DIVISION OF AGING SERVICES

SFY 2017 – SFY 2020 AAA AREA PLAN CYCLE

ATLANTA REGIONAL COMMISSION AAA
SFY 2017 AREA PLAN

January 1, 2016

Item #1
SFY 2017 Area Plan Checklist & Area Plan Contents

Enter Completed by:	Enter Date Submitted:			
***Denotes Signature Required**	**Yes**	**No**	**N/A**	**Comments**
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Item #2 - Letter of Intent

[Insert Here]

Items #3a through #3e – Executive Summary

Item #3a - Summary Description of Federal, State and Local Aging Network

The Administration for Community Living (ACL) was created on April 18, 2012 by bringing together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities. ACL was based on a commitment that people with disabilities and older adults should be able to live where they choose, with the people they choose and fully participate in their communities. The Administration for Community Living (ACL) is part of the U.S. Department of Health and Human Services and is headed by the Administrator, who reports directly to the Secretary of Health and Human Services (HHS). ACL is structured to provide general policy coordination while retaining unique programmatic operations specific to the needs of each population served. ACL is comprised of the seven units, one of which is the Administration of Aging.

The Administration on Aging is led by the Assistant Secretary for Aging and provides leadership and expertise on program development, advocacy and initiatives affecting older Americans and their caregivers and families. Working closely with regional offices, state and area agencies on aging, tribal grantees and community service providers, it plans and directs grant programs designed to provide planning, coordination and services to older Americans as authorized under the Older Americans Act and other legislation. It includes the following offices:

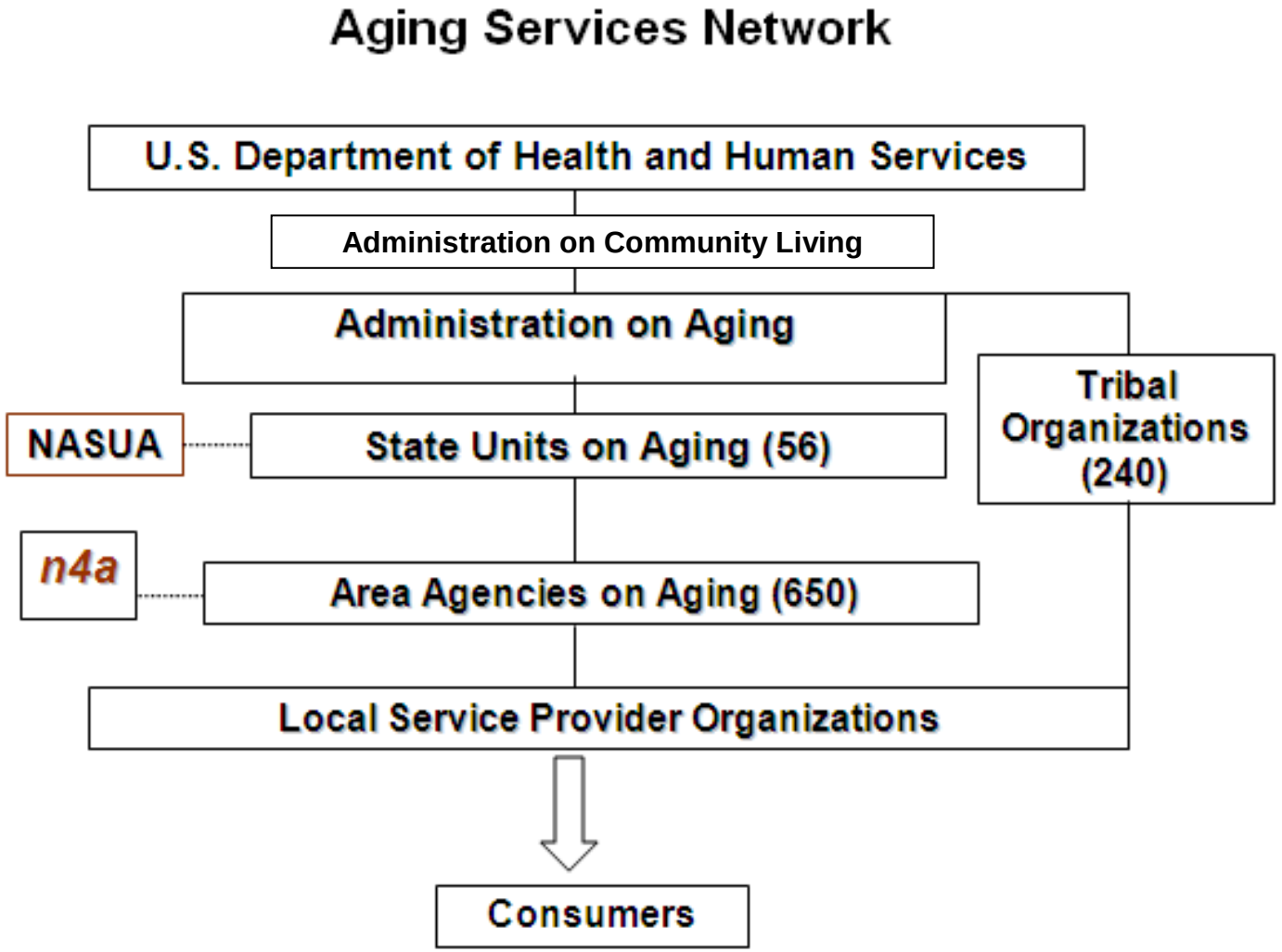
- Office of Supportive and Caregiver Services
- Office of Nutrition and Health Promotion Programs
- Office of Elder Justice and Adult Protective Services
- Office of American Indian, Alaskan Native and Native Hawaiian Programs
- Office of Long-Term Care Ombudsman Programs

The Administration on Aging awards OAA funds for supportive home and community-based services to the State Units on Aging (SUAs), which are located in every state and U.S. territory. SUAs are agencies of state and territorial governments designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs and services for the elderly and their families and, in many states, for adults with physical disabilities. These state government agencies all share a common agenda of providing the

opportunities and supports for older persons to live independent, meaningful, productive, dignified lives and maintain close family and community ties. Funding for programs is allocated to each SUA based on the number of persons over the age of 60 in the state. Most states are divided into planning and service areas (PSAs), so that programs can be tailored to meet the specific needs of older persons residing in those areas. In Georgia, the state unit on aging is the Division of Aging Services (DAS) and it is housed in the Georgia Department of Human Services and administers a statewide system of services for older adults and their caregivers. Their mission is to support the goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families and caregivers to achieve safe, healthy, independent and self-reliant lives.

Within each state, Area Agencies on Aging (AAAs) are the agencies designated by the state units on aging to be the focal points for Older Americans Act programs within defined geographic regions. Twelve of these AAAs are within the state of Georgia and are located within regional planning commissions. The Division of Aging Services (DAS) coordinated with the 12 AAA's identified by geographic boundaries. Community-based services for older Georgians are coordinated through these agencies. AAA'S are effective advocates for the needs for Georgia's aging population.

Georgia's AAAs have five basic functions: administration, advocacy, coordination, outreach and program development. As the Area Agency on Aging for the ten county Atlanta region, the Atlanta Regional Commission (ARC) incorporates these functions into the delivery of comprehensive services to address the needs of the region's older population. The Atlanta region's Area Plan on Aging is implemented through contractors to provide a continuum of home and community based services. Older adults and their families have many options, including case management, in-home services, respite, transportation, home-delivered meals, congregate meals, senior recreation, legal services, and more through this network of care. The chart below illustrates the flow of the various components of the aging network. The contract agencies and the services provided are identified in Section III; Service Delivery Plan.



Item #3b - Overview of the Area Agency on Aging

As the regional planning and intergovernmental coordination agency for the Atlanta region, the Atlanta Regional Commission (ARC) was created in 1971 pursuant to legislation passed by the Georgia General Assembly. It is made up of the ten counties of Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale and 71 municipalities including the city of Atlanta. ARC provides a forum where elected and appointed officials from these local governments, along with other community leaders come together to address mutual challenges and opportunities and, with input from the community, decide issues of region wide consequence.

As the comprehensive planning agency for the Atlanta Region, ARC coordinates planning efforts in the areas of aging, community services, environment, governmental services, job training, land use and public facilities and transportation. The Commission is also a primary source for current and comprehensive statistical data and information about the region. This information is available to the general public through ARC's Information Center and ARC's website www.atlantaregional.com.

In addition to serving as the region's Area Agency on Aging, ARC is also the local administrative agency for federal job training programs through the Metropolitan Atlanta Private Industry Council and the federally designated Metropolitan Planning Organization, which coordinates regional transportation planning.

The Atlanta Regional Commission is composed of the Office of the Director, three Centers and 14 Divisions (See ARC Organizational Chart on page 11.) The Aging Division (Area Agency on Aging) is one of two Divisions within the Center for Community Services) The Aging Division is the largest division at ARC. (See Aging Division Organizational Chart on page 12.)

Interactions between the Divisions take place at regular meetings held between the Director of ARC and the Directors of the Centers. Additionally, ARC holds quarterly staff meetings where all employees meet to share information concerning activities taking place in their Divisions.

1) *The Atlanta Regional Commission has standing committees: Governance, Advisory Committee on Aging, Aging and Health Resources, Budget and Audit Review, Community Resources, Ethics, Pension Board of Trustees, Regional Transit, Transportation and Air Quality, Strategic Relations, Water Planning Board, Atlanta Regional Workforce Board and other special task forces as needed.* The Governance Committee shall consist of the Chair, the officers of the Board and the Chairs of the policy committees (Aging and Health Resources Committee; Community Resources

Committee; Regional Transit Committee; Strategic Relations Committee; and Transportation and Air Quality Committee. The duties of the Governance Committee shall include the oversight of all internal policy related issues and to advise the Board on matters which are of general concern to the commission.

The Advisory Committee on Aging conducts meetings which are open to the public on the first Tuesday of each month at the Atlanta Regional Commission. (See C-5 in Attachment C for listing of Committee members.) The functions of the Committee are:

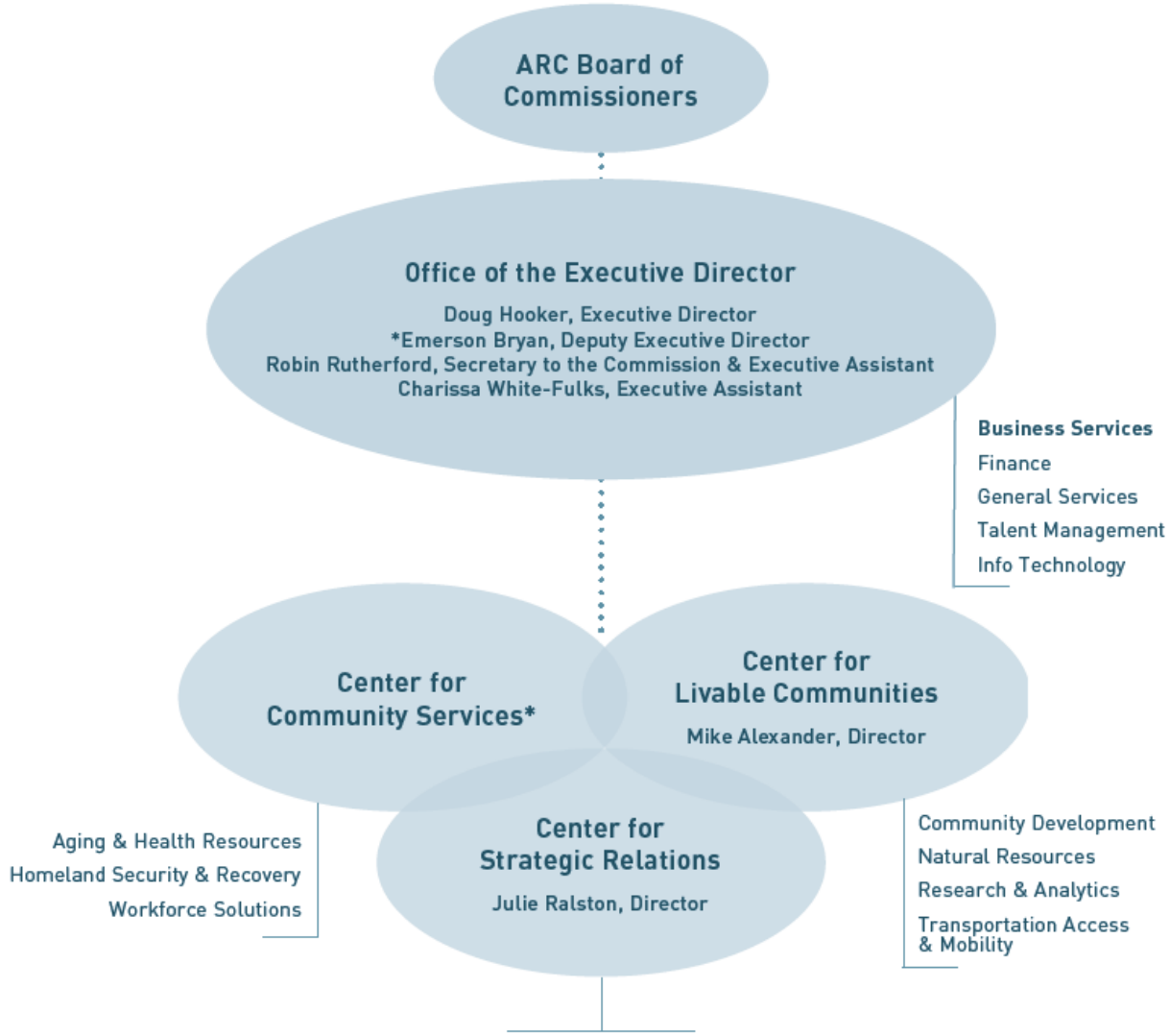
- To advise and submit recommendations on all matters relating to the development, review and evaluation of the Area Plan on Aging;
- To report on activities, needs and initiatives in local communities;
- To increase community interest in issues affecting older adults;
- To promote awareness among the public of federal, state and regional resources available for the elderly;
- To cooperate with and assist municipalities, educational institutions, private businesses and nonprofit organizations within the region in the development of programs and services for older adults.

Final policy-making authority within the Atlanta Regional Commission resides with the full Commission Board. While the Commission may, on rare occasions, assign specifically bounded decision-making responsibility for limited time periods to the Governance Committee or to one of the standing committees, the full Commission always retains the ultimate authority to review the decisions of the subordinate body.

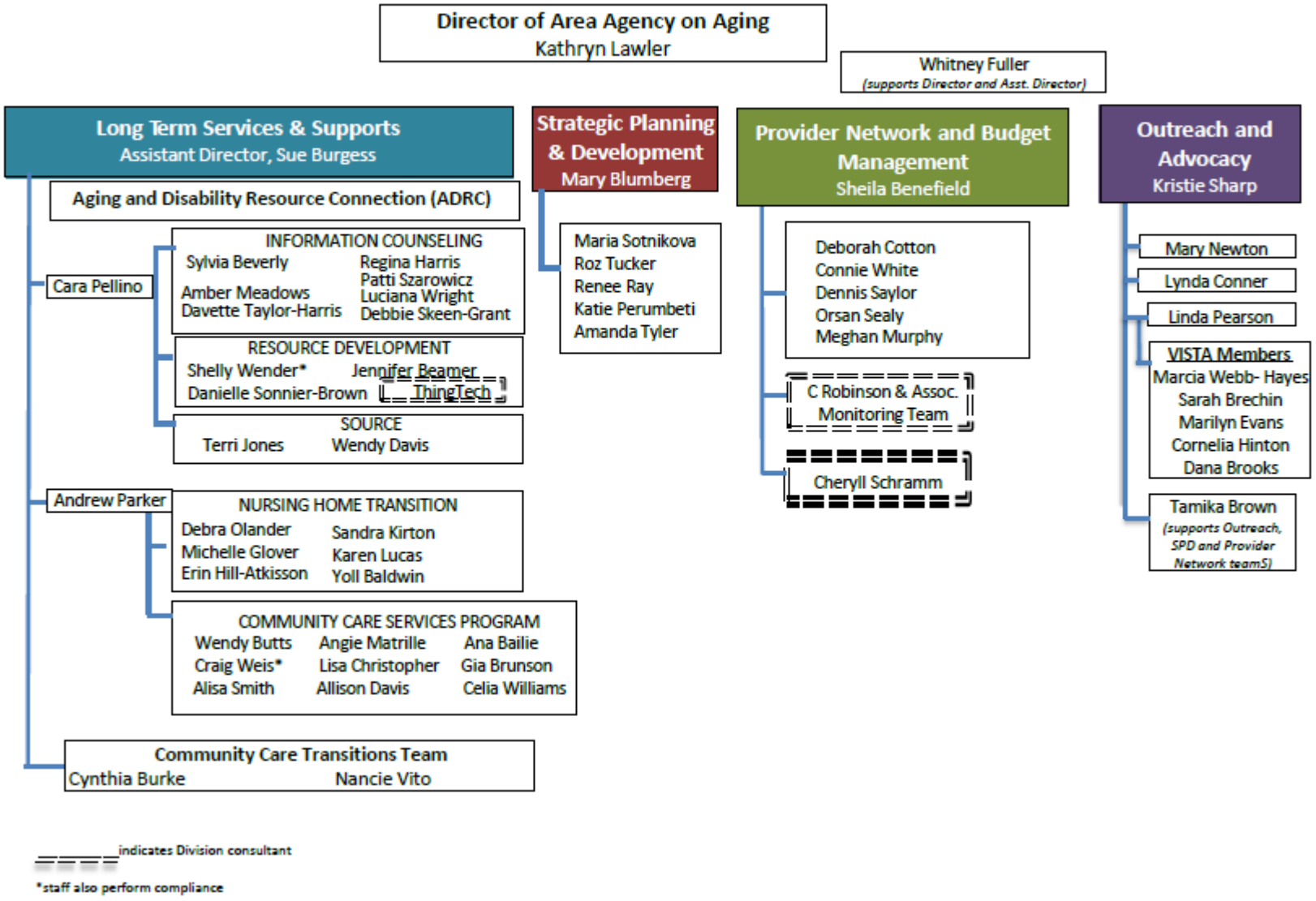
The Board membership of the Atlanta Regional Commission is composed of 23 local elected officials, 15 private citizens and one representative of the Georgia Department of Community Affairs. The ARC Board, its committees and task forces generally meet once each month. All meetings are open to the public.

Working within its organized structure of departments and committees, the Atlanta Regional Commission is dedicated to unifying the region's collective resources to prepare the metropolitan area for a prosperous future. This is accomplished within its structure through professional planning initiatives, the provision of objective information and involvement of the community in collaborative partnerships that: encourage healthy economic growth compatible with the environment, improve the region's quality of life and provide opportunities for leadership development.

ARC Staff Organization Chart



AGING AND HEALTH RESOURCES STAFF STRUCTURE



Item #3c - AAA Roles and Responsibilities

The Atlanta Regional Commission (ARC) is the designated Area Agency on Aging (AAA) serving as the regional planning, development, and intergovernmental coordination agency for the Atlanta region, comprised of ten contiguous counties Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale. ARC's Aging and Health Resources Division, in which the AAA functions are vested, is charged with both serving the needs of current older adults and planning and advocating for future needs and generations. Approximately 540,000 adults 60 or older live in the region constituting 35% of Georgia's older residents.

ARC meets this challenge by working closely with county governments, service agencies, representatives from the public and private sector, representatives from the faith based communities, senior adults and caregivers. The specific roles and responsibilities assumed by the Atlanta Regional Commission Area Agency on Aging include: operational services, Aging and Disabilities Recourse Connection (ADRC), Care Consultation, Lifelong Communities and other collaborations/partnerships that are identified on the following pages.

Area Agency on Aging Operational Services: As an AAA, ARC has the five state mandated operational responsibilities of administration, outreach, program development, coordination and advocacy. These responsibilities are defined as follows:

- Administration – Activities associated with the overall area agency operations that are not otherwise defined as a service. Administrative functions include planning, procurement, contracting, contract management, quality assurance, compliance monitoring, data collection/entry/management, financial management, technology management, personnel management, training, technical assistance, professional development, program operations and resource development.
- Advocacy – Relates to monitoring, evaluating and commenting on all policies, programs, hearings, levies and community actions which affect older persons. Activities include conducting public hearings on the needs of older adults and caregivers, supporting the state administered long term care ombudsman program, coordinating the planning with other agencies and organizations to promote new benefits and opportunities for older adults and educating public officials and legislators on issues related to aging.
- Coordination – Engaging in cooperative arrangements with other service planners and providers to facilitate access to and use of all existing services and developing home and community based services to effectively and efficiently meet the needs of older adults and their caregivers.
- Outreach – The implementation of intervention efforts with individuals initiated for the purpose of identifying potential consumers and encouraging their use of existing services and benefits.

- Program Development – Includes activities directly related to the establishment of a new service or the improvement, expansion, or integration of an existing service.

ARC embraces these mandated responsibilities as it looks for new opportunities to expand programs, leverage additional resources, incorporate business and strategic planning practices and work collaboratively with community partners in order to broaden and strengthen the opportunities for older adults to age in place with independence and dignity.

Aging & Disability Resource Connection (ADRC): ADRC is a service that *1) provides individuals with information on services available within the communities; 2) links individuals to the services and opportunities that are available within the communities; 3) to the maximum extent practicable, establishes adequate follow-up procedures; 4) assesses the individual's circumstances, as appropriate, for the purpose of determining their need(s) and referring them to the appropriate resource.*

The ultimate goal of ADRC is to provide information to all individuals concerning long-term services and to support their needs regardless of their age or disability by providing easier access to public and private resources. ARC's ADRC Resource Connection is implemented through its AgeWise Connection phone number whereby those calling are connected with trained and certified Information and Assistance (I&A) Specialists who assist callers in identifying and then linking them to appropriate community resources. The AgeWise Connection specialists are based at the Atlanta Regional Commission, These I&A Specialists respond to a high volume of callers comprising of individuals, caregivers and professionals in the community.

The specialists have access to an extensive statewide resource database, the Enhanced Services Program (ESP), which contains over 24,000 services/agencies and provides comprehensive information about home and community based resources for older adults, caregivers and individuals with disabilities. Specialists provide information and assistance and explain eligibility requirements for public benefit programs. These resources can be reduced to provide person centered details such as location, cost and to meet special needs. Specialists also provide information and screenings for SOURCE (Service Options Using Resources in Community Environment) and the Community Care Services Program (CCSP), both of which are Medicaid waiver programs. All information requested from callers is handled confidentially and protected in an automated system.

Another component of ARC's ADRC is options counseling, defined by the Administration on Aging as an "interactive decision support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumers' needs preferences, values and individual circumstances." While incorporated into information and assistance, Options Counseling goes beyond I&A in that it involves building relationships with individuals, helping them identify their goals and preferences and weigh the pros and cons of each of their various options. Options counseling ensures that consumers have considered a range of possibilities when making decisions about long-term supports.

Local Contact Agency/Nursing Home Options Counseling

Long - term support options counseling is an interactive decision support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values and individual circumstances (AoA definition 2007). ARC is the designated Local Contact Agency and as such provides options counseling to persons residing in nursing facilities whom request information about returning to community living.

Money Follows the Person Initiative

The Money Follows the Person Initiative (MFP) is a collaboration between the Georgia Department of Community Health (DCH) and the Department of Human Services (DHS) to transition persons from institutional settings to community through the Medicaid waiver programs. The goal is to develop alternative long term care opportunities which will enable the elderly and people with disabilities to fully participate in their communities. MFP will provide necessary transitional supports for eligible members who choose to leave the nursing home and receive care at home or community based settings. Barriers will be removed to allow for payments of deposits for utilities/rent, adaptive equipment, and for transportation needs such as dialysis treatment.

- Persons eligible for MFP include those who have resided in an institution for a minimum of 90 days and whose care has been covered at least 1 day by Medicaid in the month preceding their transition to home and community based services.
- The MFP individual must continue to meet institutional level of care criteria after transitioning to the community.

Lifelong Communities: The Atlanta region is experiencing a monumental demographic shift. This change includes not only a dramatic growth in the number of older adults who call Atlanta home but it is also driven by the relatively new phenomenon of longevity—people

living longer than ever before. While science, medicine and public health continued to advance our ability to live longer than previous generations, communities continued to develop as if we never grow old. Remarkably since the 1950's neighborhoods, transportation infrastructure, the location of stores and services in the US were all designed for a population that never experiences the physical changes of an aging body and mind. As most of the Atlanta region was developed after World War II, communities in the metro area do not have the housing, transportation and service options that the current and clearly the future population needs. Atlanta is not yet ready to support the changing needs and preferences of a growing older population.

In 2007, the Atlanta Regional Commission recognized this trend and adopted the development of lifelong communities, places where individuals of all ages and abilities can live throughout their lifetimes, as a core component of its work. Since 2007, ARC has been working with communities in the ten county area to help expand local transportation and housing options, encourage healthy lifestyles and empower older adults and their families with the information and supports they need to make the best decisions and maintain their quality of life in the community. Lifelong community principles serve as a guide to community leaders, planners, developers and citizens that are undertaking this effort into existing communities and local and regional development strategies. The principles include: connectivity, pedestrian access and transit, neighborhood retail and services, social interaction, diversity of dwelling types, healthy living and consideration for existing residents. Combining planning, community organizing and policy reform, ARC has worked with numerous communities on issues as diverse as adapting local zoning policy, establishing farmer's markets in areas without access to fresh fruits and vegetables and conducting walkability audits. The Lifelong Community initiative continues to grow and expand as additional communities reach out to the Atlanta Regional Commission for assistance in incorporating the principles and goals.

Working Relationships and Collaborations: In ongoing efforts to improve and expand the coordination/provision of services across the state and within the Atlanta region, ARC is actively involved in collaborations with a wide variety of professional agencies and networks that play important roles in supporting the aging population. Current collaborations include the following:

Adult Protective Services: Through its Aging and Disability Resource Connection (ADRC), ARC has strengthened its relationship with Adult Protective Services (APS) by coordinating cross training between APS and ADRC staff. Cross referral procedures have been formalized to assist and support concerns and/or challenges related to abuse neglect and exploitation. ARC ADRC staff seeks consultation with APS regarding problem solving for individuals in potential danger of abuse. APS staff frequently refers complex cases to ARC's ADRC to assist

persons in accessing home and community based services. APS partners are engaged in local advisory committee activity and serve on ARC's Advisory Committee on Aging.

Behavioral Health Agencies: Through its' strategic planning process, the Atlanta Regional Commission (ARC) adopted behavioral health as one of its top 7 priorities. ARC is an active member of the Atlanta Aging & Behavioral Health Coalition and the Georgia Aging & Behavioral Health Coalition. These coalitions have expanded knowledge within the aging network and behavioral health network regarding the growing population of older adults with behavioral health disorders and are working to increase the states capacity to care for this growing population. In 2015, ARC hosted a regional workshop which brought together contractors and county based behavioral health providers. In 2016, ARC will again provide leadership for the Atlanta Aging and Behavioral Health Coalition. The Coalition will focus on improving care coordination for older adults with behavioral health disorders. ARC in collaboration with the Fuqua Center for Late-Life Depression/ Emory University also hosts and has been an active participant in the Housing and Behavioral Health Services Network quarterly education and care collaboration meetings.

ARC has reached out to Georgia's newly appointed behavioral health services administrative service organization (ASO), Beacon Options with plans to ultimately provide seamless information and referral services through the interfacing of the behavioral health and the aging and disabilities services databases. The Atlanta region's Aging and Disabilities Resource Connection (ADRC) is deeply involved in planning related to the states' *No Wrong Door* efforts and is planning to provide training throughout the region on the tools used to screen for behavioral health disorders including depression, anxiety and substance abuse as well as dementia and providing appropriate referral resources. As an extension of the ADRC, ARC created the position of Behavioral Health Coach, which acts as resource and assists in coordination of care for residents with behavioral health challenges in all of Atlanta Housing Authority high-rises as well as several other affordable housing facilities. The Behavioral Health Coach also acts as a resource to the entire ADRC information and referral service, the Medicaid waiver providers in the region and eventually non-Medicaid based home and community services. Through collaboration with Grady Behavioral Health Services and other providers of behavioral health services in the metro Atlanta, the work of the Behavioral Health Coach is aimed at decreasing the fragmentation of services for older adults. ARC has hired a consultant with aging and behavioral health expertise to assist in its planning and implementation of efforts aimed at improving the behavioral health care of older adults in the Atlanta region.

RSVP - ARC has greatly expanded its civic engagement/volunteer program through a grant from the Corporation for National and Community Service to serve as sponsor for the RSVP program in the metro Atlanta area. This program captures the talents of experienced adults who are looking for meaningful, challenging ways to give back to their communities. Volunteers come from a wide range of experiences and many are retired nurses and medical professionals, business and non-profit executives; educators and public health professionals. Volunteers serve as ambassadors in their communities providing information to empower older adults, persons with disabilities and their caregivers with information critical to helping them remain healthy and independent in their communities. RSVP utilizes a peer to peer centered outreach approach which helps individuals access vital programs and services for seniors; understand the importance of preventive healthcare and gain access; navigate the Medicare system; better prepare for disasters and much more. This program continues to expand capacity through increasing numbers of volunteers and through the expansion into additional educational programs that are developed and implemented to address emerging critical needs.

CARE-NET: The Atlanta CARE-NET is a coalition of individuals representing community agencies, institutions, faith-based organizations and family caregivers in the 10-county Atlanta region. Community partners in the CARE-NET include: Emory Healthcare , Emory Work-Life Resource Center, the Alzheimer's Association, Atlanta Housing Authority, Gwinnett County Senior Services, Grace Arbor Adult Day Care, Cobb County Senior Services, Cherokee County Senior Services, Project Health Grandparents, Bridgebuilders, Inc., Center for Pan Asian Community Services, Peachtree Road United Methodist Church, and Region 3 Department of Behavioral Health and Developmental Disabilities (DBHDD). The CARE-NET is also part of the statewide Georgia CARE-NET Coalition initiated by the Rosalynn Carter Institute for Caregiving, which meets quarterly to promote education, advocacy, and policies to improve the lives of caregivers in Georgia. The Atlanta CARE-NET will be adopting two goals to focus on in the coming year.

CCSP: Provider Network As the lead agency for the Community Care Services Program (CCSP), a Medicaid waiver program that helps frail older adults and persons with disabilities to remain in their own homes and communities, ARC oversees network support activities for the 261 provider agencies that make up the CCSP system in the Atlanta region. The CCSP provider agency network meets quarterly at the Atlanta Regional Commission to hear updates on CCSP regulations, to discuss issues related to providing quality care and to network among themselves. The quarterly meetings are collaborative efforts with Visiting Nurse Health Systems (VNHS) and the Georgia Division of Aging Services, and draws over 150 provider agencies. (For more information on CCSP, see page 39.) As an added component to the CCSP provider network, ARC also seeks out new programs and model projects that can support CCSP clients.

Item #3d - AAA's Vision, Mission and Values

Vision: The Atlanta region is a place where people of all ages, abilities and incomes can live high quality lives.

Mission: Prepare the 10 county metro area to meet the future needs of a changing society while ensuring adequate services and supports for individuals and families living in the community today.

Core Values:
Flexible
Effective
Collective Impact
Empower individuals and families with choice
Person centered and holistic
Evidence based

Item #3e - Purpose of Area Plan

Every four years, the Administration on Aging requires state units on aging to submit a State Plan on Aging outlining the state's goals and objectives and their plans for program implementation and service delivery. In addition to the four-year plans, yearly updates are required to reflect any changes to the four-year plan. In preparation for the completion and submission of the state plan, the GA Division of Aging Services in turn requires that each of the twelve Area Agencies on Aging in the state of Georgia submit their own four-year AAA plans and yearly updates.

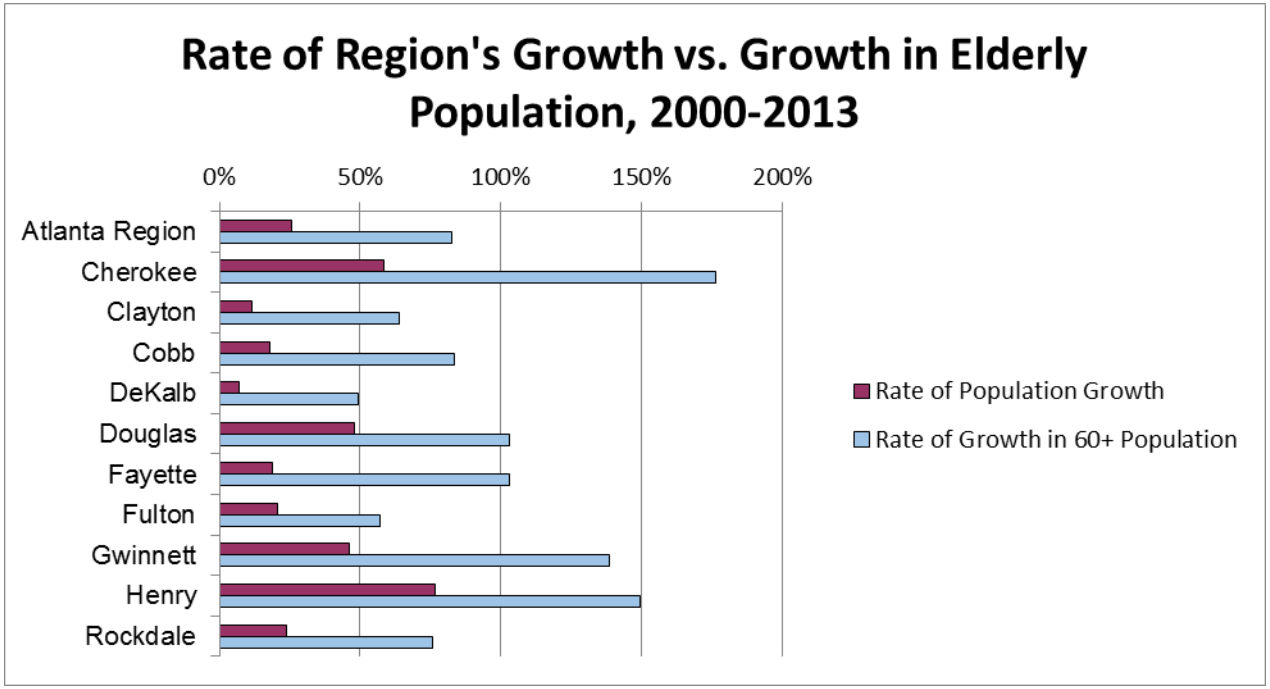
The Atlanta region's Area Plan on Aging SFY 2017-2020 is the four-year plan covering the period from July1, 2016 – June 30, 2020. This plan is developed in accordance with the requirements of the Older Americans Act and the template provided by the GA Division of Aging Services. It provides specific information on the distribution of funds and describes the aging services network proposed for the ten-county Atlanta region provided through funding sources such as the Older Americans Act, the Social Services Block Grant, the United States Department of Agriculture Nutrition Services Incentive Program, the state-funded Community Care Services Program and Alzheimer's Services.

The SFY 2017-2020 Area Plan on Aging is based upon Georgia Department of Aging State Plan and the Strategic Plan for Metro Atlanta region. Community and consumer involvement was obtained through community conversations and listening sessions for the strategic plan development. The ARC Advisory Committee on Aging and the ARC Health and Aging Resources committee also provided input on the service needs of older persons. ARC acknowledges the many individuals and groups whose contributions have directly or indirectly assisted in the formulation of this document.

Items #4a through #4d – Context

Growth:

The older adult population in the Atlanta Region has grown over the last decade at a rate significantly higher than the general population. Between 2000 and 2013, the 60+ population increased by 83 percent. Growth of the 60+ population exceeded growth in the general population in all of the region's ten counties.



Source: US Census, 2000, Summary File 1, DP1, and American Community Survey, 2013, 1-Year Estimates, DP05

Atlanta's population is younger than the US population. The median age in the Atlanta Region is approximately 35.2, whereas the median age in the United States is 37.4 (ACS 3-year estimates, 2011-2013).
Of those over age 60, 7 percent are 85 years old and over.
Source: American Community Survey, 2009-2013, 5-year estimates, S0101 and DP05

General:

13.8 percent of the population living in the Atlanta region is 60 and older.

Of those 60 years old and over:

- 66 percent are white
- 28 percent are black
- 4 percent are Asian
- The remaining 2 percent includes Native Americans, Hawaiian and Pacific Islander, and people of two or more races (ACS 5-year estimates, 2009-2013, S0102)

Older Adult Population by County, 2013						
County	**Total Population**	**Total 60+ Population**	**% of Population 60+**	**Total 85+ Population**	**% of Population 85+**	**% of 60+ Population that is 85+**
Cherokee	218,277	33,179	15.20%	1,873	0.86%	5.65%
Clayton	262,455	30,405	11.58%	1,815	0.69%	5.97%
Cobb	699,235	100,106	14.32%	6,673	0.95%	6.67%
DeKalb	700,308	100,116	14.30%	8,385	1.20%	8.38%
Douglas	133,486	18,805	14.09%	788	0.59%	4.19%
Fayette	107,105	21,262	19.85%	1,560	1.46%	7.34%
Fulton	948,554	135,063	14.24%	12,388	1.31%	9.17%
Gwinnett	825,911	97,279	11.78%	5,772	0.70%	5.93%
Henry	206,349	27,698	13.42%	1,823	0.88%	6.58%
Rockdale	85,650	14,455	16.88%	959	1.12%	6.63%
ARC Region	4,187,330	578,368	13.81%	42,036	1.00%	7.27%

Source: American Community Survey, 2009-2013, 5-year estimates, DP05

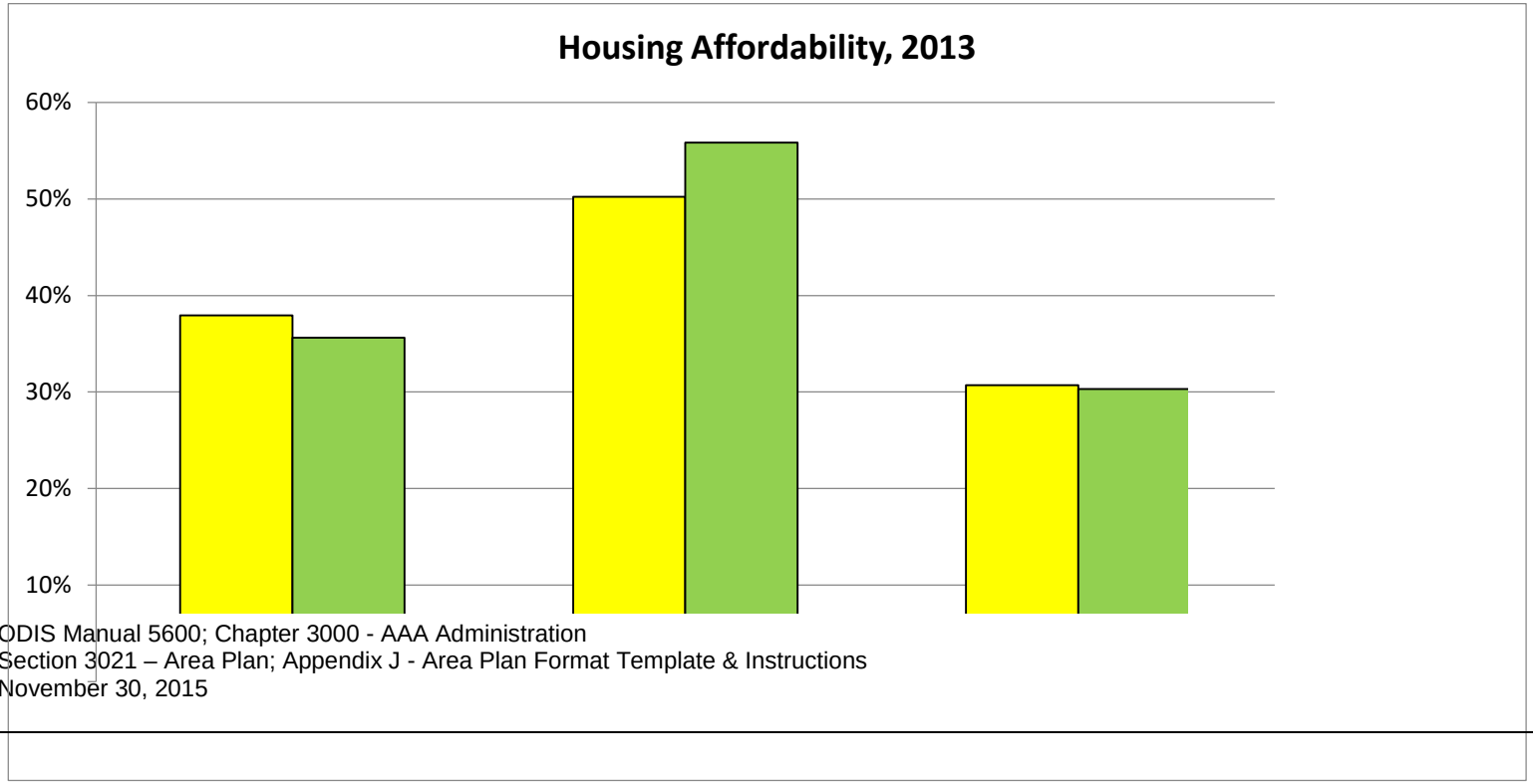
Housing:

Housing continues to pose one of the most daunting challenges to older adults in the Atlanta Region. Most seniors want to stay in their communities and homes as long as possible. It is often inadequate or unaffordable housing that forces them to move.

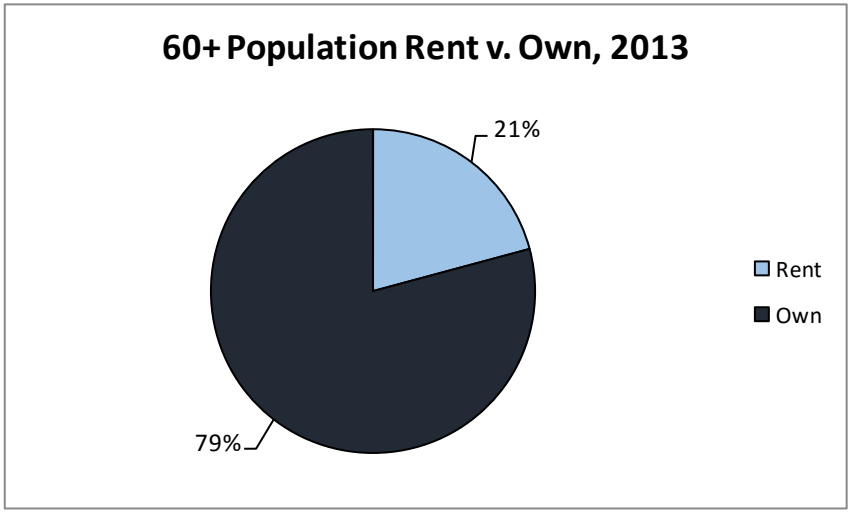
- While the vast majority of older adults are homeowners, 21 percent of older adults are renters.
- The rate of homeownership varies by county. Fayette County has the highest homeownership rates among their 60+ populations, at 90 percent. Fulton County has the lowest homeownership rate at 69 percent.
- Housing affordability is a particular problem for older adults. 36 percent of residents age 60 and over pay more than 30 percent of their income for housing. This problem is particularly acute for older renters.

Source: Population 60 and Older in the United States, 2009-2013 ACS 5-Year Estimates, SO102

County	Occupied Housing Units 60+	% Owner Occupied Housing Units	# of Occupied Units
Cherokee	19,937	87.80%	17505
Clayton	16,991	73.10%	12420
Cobb	60,134	84.80%	50994
DeKalb	61,630	76.90%	47393
Douglas	10,608	81.70%	8667
Fayette	12,594	89.80%	11309
Fulton	85,680	69.20%	59291
Gwinnett	50,324	84.70%	42624
Henry	15,649	87.90%	13755
Rockdale	8,481	81.90%	6946
ARC Region	342,028	79.21%	270905



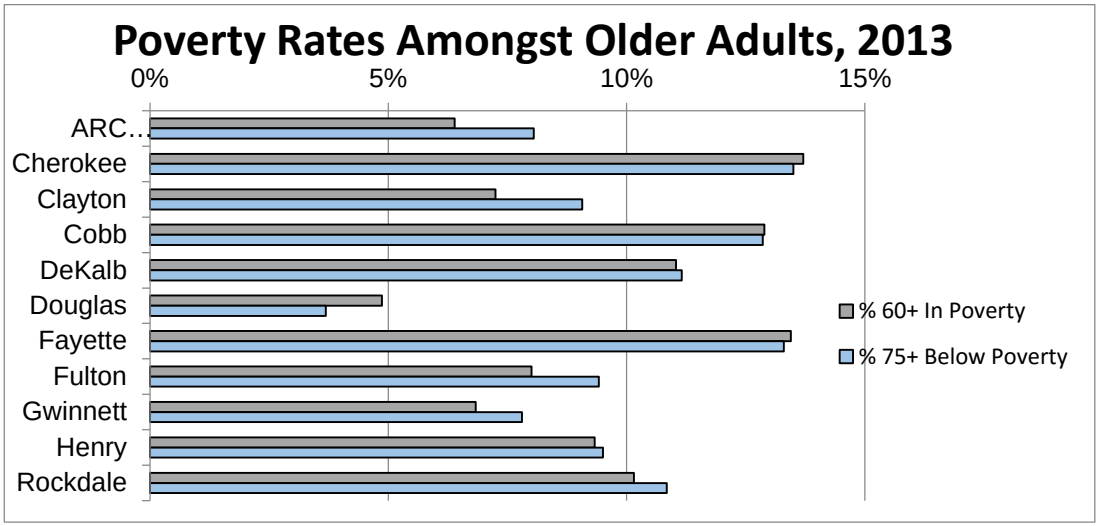
Source: Population 60 and Older in the United States, 2009-2013 ACS 5-Year Estimates, SO102 (only over 30% available, so numbers are higher)



Source: Population 60 and Older in the United States, 2009-2013 ACS 5-Year Estimates, SO102

Poverty:

6.39 percent of Atlantans over age 60 are living below poverty, and 8.05 percent of those over age 75 are living below poverty.



Source: ACS 5-Year Estimates, 2009-2013, Poverty Status in the Past 12 Months by Age, B17001

Item #4b - Needs Assessment Process and Results

The compilation and evaluation of the market sources provide the foundation for the Strategic Plan's priorities, goals, strategies. Market and data analyses were conducted between Sept 2014 and March 2015 to form this strategic plan utilizing the following methods: six community conversations (in-person town hall style meetings); a survey with 10 polling questions at conversations, events and on-line; regional, state and national industry leader interviews; key stakeholder interviews; mapping and research analysis of the region's population and infrastructure; and a Regional Strategic Plan Summit. The market analysis provided both information to community members about ARC's proposed future direction and for industry leaders and the input of community members and subject matter experts into the strategic plan for the 10 county metro area. A summary of findings by each method follows.

Community Conversations

Events were held in the Fayette, Cherokee, Fulton, Gwinnett, DeKalb, and Henry counties with 346 participants. A variety of persons attended including older adults, persons with disabilities, caregivers, civic leaders, business and service providers, faith based organizations and governmental officials and staff.

Overall, participants when asked what is working well to support healthy aging, reported:

- Senior centers
- Meals on wheels
- Congregate meals
- Parks and recreation services
- Libraries and educational and cultural opportunities
- Healthcare services

When asked what doesn't work well to support healthy aging the top answers were:

- Transportation is not accessible when/where desired or is not affordable
- Lack of awareness of services available
- Waiting lists for services
- Housing options
- Inconsistent sidewalks, unsafe street crossings, lighting, and general public safety

- "Technological divide" for the small but critical population that does not have access to the internet

Lastly, participants were asked what is needed to create a future where people have what they need and can maintain a high quality of life with dignity as they age in the community. Top answers included:

- Community development that is transparent and recognizes the aging population and ensures access to healthcare, shopping, recreation and walkability/safety
- Transportation that is accessible, affordable and flexible
- Housing stock that is diverse, affordable, safe and not segregated
- Access to information and services that is marketed well so that people know where to go, where to call and can be assured that the information is from trustworthy and trained professionals.

Survey

Ten survey questions were asked of community conversation attendees, persons at other events and through an online poll to learn more about some of the issues in the metropolitan region. In total, 518 persons provided responses. A brief summary of results follows.

- Transportation and financial resources were identified as the greatest challenge to growing older in metro Atlanta
- The services cited that would assist caregivers most were: caregiver training, transportation, daily care outside the home and occasional in-home sitters
- A vast majority of people indicated that if they were unable to drive they would rely on family and friends
- If available, a preference for senior shuttle was chosen even when the charge was slightly higher that a bus or train for the general population
- When asked if they were to move what they would look for in a new home, location near services ranked highest followed by affordability and little or no yard and upkeep
- Physical activity, healthy foods and engaging with others were the top three factors felt to be most important to staying healthy which mirrored the primary reasons persons would go to a senior center
- The internet, word of mouth, local service agencies and medical providers were cited most often as the sources for information and services

Industry Leader and Stakeholder Interviews

Seven interviews were conducted with key industry-leaders to provide market analysis on aging business trends and future direction Thirteen interviews were conducted with leaders in stakeholder organizations serving older adults and persons with disabilities to gain insight into local market forces affecting their organizations, their vision for the future and perceptions of the role ARC should play as we look to the future of aging services. Overarching issues that were stated most often included the opportunity for administrative and cost

efficiencies, the need to identify alternative revenue and funding for programs and services to fill gaps, growing competition from for-profit providers and the importance of demonstrating value and impact to funders.

The main external forces and drivers currently affecting organizations that emerged from the interviews were:

- Demographic changes driving increased demand for services
- Political landscape and funding resulting in a decrease in federal sources and need to compensate through more fundraising activities that could potentially take away from capacity to deliver optimal service
- Changing healthcare system: specifically related to the Affordable Care Act and an increased emphasis on population health and disease prevention
- Housing affordability and implications for aging in place, mainly focusing on a lack of affordable options for seniors in the region
- Lack of transportation options

The visons for the future of aging services that most often were cited were:

- More funding: focused on increased funding, especially from non-federal sources, and on creative staffing options, particularly in respect to volunteers
- Promotion of measured success of program by moving to outcomes-based practice
- Expansion of services (particularly support for caregivers and more mental health / behavioral health activities), fostering creative partnerships, and taking advantage of advances in technology

When asked what role ARC should play in shaping the future for the region, top responses were:

- Outcomes-based practice to drive operations toward effective programs
- Leadership and advocacy for aging services and the policy changes that could facilitate innovation in funding and service delivery
- Expand partnerships by building relationships to secure philanthropic funding, to better share knowledge and innovations, and to integrate with health care
- Promote flexibility and adaptability while focusing on the core value: helping people

In general, the industry thought leaders voiced greater emphasis on the following actions:

- All organizations must demonstrate cost effectiveness and measureable impact; Funding competition is strong across sectors to provide services. Managed care organizations' methods of measuring effectiveness was cited as the marketplace's prevalent model
- Marketing to reach the broader community and engage with more partners is critical; aging services are not well known
- The investment in technology at an accelerated pace is required to extend services and provide services in a way relevant to consumers, i.e. internet used to provide connections and socialization and medical care at home

The stakeholders identified the following as chief actions needed:

- Increase advocacy for program funding and government policy revisions
- Increase transportation options
- Increase support for caregivers

Overall the interviews with industry leader and key stakeholders, mirrored much of what was gathered from the community conversations dialogue and survey responses. The same top issues and needs were identified by all groups lending adding strong support to the recommendations.

Regional Summit

Multiple sectors and key stakeholder groups were represented at the regional *Live Beyond Expectations Summit* in March 2015, with 325 persons attending. The purpose of the meeting was to provide information about the changing metropolitan Atlanta region, present innovative solutions to meet needs, share findings from the community conversations and market analysis and introduce the priorities that had emerged. An interactive poll was conducted at the end of the summit to gauge community support for the priority areas and 89% indicated that the priorities were either "right on the money" or "almost there." Further affirmation of the plans relevancy and support was demonstrated when participants were asked if they were willing to help work on the priorities and 74% signed up to become involved by completing commitment cards with their contact information.

Item #4c - Gap/Barriers/Needs to Improve Existing System

As a result of the extensive conversations held, interviews with community leaders and stakeholders, surveys and regional summit, the following top issues and needs were identified by all groups are listed below.

Transportation: Although Americans are healthier and living longer than ever before, seniors are outliving their ability to drive safely by an average of 7 to 10 years according to the American Automobile Association. Loss of vision, hearing loss, weaker muscles, reduced flexibility and limited range of motion that may accompany aging all negatively affect the ability to drive. Transportation options other than individual cars are not consistently available nor affordable throughout the Atlanta region. In 2015, it is estimated that 90% of adults in greater Atlanta ages 65 to 79 will have poor public transportation access. Currently, there are an estimated 32,201 senior-led households (65+ head of household) in the Atlanta area that have no vehicles. Expanding affordable transportation options must be a priority to meet

growing need and one promising practice is increasing the capacity of Volunteer Driver Programs. Nationally, operating cost per trip for ADA paratransit in large urbanized areas was estimated to be $34.71 in 2010, whereas volunteer driver transportation cost on average were $14.33 per trip. As an added value, it is estimated that nationally, 63% of volunteer drivers are 65 years or older, providing important social and civic engagement activities to healthier older adults.

Caregiver Support: Family and other informal caregivers provide the majority of care for frail older adults and persons with disabilities living in communities. It does not occur without costs to employers due to missed time at work and costs in caregiver health due to stress and neglect of their own health issues. Fifteen percent of the U.S. workforce cares for an older adult and it is estimated that by 2020 one in five workers will be over the age of 50 and managing the needs of adult children and elderly parents at once. Caring for persons with dementia or Alzheimer's disease can be especially daunting and the number of persons affected is expected to grow substantially. In Georgia, 130,000 people aged 65 and older have Alzheimer's disease, amounting to 11% of seniors in the state. This population is expected to reach 190,000 by 2025, an increase of 46.2%. In 2014, there were 506,000 Alzheimer's and dementia caregivers in Georgia that provided an estimated 576,000,000 hours of unpaid care valued at $7,015,000,000. Supporting caregivers by providing programs that reduce stress and burden is critical for an aging society. Evidence-based programs that are especially tailored for caregivers and providing reliable and accessible information about the services that are available are proven means to do this.

Long Term Supports and Services: Nearly 90 percent of people over age 65 want to stay in their home for as long as possible, and 80 percent believe their current residence is where they will always live. However, in order for many older adults to age at home, there must be high quality, affordable services available to support them. Advancing age increases the risks for multiple health conditions. 75% of U.S. adults age 65 and older are living with a chronic condition such as high blood pressure, diabetes, or heart disease. The CDC estimates that in Georgia, 38% of older adults have a disability. On average the costs to provide care in the community is much lower than other settings. The Atlanta Regional Commission's service database indicates that for the metropolitan Atlanta area, the average annual costs for skilled nursing homes is $67,677, assisted living facilities is $ 47, 208 and personal care homes $ 22,789. Unfortunately, there are far too many low income vulnerable persons waiting for Medicaid Home and Community-based waiver services. Improvements in long term supports and services must find more effective ways to utilize current resources and leverage additional ones.

Senior Centers: There is great need for health improvements in Georgia's older adult population. Georgia's older adults rank near the bottom nationally in health indicators. Cardiovascular disease is the leading cause of death in Georgia. Cardiovascular disease (CVD)

includes all diseases of the heart and blood vessels, including ischemic heart disease, stroke, congestive heart failure, hypertension, and atherosclerosis. Georgia has the 18th highest adult obesity rate in the nation. The state's adult obesity rate was 30.3 percent as of 2013, up from 24.5 percent in 2004 and from 10.1 percent in 1990. 25.8% of adults 65 years or older are obese in Georgia. As reported in a study for the Center for Disease Control in 2009, older adults in Georgia reported six unhealthy days per month, ranking the state 44th nationally; 34% do not participate in physical activity, 31st in nation, and 75% do not eat enough fruits and vegetables, 36th in nation. Another study found that approximately 20% of adults in Georgia aged 65 and older are not receiving the social and emotional support they need on a regular basis.

Senior centers are valued by area residents and were cited in ARC's strategic plan survey as one of the top places that supports healthy aging. Physical activity, healthy food and engaging with others were the primary reasons persons polled would choose to attend a senior center. The region has approximately 80 senior centers but is reaching a small number of the region's older adults making it difficult to realize large scale population health improvements. Incorporating additional senior center models by utilizing technology and nontraditional settings offers the possibility of expanding the reach of senior centers to serve more people.

Behavioral Health: Behavioral health encompasses the emotions, behaviors and biology relating to a person's mental well-being and their ability to function. Behavioral health is used to describe the connection between behaviors and health and well-being. It includes the prevention and intervention in mental illnesses, such as depression and anxiety, and as well as interventions in substance abuse and other addictions. Recent data indicate that an estimated 20.4 percent of adults aged 65 and older met criteria for a mental disorder, including dementia during the previous 12 months and this translates into approximately 222,363 of Georgia's older adults being affected by mental illness. The number of older adults nationally in need of substance abuse treatment is estimated to increase from 1.7 million in 2000 and 2001 to 4.4 million in 2020. Fifteen to twenty percent of older adults in the United States have experienced depression. Even mild depression lowers immunity and may compromise a person's ability to fight infections and cancers. Older adults underutilize behavioral health services for a variety of reasons, including: inadequate insurance coverage; a shortage of trained geriatric mental health providers; lack of coordination among primary care, mental health and aging service providers; stigma surrounding mental health and its treatment; denial of problems; and access barriers such as transportation. There is a need for better access to behavioral health screening and treatment in the region.

Information Services: ARC's Aging and Disability Resource Connection's (ADRC) purpose is to serve as a highly visible and trusted places where people of all ages can turn for information on the full range of long-term support options and for a single point of entry to publicly-funded long-term support programs and benefits. ADRCs were created in response to individuals' confusion on where to find assistance and frustration when having to provide the same information multiple times to gain access to services. The Atlanta ADRC answers over 80,000 calls each year, yet there are still many who don't know of its existence or prefer a more self-directed inquiry for assistance. Resources and infrastructure has been at capacity for years resulting in reluctance to aggressively market this vital service. Consumers expect to be able to search on-line as a first step and if needed seek more personalized assistance afterwards. Efforts must focus on expanding the reach of information services through improvements in delivery. Eighty-seven percent of caregivers in the U.S. own a cell phone and, of those, 37% say they have used their phone to look for health or medical information online. In 2014, it is estimated that 59 percent of adults 65 and older use the internet. ARC's strategic plan survey data identified the internet as the "most often used way to get information on services for myself or someone else" in every community in the region. The increased use of technology offers the ability to expand marketing and outreach, streamline access and expand reach to more consumers.

Housing: Communities that offer a diversity of housing options are desirable to an aging population. Over a lifetime, housing needs change for many individuals as household size and income decreases. Housing near services becomes more important as the ability to drive decreases. Responders to ARC's strategic plan survey cited that if they were looking for a new home the most important factors would be near services, affordability and have little or no yard upkeep and home maintenance. Nationally, in 2014, a third of adults aged 50 and over—including 37 percent of those aged 80 and over—paid more than 30 percent of income for housing that may or may not fit their needs. Among those aged 65 and over, about half of all renters and owners still paying off mortgages are similarly housing cost burdened. Moreover, in the U.S., 30 percent of renters and 23 percent of owners with mortgages are severely burdened by paying more than 50 percent of income on housing. The affordable rental market in Atlanta is likewise limited with an estimated 49% of renters in the Atlanta area unable to afford a 2 bedroom home or apartment at Fair Market Rent (FMR) without paying more than 30% of income on housing. When housing and transportation costs are coupled together, the Atlanta region has the 6th worst affordability among the 25 largest metros, with housing and transportation consuming 63% of the income of moderate-income households.

The population data and needs assessment conducted for the strategic plan clearly led to the priorities areas that emerged and are in the plan. Additionally goals and strategies were developed to ensure that the needs are met. The strategic plan developed and adopted by the

ARC is very much aligned with the state plan. The goals that are within the plan will continue to advance the service delivery system and allow for a higher quality of service and potentially increase the number of available services for Georgia's growing older adult and disability populations and their families and caregivers.

Item #4d - Special Needs

Congress and the Older Americans Act regulations have always been clear that the Act is intended to assist all older persons and is not a needs-based program. However, the Act is also definitive in specifying that priority be given to serving those in greatest economic or social need, particularly low-income, minority individuals and those residing in rural areas.

The ARC has long been proactive in providing home and community-based services in a comprehensive and coordinated service delivery system focusing on those in greatest economic (resulting from an income level at or below the poverty line) and/or social need (need caused by non-economic factors, which include physical and mental disabilities, language barriers; cultural, social or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently). Minority populations in the Atlanta region for are defined as American Indian/Native American, Asian or Asian American, Black or African American, Native Hawaiian/Pacific Islander and Hispanic or Latino Older adults are defined as individuals 60 years of age or older

In addition to serving the low income population, The Atlanta Regional Commission AAA, as part of its regional focus has identified the following four underserved populations to target in FY16-18:

1. Alzheimer's/Dementia
2. Limited English Proficiency
3. Sensory Impairment
4. Aging Adults with developmental and/or physical disabilities

Additionally, the delivery of one or more of the regional services such as transportation, case management, homemaker, personal care, in home respite, congregate meals, home-delivered meals and senior recreation must be linked to one or more of the aforementioned targeted underserved populations.

Item #5 – Description of Service Delivery System
III. SERVICE DELIVERY PLAN

A. OVERVIEW OF SERVICE DELIVERY SYSTEM

As the Area Agency on Aging, the Atlanta Regional Commission (ARC) supports the development of a comprehensive regional service delivery system for older adults and their caregivers. Through a strategic planning process that began in June of 2014 and culminated in a regional summit, key themes emerged including the importance of utilizing collective impact to leverage existing funds and programs, the necessity of integrating research and best practices into both planning and service deliver and ensuring good stewardship of public funds. The charge therefore, is to find ways to delivery more support and provide greater impact with fewer resources. Programs need more flexibility to tailor and target services and they need to be achieving outcomes for those they serve and have a framework for moving to scale. With emerging trends and a rapidly growing population both of which impact service delivery models, the ARC made the decision to fund in two year contract blocks to allow the region to respond to changing needs. The data baselines within the two years will give us critical information for planning and the ability to make changes in a timely manner.

Additionally, the state of Georgia is undergoing an Access to Services Redesign multi-year project to ensure more direct access to services and ensure the effectiveness and efficient use of case management. ARC will begin to achieve the goals of this redesign by centralizing intake in the region beginning July 1, 2016 with the overall objective being to increase access to services and to ensure that individuals receive the right service at the right time. ARC is also developing and will implement a plan to support the goal of achieving conflict free case management which will involve changes in program design, process flows and resources.

ARC funds organizations in the region to develop and implement a coordinated aging program tailored to local needs.
In addition to funds allocated through ARC, contractors receive support from county and city governments, United Way of Metropolitan Atlanta and various other sources. Together these funds allow for the provision of a broad base of services that span the continuum of care for older persons and their caregivers. This base of services includes the following:

- Transportation
- Case Management
- Personal Care
- In Home Respite

- Homemaker Services
- Home Delivered Meals
- Congregate Meals
- Senior Recreation
- BRI (Benjamin Rose Institute) Care Consultation
- Regional Respite Voucher
- Elder Legal Assistance Program (ELAP)

The Atlanta Regional Commission will contract with the following contractors to provide those services to older adults and caregivers:

Cherokee County Senior Services 1001 Univeter Road Canton, GA 30115 770-479-7438		Case Management, Congregate Meals, Home Delivered Meals, Homemaker, Transportation, In Home Respite and Senior Recreation
Clayton County Senior Services 877 Battle Creek Road Jonesboro, GA 30236 770-603-4056		Case Management, Congregate Meals, Home Delivered Meals, In-Home Respite, Homemaker, Personal Care, Transportation and Senior Recreation.
Cobb County Senior Services 32 North Fairground Street Marietta, GA 30060 770-528-5366		Case Management, Congregate Meals, Home Delivered Meals, Homemaker Services, Personal Care, In Home Respite, Transportation and Senior Recreation.
DeKalb County Office of Senior Affairs 2538 Panola Road Lithonia, GA 30058 770-322-2955		Case Management, Congregate Meals, Home Delivered Meals, Homemaker, Personal Care, In-Home Respite, Transportation and Senior Recreation.
Douglas County Senior Services 6287 Fairburn Road Douglasville, GA 30134 770-920-4303		Case Management, Congregate Meals, Home Delivered Meals, Homemaker and In-Home Respite.

Fayette Senior Services, Inc. 4 Center Drive Fayetteville, GA 30214 770-461-0813		Case Management, Congregate Meals, Home Delivered Meals, Personal Care, Homemaker, In-Home Respite, Transportation and Senior Recreation
Fulton County Aging Program 137 Peachtree St., SW Atlanta, GA 30303 404-613-8994		Case Management, Congregate Meals, Home Delivered Meals, Personal Care, Homemaker, In-Home Respite, Transportation and Senior Recreation.
Gwinnett County Senior Services 75 Langley Drive Lawrenceville, GA 30045 770-822-8845		Case Management, Congregate Meals, Home Delivered Meals, Homemaker, In-Home Respite, Transportation and Senior Recreation.
Henry County Senior Services 1050 Florence McGarity Boulevard McDonough, GA 30252 770-288-6971		Case Management, Congregate Meals, Home Delivered Meals, Homemaker, Personal Care, In-Home Respite, and Senior Recreation
Rockdale County Senior Services PO Box 289 Conyers, GA 30012 770-922-4633		Case Management, Congregate Meals, Home Delivered Meals, Homemaker, In-Home Respite, Transportation and Senior Recreation.
Leona M. Kitchens Foundation 125 Church Street, Suite 220. Marietta, GA 30060 404-728-1181		Regional Respite Voucher
Monica Gilbert 5133 Christian Springs Lane Lithonia, GA 30338		BRI- Care Consultation

404-433-9232		
Atlanta Legal Aid Society, Inc. 151 Spring Street, NW Atlanta, GA 30324 404-524-5811		Elder Legal Assistance Program
Center for Pan-Asian Community Services 3510 Shallowford Road Atlanta, GA 30341 770-936-0969		Congregate Meals and Senior Recreation
Center for the Visually Impaired, Inc. 739 West Peachtree St, NE Atlanta, GA 30308 404-875-9011		Case Management
Institute for the Study of Disadvantage and Disability 776 Windsor Parkway Atlanta, GA 30342 678-595-4854		Case Management and Senior Recreation
Help at Home, Inc. 770 Greison Trail, Suite B Newnan, GA 30263 770-253-8108		In Home Respite, Personal Care and Homemaker.
Visiting Nurse Health System, Inc. 5775 Glenridge Cr., NE, Ste 375 Atlanta, GA 30328 404-222-2417		Care Coordination for the Community Care Services Program

Definitions for each of the services provided through contractors as well as specifics on how each service is delivered is provided on the following pages. (Service definitions in italics for each service are from the GA Division of Aging Services "Taxonomy of Service Definitions.")

A. ADRC Services

Aging & Disability Resource Connection (ADRC) ADRC is a service that *1) provides individuals with information on services available within the communities; 2) links individuals to the services and opportunities that are available within the communities; 3) to the maximum extent practicable, establishes adequate follow-up procedures; 4) assesses the individual's circumstances, as appropriate, for the purpose of determining their need(s) and referring them to the appropriate resource.*

The ultimate goal of ADRC is to provide information to all individuals concerning long-term services and to support their needs regardless of their age or disability by providing easier access to public and private resources. ARC's ADRC Resource Connection is implemented through its AgeWise Connection phone number whereby those calling are connected with trained and certified information and assistance (I&A) specialists who assist callers in identifying and then linking them to appropriate community resources. The AgeWise Connection specialists are based at the Atlanta Regional Commission, These I&A specialists respond to a high volume of callers comprising of individuals, caregivers and professionals in the community.

The specialists have access to an extensive statewide resource database, the Enhanced Services Program (ESP), which contains over 24,000 services/agencies and provides comprehensive information about home and community based resources for older adults, caregivers and individuals with disabilities. Specialists provide information and assistance and explain eligibility requirements for public benefit programs. These resources can be reduced to provide person centered details such as location, cost and to meet special needs. Specialists also provide information and screenings for SOURCE (Service Options Using Resources in Community Environment) and the Community Care Services Program (CCSP), both of which are Medicaid waiver programs. All information requested from callers is handled confidentially and protected in an automated system.

Another component of ARC's ADRC is options counseling, defined by the Administration on Aging as an "interactive decision support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumers' needs preferences, values and individual circumstances." While incorporated into

information and assistance, options counseling goes beyond I&A in that it involves building relationships with individuals, helping them identify their goals and preferences and weigh the pros and cons of each of their various options. Options counseling ensures that consumers have considered a range of possibilities when making decisions about long-term supports.

B. COMMUNITY CARE SERVICES PROGRAM

The Community Care Services Program (CCSP) helps frail older adults and persons with disabilities remain in their own homes or in the community as an alternative to a nursing home. These individuals may need some assistance to remain independent in their homes, or their caregivers may need some help in caring for them. CCSP provides that assistance for those individuals who are Medicaid eligible, who are at risk for institutionalization and who meet certain other criteria. CCSP gives choices about where to live, in the home or in a personal care home, and provides services where and when they are needed. CCSP offers a range of services including assessment and care coordination, adult day health, alternative living services, emergency response services, home-delivered services, personal support services, out-of-home respite care, and home delivered meals. ARC serves as the lead agency for CCSP in the ten county Atlanta region and in this capacity assumes the following responsibilities:

Intake and Screening: ARC promotes CCSP, provides information to potential clients and referral sources and serves as the central intake point for persons seeking admission to CCSP. ARC screeners conduct telephone interviews to determine the applicant's eligibility for the program, manage the CCSP wait list, conduct rescreens on individuals on the waiting list every 120 days and refer the highest priority clients to the care coordination agency for admission into the program, based on available funding. Screeners also have access to the statewide Enhanced Services Program (ESP) database which includes over 25,000 service listings so individuals can be referred to other appropriate services and resources.

CCSP Care Coordination: Care coordination is defined as *the provision of twenty-four hour, seven day per week availability for medically impaired individuals and their families to determine service needs and interventions, plan, arrange, coordinate, monitor and evaluate services, communicate with medical professionals and refer to community resources as appropriate.* ARC receives funds for care coordination through the GA Division of Human Services, Division of Aging Services (DAS) and contracts with Visiting Nurse Health System (VNHS) as the Atlanta region's care coordination provider agency.

As CCSP service benefit allocations allow, ARC screeners refer persons determined eligible for CCSP and at greatest risk for institutionalization to VNHS for admission into the program. Through its Care Coordination Unit, VNHS staff conduct comprehensive face-to-face assessments, using the assessment required by the State. Care Coordinators develop care plans based on risk areas and broker, authorize, monitor and coordinate services as required.

Coordination of CCSP Network: ARC takes lead responsibility for coordinating the implementation of CCSP in the ten county Atlanta region:

- ARC staff maintain a comprehensive listing of all enrolled CCSP providers using the ESP resource database for this purpose. Information regarding pertinent issues affecting CCSP are distributed to the provider network.
- ARC staff provide consultation to each new provider agency applying to become a CCSP provider.
- ARC convenes the CCSP Provider Advisory Committee to advise the provider network regarding the ongoing coordination and implementation of the provision of CCSP services in the ten county Atlanta region and to get provider input on various issues and barriers to delivering service. The Committee is comprised of representatives from each of the CCSP service components, VNHS and ARC staff.
- Quarterly CCSP Network meetings are convened by ARC and provide opportunities for education, sharing of information and program updates, and facilitating networking among provider representatives, care coordinators, Division of Aging staff, screening staff and others.
- ARC staff follow formal procedures for processing and handling complaints regarding CCSP providers and track these complaints on a monthly basis, as well as communicate with providers and the Division of Aging Services regarding these complaints on an as needed basis.
- ARC staff work in close liaison with the VNHS Care Coordination Unit and monitor the provision of care coordination services.
- To further the effectiveness of the Community Care Services Program, ARC staff also work closely with a range of health-related organizations such as the Georgia Health Care Association, Division of Aging Services of Georgia, the Georgia Association for Community Care Service Providers and the Georgia Medical Care Foundation.

CCSP offers an array of supportive services to help individuals remain in the community. A large network of provider agencies enrolled with the Department of Community Health serve CCSP clients. The services provided and the number of providers by service is as follows:

Service	# of Provider Agencies
Adult Day Health	43
Alternative Living Services Managing Organizations. (Family Model)	14
Alternative Living Services homes registered	240
Alternative Living Services (Group Model)	20
Emergency Response Services	12
Home Delivered Meals	9
Home Delivered Services	2
Personal Support Services	339
Respite Care Out-of-Home	11
Skilled Nursing Service	225

Services are provided in accordance with physicians' orders and the care plans and service authorizations issued by CCSP care coordinators. Providers bill the Department of Community Health directly for services rendered.

To receive services through CCSP, an individual must be eligible or potentially eligible for Medicaid. The individual must also have a functional impairment caused by physical limitations (this can include dementia), have approval for participation in the program by a physician, and have health and personal needs that can be met safely in the community and within established cost limits. In some instances an individual may be expected to pay a portion of the cost of services. In addition there is a priority based waiting list for this program.

C. ELDERLY LEGAL ASSISTANCE PROGRAM

The rights and well-being of vulnerable older adults are the focus of virtually every program and service created, administered or coordinated by the Atlanta region Area Agency on Aging. The Elderly Legal Assistance Program (ELAP), which is provided through contract with Atlanta Legal Aid Society, provides *legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.*

ELAP continues to be delivered using the successful model in place for past Area Plan cycles. The Atlanta region's Elderly Legal Assistance Program is much larger and more comprehensive than anything the funding covered by ARC can support. In addressing housing and health benefits alone, issues are targeted which are repeatedly identified by consumers and advocates as the most pressing among seniors and their caregivers. Elder rights services reach beyond these issues, and have proven flexible in meeting emerging needs as case acceptance priorities and the focus of community education activities are adapted appropriately.

ARC staff assure standards are met by monitoring ELAP, providing technical assistance, reviewing quarterly reports, program monitoring, attending contractor staff events and by following up on elder rights referrals made by ARC. Major emphasis is placed on reviewing monthly performance reports to ensure that reports are accurate and submitted in a timely manner.
The Atlanta Region provides legal advice through ARC's contract with Atlanta Legal Aid Society. These services are provided by paid staff, generally attorneys, from the Atlanta Legal Aid Society. ARC continues to seek opportunities for interaction between elder rights program staff and staff from other aging network players. Elder rights staff has access to the full Enhanced Services Program (ESP) provider and services database through counselors at ARC. The importance of the Hotline, staffed by Atlanta Legal Aid, cannot be overstated as a source of relevant, screened referrals.

AgeWise Connection specialists, taking calls through ARC's ADRC, also provide guidance and information to callers who may be requesting elder legal services. Specialists are able to provide referral information to Atlanta Legal Aid, Adult Protective Services, or other services/agencies from the Enhanced Services Program (ESP) database. Two categories in ESP focus on relevant elder legal information: Abuse/Neglect and Legal Services. These categories include information about Adult Protective Services, abuse/neglect, victim advocacy assistance programs as well as elder law attorneys and arbitration/mediation.

D. ELDER ABUSE AND CONSUMER FRAUD PREVENTION

Elder abuse prevention is defined as *the provision of information and outreach to individuals and groups to prevent elder abuse and consumer fraud; provision of referrals to organizations and agencies whose primary function is advocacy and/or legal representation, coordination with community coalitions, task forces, commissions, councils, et.al on activities aimed at protecting the rights of consumers*. Atlanta Legal Aid Society (ALAS) continues to address the incidence of elder abuse and neglect in the Atlanta region.

The Atlanta Legal Aid Society provides services to prevent elder abuse, neglect and financial exploitation through their Senior Citizens Law Project (SCLP). The Senior Citizens Law Project represents numerous clients in cases involving abuse and financial exploitation. The most common problem is financial exploitation, often by family members or other caregivers. Clients are educated on how to obtain protective orders against abusers, how to remove vulnerable individuals from exploitive living arrangements, how to prepare advance directives when appropriate, how to prevent exploitive situations, and how to defend wards or remove guardians over a client when the older adult is capable of making his or her own decisions involving person and/or property. All SCLP attorneys provide elder abuse prevention services to clients. ALAS also works with the Adult Protective Services and our contractors to facilitate the coordination of elder abuse prevention services provided by SCLP and the Ombudsman Program.

E. *ELDER RIGHTS TEAM*

A) Integration of Elder Rights into the AAA's Program and Services

The rights and wellbeing of vulnerable older adults are the focus of virtually every program and service created, administered or coordinated by the Atlanta Regional Commission (ARC) Area Agency on Aging. ARC advocates for elder rights and promotes the coordination of elder rights internally and among members of the aging services network. Elder rights is integrated into the following programs and services:

- Counselors who receive calls through ARC's Access to Services/Aging and Disability Resource Connection provides information and assistance on programs and services available through the Harmony SAMS database with access to the Elder Services Program (ESP) database in Harmony SAMS for current resources. As requested by callers, counselors provide information on

intervention, advocacy, mediation and/or other appropriate services. If the counselor believes the caller or a family member is a victim of elder abuse, neglect and/or exploitation, a direct referral is made to Atlanta Legal Aid, Adult Protective Services, and/or law enforcement agencies.

ADRC counselors also pay particular attention to identifying stress when caregivers call the ADRC. When stress is apparent, counselors screen and provide counsel to caregivers in an effort to prevent abusive situations which sometimes occur as a result of caregivers' physical, social, emotional or financial burdens. ADRC counselors follow up on all referrals to determine if client received appropriate services from the agency to which the individual was referred. Follow up time varies depending on the situation. In some instances, follow up is done immediately or the next day. In other cases follow up is done within ten business days.

- The Elder Legal Assistance Program (ELAP) is provided through contract with the Atlanta Legal Aid Society. Through ELAP, attorneys at the Atlanta Legal Aid Society provide legal advice, counseling and representation to elderly individuals on issues related to elder abuse/neglect and financial exploitation. Referrals to ELAP come from a wide variety of sources through outreach efforts made by Atlanta Legal Aid. As appropriate, attorneys represent numerous clients in cases involving a wide array of legal issues including abuse and financial exploitation. Financial exploitation continues to be the most common form of abuse, often by family members or other caregivers. In collaboration with Adult Protective Services, clients are represented to obtain protective orders against abusers, to remove vulnerable individuals from exploitive living arrangements, and/or defend wards or remove guardians over a client when the senior is capable of making his or her own decision involving person or property.

  ARC also contracts with the Atlanta Legal Aid Society to provide counseling and information to individuals and community groups about Medicare, Medicaid, prescription assistance, long term care insurance and other health insurance related issues. Beyond providing information to callers regarding the state health insurance programs, community education is provided to seniors and their caregivers on how to recognize, prevent and report fraudulent Medicare and Medicaid activities.

- ARC and its contract network interacts with Adult Protective Services (APS) on an ongoing basis in seeking advice and assistance in identifying cases of elder abuse as well as in reporting cases of abuse. Training provided by APS to ADRC staff and other

members of the Aging Network includes how to make appropriate referrals and agency roles and responsibilities. The collaboration between ARC and APS is critical to addressing issues of elder abuse within the Atlanta region.

- ARC contracts with contractors to provide a range of direct services to older adults and caregivers. As part of this service provision, staff from these agencies are alert to older adults who are being abused or neglected and follow through with mandatory reporting procedures. Older adults who are identified as being at risk of abuse or neglect are provided intensive case management services and receive information on intervention, advocacy, mediation and/or other appropriate services. In all instances, case managers follow through with individuals to make sure abuse/neglect is alleviated.

- ARC is also as a member of the Cobb County Elder Abuse Task Force. The Cobb County Task force plans and implements outreach activities in multi-disciplinary approaches to assist consumers and caregivers in Cobb within a regional approach.

2.) The Elder Rights Team

The Elder Rights Team (At-Risk Adult Team) consists of staff from ARC, the Elderly Legal Assistance Provider (Atlanta Legal Aid Society), the Social Security Administration, the Center for Pan Asian Services and the agencies providing Long Term Care Ombudsman. The Team works closely with ARC and other community agencies to encourage continuous community support and heighten community awareness of the importance of elder abuse prevention.

During 2016, the Elder Rights Team (At-Risk Adult Team) will carry out the activities as identified below.

- Develop and Distribute Brochures and Relevant Information on Elder Abuse.
  As the population of senior adults in the Atlanta region continues to increase, it becomes more important to educate families and senior adults about elder abuse and its prevention. Evidence has shown a “disconnect” with senior victims and reporting these abuses. Individuals often hesitate to report a crime for a variety of reasons. They may feel that law enforcement is too busy, or they may feel embarrassed or fear retaliation from their abuser, or they are unaware of the supports that exist in their communities. Because cases of reported abuse, particularly financial exploitation, are increasing, more efforts are needed to educate the public on abuse prevention. To this end, brochures and relevant printed information developed with the expertise of Elder Rights Team

members will be made available for distribution to the public through ADRC counselors, Home and Community Based Service (HCBS) providers, and other agencies within the aging network.

- Provide Six Community Outreach/Training Events Focusing on Elder Abuse

  Beyond the distribution of brochures, a further need within the Atlanta region is for training sessions on how to identify, report and resolve issues of elder abuse. Thus, training sessions are offered to Elder Rights Team (At-Risk Adult Team) members, for first responders (including law enforcement officers) on the reporting of At-Risk Adult Abuse, Neglect and Exploitation. Particular emphasis will be placed on conducting outreach to draw culturally diverse individuals to these training sessions. The education and collaboration of these individuals is crucial to identifying potential violence, reporting suspected acts of abuse and in resolving cases of elder abuse.

- Expand Team membership

  In order to provide a greater outreach in educating the public about elder abuse and its prevention, efforts will be made to expand the membership of the Team. In focusing on a multi-disciplinary effort, the Elder Rights Team (At-Risk Adult Team) will invite and encourage potential Elder Rights Team members to attend regularly scheduled quarterly meetings and to assist in efforts to promote public awareness of issues related to elder abuse.

  Focus will be placed on recruiting individuals from areas not currently represented on the Team. In particular, efforts will be made to recruit Team members from health departments, law enforcement, mental health and faith based institutions.

  ARC Elder Rights Team Members have become certified At-Risk Crime Tactics Specialist(s). Thus will encourage other elder rights team members to participate and receive certification in the DHS/DAS co-sponsored elder abuse awareness and prevention training program. The At-Risk Crime Tactics (ACT) Certification mission “is to equip primary and secondary responders with knowledge and skills to address the needs of at-risk adult crime victims in Georgia as part of a multi-disciplinary team, thus advancing public safety”.

3.) Priority Issue

A major gap in the Atlanta region related to elder abuse is the lack of training for law enforcement officials and other first responders. Because the identity and follow-through of elder abuse is hinged on the recognition of first responders, educating them on how to identify, report and follow-through with abuse resolution is critical. Law enforcement officials often report that they are unsure how to address issues of elder abuse, particularly when emergency shelters and funding for elderly abuse services is limited.

F. HOME AND COMMUNITY BASED SERVICES (HCBS) IN-HOME SERVICES- Homemaker, Personal Care and Respite

In-home services provided within the Atlanta region include homemaker, personal care and in-home respite. These services are defined as follows:

> Homemaker services provide *assistance with tasks such as preparing meals, shopping for personal items, managing money, using the telephone or light housework.*
>
> Personal care includes *personal assistance, stand-by assistance, supervision or cues.*
>
> In-home respite focuses on *services which 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: 1) in-home respite (personal care, homemaker, and other in-home respite). (Note: Caregiver is the client.)*

Homemaker and personal care services are provided to homebound older adults who need assistance with activities of daily living and instrumental activities of daily living. Requested services generally include light housekeeping, essential shopping, light meal preparation and personal care. Providers work according to a service plan based upon a periodic, detailed, individual assessment by a case manager. A service agreement is signed by the client outlines specific tasks and frequency.

Homemaker and personal care services. Our contractors continue to examine best practices for the provision of homemaker and personal care services and to explore mutually beneficial contractual agreements with home care agencies in the hope of expanding and enhancing services. In an effort to enhance services, Cobb and Fulton Counties provide a listing of several approved providers so that consumers can pick the provider that best suits their needs. They are free to change providers if problems arise or if not entirely satisfied with the service provision.

The third type of in-home services, in-home respite, is provided to give temporary relief to caregivers of frail or disabled elderly adults. Respite helps to maintain and strengthen the capacity of the caregiver and to provide relief from stress or responsibilities associated with providing continuous care or supervision. Contractors provide this services directly or through contract by trained respite workers who relieve caregivers for periods of two to four hours, enabling them to be away from home. This service is also provided through vouchers which gives flexibility to the caregiver.

Waiting lists continue to exist for these services. Appropriate persons who cannot be served by the County Based Agencies are referred to the Community Care Services Program (CCSP), SOURCE (another Medicaid waiver program similar to CCSP), and to the over 200 fee-for-service licensed in-home service provider agencies.

G. HOME AND COMMUNITY BASED SERVICES (HCBS) CONGREGATE MEALS

Congregate meals are *provided to qualified individuals in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and state/local laws.*
The congregate meal constitutes a major component of senior center programming. For many participants the noon meal at the center may be their only balanced meal of the day. Meals are served a minimum of 250 per days per year in each county and provide at least one-third of the Recommended Dietary Allowance as established by the National Food and Nutrition Board. Additional nutrition services provided include nutrition education and health screenings. Promoting and improving nutrition and physical activity are essential components of nutrition services.

ARC provides funds for the provision of congregate meals in three types of centers by contractors. Cherokee County Senior Services, Clayton County Senior Services, Cobb County Senior Services, DeKalb County Office of Senior Affairs and the Fulton County Aging Program serve catered meals through commercial Food vendors. Douglas Senior Services, Henry County Senior Services, Fayette Senior Services, Gwinnett Senior Services and Rockdale Senior Services prepare meals on site in their own commercial kitchens.

Senior centers must comply with state and local health and fire safety regulations in providing congregate meals. ARC staff provides extensive technical assistance and monitors programs for compliance with federal and Georgia Department of Human Services' standards.

Additionally, quarterly training sessions are provided for senior center staff and volunteers addressing health and safety issues to ensure compliance with required state mandated health standards. All senior centers are required to have at least one staff person certified through ServSafe®, a nationally recognized food safety certification agency, in order to ensure the safe quality of foods served.

The NSI (Nutrition Screening Initiative) checklist is administered to all program participants during initial and annual assessments to assess nutrition risk of older adults. The range of scores can be from 21 (extremely high nutritional risk) to 0 (no risk at all). Those participants who score above 6 are deemed to be at nutritional risk and receive one-on-one nutritional interventions and counseling. Nutrition interventions for at-risk clients are based on protocols established by the Georgia Department of Human Services and the Atlanta Regional Commission.

ARC has contracted with an agency who has a Registered Dietician who will review nutrition assessments during monitoring visits, and provides nutrition counseling as needed. They will provide technical assistance in meal enhancement and quality control. Several of the County Based Aging Programs are providing enhanced meals at their senior centers which may include choices in menus including hot or cold lunches and both salad and potato bars. Additionally, the programs that prepare meals on site are using fresh vegetables that come from gardens that are maintained at the senior centers by participants and staff.

In order to maintain the quality of meals and other nutrition services the contractors have secured the services of licensed nutrition professionals as staff or as consultants. Eight of the counties based programs have registered dietitians on staff to administer nutrition services.

H. HOME AND COMMUNITY BASED SERVICES (HCBS) HOME DELIVERED MEALS

Home delivered meals are meals that are *provided to a qualified individual in his/her place or residence. The meal is served in a program administered by State Units on Aging (SUAs) and/or Area Agencies on Aging (AAAs) and meets all of the requirements of the Older Americans Act and state/local laws. May include assistive technology for dining.*

Meals meeting one-third of recommended dietary allowances are delivered five or more days a week to homebound older adults who may be physically unable to navigate and/or are at nutritional risk. Other nutrition services accompany the home delivered meals such as nutrition education, nutrition assessment and nutrition counseling information. Clients receive home-delivered meals based upon a

comprehensive assessment completed by a case manager. The assessment covers the individual's health/functional status, mobility, nutritional status, and available support systems.

Volunteers play a major role in the delivery of meals. Recruited and trained by contractors, volunteer coordinators deliver meals on predetermined routes, greatly reducing the delivery cost of meals and enabling programs to expand. Isolated homebound persons enjoy the social stimulation and attention extended by the volunteers. These are often equally important to the client as the meal itself. Volunteers delivering meals also report any changes in the client's condition or situation to appropriate county staff.

ARC provides funding to contractors to operate home-delivered meal programs from approved service delivery sites. Meals are either delivered through food vendors or prepared on-site and are planned, prepared and delivered in accordance with the GA Department of Human Services' Nutrition Service Standards.

I. Senior Recreation

Group activities are defined as nutrition related activities; activities that promote socialization, physical and mental enrichment; clubs; education sessions and programming for other leisure activities (i.e., sports, performing arts, games, crafts, travel, volunteering; community gardening; environmental activities; and intergenerational activities, etc.) offered to eligible persons sponsored by and/or at an approved senior center facility which are facilitated by an instructor or provider. These activities are those which do not fall under funded nutrition and/or wellness programs and include as well:

Lifestyle Management – The provision of activities and/or education sessions to promote overall health and improve quality of life.
Nutrition Education – The provision of information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve nutrition status.
Physical Activity – The provision of a variety of leisure time, fun activities to improve balance, strength and flexibility.
Program Awareness/Prevention – The provision of activities and/or education sessions related to medications management group sessions; prevention of flu; pneumonia; preventing chronic disease and managing risk associated with chronic diseases.

Contractors have taken advantage of opportunities to work with their local health departments, pharmacies, and other healthcare providers to provide expanded health and wellness programs in senior centers. A variety of exercise and walking programs are flourishing in senior centers in the ten counties, enhanced by new facilities designed with physical activity in mind.

J. CARE CONSULTATION

The Benjamin Rose Institute – Care Consultation Program (BRI-CC) was developed to support service for adults with health challenges and their family or friend caregivers. Certified Care Consultants provide on-going help to find practical solutions to concerns about health and care. BRI-Care Consultation is an evidence –based program resulting in improved care, less stress, fewer visits to the emergency room or hospital, and delayed nursing home placement. Some of the topics discussed during BRI-CC include personal and household care, Medicare, Medicaid and other insurance; legal and financial issues; family communication; balancing caregiving with other responsibilities and planning for future care. The program requires the use the Care Consultation Information System (CCIS) software provided by ARC, Benjamin Rose Institute and Rosalynn Carter Institute (RCI).

K. HOME AND COMMUNITY BASED SERVICES (HCBS) CASE /CARE MANAGEMENT

HCBS case/care management is currently defined as *assistance either in the form of access or care coordination in circumstances where the older person or caregiver is experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by a formal service provider and/or family caregivers. Activities of care management include such practices as accessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.*

The state of Georgia is undergoing a redesign of case management and the broader service delivery system.
ARC will work jointly with DAS and our partners to ensure its implementation. As a result, significant changes to the long term supports and services system are anticipated. ARC will transition the redesign in phases to allow for the adjustments and tweaking that new processes require. The following plan outlines steps that will be undertaken during state Fiscal Year 2016.

- The ARC 2016 – 2018 Request for Proposals included language requiring any Offeror awarded funds to agree to participate in the case management service design and incorporate any changes to processes and procedures that result as well as the commitment to working on a regional set of outcome measures

- ARC will finalize all processes related to the Access to Service Redesign Project for the 10-county region during Fiscal Year 2016 by July 1, 2016

The redesign of case management will be the second phase of the project and ARC is developing a plan to implement any required case management changes, and to insure an orderly phased in timeline for full compliance.

L. HOME AND COMMUNITY BASED SERVICES (HCBS) TRANSPORTATION

Transportation remains a major service component of the Atlanta region and three types of transportation services are available to older adults. Demand- response services are defined as those that provide a one-way trip from one location to another. Trips are delivered through volunteer, vouchers or transportation providers' staff and fleets. Fixed or flex route shuttle services are defined as those that operate vehicles along a predetermined route and are capable of carrying multiple passengers. Group trips are ones with three or more passengers originating at a designated location and arriving back at the same location and examples include shopping trips or cultural and recreational trips. These services are provided by a combination of sources including, Federal Older Americans Act, Federal Transit Administration (FTA) Section 5310 grant, Georgia State Coordinated Transportation Program, local governmental and private funds. In addition to administering the Older Americans Act and Federal Transit Administration (FTA) Section 5310 grant funds for the region, ARC manages DeKalb County's Coordinated Transportation Services. ARC also serves as the Metropolitan Planning Organization for all or portions of 20 regional counties and as such is responsible for the development of the Human Services Transportation (HST) Plan.

Public transportation is available through MARTA to residents in Fulton, DeKalb and Clayton counties. MARTA provides discounted fare cards to seniors and also operates buses for special group transportation and lift vans that provide demand-response services for physically handicapped persons. A long waiting list exists for MARTA's specialized transportation service. Cobb County Transit provides public transportation in Cobb County and offers a discounted rate for senior and specialized transportation for disabled individuals on a limited basis. Gwinnett County Transit also provides public transportation in Gwinnett County. MARTA, Cobb and Gwinnett Transit offer para-transit services for eligible residents within a ¾ mile buffer of a fixed service route.

The Atlanta region is heavily car-centric and ARC is invested in developing alternatives to driving. As such, SimplyGetThere.org, a trip planning resource for everyone in the Atlanta region is a service of ARC. The web-based application uses a comprehensive listing of public and private sector transportation providers to help individuals, especially older adults and persons with disabilities, identify available transportation options. Users can compare different travel options and costs especially if they need extra or specialized transportation services. Work to encourage pedestrian and biker improvements also is undertaken by ARC to develop diverse mobility options.

M. CHRONIC DISEASE SELF MANAGEMENT

The Chronic Disease Self-Management Program (CDSMP) is defined *as a Stanford University evidence based program facilitated by non-health professionals to improve the skills needed to manage day-to-day problems with chronic diseases. Skills taught include appropriate exercise, communication, nutrition and pain management techniques.*
ARC contracts with the Georgia Department of Human Services Division of Aging Services to provide these workshops in the Atlanta region. The CDSMP consists of six 2 ½ hour weekly workshops. CDSMP uses trained persons to lead the workshops.

Many of the workshop leaders are volunteers living with a chronic disease which constitutes an important element of the peer-to-peer training. Both master trainers and lay leaders receive extensive training on how to conduct the workshops and only then are certified to lead a workshop. These trained leaders are the key to sustainability throughout the area plan period.
There are common factors that many people deal with regardless of their disease diagnosis. Persons with diabetes, arthritis, cancer, heart disease, depression, and most other chronic conditions can benefit from the skills taught in the workshops. Skills taught to participants include information in the following areas: stress reduction techniques, dealing with difficult emotions, physical activity, pain and fatigue management, communication skills, depression management, and working with your health care professional to achieve optimal results.

ARC sustains CDSMP within the region by facilitating the coordination of resources to increase the quality of life for seniors with chronic diseases. Collaboration will occur with all contractors and community partners to maintain and/or establish CDSMP throughout the area through meetings, training, technical assistance, data collection, and evaluation. Additional funding sources for the overall continuation of the CDSMP program will be explored on an ongoing basis.

Item #6 – Policy for Prioritizing Clients Most in Need

It is the policy of ARC to give preference to older adults with greatest economic and social need, to persons who are frail and to persons who are at risk of institutionalization. This would be inclusive of low income individuals of all minorities as identified in our region and low income with limited English proficiency, those with sensory impairments and those with Alzheimer's/dementia, aging adults with developmental and/or physical disabilities.

More specifically while greatest economic need results from an income level, those of greatest social need are those where the need is caused by non-economic factors that restrict the individual's ability to perform normal tasks or threatens the capacity of the individual to live independently. Those circumstances may include:

- Physical or developmental disabilities
- Language barriers
- Cultural, social or geographical isolation

The ARC uses several assessments to identify those that are most in need through the DON-R, NSI, Food Security Survey as well as asking for income information. In full support of the Access to Services Re-Design, the centralized intake process will also take over managing individuals being put on the waiting list to ensure that they meet the greatest economic and social need criteria.

Items #7a through #7c – Allocation, Budget and Units Plan

Item #7a - Allocation Methodology

Item #7b - Budget Narrative

Item #7c - Changes to Services/Units/Persons

Item #8 – Agency's Indirect Cost Plan

AREA PLAN ATTACHMENTS

ATTACHMENTS A - ACL GOALS AND AAA OBJECTIVES CHARTS

ATTACHMENTS B - LOCATION OF SERVICES CHARTS

- Chart B #1 – Home and Community Based Services (HCBS)
- Chart B #2 – Access Services
- Chart B #3 – Community Care Services Program (CCSP)

ATTACHMENTS C - COMPLIANCE DOCUMENTS

- C-1.a – GA DHS DAS Request for Advance Payments Against Contracts Letter
- C-1.b – GA DHS DAS Request for Advance Letter
- C-1.c – Request for Advance Worksheet
- C-1.d – Letter of Bond Coverage
- C-2 – Standard Assurances
- C-3 – Letter(s) Requesting a Waiver of Standard Assurances
- C-4 – Board Resolution

ATTACHMENTS D - REQUIRED PLANS **(No Required Plans requested to be included in the SFY 2017 Area Plan Submittal.)**

ATTACHMENT E - CERTIFICATION OF BUDGET SUBMITTAL

ATTACHMENT F - TITLE III FEDERAL ALLOCATION AND MATCH ANALYSIS (Excel)

ATTACHMENT G - AREA PLAN PROVIDER SITE LIST

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS

As required, Georgia's State Plan includes measurable objectives that address focus areas outlined by the United States Department of Health and Human Services Administration for Community Living. The focus areas include OAA Core Programs, ACL Discretionary Grants, Participant-Directed/Person-Centered Planning, and Elder Justice. The DAS developed Objectives under two of the focus areas for each of Georgia's AAAs to accomplish under its oversight: ***OAA Core Programs*** and ***Participant-Directed/Person-Centered Planning***.

The Goals, Strategies and Performance Metrics remain written in the AAA Area Plan as they are written in the Georgia State Plan, including yearly dates and numbering. AAAs should apply each Objective to its Planning and Service Area (PSA) and make no changes in the way it is written. *For the entire October 1, 2015 – September 30, 2019 Georgia State Plan, visit the DAS website and click on Publications.* http://aging.ga.gov The State Plan approved objectives and strategies to achieve these goals and to measure performance are listed below and are specifically stated in each of the following respective charts:

OAA Core Programs (OAA CP) Focus Area Goals

OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need
- (AAA #1) OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates

OAA CP Goal #2 – Create a Statewide Focus on Reaching Underserved Persons
- (AAA #2) OAA CP G#2/Objective #2:1 – Develop an Aging Network that Reaches Underserved Persons Across the State
- (AAA #3) OAA CP G#2/Objective #2:2 – Promote Greater Access to Waiver Services in Underserved/Rural Parts of the State

OAA CP Goal #3 - Expand Opportunities for Transportation in Underserved Areas of Georgia
- (AAA #4) OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities

OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible
- (AAA #5) OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services

OAA CP Goal #10 - Increase the Numbers of Individuals Served by Georgia Cares from "Targeted Populations"
- (AAA #6) OAA CP G#10/Objective #10 – Increase the Number of Client Contacts

OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)

- (AAA #7) OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion

Participant Directed/Person-Centered Planning (PD/PC P) Focus Area Goals

PD/PC P Goal #2 - Develop and Implement a Person-Centered Approach to Service Mix

- (AAA #8) PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based

PD/PC P Goal #3 - Maximize the Variety of Approaches to Support Consumer Control and Choice

- (AAA #9) PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology as an Option in Place of Services

PD/PC P Goal #4 - Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults

- (AAA #10) PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops and Utilize Technology to Increase Professional Capacity

PD/PC P Goal #5 - Support Grandparents and Other Relative Caregivers to Maximize Family Independence

- (AAA #11) PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems

PD/PC P Goal #6 - Ensure Maximum Access and Efficient Delivery of Home and Community Based Services (HCBS) to Older Adults, Persons with Disabilities and Caregivers

- (AAA #12) PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration

PD/PC P Goal #7 - Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

- (AAA #13) PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State

PD/PC P Goal #8 - Empower Residents of Facilities to Fully Participate in Directing Their Care

- (AAA #14) PD/PC P G#8/Objective #8:1 – Develop and Implement a Plan to Increase Resident and Family Self-Advocacy
- (AAA #15) PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options, Including MFP

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS
OAA Core Programs (OAA CP) Focus Area Goals

AAA #1		
OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need **OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates by September 30, 2019**		
	Strategies	
1.	Expand fee-for-service program model (example: Evidence Based Programs, Case Management, Community Living Program, Senior Centers) by 2019.	
2.	Implement evidence-based hospital transition programs in all AAAs by 2019.	
3.	All AAAs have business plan with a regular review process by 2019.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	100% of the AAAs will receive business plan training by 2019.	Baseline: No business plan training to date. 2016 status update: ARC will receive business plan training by 2018.
2.	100% of AAAs will implement business plans by 2019.	Baseline: No business plans implemented to date. 2016 status update: ARC envisions having a business plan developed by 2018.
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	Baseline: one new fund source 2016 status update: ARC will develop 3 new fund sources to support service provision by 2019.
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	Baseline: One Hospital Transition program. 2016 status update: One Hospital transition program.
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	Baseline: ARC currently monitors dollar amount increases and percentage increase in funds. 2016 status update: ARC will continue to put methods in place to further monitor changes in funding.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	100% of the AAAs will receive business plan training by 2019.	
2.	100% of AAAs will implement business plans by 2019.	
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	
5.	Monitor dollar amount increase and percentage increase in funds	

AAA #1 **OAA CP Goal #1 - Focus on Sustainability to Ensure Programs and Services Remain Available for Those in Need** **OAA CP G#1/Objective #1 - Develop an Aging Network that is Sustainable in all Economic Climates by September 30, 2019**		
	(fee for service).	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	100% of the AAAs will receive business plan training by 2019.	
2.	100% of AAAs will implement business plans by 2019.	
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	100% of the AAAs will receive business plan training by 2019.	
2.	100% of AAAs will implement business plans by 2019.	
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	100% of the AAAs will receive business plan training by 2019.	
2.	100% of AAAs will implement business plans by 2019.	
3.	Develop a minimum of 3 new funds sources to support service provision by 2019.	
4.	Number of statewide hospital transition programs in operation will increase by 25% by 2019.	
5.	Monitor dollar amount increase and percentage increase in funds (fee for service).	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #2 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** **OAA CP G#2/Objective #2:1 - Develop an Aging Network that Reaches Underserved Persons Across the State by September 30, 2019**		
	Strategies	
1.	Identify and prioritize potential underserved populations to be reached.	
2.	Develop partnerships that facilitate outreach for underserved populations such as veterans, those with limited English proficiency and those with other cultural barriers.	
3.	Develop service plan to address prioritized populations.	
4.	Focus network activity to address the needs of underserved populations (nutrition, social, etc.).	
5.	Develop and implement training for community partners to aid in outreach and service provision to underserved populations.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	Baseline: 15,311 individuals at high nutritional risk, rural, live alone and are in poverty. 2016 status update: 14,709 individuals who are at high nutritional risk, rural, live alone and are in poverty. ARC's strategic planning process identified several additional underserved populations to target in 2016-2018.
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	Baseline: 19 2016 status update: 19.
3.	Increase number of underserved populations for which service plans are developed.	Baseline: 4,410 individuals who have service plans. 2016 status update: 4,353 underserved individuals who have service plans.
4.	Increase number of trainings.	Baseline: 38 trainings. 2016 status update: 31 trainings.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	

AAA #2

OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons

OAA CP G#2/Objective #2:1 - Develop an Aging Network that Reaches Underserved Persons Across the State by September 30, 2019

	Performance Metrics	SFY 2018 Update (February 1, 2017 – January 31, 2018)
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	
	Performance Metrics	**SFY 2019 Update (February 1, 2018 – January 31, 2019)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	
	Performance Metrics	**SFY 2020 Update (February 1, 2019 – September 30, 2019)**
1.	Increase percentage of underserved individuals served by 10% after setting baseline in SFY 2015.	
2.	Increase number of partner cooperatives by 10% after setting baseline in SFY 2015.	
3.	Increase number of underserved populations for which service plans are developed.	
4.	Increase number of trainings.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #3 **OAA CP Goal #2 - Create a Statewide Focus on Reaching Underserved Persons** **OAA CP G#2/Objective #2:2 - Promote Greater Access to CCSP Waiver Services in Underserved/Rural Parts of the State by September 30, 2019**		
	Strategies	
1.	Develop effective ways to address potentially-eligible consumers' concerns related to cost-share and estate recovery.	
2.	Provide training for ADRC and Case Management staff to deliver consistent messages about cost share and estate recovery.	
	SFY 2016 Status **(July 1, 2015 – January 31, 2016)**	
	2016 status update: All staff receive training on cost-share and estate recovery at onboarding and team meetings. Annual trainings are conducted as requested or as needed.	
	SFY 2017 Update **(February 1, 2016 – January 31, 2017)**	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	SFY 2018 to SFY 2019: Provide one (1) refresher training session on cost-share and estate recovery for the ADRC	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #4 **OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia** **OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019**		
	Strategies	
1.	Develop county-based transportation cooperatives that work on local transportation options for older adults and persons living with disabilities.	
2.	Develop volunteer transportation programs in each AAA.	
3.	Build partnerships with transportation organizations (for-profit and nonprofit) to further develop transportation options for vulnerable populations.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	Baseline: 10 cooperatives; 124,567 one way trips provided 2016 status update: 10 cooperatives. 100,899 one way trips provided. In alignment with ARC's strategic plan, transportation is a priority area, ARC will be focusing on increased trips through increased provider capacity rather than increasing number of cooperatives.
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	Baseline: one cooperative 2016 status update: one cooperative. In alignments with ARC's strategic plan transportation is a priority area, ARC will be focusing on increased trips through increased provider capacity of volunteer programs, which we see as a cost effective model for service delivery.
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	Baseline: ARC currently leverages governmental dollars which in turn leverages corporate sponsorships 2016 status update: In alignment with ARC's strategic plan transportation is a priority area and ARC will continue to leverage governmental funding to support programming. ARC will be focusing on increased trips through increased provider capacity.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each	

AAA #4 OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019		
	year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the baseline. Increase number of corporate partnerships by 10% each year.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Measure number of cooperatives developed in each year of the plan after the baseline and increase number of cooperatives developed by 10% each year.	
2.	Measure number of volunteer programs developed after the baseline. Increase number of volunteer programs by 10% each year.	
3.	Measure number of corporate partnerships developed after the	

AAA #4 OAA CP Goal #3 - Expand the Opportunities for Transportation in Underserved Areas of Georgia OAA CP G#3/Objective #3 – Increase Community Based Transportation Opportunities By September 30, 2019		
	baseline. Increase number of corporate partnerships by 10% each year.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #5 **OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible** **OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services by September 30, 2019**		
	Strategies	
1.	Develop co-op with local organizations (Boy Scouts; home improvement stores; high schools; tech programs; and faith-based communities).	
2.	Increase home modification/home repair services access statewide.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	Baseline: 30 referral based agencies providing home modification services and 26 referral based agencies providing maintenance and repair services. 2016 status update: Home modification/repair is being provided in the Atlanta Region. 30 referral based agencies provide the home modification services and 26 referral based agencies provide maintenance and repair services.
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	Baseline: zero 2016 status update: ARC maintains a referral database for repair/modifications. ARC will develop a mechanism to capture the number of consumers referred to home repair/modification, as well as increasing the number of available resources in the database by 2018.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	
2.	Increase number of consumers receiving home modification/home	

AAA #5 **OAA CP Goal #8 - Expand Efforts to Support Individuals to Remain in Their Desired Residence as Long as Possible** **OAA CP G#8/Objective #8 – Expand and Increase Statewide Access to Home Modification/Home Repair Services by September 30, 2019**		
	repair services by 40% by 2019	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Home modification/home repair services are available in all 12 AAAs by 2019	
2.	Increase number of consumers receiving home modification/home repair services by 40% by 2019	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

Georgia Cares Program is not contracted for by the ARC.

	AAA #6 **OAA CP Goal #10 - Increase the Numbers of Individuals Served by Georgia Cares from "Targeted Populations"** **OAA CP G#10/Objective #10 – Increase the Number of Client Contacts by September 30, 2019**
	Strategies
1.	Market the DAS toll-free number to increase calls routed to the local Georgia Cares programs. Provide various methods of contact; one-on-one, mail, telephone, e-mail, Georgia Cares website (www.mygeorgiacares.org) for clients seeking Medicare assistance.
2.	Expand reach to limited English proficient populations by recruiting bilingual volunteers and use the Language Line services to assist clients.
3.	Maintain off-site counseling stations in every county to provide services locally to clients.
	Performance Metrics / **Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	Increase the number of client contacts by 3% each year.
2.	Maintain 2-day standard of promptness for returning client calls (Georgia Cares Standards and Guidelines).
	Performance Metrics / **SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	Increase the number of client contacts by 3% each year.
2.	Maintain 2-day standard of promptness for returning client calls (Georgia Cares Standards and Guidelines).
	Performance Metrics / **SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	Increase the number of client contacts by 3% each year.
2.	Maintain 2-day standard of promptness for returning client calls (Georgia Cares Standards and Guidelines).
	Performance Metrics / **SFY 2019 Update (February 1, 2018 – January 31, 2019)**
1.	Increase the number of client contacts by 3% each year.
2.	Maintain 2-day standard of promptness for returning client calls (Georgia Cares Standards and Guidelines).
	Performance Metrics / **SFY 2020 Update (February 1, 2019 – September 30, 2019)**
1.	Increase the number of client contacts by 3% each year.
2.	Maintain 2-day standard of promptness for returning client calls (Georgia Cares Standards and Guidelines).

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #7 **OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)** **OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion by September 30, 2019** **MIPPA dollars were not in the ARC Atlanta Region during the baseline timeframe. We do not have MIPPA funding currently.**		
	Strategies	
1.	Develop collaboration between Georgia Cares, ADRC and Health and Wellness staff to conduct outreach and educate Medicare beneficiaries.	
2.	Establish and foster community partnerships with organizations and agencies serving Medicare beneficiaries.	
3.	Increase marketing efforts for the Georgia Cares program to improve brand awareness.	
4.	Continue partnership with Fort Valley State University mobile information technology center to reach individuals in rural counties.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	ARC continues to provide information to consumers on Medicare Savings program but does not have MIPPA funding.
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**

AAA #7 **OAA CP Goal #11 - Increase the Number of Consumers Reached that Could Benefit from Assistance Offered Through the Medicare Improvements for Patients and Providers Act (MIPPA)** **OAA CP G#11/Objective #11 – Extend Outreach and Assistance Efforts for Medicare Beneficiaries, Including Disease Prevention and Wellness Promotion by September 30, 2019** **MIPPA dollars were not in the ARC Atlanta Region during the baseline timeframe. We do not have MIPPA funding currently.**		
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase the number and percent increase of enrollments for Medicare Savings Program (MSP) and Low Income Subsidy (LIS) applications each year by 3% within the state during SFY 2016 – SFY 2020.	
2.	Establish one (1) offsite counseling station in each county within the state during SFY 2016 – SFY 2020.	
3.	Establish one (1) new partnership in each county within the state during SFY 2016 – SFY 2020.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…
Participant Directed/Person-Centered Planning (PD/PC P) Focus Area Goals

AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**	
	Strategies
1.	Analyze and assess current wait lists and how they are used.
2.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
3.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2016 Status **(July 1, 2015 – January 31, 2016)**
	Baseline: 30,178 Individuals on wait list 2016 status update: 15,271 from July 1, 2015-December 31, 2016 1. The management of putting individuals on the waitlists will be centralized at ARC effective July 1, 2016. 2. ARC contracts for the regional provision of services in homemaker, personal care and respite ensuring no gap in services. If there were to be a gap in service, it would be in home delivered meals due to route capacity or where routes don't exist. ARC will RFP for alternative meal delivery options by 2018. 3. The Risk Assessment Tool (RAT) has not been officially implemented by the state. ARC intends to apply the tool when it becomes available.
	Strategies
1.	Analyze and assess current wait lists and how they are used.
2.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
3.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2017 Update **(February 1, 2016 – January 31, 2017)**

	AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2018 Update **(February 1, 2017 – January 31, 2018)**
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2019 Update **(February 1, 2018 – January 31, 2019)**
	Strategies
1.	In instances when a client needs a service and is the most in need and the area provider does not reach that particular address, an amount of money commensurate with the cost of the provider's services will be set aside by the provider to allow for Support Options model to meet the individual's needs.
2.	Use the Risk Assessment Tool (RAT) as a means of determining what service meets the individual's greatest need.
	SFY 2020 Update **(February 1, 2019 – September 30, 2019)**

AAA #8 **PD/PC P Goal #2 – Develop and Implement a Person-Centered Approach to Service Mix** **PD/PC P G#2/Objective #2 – Develop and Implement a New Non-Programmatic Regional Wait List for HCBS Services Based by September 30, 2019**	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #9 **PD/PC P Goal #3 – Maximize the Variety of Approaches to Support Consumer Control and Choice PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology (AT) as an Option in Place of Services by September 30, 2019**		
	Strategies	
1.	Implement an assistive technology program.	
2.	Establish a baseline of number of HCBS consumers referred for AT.	
3.	Establish a baseline of number of HCBS consumers currently using AT.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	All AAAs have AT program implemented and functioning by 2019.	Baseline: 58 referral based agencies in region providing Assistive Technology. 2016 status update: ARC's AT program is the partnership with agencies that provide Assistive Technology and the referral of consumers to those 58 referral based agencies.
2.	Increase number of consumers referred for AT by 25% by 2019.	Baseline: zero 2016 status update: ARC will develop a mechanism to track referrals.
3.	Increase number of consumers using AT by 25% by 2019.	Baseline: zero 2016 status update: ARC is unable to track the outcome of referrals to agencies providing assistive technology because the agencies do not track referral sources.
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	All AAAs have AT program implemented and functioning by 2019.	
2.	Increase number of consumers referred for AT by 25% by 2019.	
3.	Increase number of consumers using AT by 25% by 2019.	
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	All AAAs have AT program implemented and functioning by 2019.	
2.	Increase number of consumers referred for AT by 25% by 2019.	
3.	Increase number of consumers using AT by 25% by 2019.	
	Performance Metrics	**SFY 2019 Update**

AAA #9

PD/PC P Goal #3 – Maximize the Variety of Approaches to Support Consumer Control and Choice
PD/PC P G#3/Objective #3 – Develop and Implement the Purchase and Use of Assistive Technology (AT) as an Option in Place of Services by September 30, 2019

		(February 1, 2018 – January 31, 2019)
1.	All AAAs have AT program implemented and functioning by 2019.	
2.	Increase number of consumers referred for AT by 25% by 2019.	
3.	Increase number of consumers using AT by 25% by 2019.	
	Performance Metrics	**SFY 2020 Update (February 1, 2019 – September 30, 2019)**
1.	All AAAs have AT program implemented and functioning by 2019.	
2.	Increase number of consumers referred for AT by 25% by 2019.	
3.	Increase number of consumers using AT by 25% by 2019.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #10 **PD/PC P Goal #4 – Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults** **PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops, and Utilize Technology to Increase Professional Capacity by September 30, 2019**		
	Strategies	
1.	Facilitate conference calls and webinars between Health and Wellness coordinators and caregiver specialists to increase cross referrals between programs.	
2.	Co-sponsor an annual financial exploitation summit with other organizations.	
3.	Participate in DAS-sponsored Financial Exploitation Work Team.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify baseline of class leaders and Master Trainers for each AAA.	Baseline: 31 trained Powerful Tools for Caregiver Lay Leaders; 8 of which are also Master Trainers. 2016 status update: 31 trained Powerful Tools for Caregiver Lay Leaders; 8 of which are also Master Trainers
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	Baseline: zero 2016 status update: The region is working to improve the way it tracks support for and impact on caregivers. Resources will be developed and implemented across all programs.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers	

AAA #10 **PD/PC P Goal #4 – Increase Professional Capacity of Georgia's Aging Network to Better Meet the Needs of Family Caregivers and At-Risk Adults** **PD/PC P G#4/Objective #4 – Form Collaborative Teams and Partnerships, Conduct Workshops, and Utilize Technology to Increase Professional Capacity by September 30, 2019**		
	for each AAA.	
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	**Powerful Tools for Caregivers** SFY 2016: Identify number of class leaders and Master Trainers for each AAA.	
2.	**Caregiver Programs** Establish a baseline of caregiver intention to place care receiver in a nursing facility during 2016. During FY 2017, FY 2018 and FY 2019 decrease intention to place by 10%.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #11 **PD/PC P Goal #5 – Support Grandparents and Other Relative Caregivers to Maximize Family Independence PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems by September 30, 2019**		
	Strategies	
1.	Meet at least twice per year with state's Kinship Care Coordinators.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	Baseline: 156 activities 2016 status update:828 activities ARC will increase its referral database that provides services that supports grandparents and/or children.
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	Baseline:4,442 individuals 2016 status update: 8727 individuals. ARC will increase its referral database that provides services that supports grandparents and/or children.
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	Baseline: ARC did not track the number of referrals. 2016 status update: ARC will increase its referral database that provides services that supports grandparents and/or children. ARC will develop a mechanism to capture the number of consumers referred to kinship care services as well as increase the number of available resources in the database by 2019.
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	
2.	Increase number of caregivers and children served by Kinship	

AAA #11 **PD/PC P Goal #5 – Support Grandparents and Other Relative Caregivers to Maximize Family Independence PD/PC P G#5/Objective #5 – Increase Access to and Use of Formal Resources and Prevention of Disruption of Family Care Systems by September 30, 2019**		
	Care services by 10% by 2019.	
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase Kinship Care activities that serve caregivers and/or children by 10% by 2019.	
2.	Increase number of caregivers and children served by Kinship Care services by 10% by 2019.	
3.	Increase number of referrals on behalf of kinship families by 10% by 2019.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #12

PD/PC P Goal #6 – Ensure Maximum Access and Efficient Delivery of Home and Community Based Services to Older Adults, Persons with Disabilities, and Caregivers
PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration by September 30, 2019

	Performance Metrics	Baseline as of June 30, 2015/SFY 2016 Status (July 1, 2015 – January 31, 2016)
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	Baseline: 15,311 individuals 2016 status update: 14,709 individuals
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	Baseline: 15,251 Individuals on wait list 2016 status update: ARC is actively engaged in the Access to Services re-design to centralize waitlist and ensure that all individuals meet target criteria.
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	Baseline: In alignment with ARC's strategic plan to lower the cost of service delivery through greater efficiency and targeted services. ARC will improve cost savings by providing the right service to the right person at the right time, with or without the provision of case management. 2016 status update: ARC is targeting HCBS services and improving cost effectiveness of HCBS through implementing the state's Access to Services redesign to ensure greater efficiency of services.
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	Baseline: ARC is identifying those individuals in a high score range indicating eligibility for nursing home placement and determining an average for baseline. 2016 update: ARC will use this measurement mechanism to evaluate extended community placement.
1.		
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	.

AAA #12 **PD/PC P Goal #6 – Ensure Maximum Access and Efficient Delivery of Home and Community Based Services to Older Adults, Persons with Disabilities, and Caregivers** **PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration by September 30, 2019**		
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase persons served who meet target criteria (At Risk, Greatest Need) by 25% by 2019.	
2.	100% of persons referred for HCBS from wait list will meet target criteria by 2019.	
3.	Increase the cost savings of HCBS services as % of cost of NH care by 5% per year.	

AAA #12 **PD/PC P Goal #6 – Ensure Maximum Access and Efficient Delivery of Home and Community Based Services to Older Adults, Persons with Disabilities, and Caregivers** **PD/PC P G#6/Objective #6 – Provide the Right Service(s) to the Right Person at the Right Time for the Right Duration by September 30, 2019**		
4.	Length of stay in community for persons at risk of nursing home placement will increase 10% by 2019.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
	Strategies	
1.	Present available evidence-based programs to health care professionals via association meetings, conference calls, conferences, etc.	
2.	Partner with local, state and national organizations to increase referrals and promote continuous quality improvement for evidence-based programs in Georgia.	
	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	Baseline: zero 2016 status update: The source of referral has not previously been tracked for Evidence Based Programs. ARC will identify a method to track this information to identify a baseline in the next year.
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	Baseline: zero 2016 status update: ARC does not currently have an

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
		established healthcare professional referral mechanism to community-based, evidence-based health and wellness programs, but will build relationships with networks.
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	Baseline: 103 participants served through evidence based health and wellness programs. Retention rate for these participants is 81% completion rate. 2016 status update: 82 participants and 43 completers for a retention of 52%.
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	Baseline and 2016 service update: ARC began a process to support the sustainability of evidence based health and wellness programs in the fall of 2015. Focusing initially on expanding volunteer infrastructure, and increasing the scale of delivery, ARC will now begin to diversify funding.
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	Baseline: Evidence-based health and wellness programs are currently offered in each of the 10 counties in ARC's service area. 2016 status update: Evidence-based health and wellness programs will continue to be offered in each of the 10 counties of ARC's service area.
6.	Increase statewide marketing of evidence-based health and wellness programs.	Baseline: zero 2016 status update: ARC is developing new marketing materials for evidence-based health and wellness programs to support increased marketing efforts that will be kicked off at the start of FY 2017.
	Performance Metrics	**SFY 2017 Update**

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
		(February 1, 2016 – January 31, 2017)
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	
6.	Increase statewide marketing of evidence-based health and wellness programs.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
6.	Increase statewide marketing of evidence-based health and wellness programs.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by 2019.	
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	
6.	Increase statewide marketing of evidence-based health and wellness programs.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	Increase the number of ADRC referrals to evidence-based health and wellness programs by 25% by 2019.	
2.	Establish healthcare professional (doctor, physical therapist, occupational therapist, registered nurse, discharge planner etc.) referral mechanism to community-based, evidence-based health and wellness programs by 2019.	
3.	Increase the number of people served through evidence-based health and wellness programs by 20% by 2019 maintaining at least a 72% retention rate for all programs.	
4.	Use fee-for-service funding mechanisms to support the sustainability of evidence-based health and wellness programs by	

AAA #13 **PD/PC P Goal #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State** **PD/PC P G#7/Objective #7 – Increase Participation in and the Sustainability of Evidence-Based Health and Wellness Programs Offered Across the State by September 30, 2019**		
	2019.	
5.	Increase the number of counties offering evidence-based health and wellness programs to 90% by 2019.	
6.	Increase statewide marketing of evidence-based health and wellness programs.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…

AAA #14

PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care
PD/PC P G#8/Objective #8:1 – Develop and Implement a Plan to Increase Resident and Family Self-Advocacy by September 30, 2019

	Strategies	
1.	Determine what resources for self-advocacy are currently available.	
2.	Determine any gaps.	
3.	Develop resources to fill the gaps.	
4.	Analyze resident councils and family councils in each LTCO region.	
5.	Increase the number of resident councils and family councils.	
6.	Increase local LTCO representative participation in resident and family councils.	
	Performance Metrics	**SFY 2016 Status (July 1, 2015 – January 31, 2016)**
1.	SFY 2016: Convene workgroup to determine resources and gaps.	
	Performance Metrics	**SFY 2017 Update (February 1, 2016 – January 31, 2017)**
1.	SFY 2016: Convene workgroup to determine resources and gaps.	
2.	SFY 2017: Create materials to be distributed and a plan for deployment.	
	Performance Metrics	**SFY 2018 Update (February 1, 2017 – January 31, 2018)**
1.	SFY 2017: Create materials to be distributed and a plan for deployment.	
2.	SFY 2018: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy.	**Baseline**
	Performance Metrics	**SFY 2019 Update (February 1, 2018 – January 31, 2019)**
1.	SFY 2018: Require an increase of 10% participation in resident and family councils specifically to deploy the plan for resident and family self-advocacy.	
2.	SFY 2019: Evaluate success of plan.	
	Performance Metrics	**SFY 2020 Update (February 1, 2019 – September 30, 2019)**
1.	SFY 2019: Evaluate success of plan.	

ATTACHMENT A - ACL GOALS AND AAA OBJECTIVES CHARTS Continued…
AAA#15 HAS ALSO BEEN COMMUNICATED TO LTCO for objective #3

AAA #15 **PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care** **PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options including MFP by September 30, 2019**	
	Strategies
1.	Provide local LTCO representatives with materials to distribute to residents and families, including brochures and other materials about the ADRC, MFP and HCBS.
2.	Provide regular outreach to nursing home staff about Community Options and MFP.
3.	Include in local LTCO representatives' training conferences information about how to use the materials to provide information to residents about other options.

	Performance Metrics	**Baseline as of June 30, 2015/SFY 2016 Status** **(July 1, 2015 – January 31, 2016)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	Baseline: one resident council presentation 2016 status update: The timeline for marketing and presentations has been developed and will be initiated by June 30, 2016 and will be ongoing.
	Performance Metrics	**SFY 2017 Update** **(February 1, 2016 – January 31, 2017)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	
	Performance Metrics	**SFY 2018 Update** **(February 1, 2017 – January 31, 2018)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	
	Performance Metrics	**SFY 2019 Update** **(February 1, 2018 – January 31, 2019)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more	

AAA #15 **PD/PC P Goal #8 – Empower Residents of Facilities to Fully Participate in Directing Their Care** **PD/PC P G#8/Objective #8:2 – Increase Awareness of Community Options including MFP by September 30, 2019**		
	information.	
	Performance Metrics	**SFY 2020 Update** **(February 1, 2019 – September 30, 2019)**
1.	SFYs 2016, 2017, 2018 and 2019: Increase by 5% each year the number of Resident Council presentations that include information about community options and how to access the ADRC for more information.	

ATTACHMENT B – LOCATION OF SERVICES CHARTS

ATTACHMENT B: CHART #1 - <u>Home and Community Based Services (HCBS)</u> Provided in Each County Chart (Include HCBS Individual Services, HCBS In-Home Services, HCBS Nutrition/Wellness, HCBS Caregiver, HCBS Kinship Care Programs, Support Options, Alzheimer's, Evidence Based Programs, Fee-For-Services, Services provided through other Local Funds and Grants, etc.)

Chart #1	Counties ⇨ / Services ⇩	Cherokee	Clayton	Cobb	Dekalb	Douglas	Fayette	Fulton	Gwinnett	Henry	Rockdale								
1.	Transportation																		
2.	Case Management																		
3.	Personal Care																		
4.	Homemaker																		
5.	In home respite																		
6.	Congregate meals																		
7.	Home delivered meals																		
8.	Senior recreation																		
9.	Regional respite voucher																		
10.	BRI-Care Consultation																		
11.																			
12.																			
13.																			
14.																			
15.																			
16.																			
17.																			

Chart #1	Counties ⇨ Services ⇩	Cherokee	Clayton	Cobb	Dekalb	Douglas	Fayette	Fulton	Gwinnett	Henry	Rockdale								
18.																			
19.																			
20.																			

ATTACHMENT B – LOCATION OF SERVICES CHARTS Continued…

ATTACHMENT B: Chart #2 – <u>Access Services</u> Provided in Each County Chart

Chart #2	Counties ⇨ Services ⇩																	
1.	GeorgiaCares SHIP Counseling/Education																	
2.	GeorgiaCares SMP Counseling/Education																	
3.	Elderly Legal Assistance Program Counseling/Education																	
4.	Aging & Disability Resource Connection – Counseling/Education/ Assessments/Information & Assistance																	
5.	Money Follows the Person – Options Counseling/ Transitions																	

Chart #2	Counties ⇨ Services ⇩																		
6.																			
7.																			
8.																			
9.																			
10.																			

ATTACHMENT B – LOCATION OF SERVICES CHARTS Continued…

ATTACHMENT B: Chart #3 - <u>Community Care Services Program (CCSP) Services</u> Provided in Each County Chart

Chart #3	Counties → / Services ↓																		
1.	Adult Day Health																		
2.	Alternative Living Services																		
3.	Emergency Response System																		
4.	Home Delivered Meals																		
5.	Home Delivered Services																		
6.	Personal Support Services																		
7.	Personal Support Services Extended																		
8.	Respite Care – Out of Home																		
9.	Skilled Nursing Services																		
10.	Care Coordination																		

ATTACHMENT C – COMPLIANCE DOCUMENTS

ATTACHMENT C-1.a – GA DHS DAS REQUEST FOR ADVANCE PAYMENTS AGAINST CONTRACTS LETTER

Georgia Department of Human Services - Division of Aging Services
REQUEST FOR ADVANCE PAYMENT AGAINST CONTRACTS

FROM: **(Type Name of Contracting Entity Here)** Fidelity Bond #: **(Type Fidelity Bond # Here)**

THROUGH: **Jean O'Callaghan, Program Officer, DAS** Bank Account#: **(Type Last 4 Digits ONLY Here)**

OFFICE OF FINANCIAL SERVICES USE ONLY: Contract # _____

TO: Office of Financial Services

It is requested that an advance for the amount(s) listed below in column (A) be made against our contract which begins **(Type Begin Date Here)** and ends **(Type End Date Here)**.

(A) ADVANCE REQUESTED	(B) PURPOSE	(C) BALANCE OWED DHS
	Title III/VII of the Older Americans Act	
	Social Service Block Grant (SSBG)	
	Title V Senior Employment Program	
	Community Care Services Program (CCSP)	
	State Alzheimer's Program	
	State Community Based Services (CBS)	
	State Health Insurance Program/GACARES	
TOTAL:		TOTAL:

We currently have the amount(s) listed in column (C) above in DHS advance funds in our possession which is un-liquidated against valid expenditure reports. **[NOTE: If the last advance granted has not been repaid entirely, the current balance owed to DHS should be listed in column C above.]**

It is understood that this/these advance funds will be liquidated against valid expenditure reports before the end of the contract.

_____ Signed: _____ **(Type Name and Title Here)**
Date Contractor Administrator/Director

_____ Recommended Approval/Disapproval _____
Date Program Officer, DAS

_____ Recommended Approval/Disapproval _____
Date Division Director, DAS

_____ Approval/Disapproval _____
Date Director, DHS Office of Financial Services

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.b – GA DHS DAS REQUEST FOR ADVANCE LETTER

GEORGIA DEPARTMENT OF HUMAN SERVICES

Division of Aging Services

Date:

TO: Office of Financial Services Department of Human Services

FROM: _____ Contract Number 427 _____
Division/Office Director Control Number _____

SUBJECT: Statement of Need for a Contractor
Advance of Funds

Name of Program(s) ☐ Title III/VII ☐ Long-term care Ombudsman ☐ Social Service Block Grant
☐ Title V Employment ☐ Community Care ☐ Alzheimer's ☐ State Community Based Services
☐ State Health Insurance Program (SHIP)

Name of Contractor: [Type Here]

Address: [Type Here]

1. What is the specific financial status of the contractor?
2. If the contractor currently has any DHS advance in its possession, when was it received and when will it be repaid?
3. What is the minimum advance dollar amount necessary to support contractor's operations for this contract?
4. When will the contractor no longer need an advance and begin performing contract on a reimbursement basis?
5. Narrative justification for this advance and why some other contractor could not perform the requirements of this contract without an advance of funds from DHS.
6. Monthly advance repayment schedule, if approved.

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.c – REQUEST FOR ADVANCE WORKSHEET

Fund Source	Federal/State/Local Funds*	Total Advance (Col. B/12)
Title III/VII of the Older Americans Act		
Social Service Block Grant (SSBG)		
Title V Senior Employment Program		
Community Care Services Program (CCSP)		
State Alzheimer's Program		
State Community Based Services (CBS)		
State Health Insurance Program/GACARES		
TOTAL		

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-1.d – LETTER OF BOND COVERAGE

[Insert Bond Letter after this page.]

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-2 – STANDARD ASSURANCES

STANDARD ASSURANCES - OLDER AMERICANS ACT (OAA)
Public Law 89-73, 42 U.S.C.A. § 3001, et seq., as amended

I) ORGANIZATIONAL ASSURANCES

1. SEPARATE ORGANIZATIONAL UNIT

If the Area Agency on Aging has responsibilities which go beyond programs for the elderly, a separate organizational unit within the agency has been created which functions only for the purposes of serving as the Area Agency on Aging.

2. FULL TIME DIRECTOR

The Area Agency or the separate organizational unit which functions only for the purposes of serving as the Area Agency on Aging is headed by an individual qualified by education or experience, working full-time solely on Area Agency on Aging functions and Area Plan management.

II) AREA AGENCY MANAGEMENT COMPLIANCE ASSURANCES

3. EQUAL EMPLOYMENT OPPORTUNITY (5CFR Part 900, Subpart F)

The Area Agency assures fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

4. EMERGENCY MANAGEMENT PLAN

The Area Agency has assigned primary responsibility for Emergency Management planning to a staff member; the Area Emergency Management Plan which was developed in accordance with the Georgia Department of Human Resources Division of Aging Services (now the Georgia Department of Human Services, and hereafter Division of Aging Services) memorandum of February 9, 1979 shall be reviewed at least annually and is revised as necessary. The Area Agency also assures cooperation subject to client need in the use of any facility, equipment, or resources owned or operated by the Department of Human Services which may be required in the event of a declared emergency or disaster.

As in Sec. 306 (a) (16) or (17), the Area Agency shall include information detailing how the Area Agency on aging will coordinate activities, and develop long-range emergency response plans with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for relief service delivery.

5. DIRECT PROVISION OF SOCIAL SERVICES

No Title III supportive services, nutrition services, or in-home services are being directly provided by the Area Agency except where provision of such services by the Area Agency has been determined by the Division of Aging Services to be necessary in assuring an adequate supply of such services; or where services are directly related to the AAA administrative functions; or where services of comparable quality can be provided more economically by the Area Agency.

6. REVIEW BY ADVISORY COUNCIL

The Area Agency has provided the Area Agency Advisory Council the opportunity to review and comment on the Area Plan and operations conducted under the plan.

7. ATTENDANCE AT STATE TRAINING

The Area Agency assures that it will send appropriate staff to those training sessions required by the Division of Aging Services.

8. PROPOSAL FOR PROGRAM DEVELOPMENT AND COORDINATION

The Area Agency has submitted the details of its proposals to pay for program development and coordination as a cost of supportive services to the general public (including government officials, and the aging services network) for review and

comment. The Area Agency has budgeted its total allotment for Area Plan Administration before budgeting Title III-B funds for Program Development in accordance with 45 CFR 1321.17(14).

9. COMPETITIVE PROCESS FOR NUTRITION PROVIDERS, SUPPORTIVE SERVICES PROVIDERS, AND FOOD VENDORS

a) Nutrition providers and supportive service providers will be selected through competitive negotiations or a Request for Proposal process. Documentation will be maintained in the Area Agency files.

b) Nutrition service providers who have a central kitchen or who prepare food on- site must obtain all food and supplies through appropriate procurement procedures, as specified by the Division of Aging Services.

c) Food vendors will be selected through a competitive sealed bid process.

d) Nutrition service providers who have a central kitchen or who prepare meals on-site must develop a food service proposal.

e) Copies of all Requests for Proposals and bid specifications will be maintained at the Area Agency for review.

10. REPORTING

The Area Agency assures that it will maintain required data on the services included in the Area Plan and report such data to the Division of Aging Services in the form and format requested.

11. NO CONFLICT OF INTEREST

No officer, employee, or other representative of the Area Agency on Aging is subject to a conflict of interest prohibited under this Act; and mechanisms are in place at the Area Agency on Aging to indentify and remove conflicts of interest prohibited under this Act.

III) SERVICE PROVISION ASSURANCES

12. MEANS TEST

No Title III service provider uses a means test to deny or limit receipt of Title III services under the Area Plan.

13. EQUAL EMPLOYMENT OPPORTUNITY BY SERVICE PROVIDERS

The Area Agency assures that service providers provide fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age or handicap and with proper regard for their privacy and constitutional rights as citizens. This "fair treatment" principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws. These include Title VII of the Civil Rights Act of 1964, the Equal Pay Act of 1963, the Age Discrimination in Employment Act of 1967, the Rehabilitation Act of 1973, the Americans with Disabilities Act, and other relevant laws.

14. STANDARDS/GUIDELINES/POLICIES AND PROCEDURES

The Area Agency and all service providers will comply with all applicable Georgia Department of Human Services Division of Aging Services standards, guidelines, policies, and procedures.

NOTE: No additional waiver of the Multi-Purpose Senior Center (MPSC) Standards is necessary IF the Area Agency has previously obtained such a waiver AND there have been no changes since the submission of the waiver request.

15. SPECIAL MEALS

Each nutrition program funded under the Area Plan is providing special meals, where feasible and appropriate, to meet the particular dietary needs, arising from the health requirements, religious requirements, or ethnic backgrounds of eligible individuals.

16. CONTRIBUTIONS

Older persons are provided an opportunity to voluntarily contribute to part or all of the cost of Title III services received under the Area Plan, in accordance with procedures established by the Division of Aging Services. Title III services are not denied based on failure to contribute.

The area agency on aging shall ensure that each service provider will-

(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;

(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;

(D) establish appropriate procedures to safeguard and account for all contributions; and

(E) use all collected contributions to expand the service for which the contributions were given and to supplement (not supplant) funds received under this Act.

Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act if the method of solicitation is not coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.

17. PERSONNEL POLICIES

Written personnel policies affecting Area Agency and service provider staff have been developed to include, but are not limited to, written job descriptions for each position; evaluation of job performance; annual leave; sick leave; holiday schedules; normal working hours; and compensatory time.

18. COORDINATION WITH TITLE V NATIONAL SPONSORS

The Area Agency will meet at least annually with the representatives of Title V Older American Community Service Employment Program (formerly SCSEP) sponsors operating within their Planning and Service Areas (PSAs) to discuss equitable distribution of enrollee positions within the PSA and coordinate activities as appropriate.

19. PREFERENCE IN PROVIDING SERVICES

The Area Agency on Aging provides assurance that preference will be given to services to older individuals with the greatest economic need and older individuals with the 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 Area Plan. [Section 305 (a) (2) (E)]

IV) TITLE III, PART A ASSURANCES

The Area Agency on Aging assures that it shall --

20. Sec. 306(a)(2) - 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.

21. Sec. 306(a) (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 sub clause (I);

22. Sec**.** 306(a)(4)(A)(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

23. Sec. 306(a)(4)(A)(iii) - With respect to the fiscal year preceding the fiscal year for which such plan is prepared, the 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).

24. Sec. 306(a)(4)(B)(i) - 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

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance;

25. Sec. 306(a)(4)(C) - 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.

26. Sec. 306(a)(5) 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.

27. Sec. 306(a)(6)(A) - take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

28. Sec. 306(a) (6) (B) -serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals

29. Sec. 306(a) (6) (C) (i) – enter, where possible, into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that-

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42 U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 675(c)(3) of the Community Services Block Grant Act (42 U.S.C. 9904(c)(3)); and

30. Sec. 306(a) (6) (C) (iii) - make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

31. Sec. 306(a)(6)(D) – establish and maintain an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

32. Sec. 306(a)(6)(F) – The Area Agency on Aging will in coordination with the State Agency on Aging (Georgia Department of Human Services Division of Aging Services) and the State agency responsible for mental health services (Georgia Department of Behavioral Health and Developmental Disabilities), 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 the mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

33. Sec. 306(a)(7) - provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by –

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better –

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidenced-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information related to –

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources.

34. Sec. 306(a) (8) that case management services provided under this title through the area agency on aging will -

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that -

(i) gives each older individual seeking service under this subchapter a list of agencies that provide similar services within the jurisdiction of the area agency on Aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirement described in clauses (i) through (iii); and

(v) is not located, does not provide, and does not have a direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with, an entity that provides, services other than case management services under this title.

35. Sec. 306(a)(9) - 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 subchapter.

36. Sec. 306(a) (10) establish a grievance procedure for older individuals who are dissatisfied with or denied services under this subchapter;

37. Sec. 306 (a) (11) – provide information and assurances by the Area Agency on Aging 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.

38. Sec**.** 306 (a**)**(13)(A) - 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.

39. Sec. 306 (a) (13) (B) - 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.

40. Sec. 306(a)(13)(C) - 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.

41. Sec. 306(a)(13)(D) - 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.

42. Sec. 306(a**)**(13)(E) - 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.

43. Sec. 306(a**)** (14) -. 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.

44. Sec. 307(a)(15)(A) - provide assurances that funds received under this title will be used - to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

45. Sec. 307(a)(15)(B) – provide assurances that funds received under this title will be used in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212 (42 U.S.C.A. § 3020c);

46. Sec. 306(a) (16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

47. Conduct annual evaluations of, and *public hearings* on, activities carried out under the area plan and an annual evaluation of the effectiveness of outreach conducted under paragraph (5) (B);

48. Furnish appropriate technical assistance and timely information in a timely manner, to providers of supportive services, nutrition services, or multipurpose senior centers in the planning and service area covered by the area plan;

49. Sec. 306 (a)(6)(C)(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

50. Develop and publish methods by which priority of services is determined, particularly with respect to the delivery of services under paragraph (2);

51. Establish effective and efficient procedures for coordination of -

(I) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

52. Identify the public and private nonprofit entities involved in the prevention, identification, and treatment of the abuse, neglect, and exploitation of older individuals, and based on such identification, determine the extent to which the need for appropriate services for such individuals is unmet;

53. Compile available information on institutions of higher education in the planning and service area regarding-

(I) the courses of study offered to older individuals by such institutions; and

(II) the policies of such institutions with respect to the enrollment of older individuals with little or no payment tuition, on a space available basis, or on another special basis;

(III) include in such compilation such related supplementary information as may be necessary; and

(IV) based on the results of such compilation, make a summary of such information available to older individuals at multipurpose senior centers, congregate nutrition sites, and other appropriate places;

54. Sec. 306 (a) (6) (Q) enter into voluntary arrangements with nonprofit entities (including public and private housing authorities and organizations) that provide housing (such as housing under section 202 of the Housing Act of 1959 (12 U.S.C. 1701Q) to older individuals, to provide-

(I) leadership and coordination in the development, provision, and expansion of adequate housing, supportive services, referrals, and living arrangements for older individuals; and

(ii) advance notification and non-financial assistance to older individuals who are subject to eviction from such housing;

55. List the telephone number of the agency in such telephone directory that is published, by the provider of local telephone service, for residents in any geographical area that lies in whole or in part in the service and planning area served by the agency -

(I) under the name "Area Agency on Aging";

(ii) in the unclassified section of the directory; and

(iii) to the extent possible, in the classified section of the directory, under a subject heading designated by the Commissioner by regulation; and

56. Identify the needs of older individuals and describe methods the area agency on aging will use to coordinate planning and delivery of transportation services (including the purchase of vehicles) to assist older individuals, including those with special needs, in the area;

57. Provide assurances that any amount received under part E will be expended in accordance with such part;

58. Provide assurances that any amount received under part F will be expended in accordance with such part;

59. Provide assurances that any amount received under part G will be expended in accordance with such part;

60. In the discretion of the area agency on aging, provide for an area volunteer services coordinator, who shall -
(A) encourage, and enlist the services of, local volunteer groups to provide assistance and services appropriate to the unique needs of older individuals within the planning and services area; and

(B) encourage, organize, and promote the use of older individuals as volunteers to local communities within the area; and

(C) promote the recognition of the contribution made by volunteers to programs administered under the area plan;

(D) assure that the activities conform with -

(i) the responsibilities of the area agency on aging, as set forth in this subsection; and

(ii) the laws, regulations, and policies of the State served by the area agency on aging;

61. Projects in the planning and service area will reasonably accommodate participants as described in the Act'

62. Before an Area Agency on Aging requests a waiver under paragraph (1) of this subsection, the Area Agency shall conduct a timely public hearing in accordance with the provisions of this paragraph. The Area Agency on Aging requesting a waiver shall notify all interested parties in the area of public hearing and furnish the interested parties with an opportunity to testify.

63. The Area Agency on Aging shall prepare a record of the public hearing conducted pursuant to Section 306(b)(2)(A) and shall furnish the record of public hearing with the request for a waiver made to the State under paragraph (1).

64. Provide that the Area Agency on Aging will 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 of long-term care facilities, but who can return to their homes in community-based options are provided to them.

65. Provide that the Area Agency on Aging will facilitate coordination of community-based, long-term care services designed to enable older individuals to remain in their homes, by means including –

(A) development of case management services as a component of the long-term care services, consistent with the requirements of paragraph (64);
(B) involvement of long-term care providers in the coordination of such services; and
(C) increasing community awareness of and involvement in addressing the needs of residents of long-term care facilities;

66. Provide that case management services provided under this title through the area agency on aging will--
(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and
(C) be provided by a public agency or a nonprofit private agency that--
(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;
(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;
(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or
(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

67. Provide that the Area Agency on Aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in Section 203(b) within the planning and service area.

68. Provide that the Area Agency on Aging, with respect to the needs of older individuals with severe disabilities, will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the Sate 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 and disabilities.

V) TITLE VII/LONG-TERM CARE OMBUDSMAN PROGRAM ASSURANCES

69. The Area Agency assures the provision of long-term care ombudsman services that fulfill the mandate for sub state ombudsman programs as specified in Title III and Title VII of the Older Americans Act and in state law (O.C.G.A Section 31-8-50, et seq.).

70. The Area Agency provides assurance that, in carrying out programs with respect to the prevention of elder abuse, neglect, and exploitation under the Older Americans Act, it will expend from the funds appropriated under Section 702 (b) of the Older Americans Act not less than the total amount allocated by the Division of Aging services for that fund source.

71. 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 the Older Americans Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

VI) TITLE VII/LEGAL ASSISTANCE ASSURANCES

72. Sec. 307(11) (A) provide assurances that the Area Agency 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 in pro bono and reduced fee basis

73. Sec. 307(11)(D) provide assurances that, to the extent practicable, that legal assistance furnished under the Area 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.

74. Sec. 307(11)(E) provide 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.

My signature below indicates that the **[Type Name or AAA]** Area Agency on Aging is in compliance and will maintain compliance with all aforementioned Standard Assurances.

Signature: _____ Date: _____
[Type Name of Signatory]
Area Agency on Aging, Director

Signature: _____ Date: _____
[Type Name of Signatory]
Chairperson of Governing Board
[Type Name of Governing Board]

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-3 – LETTER(S) REQUESTING A WAIVER OF STANDARD ASSURANCES

[Insert Waiver Request Letter(s) After This Page]

ATTACHMENT C – COMPLIANCE DOCUMENTS Continued…

ATTACHMENT C-4 – BOARD RESOLUTION

[Insert Resolution After This Page]

ATTACHMENT D – REQUIRED PLANS

No Required Plans requested to be included in the SFY 2017 Area Plan Submittal.

Do not delete this Page.

ATTACHMENT E – CERTIFICATION OF BUDGET SUBMITTED IN "PENDING" STATUS IN THE DIVISION OF AGING SERVICES' INFORMATION SYSTEM

ACKNOWLEDGEMENT OF BUDGET SUBMISSION: In accordance with the SFY 2017 Planning Allocation and requirements, all financial information and budgets have been entered into the Division of Aging Service's Information System and submitted in "pending" status.

Date Submitted: [Type Date]

Signature: _____

[Type Name of Signatory]
Area Agency on Aging, Director

Signature Date: [Type Date]

Note: No budgets will be reviewed by the DAS in "working" status.

ATTACHMENT F – TITLE III OAA FEDERAL ALLOCATION AND MATCH ANALYSIS (EXCEL)

[Insert Here]

ATTACHMENT G – AREA PLAN PROVIDER SITE LIST
(Division of Aging Services Information System Report)

[Insert Here]