State Plan on Aging

Federal Fiscal Year

October 1, 2011 through September 30, 2015

DHS
Georgia Department
of Human Services

DIVISION OF AGING SERVICES
DAS
Aging • Disability • Support • Safety

Georgia Department of Human Services
Division of Aging Services

Georgia Department of Human Services
Division of Aging Services
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Clyde L. Reese, Esq. Commissioner

Georgia Department of Human Services • Division of Aging Services • Dr. James J. Bulot, Director
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August 1, 2011

Constantinos I. Miskis
Regional Administrator
U.S. Administration on Aging Region IV, DHHR
Atlanta Federal Center
61 Forsyth Street, SW, Suite 5M69
Atlanta, Georgia 30303-8099

Dear Mr. Miskis:

The State Plan on Aging is hereby submitted for the State of Georgia for the period of October 1, 2011, through September 30, 2015.

The enclosed plan describes the values, resources, goals and strategies designed to achieve the State of Georgia's objectives in providing services that will champion Choices for Independence for Older Americans. Included are required assurances and a description of programs and services under the provisions of the Older Americans Act of 1965, as Amended.

While much progress has been made in providing elderly Georgians a wide array of services, our intent is to continue our concerted efforts to improve the quality and capacity of long-term services and supports provided.

If you have any questions about the 2012-2015 State Plan, you may contact me at 404-657-5252 or Arvine Brown at 404-657-5278.

Sincerely,

Dr. James J. Bulot, Director
Division of Aging Services

cc: Clyde L. Reese, III, Esq., Commissioner
Sharon King, Esq., Deputy Commissioner
DAS Leadership Team

State Plan Assurances

For

Older Americans Act of 1965, as amended, P.L. 89-73, 42 U.S.C. § 3001, et seq.

I, the undersigned, affirm and give the assurances required by sections 305, 306, and 307 of the Older Americans Act, as amended, P.L. 89-73, 42 U.S.C. §§ 3001, et seq., §§ 3025, 3026, and 3027.

I, the undersigned, affirm and give the assurances required by sections 305, 306, and 307 of the Older Americans Act, as amended in 2006 (P.L. 89-73, 109-365).

Date 9/30/2011

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services
State Agency on Aging Director

Date 9/30/2011

Clyde L. Reese, III, Esq., Commissioner
Georgia Department of Human Services

Date 9-30-2011

Nathan Deal, Governor
State of Georgia

Verification of Intent
Designation of the State Agency on Aging

The State Plan on Aging for Fiscal Years 2012 through 2015 is hereby submitted for the State of Georgia. The plan covers the period October 1, 2011, through September 30, 2015. It includes all assurances and plans to be conducted by the Georgia Department of Human Services Division of Aging Services under the provisions of the Older Americans Act, that is amended, during the period identified. The State Agency named above has been authorized to develop and administer the State Plan on Aging in accordance with all requirements of the Act, i.e., the development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in the State.

This State Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the State Plan upon approval by the Assistant Secretary on Aging.

The State Plan on Aging for Fiscal Years 2012 through 2015 hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

9/3/11
(Date)

Dr. James J. Bulot, Director
Georgia Department of Human Services
Division of Aging Services

9/30/2011
(Date)

Clyde L Reese III
Clyde L. Reese, III, Esq., Commissioner
Georgia Department of Human Services

I hereby approve the State Plan on Aging and submit it to the Assistant Secretary on Aging for approval.

9-30-2011
(Date)

Nathan Deal
Nathan Deal, Governor
State of Georgia

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Executive Summary

The Georgia Department of Human Services Division of Aging Services, as the State Agency on Aging, hereby presents Georgia's four-year strategic plan for federal fiscal years (FFY) 2012 through 2015. The State Plan provides leadership and guidance in rebalancing the long-term care system and development of a comprehensive and coordinated infrastructure for home and community based services. The Plan documents the goals, objectives, and strategies that will be implemented to: 1) identify and address the needs of Georgia's older adult and disabled adult populations; 2) address marketing, outreach, and advocacy issues; and 3) development of initiatives geared towards promoting evidence-based, consumer-directed, and community-based long-term care services and supports.

The Georgia Department of Human Services (DHS) Division of Aging Services' (DAS) mission is to assist older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives. DAS strives to create a system that efficiently and effectively responds to the needs of Georgians. Through continuous service improvements and innovation, DAS provides programs and services that assist Georgians in living longer, living safely and living well.

The Georgia Department of Human Services Division of Aging Services (State Agency on Aging) and Georgia's Aging Services Network (Area Agencies on Aging, their providers, older adults and advocates) are committed to developing a person-centered, statewide comprehensive and coordinated system of programs and services. The system aims to serve all eligible individuals, regardless of age or ability, by providing seamless access to long term supports and services that are needed to remain at home and in the community, for as long as possible. Necessary to meeting this goal, DAS and Area Agencies on Aging partner with public and private organizations, including various state agencies, to provide advocacy and guidance in long-term care policy and the development of community supports for community integration, including barriers (or critical issues) such as housing and transportation.

DAS assesses its competitive environment through processes consisting of identification of strategic advantages and strategic challenges, opportunities for innovation, and focus on action to seek to attain the DHS and DAS vision, mission, and values. The performance improvement system comprises the utilization of strengths, weaknesses, opportunities, and threats (SWOT) analysis, Environmental Scan, Public Input from hearings and surveys, Georgia Oglethorpe Award Assessment based on the Malcolm Baldrige Criteria for Performance Excellence, customer monitoring and/or satisfaction results, and workforce capability, capacity, and satisfaction. DAS aligns its strategic planning goals with the Administration on Aging, Office of the Governor, and the Department of Human Services.

DAS' determination of its key strategic challenges includes:

- Federal and state budget reductions resulting in reduced or eliminated programs or services
- Growth in targeted populations without adequate capacity and funding
- Comprehensive and coordinated infrastructure for home and community based services
- Increased waiting lists for services
- Inadequate marketing for access to services; however, effective marketing will increase consumers and/or customers need for services
- Information technology that is agile and provides accuracy, reliability, security and confidentiality.

The following competitiveness changes are occurring to leverage strategic advantages and minimize strategic challenges:

- Advancement of a single entry point for access to long term services and supports and integrated eligibility of health and human services programs.
- Community Living Program initiatives to shift long-term care from institutionalized or facility-based services to the home and community.
- Managing using data, including the Malcolm Baldrige Criteria and the Plan-Do-Check-Act (PDCA) methodology.
- Increased marketing and training with collaborative professionals regarding the prevention of abuse, neglect and exploitation.
- Pursuit of grants to maximize evidenced-based models and innovation
- Innovation with technology in service delivery and performance operations.

DAS is committed to strengthening and expanding Older Americans Act (OAA) core programs, discretionary grants, and consumer control and choice programs. DAS is fostering an integrated and systematic approach to delivering consumer-directed long term supports and services and community living initiatives. Enterprise strategies include the following:

- Expansion of the Gateway/Aging and Disability Resource Connection (ADRC) as the "no wrong door" entry point for access and referral to services by collaborating with DAS programs such as GeorgiaCares (prescription assistance and counseling regarding Medicare rights, benefits and services), including the State Health Insurance Program (SHIP) and the Senior Medicare Patrol (SMP), Medicare Improvements for Patients and Providers Act (MIPPA), Adult Protective Services (APS), the Long-Term Care Ombudsman (advocates for nursing and personal care home residents), and Community Living Programs, including home and community based services and the Community Care Services Program, which seeks to assist non-Medicaid and Medicaid eligible customers remain in their home or community as they age.

- Promotion and coordination of Elder Rights and Elder Abuse programs to create a unified message that it is a crime in Georgia to abuse, neglect, exploit and violate the rights of older adults and adults with disabilities. Cross-cutting inventiveness with the Elderly Legal Assistance Program (ELAP), Adult Protective Services, the Long-Term Care Ombudsman, the Gateway/Aging and Disability Resource Connection, GeorgiaCares SMP and SHIP, and the Forensic Special Investigations Unit will maximize marketing, outreach, and educational events to targeted populations, including the use of elder abuse prevention (EAP) funds for marketing and social media dissemination. The Forensic Special Investigations Unit is developing a public health model of abuse prevention including the At-Risk Adult Crime Tactics (ACT) Specialist certification which is geared towards providing a basic foundation of information about abuse, neglect & exploitation to all primary and secondary responders including the Aging Network Elder Rights personnel with an emphasis on criminal justice professionals.

- Strengthen Nutrition and Disease Prevention and Health Promotion Services initiatives to include evidence-based health and wellness options such as the Chronic Disease Self-Management Program (CDSMP), which is designed to assist older adults to better manage chronic diseases and introduce intervention to reduce the risk of disease, injury and disability for older adults. Additional strategies include a focus on the reduction of food insecurity,

maintaining or increasing consumption of fruits, vegetables, and dairy products, and expansion of food delivery and/or menu dining options among clients.

- Enhance the National Family Caregiver Support Program by integrating evidence-based Alzheimer's Disease Supportive Services Program (ADSSP) discretionary grants, in collaboration with the Rosalynn Carter Institute at Georgia Southwestern University and DAS, to reduce caregiver burden, stress, and depression among family caregivers. Additional strategies include a statewide system redesign to introduce new screening tools for identifying persons at risk with early state dementia, clinical counseling protocols, and improved inter-agency collaboration and incorporation of the Tailored Caregiver Assessment and Referral® (TCARE®) assessment that provides guidance for understanding caregivers needs.

- Enhance Consumer Control and Choice by expanding community living initiatives such as the Veterans Directed Home and Community Based Services and Community Living Program, which seeks to serve veterans and individuals sixty years of age or older living in the community who are at medical or financial risk for moving to a nursing home by providing Support Options. Support Options offer a consumer the ability to choose who will provide the services they need, when the services will be delivered, and the chargeable pay rates for services.

The Georgia Department of Human Services Division of Aging Services, as the State Agency on Aging, will continue to emphasize enhancing and sustaining Older Americans Act core programs, discretionary grants, and support consumer control and choice initiatives to continue modernization of long-term services and supports delivery. As preparation continues for the growth of older adults and disabled adult populations, including the retirement of baby boomers, DAS will continue methodologies to efficiently and effectively expand capacity, collaborations, and cost effectiveness to deliver a comprehensive system of programs and services. Ultimately, the State Agency on Aging will translate activities, data, and outcomes into proven best practices and document tangible outcomes achieved to assist older adults, disabled adults, their families and caregivers remain in their homes and communities.

Public Input

The Georgia Department of Human Services Division of Aging Services contracted with The Georgia State University (GSU) Gerontology Institute and The Georgia State University Georgia Health Policy Center (GHPC) to collect representative public input. The primary project objectives were to ascertain the perceived value of and barriers to DAS programs and services, obtain consumer suggestions for recommended improvements to the service delivery system and home and community based services, and ideas for new DAS initiatives. Statewide public hearings, a general population telephone survey of Georgians 60 years of age and older, a telephone survey of caregivers of home and community based services (HCBS) and Community Care Services Program (CCSP) clients discharged to a nursing facility in SFY10; and CCSP focus groups were conducted.

- Public hearing participants identified services most needed by older adults to remain in the community. The top three services, ranked in order of importance statewide are: (1) transportation, (2) health care, and (3) services to keep people at home.

Services Most Needed by Older Adults Living in the Community [a]

Responses	Number of Responses	% of Responses	% of All Respondents
Transportation	**332**	**17%**	**57%**
Health care	**284**	**14%**	**49%**
Services to keep people at home	**280**	**14%**	**48%**
Prescription drug assistance	214	11%	37%
Housing	176	9%	30%
Exercise & nutrition	173	9%	30%
Caregiver/Respite care	146	7%	25%
Income/Financial assistance	146	7%	25%
Abuse prevention	69	3%	12%
Legal	66	3%	11%
Employment	35	2%	6%
Volunteer opportunities	35	2%	6%
Other	38	2%	7%

[a] Of the 610 participants who completed surveys, 586 answered Q1 resulting in a total of 1,994 responses.

- Comparison of the above question to the Georgia General Population, respondents indicated the most frequent responses were related to health (30%), caregiver assistance (28%), and financial assistance (26%). These were followed by assistance with shopping (20%) and transportation (18%).
- 2007 public hearing respondents indicated transportation (17.6%), prescription assistance (9.6%), and caregiver assistance/respite care (6.8%), income/financial assistance (6.6%), and housing (6.1%) as the most needed services.

- Public hearing participants identified services most needed by older adults to continue living in their home. 47% of respondents indicated the need for transportation followed by caregiver/respite care and meal delivery/food services at (27%).

Services Older Adults Need to Continue Living in Their Home [a]

Response Category	Number of Responses	% of Responses	% of All Respondents
Transportation	**216**	**47%**	**18%**
Caregiver/Respite care	126	27%	10%
Meal delivery/Food services	122	27%	10%
Assistance with ADLs	117	25%	10%
Financial assistance	106	23%	9%
Homemaker services	99	22%	8%
Health care	95	21%	8%
Prescription drug assistance	67	15%	6%
Nutrition/Exercise	60	13%	5%
Other [b]	199	43%	16%

[a] Of the 610 participants who completed surveys, 586 answered Q2 resulting in a total of 1,242 responses.
[b] Includes several miscellaneous response categories, which individually account for fewer than 5% of responses.

In comparison, the Georgia General Population Survey respondents cited health care (27%) and financial assistance and transportation (23%) as the most needed services to remain in their home. See the segmentation chart below.

Needs of Older Adults by Age Group

Age Group (Years)	Primary Need Identified	Percent by Age Group	Secondary Need Identified	Percent by Age Group
60-64	Health Care	17%	Transportation	13%
65-69	Health Care	15%	Income/Financial Assistance	14%
70-74	Health Care	17%	Transportation	15%
75-79	Don't Know	16%	Health Care	14%
80-84	Don't Know	15%	Transportation	14%
85+	Health Care	15%	Income/Financial Assistance & Transportation	13%

- Of the 156 General Population respondents who indicated financial assistance necessary for older adults to remain in their homes, 44 percent said they do have sufficient financial resources to live well in retirement years, 43 percent said they do not, and 19 percent responded "Don't Know."
- In contrast, 67% of public hearing participants did not expect to have sufficient financial resources to live well in retirement years.

Responses from caregivers of home and community based services (HCBS) and Community Care Services Program (CCSP) clients discharged to a nursing facility in SFY10 indicate:

- Over half (64%) reported providing care for a parent [mother (50%), father (8%), mother- in-law (5%), father-in-law (1%)].
- Almost 70 percent of caregivers provided care for three years or more [3-4 years (23%); 5 year or more (46%)].

- Caregiver respondents reported that the care recipient's physical health (68%) followed by caregiver burden (21%) were the two main categories for care recipients to be placed in a nursing home.

  Within each of the major categories, respondents were asked to provide details to describe why care recipients required nursing home placement.

Category	Detail	Frequency	Percent of Respondents
Physical health	**Dementia/Alzheimer's**	**69**	**25%**
Physical health	Falls	39	14%
Caregiver burden	Unable to provide required care	38	14%
Physical health	Other	23	8%
Physical health	Stroke	17	6%
Physical health	Broken Hip	15	5%
Caregiver burden	Caregiver in poor health	14	5%
Physical health	Ambulatory problems	11	4%
Total Responses		**226**	**81%**
Total Respondents		**280**	**100%**

- Seventy-four percent of caregiver respondents reported that Assistance with Instrumental Activities of Daily Living (IADLs) could have assisted them to help the care recipient remain at home.

Additional Services that Could Have Helped Care Recipients Remain at Home

Category	Detail	Frequency	Percent of Respondents
Assistance with Instrumental Activities of Daily Living	**Respite services (need break/time off)**	**123**	**44%**
Assistance with Instrumental Activities of Daily Living	No additional help needed	55	20%
Other/Refused	Other	30	11%
Assistance with Instrumental Activities of Daily Living	Other Services	12	4%
Assistance with Activities of Daily Living	Transferring (in & out of bed)	10	4%
Total Responses		**230**	**82%**
Total Respondents		**280**	**100%**

Opportunities for improvement from all data collection methods

- Increase the amount, flexibility, and quality of transportation services.
- Increase the amount of services that support caregivers, which include personal support/homemaker services, as well as respite services in and out of the home.
- Increase mental health services and supports.
- Provide more personal support services, as well as higher quality services and more flexible and individualized services.
- Provide access to durable medical equipment, specifically wheelchairs, walkers, and stair chair lifts. Increase assistance with home modifications and home repairs.
- Increase access to services.
    - Decrease service wait times.
    - Make eligibility criteria less restrictive.
    - Increase staff outreach, community partnerships, and marketing of programs.
    - Increase training of agency personnel to improve their knowledge.
- Enhance wellness and prevention programs, including increased opportunities for exercise and classes about disease prevention and nutrition.
- Provide assistance with long-term planning.
- Continue to enhance Adult Protective Services and Legal Assistance services.
    - The greatest area of concern in reference to abuse of older adults and adults with disabilities was financial abuse. Through programmatic efforts, ensure that older adults and adults with disabilities have financial security, including enough food to eat and enough money to pay rent.
    - Increase awareness of whom to contact in the event of abuse or risk.

Recommendations for Rural Areas

- As with the statewide recommendations, there is a great need for additional, more flexible, and higher quality transportation services, especially in rural areas.
- Provide more emergency and urgent care services in rural areas.
- Provide pest control services, heating and air conditioning service, and home repair for safety in rural areas.
- Provide mobile grocery and drug services in rural areas to improve service accessibility.

DAS Mission, Vision, and Values

Mission

The Division of Aging Services (DAS), together with the Aging Network and other partners, assists older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives.

Vision

Living longer, Living safely, Living well

Values of the Division

- **A Strong Customer Focus:** We are driven by customer, not organizational, need. Our decisions involve our customers and include choice.
- **A Proactive Approach:** We anticipate the needs of our consumers and advocate on their behalf.
- **Empowerment:** We believe in self-determination for consumers. We support the right of consumers and workforce to make choices and assume responsibility for their decisions.
- **Dignity and Respect:** We respect the rights and self-worth of all people and are dedicated to preserving individual dignity.
- **Open Communication:** Communication is the lifeblood of organizations. Ours is open, two-way and responsive. We listen to our staff, customers and partners and provide them accurate, timely information.
- **Our Workforce:** Our workforce, including volunteers, are our best asset. We respect one another and treat one another with honesty and fairness.
- **Positive Work Environment:** The Division maintains a learning environment with opportunities to increase professional growth, knowledge, and stimulate creative thinking. We share a sense of family.
- **Accountability and Results:** We are good stewards of the trust and resources that have been placed with us. Because we are committed to continuous quality improvement, we base our decisions on customer need and analysis of data.
- **Teamwork:** Teamwork is the way we do business. Our decision-making is shared and everyone's opinion is valued. We value teamwork because it generates innovation, creativity and opportunity. We value collaboration and seek ways to include others.
- **Partnership:** We value our partners and actively pursue new partnerships and opportunities for collaboration.
- **Technology:** We value using new technologies to improve the efficiency and effectiveness of our work processes and to obtain outcome measures.
- **Trust:** We are honest with one another and with our customers. Compassion and integrity underlie what we do and who we are.
- **Diversity:** We value a diverse workforce because it broadens our perspective and enables us to better serve consumers.
- **Excellence:** There is a spirit of excellence. A visionary approach to management where we seek to do new and unique things, especially as it relates to the needs of families.

Georgia's Aging Network

State Agency on Aging

The Georgia Department of Human Services Division of Aging Services, as the State Agency on Aging [commonly referred to as State Units on Aging (SUAs)], provides state leadership to administer a statewide system of comprehensive and coordinated array of services for older adults and their families and caregivers, in partnership with Area Agencies on Aging. DAS administers federal and state funding to Area Agencies on Aging manages contract requirements with Area Agencies on Aging and their governing bodies, and provides the policy framework for programmatic direction and operations, standards, and guidelines for service delivery systems, quality assurance and training. DAS continuously seeks to improve the effectiveness and efficiency of the services provided to older adults and their families.

As Georgia's State Agency on Aging, DAS assures that preference will be given to the provision of services to older individuals with the greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals, individuals at risk for nursing home placement, and individuals living in rural areas. The Gateway/Aging and Disability Resource Connection (ADRC) provides a "no wrong door" single entry point for older and disabled adults to access long-term care support services. The ADRC provides information and assistance and referrals to community resources.

State Agencies on Aging administering funds under Titles III and VII of the Older Americans Act of 1965, as amended, are required to develop and submit to the Assistant Secretary on Aging a State plan for approval under Section 307 of the Older Americans Act. The Georgia Department of Human Services Division of Aging Services (DAS) has adopted a four-year State Plan on Aging for the period extending from October 1, 2011 through September 30, 2015.

The State Plan is based, in part, on Area Plans developed by the twelve (12) Area Agencies on Aging (AAAs) within the State, designated under Section 305. The agencies formulated their area plans using a uniform format developed by the State agency, in collaboration with the Area Agencies.

Area Agencies on Aging

In Georgia, DAS has designated twelve (12) Planning and Service Areas (PSAs) and Area Agencies on Aging (AAAs). All community based services for older adults are coordinated through the AAAs. Ten of the Area Agencies are housed within Regional Commissions (RCs), which are the units of general purpose local government. The remaining two agencies are free-standing, private non-profit organizations, both of which have 501(c)3 status with the Internal Revenue Service.

The AAAs are responsible for:

- Assuring the availability of an adequate supply of high quality services through contractual arrangements with service providers, and for monitoring their

performance;
- Local planning, program development and coordination, advocacy, monitoring;
- Developing the Area Plan on Aging and area plan administration, and resource development;
- Working with local business and community leaders, the private sector and local elected officials to develop a comprehensive coordinated service delivery system;
- Establishing and coordinating the activities of an advisory council, which will provide input on development, and implementation of the area plan; assist in conducting public hearings; review and comment on all community policies, programs and actions affecting older persons in the area.

A listing of Georgia's Area Agencies on Aging is encompassed within the State Plan. The map on the following page depicts geographical boundaries of the Area Agencies on Aging within the State of Georgia.

Georgia Council on Aging

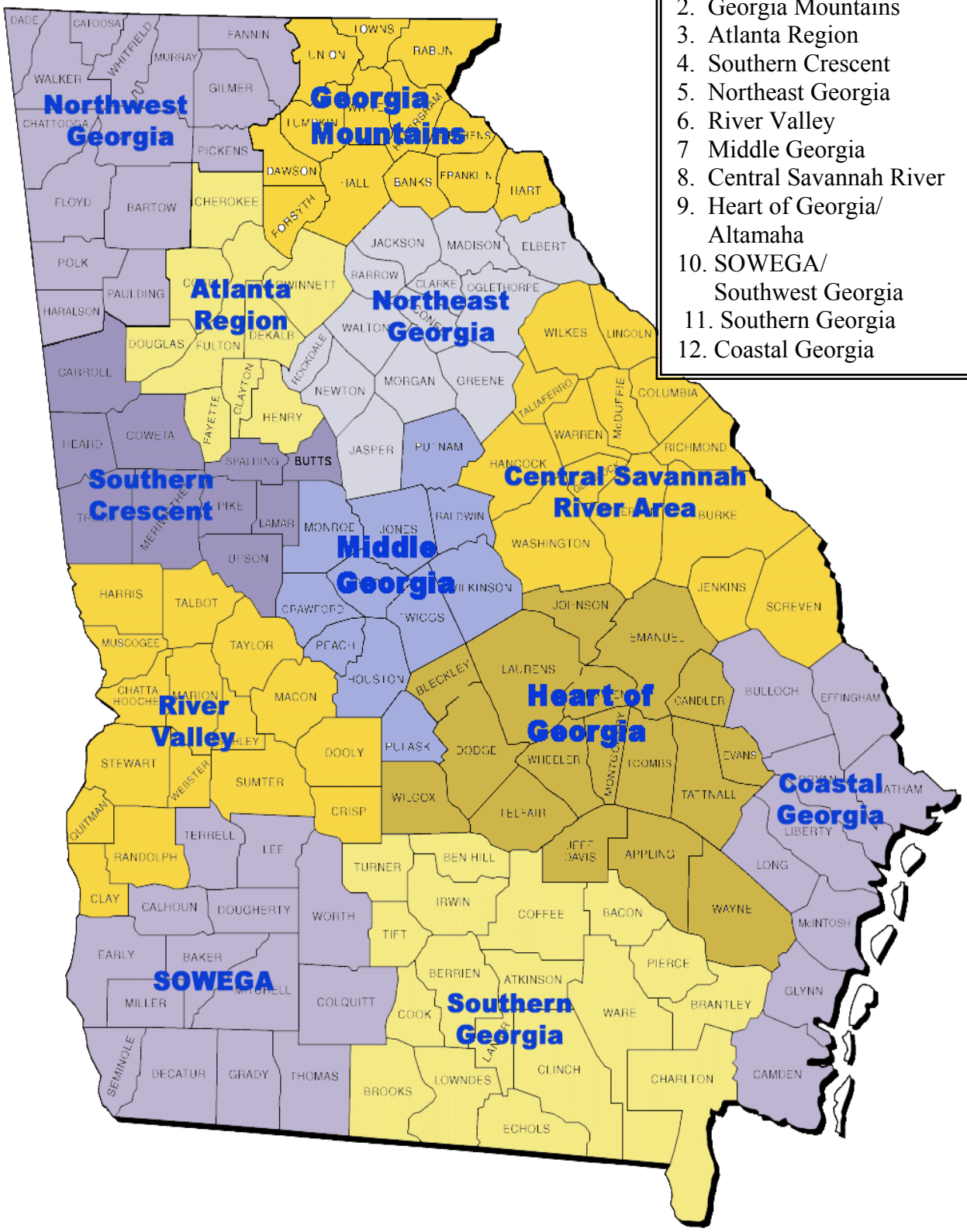
The Georgia Council on Aging (GCOA) primary mission is *"to serve in an advisory capacity to the Governor, the General Assembly, the Board of Human Services, and all other state agencies on aging issues, as well as to advocate with and on behalf of aging Georgians and their families to improve their quality of life."* CO-AGE (Coalition of Advocates for Georgia's Elderly) was created and is convened by the Georgia Council on Aging. It is a forum through which the concerns of older Georgians are identified and addressed. CO-AGE is a diverse coalition, comprised of older adults, consumers, advocates, advocacy groups, and providers from throughout the state.

Advocates

The Aging Network is working to increase the level of additional advocacy on behalf of Georgia's elderly. The Aging Network consists of SUAs, AAAs, service providers, advocates, adult care centers, volunteers, and older adults – their families and caregivers. Through AAAs and their alliances, meetings are held for seniors to talk with and educate their elected officials. Newly elected local officials are oriented about aging issues, and advocates help educate the community about aging concerns. For example, the Georgia Association of Area Agencies on Aging (G4A) partners with the Georgia Gerontology Society (GGS) to contract for a director of the Senior Citizens Advocacy Project, who in turns represents their views at CO-AGE and works closely with GCOA. Their "Be There 4 Seniors" campaign has been extremely effective during the past three years at the Georgia General Assembly and will continue. Additionally, Area Agency Advisory Councils also provide a forum for advocacy and education. Council members are charged with representing the Area Agencies and issues on aging and long term care to their communities, as well as communicating with the Area Agency about issues affecting their communities and professions.

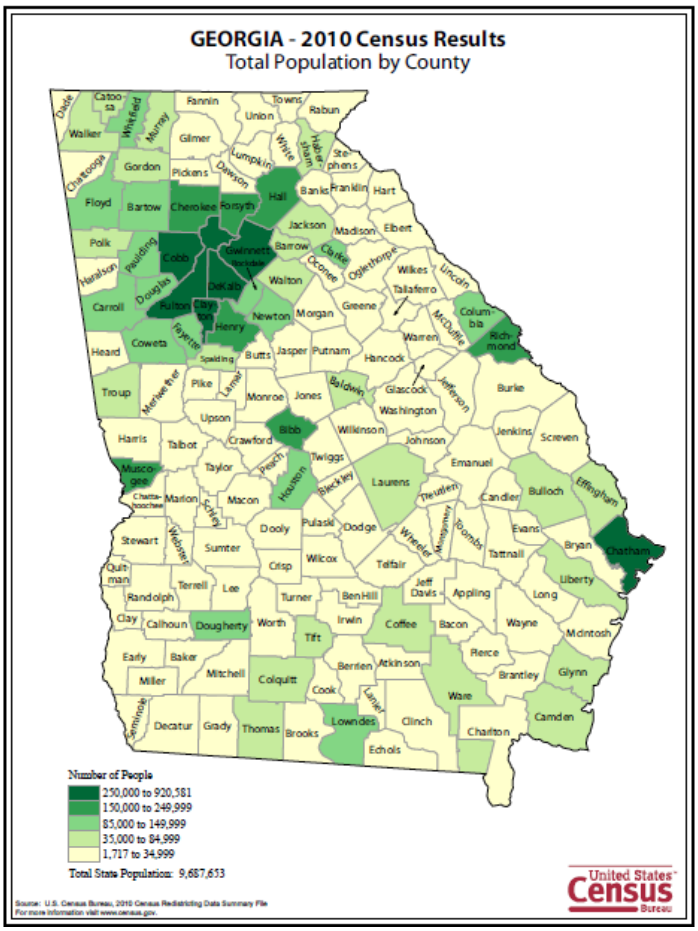
Planning and Service Areas Overview

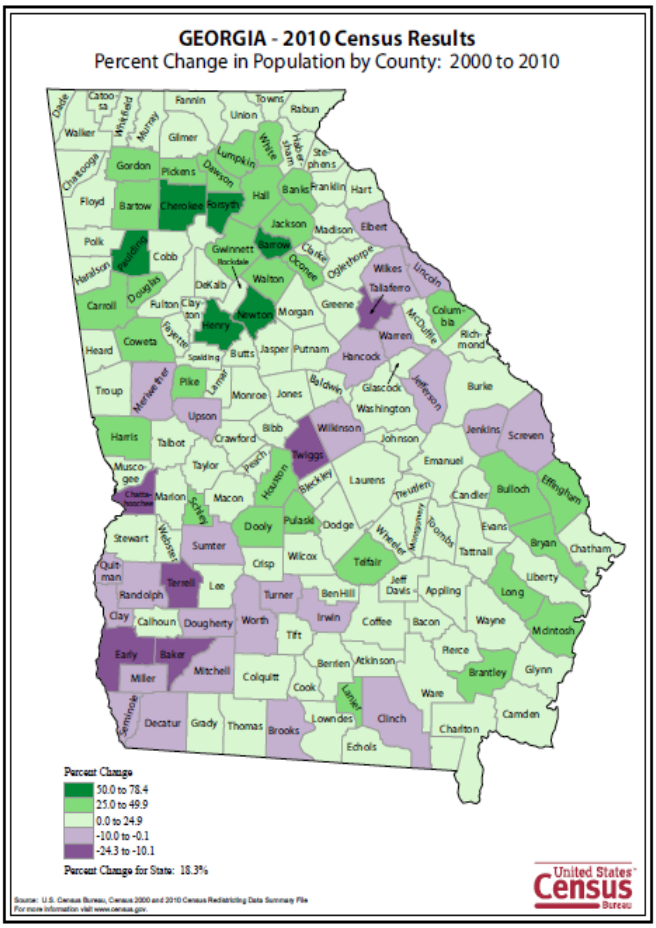
PSAs:
1. Northwest Georgia
2. Georgia Mountains
3. Atlanta Region
4. Southern Crescent
5. Northeast Georgia
6. River Valley
7 Middle Georgia
8. Central Savannah River
9. Heart of Georgia/ Altamaha
10. SOWEGA/ Southwest Georgia
11. Southern Georgia
12. Coastal Georgia



Aging Trends in Georgia

- The 2010 Census indicates Georgia's population increased from of 8,186,453 in 2000 to 9,687,653. This is an 18.3% population increase. There are 1,032,035 seniors age 65 and over. From 2000 to 2010, seniors age 65 and over increased 31.4%.
- Georgia's population, ages 65 and above, is expected to increase 142.95% and 65.5% as a percent of the total population, between 2000 and 2030.
- During the 20th century, the number of Georgians age 60 and above increased ten-fold, compared to a four-fold growth in the population overall.
- Georgia continues to be a young state compared to the nation. Although the median age continues to rise, it is lower than all but five states. This is due to several factors. Georgia has a higher minority population than the national average. These groups have higher birth rates and lower median age than the non-Hispanic white population. Also, Georgia's high level of migration from other states is concentrated in younger population age cohorts. This is demonstrated by the fact that Georgia has a higher percentage of its population in the 25 to 44 age group than the national average (32.4 percent versus 30.2 percent). Only two states, Alaska and Colorado, have a higher percentage of their population in this group.





State Data and Demographics

Georgia Population Data Summary
2009 Estimates

PSA	60+ Population	60+ as % of Total Popu-lation	65+ Living Alone	65+ Living Alone as % of 65+ Popu-lation	65+ In Poverty	65+ In Poverty as % of 65+ Popu-lation	65+ Limited English	65+ Lim Eng as % of 65+ Population
1-Northwest Georgia	154,114	18%	24,997	24%	12,284	12%	817	0.8%
2-Georgia Mountains	116,589	19%	15,899	21%	8,626	11%	1,550	2.0%
3-Atlanta Region	539,254	13%	78,602	22%	28,136	8%	14,556	4.0%
4-Three Rivers/ Southern Crescent	86,437	18%	13,150	23%	6,806	12%	238	0.4%
5-Northeast Georgia	94,358	16%	15,052	23%	7,094	11%	387	0.6%
6-River Valley/Lower Chattahoochee	66,356	18%	13,427	31%	6,109	14%	193	0.4%
7-Middle Georgia	87,717	18%	15,722	26%	7,680	13%	346	0.6%
8-Central Savannah	82,626	18%	16,277	29%	7,674	14%	551	1.0%
9-Heart of GA Altamaha	58,388	19%	11.255	29%	7,453	19%	190	0.5%
10-Southwest Georgia	67,369	19%	13,223	28%	7,160	15%	250	0.5%
11-Southern Georgia	71,598	18%	13,733	29%	7,436	15%	224	0.5%
12-Coastal Georgia	103,235	16%	18,183	27%	7,438	11%	464	0.7%
State of Georgia Totals	1,528,041	16%	249,520	25%	113,896	11%	19,766	2.0%

PSA 1 – Northwest Georgia	Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
PSA 2 – Georgia Mountains	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White
PSA 3 – Atlanta Region	Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale
PSA 4 – Three Rivers/Southern Crescent	Butts, Carroll, Coweta, Heart, Lamar, Meriwether, Pike, Spalding, Troup, Upson
PSA 5 – Northeast Georgia	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
PSA 6 – River Valley/Lower Chattahoochee	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
PSA 7 – Middle Georgia	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson
PSA 8 – Central Savannah River	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes
PSA 9 – Heart of Georgia Altamaha	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox
PSA 10 – Southwest Georgia	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth
PSA 11 – Southeast Georgia	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
PSA 12 – Coastal Georgia	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Sources:	60+ Populations from 2010 Census, Summary File 1, U.S. Census Bureau 65+ Populations from the Governor's Office of Planning & Budget, 2009 County Populations by Age, http://opb.georgia.gov/00/channel_title/0,2094,161890977_162720430,00.html Remainder of data from 2005-2009 American Community Survey 5-Year Summary File, U.S. Census Bureau, American Community Survey Office

Population by Age Group: July 1, 2009									
Geography	All Ages	50+	55+	60+	65+	70+	75+	80+	85+
United States Total (50 States + DC)	100.0%	31.3%	24.2%	18.0%	12.9%	9.1%	6.1%	3.7%	1.8%
Georgia	100.0%	27.5%	20.8%	15.1%	10.3%	6.9%	4.4%	2.6%	1.2%

Source: Census 2009 Estimates
http://www.census.gov/popset/datasets.html
Tabled compiled by the U.S. Administration on Aging
File: stterr2009.xls: 2009- 50+%

Profile of the General Demographic Characteristics for the United States and Georgia: 2009 Estimates									
Geography	Total Population	60 to 64 years	65 to 74 years	75 to 84 years	85 years and over	60 years and over	65 years and over	Percent 60+	Percent 65+
US Total	307,006,550	15,811,923	20,792,067	13,147,862	5,630,661	5,382,513	39,570,590	18.0%	12.9%
Georgia	9,829,211	471,705	578,626	316,509	119,679	1,486,519	1,014,814	15.1%	10.3%

Source: Census 2009 Estimates
http://www.census.gov/popset/datasets.html
Tabled compiled by the U.S. Administration on Aging
File: stterr2009.xls: 2009- 50+x5

Percent of Persons 60+ By Race and Hispanic Origin – 2009 Estimates								
		Persons Not Hispanic or Latino						
Geography	Total 60+	Black/African American	American Indian/Alaskan Native (Alone)	Native Hawaiian/Pacific Islander (Alone)	Asian (Alone)	Two or more Races	White (Alone – Non-Hispanic)	Hispanic/Latino (may be of any race)
US Total (50 States + DC)	100.0%	8.7%	0.5%	0.1%	3.5%	0.7%	79.3%	7.3%
Georgia	100.0%	21.1%	0.2%	0.0%	1.9%	0.6%	73.8%	2.4%

Source: Census 2009 Estimates
http://www.census.gov/popset/datasets.html
Tabled compiled by the U.S. Administration on Aging
File: stterr2009.xls: 60+%xRace-HO

Age by Types of Disability for the Civilian Non-institutionalized Population 65 Years and Over with Disabilities							
Note: A person may have more than one disability							
Data Set: Census 2006 American Community Survey – Sample Data							
Geography	Civilian non-institutional population 65 years and over	Persons with any disability	Persons with Sensory disability	Persons with Physical disability	Persons with Mental disability	Persons with Self-Care disability	Persons with Go-outside-home disability
		Number	Number	Number	Number	Number	Number
US Total (50 States + DC)	35,570,460	14,567,090	5,885,155	11,142,627	4,405,827	3,719,244	6,301,502
Georgia	871,446	393,364	159,394	314,112	131,256	105,719	173,220

Age by Types of Disability for the Civilian Non-institutionalized Population 65 Years and Over with Disabilities for Each State							
Note: A person may have more than one disability							
Data Set: 2006 American Community Survey – Sample Data							
Geography	Civilian non-institutional population 65 years and over	Persons with any disability	Persons with Sensory disability	Persons with Physical disability	Persons with Mental disability	Persons with Self-Care disability	Persons with Go-outside-home disability
		Percent	Percent	Percent	Percent	Percent	Percent
US Total (50 States + DC)	35,570,460	40.95%	16.55%	31.33%	12.39%	10.46%	17.72%
Georgia	871,446	45.14%	18.29%	36.04%	15.06%	12.13%	19.88%

Projections of the Population by Age 1990 to 2030					
Ages 65 and Up	1990	2000	2010	2020	2030
Georgia	654,270	785,275	980,824	1,409,923	1,907,837
Increase by each 10 year period		131,005	195,549	429,099	497,914
Percent increase by each 10 year period		20.02%	24.90%	43.75%	35.31%
Increase with 2000 as base		0	195,549	624,648	1,122,562
Percent increase 2000 to 2030					142.95%
http://aoa.gov/prof/Statistics/future_growth/State-5-yr-age-projections-2005-2030.xls					

Projections of the Population, by Age, 1990 to 2030 (in thousands)					
Georgia	1990	2000	2010	2020	2030
ages 0 – 4		595	731	817	923
ages 5 – 17		1574	1772	2020	2224
ages 18 – 24		838	976	1050	1171
ages 25 – 64		4394	5130	5546	5792
ages 65 and up		785	981	1410	1908
Total population		8186	9589	10844	12018
65+ as a percent of total		9.59%	10.23%	13.00%	15.88%
Percent in percent of total 2000 to 2030					60.39%
http://aoa.gov/prof/Statistics/future_growth/State-age-projections-2005-2030-full-dataset.xls					

Context – Focus Areas

The Georgia Department of Human Services (DHS) Division of Aging Services (DAS) aligned the following priorities with Administration on Aging goals for the next four year State Plan cycle. They are: (1) Gateway/Aging and Disability Resource Connection, (2) Evidence-Based Programming, (3) Technology, (4) Consumer Direction, and (5) Elder Rights. A synopsis of programs and services describe our system to sustain older Georgians in their homes and communities as follows:

- The Gateway/Aging and Disability Resource Connection (ADRC) serves as the "no wrong door" to information and referral to services for public and private long-term supports and services for older individuals, individuals with disabilities of all ages, families, caregivers and professionals. The Gateway/ADRC is integral to several cross-cutting initiatives within DAS such as the following:

    - Money Follows the Person (MFP) is a collaboration between DAS programs such as the Community Care Services Program (CCSP) and the Long-Term Care Ombudsman Program (LTCOP) in conjunction with the Georgia Department of Community Health (DCH), and the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). Through the administration of MFP, DAS will be instrumental in rebalancing long-term care (LTC) and assisting individuals to transition from an institutional setting to a home and community based setting.

    - Medicare Improvements for Patients and Providers Act (MIPPA) provides enhanced beneficiary outreach and assistance to Medicare beneficiaries in relation to the Medicare Savings Programs (MSP), Medicare Part D, Low-Income Subsidy (LIS), and prevention of disease and wellness promotion. Initiatives include collaboration with GeorgiaCares SHIP, AAAs, and the Centers for Medicare and Medicaid Services (CMS).

    - Care Transitions/Hospital Transitions consists of interdisciplinary communication and collaboration, transitional care staff, patient activation, and enhanced follow-up for consumers transferring from a hospital setting to a home or community based setting. The Care Transitions initiative will utilize an evidence-based model to conduct discharge planning, improve quality assurance, and decrease readmission rates among Medicare beneficiaries. ADRCs have been designated as local contact agencies (LCA) by the Georgia Department of Community Health (DCH) as the first point of contact for persons wanting to transfer out of a nursing home. We encourage other health care providers to utilize these resources for other consumer directed initiatives.

- Evidence-Based Programming has an outcome based philosophy which includes program replication of a specific intervention, tested through randomly controlled experiments with results published in peer-reviewed journals. DAS is

committed to implementing evidence-based practices to achieve improvements in health status and gain greater efficiencies and cost effectiveness in contracting with local aging service providers.

- The Stanford Chronic Disease Self-Management Program (CDSMP) is an evidence-based initiative designed to increase access to effective interventions to reduce the risk of disease, injury, and disability for older adults. The program helps older adults better manage their chronic diseases and establishes an infrastructure across the state to implement health and wellness focused programming.

- Tailored Caregiver Assessment and Referral (TCARE®), developed at the University of Wisconsin Milwaukee (UWM), guides care managers through an assessment and care planning process that helps them examine the care context and identification of sources and stressors a caregiver is experiencing. Care managers can more effectively support family caregivers by efficiently targeting services to their needs and strengths. All AAAs will implement TCARE® over the next four year cycle and collaborate with programs such as CCSP.

- Caregiver initiatives in collaboration with The Rosalynn Carter Institute of Georgia Southwestern State University, including but not limited to, the Georgia REACH and Georgia REACH- Coastal Projects that targets dementia caregivers in rural areas in central, western, and southern coastal Georgia counties to reduce caregiver burden and distress. The Georgia New York University Caregiver Intervention (NYUCI) purposes to decrease negative impacts associated with family caregiving such as depression, isolation, and stress related illnesses by targeting rural and African American caregivers who provide in-home care to spouses with Alzheimer's Disease (AD).

- Mental Health and Aging priority to support the mental health needs of older adults and their caregivers by improving access, screening, assessment and treatment of older adults and their caregivers, and to disseminate and sustain evidence-based practices and programs (EBPs) throughout the Aging Network and mental health service delivery system. DAS works together with the following entities and programs to promote mental health initiatives: Fuqua Center on Late-Life Depression (Emory University) for training in EBPs such as Healthy Ideas for CCSP care coordination; Fuqua and DBHDD on its Medicaid evidence-based program of Certified Peer Support Specialists to increase older adult peer specialists and training on geriatric mental health; the Georgia Coalition on Older Adults and Mental Health, as statewide Mental Health and Aging coalition affiliated with the National Coalition on Mental Health and Aging; and the Atlanta Regional Commission AAA (ARC - Atlanta region) and the Central Savannah River AAA (CSRA – Augusta region) have provided leadership for EBP training on the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), Healthy Ideas, and other evidence-based practices and programs.

Implemented DAS EBPs include Healthy Ideas for care coordination staff of its Medicaid Waiver Program, Community Care Services Program (CCSP); pilot training for Peer Support Specialists for Older Adults; T-CARE for caregivers; Mental Health First Aid training for Adult Protective Services, Long-Term Care Ombudsman, and other DAS staff. DAS, AAAs, and others through the Georgia Coalition on Older Adults and Mental Health [(GCOAMH), affiliated with the National Coalition on Mental Health and Aging (NCMHA)] will work with National Association of State Mental Health Program Directors (NASMHPD) Older Persons Division, the Administration on Aging, National Council on Aging (NCOA), Substance Abuse Mental Health Services Administration (SAMHSA), National Institute of Mental Health (NIMH) and other federal agencies and associations to integrate mental health and aging to improve the lives of older adults with mental health needs. DAS and the GCOAMH will disseminate best practices and incorporate with additional evidence-based programs on healthy aging to cross silos and reach those in need.

Additionally, DAS is commenting on Georgia's vision for older adults of the former First Lady's Rosalynn Carter Georgia Mental Health Forum held at The Carter Center May 20, 2011 for Georgia's Vision on Mental Health. This vision tool will become a focus of DAS' efforts to integrate mental health, primary care, and aging for the state plan cycle along with its mental health and aging partners and through the Aging Network and mental health service delivery system.

- Technology strategies for DAS include a focus on Self-Direction, Emergency Preparedness, ADRC, and Assistive Technology to allow adults to remain at home for as long as possible, and the Aging Information Management System (AIMS), which provides the IT backbone to support initiatives and create a focus on continuous quality improvement (CQI) of services.

    - DAS designated a full-time Emergency Preparedness Coordinator whose focus is on natural and human-made disasters impacting the community, our customers, and workforce. The Coordinator serves as a liaison with primary emergency agencies and maintains a business continuity plan and an emergency preparedness guide, which provides education and guidance to community partners.

    - Assistive technology consists of equipment and/or devices, technology, and hardware, software, and peripherals to assist individuals with a disability or limitation. DAS is committed to using assistive technologies as a solution to enhancing and extending home and community based living.

    - The Aging Information Management System (AIMS) is the web-based, consumer-centered tracking, accountability and payment system that documents all aging services contracted between DAS, the twelve AAAs, and the network of contract service providers. DAS plans to expand the

capability of AIMS to include self-direction and self-management of home and community based services.

- Self-Direction is a home and community based services approach that shifts decision-making from service providers to consumers and families. Consumer Direction gives input and options for receipt and payment of long-term services and supports. DAS initiatives include the following:

    - The Community Living Program (CLP) and Veterans Directed Home and Community Based Services (VDHCBS) provide support options for individuals, 60 years of age or older, living in the community, who are at medical or financial risk for moving to a nursing facility. Support options offer consumers the ability to choose who will provide and deliver services and the pay rates for services.

    - The Community Care Services Program (CCSP) assists Medicaid eligible beneficiaries to live in the community and delay or avoid institutionalization. Clients served through CCSP must meet the same medical, functional, and financial criteria for placement as residents in a nursing facility. The Home and Community Based Services Program assists non-Medicaid eligible beneficiaries to live in the community and delay or avoid institutionalization. Clients served through HCBS must be 60 years of age, or older, who are functionally impaired to perform activities of daily living.

    - Other consumer directed initiatives include: Nutrition and Wellness strategies and Senior Community Service Employment Program (SCSEP). Nutrition and Wellness Programs aim to increase the ability of older adults to perform everyday activities and remain in their homes. SCSEP promotes economic self-sufficiency for older individuals.

- Elder Rights programs identify and prioritize statewide activities aimed at ensuring older adults have access to and assistance with securing and maintaining services and benefits; knowledge about making informed choices and decisions; understanding of their basic rights; and protection from abuse, neglect and exploitation. Elder Rights programs serve persons with disabilities and incorporate the following State Unit on Aging programs, including collaborations among Law Enforcement, Prosecutors, Court Representatives, Georgia Senior Legal Hotline, Coroners, Social Workers, Medical Professionals, and other multi-disciplinary professionals such as:
    - Adult Protective Services (APS)
    - Aging and Disability Resource Connection/Gateway
    - Elderly Legal Assistance Program (ELAP)
    - Forensic Special Investigator Unit (FSIU)
    - GeorgiaCares (which includes Prescription Assistance Information & Assistance, SHIP, and SMP)
    - Long-Term Care Ombudsman Program (LTCOP).

  Initiatives include the following:

- Forensic Special Investigation Unit ACT certification is geared to all first-responders, mandated reporters and Aging Network personnel with an emphasis on law enforcement. The At-Risk Adult Crime Tactics (ACT) Specialist certification is a step towards increasing the visibility of at-risk adult crime victims and improving the protection of their person, rights, and assets.

- The Georgia Model Approaches grant will integrate a comprehensive system of legal services to older persons using Title III B legal services, hotlines, pro bono programs and other low cost delivery mechanisms into the Aging Network, under the leadership of the state's legal developer.

- Responsive management includes the Program Integrity Section in DAS which provides programmatic oversight of the Area Agencies on Aging (AAAs), quality assurance, data analysis, research and evaluation, and compliance monitoring.

    - Quality Assurance efforts including utilization of the Malcolm Baldrige Criteria for Performance Excellence to assist in providing an integrated approach to organizational performance management that result in delivery of ever-improving value to customers and stakeholders. Additional benefits include: mechanisms contributing to organizational sustainability; improvement of overall organizational effectiveness and capabilities; guidance of organizational planning and opportunities for learning; and improvement of organizational performance practices, capabilities, and results by managing using data.

Administration on Aging Strategic Action Plan 2007-2012

Goals and Objectives

The Administration on Aging (AoA) goals indicate priorities for the agency and the Aging Network. These goals provide a strategic framework for planning, including strategic objectives and action plans. This framework enhances strategy development for future long-term services and supports.

Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and Long-term care options

Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community based services, including supports for family caregivers

Goal 3: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation

Goal 5: Maintain effective and responsive management

The following pages indicate goals, objectives, and action plan steps for the Division of Aging Services for the next four year State Plan cycle. Goals and objectives are indicated by program and/or service. Narrative describing programs or services can be found in **Appendix C**. DAS utilizes the Plan-Do-Check-Act (PDCA) continuous quality improvement methodology to review and revise action plans and objectives.

Goal 1: Empower older people, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and Long-term care options

Name of Service or Program: **Aging and Disability Resource Connection (ADRC) Expansion Grant**

The Gateway/Aging and Disability Resource Connection (ADRC) serves as the "no wrong door" entry point to information and referral to services for public and private long-term supports and services for older adults, adults with disabilities, families, caregivers and professionals.

Objective #1.1	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Establish the Gateway/ADRC as the "No Wrong Door – Single Point of Entry" for all long-term care support services.	• 20% of ABD and/ or Food Stamp Medicaid applications approved within 10 days. • Number (#) of calls routed through the ADRC from all sources.	• Establish Data Sharing Agreement with the Georgia Department of Community Health (DCH) for access to the Medicaid portal. • Begin MFP transition coordination. • Expand Options Counseling collaborations with CCSP, non-Medicaid HCBS, Caregiver Support, Community Living Program, SHIPs, SMP, Health & Wellness, and APS. • Implement Care Transitions. • Collaborate with the Department of Human Services (DHS) Division of Family and Children Services (DFCS) to deploy online aged, blind, or disabled (ABD) Medicaid applications or COMPASS access to statewide ADRC staff. • ADRCs are fully functional.
Sustainability		
• The ADRC state lead will use results from annual site visits to measure progress toward goals for each individual area. DAS will use the AoA/Lewin report on Georgia's status to measure progress at the state level. Annual review of this report by the State ADRC Advisory Council will determine progress in each of the identified domains. Recommendations from the Council will be used to continue progress towards fully functional status. • To meet the goals of ADRCs to serve disability populations, the ADRCs will continue its efforts to include current references to behavioral health resources and strengthen its partnerships with organizations in each PSA. • ADRCs seek partnerships with hospitals in their areas related to Care		

Transitions. These partnerships are viewed as opportunities to expand services to individuals in the communities, divert individuals from nursing homes and assist hospitals in meeting the expectations of CMS related to reducing the readmission rate to the hospital. DAS will partner at the state level with the Georgia Medical Care Foundation and the hospital associations to provide the framework for local partnerships.

- DAS' partnership with DCH, where ADRCs are designated the Local Contact Agency (LCAs), is expected to create funding for staff positions, which may result in future funding opportunities related to Options Counseling for individuals who are considering nursing home placement.

Name of Service or Program: **GeorgiaCares**

GeorgiaCares helps beneficiaries and their families understand rights, benefits and choices under the Medicare and Medicaid programs. Georgia's State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) are components of GeorgiaCares. Through SHIP and SMP, a statewide coalition of staff, volunteers and partners provide free, unbiased and factual health insurance related information and assistance. GeorgiaCares assists recipients in making informed decisions about healthcare options and Medicare plans that best meet their needs.

Objective #1.2	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
• Increase one-on-one counseling sessions by 5% each year.	• 97% of hotline calls completed. SFY10 results – 95.75% • 5% annual increase in counseling sessions. SFY10 results – 17,354 • Maintain 2-day standard of promptness for returning hotline calls (GeorgiaCares Standards and Guidelines).	• Market the DAS hotline number to maintain and increase calls automatically routed to local GeorgiaCares programs. • Provide various methods of contact, including Social Media, GeorgiaCares website (www.mygeorgiacares.org), face-to-face, mail, telephone, email, etc.) for clients seeking Medicare assistance. • Expand reach to limited English proficient populations by recruiting bilingual volunteers and use of language line services. • Begin establishing /maintaining an off-site counseling station in every county.

Objective #1.3	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase financial savings for clients by 25% by 2015 over SFY11 results.	• Number (#) and percent (%) of savings with a five percent (5%) increase per year. SFY10 results – SHIP - $36,645,645 SMP - $11,251	• Inform clients of available financial savings through one-on-one counseling sessions, community education events and outreach events. • Provide effective training to counselors, quarterly, on how to calculate savings. • Enter financial savings into the Aging Information Management System (AIMS) monthly. • Determine savings by plan annual costs through Medicare Plan Finder Tool and standard financial assistance program calculations.

Name of Service or Program: **Medicare Improvements for Patients and Providers Act for Beneficiary Outreach and Assistance (MIPPA)**

The Medicare Improvements for Patients and Providers Act (MIPPA), signed into law on July 15, 2008, encompasses enhanced opportunities for Medicare beneficiaries, particularly those who are low-income. This legislation enhances the Medicare Savings Programs (MSP) and Medicare Part D Low-Income Subsidy (LIS) for beneficiaries including expansion of outreach and assistance efforts and disease prevention and wellness promotion. The Medicare Savings Programs assists low-income beneficiaries with cost-sharing requirements for Parts A and B. The Low-Income Subsidy provides "extra help" regarding payment of monthly premiums, annual deductibles, and prescription drug copayments or coinsurance.

Objective #1.4	Annual Performance Measure	Action Steps
SFY 2012 – 2015		
Extend outreach and assistance efforts for Medicare beneficiaries, including disease prevention and wellness promotion.	• Number (#) and percent (%) increase in enrollment s SFY10 results – 4,968 • Increase enrollments by 5%	• Implement strategies to expand statewide financial assistance, outreach and enrollment to Medicare beneficiaries in relation to Medicare Part D, Low-Income Subsidy Outreach (LIS), and Medicare Savings Program (MSP).

	over SFY10 results. • Number (#) and percent (%) of repeat customers. • Number (#) of additional MIPPA outreach events per month, specific to SHIP, ADRC, and AAA.	• Work with agencies that provide in-home and out of home care. • Increase outreach activities in the form of media outreach, enrollment, application assistance, partnerships and material dissemination. • Use of Social Security Administration (SSA) leads data to provide direct mailings to all eligible individuals coordinating outreach activities for LIS and MSP populations. • AAAs will partner with SHIP, ADRC, APS, & LTCO staff to cross-train on referrals and community outreach. • AAAs will target grocery stores, pharmacies, physician offices, food banks, thrift stores, churches, health fairs, and community events.
Sustainability		
• Outreach and assistance to LIS, MSP, and Medicare Part D populations will continue under the current GeorgiaCares SHIP, ADRC, and AAA initiatives. • DAS will cross-train staff to increase program viability and breadth of knowledge; thereby, a synergy will be created with the ADRC as the entry point to expand targeting.		

Name of Service or Program: **Money Follows the Person (MFP)**

Georgia was awarded a "Money Follows the Person" (MFP) Rebalancing Demonstration grant in May 2007, through the Department of Community Health. Georgia's plan will assist elderly persons to transition from institutions back to the community over the five-year grant period. The local ombudsmen (advocates for nursing home and personal care home residents) are collaborating with the Area Agencies on Aging through the Aging and Disability Resource Connection (ADRC) as they offer Options Counseling (decision support and counseling) to resident in skilled nursing facilities. Ombudsmen will assist residents who request their assistance with returning to the community. Eligible persons must continue to meet institutional level of care criteria after transitioning to the community.

Objective #1.5	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase the number of elderly persons transferring to the community from an institutionalized setting. Members must continue to meet institutional level of care criteria after transition to the community.	• Number (#) of elderly persons transitioned to a home or community based setting from a skilled nursing facility (SNF) or intermediate care facility (ICF). • Successful Transitions / Length of Stay – Number (#) of participants who remain in the community for 365 days. Provisions for hospital or extended facility visits are included. • Average cost savings per member. • Cost per member per month.	• Collaboration between DAS and its programs such as CCSP, LTCO, ADRC and the Georgia Department of Community Health (DCH) as well as the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) to transition persons from institutional settings to a home and community based setting. • Determine eligibility of persons who have lived in a nursing facility or institution for at least three months and whose care has been covered by Medicaid in the month preceding their transition to home and community based services. • Establish a seamless information and referral process, transition coordinators, support services to ease transition, transition counselors and peer counselors and increased availability of affordable housing and transportation. • Increase the rate of successful transitions each year.
Sustainability		
• Five-year demonstration project funded by the Centers for Medicare and Medicaid Services (CMS) across the nation, which is the single largest investment in Medicaid Long Term Care. • DAS will integrate MFP within core home and community based services. • DAS will identify and advocate for elimination of barriers in state law, State Medicaid Plan and State budgets to prevent or restrict the flexible use of Medicaid funds.		

Goal 2: Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community based services, including supports for family caregivers

Name of Service or Program: **HCBS Transportation**

Georgia's Coordinated Transportation System is administered by the Transportation Services Section within the Department of Human Services Office of Facilities and Support Services (OFSS). This human services transportation system serves clients of the Department of Human Services Division of Aging Services, the Department of Human Services Division of Family and Children Services (DFCS) Temporary Assistance to Needy Families (TANF) program, and the Department of Behavioral Health and Developmental Disabilities. The Coordinated Transportation System also serves some consumers of the Department of Labor's Vocational Rehabilitation Services program. Non-emergency transportation (NET) to Medicaid recipients is provided by the Department of Community Health (DCH), and the Department of Transportation (DOT) administers public transportation services to the general public.

Objective #2.1	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Develop a rural, volunteer-based transportation pilot program for nonprofit organizations or faith-based communities.	• Number (#) of local coalitions developed. • Number (#) and percent (%) of funding applied for and obtained. • Number (#) of hours contributed by volunteers.	• Identify local organizations with interest in developing a volunteer driver program. • Develop startup plan template based on adapted volunteer drivers guide. • Assist coalitions, AAAs, and/or partners in their efforts to apply for funds through letters of support, development of multi-site proposals, etc. • Seek to establish statewide, primarily peer-led mentorship network for voucher programs and selected other supplemental transportation programs.

Objective #2.2	Annual Performance Measure	Action Steps
SFY 2012 – 2015		
Develop replicable transportation voucher programs.	• Number (#) of AAAs developing voucher	• Assist AAAs with the development of a startup plan. • Identify public and private

	transportation programs. • Baseline/Percent (%) of customers satisfied with program	funding sources. • Identify key challenges and training needs. • Seek to establish statewide, primarily peer-led mentorship network for voucher programs and selected other supplemental transportation programs.

Objective #2.3	Annual Performance Measure	Action Steps
SFY 2012		
Develop shared ride programs in 12 senior centers statewide.	• Number (#) of shared ride programs developed in senior centers statewide. • Percent (%) of successful completers of driver training. • Number (#) and percent (#) of new persons receiving rides.	• Coordinate with Older Driver Task Force and affiliated organizations to make driver training and self-assessment tools available to participants. • Develop and test promotional and coordination materials. • Assist AAAs and senior centers with the development of a startup plan. • Conduct project evaluation and best-practices exchanges.

Objective #2.4	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase income tax check-off donations to the Georgia Fund for Children and Elderly (which supplies funds for senior transportation and home-delivered meals) by 20% by 2015.	• Increase donations by 5% each year over baseline established for 2010 tax year. Baseline SFY10 - $225,805.33	• Assist and coordinate promotional tasks performed by the "Check-off Georgia" coalition of income tax donation fund organizations. • Provide outreach and educational information for tax preparers about income tax check-off options through outreach to membership associations. • Conduct initial public awareness campaign, using media and Internet vehicles. • Mobilize civic organizations to

		deploy local awareness projects.

Name of Service or Program: **HCBS Case Management**

Georgia's case management system is a comprehensive access system that consists of intake, screening and referral processes, as well as a systematic approach to case management, also referred to as care coordination. Georgia uses a standardized assessment instrument, the Determination of Need-Revised (DON-R). Gateway/Aging and Disability Resource Connection (ADRC) staff serve as the "front door" to information and referrals to publicly and privately financed long-term supports and services. It measures functional impairment and the need for care as a basis to assess consumers. It is utilized to develop individual care plans based on consumers' needs and preferences.

Objective #2.5	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Expand case management to rural service areas and to care transition initiatives.	• Amount of revenues generated to enhance services (in dollars). • Number (#) of additional revenue sources generated or expanded. • Number (#) of new programs or services initiated to address gaps in services. • Number (#) of persons choosing self-direction activities. • Average length of stay (LOS) in the community. • Percent change in average LOS in the community.	• Encourage and support certification of AAA case management staff through Boston University School of Social Work Institute on Aging. • Develop/replicate an evidence-based case management system appropriate for rural areas of the state. • Research and incorporate principles of self-management and consumer direction (person-centered) into case management. • Work with AAAs to implement and evaluate evidence-based Care Transitions programs that assist seniors discharged from hospitals and prevent readmissions. • Develop mental health screening and referral processes in Case Management services through examples from CCSP and the Georgia Coalition on Older Adults and Mental Health.

Objective #2.6	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Enable seniors to continue to live in their community through interdependence on support systems and services, including fee-for-service programs.	• Number (#) and percent (%) of consumers who continue to live in their homes and communities as a result of case management interventions and the coordination of services and resources. • Number (#) of consumers who private pay.	• Implement asset based case management services. • Provide case management based interventions that reduce the risks of falls for seniors by partnering with CCSP and HCBS. • Pilot a consumer-oriented approach to case management to increase access to resources and services for persons on the waiting list for services. • Provide Options Counseling training to Case Management staff. • Work with Area Agencies and providers to develop business plans marketing case management services as a self-sustaining, fee-for-service program.

Name of Service or Program: **Community Care Services Program (CCSP)**

The CCSP Medicaid Waiver assists eligible Medicaid beneficiaries to live in the community and delay or avoid institutionalization. Clients served through the CCSP must meet the same medical, functional, and financial criteria for placement as residents in a nursing facility. The Community Care Services Program (CCSP) is approved and funded pursuant to Title XIX of the Social Security Act, as a federal Medicaid 1915(c) Home and Community-Based Services Waiver Program. The waiver must be reviewed and approved for renewal every five years by the Centers for Medicare and Medicaid Services (CMS). The Georgia Department of Human Services Division of Aging Services operates and manages the CCSP through an inter-agency agreement with the Georgia Department of Community Health (DCH) Division of Medical Assistance (DMA).

Objective #2.7	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase CCSP client Length of Stay (LOS) by 5%	• Five (5) percent (%) increase in LOS from 48 months to	• Assess lack of services by planning and service area (PSA) and conduct data

(48 months to 50 months) by SFY14.	50 months. SFY10 –48 months	analysis. • Develop support options for CCSP caregivers. • Research and implement consumer direction options for expansion in conjunction with the CMS waiver renewal. • Research and implement evidence-based fall prevention initiatives for implementation, including Matter of Balance and Tai Chi, in partnership with Wellness Coordinators, the Georgia Department of Public Health, and HCBS and Case Management.

Objective #2.8	**Annual Performance Measure**	**Action Steps**
SFY 2012 - 2015		
Advocate for additional consumer directed, support services options, and caregiver supports to be Medicaid reimbursed services in the next CCSP waiver renewal	• Number (#) of additional services incorporated into the waiver renewal.	• Assess data for requested/ and additional needed services. • Request support from DCH on additional services and determine reimbursement for additional services. • Determine mechanism to train/certify professionals for validated caregiver assessment/care plan. • Research and implement mental health screening options for caregivers; partner with HCBS care management. • Implement evidence-based initiatives for caregivers such as TCARE®. • Enhance use of technology for consumer directed, support services options, and caregiver supports.

Name of Service or Program: **SCSEP**

The Senior Community Services Employment Program (SCSEP) mission is to promote economic self-sufficiency for older individuals. SCSEP is a community service and employment based training program for older workers. It provides part-time employment assignments and training for unemployed, low-income older Georgians, aged 55 and over. SCSEP is authorized under Title V of the Older Americans Act and is administered by the Department of Labor. As of FFY12, the Administration on Aging (AoA) will provide administrative oversight of the SCSEP.

Objective #2.9	Annual Performance Measure	Action Steps
QPR 2009-2010		
Achieve or exceed 47% Entered Unsubsidized Employment to meet federal requirements.	Measure - 47% of program participants obtain entered unsubsidized employment and are final during the reporting period. SFY10 - 61.4%	• Continue recruitment of employers and on-the-job experience (OJE) partnerships. • Match participant's individual employment plan (IEP) goals to host agency training.
Achieve or exceed 65.5% of retained employment to meet federal requirements.	Measure - 65.5% of program participants will be placed in unsubsidized employment in which the retention outcome became final during the reporting period. SFY10 - 86.7%	• Maintain regular follow-up with participants and employers to ascertain whether each are achieving their expectations. • Communicate with participant to remain proactive with problem solving. • Continue training to address participant needs.
Achieve or exceed 2.49% Service to the Most-in-Need to meet federal requirements. Includes Age 60 and over and: - Income at or below the poverty level - Physical or mental disability	Measure - 2.49% of program participants are active on the last day of the reporting period. SFY10 - 2.58%	Continue outreach to: • Senior Centers • Masonic related fraternities for men & women • Civic Organizations, i.e. Shriners, etc. • Veteran Administration • Senior housing communities • Retirement homes • Minority associations • Homeless organizations

- Language barrier or Limited English Proficiency (LEP) - Cultural, social, or geographic isolation - Poor employment history or prospects - Homelessness - Other social barriers		
Achieve or exceed 100% Service Level to meet federal requirements.	Measure - 100% of the AAAs' modified slot level or number of program participants who are active on the last day of the reporting period or who exited during the reporting period. SFY10 - 196.2%	• Maximize enrollment at the beginning of each planning year. • Heavy recruiting for seniors in One-Stop Centers, DOL offices, Veteran Administrations, job fairs & job clubs. • Advertising and promotions.
Achieve or exceed 80% of Community Service to meet federal requirements.	Measure –80% of the number of hours of community service in the reporting period is divided by the number of hours of community service funded by the grant, minus the number of paid training hours in the reporting period. SFY10 - 87.3%	• Sustain partnerships with Senior Centers, Libraries, Nursing homes, Homeless Shelters, DFCS offices. • Advertise services for seniors in senior papers, magazines, radio stations, job fairs, etc. • Assign additional participants to different host agencies that have training positions in varied department positions.
Achieve or exceed 6011 Average Earnings to meet federal requirements.	Goal –6011 Measure - Of those participants who are employed in the first, second, and third quarters after the program exit, total earnings in the second and third quarters after the exit	• Match participant's skills to higher skill positions at their host site. • Seek additional training comparable with higher skill set requirement to achieve earnings. *Note - Once a participant has mastered higher level skills at*

	quarter/divided by the number of exiters during the period SYF10 –-6421	*their host site, they are more inclined to be hired at a higher pay scale.*

Name of Service or Program: **Community Living Program (CLP)**

Discretionary Grant Period – September 30, 2009 through September 29, 2011

The Community Living Program (CLP) grant provides Support Options for individuals 60 years of age or older living in the community who are at medical or financial risk for moving to a nursing home. Support Options offer a consumer the ability to choose who will provide the services they need, when the services will be delivered, and the chargeable pay rates for services. This model of care delivery is called Self-Direction (consumer-directed), which recognizes the unique needs of each individual consumer. It allows the consumer a high degree of choice and control over how their care is provided.

Objective #2.10	Annual Performance Measure	Action Steps
SFY 2011 and Ongoing		
Expansion of Georgia's Community Living Program statewide.	• Number (#) of consumers within the community living initiative. • Average LOS at home or in the community.	• Maintain and increase program capacity to consumers. • Provide support options to promote client independence, mobility, health and safety. • Sustain and enhance the fiscal management service. • Maintain length of stay in the community and consumer satisfaction. • Deploy CLP to additional AAAs.
Sustainability		
To achieve and maintain fiscal and operational sustainability of the CLP: • DAS will assure policies and procedures are in place to allow AAAs to repurpose funds from identified funding streams into a flexible spending pool to utilize for consumer budgets. DAS will provide training and technical assistance to AAAs interested in community initiatives. • As part of the CLP grant, the State Unit on Aging (SUA) will be providing one-on-one technical assistance and training to each AAA on consumer direction and deployment.		

• CLP builds upon the Village Concept, which helps its members remain in their homes and communities as they age. The Village coordinates access to services for members through volunteers and/or paid staff; services may include transportation, home repairs, grocery shopping, pet sitting, or other day-to-day needs. DAS will provide training and technical assistance and develop policies and procedures to infuse community living into federally funded programs.

Name of Service or Program: **Veteran Directed Home and Community Based Services (VDHCBS)**

Discretionary Grant Period – September 30, 2009 through September 29, 2011

The Veterans Directed Home and Community Based Services (VDHCBS) program is offered as a component of the Community Living Program. The Atlanta Veterans Administration Medical Center (VAMC) will execute a provider agreement with the Northwest Georgia (NWGA) AAA to purchase the Community Living Program for veterans identified as eligible by the VAMC. NWGA will also provide the Tailored Caregiver Assessment and Referral (TCARE)® process to the caregivers of veterans.

Objective #2.11	Annual Performance Measure	Action Steps
SFY 2011 and Ongoing		
Expand Veteran Directed Home and Community Based Services (VDHCBS).	• Number (#) of veterans receiving VDHCBS. • Average LOS at home or in the community.	• Build relationship with the Atlanta Veterans Administration Medical Center (VAMC) to provide support options for eligible veterans. • Provide training and technical assistance as needed to facilitate the signing of the provider agreement. • Provide training and technical assistance to the AAAs to build the capacity to implement Support Options, including training on consumer direction and steps to become a VDHCBS provider. • Assist the AAAs with the completion of the Readiness Review as part of the approval process by the VAMCs to provide VDHCBS. • Provide training and technical

		assistance to the AAAs regarding the steps to become a VDHCBS provider. • Deploy VAMC to additional AAAs.
Sustainability		
• The partnership with the VAMC will include an administrative fee to the AAA, which will foster consumer direction and Support Options. • VDHCBS builds upon the Village Concept, which helps its members remain in their homes and communities as they age. The Village coordinates access to services for members through volunteers and/or paid staff; services may include transportation, home repairs, grocery shopping, pet sitting, or other day-to-day needs. DAS will provide training and technical assistance and develop policies and procedures to infuse community living into federally funded programs. • DAS intends to develop an information technology (IT) infrastructure to support community living initiatives.		

Name of Service or Program: **Georgia Naturally Occurring Retirement Community (NORC)**

The Georgia Naturally Occurring Retirement Communities (NORC) Initiative is administered by the Jewish Federation of Greater Atlanta to help support older adults in the community so they can remain in their homes for as long as possible and avoid premature institutionalization. The project is based on a community-level intervention designed to reduce service fragmentation and create healthy, integrated communities. Thus, NORCs or Naturally Occurring Retirement Communities is a demographic term used to describe a community not originally built for seniors that now has a significant proportion of its residents who are seniors.

Objective #2.12	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Grantee: The Jewish Federation of Greater Atlanta Maintain older adults' ability to age in place within their home and community.	• Number (#) of months a person resides in one's home or community.	• Continue to organize and develop services and programs to help seniors successfully age in place. • Maintain and increase collaborative partnerships. • Enhance existing services to respond to gaps in the service safety net.

Sustainability
• The Village Concept helps its members remain in their homes and communities as they age. The Village coordinates access to services for members through volunteers and/or paid staff; services may include transportation, home repairs, grocery shopping, pet sitting, or other day-to-day needs. DAS will provide training and technical assistance and develop policies and procedures to infuse community living into federally funded programs. • Currently, the SUA does not provide funding for this initiative due to budget reductions; however, DAS policies and action plans support aging in place strategies.

Name of Service or Program: **Caregiver Initiatives/Alzheimer's Disease Supportive Services Program (ADSSP)**

Discretionary Grant Period – October 1, 2008 through September 30, 2011

*See **Appendix C** for the detailed Georgia Reach Project narrative for a description of all measures and collaborative partners.*

Objective #2.13	Annual Performance Measure	Action Steps
SFY 2008-2011		
Grantee: The Rosalynn Carter Institute (RCI) Georgia REACH II Project. Via partnership with RCI, expand evidence-based caregiver programs statewide.	• Statistically significant improvements in depression and burden.	• Deploy interventions to reduce caregiver burden and depression among family caregivers of person with Alzheimer's Disease or related disorders. • Install the program in a provider agency of the Aging Network in rural Georgia. Operational in central and west Georgia counties. • Implement the program to serve a minimum of 150 families using the REACH II intervention and evaluate its impact on participants. Ongoing initiative. • Adapt the program as necessary in light of evaluation results and real world experience. • Seek initiatives and strategies for statewide expansion.

Sustainability
• DAS and RCI support expansion of Georgia REACH to support family caregivers in the entire state to assure the long-term sustainability and continued effectiveness of the program, based on experience with implementation and caregiver outcomes. • Develop materials and information that support successful adoption by others. • GA REACH manuals are being revised to include additional training components (safety for in-home service delivery, strategies for working with family caregivers, etc.). RCI will add an implementation manual to address specific evidence-based intervention strategies as well (hiring, training, supervising, ensuring fidelity, etc.). • DAS will seek to assure policies and procedures that will allow AAAs to implement evidence-based initiatives for caregivers.

Name of Service or Program: **Caregiver Initiatives/Alzheimer's Disease Supportive Services Program (ADSSP)**

Discretionary Grant Period – September 1, 2010 through August 13, 2013

*See **Appendix C** for the detailed Georgia Reach- Coastal Project narrative for a description of all measures and collaborative partners.*

Objective #2.14	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Grantee: The Rosalynn Carter Institute (RCI) Georgia REACH - Coastal Project Via partnership with RCI, expand evidence-based caregiver programs statewide.	• Statistically significant improvements in depression and burden.	• Deploy interventions to reduce caregiver burden and depression among family caregivers of person with Alzheimer's Disease or related disorders. • Develop a Steering Committee and Implementation Team of key stakeholders to provide oversight and facilitate adoption implementation and evaluation of REACH II. • Implement the program to serve a minimum of 150 families using the REACH II intervention with fidelity and evaluate its impact on participants. • Adapt the program as necessary in light of evaluation results and real world experience, if

		requested. • Seek initiatives and strategies for statewide expansion.
Sustainability		
• DAS and RCI support sustainability and continued expansion of the Georgia REACH-Coastal Project by creating a REACH II Training Center available to all providers in the State of Georgia. • Develop materials and information that support successful adoption by others. • Georgia REACH – Coastal Project training manual is under revision based on observations from training feedback. • DAS will seek to assure policies and procedures that will allow AAAs to implement evidence-based initiatives for caregivers.		

Name of Service or Program: **Caregiver Initiatives/Alzheimer's Disease Supportive Services Program (ADSSP)**

Discretionary Grant Period – September 2009 through August 2012

*See **Appendix C** for the detailed Georgia NYUCI Evidence-Based Project narrative for a description of all measures and collaborative partners.*

Objective #2.15	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Grantee: The Rosalynn Carter Institute (RCI) Georgia NYUCI Evidence-Based Project. Via partnership with RCI, expand evidence-based caregiver programs statewide.	• Statistically significant improvements in depression and burden. • Number(#) and/or time regarding delayed nursing home placement.	• Deploy interventions to reduce caregiver burden and depression among family caregivers of person with Alzheimer's Disease or related disorders in rural and African American areas. • NYUCI implemented in Southern Crescent and Northeast AAAs. • Launch the GFSP Steering Committee to address issues around adoption and maintenance. • Fully implement the NYUCI and evaluate its impact on participants. • Adapt the program as necessary in light of evaluation results,

		observatory experience, and in consultation with the Administration on Aging. • Seek initiatives and strategies for statewide expansion.
Sustainability		
• DAS will seek to assure policies and procedures that will allow AAAs to implement evidence-based initiatives for caregivers. • RCI, upon cost analysis, will identify possible partners and funding streams to support continuation to assure the long-term sustainability and continued effectiveness of the program. • Deliver an implementation package with a training manual, including all forms and procedures required to carry out the intervention. • Dissemination of published articles and presentations at national conferences.		

Name of Service or Program: **Caregiver Initiatives/Alzheimer's Disease Supportive Services Program (ADSSP)**

Discretionary Grant Period – September 1, 2010 through August 31, 2013

*See **Appendix C** for the detailed Georgia Care Consultation Project narrative for a description of all measures and collaborative partners.*

Objective #2.16	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Grantee: The Rosalynn Carter Institute (RCI) Georgia Care Consultation Project. Via partnership with RCI, expand evidence-based caregiver programs statewide.	• Statistically significant improvements in depression and burden.	• Deploy telephone-based empowerment interventions to reduce caregiver burden and depression among family caregivers of person with Alzheimer's Disease or related disorders. • Implement and operate the Care Consultation program and evaluate its impact upon ADRD patients, caregivers and the service delivery system. • Fully implement the NYUCI and evaluate its impact on participants. • Adapt the program as necessary in response to ongoing evaluation. • Seek initiatives and strategies for statewide expansion.

Sustainability
• DAS will seek to assure policies and procedures that will allow AAAs to implement evidence-based initiatives for caregivers. • RCI & AAAs will implement Care Consultation at three sites with Gateway staff serving as consultants. • Cost analysis and cost effectiveness will be developed. • Integration of the Care Consultation Information System (CCIS) into the state data management system and seek full integration. • Create manuals to implement the intervention throughout the Aging Network in the State of Georgia for replication.

Name of Service or Program: **Caregiver Initiatives/Alzheimer's Disease Supportive Services Program (ADSSP)**

Discretionary Grant Period – October 1, 2010 through September 30, 2013

*See **Appendix C** for the detailed Georgia Re-design narrative for a description of all measures and collaborative partners.*

Objective #2.17	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Grantee: The Division of Aging Services (DAS) Georgia Re-design: New Protocols and Interventions to Better Serve Persons with Early-Stage Alzheimer's Disease.	• Established screening tools for identifying persons at risk with early stage dementia. • Development of clinical counseling protocols. • Percent (%) of consumer satisfaction responses maintained or increased.	• Refine Georgia's comprehensive social service assessment to identify people with early stage Alzheimer's Disease (AD) by integrating multi-faceted interventions for persons with early stage AD. • Improved proficiency of identifying persons with early stage dementia by training AAA Gateway/ ADRC staff and Adult Protective Services intake staff and, with administering pre and post tests. • Increased awareness of wandering behaviors and driving safety in person with AD by law enforcement agencies. • Improve satisfaction of affected consumer with services, supports, and

		interventions will be achieved by analyzing the TCARE® assessment and re-assessment data for caregivers receiving TCARE®. Seek initiatives and strategies for statewide expansion.
Sustainability		
DAS will seek to assure the long-term sustainability and continued development of the program in Georgia by: • Implementing screening tools for identifying persons at risk of early stage dementia. • A clinical counseling protocol for persons with Early Stage AD. • An improved process for inter-agency referrals.		

Name of Service or Program: **TCARE®**

The Tailored Caregiver Assessment and Referral® (TCARE®) protocol is a methodology designed to enable care managers to more effectively support family caregivers by efficiently targeting services to their needs and strengths. The TCARE® protocol, developed at the University of Wisconsin at Milwaukee (UWM), guides care managers through an assessment and care planning process that helps them examine the care context and identify the sources and types of stress that a caregiver is experiencing.

Objective #2.18	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Implement TCARE® caregiver assessment and referral protocol.	• Number (#) of screens provided to callers at intake through the ADRCs. • Number (#) of quarterly reassessments. • Number (#) and percent (%) of lowered scores on measures compared to scores obtained at initial assessment. • Percent (%) of TCARE ® screens	• All AAAs integrate TCARE® into their central intake unit (Gateway/ADRC). • Reassessments will be conducted by care managers to caregivers which will enable identification of caregiver burden, depression, identity discrepancy. • Care managers will complete 50% of TCARE ® screens the first year of implementation and increase the % each year thereafter.

	completed on in-home respite caregivers.	• Evaluate and utilize the Plan-Do-Check-Act (PDCA) for strategies.

Goal 3: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Name of Service or Program: **Nutrition and Wellness**

"Living Longer, Living Well" -- The Nutrition and Wellness Programs aim to increase the ability of older adults to perform everyday activities and remain in their homes. Activities focus on health promotion and disease prevention. Services are designed to enhance quality of life by improving nutritional and health status, increase functional abilities, promote home safety, and avoid or delay problems caused by chronic disease.
http://www.livewellagewell.info
http://ruralhealth.und.edu/projects/nrcnaa/wellbalanced.php

Objective #3.1	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Maintain or improve nutrition status of 98% of nutrition program consumers as measured by the Nutrition Screen Initiative (NSI) tool focusing on improving meal consumption, fruit and vegetable consumption and dairy consumption.	• % NSI on meal consumption, fruit and vegetable consumption and dairy consumption of 98% or better. SFY10 baseline – Meal Frequency – 97% Fruit & Veggie – 94% Dairy – 99%	• Convene a committee of registered dietitians from planning and service areas to review the current nutrition program regulations and align them with the Dietary Guidelines for Americans 2010. Consumer satisfaction survey deployment will also be taken into consideration at the local and regional level. • Change policy to include a food security questionnaire during the initial intake and annual rescreening processes. The data collected from this survey will be used for strategic planning, grant writing and focusing service delivery on those most in need. • Gateway/ADRC staff will begin submitting completed Food Stamp applications for clients on the waiting list to receive home delivered meals (HDM). • Establish a choice component to meals programs in all 12 AAAs.

Objective #3.2	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Reduce food insecurity among clients.	• Decrease in number (#) and percent (%) of clients indicating food insecurity by using the Food Security Assessment Survey.	• In conjunction with the ADRC, implement an annual assessment (Food Security Survey) on all new and renewing clients. • Collaborate with the Performance Outcome Measurement Program (POMP) to review annual food insecurity data with The University of Georgia, The College of Public Health, Institute of Gerontology. • Review data collection results at the state and local levels. • Determine best practices for utilization by convening subject matter experts (SME).

Objective #3.3	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Expansion of food delivery/dining options.	Number (#) and percent (%) of client-centered delivery and/or dining options. Percent (%) increase and maintenance of consumer satisfaction scores by region and statewide. Number (#) and percent (%) of congregate meal sites using menu options, vouchers, etc.	• Convene forum with providers, Dieticians, Nutrition Coordinators, and AAA Directors/Staff to review current policy and dietary guidelines and discuss consumer-centered choice and select entrée options. • Conduct strengths, weaknesses, opportunities, and threats (SWOT) analysis with AAAs and providers by June 2012. • Research client-centered menu options for clients • Deploy demonstration programs.

Name of Service or Program: **Chronic Disease Self Management Program (CDSMP)**

Discretionary Grant Period: April 1, 2010 through March 31, 2012

The Chronic Disease Self-Management Program (CDSMP) is an Evidence-Based Disease and Disability Prevention Program designed to increase access to effective interventions to reduce their risk of disease, injury, and disability for older adults. The program helps older adults better manage their chronic diseases and establishes an infrastructure across the state to implement health and wellness focused, evidence-based programming.

Objective #3.4	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Expand CDSMP statewide.	• Number (#) of AAAs implementing CDSMP. • Number (#) of persons completing CDSMP.	• Fully implement CDSMP in twelve geographic regions to reach older adults. • Train Local Lead Agency leaders to conduct CDSMP Workshops. • Conduct workshops targeting older adults, especially in underserved groups. • Develop a quality assurance plan to assure fidelity for evidence-based prevention programs. • Evaluate program impact for changes in behavior, health status, and healthcare utilization. • Seek strategies to implement CDSMP statewide. • Research other evidence-based programming for statewide implementation.
Sustainability		
• DAS will require AAAs to utilize Title IIID funding for evidence-based programming. AAAs choosing to implement CDSMP will be able to use those dollars to support its sustainability. • DAS will continue to apply for grants to continue the implementation of CDSMP across Georgia.		

Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation

Name of Service or Program: Adult Protective Services (APS)

The Adult Protective Services (APS) program is mandated under Georgia's Disabled Adults and Elder Persons Protection Act (O.C.G.A. § 30-5-1, et seq.) to address situations of domestic abuse, neglect or exploitation (ANE) of disabled persons 18 years of age and older and elder persons 65 years of age and over, who are not residents of long-term care facilities. The purpose of the APS program is to investigate reports alleging abuse, neglect or exploitation and to prevent recurrence through the provision of protective services intervention. Principles that guide the assessment consider an adult's right to personal autonomy, self-determination and the use of the least restrictive means of eliminating or reducing risks prior to implementing more intrusive interventions. APS is also responsible (through a separate Public Guardianship unit) for providing case management services for individuals when a probate court has appointed the Department of Human Services as guardian of last resort. (O.C.G.A § 29-4-3(b.1)).

Objective #4.1	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Assure timely completion of investigations of abuse, neglect and exploitation of disabled and elder Georgians.	• Measure: 95% of referrals include an initial face-to-face contact with the victim by Field Operations within 10 calendar days of the date of the Intake. • Measure: 85% of investigations are completed within 30 business days of the date of the Intake. • Number (#) of outreach trainings conducted	• Identify regions monthly where timeliness measures are exceeded, met and not met. • Identify best practices for meeting/exceeding timeliness measures quarterly and/or root cause(s) why measures are not met in regions not performing at or above measures. • Work with regions where timeliness measures are not met, quarterly and ongoing, to develop strategies to address root causes for not meeting standards. • Train on and implement strategies to increase timeliness bi-annually. • Gateway/ADRC will screen APS clients to determine if they meet criteria for service options or if they will need to be on a waitlist.

Objective #4.2	Annual Performance Measure	Action Steps
SFY 2012 -2015		
Increase criminal investigations and/ or prosecutions of APS cases substantiated for physical/sexual abuse or financial exploitation.	• Number (#) and percent (%) of criminal investigations and/or prosecutions resulting from APS referrals.	• Identify three (3) non metropolitan regions with <5% investigation/prosecution of APS cases involving physical/sexual abuse, or financial exploitation. • Develop an interagency coordination with the local law enforcement (LE)/ prosecutors to determine strategies for increasing the investigation/ prosecution of these cases. • Design a tracking system to follow cases sent to LE agency. • Monitor system to determine any increase in number (#) of cases investigated/ prosecuted post APS involvement. • Evaluate progress, determine if there is a need to revise strategies for increased investigation/ prosecution of cases and revise process(es), if needed. • Select additional regions to implement processes.

Name of Service or Program: **Public Guardianship Services**

Objective #4.3	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Enhance Public Guardianship Services	• Number (#) and percent (%) of staff receiving ongoing education/training in Guardianship. • Number (#) and percent (%) of staff who become certified Guardians from the Center for	• Assess unit effectiveness due to separation of case management and guardianship duties. • Identify cross-cutting issues and best practices for DHS when it is appointed guardian. • Continue collaboration with APS and Gateway/ADRC to determine appropriate community based services for

	Guardianship Certification. • Number (#) and percent (%) of Guardianship contacts per month.	Guardians. • Increase the number (#) and percent (%) of certified Guardians. • Draft policy manual.

Name of Service or Program: **Elderly Legal Assistance Program (ELAP)**

The Elderly Legal Assistance Program (ELAP) provides legal services to persons sixty years of age and older who are in the greatest social and/or economic need with particular attention to low-income minorities, rural residents, or persons with limited English speaking proficiency.

Objective #4.4	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase successful resolution of client issues by 20% by 2015 to the target population as identified in the Georgia ELAP Standards for each Title III B legal provider. Successful Resolution is achievement of mutual goals initially set between the legal representative and the client.	• Baseline results of priority cases in comparison to the number/percent of ELAP cases that are not within the core priorities. • Percent (%) of successful resolution of priority cases with a five percent (5%) increase annually. Priority cases will include foreclosure prevention, financial exploitation, long-term care appeals, and Medicaid eligibility and Medicare assistance.	• Baseline results of priority cases in comparison to the number/percent of ELAP cases that are not within the core priorities. • Analyze AIMS data to determine specific areas within designated PSA that demonstrate a constrained level of public benefit activity when compared with public data indicating the numbers of persons receiving various public benefits in those areas. • Develop a plan for outreach to the target population. • Develop and implement an education and publicity protocol to disseminate information to the targeted population. • Host a series of public forums and education sessions specifically designed to reach the population targeted as likely eligible for public benefits but not accessing them.

Objective #4.5	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase successful resolution of appeals in each planning and service area by 25% by 2015. Appeal priorities include: foreclosure prevention activity, Social Security Administration appeals, Medicare appeals, Medicaid appeals and/or Nursing Home/Personal Care Home (Assisted Living).	• Baseline results of successful resolution of appeals in priority areas in comparison to the number (#)/percent (%) of ELAP appeals that are not within the core priorities. • Percent (%) of successful resolution of priority appeals.	• Develop a dedicated screening tool to utilize with all potential clients; detect existing issues requiring administrative or judicial intervention to assist with appeals. • Engage in active screening using the dedicated screening instrument to identify potential clients and their specific areas of need. • Involve any and all additional resource agencies to aid the client. • Utilize collaborations with ADRC, Guardianship, and APS as a referral source to and from ELAP.

Objective #4.6	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase monetary savings realized and/or benefits obtained for clients by 20% by 2015.	• Percent (%) of monetary savings realized and/or benefits for clients. SFY10 results – $7,328,852	• Analyze ELAP data entered into AIMS regarding document preparation, counseling, case representation, hours of legal counsel, and benefits and/or restored funds. • Target geographic areas where income and assets are in jeopardy due to the level of threat and priority cases and appeals. • Develop an outreach plan to educate and inform older persons in these areas; utilize collaborations with ADRC, SHIP, SMP, APS, and LTCO. • Create and implement a

		publicity campaign to alert citizens of available services. • Host public forums, education sessions and information and intake sessions to provide assistance. • Prioritize representation of cases identified in priority subject matter areas. • Periodically, but no less than annually, assess, evaluate and determine the impact upon clients served.

Name of Service or Program: **Elder Rights and Forensic Special Investigation Unit (FSIU)**

Elder Rights programs identify and prioritize statewide activities aimed at ensuring older adults have access to and assistance with securing and maintaining services and benefits; knowledge about making informed choices and decisions; understanding of their basic rights; and protection from abuse, neglect and exploitation.

Objective #4.7	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Increase awareness of DAS staff, contracted providers and community partners regarding recognition and reporting of abuse, neglect & exploitation to create a unified message: It is a crime in Georgia to abuse, neglect, exploit and violate the rights of older adults and adults with disabilities.	• Establish baseline of calls to APS, LTCO, ELAP, and AAA, Gateway/ADRC specific to abuse, neglect, exploitation and violation of rights. • The number (#) and discipline of professionals successfully completing the certification program. • The number (#) of APS professionals successfully completing the basic investigative course.	• Continue deployment of state-wide multi-disciplinary ANE certification program (At-Risk Adult Crime Tactics [ACT] Specialist). • Develop 6-month post evaluation for all attending ANE certification program, the number who report having used the information presented during the training. • Increase marketing and outreach with collaborations of Forensics and Elder Rights programs. • Develop training for District Attorneys/Prosecutors statewide. • Develop multidisciplinary curriculum and interventions. • Deployment and assessment of interventions.

		• Develop training for Judicial Personnel statewide.

Name of Service or Program: **SMP (Senior Medicare Patrol) Capacity Building and Expansion Discretionary Grants**

The SMP High Fraud States without Heat Joint Strike Forces: Health Care Fraud Prevention Program Expansion and SMP Capacity Building Grant provide increased funding to the SMP Senior Medicare Patrol to expand the SMP project's capacity to reach more Medicare and Medicaid beneficiaries, their families and caregivers. This is accomplished by expanding and enhancing the SMP volunteer workforce; expanding SMP outreach and education to beneficiaries statewide; and expanding the SMP's ability to manage beneficiary inquiries and complaints in a timely, professional manner, and improving and enhancing state-level SMP program and volunteer management.

Objective #4.8	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Increase the number (#) of volunteers, education and media events to beneficiaries statewide.	• Number (#) of volunteers by service area. • Number (#) of education events. • Number (#) of media events.	• Develop partnerships to advertise volunteer opportunities and host SMP educational presentations. • Provide the SMP Foundations Training in each planning and service area. • Develop drop in articles on various SMP topics for service areas to use. • Utilize Social Media and a media campaign, including billboards and advertisements, and PSAs for volunteer recruitment. • Develop a volunteer recruitment brochure in English and Spanish.
Sustainability		
DAS will assure sustainability by: • Expanding the volunteer workforce, creating new partnerships, and developing tools that can be reused. The objectives and deliverables of this grant will then continue beyond the grant cycle and will be incorporated into the existing SMP project. • Enhancing and increasing the volunteer base allowing more education to be provided to Medicare beneficiaries.		

- DAS will continue to develop partnerships and coordinate funding to expand the volunteer workforce to allow continuation of expanded events. SMP Capacity Building and Program Expansion allows the program to educate more Medicare and Medicaid beneficiaries about how to protect their Medicare number and how to detect and report potential instances of error, fraud and abuse, which is the current purpose of the SMP Project.
- DAS will continue to take the lead in a statewide media campaign and partnership development will increase interest in volunteering and increase the number of beneficiaries contacting the SMP project. These initiatives will continue statewide expansion and knowledge of the program.

Name of Service or Program: **Long-Term Care Ombudsman (LTCO)**

Title VII of the Older Americans Act authorizes the Long-Term Care Ombudsman Program (LTCOP) to work to improve the quality of life of residents in nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), personal care homes (PCH) and community living arrangements (CLAs) by acting as their independent advocate. Ombudsman staff and volunteers informally investigate and resolve complaints on behalf of residents. They visit long-term care facilities to be accessible to residents and monitor conditions and also provide education regarding long-term care issues, identify long-term care concerns and advocate for needed change.

Objective #4.9	Annual Performance Measure	Action Steps
SFY 2012 -2015		
Increase long-term care residents' access to LTCO services.	• Percent (%) of positive outcomes - Complaint resolution rate. • Percent (%) of visits per quarter Ombudsman frequent NH and PCHs.	• Increase literature provided to facility staff and clients regarding the ombudsman program as well as resident's rights. • Increase the number of persons receiving education about elder abuse and fraud prevention. • Provide LTCO services to residents with mental health needs who reside in PCHs. • Provide educational training to professionals within the Aging Network, including in-service training at facilities regarding culture change, resident's rights, virtual dementia tour and mental health training. • Sustain or increase the number

		of routine visits provided to Nursing Homes, PCHs, while continuing to respond to complaints of residents in ICF/MRs and CLAs.
Increase access to quality services.	• Percent (%) maintenance or increase of customer satisfaction rate. Goal – 96% or better.	• Evaluate customer satisfaction with Ombudsman complaint processing. • Provide training to local LTCOPs to improve their skills to assist residents. • Deploy bi-annual survey. • Provide two statewide trainings each year for staff LTCOs to include ADRC staff, HFR staff, and other aging professionals to increase overall knowledge of long-term care issues and trends, specific knowledge of disaster response, mental health resources, public policy concerns and more.
Increase the number of people served by LTCOP.	• Number (#) of website sessions per year.	• View the number of website sessions for the LTCOP to determine frequency of site use. Seek strategies to increase access to clients. • Serve additional clients through collaboration with ADRC to establish relationships with SNFs to increase resident access to options counseling related to MDS 3.0 Section Q efforts and related to MFP.
Increase resources for the LTCOP to improve services for LTC residents.	• Number (#) of hours contributed by certified volunteers. • Number (#) of certified volunteers active during	• Recruit and certify additional volunteers. • Evaluate hours contributed in relation to work hours of a full-time equivalent.

	defined periods of time.	
Improve accuracy and timeliness of data.	• Percent (%) of timely submissions of data check e-mails by local coordinators.	• Sustain communication and training with local coordinators to meet and exceed policy and operational requirements.
Increase public policy advocacy.	• Increase outreach to additional public policy makers to improve services to LTC residents.	• Raise awareness with the Secretary of State to promote access to LTC residents having voting rights. • Provide regular presence at DCH meetings including board meeting and work groups. • Invite local LTCO and LTC resident participation in rule making, and legislative policy making. • Continue to evaluate and utilize the Plan-Do-Check-Act (PDCA) processes.

Name of Service or Program: **Georgia Model Approaches Project Discretionary Grant**

The Georgia Model Approaches grant seeks to integrate into the Aging Network, under the leadership of the state's legal developer, a comprehensive, delivery system of legal services to older persons using Title III B legal services, hotlines, pro bono programs and other low cost delivery mechanisms.

Objective #4.10	Annual Performance Measure	Action Steps
SFY 2012 and Ongoing		
Implement a comprehensive legal services system for older adults.	• Establishment of a formal referral protocol between programs and a referral tracking system. • Online survey sent to providers in year one and year three	• Evaluate completed legal needs assessments; capacity assessments; hotline outcomes study; and on-line screening aid. • Establish a formal referral protocol between programs and a referral tracking system that captures transition/resolution

	of grant.	of referrals from hotline to IIIB providers and from IIIB providers to hotline. • Develop protocols and training materials for cross-referral reporting. • Deploy an on-line survey in to determine knowledge gained regarding when a legal services case is more appropriate for the hotline or for full representation. • Repeat outcomes study and implement outreach plan. • Establish a permanent advisory group for the hotline. • Complete project evaluation and draft project report.
Sustainability		
DAS supports the following action steps as sustainability initiatives for the Georgia Model Approaches grant: • The hotline will recruit and train at least five new volunteer attorneys. • Georgia Senior Legal hotline staff and volunteer attorneys will report increased productivity and quality of their screening and advice as a result of online screening aids. • Hotline staff and volunteer attorneys will report increased knowledge of areas of law governing the most urgent legal problems affecting the target populations as a result of online resources. These results will be measured by an online survey. • Hotline staff and volunteer attorneys will report improved ease of producing follow-up letters and standard forms as a result of implementing three to five pilot HotDocs automated documents. These results will be measured by an online survey.		

Goal 5: Maintain effective and responsive management

Name of Service or Program: **Emergency Preparedness**

The Georgia Department of Human Services Division of Aging Services emergency planning process encompasses an external risk assessment focused on various human-made (i.e., bioterrorism) and natural (i.e., hurricanes, pandemic, or influenza) disasters, which identifies concerns for the community, our customers, and workforce.

Objective #5.1	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Administer Emergency Preparedness and response for older Georgians.	Updating of the annual Business Continuity Plan and Emergency Preparedness Guide.	• Focus on the sustainability of operations during a disaster and preventative measures for protections of data. • Maintain partnerships with the AAAs to provide alternate worksites for Division staff. • Maintain a current emergency preparedness guide. • Continue with development of the Georgia Emergency Preparedness Coalition's current initiatives. • Increase outreach to older adults and people with disabilities. • Assist American Red cross to build the capacity of shelters for those with special medical needs. • Develop technical assistance to coincide with events on the Ready Georgia Planning Calendar Observances.

Name of Service or Program: **Baldrige Criteria for Performance Excellence**

The Baldrige Criteria for Performance Excellence is a continuous quality improvement methodology which provides a comprehensive approach to organizational performance management that results in the delivery of ever-improving value to customers and stakeholders; improvement of overall organizational effectiveness and capabilities; guidance of organizational planning and opportunities for learning; and improvement of organizational performance practices, capabilities, and results by managing using data.

Objective #5.2	Annual Performance Measure	Action Steps
SFY 2012 - 2015		
Managing using data (MUD)	• Quarterly and Annual measurement and analysis plans (MAPs) for each section. • Percent (%) of MAPS updated annually. • Percent (%) of MAPS that achieve targets/ outcomes.	• Revision of DAS and section priorities for fiscal year. • Updating of section action plans to determine achievement of goals and objectives. • Quarterly review of section results. • Quarterly review of applicable AIMS reports. • Year end review of MAPS, action plans, and results. • Continue search of comparative data for best practices and benchmarking data. • Continue to evaluate and utilize the Plan-Do-Check-Act (PDCA) processes.

Name of Service or Program: **Aging Information Management System (AIMS)**

The Aging Information Management System (AIMS) is the web-based, consumer-centered tracking, accountability and payment system that documents all aging services contracted between the Division of Aging Services, the twelve (12) Area Agencies on Aging (AAAs), and the network of contract service providers. AIMS is a relational database, maintained on an Oracle platform, that provides for centralized data collection regarding planning and contracting, authorizing providers and services, tracking client data, and generating programmatic data that drives reimbursements for AAAs and service providers.

Objective #5.3	Annual Performance Measure	Action Steps
SFY 2012 and 2015		
Increase technology initiatives	• Accurate data collection	• Continue efforts to move data from CHAT database to AIMS for centralization. • Continue revisions to client screens. • Hire a Business Analyst to assist with programming components of AIMS and alignment of budget and strategic initiatives.

		• Include AIMS allowance for future funding of grants for data collection. • Review of missing data elements to enhance Database integrity and accuracy.

Attachment A

State Plan Assurances, Required Activities and Information

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c),
ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals

residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native

Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances
that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency
or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need;

and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of Low-Income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to

such area agency on aging on a full-time basis, whose responsibilities will include
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income
older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public

protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

REQUIRED ACTIVITIES
Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.
Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements

as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency-
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

INFORMATION REQUIREMENTS

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))

The term "in-home services" includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)
provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)
Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)
(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)
The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the*

allocation of funds to each planning and service area)

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met
and describe how funds have been allocated to meet those needs.

Section 307(a)(21)
The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals

with Low-Incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*
In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities

for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households;
and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

Signature and Title of Authorized Official

9/30/11
Date

Attachment B
Intrastate (IFF) Funding Formula Requirements

Each State IFF submittal must demonstrate that the requirements in Sections 305(a)(2)(C) have been met: OAA, Sec. 305(a)(2) "*States shall,*

(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account (i) the geographical distribution of older individuals in the State; and (ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

• For purposes of the IFF, "best available data" is the most recent census data (year 2000 or later), or more recent data of equivalent quality available in the State.

• As required by Section 305(d) of the OAA, the IFF revision request includes: a descriptive Statement; a numerical Statement; and a list of the data used (by planning and service area).

• The request also includes information on how the proposed formula will affect funding to each planning and service area.

• States may use a base amount in their IFFs to ensure viable funding for each Area Agency but generally, a hold harmless provision is discouraged because it adversely affects those planning and service areas experiencing significant population growth.

Intrastate Funding Formula Assumptions and Goals

The Division of Aging Services utilizes the following factors to distribute Older Americans Act funds by Planning and Service Area (PSA). The current formula provides a specific weight for each of the following populations: persons age 60 years of age and older, Low-Income minority population age 65 and older, Low-Income 65 and older population, estimated rural population 60 years of age and older, Limited English speaking population 65 years of age and older, and disabled adults 65 years of age and older.

DAS traditionally revises the funding formula decennially (every ten years) based upon demographic and population data changes from the Census. DAS will revise the IFF based on 2010 Census older adult population data. Future updates to the IFF will be based on population estimates provided by the Census.

Definitions for each population are indicated below.

60+ population

The number of persons in the age group 60 and above.

Low-Income minority 65+ population

Numbers of persons in the age groups 65 and above who are minorities (non-white) and are below the poverty level, as established by the Office of Management and Budget in Directive 14 as the standard to be used by Federal agencies for statistical purposes. This factor represents "special attention to Low-Income minority older individuals" as required by the Older Americans Act.

Low-Income 65+ population

Numbers of persons in the age groups 65 and above who are below the poverty level as established by the Office of Management and Budget in Directive 14 as the standard to be used by Federal agencies for statistical purposes. This factor represents economic need as defined by the Older Americans Act.

Estimated rural 60+ population

An estimate of the numbers of persons in the age groups 60 and above who reside in a rural area as defined by the Census Bureau. This factor represents the social need factor of "geographic isolation" as defined by the Older Americans Act.

Limited English speaking 65+ population

Numbers of persons in the age groups 65 and above who speak a language other than English and speak English "not well" or "not at all. This factor represents the social need factor of language barriers as defined by the Older Americans Act.

Disabled 65+ population

Numbers of persons in the age groups 65 and above who have a "mobility or self care limitation" as defined by the Census Bureau. This factor represents the social need factor of "physical and mental disability" as defined by the Older Americans Act.

Intrastate Funding Formula Factors and Weights

Factors	Weights
Population 60+	50%
Low-Income Minority 65+	10%
Low-Income 65+	15%

Rural 60+ (estimate)	13%
Disabled 65+	10%
Limited English Speaking 65+	2%

The above factors have been incorporated into a mathematical formula for administration as reflected below. ***In addition to these factors and weights, the Division of Aging Services incorporates a 6 percent funding base for parts B, C1, C2, and E.***

Intrastate Funding Formula

Y=(.50(X)(%60))+(.10(X)(%LIM))+(.15(X)(%LI))+(.13(X)(%RUR))+(.10(X)(%DIS))+(.02(X)(%LES))

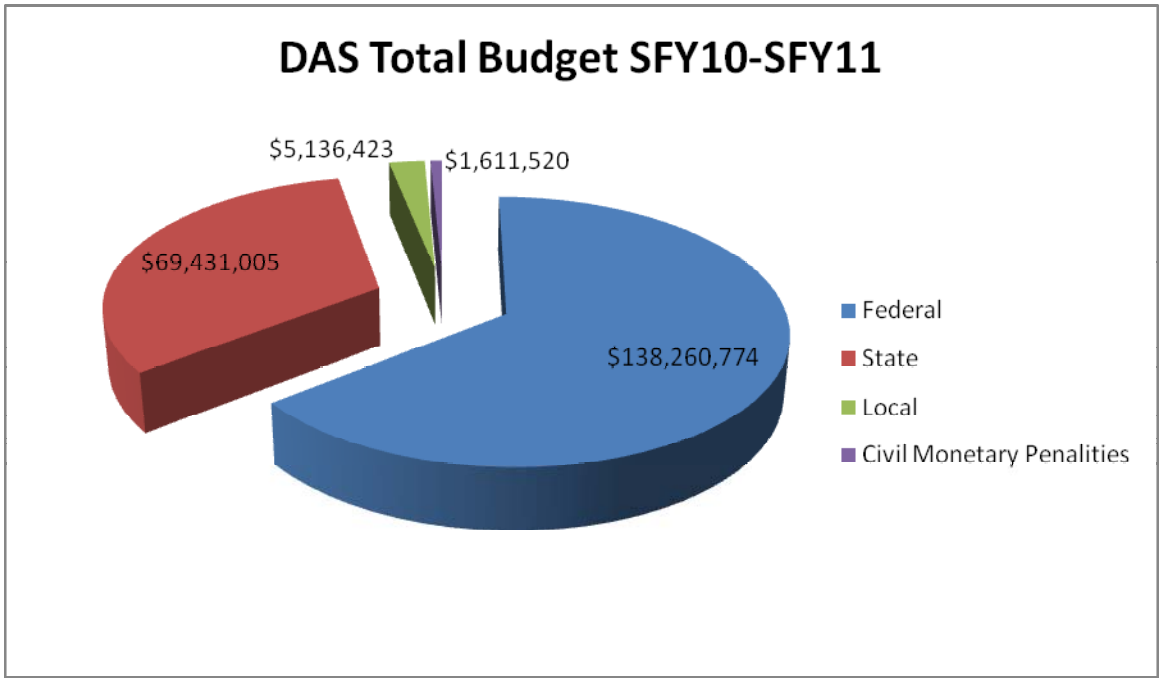
Factors:

- Y = The service allocation for a Planning and Service Area (PSA).
- (X) = The total services allocation amount for the state.
- % 60 = The PSA percentage of the State total population ages 60 and above.
- % LIM = The PSA percentage of the State total population ages 65 and above who are Low-Income and are minorities.
- % LI = The PSA percentage of the State total population age 65 and above who are Low-Income.
- % RUR = The PSA percentage of the State total population age 60 and above who live in rural areas.
- % DIS = The PSA percentage of the State total population who are age 65 and above and are disabled.
- % LES = The PSA percentage of the State total population age 65 and above and have limited English speaking ability.

LTCO Program Expenditures

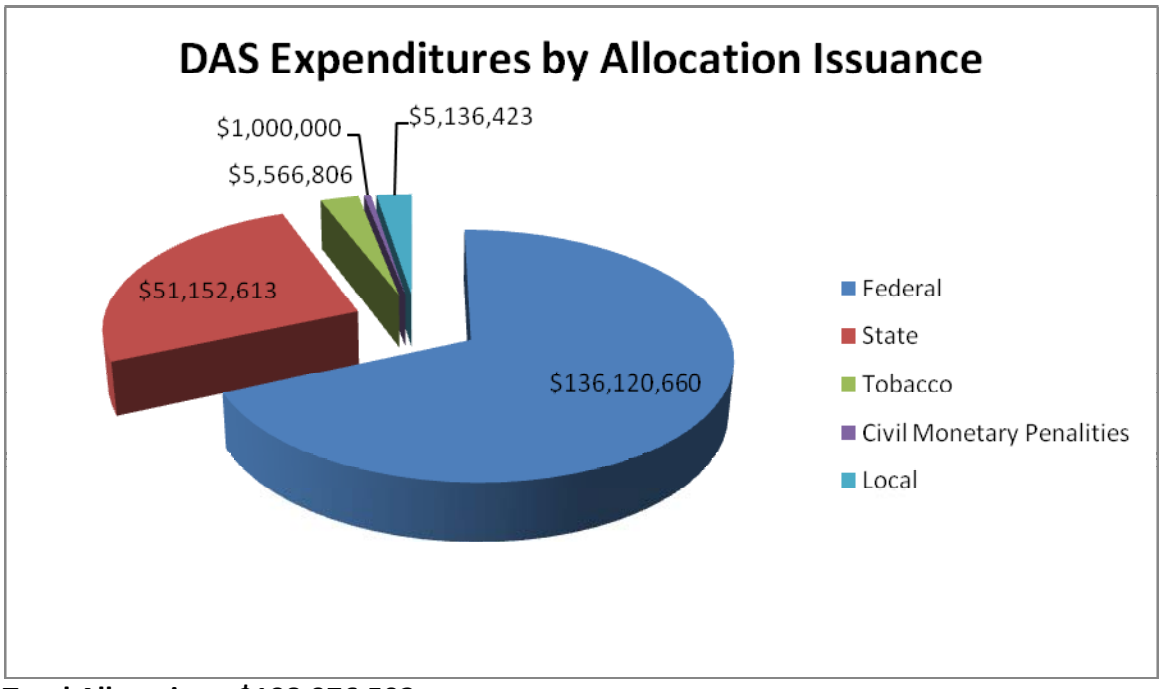
Source	2000	2010
Title VII, Chapter 2, Ombudsman	$173,979	$457,817
Title VII, Chapter 3, Abuse Prevention	$ 36,627	$ 47,546
Title III, expended by State, as Authorized in OAA, Sec.304 (d)(1)(B)	$231,263	$234,467
Title III provided at AAA level	$672,642	$695,803
Other Federal	$136,059	$ 58,663
State Funds	$444,737	$1,017,024
Local (does not include "in kind.")	$310,021	$278,725
TOTAL	$2,005,328	$2,790,045

Note: A state must expend its full annual allocation of Title VII, Chapter 2 Ombudsman funds on the Ombudsman Program, as the program is defined in Section 712 of the Older Americans Act. The 2000 figure is for reference only. The SFY10 data indicates federal, state, and local cash match only.



Total Budget - $220,631,528

- This number includes CCSP Benefit Dollars, which is appropriated to the Department of Community Health.



Total Allocation - $198,976,502

- CCSP client benefit dollars and Adult Protective Services allocations are not included in the graph.

Attachment C
Program and Service Narrative

Appendix C provides greater detail for various programs and services administered by DAS.

Below is the link to the 2010 Just the Facts document that provides an overview of programs and services.

http://aging.dhr.georgia.gov/DHR-DAS/DHR-DAS_Publications/Just%20the%20Facts%20FY%202010-R.pdf

Alzheimer's Disease Supportive Services Program
Georgia REACH Project

The Georgia REACH Project is an evidence-based grant awarded to the Rosalynn Carter Institute at Georgia Southwestern State University from October 1, 2008, through September 30, 2011, to implement REACH II. REACH II is a multi-component caregiver intervention being deployed in rural Georgia evaluating the effectiveness of reducing burden and depression among family caregivers of persons with Alzheimer's Disease (AD) or related disorders. This grant will build on existing infrastructures and results obtained from its parent multi-site feasibility study, Resources for Enhancing Alzheimer's Caregiver Health (REACH). REACH [funded by the National Institute on Aging (NIA) and the National Institute for Nursing Research (NINR) UO1-AG13305] explored the effectiveness of different interventions to reduce burden and distress of family caregivers in six participating sites.

REACH II targets dementia caregivers in rural areas in central and west Georgia counties. The Rosalynn Carter Institute at Georgia Southwestern State University will collaborate with the following partners: Middle Flint Council on Aging, River Valley Area Agency on Aging, the Georgia Alzheimer's Association and three local affiliates servicing the target area, the Mattie Marshall Alzheimer's Center, and the Division of Aging Services. The anticipated outcomes for caregivers include reduced strain, burden, and depression and increased social support, good health behaviors, and improved quality of life among caregivers at the program conclusion.

Objective: Reduce burden and depression among family caregivers of persons with Alzheimer's Disease or related disorders over baseline in SFY09.

Measures:

Caregivers are assessed at intake and again at the completion of the 6 month intervention.

1. Zarit Burden Interview- a 12-item scale measuring caregiver burden. Higher scores indicate greater burden.
2. Center for Epidemiologic Studies Depression Scale (CES-D): This 10 item version of the CESD assesses depression. A score of 10 reflects extremely high levels of depression symptoms. This score serves as an alert value for reporting to the Principal Investigator for follow-up and for designating individuals with clinical depression.
3. Risk Priority Inventory: This is a 21-question risk appraisal, adapted from REACH II, assesses caregiving risk areas of education, advanced care planning, safety, health and healthy behaviors, social support, and caregiving frustrations. Five safety questions examined care recipient access to dangerous objects, driving, wandering, smoking while alone, or being left home alone. Higher scores indicate greater safety risk. Five questions examine caregiving negative health behaviors of weight change, missed appointments, activity, eating, and medications. Higher scores indicate increased health risk. Three social support items assess satisfaction with help and emotional support and whether the caregiver had someone to take over care, if needed. Higher scores indicate increased social support risk. Three items focus on caregiver stress or difficulty with toileting, activities of daily living, and working with the patient's health care providers. Higher scores indicate greater difficulty. Two items assess caregiver frustrations (e.g., feel like yelling at or hitting patient). Higher scores indicate greater frustrations.
4. Revised Memory and Problem Behaviors Checklist: A checklist including 36 problem behaviors were assessed as occurring or not during the past month. For each behavior present, the caregiver was asked to rate the level of bother or concern caused by that behavior. Higher scores indicate higher level of bother or concern.
5. Desire to Institutionalize: A six item assessment of the caregivers intent to institutionalize the care recipient over the past six months.
6. Revised Scale for Caregiving Self-Efficacy: A fifteen item scale addressing self efficacy for obtaining respite (5 items), responding to disruptive behaviors (5 items) and controlling upsetting thoughts about caregiving (5 items).
7. Global Deterioration Scale (GDS): The GDS is a checklist used to determine the stage of care recipient cognition and function.

Alzheimer's Disease Supportive Services Program
Georgia REACH-Coastal Project

The Georgia REACH - Coastal Project is an evidence-based grant awarded to the Rosalynn Carter Institute (RCI) at Georgia Southwestern State University from September 1, 2010, through August 31, 2013. This project is an expansion of Georgia REACH as implemented through funding awarded in 2008 in Coastal Georgia. Replicating REACH II, this is a multi-component caregiver intervention being deployed

in Georgia evaluating the effectiveness of reducing burden and depression among family caregivers of persons with Alzheimer's Disease (AD) or related disorders as implemented by an AAA. This grant will build on existing infrastructures and results obtained from its parent multi-site feasibility study, Resources for Enhancing Alzheimer's Caregiver Health (REACH). REACH [funded by the National Institute on Aging (NIA) and the National Institute for Nursing Research (NINR) UO1-AG13305] explored the effectiveness of different interventions to reduce burden and distress of family caregivers in six participating sites.

Georgia REACH - Coastal targets dementia caregivers in nine rural counties along the southern coast of Georgia. The anticipated outcomes for caregivers include reduced strain, burden, and depression and increased social support, good health behaviors, and improved quality of life among caregivers at the program conclusion.

Objective: Reduce burden and depression among family caregivers of persons with Alzheimer's Disease or related disorders over baseline in SFY11.

Measures:

Caregivers are assessed at intake and again at the completion of the 6 month intervention.

1. Zarit Burden Interview- a 12-item scale measuring caregiver burden. Higher scores indicate greater burden.
2. Center for Epidemiologic Studies Depression Scale (CES-D): This 10 item version of the CESD assesses depression. A score of 10 reflects extremely high levels of depression symptoms. This score serves as an alert value for reporting to the Principal Investigator for follow-up and for designating individuals with clinical depression.
3. Risk Priority Inventory: This is a 21-question risk appraisal, adapted from REACH II, assesses caregiving risk areas of education, advanced care planning, safety, health and healthy behaviors, social support, and caregiving frustrations.
    a. Five safety questions examined care recipient access to dangerous objects, driving, wandering, smoking while alone, or being left home alone. Higher scores indicate greater safety risk. Five questions examined caregiving negative health behaviors of weight change, missed appointments, activity, eating, and medications. Higher scores indicate increased health risk. Three social support items assess satisfaction with help and emotional support and whether the caregiver had someone to take over care, if needed. Higher scores indicate increased social support risk. Three items focus on caregiver stress or difficulty with toileting, activities of daily living, and working with the patient's health care providers. Higher scores indicate greater difficulty. Two items assess caregiver frustrations (e.g., feel like yelling at or hitting patient). Higher scores indicate greater frustrations.
4. Revised Memory and Problem Behaviors Checklist: A checklist including 36 problem behaviors were assessed as occurring or not during the past month. For each behavior present, the caregiver was asked to rate the level of bother or

concern caused by that behavior. Higher scores indicate higher level of bother or concern.

5. Desire to Institutionalize: A six item assessment of the caregivers intent to institutionalize the care recipient over the past six months.
6. Revised Scale for Caregiving Self-Efficacy: A fifteen item scale addressing self efficacy for obtaining respite (5 items), responding to disruptive behaviors (5 items) and controlling upsetting thoughts about caregiving (5 items).
7. Global Deterioration Scale (GDS): The GDS is a checklist used to determine the stage of care recipient cognition and function.

Alzheimer's Disease Supportive Services Program
Georgia NYUCI Evidence-Based Project

The Georgia New York University Caregiver Intervention (NYUCI) Project is an evidence-based grant awarded to the Rosalynn Carter Institute at Georgia Southwestern State University from September 2009 through August 2012 to serve a minimum of 150 spouse caregivers of individuals with Alzheimer's disease. Special emphasis will be made to recruit rural and African American caregivers. The goal of the project is to support Georgia caregivers providing in-home care to spouses with Alzheimer's disease.

The purpose of the NYUCI Project is to decrease negative impacts associated with family caregiving such as depression, isolation, and stress related illnesses, and increase the positive, supportive elements of family caregiving such as bringing families together to support the care recipient. Success is achieved through a combination of individual and family counseling sessions and additional support activities, such as ongoing support groups and the availability of ad hoc counseling. Collaborative partners for the grant include the Georgia Chapter of the Alzheimer's Association, Southern Crescent AAA, Northeast Georgia AAA, and the Division of Aging Services (DAS).

Objective: Reduce burden and depression among family caregivers of persons with Alzheimer's Disease or related disorders over baseline in SFY11.

Measure:

Attainment of objectives and outcomes is measured by pre and post intervention assessments. The instrument used has been revised by the AoA. In addition to the Revised NYUCI Baseline Assessment, RCI is utilizing the CESD-10 and the Desire to Institutionalize to capture the outcomes of decreased depression and delayed nursing home placement.

Determine baseline in SFY10. Utilize the following measures to demonstrate achievement of proposed outcomes:

1) Zarit Burden Interview- a 12-item scale measuring caregiver burden. Higher scores indicate greater burden.
2) Two scales are used to measure caregiver depression.

a. The Geriatric Depression Scale is a 30-item, yes/no depression scale specifically designed for older adults.
b. Center for Epidemiologic Studies Depression Scale (CES-D): This 10 item version of the CESD assesses depression. A score of 10 reflects extremely high levels of depression symptoms. This scale was added so that cross intervention comparisons could be made with other projects implemented by RCI.

3) Revised Memory and Problem Behaviors Checklist: A checklist including 24 problem behaviors were assessed as occurring or not during the past month. For each behavior present, the caregiver was asked to rate the level of bother or concern caused by that behavior. Higher scores indicate higher level of bother or concern.
4) Desire to Institutionalize: A six-item assessment of the caregiver's intent to institutionalize the care recipient over the past six months.
5) Caregiver satisfaction with social support is assessed using eight questions from the Stokes Social Network Scale.
6) Caregiver Physical Health Form adapted from the OARS battery (Duke Center for Study of Aging and Human Development, 1978) is used to assess caregiver health.

Alzheimer's Disease Supportive Services Program
Georgia Care Consultation Project

The Georgia Care Consultation Project is an evidence-based grant awarded to the Rosalynn Carter Institute at Georgia Southwestern State University from September 1, 2010, through August 31, 2013, to implement a phone-based care consultation intervention for Alzheimer's Disease and Related Disorders (ADRD) patients and caregivers. Care Consultation is a telephone-based, empowerment intervention that helps family caregivers and care receivers by providing information about health problems and available resources mobilizing and facilitating the use of informal supports and formal services; and providing emotional support. Care consultants act as coaches and work in partnership with caregivers, care receivers, and other family members.

The objective of the initiative is to begin in three AAAs within Georgia and evaluate the effectiveness of the program in relation to the RE-AIM framework. RE-AIM stands for Reach, Effectiveness, Adoption, Implementation, and Maintenance. Translation involves implementing research interventions in communities with fidelity to the major program design elements that were included in the original study. During the translation process, tools and manuals are developed to assist in the dissemination of the evidence-based program. The overall goal of the RE-AIM framework is to assist researchers and practitioners understand the issues related to planning, implementation, evaluation and sustainability of evidence-based ADRD interventions and translate research into practical application.

The Georgia Care Consultation Project will replicate a component of the Cleveland Alzheimer's Managed Care Demonstration ("Care Consultation") under the category: Interventions for Both Persons with Dementia and their Family Caregivers. The

Rosalynn Carter Institute on Caregiving will work in collaboration with the Division of Aging Services, Georgia Alzheimer's Association, three AAAs, and the Benjamin Rose Institute.

Objective: Reduce burden and depression among family caregivers of persons with Alzheimer's Disease or related disorders over baseline in SFY11.

Measures:

In order to measure achievement of caregiver goals and outcomes, RCI will employ the Caring Consultation Caregiver Interview Time1 and Time2 assessments developed and utilized by the Benjamin Rose Institute for the original intervention. Care Consultation provides services to both the caregiver and the care recipient when appropriate. In these cases, assessments are conducted on both individually.

1) Caregiver Strain Index: This is a 30 item caregiver (CG) strain index, the 6 item relationship strain index and the 4 item work-care related strain completed with caregivers currently employed.
2) Center for Epidemiologic Studies Depression Scale (CES-D): This 10 item version of the CESD assesses depression. A score of 10 reflects extremely high levels of depression symptoms.
3) Caregiver Satisfaction Survey- as measured for the CG by ten subscales of the CG Satisfaction survey: (Personal Care and Supervision, Chores and Running Errands, Home Health Care, Finding or arranging for services, Legal matters, Health information, Emotional Support or Counseling, Getting Relief from Caregiving, Living arrangements, Number of Friends and Family helping) and for the care receivers (CR) by the eight-item CR Satisfaction with Care Scale.
4) Care Quality Scale: The 14-item Care Quality Scale for CG and the 11-item Care Quality Scale for CR assesses the quality of care the CR is receiving.
5) Need for Information or Assistance Scale: To measure the reduction of Unmet Service/Information Needs this measure includes 49-items (CG) and the 15-items (CR).

Alzheimer's Disease Supportive Services Program Innovation Programs to Better Serve People with Alzheimer's and Related Disorders

The Georgia's System Re-design: New Protocols and Interventions to Better Serve Persons with Early-Stage Alzheimer's Disease is a discretionary grant, funded from October 1, 2010, through September 30, 2013. The Division of Aging Services will collaborate with grantee partners to re-design statewide delivery of services for persons with early stage Alzheimer's Disease (AD), and develop new protocols and interventions. The target population also includes underserved caregivers of persons with early stage AD in rural areas. Grantee partners include the Georgia Chapter of the Alzheimer's Association, Coastal Georgia Area Agency on Aging (AAA), Central Savannah River Area

Agency on Aging, Georgia Aging and Disability Resource Connection Gateway, and Georgia State University Gerontology Institute.

The primary objectives of the project are as follows:

1) Improve service access for persons with early stage AD;

2) Refine Georgia's comprehensive social service assessment to identify people with early stage AD; and,

3) Implement and/or integrate into the access system multi-faceted interventions for persons with early stage AD.

The project will encompass an evaluation to gauge the effectiveness of the interventions deployed and consumer satisfaction.

The Division of Aging Services chose the systems change track for implementation of this grant. Therefore, a number of products of the grant will mark permanent changes for the Aging Network continuing after the grant funding ends. These products include: 1) Screening tools for identifying persons at risk of with early stage dementia; 2) A clinical counseling protocol for persons with Early Stage AD; and 3) An improved process for inter-agency referrals.

Strategies

1) Improve proficiency of AAA access services staff will be accomplished by training sessions, with pre and post tests administered. Training sessions will be conducted for Gateway and Adult Protective Services staff.

2) Improve knowledge/understanding of affected consumers of Alzheimer's Disease. Georgia Health Policy Center staff will interview individuals with early stage AD prior to and after the clinical counseling intervention to measure changes in knowledge of AD and changes in the individual's ability to plan for their needs.

3) Improve satisfaction of affected consumer with services, supports, and interventions will be achieved by analyzing the TCARE® assessment and re-assessment data for caregivers receiving TCARE®. TCARE® is an assessment process that provides guidance for understanding caregivers' needs, consulting with caregivers, and strategically selecting and recommending services.

4) Every six months, progress reports are turned in to the Administration on Aging. All grant data is collected and compiled by the Division of Aging Services.

Long-Term Care Ombudsman Program

Title VII of the Older Americans Act authorizes the Long-Term Care Ombudsman Program (LTCOP) to work to improve the quality of life of residents in nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), personal care homes (PCH) and community living arrangements (CLAs) by acting as their independent

advocate. Ombudsman staff and volunteers informally investigate and resolve complaints on behalf of residents. They visit long-term care facilities to be accessible to residents and monitor conditions and also provide education regarding long-term care issues, identify long-term care concerns and advocate for needed change.

Complaints Handled

The Ombudsman Program received 4,064 complaints in SFY10: 2,946 Nursing Home and ICF/MR and 1,124 Personal Care Home and CLA's. Ombudsmen resolved 94% of complaints in SFY 2010. Ombudsman responded to 100% of complaints received regarding abuse and the resident was believed to be at risk within 1 working day; 98% resolution of complaints received regarding abuse and the resident was not believed to be at risk within 3 working days, and 99% resolution of all other types of complaints within 7 working days. Future goals include increasing access to quality services by completing positive outcomes to complaints with a target of 97% across the program. Target achievement will consist of annual training and continuous technical assistance to local programs.

The Ombudsman Program is in a rebuilding phase after sustaining budget cuts which resulted in the loss of full-time equivalents (FTEs) in local programs across the state. The Ombudsman Program will increase access to quality services by providing routine visits to nursing homes and personal care homes with a target of 91% for nursing homes and 80% for personal care homes.

Volunteers

In SFY 2010, 94 volunteers – 8 certified and 86 other volunteers performed services to assist the Ombudsman Program. State Office staff approved volunteer training curricula, administered certification examinations, provided guidance, and participated in community ombudsman program volunteer training. The Ombudsman Program will be implementing strategies to assist local programs that have had challenges in recruiting and retaining volunteers.

The Ombudsman Program will improve resource development by increasing the number of hours contributed by volunteers to 352 hours annually and increasing the number of volunteers who are active in the program. The resource development goal will also increase the number of volunteers by adding three regular volunteers in three of the local programs that did not have volunteers in SFY2010.

Advocacy

- Ombudsmen -- together with Georgia Medical Care Foundation, regulators, other consumer advocates, and providers -- worked to promote quality in Georgia's nursing homes. Ombudsmen are participating in the Local Area Networks for Excellence as a part of the Advancing Quality in Nursing Homes campaign to improve care delivery systems and clinical outcomes, enhance quality of life for residents and stabilize the work force.
- Ombudsman supported legislation to create a level of long-term care between the existing personal care homes that provide watchful oversight and skilled nursing facilities providing 24 hour medical care.
- Ombudsmen supported legislation to allow for training of non-professional

caregivers, what are termed "Proxy Caregivers" to provide health maintenance activities to residents of personal care homes.

Money Follows the Person (MFP) & Minimum Data Set (MDS) 3.0 Section Q
Georgia was awarded a "Money Follows the Person" (MFP) Rebalancing Demonstration grant in May 2007, through the Department of Community Health. Georgia's plan will assist 1,347 persons, 375 of whom will be elderly, to transition from institutions back to the community over the five-year grant period. In three local programs, Ombudsmen review quality of services, monitor satisfaction and help to ensure safety and consumer choice during the first twelve months of transition. The local ombudsmen are collaborating with the Area Agencies on Aging through the Aging and Disability Resource Connection (ADRC) as they offer Options Counseling to resident in skilled nursing facilities. Ombudsmen will assist residents who request their assistance with returning to the community. This collaboration is important with the implementation of the MDS 3.0 Section Q initiative to assist those long-term care residents who wish to return to the community.

Culture Change
The Long-Term Care Ombudsman Program is committed to promoting resident directed care in nursing facilities. The Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in Nursing Homes (2001) defines culture change as follows:

> "Culture change engages all facility staff in a total transformation of thinking and practice, instead of changing an element or a program within the prevailing culture. Changing the culture is a means to the end of building resident-directed approaches to care responsive to residents' experience and needs."

The Long-Term Care Ombudsman Program will incorporate statewide training on this initiative and research strategy options for deployment during the next four year cycle.

AAA Areas of Emphasis
All Area Plans require that LTCOP plans address the following items: complaint processing; information and assistance requests; routine visits; issues advocacy; resident council activities; volunteer management; and nursing home pre-survey information. In addition, each program must perform two or more of the following other program components: community outreach and education; in-service education to facilities; family council activities; interagency coordination; and advisory council. Other areas of emphasis include:

- Increase the number of persons receiving education about elder abuse and fraud prevention through literature provided to facility staff and clients.
- Provide LTCO services to mental health clients who reside in PCHs.
- Provide educational training to professionals within the Aging Network.
- Sustain and increase the number of routine visits provided to Nursing Homes, PCHs while continuing to respond to complaints of residents in ICF/MRs and CLAs.

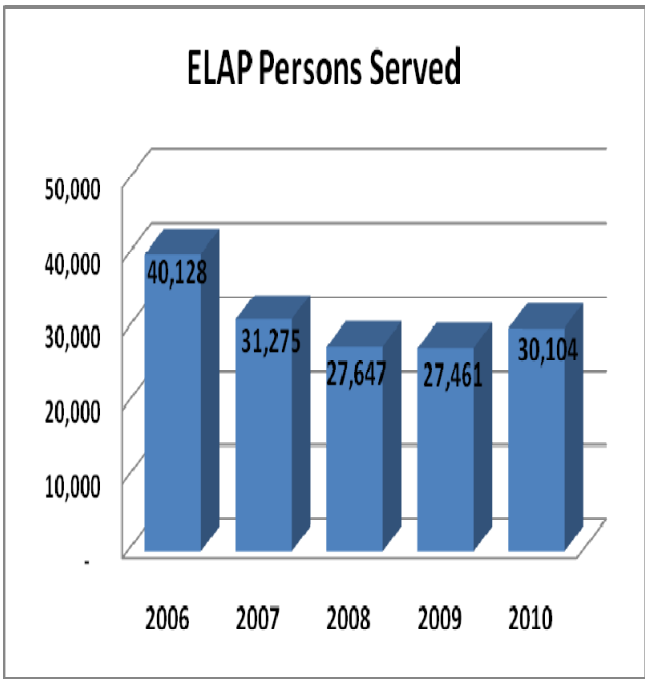
State Legal Assistance Development Program

Description of System

Georgia's obligations pursuant to Title VII of the Older Americans Act (OAA), 42 U.S.C.A. § 3027 (a) (13) and Title IIIB of the OAA, 42 U.S.C.A. § 3027 (a)(2)(A) & (C) by having in place an individual who serves the state as the legal assistance developer and ensures the state's capacity to deliver the priority legal services under Title IIIB of the OAA. Georgia's State Legal Services Developer (LSD) is the full-time state legal assistance developer and is responsible for administering a quality Elderly Legal Assistance Program (ELAP), which provides OAA Title IIIB legal services to persons sixty years of age and older who are in the greatest social and/or economic need with particular attention to low-income minorities, rural residents, or persons with limited English speaking proficiency.

Providers of Title IIIB legal services contract with one of the state's twelve AAAs. Legal services are delivered through twelve Legal Services Corporation grantee entities and one minority private law firm. Services are available to seniors in each of the state's one-hundred fifty-nine counties. Specific services available to older people include: legal information, legal community education and full direct representation of legal issues all the way to their administrative and/or judicial conclusions.

(See the number of ELAP Persons Served below and the Overview of ELAP Trends).



Overview of ELAP Trends

2006 – Hurricane Katrina, New Guardianship Law, Estate Recovery and implementation of Medicare Part D

2007 – Recovery from the previous year's neighboring hurricane and floods within the state brought emphasis in education, particularly, newly created mandatory emergency disaster preparation training for seniors struggling to regain their footing

2008 – Focus on case representation in the areas of consumer, housing and income maintenance

2009 – Nursing home Medicaid eligibility, foreclosure and debt collection continued to take priority over case types such as wills and document preparation

2010 – Case emphasis includes end-of-life planning and consumer issues such as foreclosures, reverse mortgages, predatory lending, debt collection and harassment by debt collectors including attempts at garnishing federally protected income like Social Security and Supplemental Security Income

Goal and Objectives

The primary goal of the State Legal Assistance Development Program in Georgia is to ensure the legal rights of older Georgians and their capacity to understand, access and exercise those rights to safely extend their independent lifestyles as long as possible. The State LSD works with the state agency, AAAs and IIIB legal assistance providers to establish programmatic goals, objectives, outcomes and strategies for obtaining them.

Goal: Strengthen the Title IIIB program by targeting legal services for vulnerable older adults. Resources - financial, personnel and legal services, will be geared toward the most pressing priorities challenging older persons throughout the state that protects income, shelter, sustenance and access to better health care.

Objective 1: Increase successful resolution of client issues by 20% by 2015 to the target population as identified in the Georgia ELAP Standards by each Title III B legal provider. Priority cases will include foreclosure prevention, financial exploitation, long-term care appeals, and Medicaid eligibility and Medicare assistance.

Successful Resolution is achievement of the mutual goals initially set between the legal representative and the client; however, whenever ELAP is able to have a positive impact on the life of the client and place them in a better position economically or equitably.

Measure: SFY12 – Baseline results of priority cases identified in Objective 1 in comparison to the number/percent of ELAP cases that are not within the core priorities. Data collection will consist of using the AIMS ELAP Activity Log Case Representation Report.

SFY13 – Increase successful resolution of client priority cases by 10% of 2012 baseline
SFY14 – Increase successful resolution of client priority cases by 15% of SFY12 baseline
SFY15 – Increase successful resolution of client priority cases by 20% of SFY12 baseline

Strategies: Target identified communities in need of increased access to public benefits

- Analyze AIMS data to determine specific areas within designated planning and service areas that demonstrate a constrained level of public benefit activity when compared with public data indicating the numbers of persons receiving various public benefits in those areas.
- Develop a plan for outreach to the population to be targeted.
- Develop and implement an education and publicity protocol to disseminate information to the targeted population.
- Host a series of public forums and education sessions specifically designed to reach the population targeted as likely eligible for public benefits but not accessing them.

Objective 2: Increase successful resolution of appeals in each planning and service area by 25% by 2015 regarding foreclosure prevention activity, Social Security Administration appeals, Medicare appeals, Medicaid appeals and/or Nursing Home/Personal Care Home (Assisted Living).

Measure: SFY11 –Baseline priority appeals identified in Objective 2 in comparison to the number/percent of ELAP appeals that are not directed to the target population. Data collection will consist of using the AIMS Statistics Report and the Activity Log Case Representation Report field indicating counties served.

SFY12 - Increase successful resolution of priority appeals by 10% of 2011 baseline
SFY13 - Increase successful resolution of priority appeals by 15% of 2011 baseline
SFY14 - Increase successful resolution of priority appeals by 20% of 2011 baseline
SFY15 - Increase successful resolution of priority appeals by 25% of 2011 baseline

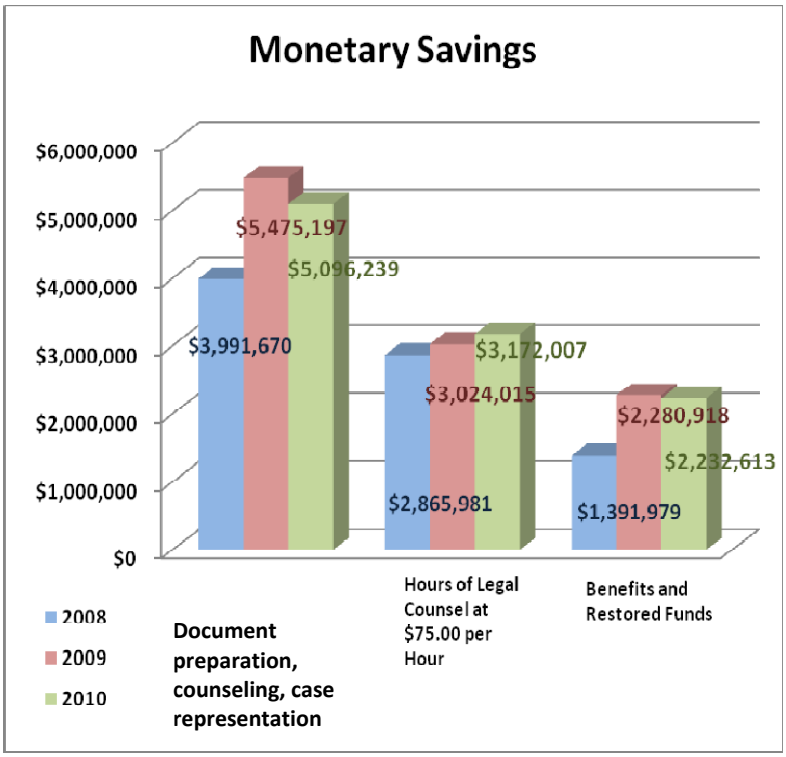
Strategies:

- Develop a dedicated screening tool to utilize with all potential clients to ascertain eligibility for available; detect existing issues requiring administrative or judicial intervention to assist with appeals
- Engage in active screening using the dedicated screening instrument to identify potential clients and their specific areas of need
- Involve any and all additional resource agencies to aid the client

Objective 3 – Increase monetary savings realized and/or benefits obtained for clients by 20% by 2015. Data collection will consist of using the AIMS ELAP Activity Log by exceeding SFY11 results in 5% increments per fiscal year.

Strategy:

- Analyze ELAP data entered into AIMS regarding document preparation, counseling, case representation, hours of legal counsel, and benefits and/or restored funds.
- Target geographic areas where income and assets are in jeopardy due to the level of threat and priority cases and appeals
- Develop an outreach plan to educate and inform older persons in these areas
- Create and implement a publicity campaign to alert citizens of available services
- Host public forms, education sessions and information and intake sessions to provide assistance
- Prioritize representation of cases identified in priority subject matter areas.
- Periodically, but no less than annually, assess, evaluate and determine the impact upon clients served.



Training

One of the other roles of the State LSD is to provide technical assistance to other elder rights partner programs and to provide training or access to training and assist in the development of other low cost mechanisms of legal services delivery. In keeping in tenor with the economic downturn with the nation and state, training opportunities for Title IIIB legal services programs were substantially reduced; however, in 2010, ELAP in conjunction with other Elder Rights programs hosted a statewide "Boot Camp" to provide training for partners regarding national and state initiatives. The State LSD also makes use of webinars sponsored by the National Legal Resource Center (NLRC) partners. Information about these trainings is made available to the Title IIIB legal services providers so that they can participate at their convenience and this practice will continue.

The State LSD continues to search for grant funds outside of those provided by the discretionary grants from AoA and uses the opportunity to partner with Georgia State University and others to apply for grant funding.

Technical Assistance

The State LSD is working with the Georgia Senior Legal Hotline of Atlanta (GSLH) Legal Aid Society, Inc. They are one of the 2010 Model Approaches Grant recipients. The concept of the Model Approaches grant purports to integrate into the Aging Network, under the leadership of the state's developer, a comprehensive system of delivery of legal services to older persons using Title III B legal services, hotlines, pro bono programs and other low cost delivery mechanisms. The State LSD assisted in writing the grant and continues to support the GSLH by participating in the work group and stakeholders group. The State LSD also meets with the Managing Attorney and project leader to provide guidance in areas such as the legal needs study, the assessment of the

capacity of the legal delivery system and overall plans to further integrate the hotline into the Aging Network.

Coordination
The State LSD coordinates with other elder rights programs at the state level and directs that coordination of the ELAPs with their regional elder rights component partners such as Long-Term Care Ombudsmen, SMP, Adult Protective Services, GeorgiaCares (the state's SHIP) and ADRC. Each program is provided the mechanism for ensuring that as necessary, client referrals can be made to the ELAP for the maximum benefit to the older person. The Long-Term Care Ombudsman Program, which may more frequently have residents in need of legal assistance but unable to directly request that assistance due mental impairment or dementia, have been found to need extra help. Without relatives or authorized representative to request ELAP intervention, the resident's rights could be irreparably harmed. The State LSD continues to offer through the use of a memorandum of understanding, the opportunity for the State Ombudsman to certify such cases on an individual basis and act on behalf of the resident to request legal assistance. In these cases, ELAP is able to provide legal assistance to benefit the resident.

State Elder Rights Plan

Elder Rights programs identify and prioritize statewide activities aimed at ensuring older adults have access to and assistance with securing and maintaining services and benefits; knowledge about making informed choices and decisions; understanding of their basic rights; and protection from abuse, neglect and exploitation. In collaboration with the Area Agencies on Aging (AAA), Elder Rights programs provide important protections against threats to the independence, well-being, and financial security of clients.

The Georgia Department of Human Services Division of Aging Services FY 2012 – 2015 Elder Rights State Plan demonstrates DAS commitment to providing innovative and efficient services to protect the person, assets and rights of Georgia's older adults and adults with disabilities. Elder Rights programs serve persons with disabilities and incorporate the following State Unit on Aging programs, including collaborations among Law Enforcement, Prosecutors, Court Representatives, Georgia Senior Legal Hotline, Coroners, Social Workers, Medical Professionals, and other multi-disciplinary professionals:

- Adult Protective Services
- Aging and Disability Resource Connection/Gateway
- Elderly Legal Assistance Program
- Forensic Special Investigator Unit
- GeorgiaCares (which includes Prescription Assistance Information & Assistance, State Health Insurance Assistance Program, and SMP)
- Long-Term Care Ombudsman Program.

DAS pursues the use of a public health model to increase the capacity of state elder rights team members, community partners, first-responders and mandated reporters

across the state to recognize, respond to and prevent violations of elder rights. DAS consulted with local universities, the former Georgia Department of Community Health Division of Public Health (now the Georgia Department of Public Health), and the US Centers for Disease Control and Prevention for guidance in developing a model.

Identify the problem: DAS, in conjunction with AAAs and ADRCs, conducted community assessments to engage stakeholders and receive input regarding identification of gaps in services and planning and to determine opportunities for improvement. Protecting the person, assets, and rights of older adults and adults with disabilities is an opportunity for state-level and state-wide elder rights teams to combine resources, knowledge, and creativity with local, state, and federal partners to address issues no one program or agency can fully address alone.

As Elder Rights programs (ELAP, LTCO, APS, ADRC/Gateway, GeorgiaCares) experience increases in requests for benefits and services and protection, significant barriers remains for older and at-risk adults and adults with disabilities to access or receive services to protect their independence, well being and financial security. Further, current funding for existing programs is decreasing; thereby, requiring efficiency in the delivery of services to Georgia's most vulnerable adults.

Identify Risk/Protective Factors: DAS uses the social-ecological model because it encompasses multiple, cross-cutting factors directly impacting an older adult or an adult with a disability. The social-ecological model examines four crucial areas of risk factors/protective factors including the following:

Individual:	Education, Income, Attitudes, Beliefs, Substance Abuse, Mental, Physical & Functional Capability
Relationship:	Family, Friends, Neighbors, Intimate Partners, Caregivers, Peers
Community:	Workplace, Housing/Transportation Availability, Population Density, Levels of Employment, Available Community Services
Societal:	Laws, Policies, Regulations, Societal Norms

1

Develop Interventions: Due to feedback received from community assessments, DAS desires to increase the capacity of state elder rights team members, community partners, first-responders and mandated reporters across the state to enable them to recognize, respond to and prevent violations of elder rights. This will be accomplished by the development and deployment of a state-wide certification program emphasizing a multi-disciplinary approach to addressing abuse, neglect and exploitation through an At-Risk Adult Crime Tactics (ACT) Specialist. Initiatives include: quarterly meeting of state-level team; continued facilitation of communication between the state team and regional teams; a standardized investigative training for Adult Protective Services;

[1] CDC Injury Prevention website (2010)www.cdc.gov/ViolencePrevention/overiew/social-ecologicalmodel.html

recognition of World Elder Abuse Day; a marketing plan including state-wide public service announcements, radio interviews, billboards and other printed and internet materials combined to address elder rights issues as an initial step in a plan to increase public and professional capacity.

Elder Abuse Prevention (EAP) 721 funding will be utilized for these endeavors regarding elder abuse, neglect and exploitation services and activities. These initiatives are intended to improve overall program efficiency and consumer outcomes by effective targeting of a unified message.

The evaluation portion of this endeavor will be ongoing once the above-referenced products are deployed. A baseline will be established in SFY12 that will determine the current number of calls specific to elder rights issues to all Elder Rights team partners particularly ELAP, APS, LTCO, GeorgiaCares, and Gateway/ADRC.

Aging and Disability Resource Connection
Georgia Statewide Five Year Plan

Section I: Vision and Goals

AoA Project Vision Statement:

To have ADRCs in every community serving as highly visible and trusted places where all persons regardless of age, income and disability can find information on the full range of long-term support options and can access a single point of entry to public long-term support programs and benefits.

AoA Project Goal #1:

Fully functional ADRCs operating statewide.[2]

Description of Approach

At the state level, DAS has a full-time staff person designated as the ADRC state lead. Responsibilities include provision of technical assistance, overseeing standards and monitoring, and administrative oversight for all of the local ADRCs. As of July 1, 2010, all of Georgia's twelve AAAs are funded to serve as the center of Aging and Disability Resource Connections in their respective areas. Funds from the 2009 ADRC Expansion grant award were used to add three areas (Southern, Southwest, River Valley) to the existing six (Atlanta, CSRA, Northeast, Northwest, Southern Crescent, Coastal) and a redistribution of state funding on July 1, 2010, allowed the last three areas to begin the transition to ADRCs (Georgia Mountains, Heart, Middle).

Since 2000, all of Georgia's AAAs identified the Information, Assistance, and Referral system in their agencies as the Gateway and have served as the single point of entry for aging services throughout the state. Gateway screening specialists use the Enhanced Services Program (ESP) database for all client records and resources in their areas. Each Gateway is required by DAS program standards to have a fulltime staff person dedicated as the Resource Specialist. This individual is responsible for keeping the resources in the database current and adding new resources. This existing system of information, referral, assistance and screening has provided strength and direction in the transition to an ADRC. As each area expands to include partners serving individuals with disabilities, the resource database also expands to include resources for each population.

Currently, DAS is working with all of the ADRCs to reach fully functional status. This is being accomplished by:

[2] A definition of "statewide" is included in Attachment A of this template. Fully functioning criteria are available at http://www.adrc-tae.org/tiki-index.php?page=NewSite

- Annual site visits where each area is monitored by DAS staff using the Gateway/ADRC guidelines, including the fully functional criteria. DAS will submit a report of findings and recommendations from each visit and the ADRC will be expected to submit a plan of correction based on this. The first round of site visits focusing on ADRC activities was completed in November 2010. Annual site visits take place each year in the months of September through November.
- Improving the delivery and follow up for individuals receiving Options Counseling.
- Development of formal partnerships including MOUs/MOAs at both state and local levels.
- Quarterly meetings with ADRC lead staff are used to discuss the fully functional criteria, including discussion of technical assistance resources. Of the six domains in the fully functional criteria, one is selected for review and discussion at each quarterly meeting.
- Use of the AoA/Lewin report from August 2010 on Georgia's ADRCs fully functional status to identify areas for improvement including resources and best practices of other states.
- State and regional trainings addressing ADRC responsibilities, partnering and topics such as marketing, community awareness and inclusive ADRC advisory boards.
- Including the Fully Functional criteria as an appendix to the Gateway/ADRC guidelines.
- Using the report from the Georgia State University Health Policy Center (GHPC) on each of the ADRCs self assessment on their fully functional status. A self-assessment was created by the ADRC consultant from the GHPC. Each area completed the assessment and the findings were compiled in a report.

How will you measure progress toward your goal?

The ADRC state lead will use results from the annual site visits to measure progress toward the goal for each individual area. To measure progress on the state level, DAS will use the AoA/Lewin report on Georgia's status. Annual review of this report by the State ADRC Advisory Council will determine progress in each of the identified domains. Recommendations from the Council will be used to continue progress towards fully functional status.

Other measures include the annual Customer Satisfaction Survey completed in each area and the data from quarterly ADRC reports and semiannual reports to the AoA. This information is used by the ADRC state lead during monitoring visits with each of the local ADRCs to identify progress toward reaching all populations.

With the pending funding provided by the Department of Community Health (DCH) for a state level Transitions Specialist, DAS will develop standards for the provision of Options Counseling, including the procedure for follow up and tracking of Options Counseling outcomes using the ESP and AIMS databases.

What are your anticipated barriers? How will you address these challenges?

Current barriers to achieving fully functional status for Georgia's ADRCs include:

- The process for Medicaid applications, eligibility determination, and the ability to track individual consumer's status for Medicaid, and other public programs throughout the process of determination of eligibility and re-determination.
- The need for additional trained staff in the local ADRCs to meet the demands around the increased complexity of counseling, assistance and follow up required for a fully functional ADRC.
- ADRC field staff turnover and reorganization of partner agencies.

DAS is currently in discussion with the State Medicaid Agency, DCH, on working to streamline the Medicaid eligibility process. In 2010, DAS submitted a request to DCH for access to the information portal where individual status is tracked. This request is pending with approval expected.

DCH has designated the ADRCs in Georgia as the Local Contact Agency (LCA) for the MDS Section Q. A budget was submitted to CMS by the DCH in January 2011 for ADRCs to provide counseling in nursing homes throughout the state. Currently, this counseling is being provided over the telephone in most areas due to a lack of funding for increased staff time and travel. With the approval of this budget, funding will be used to support an additional full-time staff person in each of the local areas serving as the Transitions Coordinator and an additional staff person in the DAS, serving as the Transitions and Options Counseling Specialist.

A regular ongoing working meeting involving staff from the Division of Aging Services and the Department of Community Health (Medicaid) has been established to discuss issues related to ADRCs, the Affordable Care Act, and balancing long-term care.

What is your overall timeline and key dates?

ADRCs able to track eligibility status for Medicaid	July 1, 2011
Add ADRC state level staff person-Transitions Specialist	July 1, 2011
State and local level ADRCs will have signed MOU/MOA with key partners	Dec 1, 2011
Implement statewide standards for Options Counseling follow up	July 1, 2012
ADRCs assisting with Medicaid application process	July 1, 2012
ADRCs can submit completed applications to Medicaid	July 1, 2013
Georgia's ADRCs are all fully functional	July 1, 2014

Section II: Partner Involvement

Who are the key players and responsible parties?

- DAS and the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) has a Memorandum of Understanding describing the relationship and the roles of the ADRC Developmental Disability (DD) Specialist on the local level. The MOU is currently being revised to add another ADRC DD Specialist so that each of the AAAs will have a DD partner in their area. On the state level, DBHDD has an ADRC liaison assigned who provides support to the ADRC DD staff and partners with the DAS on the state level.
- DCH is a key partner with the ADRCs. A representative serves on the State Advisory Council. Monthly meetings between DCH and DAS leadership are being held to discuss opportunities for expanding the partnership.
- The state SHIP Coordinator and the State Ombudsman are both located in DAS and work closely with the ADRC state lead including serving on the State ADRC Advisory Council. The SHIP and ADRCs continue a successful partnership through the Medicare Improvements for Patients and Providers Act (MIPPA) grant.
- The Executive Director of The Brain and Spinal Injury Trust Fund Commission (BSITFC) serves on the State ADRC Advisory Council. The ADRC state lead serves on the BSITFC Advisory Board in an effort to improve and expand services provided by the ADRCs.
- The Quality Improvement Organization (QIO) in Georgia, the Georgia Medical Care Foundation (GMCF), is a key partner in Care Transitions.
- The Georgia Hospital Association has a representative on the ADRC Advisory Board and is considered a key partner.
- Several of the local ADRCs have partnered with the Centers for Independent Living (CILs) in their areas.
- A representative from one of the CILs, Walton Options, serves on the State ADRC Advisory Council.
- Two AAA Directors serve on the State ADRC Advisory Council. The DAS considers each of the AAAs key stakeholders in all ADRC efforts.

Section III: Financial Plan – Resources to Sustain Efforts

What existing funds/programs are currently being used to carry out ADRC activities?

DAS received a legislation appropriation of $700,000 in 2007 for expansion of ADRCs and inclusion of partners in DBHDD. This funding continues to be allocated each year.

The DAS received the 2009 ADRC Expansion grant. This is a three-year award of $241,106 each year through 2012. Nine of the twelve areas received The Medicare Improvements for Patients and Providers Act funding in 2010. This is a two-year award in the amount of $220,954 each year. Each of the AAAs use multiple funding sources to support the Gateway/ADRC staff in the role of Information, Awareness, Assistance and Access. This includes:

- Home and Community Based Services-Community Based Services
- Community Care Service Program- Medicaid waiver
- Older Americans Act funding: Title III-E
- Older Americans Act funding: Title III-B
- Social Service Block Grants

What additional programs and service offerings are necessary to operate fully functional ADRCs across the state?

To serve all of Georgia's disability populations, the ADRCs must begin the process of including behavioral health resources and strengthening partnerships with organizations in each area. On the state level, DBHDD has acquired paid access to the ESP database for specific staff in their Behavioral Health (BH) Division who are working to transition clients from institutions to the community. DAS will be working with BH to provide training to the staff on the role of ADRCs and the importance of local partnering.

Specifically related to the fully functional criteria, the partnership with the state Medicaid agency, DCH, must continue for Georgia's ADRCs to be fully functioning.

What is your estimated cost to expand statewide (e.g., new MIS purchase)?

Statewide expansion is in place as of July 2010. All of the areas were using the ESP database and serving as the single point of entry for aging services prior to ADRC expansion. Currently the DAS database, AIMS, is expanding to include all assessments completed by Gateway/ADRC staff. These assessments are currently in the Client Health Assessment Tool (CHAT) which is not owned/operated by DAS. This transition is in the testing phase and will be fully implemented in July 2011. This is at no cost to the direct ADRC budget since the assessments must be completed as part of the Medicaid waiver program and the non-Medicaid Home and Community-Based Services.

How will you access the resources and create the revenue opportunities necessary for sustainable ADRC implementation on a statewide basis?

Each of the Resource Specialists in the local Gateway/ADRCs are working to identify and add private resources to the database. Currently the database has over 24,000

resources with 10,800 of these resources serving private pay individuals. This is an effort to continue to market the ADRCs to individuals seeking public and private resources.

Many of the local ADRCs are seeking partnerships with hospitals in their areas related to Care Transitions. These partnerships are viewed as opportunities to expand services to individuals in the communities, divert individuals from nursing homes and assist hospitals in meeting the expectations of CMS related to reducing the readmission rate to the hospital. It is anticipated that some of these partnerships will produce revenue for the local ADRCs.

The partnership with DCH where ADRCs are the LCAs is expected to create funding for staff positions and may result in future funding opportunities related to Options Counseling for individuals who are considering nursing home placement.

What are the estimated projected cost savings/offsets of having fully functional ADRCs statewide?

Through its ADRC, DAS has contracted with Georgia State University's Georgia Health Policy Center (GHPC) for several years to do a Fiscal Impact study for ADRCs. This study is comparing Medicaid costs in institutions versus Medicaid cost in the community in areas where ADRCs are serving and areas where they are not. This is prior to the 2010 statewide implementation. The goal of the study is to identify any differences in Medicaid costs related to the existence of an ADRC.

It is expected that areas with fully functional ADRCs, where individuals receive Options Counseling prior to nursing home admission, will be a cost saving to Medicaid due to individuals choosing to stay in their communities for longer periods of time. Results from using the ADRC Cost Offsets Calculator are below:

- 2011 projections for an estimated 1% of individuals screened remaining in the community- Total cost offsets **$3,619,031**; cost offsets for Georgia Medicaid **$1,254,718**
- 2015 projections for an estimated 2%* of individuals screened remaining in the community- Total cost offsets **$9,260,717** ; cost offsets for Georgia Medicaid **$3,210,691**

* This number could be significantly larger if Georgia's ADRCs begin screening all applicants for ABD Medicaid.

Emergency Preparedness Plans

The Georgia Department of Human Services Division of Aging Services emergency planning process begins with an external risk assessment focused on various human-made (i.e., bioterrorism) and natural (i.e., hurricanes, pandemic, or influenza) disasters, which identifies concerns for the community, our customers, and workforce. Preparation for disasters includes coordination with state agencies (i.e. Public Health Disaster Response, Georgia Emergency Management Agency), non-profit organizations (i.e. American Red Cross) and the Aging Network. DAS works together with these agencies and the Aging Network to facilitate the development and implementation of emergency and disaster preparedness and response plans for older adults and adults with disabilities. DAS collaborates with state agencies, partner organizations and the Aging Network to ensure disaster preparedness and response plans are actionable. During SFY11, DAS created a full time position to focus on disaster preparedness for the SUA.

The Georgia Emergency Management Agency (GEMA) is the lead organization in Georgia for disaster preparedness and response. GEMA develops and implements Georgia's Emergency Operations Plan (GEOP). This plan designates which agencies will take the lead in implementing the fifteen essential support functions (ESF) which are a part of every state's emergency operations plan. In the GEOP, DHS has the following responsibilities:

Primary Agency: ESF 6: Mass Care, Housing and Human Services

Support Agency:
- ESF 1: Transportation
- ESF 5: Emergency Management
- ESF 8: Public Health and Medical Services
- ESF 10: Hazardous Materials
- ESF 11: Agriculture and Natural Resources
- ESF 13: Public Safety and Security Services
- ESF 15: External Affairs

DAS, as a division within DHS, has a supporting function for the aforementioned ESFs. The purpose of a support function is to coordinate with the department, agency or office having the primary responsibility for each function. Support agencies meet with the primary agency and determine what type of support actions will be required during the preparation, response, and recovery stage of a disaster. Agencies develop detailed implementation procedures by which the office will be alerted and activated for 24-hour operations, if requested to do so by the primary agency.

During a disaster, GEMA opens and operates the State Emergency Operations Center. DHS then determines if the disaster requires the opening and operation of the DHS Emergency Operation Center (EOC). While in operation, the DHS EOC is staffed 24 hours a day by at least one representative of DAS. DAS representative serves as a liaison between the needs of the local AAA, older adults, and people with disabilities affected by the disaster and the responding emergency management officials.

DHS DAS maintains a Business Continuity Plan (BCP), which focuses on sustainability of operations during a disaster and preventive measures such as protection of data. The BCP ensures the agency will be able to resume critical business operations as soon as possible after a disaster. It also includes alternate worksites for Division staff through partnership with the AAAs.

To ensure DAS' ability to maintain business continuity in a disaster, DAS maintains an emergency preparedness guide, which includes call-down lists of DAS leadership team and staff and information for remote access to email, voicemail and internal websites. All field personnel are equipped with blackberries and either a laptop, tablet computer or the option to use their own personal home computers to connect to the Department's servers remotely through the internet.

DAS' top priorities during a disaster are individuals in public guardianship services, in which the Department of Human Services has been appointed guardian of last resort by the probate courts, and high risk clients receiving services either through Adult Protective Services or the AAA. Adult Protective Services has policies and procedures for all staff to follow to ensure the safety and well-being of wards and other high-risk clients prior to, during, and immediately after a disaster. The AAA and their providers have also developed policies and procedures to identify high-risk clients and facilitate the needs of these clients during a disaster.

DAS is a founding member of the Georgia Emergency Preparedness Coalition for Individuals with Disabilities and Older Adults (The Coalition). The Coalition began in June 2006 with three (3) organizations: Georgia Advocacy Office; GEMA; and DHR (now DHS), through its Division of Aging Services and Division of Public Health. As the Coalition identified the group's overall mission, stakeholder agencies were invited to join. The mission of the coalition is to serve as a comprehensive clearinghouse between local advocacy groups serving individuals with disabilities and older adults, and state agencies responsible for emergency preparedness and response under the Georgia Emergency Operations Plan (GEOP).

Current members of the Coalition are:
American Red Cross
Brain and Spinal Cord Injury Trust Fund
Disability Resource Group
Emory Center for Public Health Preparedness
Georgia Advocacy Office
Georgia Department of Human Services Office of Facilities and Support Services and Division of Aging Services
Georgia Department of Behavioral Health and Developmental Disabilities
Georgia Department of Community Health Division of Public Health Emergency Preparedness and Response
Georgia Emergency Management Agency
Georgia State Financing and Investment Commission
State ADA Coordinator's Office
Governor's Council on Developmental Disabilities

Southeast Disability and Business Technical Assistance Center
Southeast Americans with Disabilities Act Center
Statewide Independent Living Council
Georgia Department of Labor Tools for Life

The Coalition's current initiatives include:

1. Increase outreach to older adults and people with disabilities through:
    a. Development of an Emergency Preparedness training kit including checklists and power points for two target audiences:
        i. Persons with disabilities
        ii. First Responders and shelter workers
    b. The production of a monthly show entitled "Be Prepared" for Georgia Radio Reading Service members (who have low literacy or are visually impaired) featuring an interview with a representative from the Coalition for each show.
2. Assist American Red Cross to build the capacity of shelters to provide for those with special medical needs.
    a. Identify statewide resources for procurement and distribution of durable medical equipment for shelters.
    b. Development a plan that addresses the needs of people with a hearing impairment, including standards on the provision of sign language interpreters in a shelter.
3. Develop technical assistance (in the form of fact sheets, pamphlets, etc.) to coincide with events on the *Ready Georgia* Planning Calendar Observances.

At the local level, the AAAs take the lead in the development, revision and implementation of emergency preparedness and response plans for each planning and service area. Each AAA has developed a disaster plan for their area to be used when the situation warrants. Disaster plans are unique to each planning and service area. During SFY '11, DAS developed a standard template for the AAA disaster plans. The template is being utilized by the AAAs systematically to write their 2011 Disaster Plans, which are due to DAS, May 2, 2011, and will be approved by June 2011.

The AAAs focus for emergency preparedness is:

- Providing emergency planning and training in conjunction with emergency management officials, relief organizations, and other important partners to plan for the needs of older adults and people with disabilities during a disaster;
- Providing a process for identifying high risk clients and coordinating with local emergency management officials to ensure their safety;
- Ensuring each service provider has a current and comprehensive emergency preparedness plan addressing various emergency situations;
    - Have Nutrition Service Providers stock three (3) days supply of shelf staple meal supplies for home delivered meal consumers.
- Provide information, advocacy, communication, and outreach in the event of a disaster;
- Help older adults to be prepared for natural and man-made disasters by providing educational opportunities at senior centers for citizens and staff.

DAS and the AAAs participated in a GEMA hurricane drill during SFY '10 in which all AAAs were contacted regarding how they would respond using their disaster plan. After the disaster, the AAAs provided feedback regarding their performance. Participating in the disaster drill and the after action review allowed each AAA to assess the strengths and weaknesses of their disaster plan and implement changes accordingly.

In SFY '11, DAS conducted an Emergency Preparedness survey of its clients over the past year. A sample of 5,000 clients was surveyed and 1,660 responded, yielding a 33% response rate. The survey results gave DAS and the AAAs a better understanding of how clients interpret disaster preparedness. For example, one question asked, "How prepared do you feel you and your household are to handle a large-scale disaster or emergency" 66.3% of the clients responded that they feel either "well prepared" or "somewhat prepared" for an emergency or disaster. The next question, "Do you or your household have a disaster evacuation plan?" 63% of the clients responded that they do not have an evacuation plan. These two answers indicate an area of community education to focus on that disaster planning includes having an evacuation plan. The responses to survey questions provide direction for DAS and the AAAs disaster preparedness planning and education.

The disaster drill and client survey are a part of DAS efforts to evaluate the Aging Network's disaster plans and determine if current educational efforts are resulting in effective personal preparedness by clients. Over the next four years, DAS will focus on increasing the effectiveness of planning for disasters, strengthen working relationships with state level agencies responsible for disaster preparedness, and work with the Aging Network to increase the preparedness of older adults and people with disabilities.

Transportation Services for Older Georgians

How the Coordinated Transportation System Works

Georgia's Coordinated Transportation System is administered by the Transportation Services Section within the Department of Human Services Office of Facilities and Support Services (OFSS). This human services transportation system serves clients of the Department of Human Services Division of Aging Services, the Department of Human Services Division of Family and Children Services (DFCS) Temporary Assistance to Needy Families (TANF) program, and the Department of Behavioral Health and Developmental Disabilities. The Coordinated Transportation System also serves some consumers of the Department of Labor's Vocational Rehabilitation Services program. Non-emergency transportation (NET) to Medicaid recipients is provided by the Department of Community Health (DCH), and the Department of Transportation (DOT) administers public transportation services to the general public.

DHS divides the state into 12 regions, with each region having a Regional Transportation Coordinating Committee (RTCC) and a Regional Transportation Office (RTO) that serves as the transportation focal point within that region. The Department's regions align with the Division's designated PSAs to promote more effective

coordination. The RTOs are responsible for monitoring transportation providers' performance and contract compliance, which is tied to the use of a Purchase of Service Agreement System within each region. Transportation providers are a mix of governmental entities, for-profit companies, and private nonprofit organizations. In many regions, a prime contractor, such as a Regional Commission (RC), provides overall contract management in coordination with the RTO. Subcontractors of the Prime Contractor provide actual transportation services.

Plans for Filling the Gaps

The aging and disabilities network will continue to participate in the DHS Coordinated System and advocate for the development of strong regional transportation services. In addition to those efforts, the network will perform the following activities to improve transportation access for older adults and people with disabilities:

Statewide initiatives:

Transportation Investment Act of 2010: The DHS DAS is collaborating with public agencies, nonprofits, and businesses in support of Georgia's Transportation Investment Act of 2010, a law that sets a framework for more deeply coordinated regional approaches to transportation planning. The act, which covers both roads and transit, promotes innovation and high levels of community involvement. Roundtables of locally elected officials will collect and review transportation projects for potential funding, and, in 2012, residents in each community will vote to approve a special purpose local options sales tax to fund initiatives.

The Georgia Fund for Children and Elderly: Georgia taxpayers may use this income-tax check-off option on state returns to donate personal funds toward senior transportation, home-delivered meals, and children with special needs. The resulting funds, which are evenly split between aging and youth causes, help the Aging Network provide additional human services trips to older adults. Currently, the fund channels over $170,000 to aging transportation and home-delivered meals budgets. Through collaborative promotions with other tax check-off participating organizations, the DHS DAS will work to substantially increase the size of the fund.

Volunteer Driver Programs: The Aging Network will not only strengthen formal transportation services; it will also seek to close gaps through volunteer mobilization. DAS is adapting state and national resources for use in Georgia and will help local coalitions develop volunteer driver programs to supplement human services and public transportation systems. The resulting network of volunteer driver programs will serve as a conduit for spreading best practices, launching

peer mentorship activities, and promoting regional approaches to grant funding.

Region-specific initiatives:

Coordination & Supplemental Funding
The Georgia Transportation Investment Act of 2010 will result in significantly higher levels of coordination among public agencies. In addition to that statewide effort, AAAs are pursuing the following activities: centralized trip planning (Southwest Georgia), rider usage of computerized Smart Cards (Northwest Georgia, Atlanta Regional Commission, Northeast Georgia, Coastal Georgia); and full integration of senior transportation issues into local economic development planning (Northeast Georgia, Central Savannah River Area).

Quality Improvement and Resource Maximization
Several AAAs are committing to developing new initiatives and making the most of existing transportation resources. All PSAs conduct customer satisfaction surveys, including three (Atlanta Regional Commission, Southern Georgia, and Three Rivers/Southern Crescent) that will track customer responses to improvement efforts during the planning cycle. Increasing service dollars' impact is another strong trend. AAAs, such as Heart of Georgia, will implement measures to decrease "no shows," while River Valley will use promotions, tracking, and solution-building to increase the number of trips that riders use in the region.

Driver Assessments, Mobility Management, and Travel Training
As Georgia's Older Driver Task Force has observed, transportation decisions can set off a spectrum of major changes within one Georgian's life. The Coastal Georgia AAA and others will collaborate with the DHS DAS and the Georgia Chapter of the Alzheimer's Association to offer driver assessments to people at risk for Alzheimer's disease. When a driving cessation decision becomes necessary, individuals and their families need strategies for finding and choosing available transportation resources. The CSRA AAA will address this need by including mobility management in its expanded definitions of transportation services. The Atlanta Regional Commission (ARC), as part of its ambitious five-part senior mobility plan, will help older adults familiarize themselves with public transit options through travel training initiatives.

Transportation Vouchers, Volunteer Drivers, and Carpools
In 2012, the Three Rivers/Southern Crescent AAA will establish a voucher program to be managed at the senior center level and funded through the DHS Coordinated Transportation program. ARC will build on the success of four existing voucher programs by expanding the project within those counties and launching it in others. ARC will employ the same strategy with volunteer driver programs, using two existing faith-based programs

as models for a Metro Atlanta lifelong community initiative. The Senior Pool Carpool program, which helps senior center participants set up ride sharing arrangements, is another promising development in the region.

Walkability
AAAs are also addressing transportation needs within the broader mobility contexts, such as pedestrian access, safety, and the proximity of older adults to vital services. The CSRA will collaborate with the Georgia Health Sciences University to organize workshops, newsletters, and phone outreach to determine the impact of neighborhood revitalization on physical activity in a downtown neighborhood. ARC's new Walkable Community Tool, which includes a pedestrian safety assessment, will be used in lifelong community initiatives to measure safety, convenience, and other key livability factors.

DAS, AAAs, providers, and partners are committed to sharing lessons learned and building upon successes fueled by Georgia's Transportation Investment Act of 2010, a groundbreaking law that is now in early implementation stages. Through this new power of collaboration and regionalism, Georgia's Aging Network will connect older adults and people with disabilities with an unprecedented range of options in public and private transportation, walkable environments, and mobility information tools by the conclusion of 2015.

Aging Information Management System (AIMS)
NAPIS Data Collection

The Aging Information Management System (AIMS) is the web-based, consumer-centered tracking, accountability and payment system that documents all aging services contracted between the Division of Aging Services, the twelve (12) Area Agencies on Aging (AAAs), and the network of contract service providers. AIMS is a relational database, maintained on an Oracle platform, that provides for centralized data collection regarding planning and contracting, authorizing providers and services, tracking client data, and generating programmatic data that drives reimbursements for AAAs and service providers.

AIMS is developed and maintained by the Georgia Department of Human Services Division of Aging Services and the DHS Office of Information Technology (OIT) with assistance from our partners - the AAAs and Aging Network providers. This system enables consumers and payments for all programs and services to be tracked over time and indicates how the aging network can more effectively and efficiently serve consumer needs. AIMS data is utilized to provide State Program Reports (SPR) data for Title III and VII services of the Older Americans Act which is a component of the National Aging Program Information Systems (NAPIS).

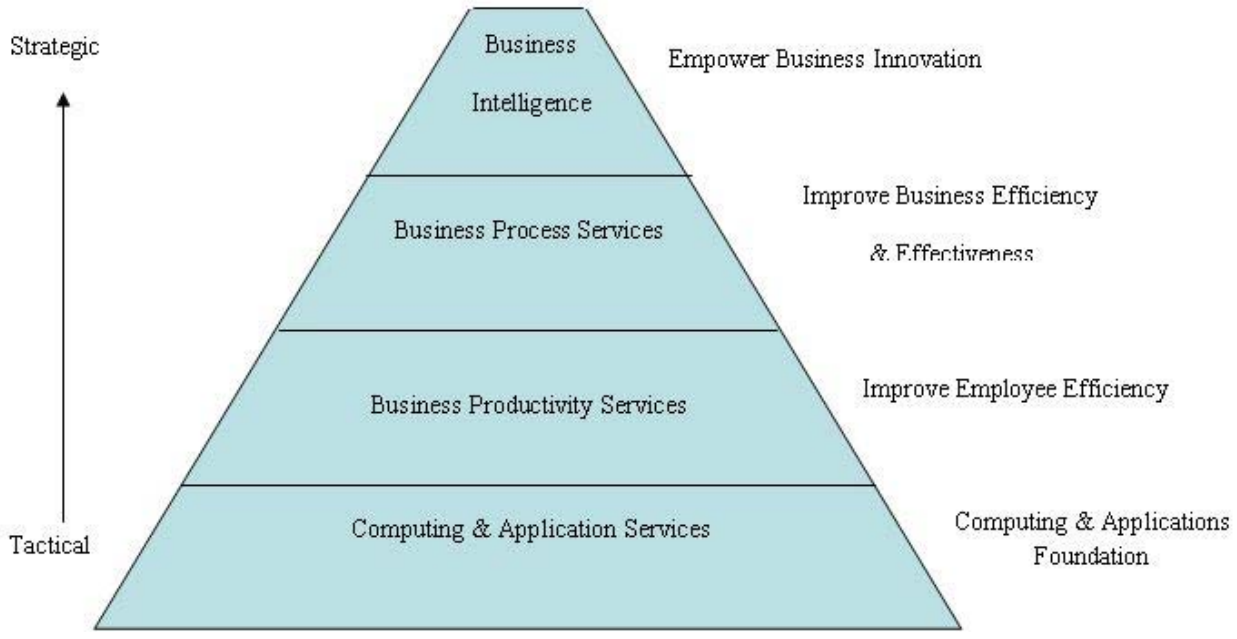
AIMS, nationally recognized as one of four (4) best practice system models by the National Association of State United for Aging and Disabilities (NASUAD), enables the

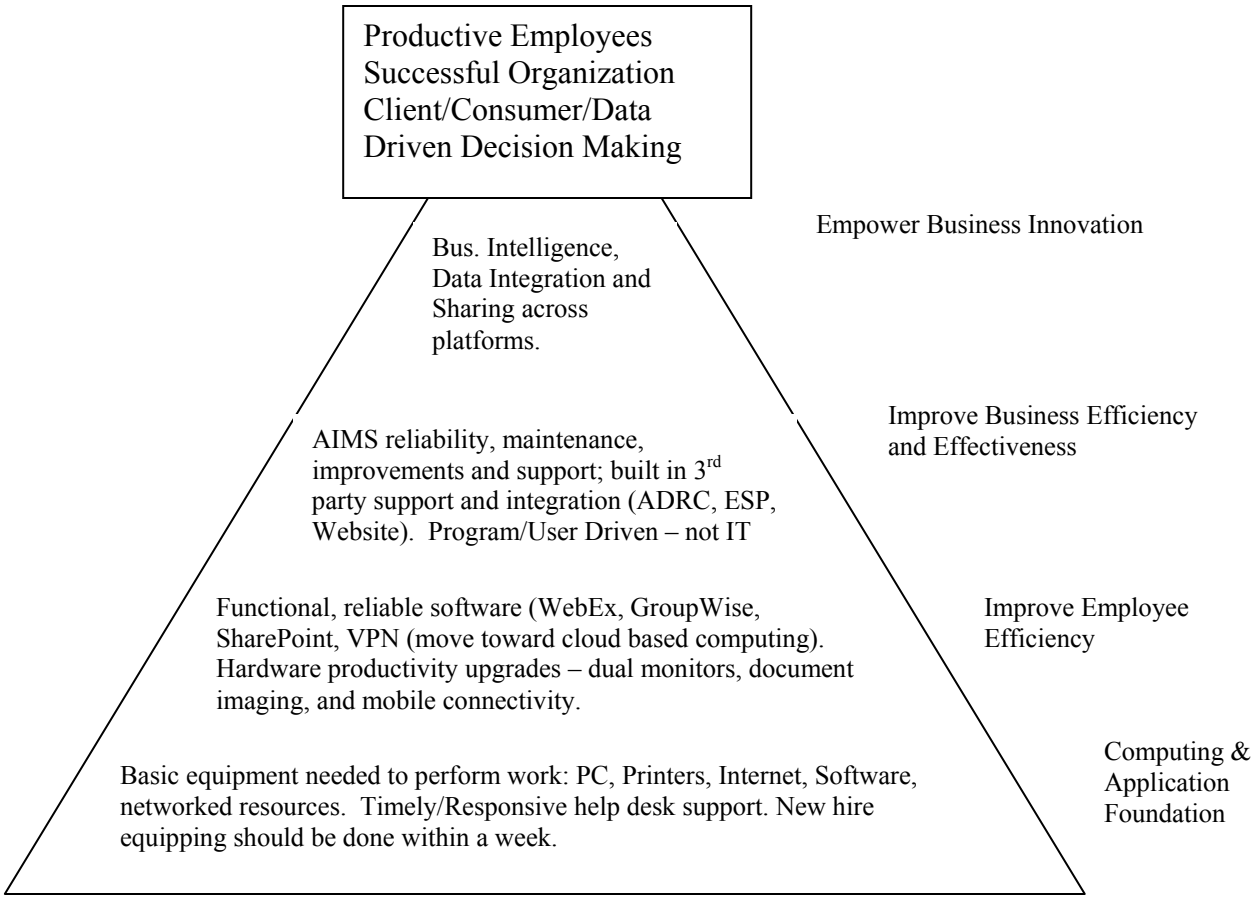
Division to manage the Aging Network by using data to provide positive outcomes for Georgia's growing senior population.

Technology

Per the Baldrige Criteria, efficient and effective work systems coordinate internal work processes and external resources necessary for an organization to develop, produce, and delivery quality products to customers to succeed in the marketplace. DAS continues to advocate for information technology that provides accuracy, integrity and reliability, timeliness, and security and confidentiality. The IT Hierarchy of Needs categorizes projects and investments into a four level progression:

- Tier 1: Computing and Application Services - a highly available, secure and scalable IT services infrastructure forming the foundation for growth, performance and reliable computing services
- Tier 2: Business Productivity Services - deliver to employees the basic tools needed to communicate and collaborate
- Tier 3: Business Process Services - automate key workflows and gather information about the business
- Tier 4: Business Intelligence Services – leverage information and corporate knowledge to measure performance, aid decision making, and drive competitive advantage.





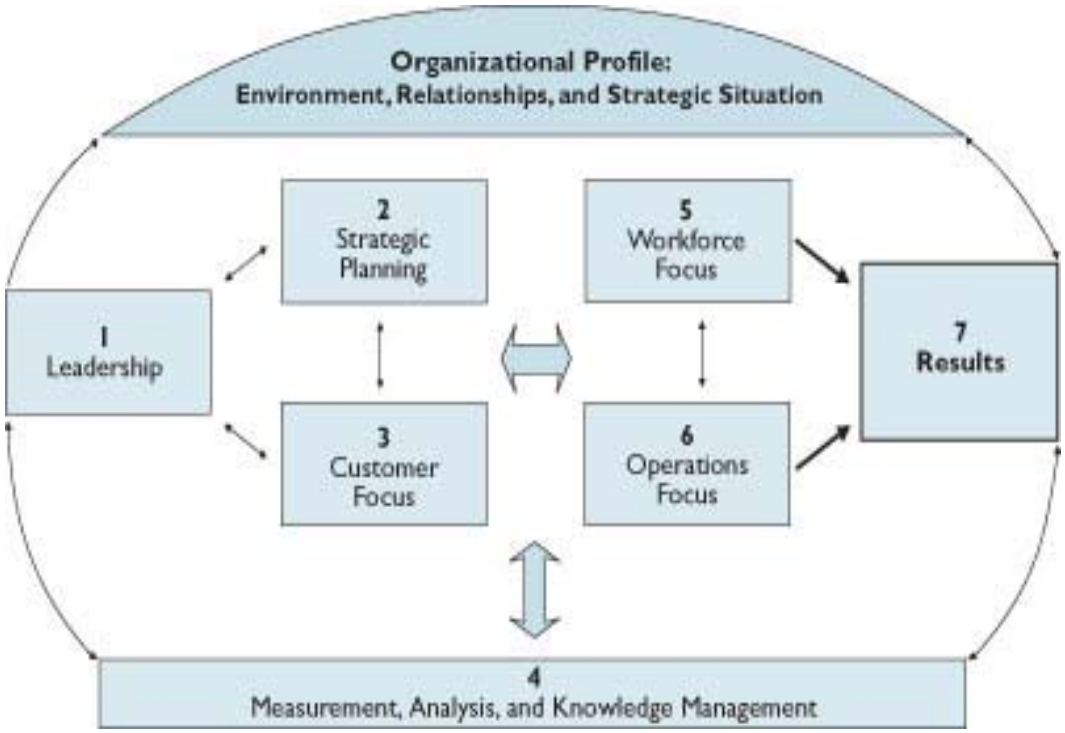
Baldrige Criteria for Performance Excellence

The Baldrige Criteria for Performance Excellence assists in providing an integrated approach to organizational performance management that results in delivery of ever-improving value to customers and stakeholders, contributing to organizational sustainability; improvement of overall organizational effectiveness and capabilities; guidance of organizational planning and opportunities for learning; and improvement of organizational performance practices, capabilities, and results by managing using data.

The Baldrige Criteria for Performance Excellence are built upon a set of eleven core values and concepts that are critical for successful organizations of any size and in any sector. They are the foundation for integrating key business requirements within a results-oriented framework that creates a basis for action and feedback. These core values and concepts are indicated below.

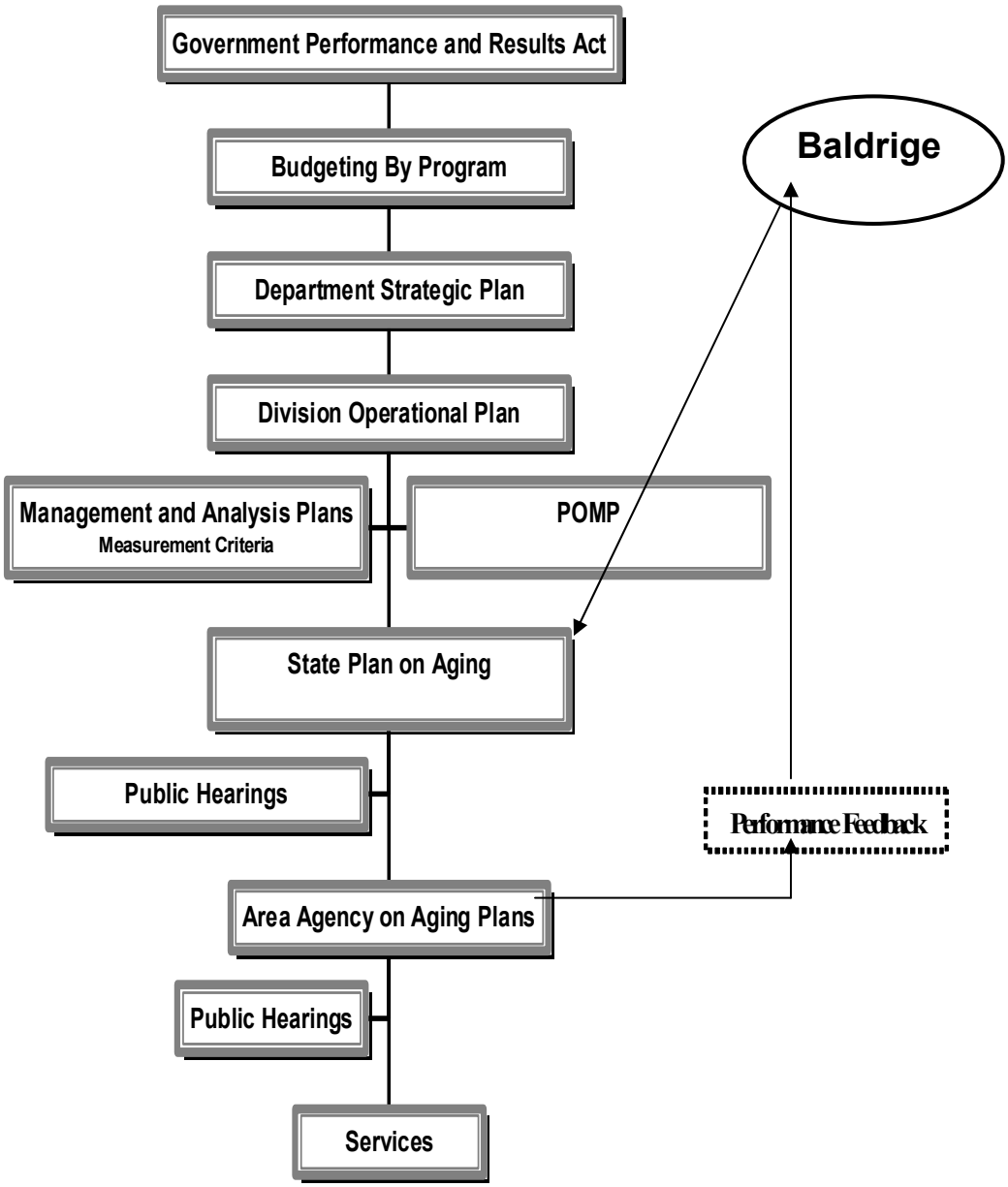
- Visionary Leadership
- Customer-Driven Excellence
- Organizational and Personal Learning
- Valuing Workforce Members & Partners
- Agility
- Focus on the Future
- Managing for Innovation
- Management by Fact
- Social Responsibility
- Focus on Results & Creating Value
- Systems Perspective

The Baldrige framework consists of a 1,000 point assessment of 7 categories, including an Organizational Profile which encompasses an overview of the organizational environment, which may consist of environmental scan and strengths, weaknesses, opportunities and threats (SWOT) analysis, strategic advantages and challenges, and organizational relationships.



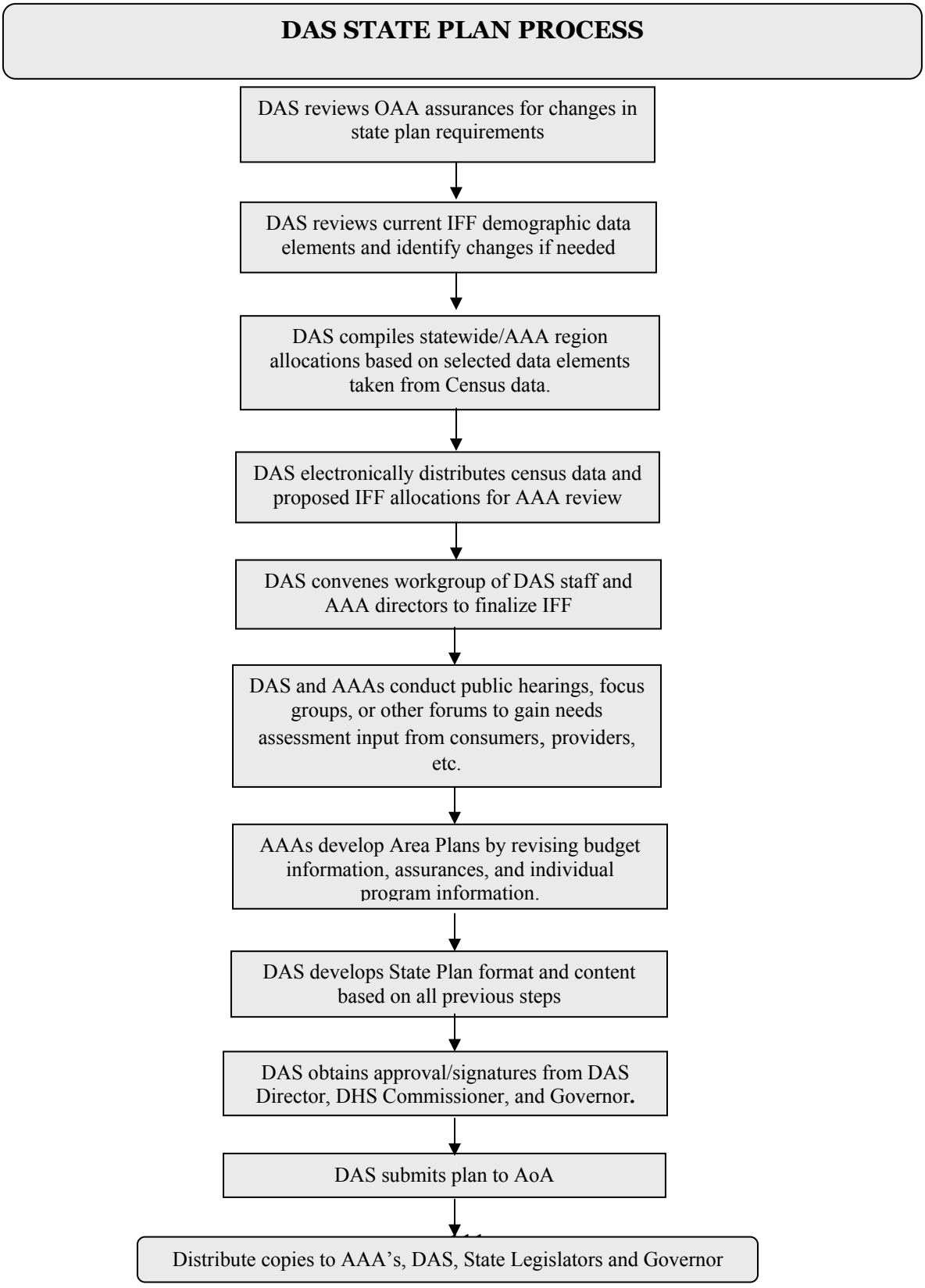
The flowchart below describes the key elements in the Division of Aging Services' planning process.

Division of Aging Services
Key Elements in the Planning Process



State Plan Development Process

The flowchart outlines the State Plan Development process utilized by the Georgia Department of Human Services Division of Aging Services.



Performance Outcomes Measurement Project

The Performance Outcomes Measures project (POMP) helps States and Area Agencies on Aging assess their own program performance, while assisting the Administration on Aging to meet the accountability provisions of the Government Performance and Results Act (GPRA) and the Office of Management and Budget's (OMB) program assessment requirements. Through annual performance reports, federal agencies provide detailed information on their progress in meeting program performance objectives. Program performance also supports budget decisions.

Next Generation: Performance Outcome Measurement (POMP)

This project will encompass the developmental and planning work for Next Generation: POMP and the development and preparation of the "POMP TO GO" generic toolkit. It will continue to enhance performance measurement capability throughout the Aging Network. The Next Generation: POMP project includes the following four performance measurement topics:

1. The development and preparation of the toolkit "POMP TO GO," along with the redesigned POMP website, which will provide user friendly performance measurement survey tools for the network. The "POMP TO GO" will provide a protocol to be used for the future dissemination of more sophisticated POMP methodologies.
2. The development of longitudinal survey instruments by using standard POMP surveys to identify performance data likely to show meaningful change over time.
3. The review of the synthesis of nursing home predictors identified in Advanced POMP and the development of a specific strategy for cross-validating the "generic" model.
4. The identification of key variables across earlier POMP surveys for consistency and likelihood of nursing home predictive value.

APPENDIX D

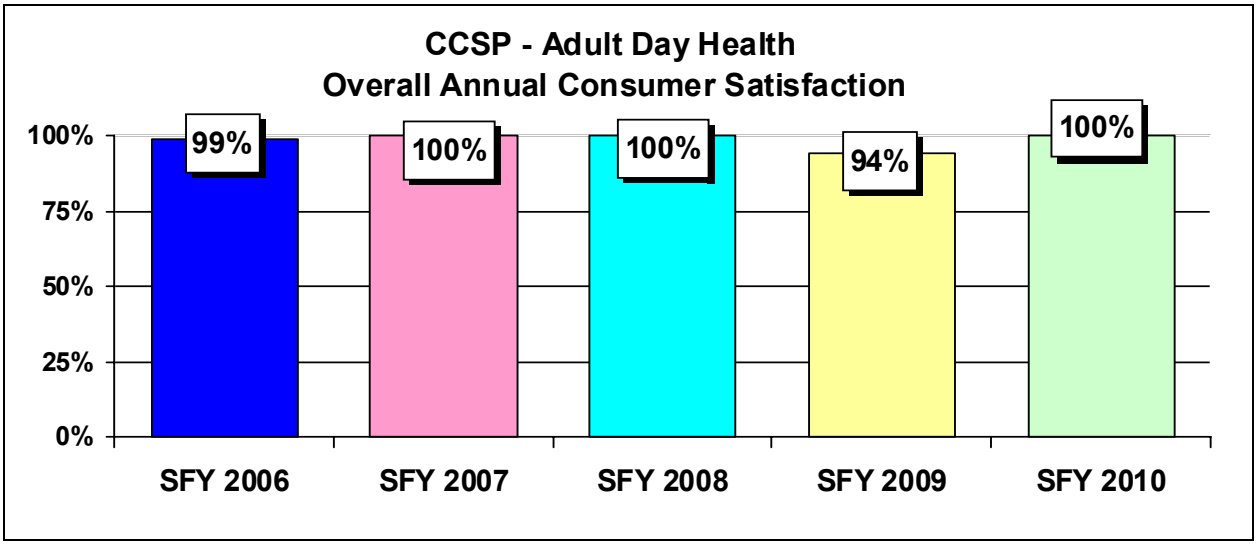
Program Integrity Monitoring Results

Note: All consumer satisfaction survey data collected and reported by the Georgia Area Agencies on Aging (AAA) are labeled as such. Not all AAAs surveyed all services.

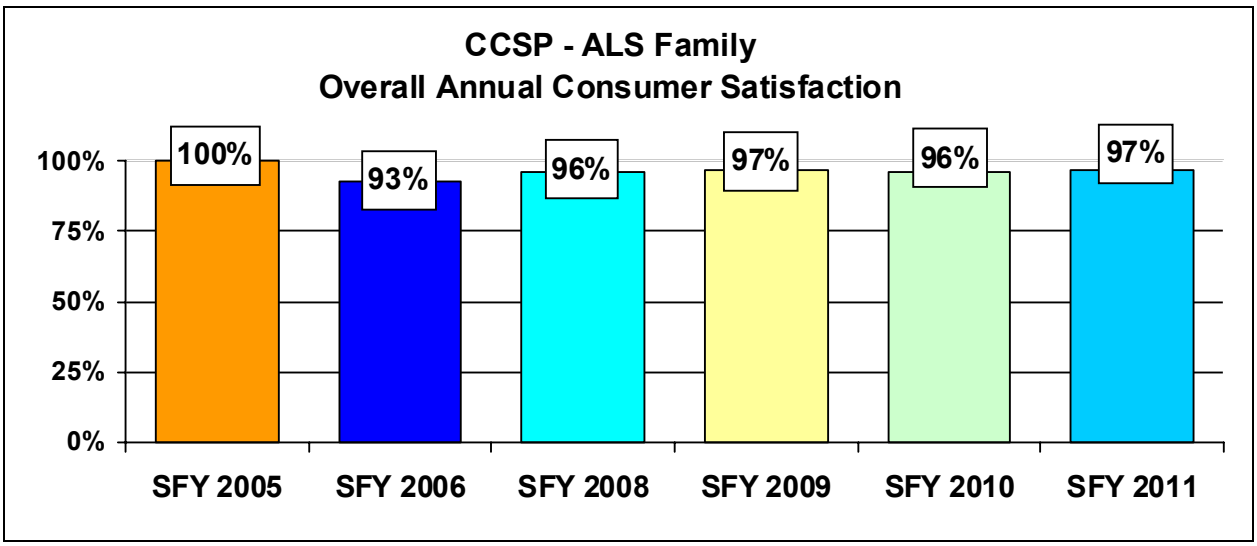
The Program Integrity (PI) section provides programmatic oversight of the Area Agencies on Aging (AAAs), quality assurance, data analysis, research and evaluation, and compliance monitoring for DAS. Below are results from state and AAA surveys conducted by PI.

Community Care Services Program (CCSP)

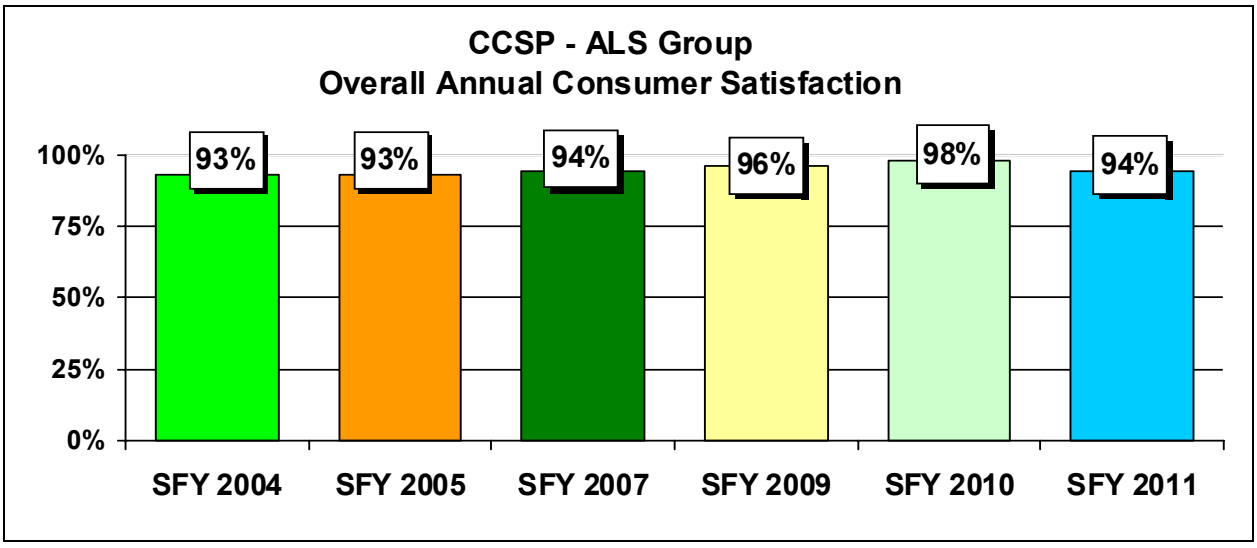
CCSP provides home and community based Medicaid services to nursing home eligible consumers. Georgia's CCSP is noted as one of the most cost effective Medicaid waiver programs, when compared to similar Medicaid waiver programs, in the Southeast.



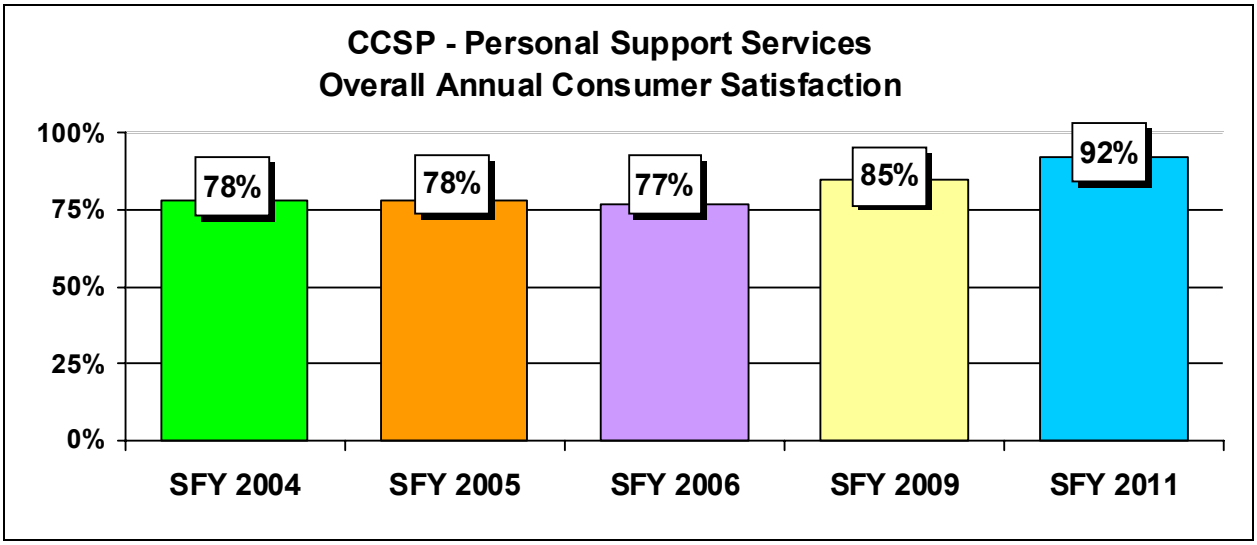
Overall Consumer Satisfactions scores in Adult Day Health are based upon the provision of social, health and rehabilitative daytime services in a community-based, medically supervised, protective, congregate setting for functionally impaired individuals who are at risk for institutionalization. The components of these scores include nursing and medical social services, skilled therapies, assistance with the activities of daily living, therapeutic activities, food services, transportation, education of caregivers, emergency care and preventive and rehabilitative services.



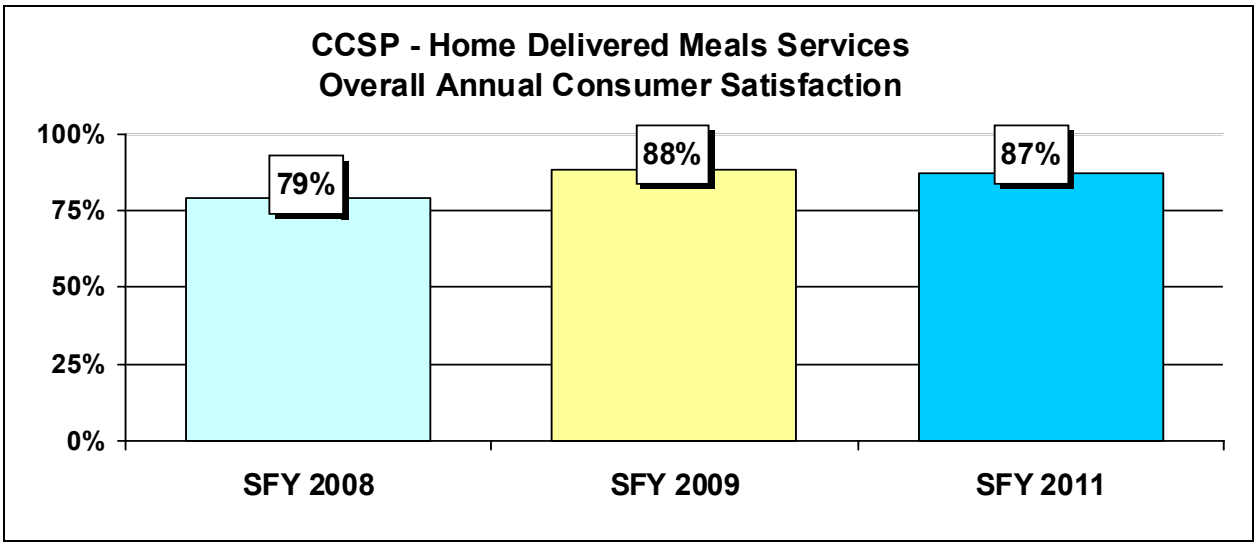
Alternative Living Solutions – Family Model is the provision of twenty-four hour supervision, medically oriented personal care, periodic nursing supervision, and health related support services in a residential setting other than the consumer's home. This service is provided through state licensed personal care homes with the Family Model specifically licensed for 2 - 6 residents.



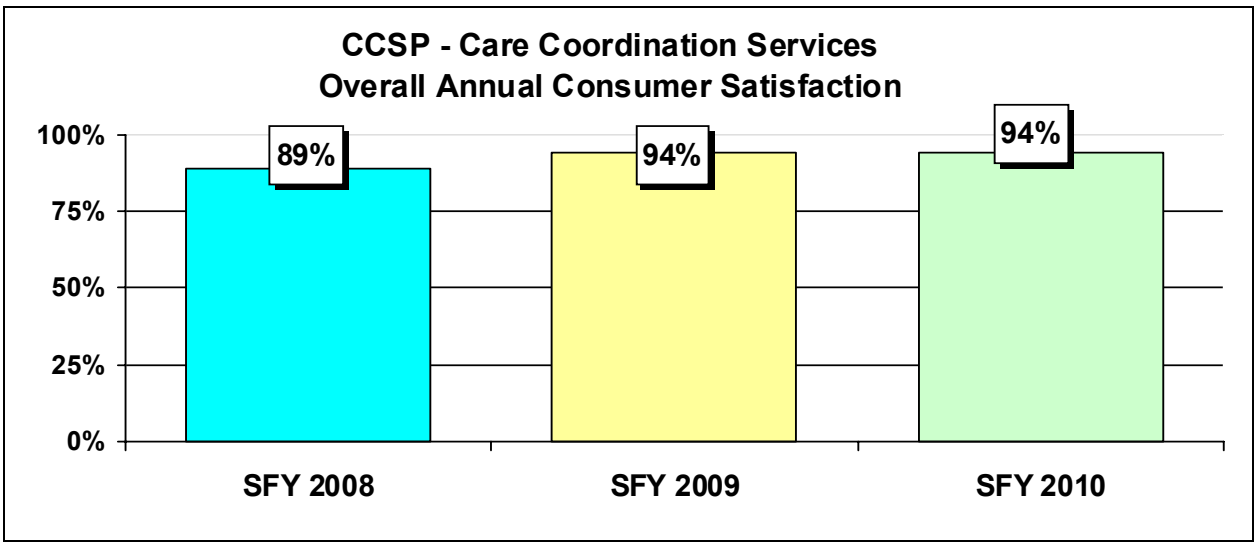
The Alternative Living Services – Group Model is the provision of twenty-four hour supervision, medically oriented personal care, periodic nursing supervision, and health related support services in a residential setting other than the consumer's home. This service is provided through state licensed personal care homes with the Group Model carrying a license specific for 7 - 24 residents.



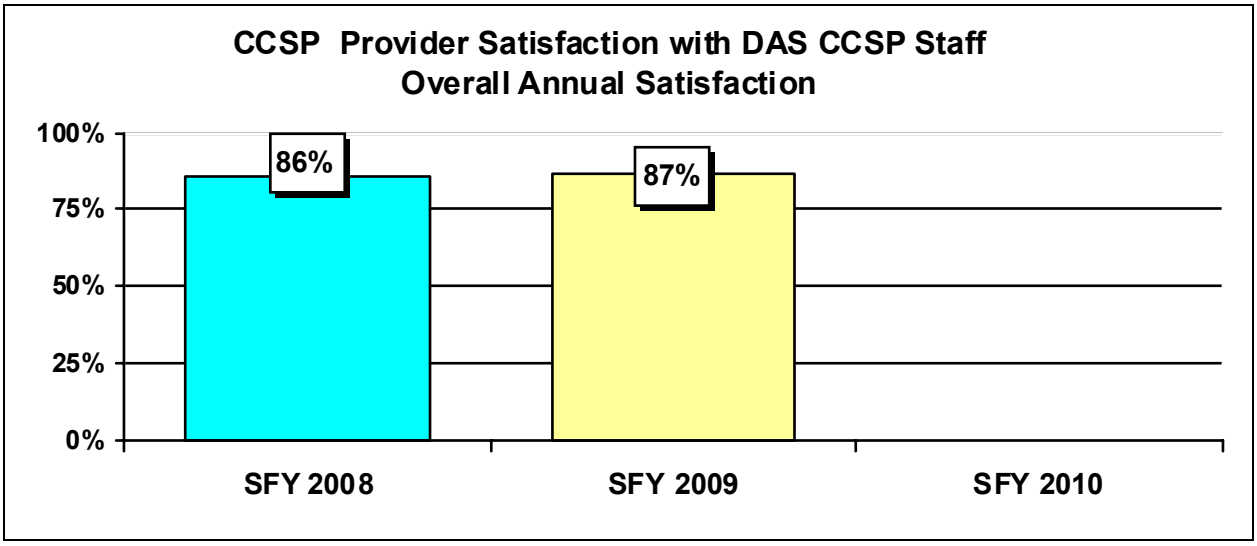
Personal Support Services(PSS) is the provision of personal assistance, standby assistance, supervision or cues for functionally impaired persons with the inability to perform at least one Activity of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLS). Tasks provided by staff provide PSS include: meal preparation, hygiene, nutrition, light housekeeping, shopping and other support services.



HDM ensures improved nutrition to enhance consumer health and well-being. Consumers may receive home delivered meals only in conjunction with another CCSP service.



Care Coordination provides accurate, up-to-date information about community resources and support to CCSP consumers, their families, and their caregivers.



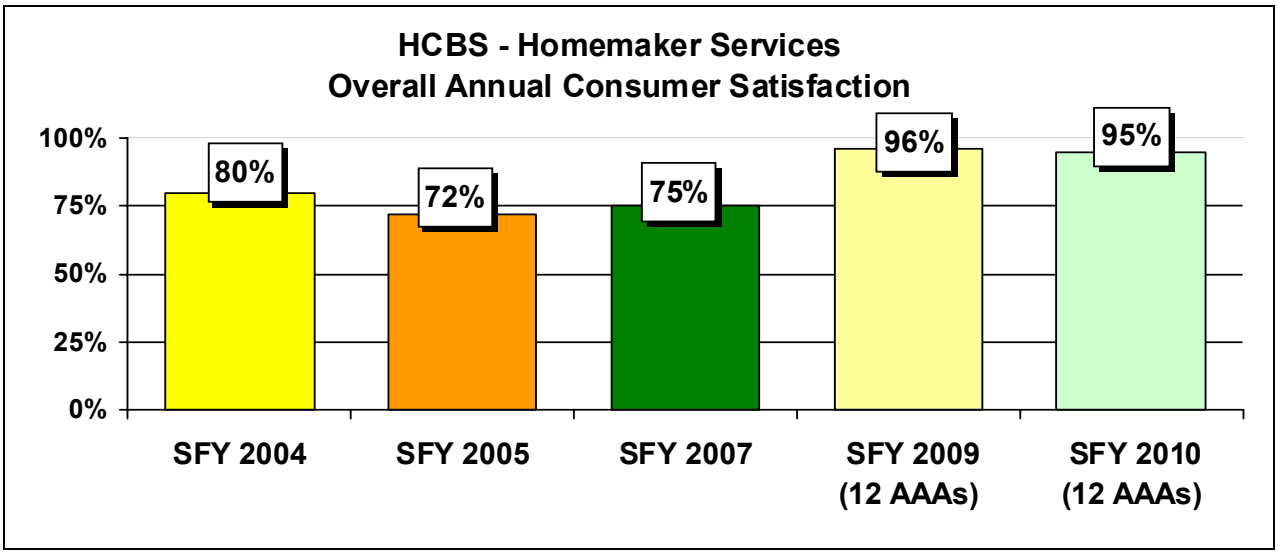
- In SFY09, CCSP providers rated their satisfaction with Care Coordination Agencies and indicated an 89% satisfaction rate. Care Coordination Agencies are the conduit to the provision of twenty-four hour, seven days per week availability to medically impaired individuals and their families. These agencies, located in every PSA determine service needs and outcomes, plan, arrange, coordinate, monitor and evaluate services, communicate with medical professionals and refer to community resources as appropriate.

- In SFY10, CCSP conducted an overall satisfaction survey with Consumer-Directed Option of Personal Support Services. Respondents indicated a 100% satisfaction rate. Consumer Directed Option PSS clients who are eligible and choose to participate in Consumer-Directed Care are assigned the tasks and duties of employer and participate in care planning, service budgeting, selection, employment, and training of the caregiver(s) of choice. As employer of his/her personal support aide(s), the client will assume all responsibilities for hiring, training, supervising, and scheduling services within the framework and budget of the comprehensive care plan.

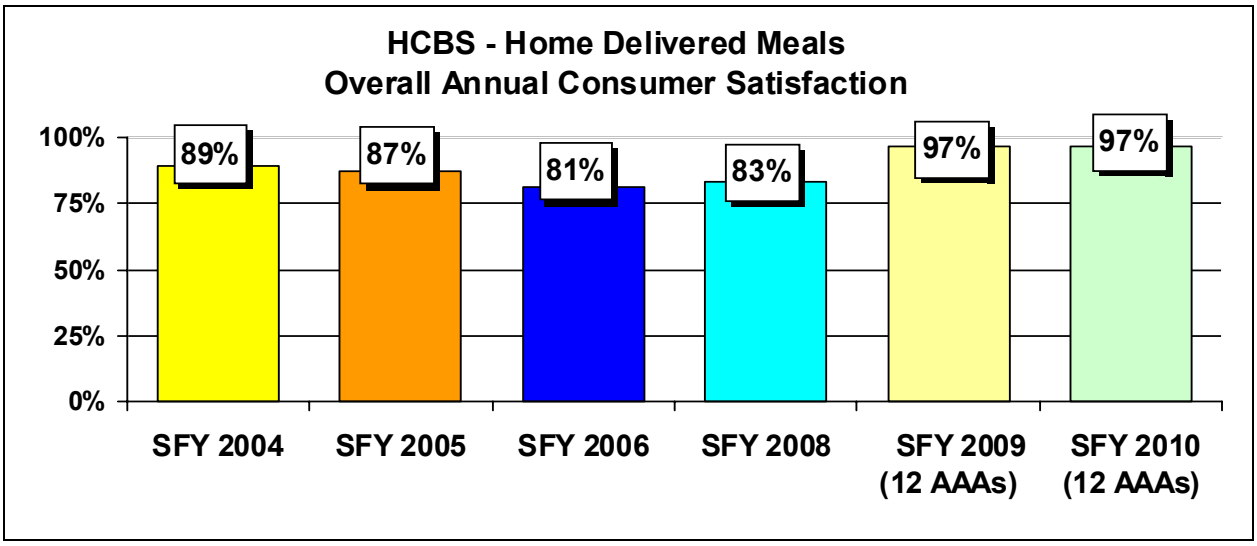
Home and Community Based Services

Home and Community Based Services (HCBS) provides 47 individual and group services to support and assist older Georgians in staying in their homes and communities. These services include Personal Care, Homemaker, Chore, Home Delivered Meals, Adult Day Care, Case Management, Congregate Meals, Nutrition Counseling, Assisted Transportation and other supportive services.

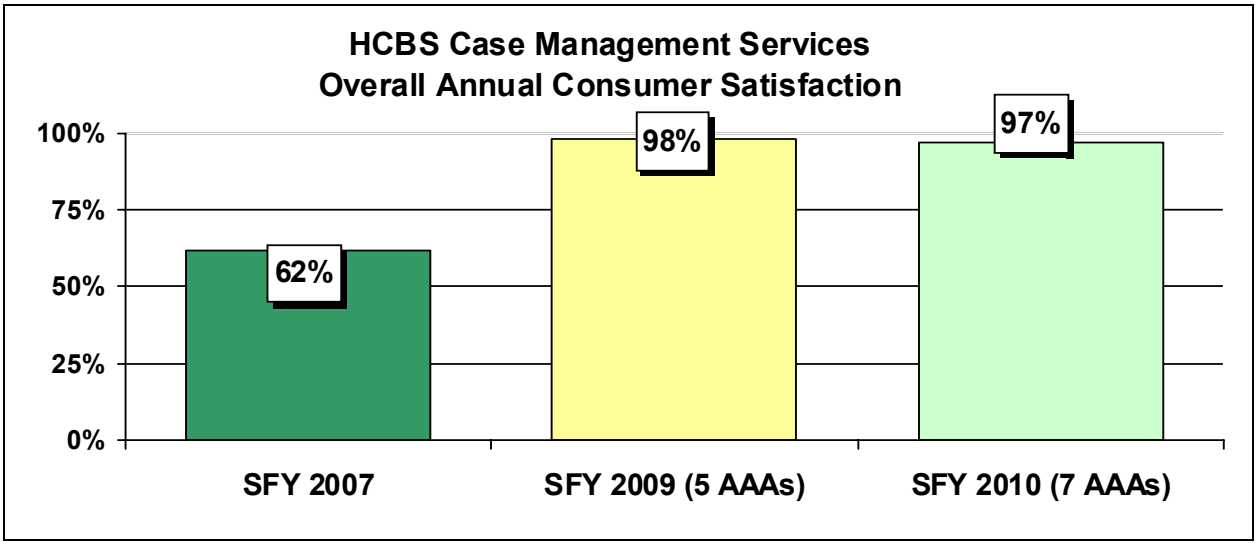
Note – Some HCBS services were surveyed at the state and AAA level. Graphs indicating the number of AAAs in parenthesis were surveyed at the local level.



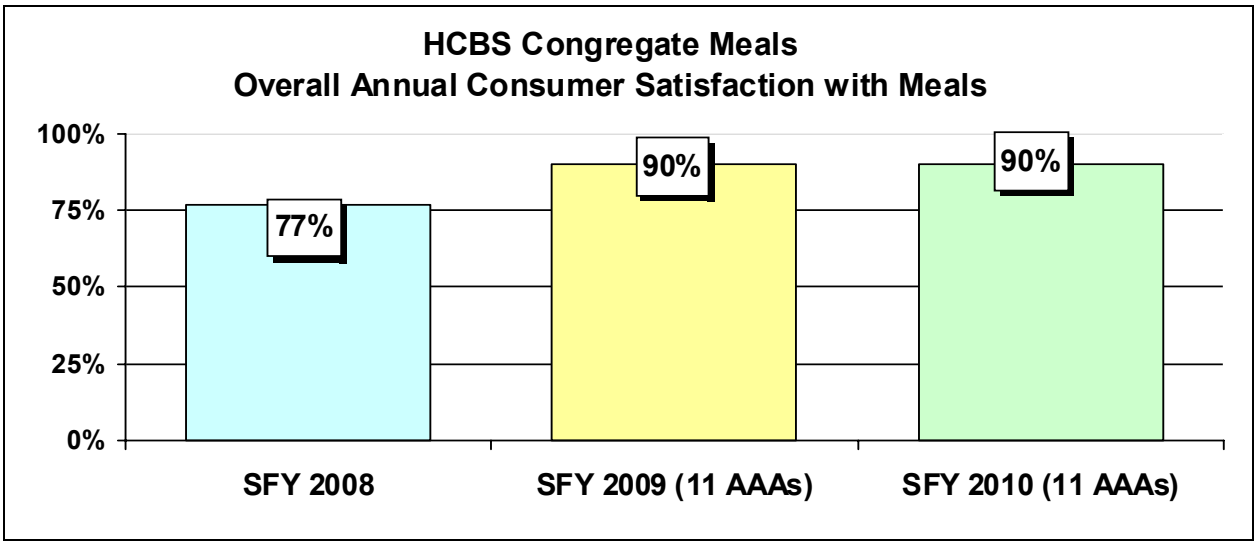
Homemaker Services provides assistance to individuals unable to perform one or more of the following Instrumental Activities of Daily Living (IADLS): meal preparation, shopping for personal items/groceries, managing money/bill paying, using the telephone, light housework.



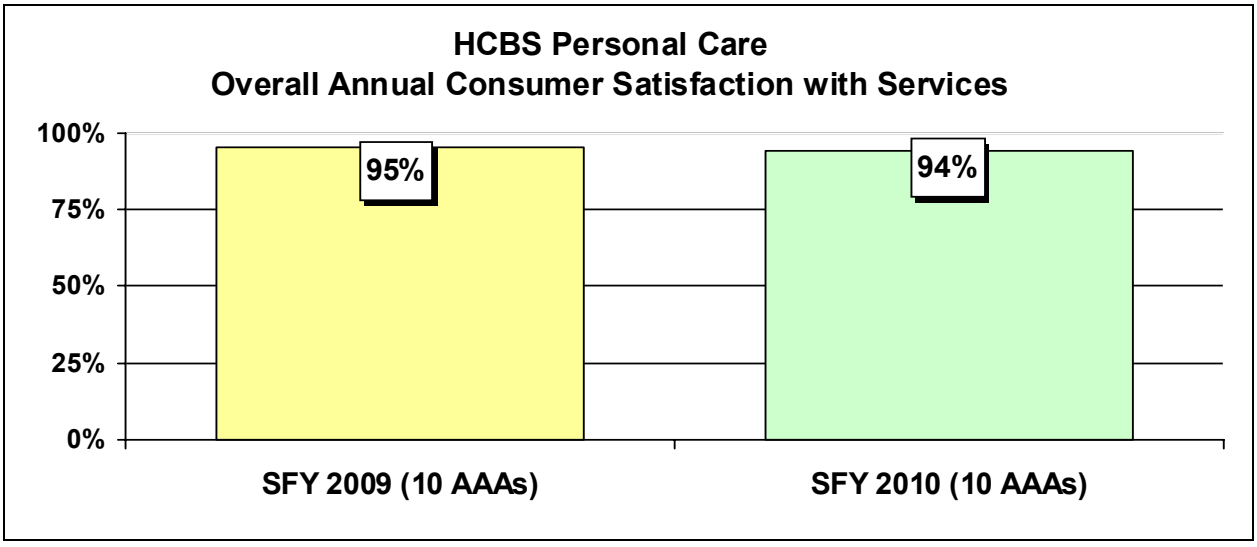
Home Delivered Meals service is the provision of a meal to a qualified individual in his/her place of residence. The meal, which provides 1/3 of the recommended daily nutritional allowance is served in a program administered by SUAs and/or AAAs, which meets all of the requirements of the Older Americans Act and State/Local laws.



Case management services include the provision of needs assessments, development of care plans, coordination of services available in the community, follow-up, and reassessment.

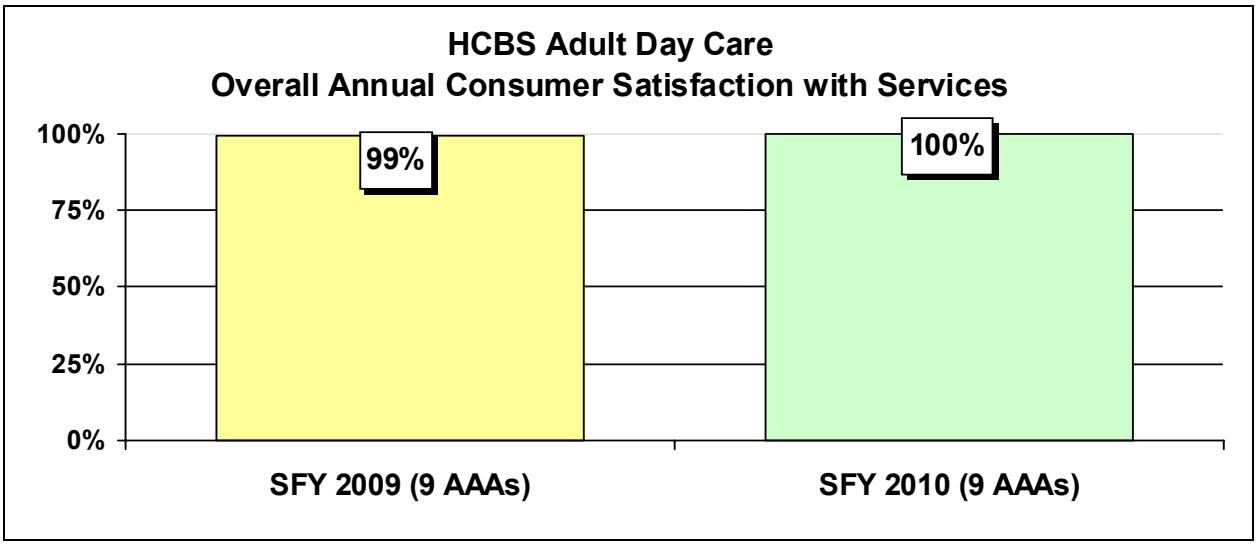


Congregate meals are meals provided to a qualified individual in a congregate or group setting. The meal as served meets all requirements of the Older Americans Act and State/Local laws.

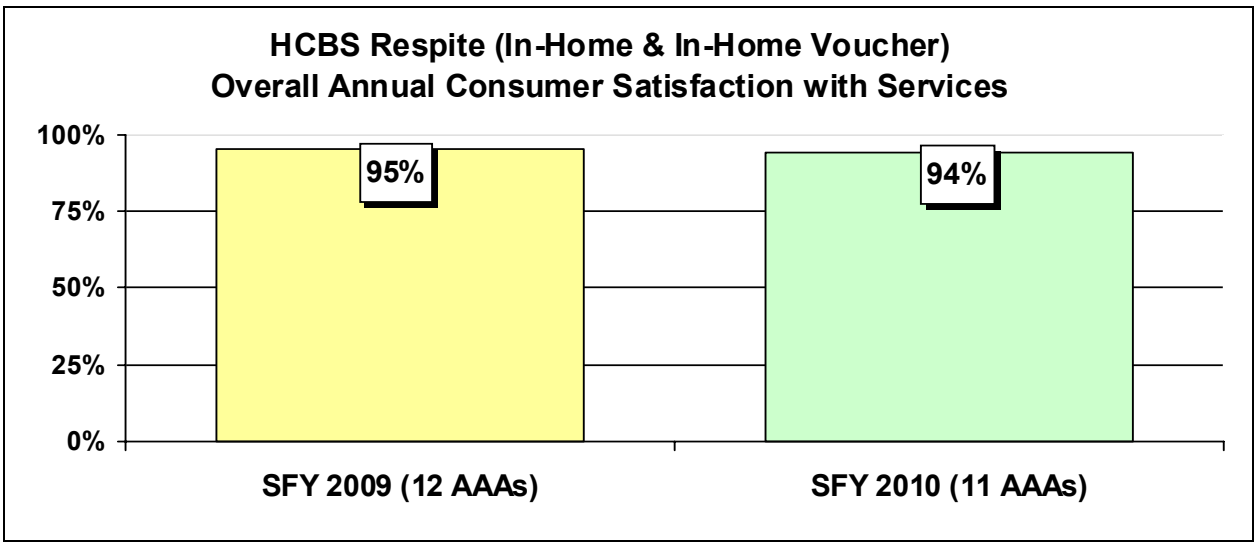


Personal Care is the provision of personal assistance, stand-by assistance, supervision or cues. (NAPIS_5_2007).

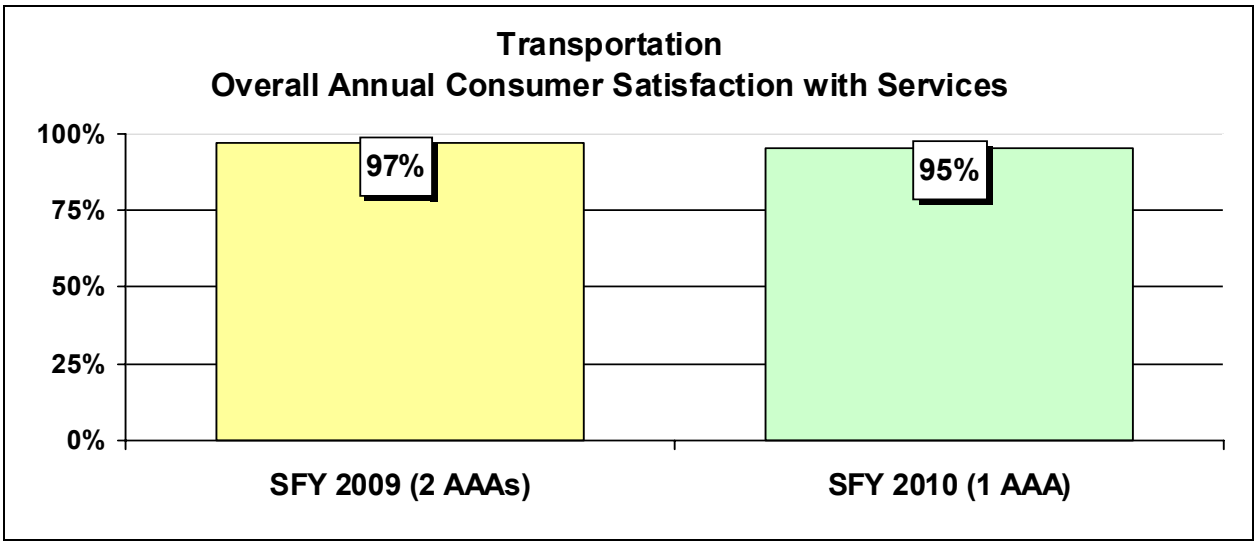
Personal Support Services(PSS) is the provision of personal assistance, standby assistance, supervision or cues for functionally impaired persons with the inability to perform at least one Activity of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLS). Tasks provided by staff provide PSS include: meal preparation, hygiene, nutrition, light housekeeping, shopping and other support services.



Adult Day Care is the provision of personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care typically include social and recreational activities, training, and counseling. Staff that travel from a central location on a daily basis to various sites, primarily, but not limited to rural areas may provide Mobile Day Care services.



Respite (both In home and In-Home Voucher) Services offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care includes: In-Home Respite (personal care, homemaker, and other in-home respite).

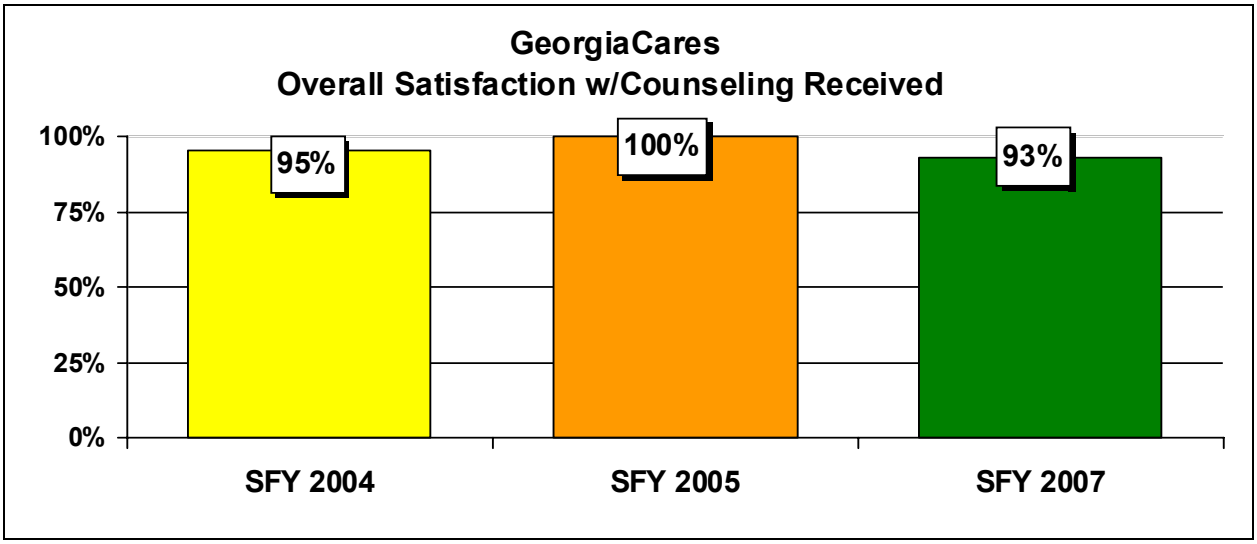


Transportation services provide a means of conveyance from one location to another. This service, and the satisfaction scores above, does not include any other activity.

- In SFY10, a Senior Farmers Market Nutrition Program (SFMNP) Consumer Satisfaction Survey with Services was deployed and respondents indicated a 95% overall satisfaction rate. SFMNP benefits are issued to eligible seniors to use to purchase fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs at authorized farmers' markets, roadside stands, and community supported agriculture programs.

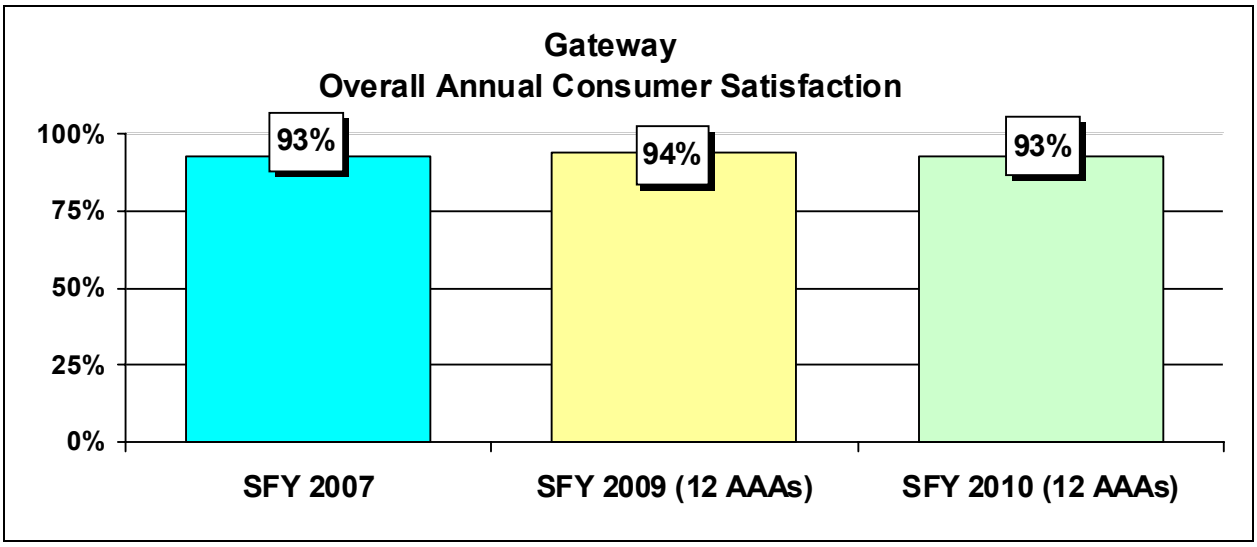
Access to Services

The Access to Services Programs coordinate with other elder rights programs statewide to help older Georgians understand and exercise their rights, exercise choice through informed decision-making, benefit from support and opportunities promised by law, maintain autonomy consistent with capacity, and resolve grievances and disputes through appropriate representation and assistance.



The GeoriaCares Program provides information to individuals regarding their eligibility for Medicare and Medicaid benefits and providing one-on-one assistance with pursuing claims or benefits and advocacy on behalf of the beneficiary.

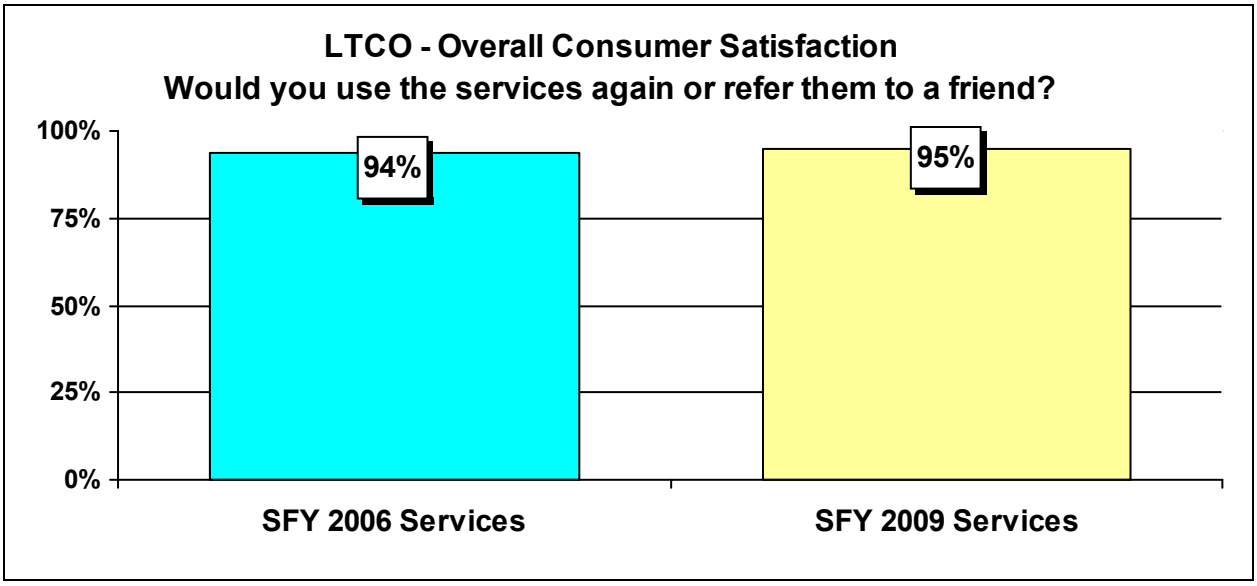
Gateway Services



The Gateway/ADRC provides older persons, individuals with disabilities, and/or their family members or other caregivers, efficient access to needed services. Gateway/ADRC counselors screen for individual needs, maintain wait lists for services; target resources so that persons most in need receive assistance; and establishes the Area Agency on Aging (AAA) as the source of information and assistance for older persons and/or their family members or other caregivers.

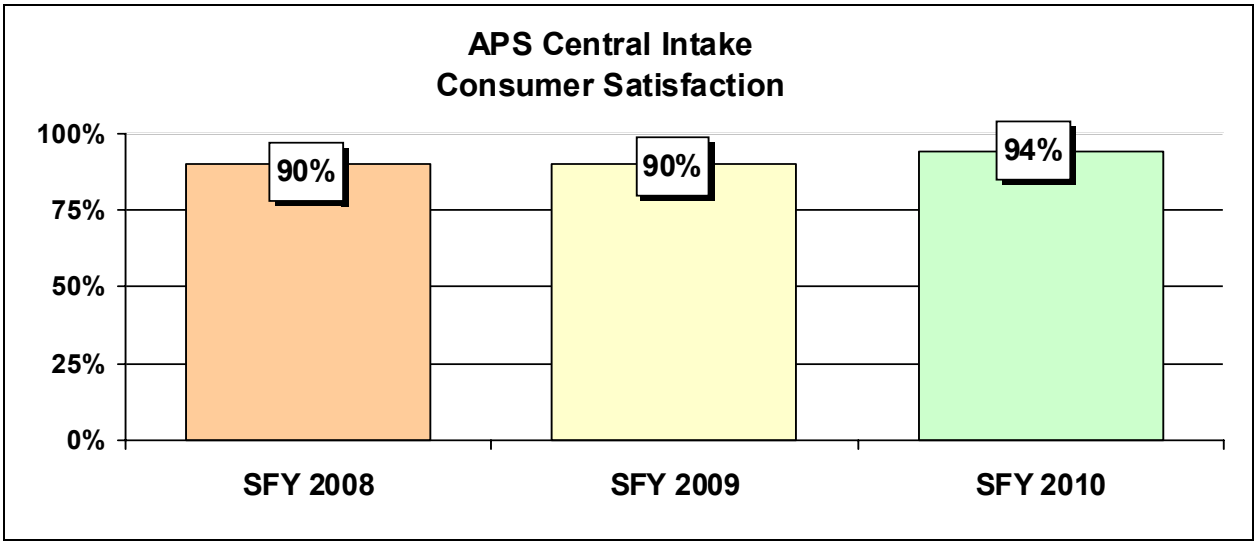
Long Term Care Ombudsman

Ombudsman services include resolving residents' rights and care issues; resolving quality of life issues; providing education and assistance about long-term care issues, public benefits and resident rights; identifying long-term care issues; sponsoring training events for certified nursing assistants; and advocating for needed change.



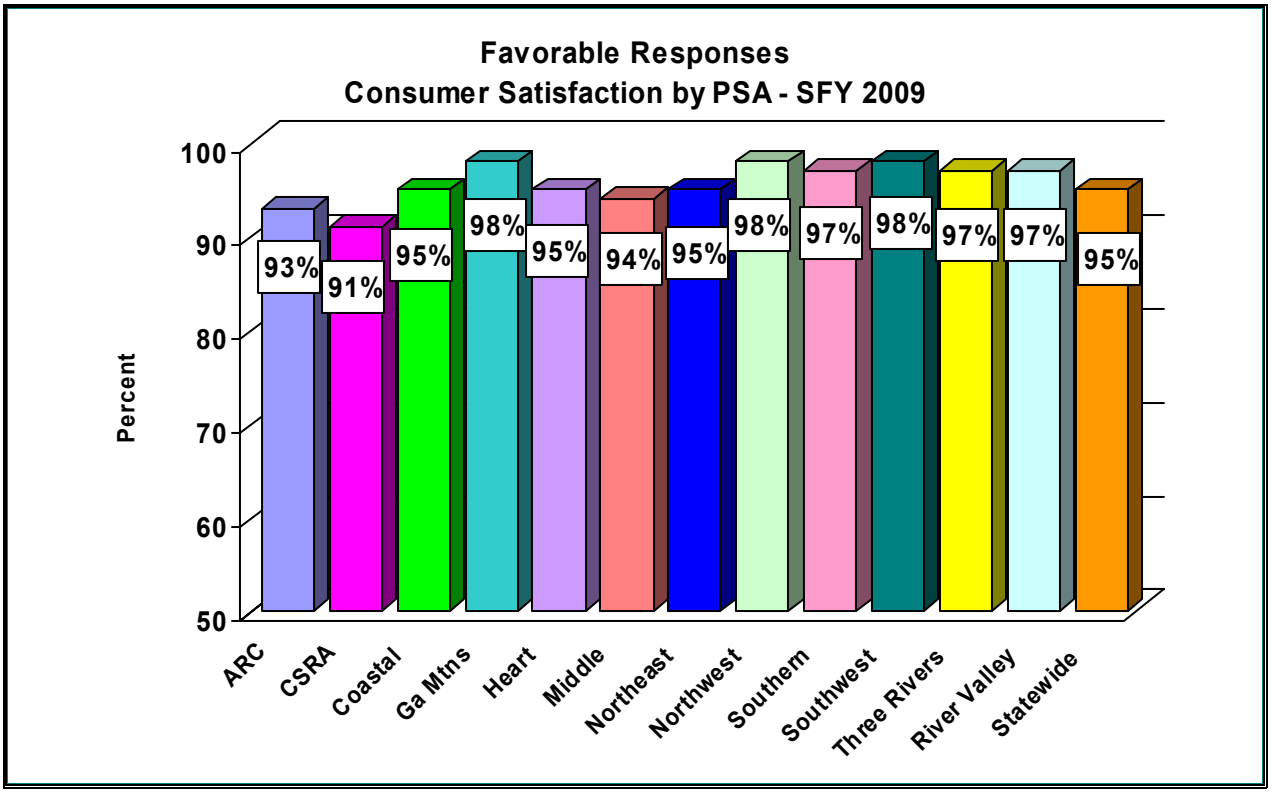
Long-Term Care Ombudsmen provide services that protect and improve the quality of care and quality of life for residents of long-term care facilities. These services are performed through advocacy for and on behalf of residents and through the promotion of community involvement in long-term care facilities.

Adult Protective Services Central Intake Unit



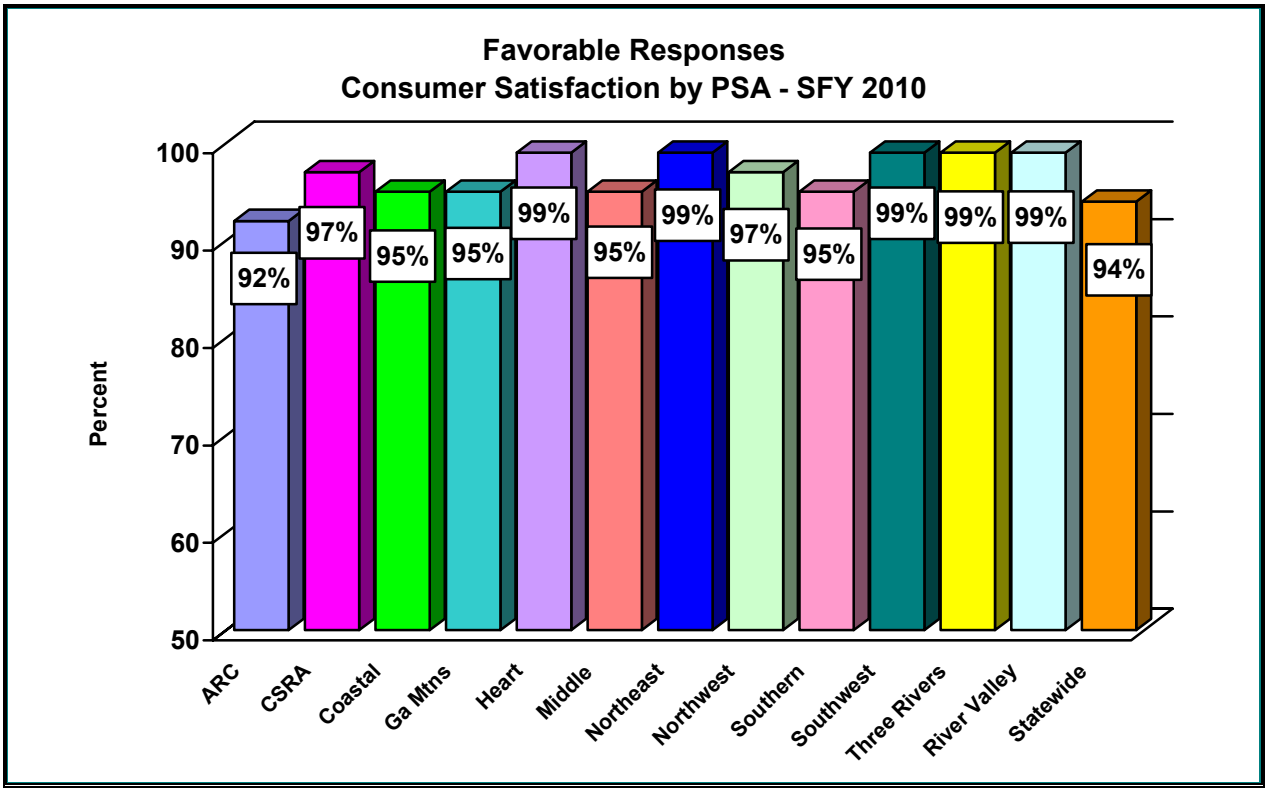
The Adult Protective Services (APS) program is mandated under the Disabled Adults and Elder Persons Protection Act to address situations of domestic abuse, neglect or exploitation of disabled persons age 18 and over and elders age 65 and over who are not residents of long term care facilities. The APS Program receives reports of abuse, neglect and/or exploitation through its Centralized Intake Unit. Six staff persons handle calls through a statewide toll-free number to determine if the referrals meet the criteria for APS to investigate a case. If the criteria are not met, referrals are made to community resources including those in the aging network.

Statewide Consumer Satisfaction by Planning and Service Areas (PSA)
SFY 2009



SFY 2009 Consumer Satisfaction Surveys: The above percentages represent consumer satisfaction for Gateway, HCBS Home Delivered Meals, Congregate Meals, Homemaker, Personal Care, Adult Day Care, Respite, Case Management, Transportation, Telephone Reassurance, and Home Modification/Repair, and CCSP Care Coordination services and were calculated from the raw data. With the exception of the CCSP Care Coordination survey, which was administered by the DAS Regional Coordinators, all other consumer satisfaction survey data were collected by the reporting Area Agency on Aging. As noted in the individual service charts above, the services surveyed for consumer satisfaction by the AAAs in SFY 2009 varied from one PSA to another.

Statewide Consumer Satisfaction by Planning and Service Areas (PSA)
SFY 2010



SFY 2010 Consumer Satisfaction Surveys: The above percentages represent consumer satisfaction for HCBS services: Home Delivered Meals, Congregate Meals, Homemaker, Personal Care, Adult Day Care, Respite, and Case Management; and were calculated from the raw data. All consumer satisfaction survey data were collected by the reporting Area Agency on Aging. As noted in the individual service charts above, the services surveyed for consumer satisfaction by the AAAs in SFY 2010 varied from one PSA to another. For these seven services, statewide, overall satisfaction slightly decreased from **95%** in SFY 2009 to **94%** in SFY 2010.

Area Agency on Aging Listing

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
Atlanta Region Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale	**Cathie Berger, AAA Director** Atlanta Regional AAA 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3264 **Aging Connection**: **1-800-676-2433** or (404) 463-3333 Email: cberger@atlantaregional.com Website: aginginfo@atlantaregional.com/aging Website: agewiseconnection.com	**Charles C. Krautler, Executive Director** Atlanta Regional Commission 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3100 Fax: (404) 463-3105 Email: ckrautler@atlantaregional.com **Fulton County**
Central Savannah River Area Burke Columbia Glascock Hancock Jefferson Jenkins Lincoln McDuffie Richmond Screven Taliaferro Warren Washington Wilkes	**Jeanette Cummings, AAA Director** **Central Savannah River AAA** 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2013 Director Direct Line (706) 210-2000 Aging Program Fax: (706) 210-2006 **Aging Connection**: **1-888-922-4464** E-mail: jcummings@csrarc.ga.gov Website: www.csrarc.ga.gov	**Andy Crosson, Executive Director** **Central Savannah River Area Regional Commission** 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2000 Fax: (706) 210-2006 E-mail: acrosson@csrarc.ga.gov **Richmond County**

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
Coastal Georgia Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh	**Jill Jackson-Ledford** Coastal Georgia AAA 127 F Street Brunswick, GA 31520 (912) 262-2840 Fax: (912) 262-2313 **Information Link: 1-800-580-6860** Email: jjacksonledford@crc.ga.gov Website: www.crc.ga.gov	**Allen Burns, Executive Director** Coastal Regional Commission of Georgia 127 F Street Brunswick, GA 31520 (912) 262-2800 Fax: (912) 262-2313 Email: aburns@crc.ga.gov **Glynn County**
Legacy Link Banks Dawson Forsyth Franklin Habersham Hall Hart Lumpkin Rabun Stephens Towns Union White	**Pat Freeman, AAA Director** Legacy Link AAA P. O. Box 2534 Gainesville, GA 30503-2534 (770)538-2650 Fax: (770)538-2660 **Intake Screening: 1-800-845-5465** Physical Address: 508 Oak St., Ste 1, 30501 E-mail: pvfreeman@legacylink.org Website: www:legacylink.org	**Pat Freeman, Executive Director** The Legacy Link, Inc. P.O. Box 2534 Gainesville, Georgia 30503-2534 (770) 538-2650 Fax: (770) 538-2660 E-mail: pvfreeman@legacylink.org **Hall County**

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
Heart of Georgia Altamaha Appling Bleckley Candler Dodge Emanuel Evans Jeff Davis Johnson Laurens Montgomery Tattnall Telfair Toombs Treutlen Wayne Wheeler Wilcox	**Gail Thompson, AAA Director** Heart of Georgia Altamaha AAA 331 West Parker Street Baxley, GA 31513-0674 (912)367-3648 Fax: (912)367-3640 or (912)367-3707 **Toll Free: 1-888-367-9913** E-mail: thompson@hogarc.org Website: www.hogarc.org	**Alan R. Mazza, Executive Director** Heart of Georgia Altamaha Regional Commission 5405 Oak Street Eastman, Georgia 31023-6034 (478) 374-4771 Fax: (478) 374-0703 E-mail: mazza@hogarc.org **Dodge County**
Middle Georgia Baldwin Bibb Crawford Houston Jones Monroe Peach Pulaski Putnam Twiggs Wilkinson	**Geri Ward, AAA Director** Middle Georgia AAA 175 Emery Highway, Suite C Macon, GA 31217-3679 (478)751-6466 Fax: (478)752-3243 **Toll free: 1-888-548-1456** E-mail: gward@mg-rc.org Website: http://www.middlegeorgiarc.org/	**Ralph Nix, Executive Director** Middle Georgia Regional Commission 175 Emery Highway, Suite C Macon, GA 31217-3679 (478) 751-6160 Fax: (478) 369-6517 E-mail: rnix@mg-rc.org **Bibb County**

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
Northeast Georgia Barrow Clarke Elbert Greene Jackson Jasper Madison Morgan Newton Oconee Oglethorpe Walton	**Peggy Jenkins, AAA Director** Northeast Georgia AAA 305 Research Drive Athens, GA 30610 (706)369-5650 Fax: (706)425-3370 **Toll free: 1-800-474-7540** E-mail: pjenkins@negrc.org Website: www.negrc.org	**James R. Dove, Executive Director** Northeast Georgia Regional Commission 305 Research Drive Athens, GA 30605 (706) 369-5650 Fax: (706) 369-5792 E-mail: jdove@negrc.org **Clarke County**
Northwest Georgia Bartow Catoosa Chattooga Dade Fannin Floyd Gilmer Gordon Harralson Murray Paulding Pickens Polk Walker Whitfield	**Debbie Studdard, AAA Director** Northwest Georgia AAA P.O. Box 1798 Rome, GA 30162-1798 (706) 295-6485 Fax: (706) 295-6126 **Toll Free: 1-800-759-2963** Screening Fax: (706) 802-5506 Physical Address: 1 Jackson Hill Dr. 30161 E-mail: dstuddard@nwgrc.org Website: www.nwgrc.org	**William R. Steiner, Executive Director** Northwest Georgia Regional Commission P.O. Box 1793 Rome, GA 30162-1793 (706) 295-6485 Fax: (706)295-6126 E-mail: wsteiner@nwgrc.org **Floyd County**

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
River Valley Chattahoochee Quitman Clay Randolph Crisp Schley Dooley Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster	**Tiffany Ingram, AAA Director** River Valley AAA 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706) 256-2910 Fax: (706) 256-2908 **Toll Free: 1-800-615-4379** E-mail: tingram@rivervalleyrcaaa.org Website: www.rivervalleyrc.org	**Patti Cullen, Executive Director** River Valley Regional Commission 1428 Second Avenue P.O. Box 1908 Columbus, GA 31902-1908 (706) 256-2910 E-mail: pcullen@rivervalleyrc.org **Muscogee County**
Southern Georgia Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley Lowndes Brooks Pierce Charlton Tift Clinch Turner Coffee Ware	**Wanda Taft, AAA Director** Southern Georgia AAA 1725 South Georgia Parkway, West Waycross, GA 31503-8958 (912) 285-6097 Fax: (912) 285-6126 **Toll Free: 1-888-732-4464** E-mail: wttaft@sgrc.us Website: www.sgrc.us	**John L. Leonard, Executive Director** Southern Georgia Regional Commission 327 West Savannah Avenue Valdosta, GA 31601 (229) 333.5277 Fax: (229) 333-5312 E-mail: jleonard@sgrc.us **Ware County**

Planning & Service Area	*AAA Director* *Name of AAA* *Address, Phone & E-Mail*	*Executive Director* *Name of Agency* *Address, Phone & E-Mail*
Southwest Georgia Baker Calhoun Colquitt Decatur Dougherty Early Grady Lee Miller Mitchell Seminole Terrell Thomas Worth	**Kay Hind, AAA Director** SOWEGA AAA 1105 Palmyra Road Albany, GA 31701-1933 (229)432-1124 Fax: (229)483-0995 **Toll free: 1-800-282-6612** E-mail: kayhhind@gmail.com Website: www.sowegacoa.org	**Kay Hind, Executive Director** SOWEGA Council on Aging, Inc. 1105 Palmyra Road Albany, GA 31701-1933 (229) 432-1124 E-mail: kayhhind@gmail.com **Dougherty County**
Three Rivers Butts Carroll Coweta Heard Lamar Meriwether Pike Spalding Troup Upson	**Joy Shirley, AAA Director** Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 (706)407-0016 or (678)552-2853 Fax: (706) 675-9210 or (770)854-5402 **Toll Free: 1-866-854-5652** Physical Address: 13273 Hwy. 34 East E-mail: jyshirley@threeriversrc.com Website: www.scaaa.net	**Lanier E. Boatwright Jr., Executive Director** Three Rivers Regional Commission 120 North Hill Street P.O. Box 818 Griffin, GA 30224-0818 (770) 227-6300 Fax: (770) 227-6488 E-mail: lboatwright@threeriversrc.com **Spalding County**

Acronyms/Abbreviations

AAA	Area Agency on Aging
ABD	Aged, Blind, and Disabled
ACCA	Athens Community Council on Aging
ACT	Adult Crime Tactics
ADH	Adult Day Health
ADLs	Activities of Daily Living
ADRC	Aging and Disability Resource Connection
ADRD	Alzheimer's Disease and Related Disorders
ADSSP	Alzheimer's Disease Supportive Services Program
AIMS	Aging Information Management System
ALS-F	Alternative Living Services-Family Model
ALS-G	Alternative Living Services-Group Model
ANE	Abuse/Neglect/Exploitation
AoA	Administration on Aging
APS	Adult Protective Services
ARC	Atlanta Regional Commission
BSITFC	Brain and Spinal Injury Trust Fund Commission
CCIS	Care Consultation Information System
CCSP	Community Care Services Program
CDSMP	Chronic Disease Self Management Program
CHAT	Client Health Assessment Tool
CILS	Centers for Independent Living
CLA	Community Living Arrangement
CLP	Community Living Program
CMS	Centers for Medicare and Medicaid Services
COAGE	Coalition of Advocates for Georgia's Elderly
CSRA	Central Savannah River Area
DAS	Georgia Division of Aging Services
DBHDD	Georgia Department of Behavioral Health and Developmental Disabilities
DCH	Department of Community Health
DD	Developmental Disabilities
DFCS/DFACS	Department of Family and Children Services
DHS	Department of Human Services
DMA	Division of Medical Assistance
DMD	Dual Eligible's with Mental Disabilities
DON-R	Determination of Need - Revised
DOT	Department of Transportation
EAP	Elder Abuse Prevention
EBHW	Evidence-Based Health and Wellness

EBP	Evidence-Based Practices and Programs
ELAP	Elderly Legal Assistance Program
EMS	Emergency Management Services
EOC	Emergency Operations Center
ESF	Essential Support Functions
ESP	Enhanced Services Program
ERS	Emergency Response System
FBI	Federal Bureau of Investigation
FSIU	Forensic Special Investigations Unit
G4A	Georgia Association of Area Agencies on Aging
GCOAMH	Georgia Coalition on Older Adults and Mental Health
GEMA	Georgia Emergency Management Agency
GGS	Georgia Gerontology Society
GHPC	Georgia Health Policy Center
GMCF	Georgia Medical Care Foundation
GPRA	Government Performance and Results Act
GSU	Georgia State University
HCBS	Home and Community Based Services
HDM	Home Delivered Meals
HDS	Home Delivered Services
IADLs	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facilities for the Mentally Retarded
IEP	Individual Employment Plan
IFF	Intra-State Funding Formula
LE	Law Enforcement
LEP	Limited English Proficiency
LIS	Low-Income Subsidy
LOS	Length of Stay
LTC	Long Term Care
LTCO	Long Term Care Ombudsman
LTCOP	Long Term Care Ombudsman Program
MAP	Measurement and Analysis Plan (performance indicators)
MDS	Minimum Data Set
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MOU	Memorandum of Understanding
MSP	Medicare Savings Program
MUD	Managing Using Data
NAPIS	National Aging Program Information System
NASMHPD	National Association of State Mental Health Program Directors
NCMHA	National Coalition on Mental Health and Aging
NCOA	National Council on Aging
NET	Non-Emergency Transportation

NH	Nursing Home
NIA	National Institute on Aging
NIMH	National Institute on Mental Health
NINR	National Institute on Nursing Research
NSI	Nutrition Screening Initiative
NORC	Naturally Occurring Retirement Community
NYUCI	New York University Caregiver Intervention
OAA	Older Americans Act
OHRC	Out-of-Home Respite Care
OJE	On the Job Experience
OMB	Office of Management and Budget
PCH	Personal Care Home
PDCA	Plan-Do-Check-Act
PEARLS	Program to Encourage Active, Rewarding Lives for Seniors
POMP	Program Outcome Measurement Project
PSA	Planning and Service Area; Personal Support Aide
PSS	Personal Support Services
PSS-X	Personal Support Services- Extended
QIO	Quality Improvement Organization
RC	Regional Commission
RCI	Rosalynn Carter Institute
RC	Regional Commissions
REACH	Resources for Enhancing Alzheimer's Caregiver Health
RTCC	Regional Transportation Coordinating Committee
RTO	Regional Transportation Office
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSEP	Senior Community Service Employment Program
SME	Subject Matter Expert
SMP	Senior Medicare Patrol (See SHIP)
SFY	State Fiscal Year (July 1 through June 30)
SHIP	State Health Insurance Assistance Program
SSA	Social Security Administration
SUA	State Unit on Aging
TANF	Temporary Assistance to Needy Families
TCARE	Tailored Caregiver Assessment and Referral
UGA	University of Georgia
USDA	United States Department of Agriculture
UWM	University of Wisconsin - Milwaukee
VAMC	Veterans Administration Medical Center
VC	Volunteer Coordinator