

**Fiscal Year 2012**

**Just the Facts**

**Georgia Division of Aging Services**



**Dr. James Bulot, Director**





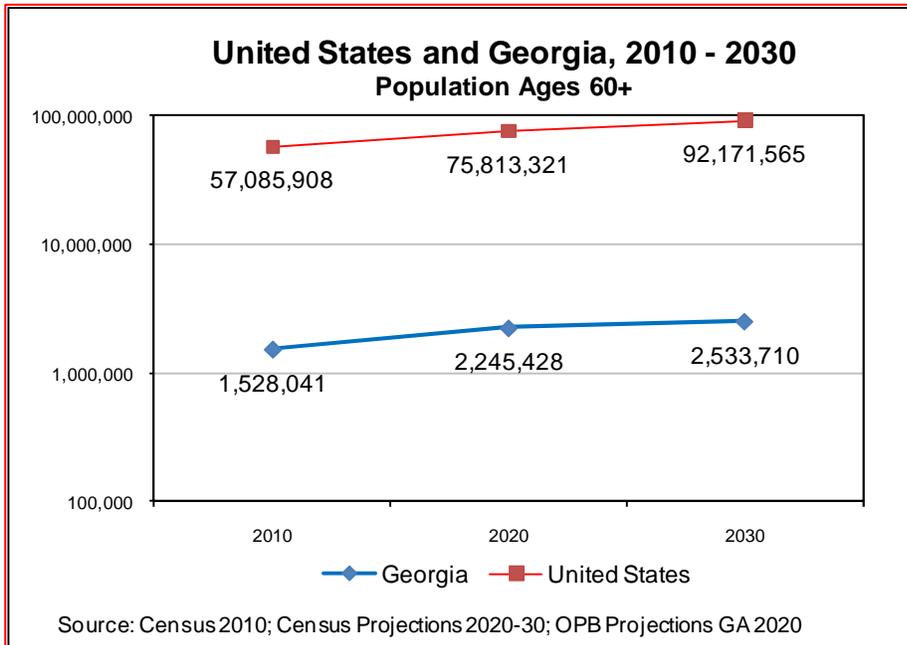
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# Aging Trends in Georgia

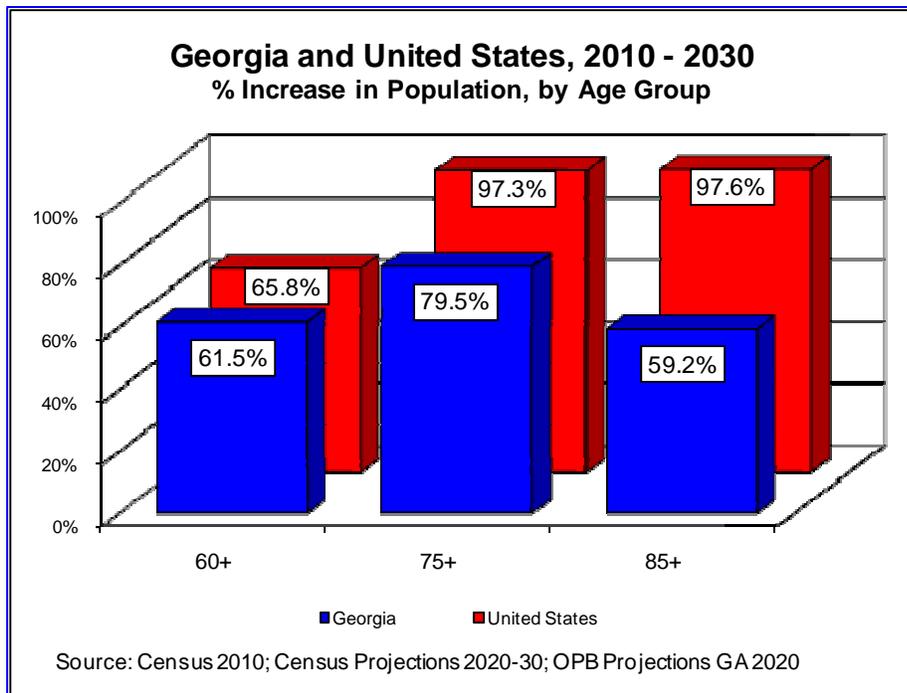
## GA DHS Division of Aging Services and the Aging Network

The 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. Through continuous service improvements and innovation, DAS provides programs and services that assist Georgians in living longer, living safely and living well.



- Georgia has the 11th fastest growing 60+ population and the 10th fastest growing 85+ population in the United States between 2010-30.

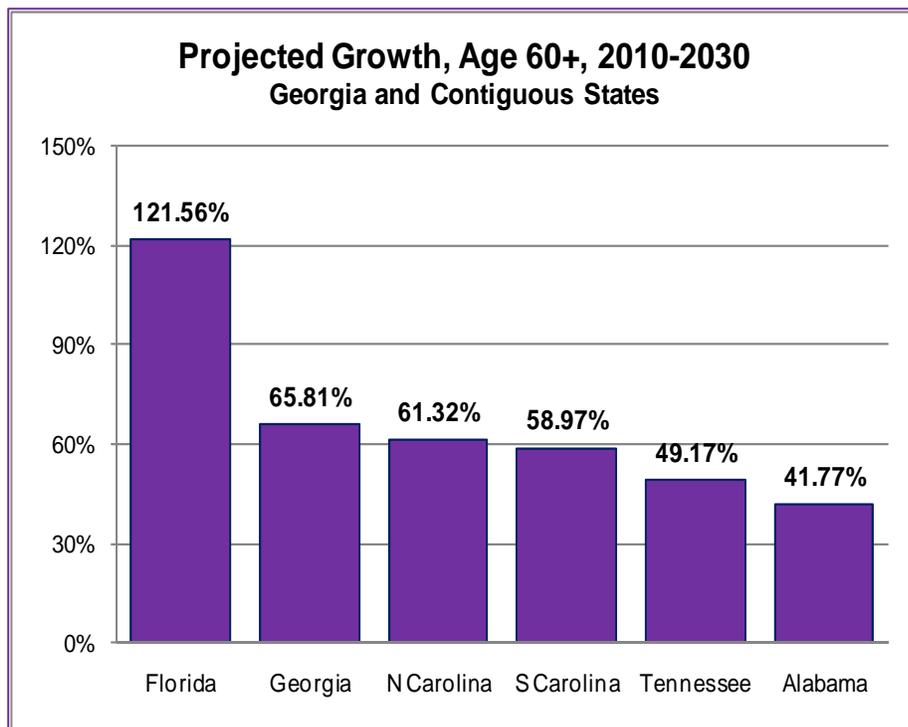
- Georgia's 60+ population is expected to increase 65.8% between 2010 and 2030, from 1 in 6 persons in 2010 to 1 in 5 persons in 2030.



- Georgia's 85+ population is expected to increase 97.6% from 2010 to 2030. Those 85 and above are by far the fastest growing group, projected to total 224,926 in 2030.

- During the 20<sup>th</sup> century, the number of Georgians age 60+ increased nine-fold, compared to a four-fold growth in the population overall.

- In 2010 among Georgians ages 60 and above, there were 78.6 males for every 100 females; for Georgians ages 85 and above there were 41.4 males for every 100 females.
- Of Georgia's population ages 60 and above, an estimated 326,855 lived alone.<sup>1</sup>
- 307,465, or 22.46% of Georgia's population ages 60 and above, were veterans.<sup>2</sup>
- A greater number of Georgia's elderly ages 60 and above completed high school and earned higher degrees:<sup>3</sup>
  - High school graduates 436,160
  - Bachelor's degree 159,155
  - Master's degree 74,650
  - Doctorate degree 17,125



- An estimated 25.93% of Georgians 60+ were in the work force.<sup>4</sup>
- 11.98% of the state's population ages 60 and above were at or below poverty level.<sup>5</sup>
- Georgia has the second highest percent increase in population ages 60+ in comparison with the states that border it.<sup>6</sup>

<sup>1</sup> AGID Table S21004, GA 2005 – 2009, aggregated for 60+.

<sup>2</sup> AGID Table S21025, GA 2005-2009.

<sup>3</sup> AGID Table S21021B, GA 2005 – 2009.

<sup>4</sup> AGID Table S21023, GA 2005-2009.

<sup>5</sup> AGID Table S21043B, GA 2005-2009.

<sup>6</sup> 2010 Census compared to 2030 Projections from File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030; Source: U.S.Census Bureau, Population Division, Interim State Population Projections, 2005.

# Section

# 1

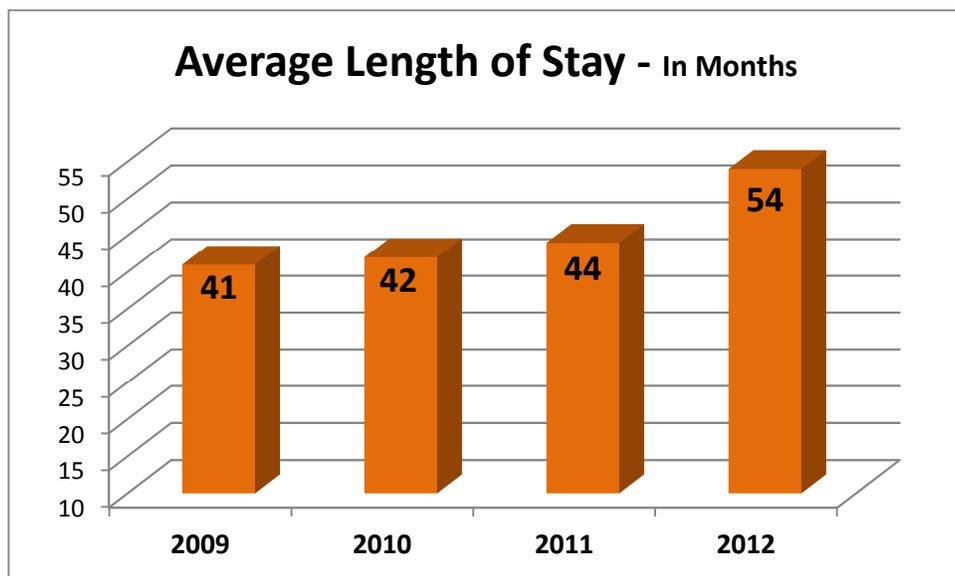
## Providing a Foundation of Home and Community Based Services

The Administration for Community Living core programs provide a wide range of in-home and community based supports that are helping older Americans remain independent, active, and at home. These programs serve as the foundation for the Network's responsibility to bring together and coordinate a variety of services and activities for older adults.

All Older Americans Act services are targeted toward clients who are the most socially and economically vulnerable population of older Americans, and Older Americans Act clients tend to be among the oldest of the old.

## Non Medicaid Home and Community Services

Non Medicaid Home and Community Based Services (HCBS) provides individual and group services to support and assist older Georgians in staying in their homes and communities. These services promote health, self-sufficiency and independence. During SFY 12, 35,438 clients received HCBS services. Length of Stay (LOS) is the metric used to define return on investment by keeping people at home and in the community. Studies have shown that the longer a person is able to stay at home with support, the more it saves taxpayer dollars.



## Nutrition and Wellness Programs

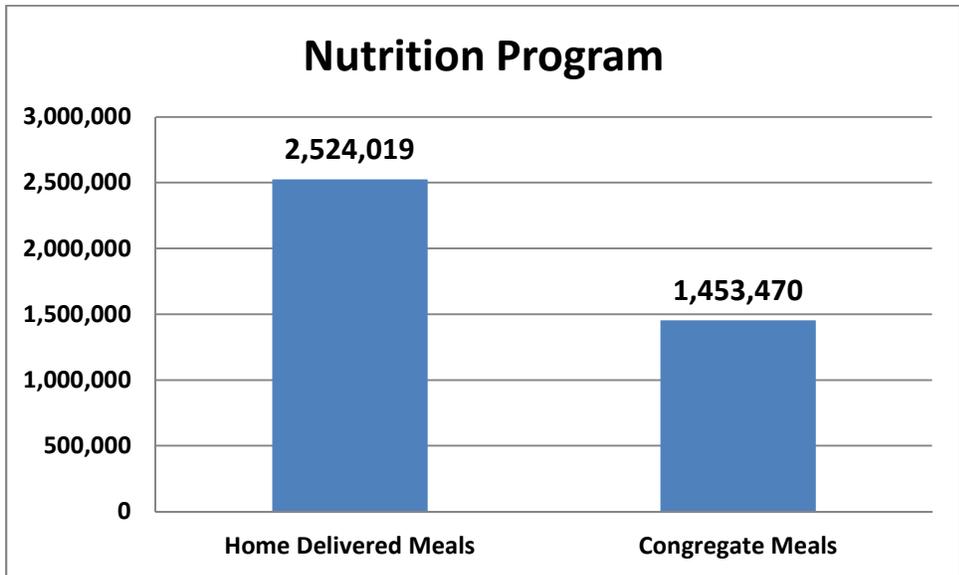
**"Living Longer, Living Well"** – The Nutrition and Wellness Programs are aimed at increasing the ability of older adults to perform everyday activities and remain living in their own homes. Activities are focused on Evidence Based health promotion and disease prevention. Services are designed to improve nutrition and health status, increase functional abilities, promote safety at home, avoid or delay problems caused by chronic diseases and enhance quality of life.

### Partners in Service Delivery System

The Division of Aging Services partners with the Aging Network and other public and private sector agencies to provide nutrition and wellness program services. These partners include; University of Georgia, Georgia State University, Area Agencies on Aging, Senior Centers, Community Service Providers, Diabetes Association of Atlanta, Georgia Extension

Service, Division of Public Health, AARP, American Cancer Society, Medicare Diabetes Screening Project, Parks & Recreation, Administration on Community Living and NCOA, etc.

Nutrition counseling provides individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietician, and addresses the options and methods for improving nutrition status. Nutrition Education is a program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers or participants and caregivers in a group of individual settings overseen by a dietician or individual of comparable expertise. Congregate Meals are meals provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act, State and Local laws. Home Delivered Meals are meals provided to a qualified individual in his/her place of residence. The Home Delivered Meal program is administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act, State and Local laws. Funds may also be used to provide assistive technology for dining.



**SFY2012 Total Meals Served 3,977,489 (congregate meals: 1,453,470 and Home delivered meals: 2,524,019)**

- Home Delivered Meals served to 28,244 persons
- Congregate Meals served to 18,870 persons
- More than 3,000 persons benefit from the following services:
  - Exercise and Physical Fitness
  - Medications Management
  - Nutrition Counseling
  - Health Related and Health Screening
  - Georgia Living Well, the Stanford Chronic Disease Self-Management Model (CDSMP)
  - Physical Activities included chair exercise, dancing, aerobics, walking, weight exercises, water aerobics, yoga, etc.
  - Lifestyle Management including recreation, safety, therapeutic activities, and tobacco cessation

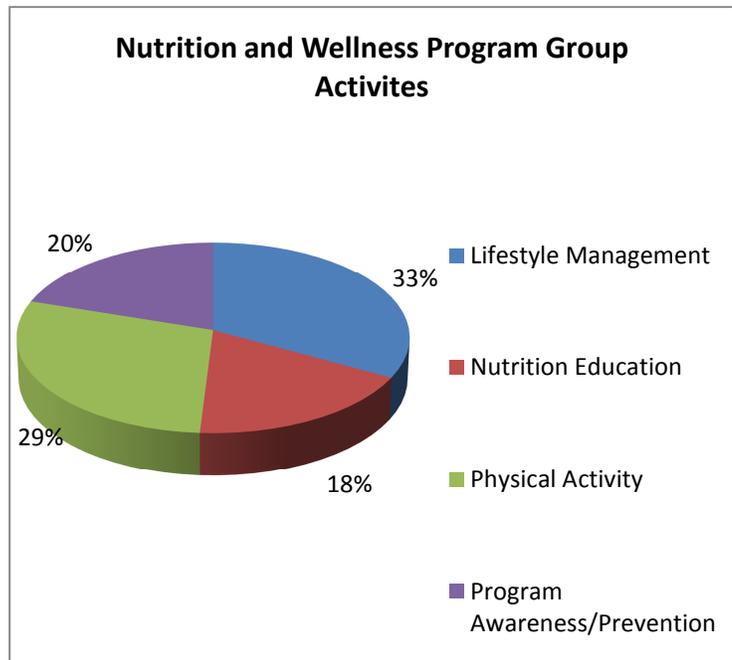
- Program Awareness/Prevention including community events, distribution of materials, medications management, immunizations and group screening activities
- Nutrition Education including: nutrition and health sessions, menu planning and food preparation, explanation of Dietary Guidelines, eating and feeding information, and food safety

## Success Stories

**The Website (livewellagewell.info):** The web site’s main purpose is to provide information on healthy aging for people aged 50 and older, their families, and their caregivers. The website tracking shows that during SFY 2012, Live Well Age Well web site had 213,078 hits (1,776 average per month), 99,742 pages viewed (8,312 pages viewed on average per month), 47,803 unique visitors (3,984 average per month). Most frequently visited information sections on the web site included: CDSMP Information; Chair exercises; In the News; Recipes/Menus; Community Intervention materials and Success Stories. We received several requests during the year from universities, teaching hospitals and churches to grant them permission to use our program materials posted on this web site. The website is now used as an electronic portal for the CDSMP workshops, allowing registration for some of the trainings. This functionality will increase in coming years.

### Senior Farmers’ Market Nutrition

**Program:** The Division of Aging Services in collaboration with the Department of Public Health administers the Senior Farmers’ Market Nutrition Program. The program was a huge success with one of the highest voucher redemption rates in the country (97.5%). More than 11,000 seniors benefited from this program. The program participants received \$20 worth of coupons for the purchase of locally grown fresh produce and received nutrition education information on cooking tips, canning and freezing tips, and importance of consuming fresh fruits and vegetables to overall health. The Farmers Market Program in Georgia now works with an on line system increasing efficiency and ease of record keeping.



### Chronic Disease Self-Management Program (CDSMP)

The DHS Division of Aging Services (DAS) was successful in writing a grant to receive \$400,000+ in year one from the Administration on Community Living (ACL) to continue offering the Stanford University’s Chronic Disease Self- Management Program (CDSMP) and the online version, Better Choices Better Health (BCBH), across Georgia as well as to introduce the Diabetes Self-Management Program (DSMP), Positive Self-Management Program (PSMP) and Tomando du su Salude (Tomando) through interested

Georgia Area Agencies on Aging and in partnership with the Georgia Department of Public Health and their 18 Public Health Districts.

The core of all of these train-the-trainer programs is a six-week workshop, which is held 2-1/2 hours once per week. The series provides "tools" to persons suffering from chronic conditions to better manage symptoms commonly associated with such health issues (pain, fatigue, depression, difficult emotions, shortness of breath, etc.). Through this ACL grant, DAS is charged with empowering 2,500 persons over the three year grant period by ensuring that these participants complete at least four classes in the six-week workshop.

As of November 1, 2012, more than 180 workshops have been offered and nearly 1,800 participants have completed either the in-person, community based CDSMP workshop or the BCBH version.

### **Accomplishments Highlighted**

- More than 3,000 program participants participated in various physical activity programs such as walking, Tai Chi, chair exercises and other resistance exercise programs and improved their strength, balance and flexibility. More than 335,000 physical activity opportunities were offered through the aging network during the 2012 fiscal year.
- More than 38,000 program participants participated in various nutrition education activities and learned ways to prevent/manage chronic diseases by eating healthy, keeping food safe to eat and planning healthy meals on a budget.
- Grant funding received to help integrate systems and increase evidence based nutrition and health management programming across the state. This grant will support such programs as "A Matter of Balance," and placing EBT machines in local farmers' markets to increase fresh produce consumption.
- Implemented a food security survey to help increase understanding of food insecurity in Georgia's older adult population. This data will be utilized to help with strategic planning and grant writing to help eliminate this issue. The data is retrievable for the entire state, region or by zip code.

### **Future Directions and Opportunities**

- Increase partnerships with the Division of Public Health, Georgia Medical Care Foundation, Georgia Diabetes Coalition, Georgia Food Policy Council, FNS, Center for Disease Control, Food and Drug Administration, Georgia Osteoporosis Initiative, Georgia Commission on Women, hospitals and other public/private sector agencies to expand wellness program activities and resources.
- Coordinate efforts with Department of Public Health and United States Department of Agriculture to increase funding for the Georgia Senior Farmers' Market Nutrition Program. With increased funding, we will be able to increase the number of older adults participating in the SFMNP program and also help improve access to fruits and vegetables.

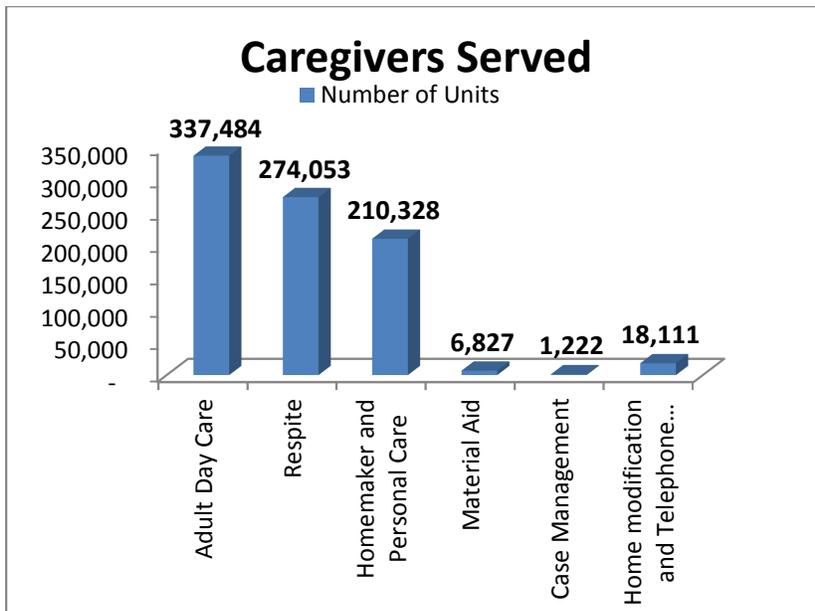
- Coordinate efforts with the Aging Network, Department of Family and Children Services, USDA FNS, University of Georgia, food banks and other public/private sector agencies to address food insecurity & hunger issues in older adults and increase awareness regarding their participation. Community partnership developing currently will support this goal.

## Caregiver Programs and Services

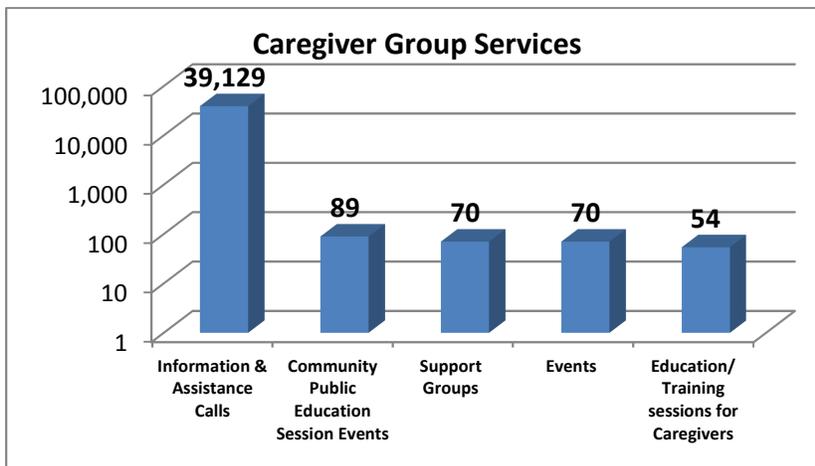
### Overview

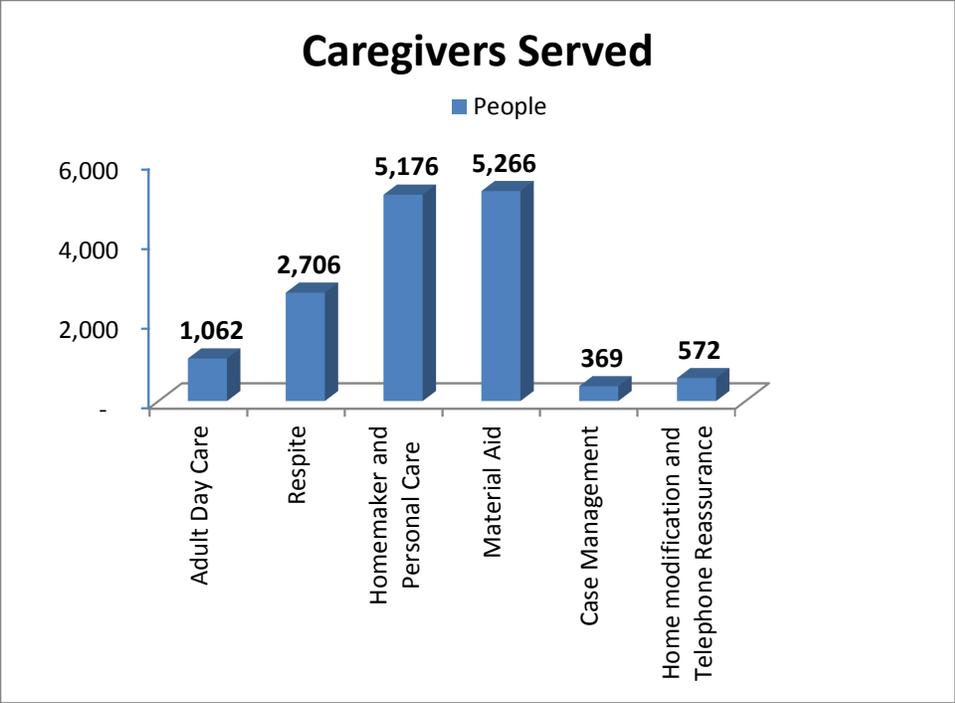
Georgia's aging network provided an array of services designed to support family caregivers. During SFY 2012, services to caregivers included day care, in-home respite, information and assistance, caregiver education/training sessions, support groups, material aid (help with purchasing transportation, food or groceries) homemaker and personal care, and caregiver assessment (helping assess needs of caregivers with services enabling them to keep loved ones at home).

Work also continued on new programs and services to support persons with dementia and their caregivers, including but not limited to clinical counseling, driving assessments, and care consultation.



*Caregiver Group Services documented over 78,081 hours of services*





**Caregiver Success Stories**

**Care Consultation**

When I heard about the Care Consultation program, I was anxious to try it. Anything that could ease the stress I was feeling as a caregiver was worth trying. Following my mother's stroke and her decision that she could no longer live successfully alone, my husband and I wanted very much for her to come and live with us. We were not prepared, though, for the constant demands of caregiving and the feelings of inadequacy we experienced from the start. The Care Consultation program assisted us greatly in getting through the toughest times and helping us sort things into manageable pieces that we could handle. It started with access to resources and information. Bethany helped me find information I needed about medications for dementia and doctors specializing in geriatrics. Although I could probably have obtained this information myself, there was not a minute in my more-than-busy day to even begin to look. When I experienced family conflict and had questions about how to maintain positive family relations around caregiving issues, Bethany sent relevant articles that validated our feelings and helped point us in the right direction. After finding my mother outside in the cold one morning and recognizing that we had to have a way to know if she opened a door while we were sleeping, Bethany quickly provided information to us about door alarms and other assistive products. When we recognized that my mother's finances were not sufficient to cover the costs of her care, Bethany helped us identify programs that could help; she then kept track of the status of various applications, offering explanations we would otherwise not have had or understood. All of these services have been of great value. Equally important has been Bethany's willingness to listen, validate and encourage. My husband and I are very grateful for the Care Consultation program!

## **TCARE®**

P and her husband began providing care for P's mother, who has mid-stage Alzheimer's Disease. Through her work with the TCARE® specialist, Ms. P has been able to receive help through the CCSP, Georgia Cares, and SNAP programs. Ms. P. has shown improvement in her ability to cope, and has expressed much appreciation to the TCARE® specialist, indicating she is sleeping better because of the support she has received.

### **Accomplishments Highlighted Evidence-Based Programs**

Evidence-based programs or interventions have been tested through randomized controlled trials and are effective at improving, maintaining, or slowing the decline in the health or functional status of older people. They are suitable for deployment through community-based human services organizations, and the research results have been published in a peer-reviewed scientific journal.

The Division of Aging Services (DAS), in collaboration with the 12 Area Agencies on Aging and the Rosalynn Carter Institute for Caregiving (RCI), have been involved in a number of such programs to help caregivers reduce burden, depression, intention to place in nursing facilities, and to promote health and wellness.

In September, DAS and RCI were invited to present on the evidence-based programs underway across the state at the National Home and Community Based Services Conference in Washington DC.

## **TCARE®**

Georgia's TCARE® program was highlighted at the National Home and Community Based Services Conference in Washington DC for its rigorous evaluation component. TCARE® is currently being implemented in all 12 Area Agencies on Aging. TCARE® is an evidence-based program which guides staff in understanding caregivers' needs, strategically selecting and recommending services, consulting with caregivers, and creating a care plan that caregivers will embrace and follow.

Initial findings from the first study, demonstrated that TCARE® lowers stress burden<sup>7</sup>, depressive symptoms, and identity discrepancy<sup>8</sup>. Findings from the four state study replicated a decrease in all of the areas identified above, and additionally showed a decrease in relationship burden<sup>9</sup> and intention for nursing home placement. Published studies can be found in *The Gerontologist* and the *Journals of Gerontology*.

### **Early Stage Alzheimer's Demonstration (AD) Grant**

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<sup>7</sup> Stress burden: Generalized form of negative affect that results from caregiving.

<sup>8</sup> Identity Discrepancy: Psychological state that accrues when there is a disparity between the care activities in which a caregiver is engaging and his or her identity standard.

<sup>9</sup> Relationship burden: Caregivers' perception that the care receiver makes demands for care and attention that are over and above an appropriate level.

The Division of Aging Services continues its work on a demonstration grant from the U.S. Administration on Community Living to develop new protocols and interventions to better serve persons with Early stage Alzheimer's Disease (AD) and their caregivers. Partners in the grant are the Alzheimer's Association, Georgia Chapter, CSRA and Coastal Georgia Area Agencies on Aging, and the Georgia Health Policy Center of Georgia State University.

In September 2012, Georgia was invited to present preliminary findings of the project in Washington DC regarding driving assessments for persons in early state dementia, a new clinical counseling protocol for families of persons with Alzheimer's Disease, and an assessment tool for Adult Protective Services and law enforcement personnel to help them determine whether a person with Early Stage dementia has the cognitive ability to make prudent financial decisions.

### **Future Directions and Opportunities**

The Division of Aging Services was awarded an Alzheimer's Disease and Support Services Program (ADSSP) grant from the Administration for Community Living. The goal of the project is to create a seamless, customer-focused statewide access to a comprehensive array of services and supports to help persons with dementia and their caregivers. Partners in the initiative are the Alzheimer's Association, Georgia Chapter, Georgia's 12 Area Agencies on Aging, the Rosalynn Carter Institute for Caregiving, and the Health Policy Center of Georgia State University.

### **REACH**

The Georgia REACH Program continues to serve caregivers of loved ones with Alzheimer's and related dementia in eleven counties in central and southwest Georgia. Georgia REACH is a collaborative effort between the Rosalynn Carter Institute for Caregiving, the Coastal Georgia Area Agency on Aging, the River Valley Area Agency on Aging, Middle Flint Council on Aging, the Georgia Chapter Alzheimer's Association, and the Georgia Division of Aging Services. It is an evidence-based demonstration grant funded by the U.S. Administration on Aging. The goal of the program is to reduce caregiver burden and improve or sustain caregiver physical and emotional health. The Caregiver Coach meets with the caregiver at the caregiver's home or other convenient location over a period of six months. Together the Coach and the caregiver identify the areas that the caregiver feels are their most challenging or where they need help. Each session is tailored to address those areas. Counties served by this program include Crisp, Dooly, Dougherty, Lee, Macon, Marion, Muscogee, Schley, Sumter, Taylor and Webster. Training in REACH is now available through the Rosalynn Carter Institute for Caregiving and qualifies for Title IIID funding.

### **Care Consultation**

Care Consultation is an evidence-based program developed by Dr. David Bass and colleagues at the Benjamin Rose Institute on Aging in Cleveland Ohio. The telephone based program is designed to serve caregivers and care receivers living with Alzheimer's Disease and related dementias. The Administration on Aging grant was awarded to the Rosalynn Carter Institute for Caregiving at Georgia Southwestern State University to be completed in September 2013. The Rosalynn Carter Institute is

collaborating with the Atlanta Regional Commission Division on Aging, Heart of Georgia Regional Commission Area Agency on Aging, and the Legacy Link, Inc. Area Agency on Aging to serve 40 counties in Georgia. Through this program Care Consultants empower clients to manage care and make decisions more effectively while assisting in finding simple and practical solutions to their caregiving challenges. Consultants help clients find services and understand insurances in addition to facilitating effective communication with doctors and other health care providers. The expected outcomes are reduced caregiver and care receivers burden and depression and avoidance or delay in nursing home placement.

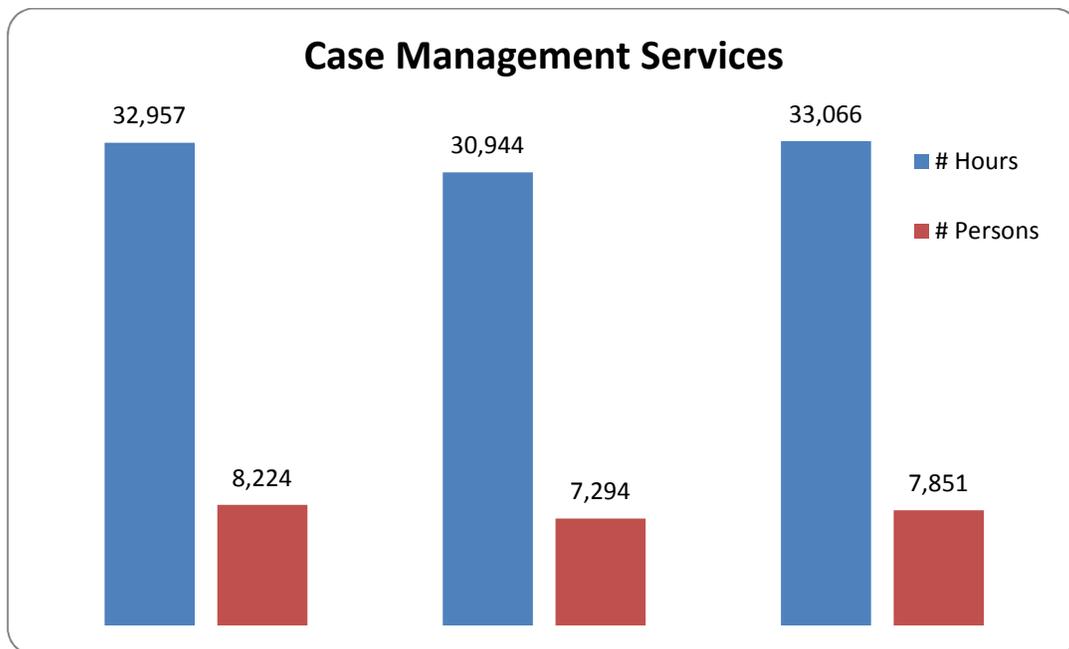
## Case Management Services

Case Management provides consumers access to community resources. Case Management is a collaborative process with the consumer and often with the consumer’s support system that involves assessment, planning and coordination of services, and monitoring and evaluation of options and services to meet the individual’s unique needs. Case Management is designed to provide the right service in the right amount at the right time in a manner that is person centered.

Case Management Services are offered in all twelve areas of the state. Consumers accessing case management services include persons on the waiting list for services, consumers who are receiving services and have ongoing needs for support, and/or persons who need short-term services or an assessment during a time of crisis. Often, Case Managers work directly with caregivers, both local and long-distance, to identify and respond to the needs of an older adult or someone with dementia.

The role of Case Managers has become increasingly important as demographics change, families and caregivers are facing more stress, persons are living longer and often with chronic conditions or impairments, and the needs of older persons and their caregivers become more complex.

The number of persons receiving Case Management Services and the number of hours of this service has remained fairly consistent over the last 3 years, and demonstrates the significant quantity of services provided to Georgia’s families.



## Success Stories

### Mrs. B.

Mrs. B. was being cared for in her home by her son. She had a stroke several years ago which left her wheelchair bound and unable to move her left side. After being unemployed for several years and caring for his mother, her son found fulltime employment and was no longer able to care for her. The family decided that it would be better to move Mrs. B. in with her eldest daughter because of her son's rotating work schedule.

After the move, the agency providing respite services reported that Mrs. B's daughter lived upstairs in an apartment and there were some concerns about her ability to exit the home in an emergency, and her daughters' ability to manage Mrs. B.'s personal care needs. Her daughter indicated she had become overwhelmed with caring for Mrs. B. while also caring for her foster children.

The Case Manager conducted a reassessment with the family and Mrs. B was able to move back to her home with support and services from family and local agencies. She continues to live in her home where she wishes to be.

### Mrs. M.

Mrs. M. has participated in the home delivered meals program since 2009. Recently, she fell in her home and fractured her right hip, requiring surgery. She returned home two weeks after the surgery and now has one of her granddaughters living with her for support. Mrs. M's doctor told her to stay off her feet as much as possible and has to use a wheel chair when out of the home. She has been unable to get into and out of her granddaughters vehicle, thus making it difficult to get to medical appointments and to perform other errands.

The Case Manager worked with the family and located appropriate transportation services. Mrs. M. has been able to attend all scheduled medical appointments by using the transportation services for the past two months. She is also on the waiting list for in-home services to help her during the day and to provide support to her granddaughter.

### Mr. D.

Mr. D. is wheelchair bound and needs assistance with getting in and out of bed and into his wheelchair, and needs total assistance getting in and out of the shower. He has little support other than the Case Manager and the senior center he attends.

The Case Manager assisted Mr. B. with applying for a USDA Rural Development Grant that resulted in a grant of \$7,500 for home repairs to make his home accessible for his needs.

Mr. D. is now able to use his bathroom and shower on his own. This grant also provided him with a ramp, and his doorways were widened to allow access with his wheelchair. Mr. D. is now able to live more safely and independently in his home.

# Section

## 2

### Modernizing Long-Term Care

Since 2003, the Administration on Aging has been supporting the replication of a variety of innovative programs that are increasing the capacity of the Network to help disabled citizens and seniors remain healthy and independent. These innovations come directly out of the experience of states and communities implementing the Older American's Act core programs.

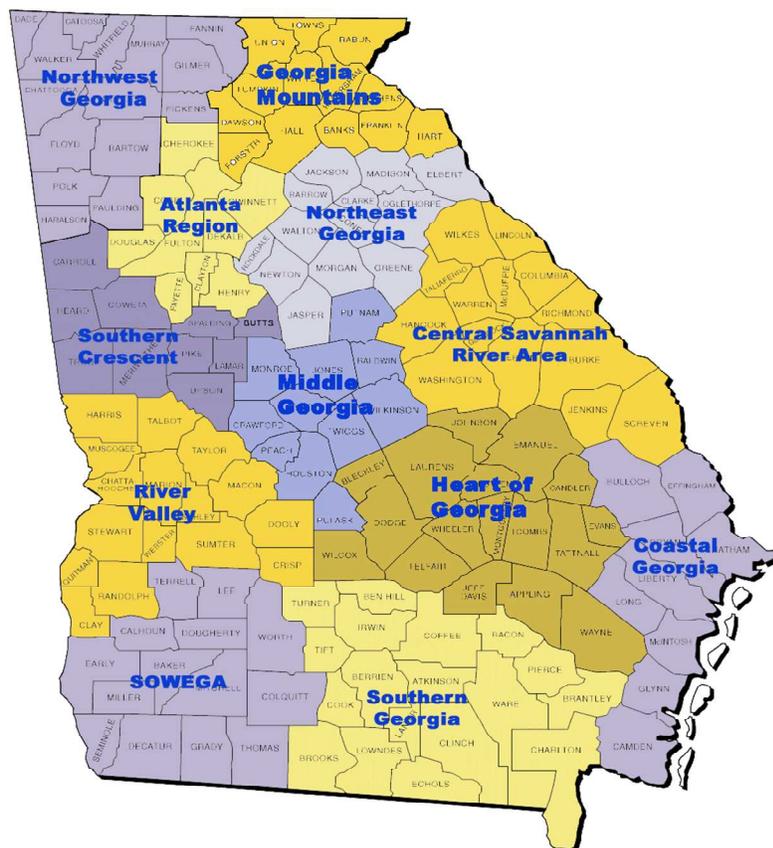
The Aging and Disability Resource Center Program is a collaborative effort of Administration on Aging and the Centers for Medicare and Medicaid Services, helping make it easier for consumers to learn about and access long-term supports and services. ADRCs are also serving as an entry point for all publically administered long-term supports and services.

## Aging & Disability Resource Connection

The Georgia Aging & Disability Resource Connection (ADRC) is a partnership between the Division of Aging Services (DAS) and the Department of Behavioral Health and Developmental Disabilities (DBHDD). ADRCs serve individuals who are aging or have a disability and use the “no wrong door” approach to provide information, assistance and access to these individuals, their families, caregivers and professionals.

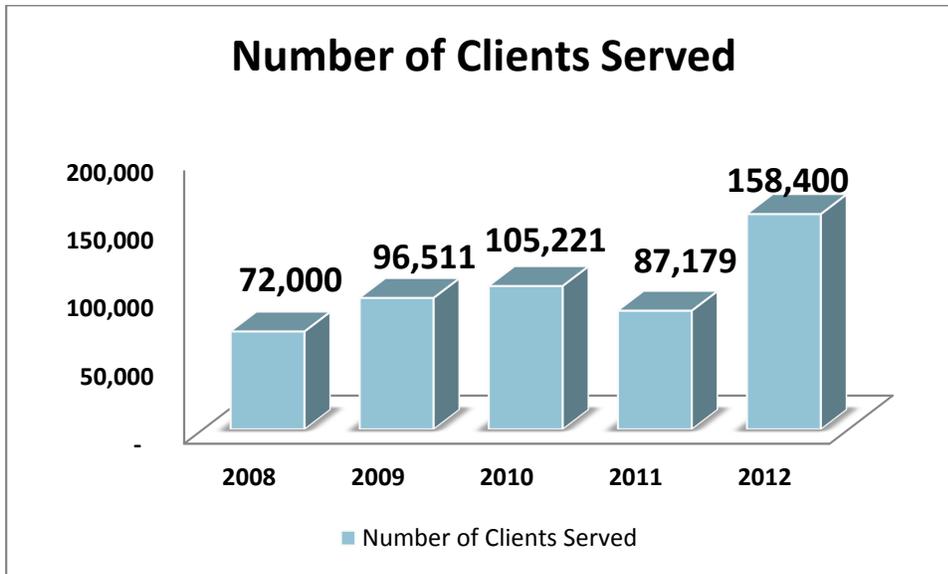
### ADRC Partners

ADRCs have partnerships on the state and local level with other agencies such as DFCS, DCH, LTCO, GeorgiaCares, the Department of Labor-Tools for Life, the Alzheimer's Association, Public Health, the Brain and Spinal Injury Trust Fund Commission, the Georgia Hospital Association, the Georgia Council on Aging and Adult Protective Services.



### Information, Referral and Assistance

- In **SFY 12** the twelve ADRC sites served **95,237** older individuals looking for a variety of home and community based services.
- During the same time period a little more than **41,591** individuals with developmental, physical, or behavioral disabilities contacted the ADRC seeking information about long term care options.
- Together, the ADRC sites served over **158,400** clients seeking LTC options for seniors and individuals with disabilities.

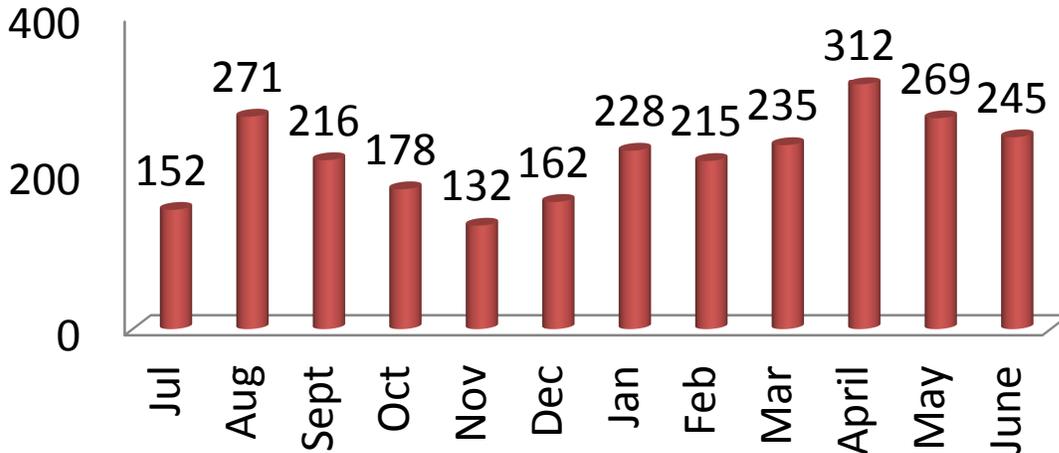


### ADRC and MDSQ Options Counseling

The ADRCs Statewide have full time staff designated as MDSQ (Minimum Data Set Section Q) Options Counselors to provided options counseling to individuals residing in nursing homes who have indicated an interest in potentially returning to the community to live. Options Counseling is a person-centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. The process may include developing action steps toward a goal or Long-term services and supports plan (LTSS), and when requested, assistance with accessing supports options. It also includes following-up with the individual. Options counseling is available to all persons regardless of their income or financial assets.

Georgia has approximately 360 nursing homes that participate in the Section Q referral process and the chart shows SFY12 MDSQ referral data statewide.

### SFY 12 Statewide MDSQ Referrals



Georgia's ADRC has been awarded a Part B grant from the Administration for Community Living (ACL) to provide options counseling to individuals and families residing in the community around long term services and support needs. With the grant funding GA plans to expand partnership and work with community based organizations (CBOs) to provide options counseling to populations across the state. GA is also in the development phase of a training and certification process for options counseling that falls in line with the draft National Standards for Options Counseling put forth by ACL.

The core components of options counseling include:

1. Personal interview
2. Assisting with identification of available choices
3. Facilitating the decision-support process
4. Assisting in the development of an action plan
5. Connecting to services
6. Follow-up

Goals of Options Counseling

1. To provide people with the information they need to make informed choices
2. To provide appropriate guidance to proactively match people's needs, preferences and values with available services
3. To help people plan for the future and avoid "crisis" planning
4. To help improve the quality of life of individuals receiving long-term care services in the community based setting

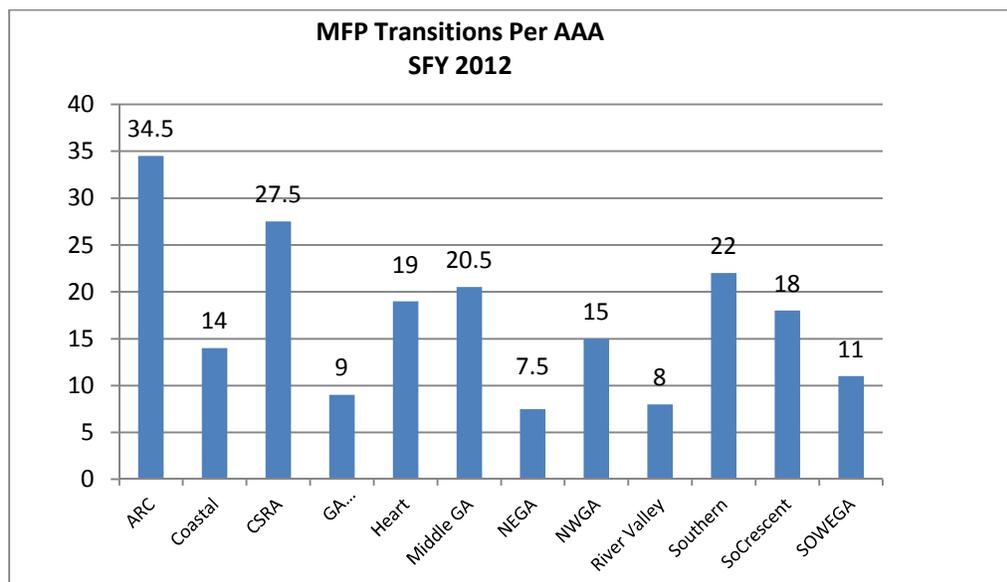
## Money Follows the Person

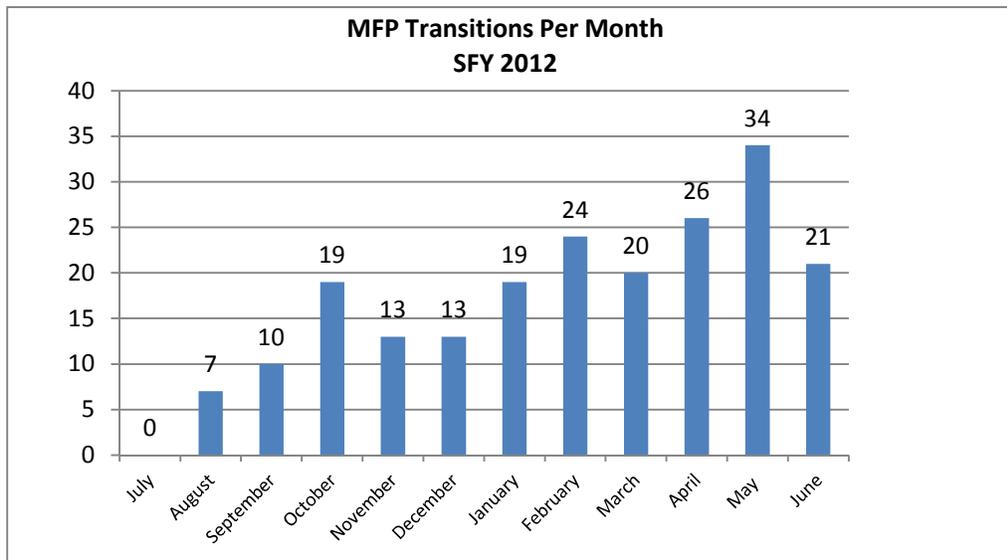
The Money Follows the Person (MFP) program was authorized by the 2005 Deficit Reduction Act. Its primary purpose is to transition eligible individuals from long term inpatient facilities back into community settings. The program is a demonstration grant through the Centers for Medicare & Medicaid Services (CMS). The Department of Community Health (DCH) is the administrator for Georgia. The first MFP transitions in Georgia occurred in 2008.

DCH currently partners with the Department of Behavioral Health & Developmental Disabilities (DBHDD) and the Division of Aging Services (DAS) to execute the program at the field level. DAS has been a part of the MFP program since July 2011. An independent contractor with DCH executed transitions prior to DAS involvement.

### MFP Transitions

DAS utilizes the Area Agencies on Aging (AAAs) to coordinate local transitions with 16 Transition Coordinators across the state. During SFY 2012, DAS and the AAAs transitioned 206 individuals back into the community.





## Success Stories

MFP has homecoming stories to share each and every month the program progresses. The most compelling are those that allow individuals to once again live fulfilling and productive lives. Two are highlighted below. (Pseudonyms are used).

Cheri:

Cheri was a young mother with an aggressive diagnosis of diabetes. Due to diabetes, she is legally blind and has chronic kidney disease. Her family was unable to care for both her and her small children. After an acute episode she found herself in the hospital, and shortly thereafter, a nursing home. She was in the facility for two and half years but eventually transitioned with the MFP program.

Cheri now attends a community college and will complete her Business Administration degree soon. MFP services were used to purchase adaptive technology to allow her to participate in-person in the classroom. A computerized vision assistance device allows her to view the lecturer and the blackboard on a screen at her desk.

Cheri lives in an apartment; she uses the SOURCE waiver program for personal assistance. Her children live with her once again, and she sends them off to school every weekday; an experience in which she was unable to participate for 2 years.

Cheri was invited to the 2012 Money Follows the Person national conference by CMS staff to share her compelling story, but she was unable to attend due to hospitalization. She hopes to attend next year.

Al:

Al was diagnosed with Multiple Sclerosis (MS) when he was in his twenties. He was successful in living a life without complications from his disability for twenty years. Eventually, the disease progressed to the point where he was unable to complete some activities of daily living. He was determined to live as full a life as possible and did so with a power wheelchair and other adaptive technology. He lived in his own home with his wife and children. While using a local paratransit service, he was involved in an automobile accident and was hospitalized. He spent a year in a nursing facility recovering before he learned of the MFP program.

Though it took another year for his transition to take effect, Al is now in his own apartment, participating in the Independent Care Waiver, and thinking about starting his own business. He is also eager to become a Peer Supporter with the MFP program.

### **Accomplishments**

MFP has transitioned nearly 400 participants in the first eighteen months DAS has been working with the program. This means 400 individuals have had an opportunity to lead a more fulfilling life.

Evaluation of the MFP program is done through a survey called the Quality of Life. This survey was developed for CMS by Mathematica Policy Research and they publish yearly reports on the quality of the MFP program. Data is analyzed locally by the Georgia State University Health Policy Research center. Currently, MFP participants in Georgia report they are happier and more satisfied with their lives after leaving the nursing home. The survey is separated into 7 major categories, and MFP participants share that they are more satisfied in nearly every one.

DAS and the AAAs, in a very short time, have developed a provider network to deliver very specialized services to MFP participants. MFP providers are structured very differently than typical aging services providers; therefore, the development of a new network became imperative.

### **Future Directions and Opportunities**

The MFP program is currently funded through 2016 (with a possible extension through 2020). DAS and the Aging Network intend to continue to support the program through this time period. In calendar year 2013, DAS will implement an evidenced based caregiver program to help the caregivers of MFP Participants. This is a new service that is offered in coordination with DCH, DAS, and the AAAs. By fiscal year 2014, DAS will have launched a data management system to specifically support the intense data and reporting needs of the MFP program. Soon, MFP will launch a Supported Employment program to assist MFP participants in returning to the workforce. Many MFP participants express a desire to return to work. DAS looks forward to growing and learning with the MFP demonstration grant as it continues to evolve into a system that is able to support the goals and dreams of those who desire to return home.

# Section

## 3

### Enhancing Elder Rights Programs

Ensuring the rights of older adults and preventing their abuse, neglect and exploitation continues to be a strategic priority for the Administration on Aging.

## Long Term Care Ombudsman

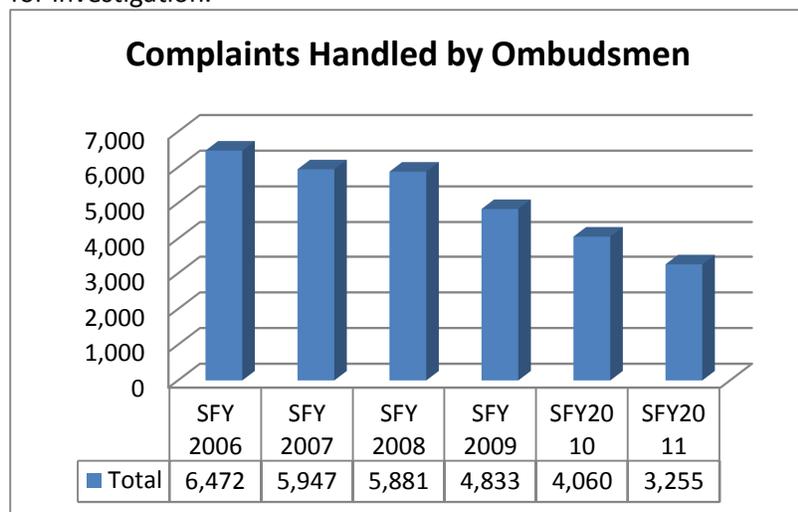
The Long-Term Care Ombudsman Program works to improve the quality of life of residents of long-term care facilities by acting as their independent advocate. This includes residents of nursing homes, personal care homes (also called assisted living), intermediate care facilities for the mentally retarded (ICF/MR), and community living arrangements (CLAs). Ombudsman staff and volunteers informally investigate and resolve complaints on behalf of residents

### Persons Served

In SFY 2011, the Long-Term Care Ombudsman Program served 179,223 persons, duplicate count. Eighty percent of these individuals were served during ombudsman visits to facilities. This represents an average of 1.9 ombudsman visits for each resident bed during the year. Over 11,700 individuals received information and assistance regarding long-term care options, public benefits, residents' rights, etc.

### Complaints Handled by Ombudsmen

In SFY 2011, the Ombudsman Program received 3,255 complaints. Ombudsmen received an average of 1.7 complaints per complainant for investigation.



Budget cuts beginning in SFY 10 resulted in a reduction in the LTCO workforce. Fewer LTCO to cover a growing number of facilities and

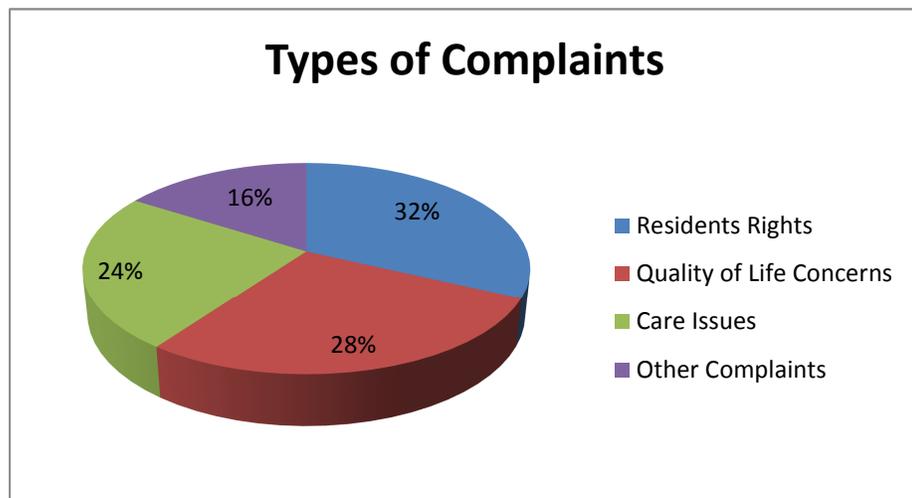
residents meant that LTCOs had to reduce the frequency of routine visits to facilities. With fewer visits, residents had fewer opportunities to routinely access LTCO. With replacement funding for the LTCO program, particularly in SFY '12, local LTCO programs have begun the process of hiring and training staff to be certified Long-Term Care Ombudsman. All LTCO programs are making efforts to increase their visibility at facilities to be accessible to residents providing information and assistance as well as complaint resolution.

Ombudsmen responded to complaints promptly:

- Abuse complaints where the resident was believed to be at risk: 97% within 1 working day
- Abuse complaints where the resident was *not* believed to be at risk: 94% within 3 days
- All other complaints: 99% within 7 working days
- Ombudsmen achieved **satisfactory outcomes for 94%** of complaints in SFY 2011

### Types of Complaints

Residents' rights (32%), quality of life concerns (28%), and care issues (24%) accounted for almost 84 percent of the complaints received by ombudsmen in SFY 2011.



### LTCO Accomplishments

Advocated for long-term care residents, including:

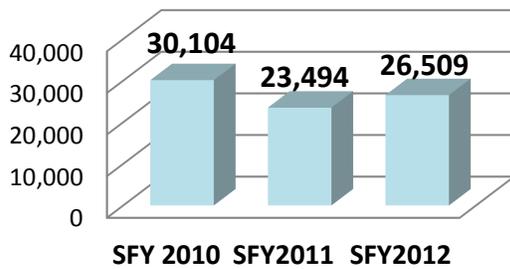
- Supported state legislation to create an additional licensing category of long-term care facilities known as assisted living communities which will provide more services than the current personal care homes, but fewer services than a skilled nursing facility provides
- Advocated for consumer protections in the assisted living communities bill
- Promoted the Advancing Excellence in America's Nursing Homes campaign with residents, families, facility staff, and the general public
- Participated in Money Follows the Person (advocating for skilled nursing facility residents making the transition from the nursing home to community settings)
- Advocated for Older Americans Act reauthorization language to strengthen the Long-Term Care Ombudsman Program

- Participated in discussions with AoA Region IV, State Unit on Aging directors, and State Long-Term Care Ombudsmen to enhance LTCO program management throughout the Southeast
- Served on work groups convened by the Healthcare Facility Regulation Division of the Georgia Department of Community Health, to develop regulations for proxy caregivers and to revise regulations for personal care homes
- Advocated with members of the Georgia Congressional delegation for funding for the Elder Justice Act
- Participated in the Advisory Group for the Culture Change Network of Georgia, including training on person-centered care and culture change

## Elderly Legal Assistance Program

The Georgia Elderly Legal Assistance Program (ELAP) serves persons 60 years of age and older by providing legal representation, information and education in civil legal matters throughout the state of Georgia. Services are provided by legal providers throughout the state, who contract with the state's twelve Area Agencies on Aging.

### Person's Served



### Person's Served

26,509 seniors received legal representation, information and/or education during SFY2012.

### Monetary Benefits Realized

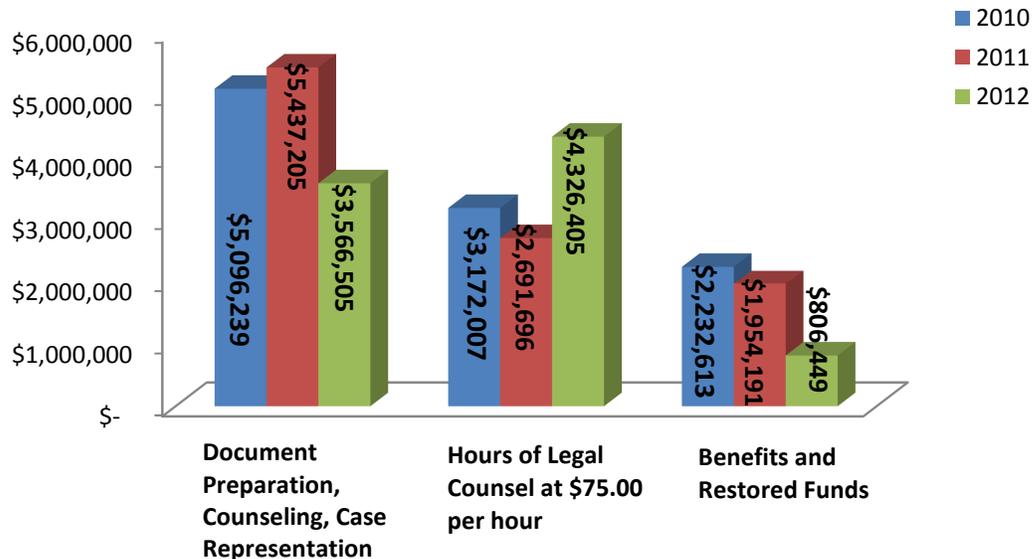
In SFY 2012 ELAP saved older Georgians \$3,566,505, by providing document preparation, legal counseling and case representation.

An additional \$4,326,405 was saved by providing more than 35,665 hours of legal counseling, calculated at a conservative \$75.00 per hour.

More than \$806,449 was obtained in benefits and restored funds for older Georgians through the work of ELAP.

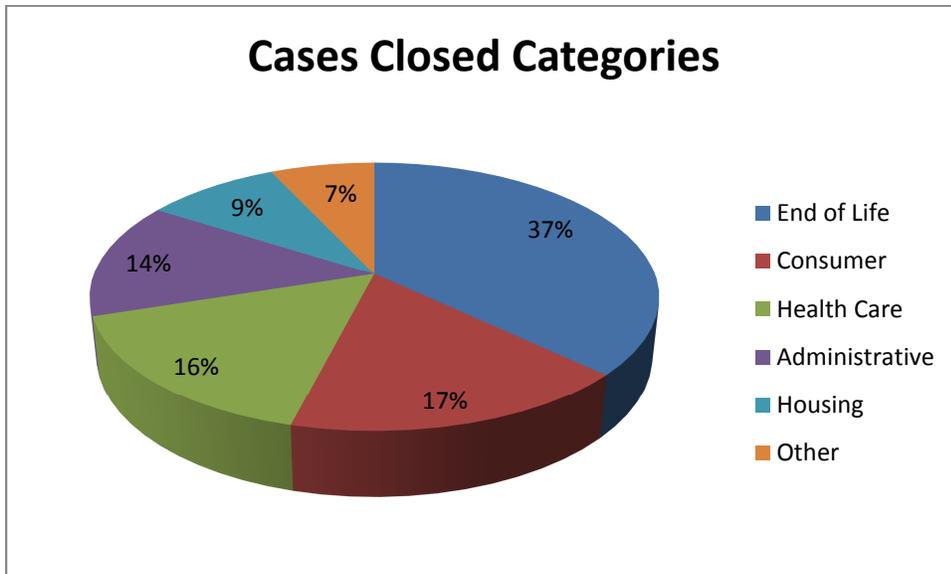
In SFY2012, more than \$8,699,359 was saved by older Georgians.

## Monetary Savings



-

There were case types that emerged this fiscal year that have not previously been significant in numbers. While Supplemental Security Income case totals decreased by ½, there were two other categories of disability cases that gained in significance, Supplement Security Income-disability and Social Security Disability. These completely replaced Unemployment Compensation in the top five categories of income maintenance (Administrative) cases.



## ELAP Community Education Offered

Community education is a method of prevention that helps seniors avoid more costly, time consuming legal problems. In SFY 2012, 578 legal education sessions were conducted by the Georgia Elderly Legal Assistance Program.

The top ten topics covered in community education sessions in SFY 2012 were:

1. ELAP/Legal Issues
2. SNAP/Food Stamps
3. Medicare
4. Health Law/POA/GA Advance Directive for Health Care
5. Consumer Fraud/Scams
6. Wills and Estates
7. Consumer
8. Housing/Home Repair
9. Debt Collection
10. Abuse/Neglect/Financial Exploitation

## ELAP Success Stories

1. An 82 year old client received a \$3,000 insurance payment for property damage. She and her spouse are both SSI recipients. When she reported the proceeds to SSA, their **benefits were terminated** and they were charged with overpayments. The client sought assistance from ELAP. The SSA regulations were presented providing proof that the money should have been excluded as it was received for the repair or replacement of an excluded resource. The client and her spouse were both reinstated and had their benefits fully restored.
2. A 76 year old **client had her identity stolen** by person who used her information to file fraudulent tax returns. The IRS held client liable for more than \$41,000 in fraudulently obtained tax refunds and the SSA charged client an increase in her Medicare premium based on the income from those returns. ELAP contacted the IRS and completed the required affidavits showing client's identity had been stolen. The SSA was contacted and the necessary paperwork completed to change the Medicare premium amount. The IRS released client from liability of the \$41,000 in fraudulent tax refunds and the SSA returned client's Medicare premium to its correct amount.
3. ELAP was asked to assist a 65 year old client who had been served with a **suit to collect debt on a credit card**. The client admitted to owing the money but was on a fixed income, living in subsidized housing and was suffering from Stage 4 lung cancer among other illnesses. A letter was sent to the adverse party's attorney, not to dispute the debt but to explain the circumstances and simply request that collection attempts and harassment strategies not be used against client at this point once the judgment was obtained. The attorney for the adverse party went back to his client, explained the circumstances and in days made the decision to voluntarily dismiss the suit in its entirety. A notice of dismissal of the action was faxed to the ELAP attorney but had not been filed with the court by the time the hearing was scheduled. Neither the adverse party nor counsel for the adverse party made an appearance in court and the Judge after seeing the Notice of Dismissal that had been faxed to the ELAP attorney, dismissed the case. Client was relieved of the worry of the suit and future collection/harassment attempts.
4. An **81 year old husband and his 85 year old wife** were each provided representation having entered the same skilled nursing facility, **applied for Medicaid and were both denied** upon allegations that their assets exceeded the limitations, jointly. Each was a private pay resident after entering the facility separately in June 2011 and continued to privately pay until September 2011 when each applied for NH Medicaid. The SSI limit was applied to the couple and they were found by DFCS to exceed the limit. ELAP contacted DFCS in writing asserting that the clients should have been treated as individuals and not couples as the Medicaid Manual provides that spouses entering a nursing home setting should be considered separated and treated as individuals for eligibility purposes. Had this been done, each would have only been deemed to own ½ of the joint account and would both have been within the required limitation. DFCS did not respond to the ELAP attorney's letter. The Power of Attorney had appealed on behalf of the clients and ELAP agreed to represent them at the OSAH hearing. Prior to the hearing, a DFCS supervisor contacted ELAP and acknowledged an agency error and approved both clients for NH Medicaid from the month of application forward. A written notice confirmed the new status and ELAP dismissed the appeal.

# Section

## 4

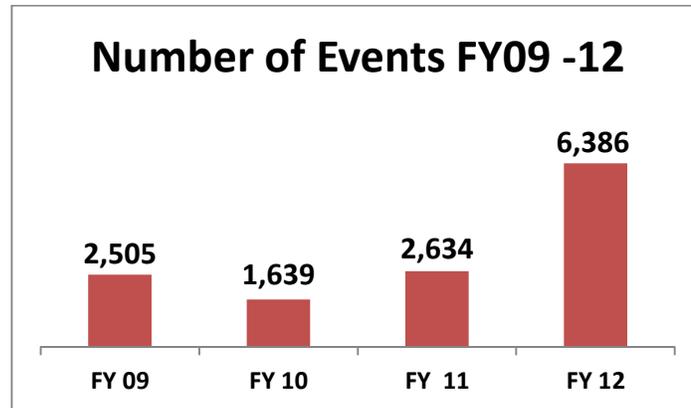
### Expanding Access and Outreach

This program is designed to assist Georgia's Medicare beneficiaries and families in understanding their rights, benefits and services under the Medicare program; improve the nutritional health of elderly Georgians by providing nutritious meals; promote successful aging by improving or maintaining the functional ability and health status of elderly Georgians; and provide accurate, up-to date information about community resources for elderly Georgians.

## GeorgiaCares

GeorgiaCares helps Georgia's Medicare beneficiaries, their families and others understand their rights, benefits and services under the Medicare program and other related health insurance options. GeorgiaCares is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol).

### Outreach and Media Events

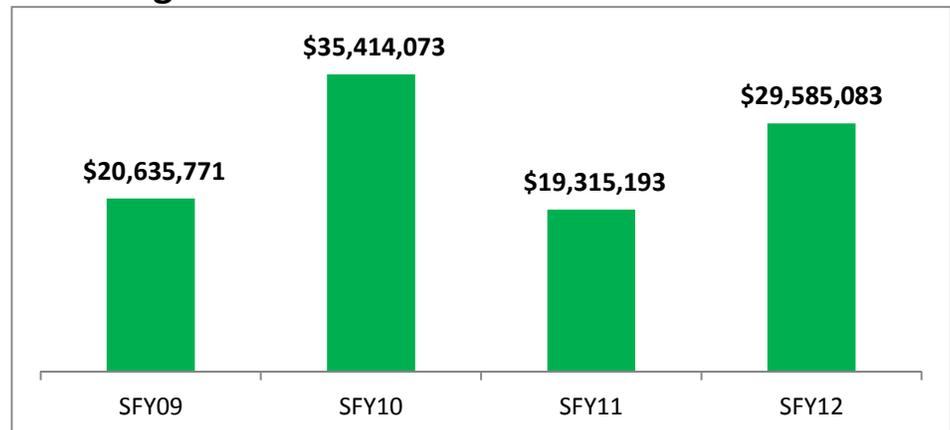


In State Fiscal Year 2012, GeorgiaCares conducted a total of 6,386 outreach and 925 media events (TV/Cable, radio, newspaper viewership) reaching 27,370,091 individuals regarding health insurance information on Medicare, Medicaid, prescription assistance, Medigap, long-term care services, and other health insurance needs and Medicare fraud prevention.

254 trained volunteers served clients in SFY 2012.

A total of 37,161 clients received one-on-one counseling.

### Reducing "Out-of-Pocket" Costs –

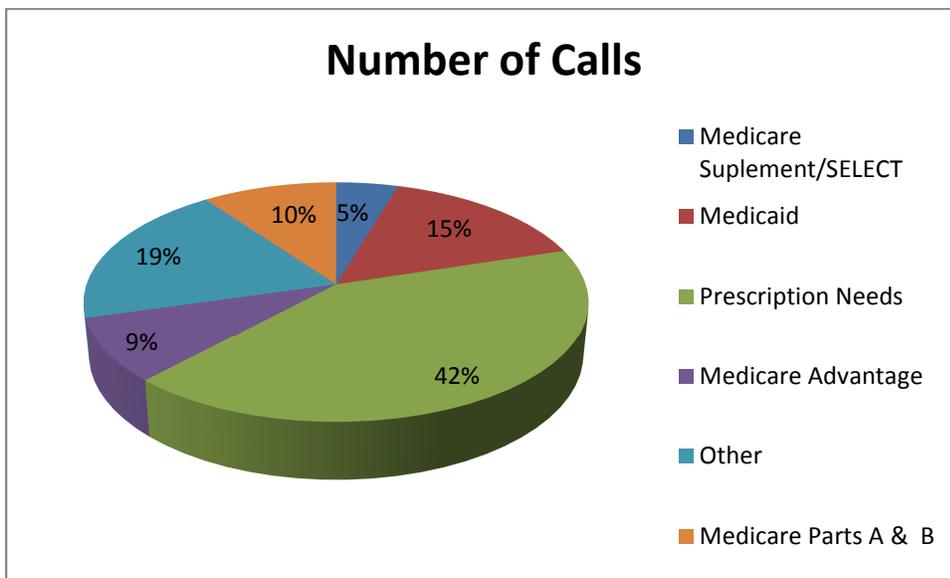


Over the last three years, GeorgiaCares has enabled clients to save more than \$84 million in health insurance and related expenses.

In SFY 2012, GeorgiaCares saved beneficiaries \$29,585,083 in out-of-pocket expenses.

## Topics Discussed with GeorgiaCares Clients

In SFY 2012, 42% of GeorgiaCares calls dealt with Medicare beneficiaries needing prescription assistance through Medicare Part C, Part D, and patient assistance programs.



## Outstanding Accomplishments for GeorgiaCares

- Received recognition at the National SHIP Directors Conference for having exemplary performance in 17 areas of the SHIP Performance Measures
- Continued partnership with the Department of Community Health to obtain client contact information for individuals eligible for the Low Income Subsidy (LIS) financial assistance program
- Renewed local program benchmarks for SHIP Performance Measures
- Continued annual Coordinator Recertification process
- Celebrated 20 years of providing information and assistance to Georgia's Medicare population

## Challenges for the Future

- Georgia has over 48,000 Medicare beneficiaries that appear to be eligible for Low Income Subsidy (LIS), but have not yet completed an application for the service to reduce their out-of-pocket costs for prescriptions. These individuals are a hard to reach population.
- GeorgiaCares is a statewide program serving all 159 counties in the state. However, it is often difficult to deliver services to each county due to location, accessibility and availability.
- Georgia is considered a high fraud state. This highlights the need for more education on the prevention, detection and reporting of health care fraud.
- Due to the lack of transportation, it is very challenging to recruit and maintain a volunteer workforce.
- Fewer financial assistance programs are available to assist Medicare beneficiaries with reducing out-of-pocket health care expenses.

# Section

## 5

### Elder Abuse Investigation and Prevention

Elder Abuse Investigations and Prevention provides a range of services to protect seniors from abuse, neglect, and exploitation. In addition, it works to improve the quality of life of residents in nursing homes and provides legal assistance to seniors. Program activities are distributed among various sub-programs:

- Adult Protective Services
- Elderly Legal Assistance
- Elder Abuse Prevention
- Long Term Care Ombudsman

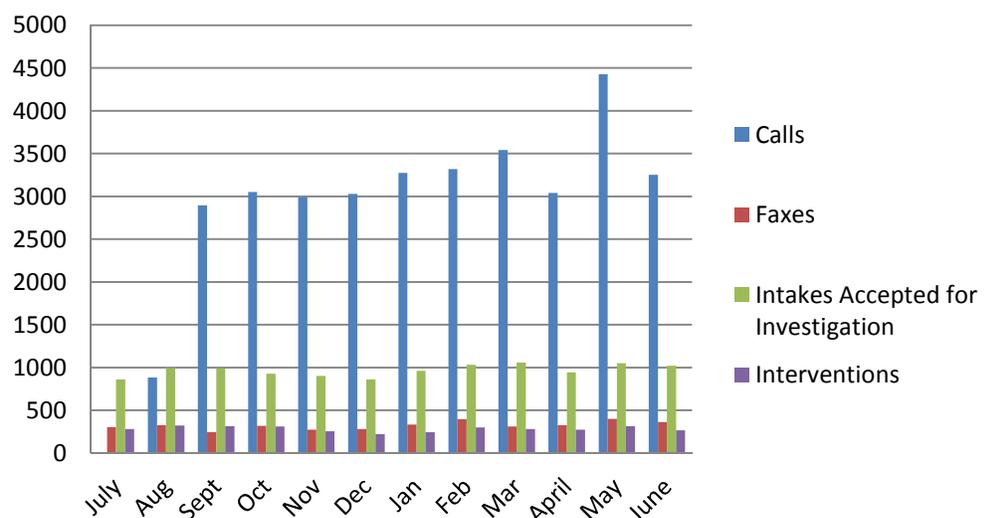
## Adult Protective Services Program

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 over the age of 18, or elders over the age of 65 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 method of providing safety prior to more intrusive methods.

### Central Intake

The APS Program receives reports of abuse, neglect and/or exploitation through its Central Intake Unit. Twelve APS specialists handle calls through a statewide toll-free number (1-866-552-4464) and respond to faxed reports from the community to determine if reports meet criteria for APS to investigate a case. If the criteria are not met, Central Intake staff often provides limited telephone case management to resolve the reporters issue and/or make referrals to community resources including those in the aging network.

### APS Central Intake - SFY 12



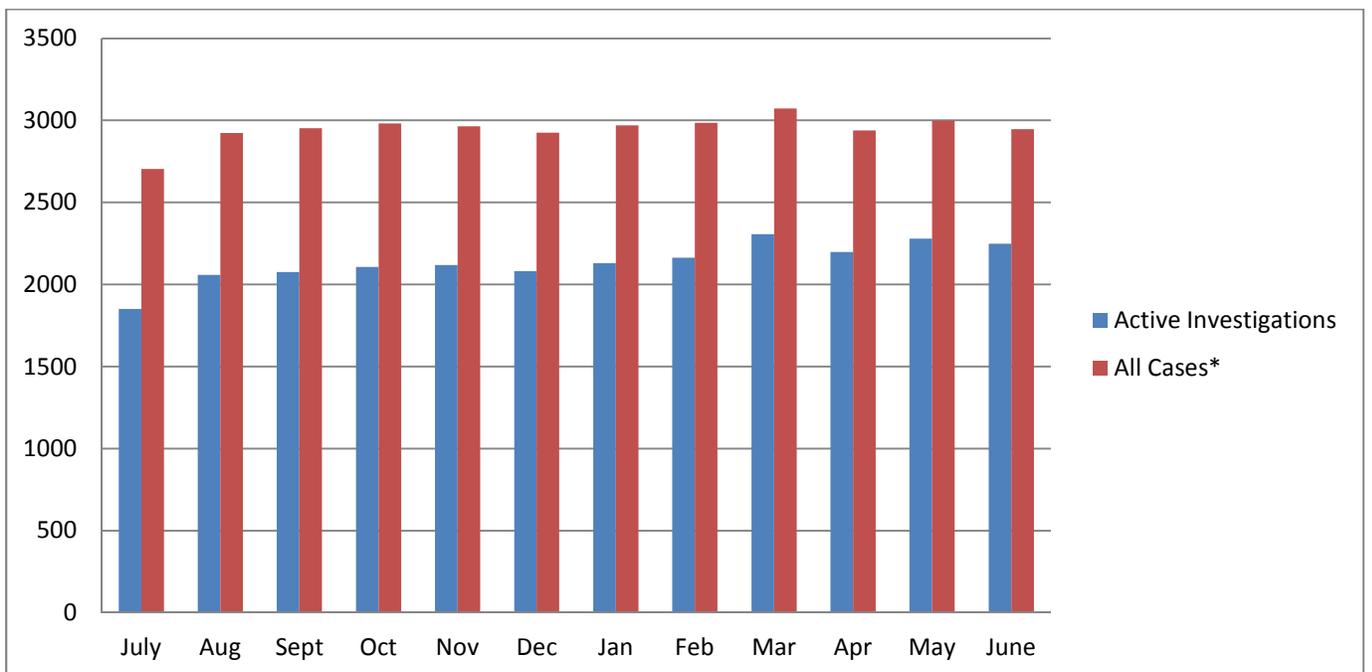
During SFY12, Central Intake staff handled a total of 33,709 calls on the toll free hotline and 3,889 faxed reports.

- A total of 11,608 reports were investigated
- CI staff provided limited case management intervention services on 3,396 reports that did not meet APS criteria for investigation.
- Other calls handled by CI consisted of time spent with calls back to reporters and coordinating referrals to community resources and other service providers to ensure callers' issues were addressed.

## APS Field Operations

Adult Protective Services uses a regional-based multi-disciplinary approach to meet the needs of vulnerable disabled and senior adults in the State of Georgia. APS regions are aligned with the aging network planning and service areas and reside in four Districts with 135 APS case managers who handle both investigations and case management services.

## APS Case Totals

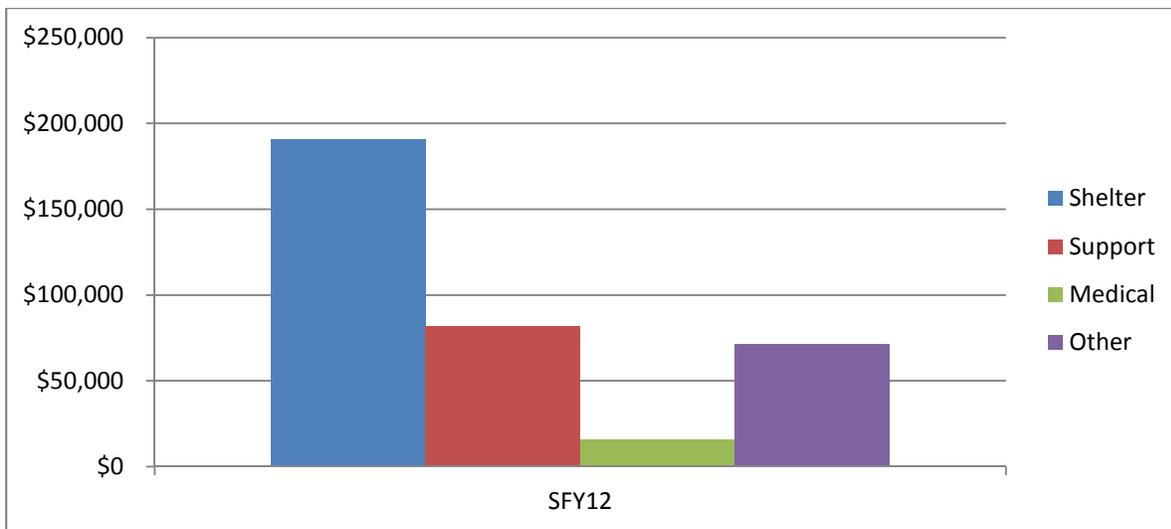


\*APS averaged 2,947 cases per month. Approximately 72% of all APS cases are investigations. The number of APS ongoing case management services declined from 925 in July, 2011 to 782 in June, 2012 due to the closure of many long-term Representative Payee cases. However, APS new investigations continued to increase during this same period, with 3<sup>rd</sup> – 4<sup>th</sup> quarter SFY12 averaging over 1,000 new investigations.

Caseload data represents unduplicated cases (investigations and ongoing): active investigations are those investigations active during the month.

## APS Emergency Relocation Funds

The APS program receives \$400,000 each year from the legislature to provide emergency relocation services to individuals who need relocation from an abusive situation. Emergency relocation funds can be used either to relocate APS clients or DHS wards to safe places or to provide for their needs in an emergency situation to allow them to remain at home. The majority of funds were spent on shelter for clients (\$190,684). Utilities (i.e. electricity, gas, telephone, water, sewage, etc.) accounted for approximately 77% of the Support category expenditures. Expenditures included in the “Other” category, which accounted for almost 20% of ERF usage, paid for items such as heavy cleaning and home modification and repair that often are needed to address issue related to self-neglect cases.



## Examples of Outstanding Accomplishments

- A web based reporting system was developed to provide an additional mechanism for receiving APS reports. The system is scheduled to be launched in Fall, 2012.
- During SFY12, DAS successfully completed its work to resolve conflict of interest issues raised when APS and PGO staff provide Representative Payee (Rep Payee) services for APS ongoing clients and DHS wards.\* The workgroup recommendations included a plan to transition Rep Payee case management responsibilities for the APS and DHS ward population to other SSA approved Representative Payee agencies or conservators. APS staff also worked with individual clients to restore their rights to be their own payee. In addition, APS reduced the number of Rep Payee cases from 367 to 134 by June, 2012.
- Developed a formal protocol with Division of Family and Children Services regarding transitioning challenging youth aging out of foster care.

- Developed a review process to identify cost saving measures with legal services billed by Special Appointed Assistant Attorney General's (SAAGs).
- A total of 125 staff hired between SFY09 and SFY12 participated in APS New Worker training.

## **Public Guardianship**

The DHS Office of Public Guardianship (PGO) provides case management for incapacitated adults for whom the Department serves as Guardian of Person. Case management services include, but are not limited to, maintaining sufficient contact with the ward to know of the ward's capacities, limitations, needs, opportunities, and physical and mental health; making decisions on behalf of the ward with regard to the ward's support, care, education and welfare; and ensuring that the ward's current and future needs are met (O.C.G.A. §29-4-22). During SFY12, PGO provided case management services for 754 wards.

### **Examples of Outstanding Accomplishments**

- During SFY12, DAS successfully completed its work to resolve conflict of interest issues raised when APS and PGO staff provide Representative Payee (Rep Payee) services for APS ongoing clients and DHS wards. PGO was able to eliminate Representative Payee responsibilities for all DHS wards. The DHS PGO was able to obtain successor guardianship for 5 wards and restore the rights of 4 others in SFY12.

\*DHS only serves as Guardian of Person; money management responsibilities must be handled by a conservator or an SSA approved Representative Payee agency. APS' legal mandate is to provide protective services.

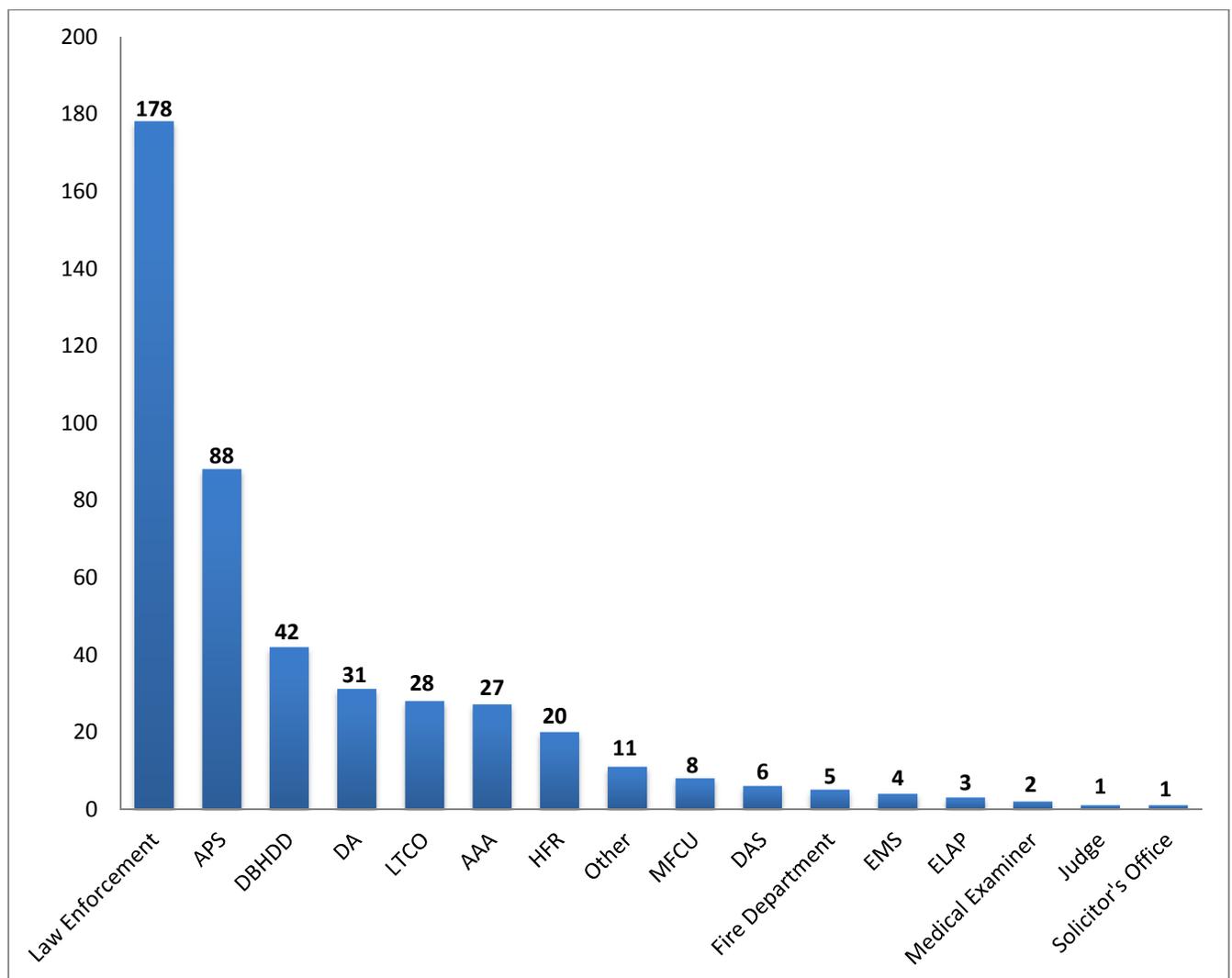
## Forensic Special investigations Unit (FSIU)

The Forensic Special Investigations Unit (FSIU) provides support to the Division of Aging Services (DAS), the Department of Human Services (DHS) and other partners by identifying and addressing system gaps and developing process improvements to protect Georgia's at-risk adults from abuse, neglect and exploitation. Some of the services provided by FSIU include training, outreach, technical assistance, and case consultation and review.

### FSIU Program Accomplishments for SFY 2012

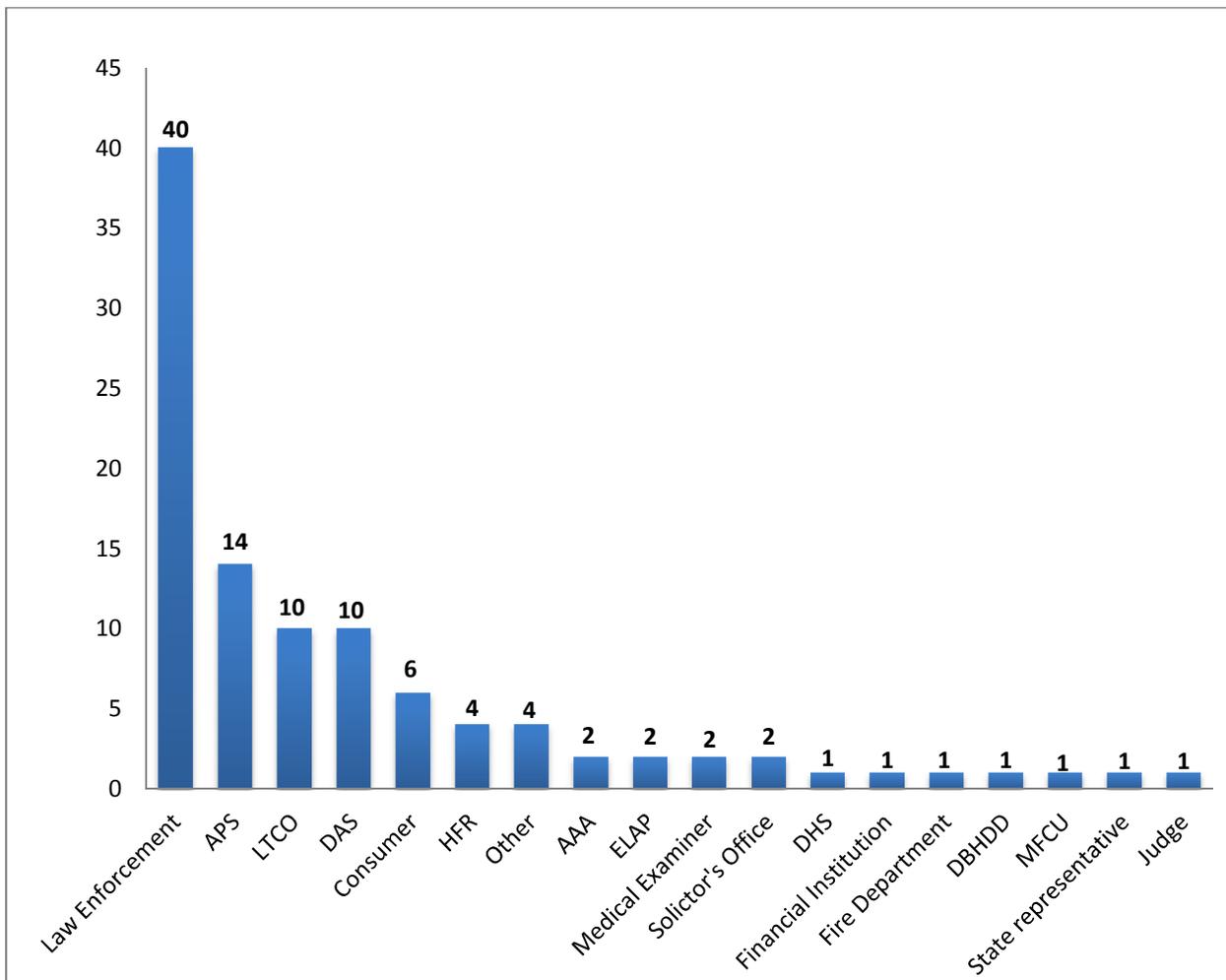
- In April 2011, FSIU deployed the At-Risk Adult Crime Tactics (ACT) Certification training program. ACT provides participants with basic knowledge and skills needed to respond to crimes involving the abuse, neglect and exploitation of older adults and adults with disabilities. During SFY 2012, 455 participants became certified ACT Specialists.

### ACT Specialists trained in SFY 2012 by Discipline



- FSIU provides an Adult Protective Services (APS) Forensics 101 course to increase investigative and testimonial skills for court. This course was provided to 107 APS professionals.
- At-Risk adult abuse, neglect and exploitation training/outreach was provided to over 578 people including the general public and other professionals.
- Technical assistance and case consultation was provided to over 103 individuals.
- Through the efforts of the ACT Certification program as well as continued efforts of APS and local Area Agencies on Aging, referrals to APS from law enforcement increased by 34.5% from SFY2011 to SFY2012.

### Technical Assistant requests in SFY2012 by Discipline



### **FSIU Success Stories:**

Individuals who have become ACT Certified and/or received technical assistance/case consultation from FSIU have reported numerous success stories of how this information assisted them in pursuing cases of abuse, neglect and exploitation.

- Upon completing ACT certification, a law enforcement detective reopened 3 cases to present to the DA using O.C.G.A 30-5-8.
- Four people were charged with felony murder and felony cruelty to an elderly person over the age of 65 over the death of a 75-year old resident who died while in the care of a personal care home.
- An individual was indicted on charges of felony theft by taking and abuse, neglect, or exploitation of disabled or elderly person after he allegedly took more than \$69,000 from his grandmother-in-law.
- A bank employee was charged using O.C.G.A 30-5-8 for allegedly withdrawing \$5,600 from the account of a 90 year old bank customer without her consent.
- An individual was charged using O.C.G.A. 30-5-8 for allegedly stealing \$16,500 from her mother's accounts while her mother was in the hospital.
- An individual was charged using O.C.G.A 30-5-8 for allegedly opening credit cards using his 78 year old grandmother's identification and running up over \$25,000 in balances.
- The owner/operator of 2 licensed personal care homes and 6-7 unlicensed personal care homes was charged with multiple counts of felony theft by taking and exploitation and abuse of elderly and disabled adults.
- Partnered with DeKalb District Attorney, GBI, and the Governor to develop an elder abuse commercial that is being used statewide on cable television and on the DAS YouTube channel.

### **Future FSIU Initiatives:**

- Beginning in SFY 2013, FSIU will facilitate of the Serious Incident Review Team (SIRT) which reviews serious incidents of DHS Wards under public guardianship case management by APS, Community Care Service Program (CCSP) consumers in Alternative Living Situations (ALS) and Money Follows the Person (MFP) participants. The goal of the team is to reduce incidents contributing to preventable unexpected deaths and serious injuries by identifying patterns leading to these incidents and determining and developing strategies to prevent them.
- A Train-the-Trainer curriculum is being developed to expand the ACT Certification program.
- Beginning in SFY 2013, evaluations will be conducted to measure increased knowledge and application of information by ACT participants.
- FSIU is working with the Georgia Bureau of Investigations (GBI) to develop a roll call training video for law enforcement.

# Section

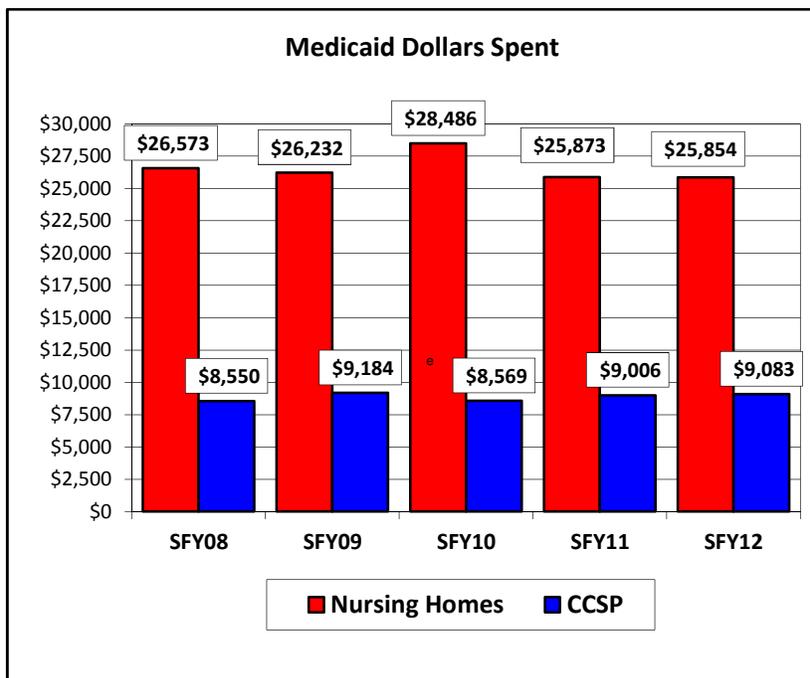
## 6

### Community Care Services Program

This program provides a continuum of supports to seniors, adults with disabilities and their caregivers in order to enable them to stay at home for as long as possible while maintaining health, independence and safety.

## Community Care Services Program (CCSP)

The Community Care Services Program (CCSP) has successfully served eligible elderly and physically disabled consumers in Georgia for 30 years. By providing home and community-based Medicaid services to consumers eligible for nursing facility placing, the CCSP gives consumers the choice of remaining in the community. Consumers are eligible for CCSP services in two categories. SSI Category is when persons receive Supplemental Security Income (SSI) and are eligible for medical assistance. The Social Security Administration takes applications for SSI. Medical Assistance Only (MAO) Category is when persons who do not receive cash benefits under the SSI program, but may qualify for medical assistance under another Medicaid category. The County Departments of Family and Children Services take applications for MAO. MAO participants may have to pay toward the cost of their services.



The graph reflects the average CCSP client service benefits cost and does not include care coordination or administrative costs.

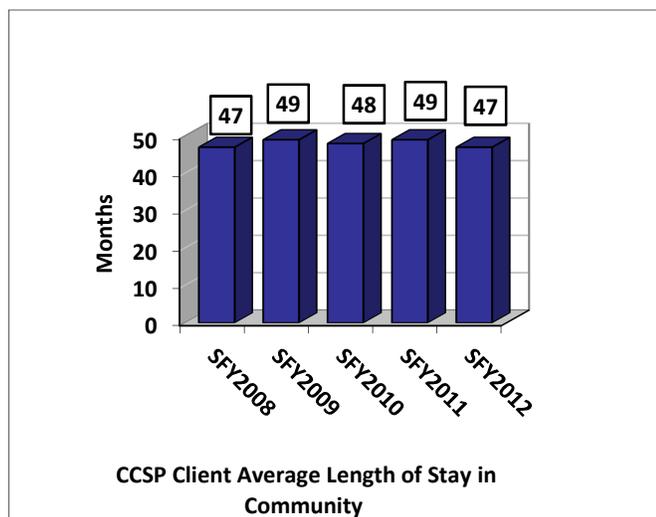
Ninety-five percent of eligible consumers choose to participate in the community based CCSP.

In SFY 2012 CCSP supported the choice of 12,825 Georgians to remain in the community, at less cost to Medicaid and effectively delaying or avoiding more expensive nursing facility placement.

CCSP saved taxpayers \$16,771 per individual in SFY2012.

Forty-six percent of CCSP clients were 75 years of age or older; 22% were 85 or older, and 111 clients were age 100 or older in SFY2012. Twenty-three percent of consumers were under 60 years of age.

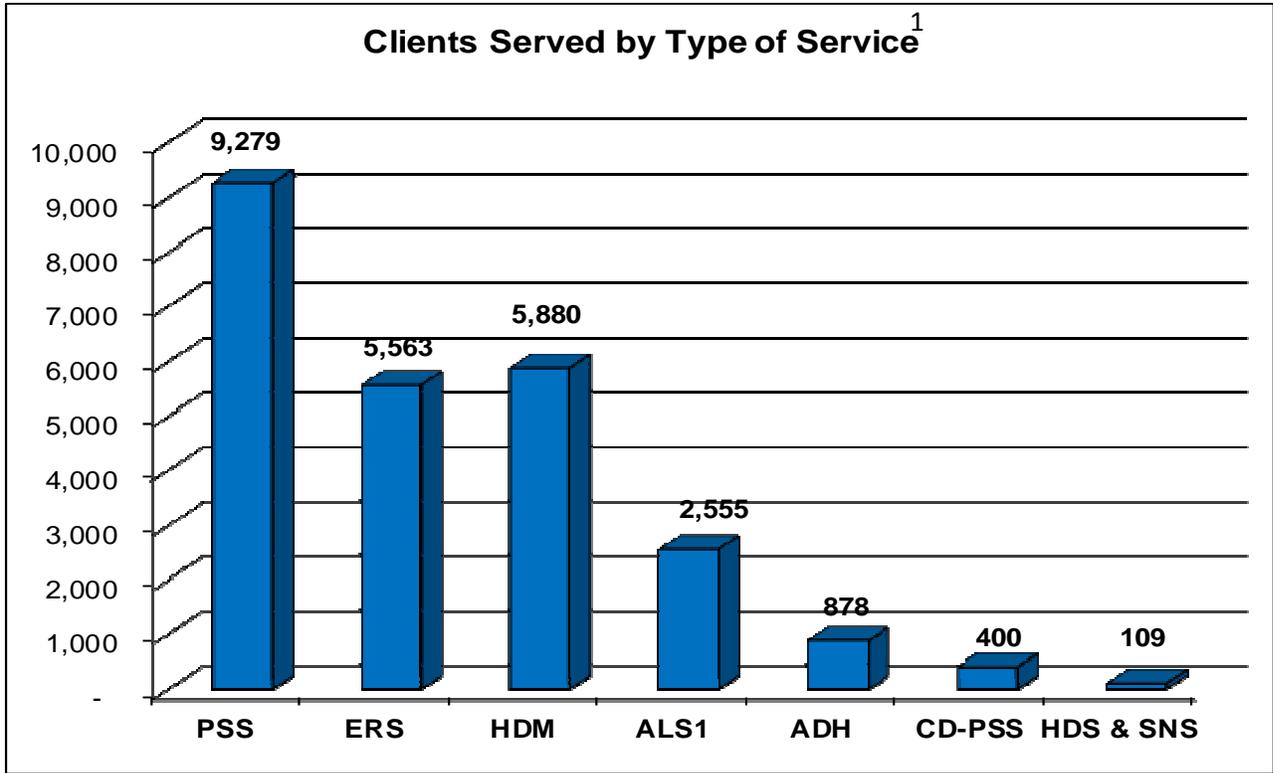
In SFY 2012, effective care coordination allowed clients' needs to be met so that the average consumer length of stay in the community was an additional 47 months, nearly four years.



## CCSP Services

- Adult Day Health (**ADH**) – health, therapeutic and support services in a day center
- Alternative Living Services ( **ALS-F** (2-6 beds); **ALS-G** (7-31 beds) – 24-hour personal care, health-related support services and nursing supervision in a licensed personal care home
- Emergency Response Services (**ERS**) – 24-hour electronic medical communication support system
- Home Delivered Meals (**HDM**) – meal delivery services
- Home Delivered Services (**HDS**) – Skilled Nursing Services (**SNS**) and personal support in the client's home
- Personal Support Services (**PSS, PSSX, CD-PSS**) – personal care, support, and respite services in the client's home. Some respite care is available for full-time caregivers. Eligible consumers may choose Consumer Directed Personal Support Services (CD-PSS) to hire and supervise their own worker(s), for personal care and in-home services.
- Out-of-Home Respite Care (**OHRC**) – temporary relief for the individual(s) normally providing care (service numbers are included in the PSS total in the graph below).
- Tailored Care for Caregivers (T-CARE®) has been implemented statewide by all 12 of Georgia's Area Agencies on Aging. The assessment and care plans are designed to meet the needs and support the caregivers of CCSP Clients.

Seventy-two percent of CCSP clients use Personal Support Services. The service accounts for 69% of total CCSP expenditures. Alternative Living Services ranks second in expenditures (12%). Forty-three percent of CCSP clients use the Emergency Response Services (accounting for 1% of CCSP Medicaid expenditures).



<sup>1</sup> Duplicated client count: clients may receive more than one service.

### CCSP Success Stories SFY 2012

“My mother is a client of the CCSP. For many years, **the program has provided her with a much better quality of life than she would have had without it.** Much needed help with housekeeping, laundry, meal preparation, assistance with bathing and so much more have been provided by the aide who is funded through the CCSP. She also provides needed companionship. The presence of the aide has also serviced to lighten the load of her primary caregiver so that he can find time for other essential caregiver duties.

After a fall, mother spent many months in a nursing home for PT. Her CCSP care coordinator was involved in the process of mother’s return to the community. She coordinated much of the support necessary for mother to continue to live in an independent setting. We will be forever grateful for the program, the program staff, and the services the program provides to keep mother in her own apartment.”

Caregiver son of Female consumer age 88 receives PSS, PSSX, MFP  
Rome, Northwest GA AAA

“I am so thankful for the services I receive from CCSP. I am unable to stand on my feet to cook a meal. Receiving home delivered meals I am able to have a hot nutritious meal. I think that this has actually improved my health. I am truly blessed to have my ERS button. I have had to use my button twice this year and I really believe this button has saved my life. With the help of these services, I am able to stay in my home.”

Female consumer age 57 receives ERS, HDM  
Alma, Southern GA AAA

“I am the primary caregiver for my 63 year old husband. The Community Care Services Program has been a great help to my family and me. The services allow me to be able to work during the hours my husband is at ADH. The ERS unit allows me to run errands without worrying about my husband’s safety. The home delivered meals give me some relief while providing my husband with a balanced meal. The CCSP program gives me and my family a peace of mind knowing someone is helping me during the week. I appreciate the program and what it has done for me and my husband.”

Spouse Caregiver of Male consumer age 63 receives ERS, HDM, and ADH  
Savannah, Coastal GA AAA

“CCSP helps me to be more independent. I would be in the Nursing Home if the services were not provided to me. The Personal Support aide assists me with my daily living tasks and she provides companionship. Sometimes no one is home and having Home Delivered Meals is very convenient for me. Having the ERS makes me feel more secure knowing that I can receive help by mashing the button.”

Female consumer age 41 receives PSSX, HDM, ERS  
Dawson, Southwest Georgia AAA

# Section

# 7

## Older Americans Community Service Employment Program

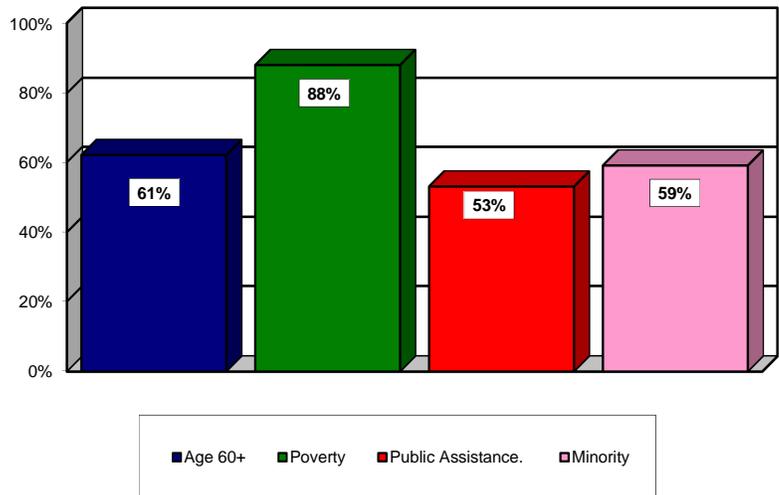
The Senior Community Service Employment Program (SCSEP) is a program of the United States Department of Labor(DOL), its Employment and Training Administration, to help more senior citizens get back into or remain active in the labor workforce. Georgia's program is administered by the Georgia Division of Aging Services. It is a community service and work-based training program through job skills training and employment assistance with an emphasis on getting a job with a suitable company or organization. The worker is paid the US minimum wage, or the prevailing wage, for an average of 20 hours per week, and experiences on-the-job learning and newly acquired skills use. The intention is that through these community jobs, the older worker will gain a permanent job, not subsidized by federal government funds.

## The Senior Community Service Employment Program

The Senior Community Service Employment Program (SCSEP) provides useful part-time community service assignments and training for unemployed, low income older Georgians and helps them obtain paid employment. While participants develop job-related skills and earn minimum wage, the community directly benefits from the work they perform.

### Persons Served

SCSEP Participant Demographics



- Although participants can be as young as 55 years of age, 61% were over age 60.
- Eighty -eight percent (88%) of persons enrolled had incomes below the federal poverty level.
- Fifty-three percent (53%) of current enrollees were receiving public assistance.
- Fifty-nine percent (59%) of enrollees were minorities.

## Examples of Outstanding Accomplishments

The Department of Labor establishes indicators for each state to measure the SCSEP program performance. The performance indicators measure six performance categories. In Program Year 2011, Georgia exceeded or came close to achieving the DOL targets:

- Community Service goal: This measure reports the participants' time spent at their community-based Host Agency training sites. For PY 2011, the DOL target goal for GA was 50% (50% of participants' time spent at their Host Agencies). GA exceeded the DOL goal and achieved 174.7%.
- Entered Employment goal: This measure reports for a given quarter the rate of participants who obtain unsubsidized employment after exiting the program. The DOL target rate for GA for PY 2011 was 58.0% (58% of exiters in any quarter must be for entered employment). GA exceeded this goal with an 80.9% entered employment rate.
- Employment Retention Rate goal: This measure reports the rate of participants who entered employment and remain employed for the two quarters following their exit quarter. The DOL target goal was 68% (68% of participants who entered employment should remain employed for the two quarters following their exit quarter). GA also exceeded this target goal and achieved 104.5%.
- Service Level goal: The service level goal shows the per cent of enrollment in GA's authorized SCSEP positions over the year. The DOL goal for GA was 100% (GA should have 100% of its authorized positions filled over the program year). GA's SCSEP program had more than the required number of participants enrolled at the end of PY 2011 (212.3%).
- Earnings goal: DOL sets this goal to determine the average earnings of participants who enter and retain employment for the first two quarter after their exit. GA achieved 94.7% of the DOL average earnings goal of \$7,185 (\$7,185 is the target average for second and third quarter earnings of participants retaining employment).
- Most-in-Need goal: The most-in-need measure reflects the average number of employment barriers a participant faces, such as disability, veterans, age 65 or older, limited English proficiency, or low literacy skills. DOL requires that participants with these employment barriers be given priority in the program's enrollment. GA achieved 95% of the DOL target goal to serve most-in-need participants with an average of 2.68 employment barriers.

## Community Benefits

Participant wages contribute to the local economy and reduce dependence on public benefits programs. Participants provided over 345,496 hours of service to community organizations.

Thirteen percent (13%) of Program Year (PY) 2011 participants were individuals with disabilities.

Thirty-one percent (31%) of PY 2011 participants were homeless or at risk of homelessness.

The most common job assignments were in organizations providing social service programs and schools, followed by services to the elderly.

## Challenges and Directions for the Future

**DAS, SCSEP grantees, and sub-projects will undertake the following strategies to improve SCSEP services:**

- SCSEP grantees and sub-projects will continue to strongly encourage participants to become more marketable by utilizing all available resources within the residing county or nearby urban counties. This will support participants who may have job opportunities but are not meeting the requirements for available positions.
- Job availability information will be provided to participants by weekly linkage to available job openings through “JobReady” announcements and other online job search websites.
- SCSEP grantees and sub-projects will enroll participants in monthly workshops at One Stop locations.
- Goodwill Success Centers will develop “Job Clubs” with outside business participation to promote hiring.
- SCSEP grantees and sub-projects will use media sources such as TV/Cable commercials and PSAs to promote SCSEP and appeal to high-growth businesses in the urban areas such as medical, social, retail and hospitality, insurance and finance.
- Over the next four years, economists anticipate development and business growth connected with Alabama and the districts along the river area dividing Alabama and Georgia. The majority of jobs will be in hospitality, retail and administrative support, which in the Columbus area is a close match to the skilled training received at the majority of host locations.
- SCSEP providers will build connections with private businesses to explore utilization of OJE with job ready participants to enhance unsubsidized employment obtainment.
- SCSEP grantees and sub-projects will reinvigorate memberships with local Chambers of Commerce to promote connections with the private sector.
- SCSEP grantees and sub-projects will continue job development with the help of the Participant Assistants to seek out unconventional job opportunities.
- SCSEP grantees and sub-projects will offer grantee-sponsored trainings to use data in SPARQ to identify trends of successful past participants and begin to recruit and enroll participants with common traits.

## **SCSEP Success Stories**

Katie D. is a great SCSEP success story because of her accomplishments since March when she accepted the position as a WIA Contract Specialist. Katie had no experience in job development in the past. She trained in a Senior Services Coordinator position for less than one year and was offered the position. Since her hire in March, she has worked hard and by the end of June when the program year ended, she had more than doubled the number of persons employed and trained through that program in the other nine months of the year. Since July, she has arranged employment for 10 participants, which is almost double the goal for the quarter. She continues to develop her own skills and to provide service to other job seekers.

Sarah H. lives in the small, rural Georgia town with her adopted daughter. As with many rural towns in Georgia, there are few job opportunities, especially in the last few years since the recession hit. Their only source of income was Sarah's social security check and it was simply not enough to pay the bills. In 2010, Sarah inquired about the SCSEP program.

After being assessed and enrolled, Sarah was assigned to a community social service agency. Earlier this year, she was transferred to a participant assistant position, working with a SCSEP sub-project. This assignment gave her the opportunity to find out about local jobs and as a result, she was hired in September, 2012, by a local Senior Center as an administrative assistant working 30 hours per week. Sarah says, "I have been given the tools I needed to find a good job. I just want everyone at [SCSEP] to know how grateful I am for the help and support I received from this wonderful program."