mistakes.	Y	N	S
2.	I can be alert and calm and awake in the middle of the night, even after a long day.	Y	N	S
3.	I can take verbal abuse and still forgive. I do not hold a grudge.	Y	N	S
4.	I am comfortable asking others for help.	Y	N	S
5.	I can place the needs of others ahead of my own wants.	Y	N	S
6.	I am comfortable taking care of residents of the opposite and same sex.	Y	N	S
7.	I have experience and am comfortable taking care of people who are elderly, who have mental illness or developmental disabilities who are not related to me.	Y	N	S
8.	I deal with emergencies without panic.	Y	N	S
9.	When planning schedules, I can be thoughtful of the needs of staff, residents, and resident's families.	Y	N	S
10.	I am aware and prepared to give up most of my privacy because I will be sharing my home with residents.	Y	N	S
11.	Confrontation with staff and residents' families do not intimidate me.	Y	N	S
12.	I follow established procedures and do not cut corners.	Y	N	S
13.	I can keep abreast of the regulations and laws that govern adult family homes.	Y	N	S
14.	I am sensitive of other cultures and points of view.	Y	N	S
15.	I respect other's rights, privileges, and privacy and strive never to control or manipulate others.	Y	N	S
16.	I save money for a crisis and routinely plan ahead.	Y	N	S
17.	The financial risks of owning a business or incurring debt do not frighten me.	Y	N	S
18.	I promptly pay my bills.	Y	N	S
19.	I speak English clearly and am easily understood.	Y	N	S
20.	I am in excellent health and have a lot of energy.	Y	N	S
21.	I am organized and efficient.	Y	N	S
22.	I am able to follow the instructions of others, doctors, and nurses who give me care directions for residents in my home.	Y	N	S
23.	I can cope well when cherished residents may pass on. I am able to comfort the dying and relatives of those who are dying.	Y	N	S
24.	I am prepared financially and emotionally for the length of time it may take to get licensed.	Y	N	S
25.	I am able to take and act on constructive criticism regarding areas of my work needing improvement.	Y	N	S

Part Two: Family or Friend Assessment

Complete the following assessment as you see your family member or friend. Circle your answer (Yes (Y), No (N), Sometimes (S) next to each question, and add up the Y responses. Your family or friend…

1.	Is patient with other people's mistakes.	Y	N	S
2.	Can be alert and calm and awake in the middle of the night, even after a long day.	Y	N	S
3.	Can take verbal abuse and still forgive; does not hold a grudge.	Y	N	S
4.	Is comfortable asking others for help.	Y	N	S
5.	They can place the needs of others ahead of their own.	Y	N	S
6.	Is comfortable taking care of residents of the opposite and same sex.	Y	N	S
7.	Has experience and is comfortable taking care of people who are elderly, who have mental illness or developmental disabilities who are not related to them.	Y	N	S
8.	Does not panic when there is an emergency.	Y	N	S
9.	Is thoughtful of the needs of staff, residents, and resident's families when planning schedules.	Y	N	S
10.	Is aware and prepared to give up most of their privacy because of sharing their home with residents.	Y	N	S
11.	Is not intimated by confrontations with staff and residents' families.	Y	N	S
12.	Follows established procedures and do not cut corners.	Y	N	S
13.	Can keep up will the regulations and laws that govern adult family homes.	Y	N	S
14.	Is sensitive of other cultures and points of view.	Y	N	S
15.	Respects other's rights, privileges, and privacy and strives to never to control or manipulate others.	Y	N	S
16.	Saves money for a crisis and routinely plans ahead.	Y	N	S
17.	Is not frightened by the financial risks of owning a business or incurring debt.	Y	N	S
18.	Promptly pays their bills.	Y	N	S
19.	Can speak English clearly and is easily understood.	Y	N	S
20.	Is in excellent health and has a lot of energy.	Y	N	S
21.	Is organized and efficient.	Y	N	S
22.	Would be able to follow the instructions of others, doctors, and nurses who give them care directions for residents in their home.	Y	N	S
23.	Would cope well when cherished residents may pass on - they are able to comfort the dying and relatives of those who are dying.	Y	N	S
24.	Is prepared financially and emotionally for the length of time it may take to get licensed.	Y	N	S
25.	Is able to take and act on constructive criticism regarding areas of their work that needs improvement.	Y	N	S

Summary Review

During this module we learned:

- What an AFH is and isn't
- How your roles, responsibilities, and skill sets are changing
- About different populations seeking AFHs; your niche
- The importance of Cultural Competency, Sensitivity, and Humility
- The challenges faced by the LGBTQ and other communities and the impact you can have
- The power of words – Your words can have a significant impact on others
- About the importance of using Person Centered Philosophy
- And…

Resources/Websites to Start Exploring Now

- ALTSA - Professionals and Providers
- Information for Adult Family Home Providers
- Adult Family Home Council
- Long-Term Care Foundation

Test Your Knowledge

True or False:

1. The AFH provider is not required to speak and understand English if they have access to a translation line.
2. Person centered planning is based on the unique needs and choices of each person.
3. You are responsible for your resident care and safety 24 hours a day unless you are not on site.

Get Ready for Your Next Class

- Read assigned modules for next class
- Download and review the AFH Guidebook-Partners in Protection for Module 2
- Complete Assignment #1

Acronyms Used in this Module

Acronyms	Description
ADDRESSING	Age/Generation; Disability status (developmental); Disability status (acquired); Religion/Spirituality; Ethnicity, Socioeconomic status; Sexual orientation; Indigenous heritage, National origin, Gender
ADLs	Activities of Daily Living
AFH	Adult Family Home
AFHC	Adult Family Home Council
AIDS	Acquired Immunodeficiency Syndrome
ALTSA	Aging and Long-Term Support Administration

Acronyms	Description
APS	Adult Protective Services
BAAU	Business Analysis and Application Unit
BHA	Behavioral Health Administration
BHST	Behavioral Health Support Team
BIPOC	Black, Indigenous, and People of Color
CCO	Community Correction Officer
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CHOW	Change of Ownership
CRU	Complaint Resolution Unit
DDA	Developmental Disabilities Administration
DOC	Department of Corrections
DOH	Department of Health
DSHS	Department of Social and Health Services
HCA	Health Care Authority
HCA	Home Care Aide
HCS	Home and Community Services
HIV	Human Immunodeficiency Virus
IADLs	Instrumental Activities of Daily Living
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer +
ODHH	Office of Deaf and Hard of Hearing
Ombuds	Short for Ombudsman or Ombudsman Program
RCS	Residential Care Services
RCS BHST	Residential Care Services Behavioral Health Support Team
RCW	Revised Code of Washington
RSO	Registered Sex Offender
SHDD	State Hospital Discharge & Diversion Teams
TBI	Traumatic Brain Injury
TED	Telecommunication Equipment Distribution Program
TRS	Telecommunication Relay Service
TTY	Teletypewriter
WAC	Washington Administrative Code

Revision Table

Date	Volume	Changes	Page(s)
1/2025	V5.2	Reviewed all links and made changes as needed Added Summary Review from PP slide	Through Out 39