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# Area Plan for Aging Services

Planning Cycle

July 1, 2011 to June 30, 2015

Submitted for State Fiscal Year: FY 2014

July 1, 2013 through June 30, 2014

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March 1, 2013

Dr. James Bulot, Director  
Division of Aging Services  
#2 Peachtree Street NW  
Suite 9-100  
Atlanta, GA 30303-3142



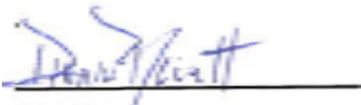
Dear Dr. Bulot:

The original Area Plan on Aging for the Planning Cycle of July 1, 2011 to June 30, 2016 is hereby submitted on behalf of the Coastal Regional Commission for the period of July 1, 2013 to June 30, 2014.

The Coastal Regional Commission Area Agency on Aging has the authority and responsibility to develop and administer the Area Plan in accordance with all requirements of the Older Americans Act (OAA), State of Georgia and other federal and state programs as appropriate.

This plan reflects meeting all federal and state statutory and regulatory requirements and was approved by the Coastal Regional Commission Council at their meeting held February 13, 2013.

Sincerely,



AAA Director  
Dionne Lovett



Executive Director  
Allen Burns



Aging Advisory Council Chairperson  
Henry Frasier



Council Chairman  
Walter Gibson

## CRC Area Agency on Aging Area Plan Submittal Checklist

Completed by: Teresa Townsend	Originally Submitted: February 28, 2013			
	Revisions Submitted:			
	Approved:			
Indicate Type of Document Submitted:	Yes	No	N/A	Comments
Area Plan Cycle Original/Fiscal Year 2014:	X			
Area Plan Amendment/Fiscal Year:				
Budget Amendment Only/Fiscal Year:				
Area Plan Narrative				
1) Letter of Intent Signed	X			
2) Area Plan Checklist Completed	X			
3) Executive Summary	X			
Summary Description of Aging Network completed	X			
Overview of the Area Agency on Aging completed	X			
AAA Roles and Responsibilities	X			
AAA Vision, Mission and Values completed	X			
Purpose of Area Plan completed	X			
4) Context	X			
Current and Future Older Persons	X			
Needs Assessment Process and Results	X			
Gap/barriers/needs to improve existing system	X			
Special Needs	X			
5) Service Delivery Plan	X			
Description of Service Delivery System	X			
6) Allocation, Budget and Units Plan				
Allocations Methodology	X			
Budget Narrative	X			
Indirect Cost Plans	X			
Changes to Services/Units/Persons	X			
AIMS Area Plan Budget Forms (See attachment E)				

<b>Area Plan Checklist (continued)</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Comments</b>
Attachments				
A) AoA Goals and AAA Objectives Instructions & Charts				
AoA Goal 1	X			
AoA Goal 2	X			
AoA Goal 3	X			
AoA Goal 4	X			
AAA Goal 5 (optional)				
B) Location of Services Charts	X			
HCBS	X			
Elder Rights	X			
CCSP	X			
C) Compliance Documents				
Request for Advance/Bond (If applicable)			X	
Standard Assurances	X			
Letter Requesting a Waiver of Standard Assurances	X			
Board Resolution	X			
D) Required Plans				
Annual Elder Rights Plan	X			
Long-term Care Ombudsman (LTCO) Annual Plan	X			
Senior Community Service Employment Program			X	
E) AIMS Budget Documents				
Title III Federal Allocation and Match Analysis (Excel)	X			
Area Plan – Budget Fund Source Summary	X			
Area Plan – Budget Service Summary	X			
Area Plan – Provider Site List	X			

# Executive Summary

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## Summary Description of federal, state and local aging network

The foundation of the Aging Network was formalized with the passage of the Older Americans Act of 1965. This legislation was instrumental in defining and creating the beginnings of what we now refer to as the Aging Network. This network has grown considerably through the years, but still includes core organizations such as the Administration on Aging, state Units on Aging, Area Agencies on Aging and service providers. The US Administration on Aging (AoA) is the federally designated agency that oversees nutrition, home and community based services for older adults and caregivers. AoA is a division of the US Health and Human Services agency. While AoA's main office is located in the DC area, there are regional offices throughout the United States covering the 10 regions. AoA works closely with each State Unit on Aging to provide vision, funding and regulations for the implementation and operation of aging programs throughout the state. The GA Division of Aging Services (DAS) is designated as the state unit on aging for Georgia. GA division of Aging Services works with Area Agencies on Aging (AAA), regional offices located in each of the 12 regional planning and service areas in GA. The Coastal Regional Commission(CRC) is the designated Area Agency on Aging for the nine-county Coastal Georgia region, offering services in Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Long, Liberty and McIntosh counties. The AAA serves all residents regardless of income, race or

national origin. The AAA assesses, plans, and coordinates services and programs for senior adults, persons with disabilities, and caregivers of the region. The AAA works with local service providers to operate services at the city and county level. The aging provider network includes city and county governments, non-profit organizations as well as for profit businesses. In order to carry out the aging plan, the AAA works with many consumers, partners and community groups across the region.

The AAA has the responsibility for addressing present and future aging and long-term care issues within Coastal Georgia's growing and diverse communities. In 2010, the AAA contracted with Kerr & Downs Research to perform a needs assessment of local adults, 50 years of age and older and caregivers, to develop a demographic trend analysis to effectively estimate the demand for services and activities through the year 2015. Previous work included projections through the year 2030. Results of a separate study commissioned in 2006 by the RDC with the Georgia Institute of Technology, Georgia Coast 2030: Population Projections for the 10-county Coastal Region were also examined. Findings from both studies -- as well as the Census 2010 -- offer the most recent and comprehensive demographic and service-related data available in the region, providing a strong foundation for future planning and program development for our region's elderly and disabled residents.

This Area Plan reflects the goals, objectives, and activities of the Coastal AAA over the four-year planning cycle, 2012 through 2016. The Plan is consistent with the Older Americans Act (OAA) legislation and the guidelines set forth by the Georgia Department of Human Services Division of Aging Services (DAS). Most importantly, the Area Plan seeks

to inform the general public and regional policymakers of the development and delivery of services designed to foster independence and improve the quality of life for one of our region's most priceless resources – our senior adults.

### Overview of the Area Agency on Aging

The Coastal Regional Commission (CRC) was formed in 1964, and has served as the Area Agency on Aging since 1973, providing nine counties and 30 cities with information and access to services for a growing and diverse aging population. Today, the CRC includes Screven County in its Planning and Service Area; however, for Aging programs, Screven continues to be served by the Central Savannah River RC.

The CRC Council serves as the governing body for the organization, and is comprised of thirty-nine (39) county, city, and at-large representatives from across the region. The CRC Executive Director reports directly to the Council and is responsible for the oversight and operations of the organization. In addition to the Aging Services, CRC supports five additional departments, including Administration, Finance, Transportation, Economic Development, and Planning and Government Services. Today, the CRC employs **forty-five (45)** professionals and other contract staff.

The Coastal AAA has experienced considerable growth over the years, and today employs twenty-one individuals and sub-contracts with fifteen organizations to deliver information, programs, and services in a manner consistent with the vision, mission, and values of the organization, the Georgia Division of Aging Services, and the U.S. Administration on Aging. The staff of the AAA consists of a director, 6 lead staff, 11 front line staff and a half time

administrative assistant. There are currently three open positions. In addition we leverage other community resources to expand our reach, having had **two** SCSEP enrollees as well as a two VISTA workers placed in our department within the last two years. We have recently formalized our volunteer program by hiring a Volunteer Coordinator to provide oversight and management of volunteers for our agency and providers. Our vision is to grow our pool of over 30 volunteers to 50 or more each year by providing engaging, meaningful assignments for those of all ages interested in volunteering their time and talents. A CRC organizational chart is provided on page 3. The AAA's organizational chart is provided on page 4.

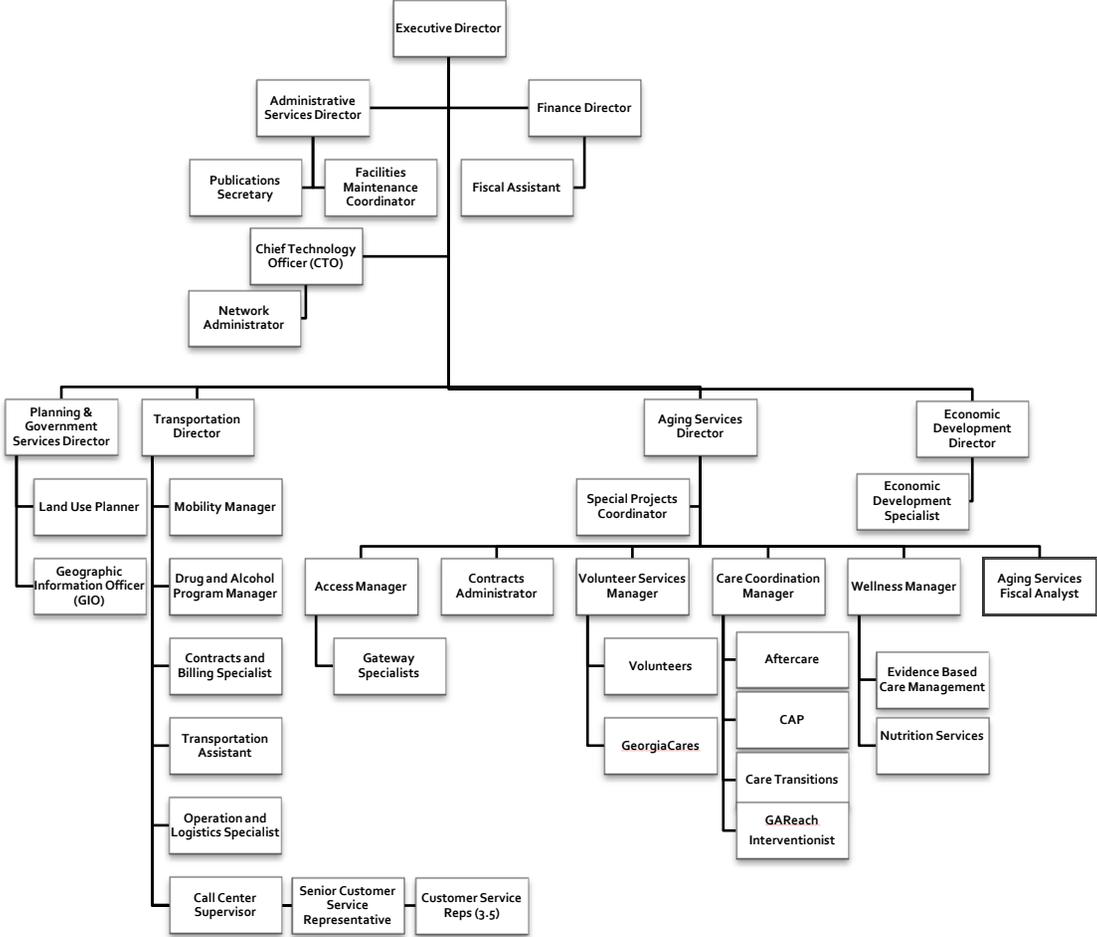
In accordance with the Older Americans Act legislation, the AAA has an Advisory Council made up of three representatives from each county in the region, the majority of who are over age 60. The Council meets quarterly to review AAA programs and to provide input regarding service and training needs in the region. The Council has an Executive Committee made up of a Chair, Co-Chair, and a Secretary, and operates under established By-Laws. On official matters requiring action, the Council takes a vote and makes its recommendations to the CRC Council for approval.

There are a total of twenty-nine (29) positions on the Coastal Aging Advisory Council, made up of three representatives from each of the nine counties and 2 more representing the City of Savannah. As of this writing, there are five vacancies to be filled. Of the 26 active Council members, 20 are female, 6 are male, and 14 are minorities. The vast majority of members (72%) are retired from a wide variety of professions. One member is on the faculty at Armstrong Atlantic University, one is a former county commissioner of

Camden County, two work-for-private businesses, and three manage programs in social service or housing organizations.

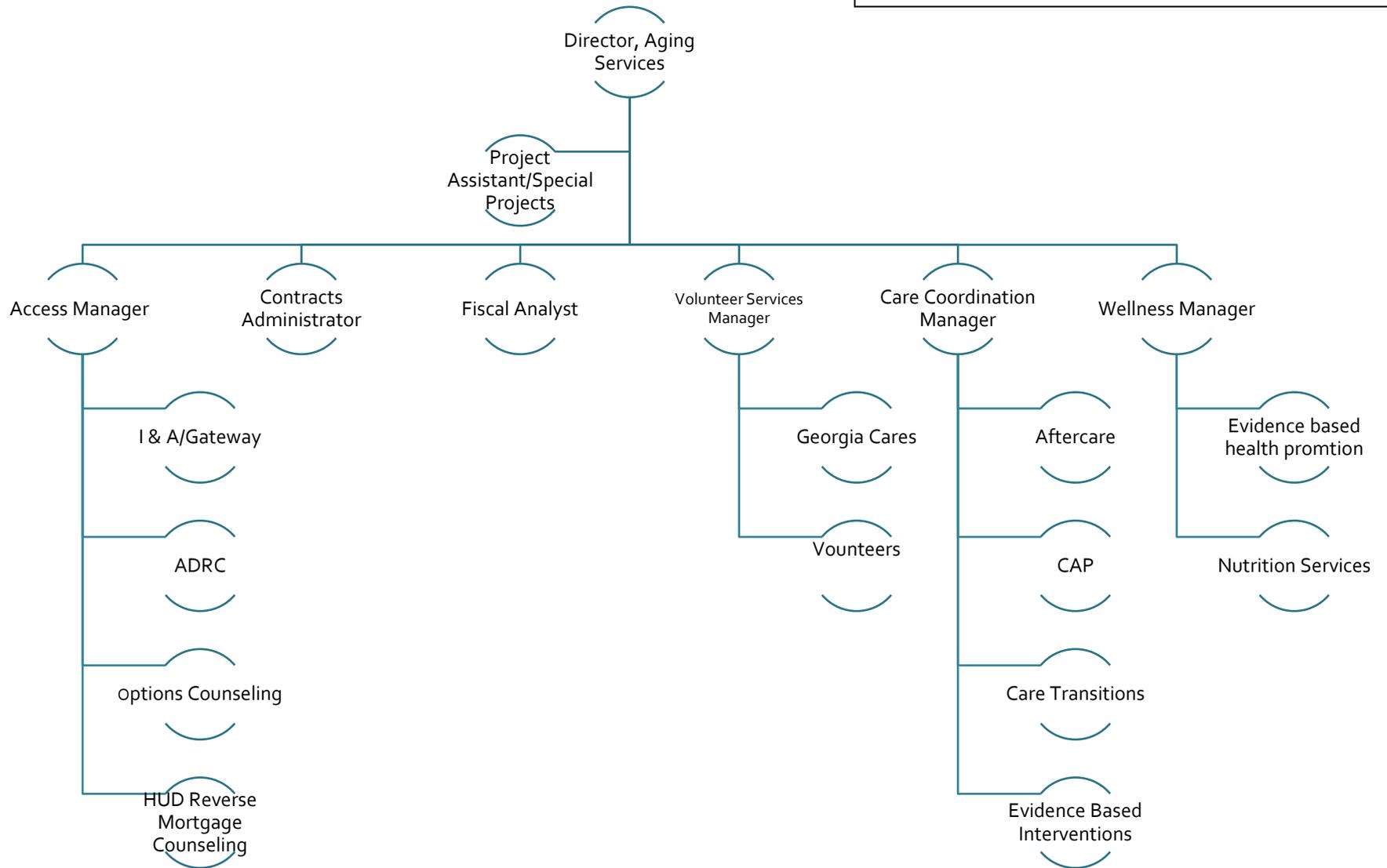
# Coastal Regional Commission

## Staff Organizational Chart



# Coastal Area Agency on Aging

## Staff Organizational Chart



## AAA Advisory Council Members

Member	County	Past/Current Professional Experience
Annie Mae Golden	Bryan	Not Provided
Eloise Kendrick	Bryan	Not Provided
Lori Gaylor	Bryan	Healthcare
Margie Pevey-Shuman	Bulloch	Higher Education / Business
Roger Branch	Bulloch	Higher Education / Clergy
Pearl H. Brown	Bulloch	Not Provided
Ceola Foreman	Camden	Not Provided
Farran Fullilove	Camden	Not Provided
Oliver Miller	Camden	Not Provided
Elizabeth Jones	Chatham	Not Provided
Howard Dawson	Chatham	Not Provided
Rev. Lloyd Dees	Effingham	Faith Community
Linda Mercer	Effingham	Not Provided
Linda Wright	Effingham	Not Provided
Dorothy Stevens	Glynn	Healthcare, Business
Miriam Perrone	Glynn	Not Provided
Henry Frasier	Liberty	Government / Clergy
David Anderson	Liberty	Government
Pat Rentz	Liberty	Not Provided
Lillian Simmons	Long	Not Provided
Joyce Williams	Long	Not Provided
Harold Tatum	Long	Not Provided
Alberta Mabry	McIntosh	Healthcare
Daniel Brantley	City of Savannah	Higher Education / Gerontology
Dessie Baker	City of Savannah	Not Provided

## AAA roles and responsibilities

The AAA roles and responsibilities are outlined in the Older Americans Act of 1965. These responsibilities include both administrative roles and direct service roles. The administrative responsibilities include conducting a needs assessment of the planning and service area in regard to aging services, program development, coordinating a comprehensive network of services, contracting for the provision of services, training and technical assistance and evaluation. The direct service responsibilities include advocacy, outreach Medicare insurance counseling, case management, information and referral and access, and volunteer management. The following chart outlines the roles and responsibilities of key staff within the AAA.

Title	Summary of Responsibilities
Aging Services Director	This position is responsible for planning, advocacy, coordination, monitoring and administration of the Area Plan and other resources available to the Area Agency on Aging. The Director maintains day-to-day operations of the agency with oversight for 50+ paid and volunteer staff. Ensures the effective coordination of aging services among a network of providers in the nine-county coastal region.
Aging Services Fiscal Analyst	Responsible for the accurate accounting of program funds and preparing financial reports for funding agencies and boards. Analyzes all financial information to know the status of program budgets and funds. Monitors and evaluates the performance of aging contractors and provides technical assistance as needed. Serves as the AIMS Security Administrator, providing access, monitoring and technical assistance to contractors on the use of the data base.
Aging Services Resource Specialist	Responsible for updating and maintaining the ESP database according to the prescribed schedule. Keeps Aging Services staff informed of new resources in the region. Assists with compilation of resource guides. Conducts training in the use of the database. Provides outreach and community education as needed.
Care Coordination Supervisor	Responsible for oversight and supervision of the various case management programs to include TCare, REACH II, CAP. Responsible for the expansion of services including Care Transitions.
GeorgiaCares Coordinator	Responsible for providing information and counseling to individuals with regard to their healthcare and Medicare benefits, including Medicare Part C and Part D. Works closely with ADRC to provide community education and outreach throughout the region. Oversees SMP.
GeorgiaCares Assistant	Assists the GeorgiaCares Coordinator with insurance counseling for customers. Provides assistance with filing, intake, referral and reporting for the GaCares, SMP, MIPPA programs.
HCBS Care Manager (3)	Provides information, assistance, and expanded case management services to individuals upon discharge from a hospital or long-term care setting for up to six months, or until the consumer can be admitted to the CCSP or receive other services which promote health and independence in the home setting. Brokers for services using the Direct Purchase of Services (DPS) model. Also provides REACH II and TCare interventions.

Title	Summary of Responsibilities
Access Manager	Responsible for the management and day-to-day operations of the AAA's Gateway Department. Also oversees access to services for Caregivers and the Aging and Disabilities Resource Connection (ADRC).
Information & Assistance Specialist (5)	Responds to all inquiries regarding access to aging and disability services in the region. Conducts client assessments and gathers other information required to evaluate individual needs for services. Coordinates with other service providers to ensure effective access to care. Conducts follow-up with consumers to determine outcomes as needed. Provides outreach and community education as needed.
Volunteer Services Manager	<b>Provides oversight for the GeorgiaCares</b> and volunteer programs including recruiting, training, retaining and recognizing volunteers helping with AAA functions and activities. This position works with other departments to manage volunteers.
Wellness Manager	Responsible for monitoring contract nutrition providers for compliance, coordination, and program development for the nine-county region. Provides technical assistance, nutrition education and counseling, conducts health promotion activities, Medication Management activities, health screenings, and outreach which promotes health and wellness for seniors. Also responsible for implementing evidence-based wellness initiatives throughout the regions congregate centers.
Contracts Administrator	Responsible for assisting the Aging Services Director with the oversight of regional human service programs. Other tasks involve working with local partners and service providers to coordinate the delivery of services. Manages contracts and projects as assigned; contributes to the sustainability of the department and its services through developing strategies, supplying relevant implementation documents, and grant preparation and administration. Responsible for monitoring aging service providers for regulatory compliance. Provides technical assistance to providers in program operations. Assists in preparation of provider contracts and budgets.
Special Projects Coordinator	Responsible for special projects within the Aging Department. Also acts as liaison with community for public relations, advocacy and disaster preparedness. Assists with ongoing staff training and recognition. Coordinates Coastal CARE-NET activities.
Options Counselor	Responsible for utilizing a person-centered approach in providing options counseling services to individuals identified on the MDS assessment as wanting to speak with the AAA about community living options. MDSQ Options Counselor shall be supervised by the ADRC Program Manager or by another staff person who is supervised by the ADRC Program Manager.

## Gateway / Aging & Disability Resource Connection (ADRC)

In the role of providing information and access, the AAA serves as the regional Aging and Disability Resource Connection (ADRC). The goal of the service is to empower individuals to make informed choices and to streamline access to long term support including a wide range of in-home, community-based and institutional services and programs that are designed to help individuals with disabilities and chronic conditions. The vision is for the ADRC serving as highly visible and trusted place where people can turn for information on the full range of long term support options. The ADRC also serves as a single point of entry for both public and private-pay individuals to public long term support programs and benefits. The ADRC serves older adults, younger adults with disabilities and chronic conditions, family caregivers, as well as persons planning for future long term support needs. In addition, the ADRC is a resource for health and long term support professionals who provide services to the older adults and to people with disabilities.

The ADRC is supported by a strong technology-based infrastructure and a team-based approach for operations management. Trained professionals from multiple functional disciplines provide education, information, assessment, and customized referrals and connections to both private-pay and publicly-supported care options.

An Advisory Committee meeting quarterly provides input, feedback, connection to resources as well as provides outreach for the ADRC. The advisory committee consists of key stakeholders and is co-lead by our partner, Department

of Behavioral Health and Development Disabilities (DBHDD). Our partner also is involved in program planning, outreach and decisions regarding the ADRC.

Once a request for information or services is received; a trained intake specialist is the first contact for a customer. The intake specialist does an initial screening and assigns to a Gateway specialists depending upon the customer's county of origin. The Gateway specialist then contacts the customer to complete the screening for services and/or provides the needed referrals. For customers desiring services, the Determination of Needs Revised (DONR) is completed to further assess the persons need. If the DONR indicates a significant level of need and services are available, referrals are made for services. At this time, if eligible, the Community Care Services Program is explained to the customer. If there is a waiting list for services, the customer is placed on the waiting list, along with given appropriate information. If the caller is a caregiver, Gateway specialists also use the TCare screening protocol to determine if a referral to caregiving services is appropriate. Individuals on the waiting list are rescreened every 120 days to identify any changes or needs.

Gateway staff provides Options Counseling. Options counseling is defined as "an interactive decision-support process whereby consumers, family members, and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer's needs, preferences, values, and individual circumstances." (Lewin Group).

Money Follows the Person Program (MFP) has been added to the Gateway. This program is designed to help individuals

who are in nursing or intermediate care homes, return to the community. The program serves people with developmental or physical disabilities and those who are aging and who wish to transition back into the community. The program can provide assistance such as security and utility deposits, furnishings and basic household items, moving costs, environmental modifications to make a home or apartment accessible, connection with peer supporters and other community resource, and other additional services.

Options counseling, using a person-centered approach, offers individuals, families and caregivers information about community living services and supports. Options counseling explores public and private pay options with the consumer based on individual's identified needs, values and preferences. Options counseling is completed by the Options Counselor (OC) who goes to the nursing home or intermediate home to complete face to face assessments with the consumer. It is the role of the OC to help the individual to consider the pros and cons of his/her various service options in assisting the individual in making an informed decision. Long-term follow-up is a component of Options counseling that allows the OC to offer continued support and resources to the consumer following the face to face assessment. Options counseling is also provided through the Gateway to callers identified as needing assistance in exploring options related to long term supports and services.

Each consumer wishing to leave the institutional setting is assigned a Transition Coordinator (TC) who provides guidance through the transition process. Each consumer

must be screened to determine the level of support needed for a successful transition into the community. Monthly contact is maintained for a period of one year (365 days) in order to offer additional support as needed.

Gateway staff receives annual and ongoing in service training on topics such as Options Counseling, motivational interviewing, HIPAA, and many other topics to enhance services offered. In addition, Gateway staff is AIRS certified as well as over half the staff have earned a Certificate in Gerontology from Boston University School of Social Work.

The ADRC is responsible for outreach in the community to increase the general public's awareness of the ADRC and services offered. To achieve this, ADRC staff and Georgia Cares staff participate in community fairs throughout the nine counties on a monthly basis. To supplement these efforts, staff also provide in services to discharge planners, social work departments and similar groups to promote the ADRC.

### Other Roles of the AAA

Coastal AAA is active in the communities we serve and strives to participate in activities and collaborations that keep us relevant at the local, state and national levels. The AAA works with other departments within the Regional Commission to always consider aging issues and integrate in planning. For example in economic development activities, resources for older adults, caregivers and those with disabilities in our communities can be discussed with potential employers as a way to showcase what will be available to their future employees. In addition, attracting retirees to the area should be considered as part of the economic development strategy. For regional planning, the

AAA plays a vital role in the link between planning and developing aging friendly communities. In addition, in assisting local governments with grant applications, the AAA assists by reviewing any grants pertaining to building senior centers, adult day care centers, assisted living facilities and similar projects.

The AAA participates in many committees and advisory groups within the region including groups such as Healthy Glynn, Family Connections, and faith based committees. Dionne Lovett serves on the College of Coastal Georgia Service-Learning Community Advisory Board, which serves to identify and create opportunities for students to practically apply and test their academic learning through hands-on experiences that also promote community interests. AAA staff also actively participates on statewide boards and committees and are involved in projects through these groups. Marvara Green is currently President of Georgia Alliance of Information and Referral Specialists (GAIRS). The organizations we work with promote the enhancement of the aging services network in our region and throughout the state.

## Working Relationships with Community Organizations

To be successful, the AAA develops and maintains a variety of connections to a large array of community organizations. Many of our partnerships with agencies such as Adult Protective Services, Mental Health, public health and others are forged through participating on one of our many advisory groups. The AAA currently oversees or supports an advisory committee for the ADRC, Wellness, Coastal Georgia Caregiver Network (CARE-Net) and Elder Rights as well as our Aging Advisory Council and the CCSP Network meetings.

These groups all have charters or purposes for existing and have attendees that are appropriate. We involve these agencies in tasks beyond those of advisory groups, such as our latest Request for Proposal review teams. We invited partners from DFCS, public health, extension, banks, university, other agencies etc. to participate in the reviews. The purpose was twofold; to help familiarize agencies with the work of the AAA as well as receive input from a different perspective.

The Elder Rights activities are supported by participating in a SALT council (Savannah region) and CAPE (Coastal Alliance for the Protection of Elders) (Brunswick area). The AAA participates in both of these organizations to forward the education around abuse, fraud and exploitation. The AAA supports both groups with staff time and funding. As a part of the Elder Rights work, the AAA Gateway staff has a good working relationship with Adult Protective Services. They work closely with APS alerting through reporting when abuse, neglect or exploitation is suspected. The AAA has partnered with these groups to provide events such as the Shred-A-Thon, World Elder Abuse Awareness (WEAAD) Walkathon and educational conferences. Similar events will be planned through the next four year cycle.

The AAA views the older worker as a great source for our community because of the wisdom, skill and work ethic they possess. Because of this value, the AAA has traditionally provided a training placement for older workers enrolled in the Senior Community Service Employment Program (SCSEP). In addition, the AAA provides space and oversight for a VISTA volunteer who is working on projects to help reduce poverty and increase volunteerism.

## AAA Vision, Mission and Values

The Area Agency on Aging reviews the mission, vision and value statements for the agency periodically and involves all levels of employees in this process. The CRC recently reviewed its own mission statements for the departments in order to develop one for CRC. A recent staff retreat allowed employees to share their input on the vision of the AAA in order to update it and make it resonate with the customers we serve. Management used staffs' input to update the AAA's mission, vision, and value statements for the FY2012 thru FY 2016 area plan. Our current mission, vision and values are relevant to the AAA responsibilities listed in the Older Americans Act (OAA) and mandated by DAS, as are our priorities.

**Our Vision:** All seniors, persons with disabilities, and family caregivers residing in Coastal Georgia will have access to information and services that promote physical health, mental well-being and options for living that ensure personal dignity and individual choice.

**Our Mission:** The mission of the Coastal Georgia Area Agency on Aging is to foster the development of a comprehensive, coordinated system of services which promotes the independence and well-being of coastal area older adults and those with disabilities, and to provide these individuals and their caregivers with information and access to needed services.

Our agency policy and procedures include sound ethical standards and an antifraud policy. Employees are required to complete a Code of Conduct Questionnaire annually and all staff demonstrates conduct consistent with agency ethics and values.

## Purpose of Area Plan

Under the Older Americans Act of 1965 as amended, the AAA is responsible for developing a regional plan for aging services to meet the needs of older adults, caregivers and those with disabilities. The purpose of the area plan is to provide a comprehensive and coordinated system of supportive services, nutrition services and senior centers, and the process used to determine the need for supportive services, nutrition services and senior centers within the planning & service area administered by the area agency. The plan describes how the area agency will implement, directly or through contractual or other arrangements, programs and services to meet identified needs within the region in accordance with the plan. Planning efforts and service delivery address the needs of older individuals with greatest economic need and older individuals with greatest social need, including low-income minority individuals, and individuals with limited English. In addition, through the development and implementation of the area plan, other agencies and organizations in the Coastal region can identify shared interests and work cooperatively to meet the needs of Coastal Region's older adults, caregivers and those with disabilities.



# CONTEXT

## Current and future older persons and caregivers

The future needs of Coastal Georgia’s elderly population will largely be driven by the rapid population changes that will occur over the next 30 years. The rising numbers of Baby Boomers reaching retirement age along with the growing in-migration to Georgia’s coastal areas is expected to significantly impact services to seniors. In order to meet this paramount need, the Area Agency on Aging (AAA) remains committed to building lasting partnerships with organizations, private businesses, and local governments to ensure that our most frail and economically disadvantaged elders receive the care and services necessary to sustain healthy, independent, and dignified lives.

Population trends were analyzed using the US 2010 Census data, the State of Georgia Governor’s Office of Planning and Budget Georgia Residential Population Projections by County: 2012 - 2030 report and the Georgia Coast 2030: Population Projections for the 10-County Coastal Region report. These documents provided valuable insight for planning for the increasing senior population of the Coastal region.

In July 2006, the Coastal Regional Commission commissioned the Georgia Institute of Technology to determine population projections to 2030 for the Coastal region. The impetus for this study was the perception that commonly used projection methods did not adjust for the unique context and most recent growth trends of the Georgia coast. In response to the research, Georgia Coast 2030: Population Projections for the 10-County Coastal

Region was published in September 2006. Recognizing the unique conditions of the region, Georgia Tech researchers applied a scientific and context-specific methodology to arrive at population projections by age and sex for each county.

This study recognizes that several factors affect population change, including demographic trends (primarily age distribution and mortality rates), in- and out-migration rates, employment rates and other economic activity, and housing construction. Between 1970 and 2000, the region has shown consistent growth, increasing in population by 62% (approximately 215,600 people). Since 2000, the in-migration rate and strong economic development have continued, and are expected to persist over the next several decades.

Using the Georgia Tech projections, the growth among those aged 55 and over is expected to increase dramatically as demonstrated in the table below:

Coastal Georgia 55+ Projected Population Growth by County							
	2000	2005	2010	2015	2020	2025	2030
Bryan	3,450	6,561	9,794	12,887	15,182	16,669	17,624
Bulloch	9,111	11,363	13,967	16,598	18,660	19,898	20,708
Camden	4,814	7,225	9,981	12,901	15,229	16,819	17,928
Chatham	49,807	61,414	73,034	84,891	94,213	100,482	105,443
Effingham	6,096	8,919	12,355	17,841	21,166	23,539	25,283
Glynn	16,560	21,405	26,247	30,843	34,483	36,981	38,870
Liberty	5,052	6,586	8,257	10,126	11,726	12,813	13,636
Long	1,194	1,649	2,244	2,922	3,683	4,322	4,945
McIntosh	2,512	3,728	4,985	6,144	7,029	7,611	7,933
<b>TOTAL</b>	<b>98,596</b>	<b>128,850</b>	<b>160,864</b>	<b>195,153</b>	<b>221,371</b>	<b>239,134</b>	<b>252,370</b>

(GeorgiaTech -- Georgia Coast 2030: Population Projections for the 10-County Coastal Region)

Using the Georgia OPB projections, the growth among the same population is slightly less than that of GeorgiaTech as demonstrated in the table below:

Georgia Residential Population Projections by County: 2012 - 2030			
	2010 Projection 55+	2015 Projection 55+	2020 Projection 55+
Bryan	6,089	7,928	10,190
Bulloch	12,621	14,324	15,951
Camden	9,541	11,992	14,508
Chatham	62,812	69,342	76,926
Effingham	10,260	13,415	17,281
Glynn	22,511	26,220	29,796
Liberty	9,296	11,813	14,450
Long	2,371	3,104	3,992
McIntosh	4,750	5,809	6,881
<b>TOTAL</b>	<b>140,251</b>	<b>163,947</b>	<b>189,975</b>

(Georgia Governor's Office of Planning and Budget)

Over the next 25 years, the 70 to 79 age cohort will experience the fastest population growth in percentage terms, with the 55 to 59 age cohort experiencing the smallest growth.

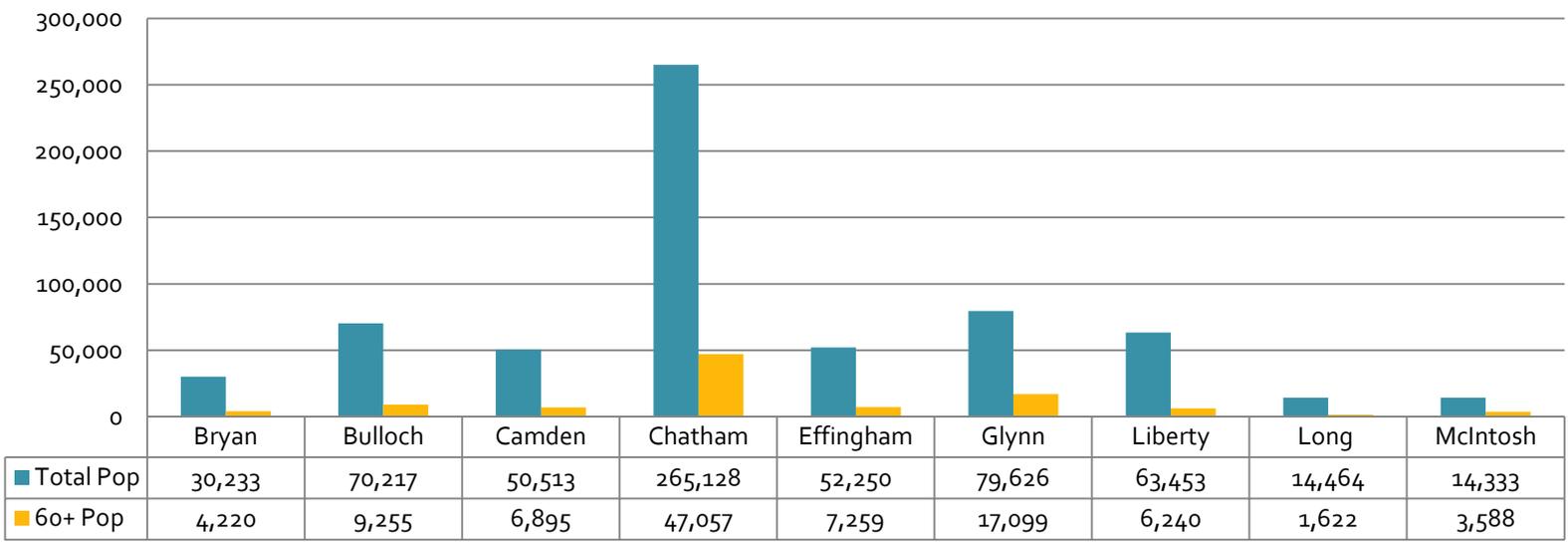
Age Cohort	2005 – 2030 % Population Growth
<b>55 – 59</b>	<b>30%</b>
60 - 64	62%
65 – 69	117%
<b>70 – 74</b>	<b>167%</b>
75 – 79	162%
80 – 84	134%
80 +	131%

## Growth in the Senior Population

The following graph reflects data taken from the 2010 Census. The total senior population for Coastal Georgia has reached 103,235. However, according to the 2006 Georgia Tech study, this number is expected to swell to 208,494 by the year 2030.

While the number of seniors age 60 and over are projected to increase in every county each year, there will be a shift in where they reside. It is projected that by the year 2030, Chatham County will be home to 42% of the seniors in the region, a drop of almost 10% from 2005. Over the same period, Bryan, Camden, and Effingham Counties will increase significantly in their percentage of coastal elders. The remaining counties will see little change over the next 25 years.

## 2010 Census 60+ Population



**Total Population for Coastal Region = 640,217    Total 60+ Population for Coastal Region = 103,325**

## Poverty among Coastal Georgia Seniors

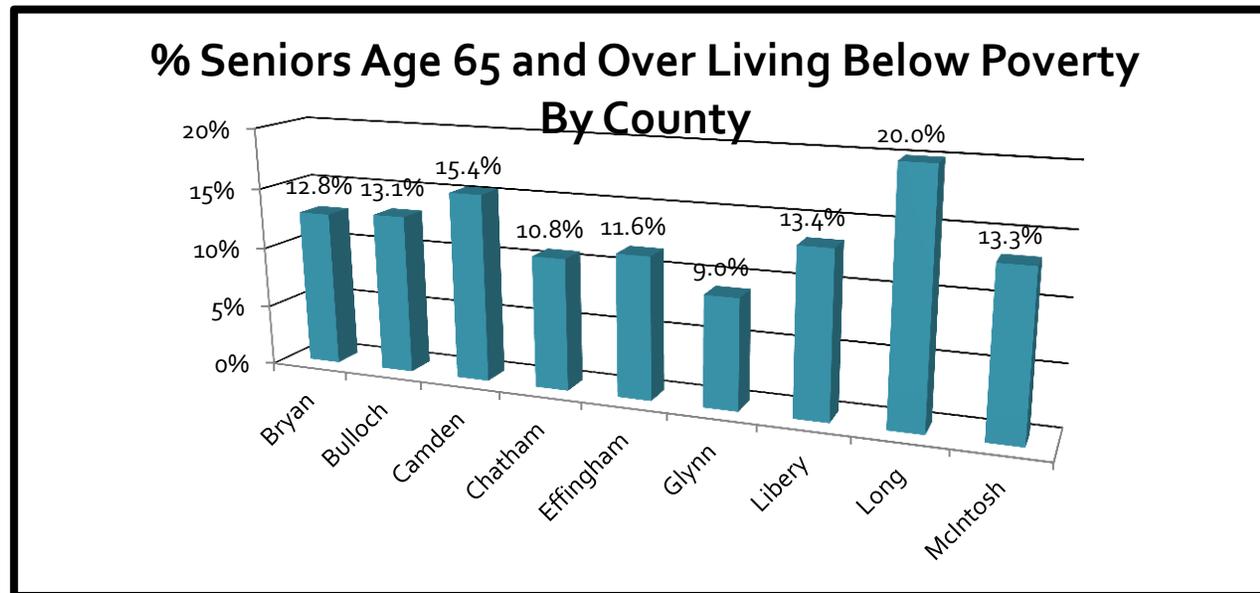
Aging in America brings concerns about economic security during old age. Although the poverty rate for the elderly is much lower today than thirty years ago, growing old and the cost of health care jeopardizes the economic security of the elderly. Specifically, the rising cost of long term health care has a great impact on the risk of the elderly being poor. According to the U.S. Census, the poverty rate for elderly women is substantially greater than the poverty rate of elderly men and the poverty rate of elderly blacks and Hispanics are more than twice the poverty rate of elderly whites in the United States.

According to Census 2010, approximately 13% of older adults in the coastal area are considered at or below the poverty level. In Long (20%), nearly 1 in 5 seniors aged 65 or older are at or below the federal poverty level. Those in the relatively urban counties of Chatham and Glynn fare best: in Chatham,

only 10.8% of elders fall into that category, and in Glynn, 9.0% of elders are impoverished.

Not surprisingly, a much higher percentage of African-Americans than Caucasians aged 65 and over are poor. The disparity between the two races is particularly evident in Bulloch, Chatham, and Glynn Counties. There are 5.4%, 5.9%, and 6.5% differences, (respectively in these counties) where African-Americans show greater numbers of being below poverty as compared to Caucasians in the same county. McIntosh County is the only exception to this trend, where 15.9% of African-Americans are impoverished in contrast to 16.6% of Caucasians.

The table below provides the Census 2010 data for poverty rates in each of the nine Coastal Georgia counties.



The following data and trends analysis was taken from a study and needs assessment completed in the Coastal region in 2010 by researching firm, Kerr & Downs.

Only 1% of residents over 55 years of age living in the Coastal Georgia region admitted they will not be able to make it financially for the rest of their lives. Over seven in ten residents (71%) were either in good shape financially or thought that they would be alright. Two in ten individuals (19%) were concerned about their ability to make ends meet for their rest of their lives.

	Financially, I am in good shape for the rest of my life	Financially, I may be OK for the rest of my life, but I'm not totally sure	Financially, I am concerned about my ability to make ends meet	Financially, there is no way I'm going to make it	Not sure
Total	29%	42%	19%	1%	9%
Bryan	23%	51%	13%	2%	11%
Bulloch	33%	47%	11%	3%	6%
Camden	30%	57%	9%	0%	4%
Chatham	32%	43%	19%	1%	5%
Effingham	30%	53%	5%	0%	13%
Glynn	35%	37%	20%	1%	7%
Liberty	37%	27%	16%	1%	19%
Long	20%	49%	32%	0%	0%
McIntosh	28%	48%	13%	0%	11%

This table shows the total household income, including social security, retirement, investments, work, etc. for the typical resident over 55 years of age living in the Coastal Georgia region.

	Less than \$650 per month	\$650 - \$899 per month	\$900 - \$1,599 per month	\$1,600 - \$1,800 per month	More than \$1,800 per month
Total	28%	6%	15%	8%	45%
Bryan	36%	2%	18%	3%	43%
Bulloch	36%	3%	14%	5%	43%
Camden	21%	1%	15%	6%	59%
Chatham	29%	6%	11%	8%	47%
Effingham	22%	5%	14%	8%	53%
Glynn	27%	1%	18%	11%	44%
Liberty	24%	4%	17%	4%	53%
Long	25%	8%	17%	17%	34%
McIntosh	23%	14%	15%	0%	49%

### Racial/Ethnic and Low-Income Population by County

According to the *Georgia State Plan on Aging FY2011 – 2015*, Coastal seniors age 65 and over made up 11.8% of all Georgia’s elderly living at or below the poverty level. This estimate is in line with the latest state data from Census 2010, which provides information about the elderly minority population living below poverty in the Coastal region.

### Persons 65+ with Limited Mobility

The impact of limited mobility among the elderly and others with disabilities places an enormous burden on one’s capacity to remain independent at home and in the community. This problem is especially difficult for those

residing in rural areas where public transportation is unavailable. Individuals unable to drive their own vehicles due to advanced age and/or disabling condition must rely on others to get to the doctor, pharmacy, grocer, church, or visit with friends and family. As a result, these individuals are at increased risk for disease, malnutrition, depression, and isolation.

In Coastal Georgia there are approximately 55,000 seniors age 65 and over with mobility impairments (Census 2010). Not surprisingly, the largest numbers of mobility-impaired elderly reside in the most populous counties – Chatham, Bulloch, and Glynn. However, only two counties, Chatham and Liberty, have public transportation systems, leaving nearly 42% of mobility-impaired residents in the region without access to goods, healthcare, and services, thereby increasing their risk for institutionalization.

### Disabled Persons Under 60

Like most organizations serving the elderly today, the Coastal AAA is increasingly working with elders who have disabling conditions and/or are responsible for other family members, including their own adult children, with disabilities. Identifying and accessing needed resources is especially difficult for these individuals, who frequently need assistance and supportive services for themselves and a loved one across multiple social agencies. Coordinating public benefits and services for families with a variety of self-help needs can best be delivered when services are managed through a single entity.

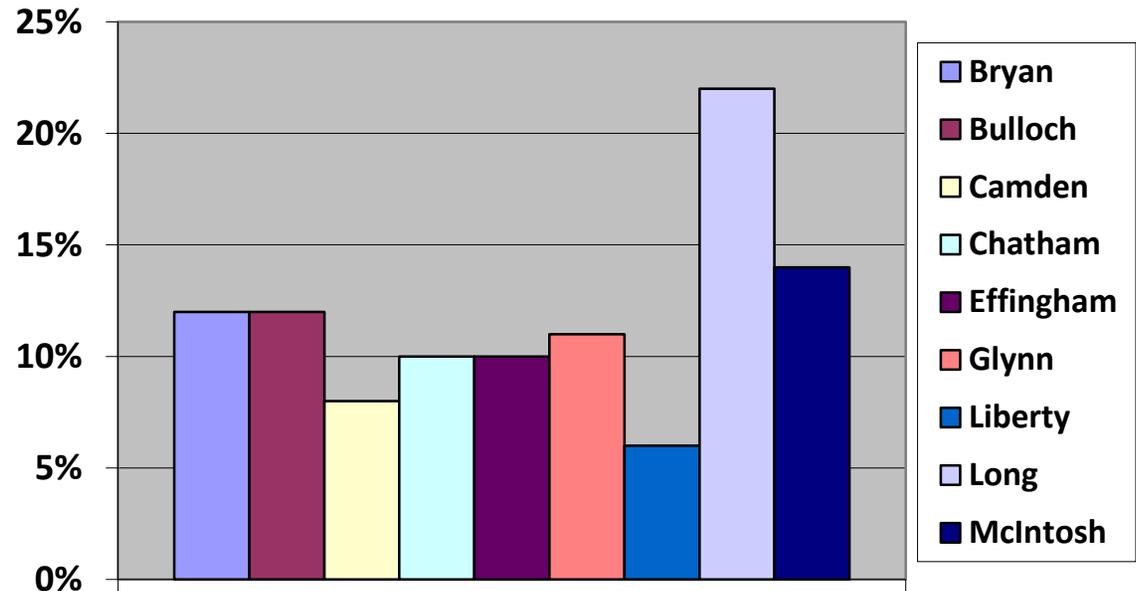
The Coastal Area Agency on Aging is able to provide information and access to needed services to any Coastal resident with long-term care needs, whether due to age or

disability. Consequently, the AAA is considered a “one-stop-shop” for families seeking resources and assistance in their local communities.

### Caregivers: Persons Age 55+

This graph shows the percentage of persons age 55+ that are primary caregivers for someone who needs assistance with everyday activities such as bathing, feeding, dressing, eating, and other personal needs.

One in eight residents (12%) function as the main helper or care giver for someone who needs assistance with everyday activities. This percentage ranged from 6% in Liberty County to 22% in Long County. Three in ten caregivers (29%) claimed they need assistance or a break from their care giving responsibilities. A majority of the care givers (61%) who want a break from their responsibilities would like someone else to perform personal care and grooming to the person for whom they have been caring. Three in five care givers (58%) also want some emotional support for themselves. Nearly half of caregivers also desire transportation assistance for the person they care for and they desire that someone be available to talk to the person and do things with the person they normally care for. A majority of care givers (65%) wanted someone to help them administer care from time-to-time to the person they typically help. About half of the care givers also wanted someone else to help them with household tasks and meal preparation.



Not quite half of the care givers (48%) reported feeling burdened from providing care to another person. Most of the caregivers who felt burdened experienced these feelings daily.

### Nutrition / Health: Persons Age 55+

The Coastal Area Agency on Aging contracted with Kerr & Downs to conduct the Demographics and Trends Analysis and Elder Needs Assessment. The study examined physical and mental health needs, personal and home-related needs, nutritional and dietary needs, social and recreational needs, and financial needs and self-sufficiency. This was conducted in 2010. Over nine out of ten residents (95%) living in the Coastal Georgia region are able to get enough fresh fruits and vegetables. All residents in Liberty County are able to do so, while residents in McIntosh County (91%) are least likely to get enough fresh fruits and vegetables. Just over nine out of ten residents (92%) are physically able to prepare their

own food. All residents in Camden and Glynn Counties are able to do so, while fewer than nine out of ten residents in Long (86%), Chatham (87%), and McIntosh (89%) counties are able to prepare their own food.

Nearly half of residents (47%) in the Coastal Georgia region suffered from diabetes, hypertension, cancer, arthritis or some other on-going condition. Incidence of one of these on-going conditions was greatest in Liberty (54%), Effingham (53%), and McIntosh (53%) counties, and lowest in Bulloch (29%) and Bryan (31%) counties. Because younger residents were included in the 2010 study, fewer individuals compared to 2006 experienced impaired vision (12%), ambulatory difficulty (11%), and significant hearing loss (9%). Over four in ten individuals (42%) experienced none of the conditions. Incidence of hearing loss was higher in Liberty (22%) and Glynn (19%) counties; incidence of ambulatory difficulties was higher in Glynn County (20%); and impaired vision was more prevalent in Liberty County (21%).

### Needs Assessment Process and Results

The needs assessment process began with identifying the information staff need in order to plan for a 4 year cycle. After this information was determined, the AAA contracted with a marketing and research firm to conduct a scientific telephonic survey of 1,000 55+ individuals in the coastal region. The firm worked with the AAA to finalize the questions which resulted in a 15-20 minute phone conversation. The study was conducted via random digit telephone interviewing during the month of June 2010. The sampling error for binomially distributed data given a 95% confidence level is 3.1 percentage points.

The study examined physical and mental health needs, personal and home related needs, nutritional and dietary needs, social and recreational needs and financial needs and self-sufficiency. Comparisons to a similar study conducted in 2006 are made throughout the report where appropriate. It should be noted that the 2006 study utilized a different data collection method and focused more on elders who already used many of the community resources available for older adults, indigent and disadvantaged persons. The 2010 study has a representative sample of all people who are over the age of 55 living in the coastal Georgia region. Results of the 2010 study are reflective of the needs of all people 55 and older rather than only the needs of elders who are already accessing community resources through various agencies, organizations, churches and local government. The survey results were summarized in August 2010 and presented to various stakeholder groups such as the Aging Advisory Council, the Community Care Services networking group, the CRC Council. The results were also discussed at both Public Hearings held in October and November 2010. The results of the needs assessment along with customer satisfaction surveys and other feedback received during the year were used in determining and refining the needs of older adults, disabled adults and caregivers for the region. In addition, staff reviewed information on state and national trends in aging services to determine areas to target for future growth as well as trends to integrate into AAA operations.

Some of the recommendations included:

- Invest time in documenting and determining the regions aggregate capabilities to serve those who need services
- Identify gaps between capability to serve and needs

- Prioritize funding/resources needs
- Better publicize AAA efforts
- 58% have a health issue - need more programs to assist in self-care or dealing with chronic conditions as well as access to healthcare
- 13% have obstacles in maintaining good mental health (or 24,732 people by 2015) – Need to develop programs and partnerships to target this need.
- 24% indicate they have emotional problems ( or 45,660 people by 2015) – need to develop programs and partnerships to deal with these issues
- 43% say they will volunteer 5 hours a week which equates to 400,000 + volunteer hours per week – need to develop easy access for these people to “plug into the system” as well as provide good support and engaging opportunities. This significant resource of volunteerism can be used to provide solutions for the other needs.
- 31% have experienced house- related problems, such as caring for a house inside or out, trouble paying housing expenses or need of home modifications.
- 14% surveyed would like to receive assistance( transportation, errands, support group, homemaker, etc. of those, half are willing to pay for the assistance – Need to match volunteers up with those in need as well as consider developing more fee for service programs
- 57% want to participate in “sponsored activities” such as one would find at a senior center, community center or YWCA/YMCA. This equals 108,441 people by 2015. The sponsored activities need to be relevant, available and accessible – This finding indicates a need to review current senior center operations and

determine a plan to increase relevancy to new generations of older adults.

- Of the caregivers surveyed, 50% were stressed 100% of the time – This finding indicates the need to expanded caregiver services and interventions.
- Of the 5% that placed a family member in an institution over the last year, 74% would have liked to talk to a trained professional before placement and over half would have paid for the service. This finding indicates the need for options counseling as well as further exploration of fee for service.

The profile of the survey respondent showed that the median age is 65 (compared to 73 in 2006), 45% male, 55% female and 64% were married. The majority of respondents live with one other person (55%) and 42% live alone. Overall, the respondents have been residents of the region for a long time. Thirty-five percent have lived in the region from 21-40 years, 24% have lived in the region for 11-20 years. Sixty-five percent of the respondents are Caucasian, 32% are African American, and 4% are Hispanic, Asian, Pacific Islander or other. To find out about what is going on in their area 61% relied on newspapers, 54% on television, 36% talking with friends and family, 30% internet and 27% radio. Only 11% cited brochures as a way of getting information, so organizations need to revisit the use of brochures to reach potential customers.

### Gaps, Barriers and Improvements Needed for Existing Aging Services

Based on the 2010 Elder Needs Assessment and Demographic Trends Analysis, information gathered at public hearings, feedback gathered from client surveys, input from the Coastal Advisory Council and contracted providers,

analysis of client ESP/CHAT records, and upon review of monthly AAA waiting list reports, there remain several serious gaps and barriers within the existing service system which prevent the AAA from achieving its vision for all seniors, those with disabilities, and caregivers of the region. In general, service gaps can be attributable to funding limitations, lack of available transportation, lack of resources, services and programs that met the needs of diverse families and older adults, and the need for increased education with outreach to access needed services.

As the demographic data indicated, the growth in the senior population will reach unprecedented proportions between now and the year 2030. The rising numbers of elderly coupled with the skyrocketing costs of healthcare in the U.S. significantly impacts the number of seniors on waiting lists for publicly-funded home and community based services. Coastal AAA has responded to this anticipated population growth and increased client need by pursuing grant dollars and forging new partnerships that help leverage limited local and state dollars and community resources to serve more clients and offer effective programs. As of January 2013, 2,318 older adults and family caregivers are waiting for services in the Coastal region, a 2.38% increase from the 2,264 waiting in January 2012, and a 91.75% increase from the 1,209 waiting in January 2011. While the AAA strives to make positive impacts on the waiting list, more than two thousand individuals wait for services, with more than 400 waiting for nutrition services. The numbers waiting for the CCSP Medicaid Waiver Program increased by 34% (208) in January 2013 compared to the 155 waiting for CCSP in January 2012.

In the Demographic Trends Analysis conducted by Kerr & Downs (2010), nearly half of the Coastal residents (45%) indicated that it was difficult to find others to perform essential errands to secure food, medical assistance, etc. Transportation to medical appointments, church, pharmacy, grocery store, and other shopping areas remains an unmet need for most seniors and those with disabilities in this largely rural region. The vast majority of seniors and other consumers rely on family and friends to get them where they need to go. For many, there are few or no alternatives, and isolation can become problematic. At each public hearing and group gathering held this year, transportation was consistently the number one service requested by seniors. Unfortunately, DHR Coordinated Transportation is limited to DHR consumers attending senior centers, with minimal dollars available to transport patients to dialysis or other medical appointments. While, DHR Coordinated Transportation through Coastal Regional Coaches has added a much needed option for transportation throughout most of the region, the program has limitations and restrictions that lessen its impact on the need for transportation services older adults.

In the Demographic Trends Analysis conducted by Kerr & Downs (2010), significant healthcare needs among seniors in the region were identified. Nearly half of older adults (47%) in the Coastal Georgia region suffered from diabetes, hypertension, cancer, arthritis or some other on-going condition. Further, many of these older adults have difficulty accessing what they need to maintain their physical and mental health. Lack of money is noted as the key obstacle that keeps people in the Coastal Georgia region from accessing what they need to maintain their health. More than 1 out of ten (11%) of Coastal seniors maintained they

could not afford health insurance or medical prescriptions. This data suggest that significant numbers of Coastal seniors are at risk for increased chronic conditions and symptoms of mental illness due to gaps in healthcare.

## Special Needs

Coastal Area Agency on Aging is increasingly working with more family members who are caring for loved ones with Special Needs. Many are under the age of 60 and are among the most vulnerable in the community. Outreach is done through professional organizations, health fairs, education seminars, mail outs, senior centers and the communities at large, in an effort to reach those in need of assistance to help them remain in their homes.

The ADRC Gateway provides Information and Assistance, Referrals and Resources to persons who request information about availability of services. Every effort is made to reach those living in rural areas to educate them about opportunities which might be available to them.

Coastal Area Agency on Aging works closely with organizations that target minorities, individuals with low income and Limited English Proficiency, as well as persons at risk for institutional placement. Partnerships with local county health departments, clinics, hospitals, Departments of Family and Children Services, Adult Protective Services, Georgia Legal Services, Su Casa and other community social service agencies help us reach the most vulnerable citizens in the Coastal region.

The information systems used by our agency to house client data captures income levels, impairments, unmet needs, limited English proficiency, race and ethnicity. All this data is

available to the Gateway staff when making referrals for service. This allows us to identify, prioritize and serve those with the greatest needs. The Gateway staff has been trained to assist LEP/SI persons both face to face and by telephone. Program information is printed in both Spanish and English.



# SERVICE DELIVERY PLAN

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## Service Delivery System

### Community Care Services Program (CCSP)

The CCSP provides Medicaid-funded, community-based services to eligible functionally impaired individuals as an alternative to institutional placement, and is based on the premise that it is desirable to enable functionally impaired persons to reside at home or with their relatives or caregivers.

The goal of the CCSP includes supporting the following for people with functional impairments:

1. A continued ability to live in the community while receiving services
2. A continued choice in living arrangements and kinds of services received

This goal is achieved through the development of a system of community health and social services which provide a continuum of care for functionally impaired clients and assures that the least restrictive living arrangement is used to maintain independence and safety in the community.

The CCSP also includes support and case management for family care givers using Tailored Care (TCARE). The addition of TCARE to CCSP allows the provider to focus on caregiver well-being and reduce stress and burden associated with the caregiving role for caregivers that express the need for additional supports not traditionally available through CCSP.

Coastal AAA contracts with a regional service agency accustomed to delivering services in multiple counties, to provide care coordination in the Coastal region. The provider's responsibilities include brokering services, development of comprehensive service plans, monitoring service delivery to CCSP clients, monitoring service providers, client assessment, reassessment and discharge planning.

### Elderly Legal Assistance Program (ELAP)

The ELAP provides persons age 60+ with legal representation, information and education in civil legal matters throughout the Coastal region. Program services include providing legal information and assistance, legal counseling, case representation and legal education session. The program focuses on helping older adults avoid more costly and time-consuming legal problems and combat exploitation. Priority is given to those with the greatest social and/or economic need, limited English speaking persons and rural or low income minorities.

Coastal AAA contracts with Georgia Legal Services to provide services for ELAP. The provider has delivered legal services to older adults in the Coastal region for many years and is the current ELAP service provider for Coastal AAA. ELAP service delivery for FY2014 includes providing legal community education for at least 2,000 individuals and providing at least 2500 hours of legal and related counseling. Service Activities will also include legal community education sessions at diverse venues throughout the Coastal region, targeting priority groups, older adults with the greatest social and/or economic need, limited English proficiency and low incomes. A minimum of 350 clients will receive case representation through ELAP in FY2014.

Georgia Legal Services will partner with the Coastal AAA to conduct outreach for ELAP and to target priority groups for service delivery. Further, this provider will assist with the development and implementation of an Elder Rights Plan for the Coastal region.

### GeorgiaCares

Coastal's GeorgiaCares Program is a Volunteer-based Program that provides free information and assistance to Medicare and Medicaid beneficiaries and their caregivers about Medicare, Medicaid and related health insurance issues including Long-Term Care insurance, prescription drug assistance programs and Medicare fraud, error and abuse.

Coastal AAA provides services through the GeorgiaCares Program in all nine counties of the Coastal region including benefits counseling, information and referral, outreach and community education. The Coastal AAA employs a part-time staff for coordination of the program, as well as a team of volunteers. Oversight for the program is provided by the Volunteer Services Manager, AAA Director and DAS GeorgiaCares Coordinator.

### Home and Community Based Services (HCBS) In-Home Services

Homemaker Services Program provides assistance to individuals unable to perform one or more of the following Instrumental Activities of Daily Living (IADLs): meal preparation, shopping for personal items/groceries, managing money/bill paying, using the telephone, light housework. Personal Care Assistance Program provides assistance to persons having difficulty with one or more of the following Activities of Daily Living (ADLs): eating, dressing, grooming, bathing, toileting, transferring in/out of

bed/chair, or walking. Respite Care Services Program offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Some services are provided by individuals skilled in Alzheimer's care which offers temporary support for care recipients with Alzheimer's disease.

These services are provided in the home to persons 60 years of age or older, who are functionally impaired in their ability to perform regular activities of daily living. Services are designed to capitalize on the client's remaining strengths, lessen the burden of impairment, or to lessen the caregiver's burden. Coastal AAA relies primarily on three home health agencies to provide these services in the Coastal region: Altamaha Home Care, Senior Citizens Inc., and Nightingale Services. All three providers are licensed home health agencies with experience serving our target population. The providers' responsibilities include:

- Providing in-home service activities including but not limited to housekeeping and home management activities, meal preparation, escort assistance, chore/errand services, client education, assistance with personal grooming and health, and temporary substitute care.
- Conducting client assessments and reassessments.
- Conducting supervisory visits monitoring aide's performance.
- Developing, implementing and revising individualized service plans.
- Maintaining adequate staffing levels perform service activities
- Collaborating with the AAA, care coordination and case management staff on service delivery

## Home and Community Based Services (HCBS)

### Caregiver Services & T-Care

The Caregivers' Assistance Program (CAP) is a multi-faceted support system focusing on caregiver needs that provides access or linkage to resources, services, and information that help to diminish caregiver stress and burden, increases caregivers' knowledge of formal in-home and community care service options, and assists caregivers with planning for service delivery for the care recipients.

Tailored Care (TCARE) is the assessment and referral process utilized through CAP to identify caregiver needs, establish a service goal and identify the appropriate strategies and services needed to accomplish that goal. The program focuses on case management, counseling and education for the caregiver, as well providing direct services for the care receiver.

In FY2012 Coastal AAA moved the Caregiver Assistance Program (CAP) in house employing a TCARE certified care manager to provide case management for CAP. The program will continue to focus on caregivers with high burden scores as evidenced by the TCARE screening process.

## Home and Community Based Services (HCBS)

### Nutrition and Wellness Programs

#### Congregate Meals

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

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C<sub>1</sub>, and Administration on Aging (AOA), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture (USDA) and local funds.

Providers of Congregate Nutrition services in the coastal region for fiscal year 2012-2015 are:

- Concerted Services, Inc.
- Senior Citizens, Inc.
- Camden County Board of Commissioners
- City of Savannah
- Bryan County Board of Commissioners
- Effingham County Senior Center
- City of Brunswick
- Long County Board of Commissioners
- City of Darien / McIntosh County Board of Commissioners

#### Home Delivered Meals

Home Delivered Meals is defined as a meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act and State/Local laws.

Services in the coastal region are funded with Social Services Block Grant (SSBG), Community Based Services (CBS), Title III-C<sub>2</sub>, Administration on Aging (AOA), Nutrition Services Incentive Program (NSIP) and United States Department of Agriculture (USDA), and local funds.

Providers of HDM Nutrition services in the coastal region for fiscal year 2012-2015 are:

- Concerted Services, Inc.
- Senior Citizens, Inc.
- Bryan County Board of Commissioners
- Effingham County Senior Center
- Mom’s Meals
- Long County Board of Commissioners

### Nutrition Education

Nutrition Education is defined as a program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers or participants and caregivers in group or individual setting overseen by a dietician or individual of comparable expertise.

In addition to the meal service provision, each contractor is responsible for coordination and providing nutrition education sessions, conducting nutrition screening activities which includes but not limited to the Determination of Need Functional Assessment (DON-R), the Determine Your Nutritional Health Checklist (NSI) and making referrals for nutrition counseling.

The Area Agency on Aging provides quarterly Nutrition and Quality Assurance Training for center managers and food service staff to ensure a comprehensive meal service program. Coastal Area Agency on Aging offers other services which maintain health; this includes Health Promotion and Disease Prevention, Medication Management, Exercise/Physical Fitness, and Recreation activities. These are provided through contract requirements.

### Home and Community Based Services (HCBS) Case Management - Care Transitions

Case management is a service designed to provide consumers access to community resources and provide on-going coordination of services and monitoring of the client’s well-being. Case management services shall include, but are not limited to, the following activities:

- Assessment for, planning and implementation of service options,
- Development of individualized service plans
- Brokering of HCBS in-home services
- On-going coordination and monitoring of services
- Client linkage to available community resources that promote health, quality of life and positive outcomes
- Education about disease processes, lifestyles choices (diet, exercise, medication compliance, etc.) and preventive measures that prolong life and promote healthy living.

Coastal offers short-term HCBS Case Management program through our Care Transitions Program in Glynn and McIntosh Counties. The Care Transitions Program utilizes the evidence-based Bridge Model developed by the Illinois Transitional Care Consortium. It is designed to reduce the number of hospital readmissions by providing high-risk older adults with care coordination for 30 days after discharge. The goals for the program include:

- Reduce hospital readmissions within 30 days after discharge,
- Promote effective and safe patient transitions,
- Increase patient ownership through physician follow-up and understanding of prescribed medication/treatment,
- Reduce the level of unmet needs through coaching

- and problem-solving,
- Increase patient knowledge of their disease process, and
- Improve collaboration between community agencies.

The Coastal AAA is partnering with the Southeast Georgia Health Systems to operate the Care Transitions Program. The focus is on vulnerable older adults with Renal Failure, Congestive Heart Failure, Pneumonia, or Acute Myocardial Infarction. Coastal AAA hopes to serve 100 clients through the Care Transition Program during FY2014.

### Adult Day Care & Mobile Adult Day Care

The Adult Day Care Program provides personal care for dependent elders in a supervised, protective, congregate setting for at least six (6) consecutive hours each day, Monday-Friday. Services offered typically include social and recreational activities, training, counseling, meals, medications assistance, and personal care assistance.

The Mobile Adult Day Care (MADC) Program is provided by agency staff who is capable of traveling from one location to another on a daily basis, to various sites, primarily in rural locations, so as to provide care in areas that are underserved. MADC services are typically provided in one or more locations in any given week, generally in a community setting, such as a church or public facility where accommodations for services can be met.

Coastal AAA contracts with the City of Savannah, Senior Citizens Inc., and the City of Brunswick to operate three ADC programs, two in Chatham County and one in Glynn County. Coastal AAA also contracts with Senior Citizens Inc. to

operate a MADC program in Liberty County offering ADC services two (2) days each week.

ADC and MADC service providers operate these programs utilizing a social model and/or medical model of service delivery and serve qualified individuals, age 60 and older who are experiencing some degree of impairment in their physical and/or cognitive functioning and to individuals under the age of 60 with a diagnoses of Alzheimer's or related dementia.

### Long-term care Ombudsman (LTCO)

Long-Term Care Ombudsman (LTCO) Program seeks resolution of problems and advocates for the rights of residents of long-term care facilities with the goal of enhancing the quality of life and care of residents. The program serves residents of nursing homes, personal care homes, community living arrangements, and intermediate care homes for individuals with developmental disabilities. The LTCO Program activities include facility visits, resolving complaints, community education, and advocacy.

Certified ombudsman staff and volunteers informally investigate and work to resolve complaints made by or on behalf of residents. Ombudsmen regularly visit long-term care facilities to be accessible to residents and monitor conditions. In addition, ombudsmen provide education regarding long-term care issues, identify long-term care concerns and advocate for needed change.

Coastal AAA will have a new provider of LTCO services in FY2014 responsible for delivering LTCO services throughout the region.

## Community Living Program (CLP)

Coastal does not currently operate a Community Living Program. Coastal AAA continually explores ways to offer Consumer Directed Service options through existing and future programs in our service delivery system. In February 2012, the CRC's Planning department (working with the AAA) sponsored an "Age Readiness" survey to help determine the level awareness/education needed in the Coastal communities to develop a "Village" concept in the region. The results are still being assessed and will help determine whether we should move forward with the "Village" concept, or offer more community education/awareness events. We understand the value of consumer direction and trust that our case management programs, as well as other programs we administer, can be enhanced to include a consumer direction option.

## Alzheimer's Programs

Coastal AAA has implemented the Georgia REACH program, an intervention for caregivers of individuals with Alzheimer's disease, dementia or related disorders, as we seek to:

- Learn as much as possible about the experiences of families with Alzheimer's or related dementia in this region, and
- Link families to the resources/programs that are most appropriate to meet their needs.

The goal of the program is to reduce caregiver burden and improve or sustain caregiver physical and emotional health. This is accomplished by identifying the areas that the caregiver feels are their most challenging or where they need help. Each session is tailored to address those areas. Coaching the caregiver in problem solving skills and how to access information and resources will empower them to

continue to cope with their challenges even after the program is ended.

Coastal AAA has certified ten (10) staff and one (1) VISTA Volunteer with the Georgia REACH Interventionist Model and employed three (3) case managers as Georgia REACH Interventionist. Georgia REACH will be offered as a regional program through FY2014 and will focus on caregivers with high burden as identified by a risk inventory assessment.

## Chronic Disease Self-Management Program (CDSMP)

Chronic Disease Self-Management Program (CDSMP) is an evidence base program. The program is based on Albert Bandura's Theory of Self-Efficacy and helps participants develop coping skills and strategies they need to manage their symptoms through action planning, interactive learning, behavior modeling, problem solving, decision-making, and social support for change. Dr. Kate Lorig and her colleagues at Stanford University's Patient Education Research Center created this program. The CDSMP is a self-management program, which empowers people to take an active role in managing their chronic illnesses. Facilitated sessions cover 17 hours of material over a six week period. Older adults and caregivers will be targeted who suffer from any chronic condition. Topics to be facilitated include pain management, eating, exercising, use of medication, emotional management, and communication with clinicians. **The CDSMP/Living Well Coastal** was initially implemented in Chatham, McIntosh, Glynn, and Liberty counties. Now, it is offered in the entire coastal region. Over, the next four years, development of partnership and collaboration with local and community agencies, churches and faith-based groups, and civic groups, will be targeted to sustain the **CDSMP Living Well Coastal Program**. The AAA CDSMP

Master Trainers will continue to train lay-leaders in our communities to continue and sustain the expansion throughout the Coastal region. The lay-leaders will assist by offering workshops in the community.

# ALLOCATION, BUDGET AND UNITS SECTION

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## Allocation Methodology

The Coastal AAA uses the intrastate funding formula to formulate a basis for allocating the funds throughout the region. A great deal of care and consideration are taken to ensure that current clients will continue to receive services as well as redistributing funds from counties that have excess funding to those that have a significant amount of people on their waiting lists. The primary goals are to ensure that funds are utilized according to federal and state guidelines, and that they disbursed in an equitable manner.

## Budget Narrative

Significant changes in funding for SFY 2014 include a reduction in funding for CBS, Title III, and SSBG fund sources. The decrease in funds was due to the recalculation of the intrastate funding formula based on new 2010 census data. This reduction represents an overall budget reduction of 7.4% (\$463,833) compared to SFY2013 planning budget. Both service and staffing levels are being affected across the region as a result of the decrease. However, every effort is being made to meet the needs of Aging and Disabled persons in the Coastal region area despite the reduction in funding. We will use recommendations provided from the DAS (memo: Preparation for Possible Sequestration) to help mitigate the effects of such reduction.

## Indirect Cost Plans

See attachment

## Describe changes to services, units and persons served

There were two new service providers added in SFY 2013 that will continue in SFY 2014. Nightingale Staffing has been contracted to provide in-home services clients in Bryan, Bulloch, Effingham, and Chatham counties. These clients were previously being served through the AAA's HCBS case management program and had services brokered to them. (While this component of the case management program is being suspended, brokered services will continue to be offered and provided to those individuals participating in the CAP and REACH programs.)

Due to pending budget reductions for FY2014, Ward Management, the regional Long Term Care Ombudsman provider, asked to be released from its contract with the Coastal AAA for the last quarter of SFY 2013. We are currently working with Coastal ConnectedCare to serve as the new LTCO provider for Coastal.

## AIMS Area Plan Documents

See Attachments Section

# ATTACHMENT A

## AOA GOALS AND AAA OBJECTIVES CHARTS

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\*Coastal AAA has simplified the language in its 2012-2015 AOA Goals & Objective Charts based on technical assistance and advice provided by DAS staff during the Area Plan Goals, Objectives and Measures Training on November 17, 2011.

**GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.**

Name of Service or Program: Gateway/ADRC

SFY 2012 Goal 1 - Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Coastal AAA will increase partnership on ADRC Advisory Council by 30% or 4.5 or 5 partners by FY2014.	<ul style="list-style-type: none"> <li>Baseline data for ADRC Council Partnership at the end of FY11 is 10.</li> </ul>	<ul style="list-style-type: none"> <li>Aging Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC.</li> <li>Staff will identify Critical Pathway providers, hospitals, nursing homes, and home health agencies to participate on council.</li> <li>Agencies will be invited to quarterly council meetings and targeted for monthly outreach events.</li> <li>AAA will collaborate with an agency to host a council meeting on the southern end</li> </ul>	<p><b>During FY2012, Coastal AAA queried ESP for Nursing Homes and Home Health Agencies in our service area. We will target a different service each month. Hospitals will be the next targeted group to focus on.</b></p> <p><b>Letters were sent to NH's in the region on 12-1-11.</b></p> <p><b>Letters were sent to home health agencies on 1-1-12.</b></p> <p><b>Currently council members are offered three ways to participate</b></p>

		<p>of the region and MHDDAD partner will work with an agency to host a meeting in the northern end of the region.</p> <ul style="list-style-type: none"> <li>Establish letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.</li> </ul>	<p>with the council: telephonically, DBHDD Office or AAA office. This was at the request of the members. They felt with the three options they would not have to leave their office and could get more people involved.</p> <p>MOU has been established with council members. Two have been received waiting for others to get through legal departments.</p> <p>Added 1 person with disabilities to the board contacted Brain Injury Association invited to next meeting. Goal will be reached by August 30, 2012.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
<p>Coastal AAA will increase membership on ADRC Advisory Council by 30% by FY2015 over the council membership at the end of FY11.</p>	<ul style="list-style-type: none"> <li>Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2013 over the council membership at the end of FY11.</li> </ul> <p>(Membership may include additional individuals and/or agencies committed to serving on the ADRC Advisory Council.)</p>	<ul style="list-style-type: none"> <li>During 1<sup>st</sup> quarter of each fiscal year, the Aging Resource Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. Council expansion efforts will be focused on adding Brain Injury Associations, Persons with Disabilities and Parent2Parent Groups.</li> <li>Quarterly, agencies will be invited to council meetings.</li> </ul>	<p><b>Aging Resource Specialist is actively seeking agencies for partnerships with the ADRC. Continued queries will be done to reach agencies interested in this effort.</b></p> <p><b>Contact has been made with Brain Injury Association and they have agreed to serve. One parent with disabilities is an active member of the council and has a child with disabilities as well.</b></p> <p><b>Each quarter new agencies are Invited to attend our meeting.</b></p>

		<ul style="list-style-type: none"> <li>• AAA will collaborate with agencies to host a council meeting on the southern end of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region.</li> <li>• During 1<sup>st</sup> quarter, establish and renew letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.</li> </ul>	<p><b>APS is now a member. Members have expressed an interest in hosting a meeting so meetings will alternate at the different agencies.</b></p> <p><b>Renewed letters of commitment will be discussed and submitted to participating agencies for continued support along with defined roles as council during the Advisory Meeting.</b></p> <p><b>Total membership is at 26. Goal is met.</b></p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Coastal AAA will increase partnership on ADRC Advisory Council by 30% or 4.5 by FY2015 over the council membership at the end of FY11.	<ul style="list-style-type: none"> <li>• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2014 over the council membership at the end of FY11.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter of each fiscal year, the Aging Resource Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. Council expansion efforts will be focused on adding Brain Injury Associations, Persons with Disabilities and Parent2Parent Groups.</li> <li>• Quarterly, agencies will be invited to council meetings.</li> <li>• AAA will collaborate with agencies to host a council meeting on the southern end</li> </ul>	

		<p>of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region.</p> <ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter, establish and renew letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<p>Coastal AAA will increase membership on ADRC Advisory Council by 30% by FY2015 over the council membership at the end of FY11.</p>	<ul style="list-style-type: none"> <li>• Coastal AAA will increase membership on ADRC Advisory Council by 10% during FY2015 over the council membership at the end of FY11.</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter of each fiscal year, the Aging Resource Specialist will query ESP to identify appropriate agencies for partnership with Coastal ADRC. Council expansion efforts will be focused on adding Brain Injury Associations, Persons with Disabilities and Parent2Parent Groups.</li> <li>• Quarterly, agencies will be invited to council meetings.</li> <li>• AAA will collaborate with agencies to host a council meeting on the southern end of the region and MHDDAD partner will work with agencies to host a meeting in the northern end of the region.</li> </ul>	

		<ul style="list-style-type: none"> <li>During 1<sup>st</sup> quarter, establish and renew letters of commitment with partner agencies defining the role each agency will play in the ADRC initiative.</li> </ul>	
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**GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.**

**Name of Service or Program: Gateway/T-Care Screening**

SFY 2012 Goal 1 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Maintain TCARE screening process for caregivers seeking services through the AAA.	Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.	<ul style="list-style-type: none"> <li>Gateway Manager will continue to have I&amp;A Specialist trained to use TCARE Screening Tool.</li> <li>I&amp;A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services.</li> <li>Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&amp;A Specialist as needed.</li> </ul> <p><b>*Action steps are on-going throughout the fiscal year.</b></p>	<p>Refresher training/ webinars on use of the TCARE Screening Tool are being offered annually.</p> <p>Caregivers will continue to be pulled from wait list according to score.</p> <p>Gateway Manager is a Master Trainer and has access to the UWM TCARE Training Website and materials. Through the website the Gateway Manager can access any changes to TCARE Tools as well as access updates on TCARE protocol.</p> <p>As of this date all I&amp;A Specialist have been trained to use TCARE. If there are new hires they will be trained as classes</p>

			<p>become available.          To date 167 caregivers have been screened FY2011, All caregivers contacting the AAA are screened using TCARE by Caregiver Specialist who completed 99 Initials for SFY12.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
<p>Screen 100% of family caregivers seeking caregiver supports through the AAA using the TCARE protocol by FY2015.</p>	<p>Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.</p> <p>Baseline for FY11 is          To date, 167 caregivers have been screened in FY12.</p>	<ul style="list-style-type: none"> <li>• Gateway Manager will continue to have I&amp;A Specialist trained to use TCARE Screening Tool.</li> <li>• I&amp;A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services.</li> <li>• Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&amp;A Specialist as needed.</li> </ul>	<p><b>Currently all I&amp;A Specialists are trained and certified to use the TCARE Screening Tool, should new staff get hired they will be trained within 6 months of employment. Scores generated by the tool will continue to be used to rank caregivers on the waiting list for services.</b></p> <p><b>Gateway Manager as a Master TCARE Trainer will stay current on any changes and train I&amp;A Specialist as the need arises.</b></p> <p>During FY2013, all caregivers contacting the Coastal AAA for caregiver supports were offered a TCARE screen. Our Caregiver Specialist has conducted 143 TCARE screens during FY2013.</p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014

<p>Screen 100% of family caregivers seeking caregiver supports through the AAA using the TCARE protocol by FY2015.</p>	<p>Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.</p>	<ul style="list-style-type: none"> <li>• Gateway Manager will continue to have I&amp;A Specialist trained to use TCARE Screening Tool.</li> <li>• I&amp;A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services.</li> <li>• Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&amp;A Specialist as needed.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<p>Screen 100% of family caregivers seeking caregiver supports through the AAA using the TCARE protocol by FY2015.</p>	<p>Coastal will screen 100% of caregivers using TCARE screening tool prior to their referral for caregiver services.</p>	<ul style="list-style-type: none"> <li>• Gateway Manager will continue to have I&amp;A Specialist trained to use TCARE Screening Tool.</li> <li>• I&amp;A Specialists will use scores generated through the TCARE screening process to rank caregivers on the waiting list for services.</li> <li>• Gateway Manager, as a TCARE Master Trainer, will stay current on any changes to the TCARE screening tool and training I&amp;A Specialist as needed.</li> </ul>	

**GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.**

**Name of Service or Program: Gateway/ ADRC MDSQ – Options Counseling**

SFY 2012 Goal 1 – Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
SFY 2013	SFY 2013	SFY 2013	SFY 2013
By FY2015, at least 80% of consumers receiving Options Counseling through the Coastal AAA will report increased knowledge of community living supports and services and long-term care services.	Establish baseline during FY12. At least 70% of clients receiving Options Counseling through the Coastal ADRC will report an increased knowledge of service options evident by annual consumer satisfaction surveys.	<ul style="list-style-type: none"> <li>The Options Counselor will handle MDSQ referrals in the order received. Referrals will be generated through SNF's, LTCO's, consumers and caregivers.</li> <li>The Options Counselor will visit nursing homes throughout the region, meet with NH residents, and conduct educational sessions for NH staff.</li> <li>During 2<sup>nd</sup> quarter, provide additional training for OC on core functions of comprehensive Options Counseling.</li> <li>During 3<sup>rd</sup> quarter, the AAA will attempt to survey all consumers receiving OC during the fiscal year to determine if consumers report increased knowledge of community living and long-term care service options.</li> </ul>	<p><b>Options Counselor has visited all nursing homes in the region Meeting with Nursing Home residents and attending Residents Council Meetings. MDSQ referrals will be done by Options Counselor in the order in which they are received through SNF's and LTCO. Any NH's those with difficulty assessing he will ask for assistance from LTCO staff.</b></p> <p><b>OC will do an online class for Option Counselors Certification through Boston University along with Gateway Manager and an I&amp;A Specialist beginning in February 2013.</b></p> <p><b>The ADRC Program Manager and OC have developed a survey tool to evaluate the</b></p>

			<p>effectiveness of the Options Counseling Program. The survey has been submitted to the Aging Services Director and QA Specialist for review. The evaluation tool will be mailed to clients in March 2013.</p> <p>Survey data indicated a response rate of 20% with 86% of survey respondents reporting an increased knowledge of community living supports and long term care services, 7% indicated that they were not sure if their knowledge was increased and 7% reported no increase in knowledge. While the Coastal AAA will work on increasing the survey response rate during FY2014, the goal is met.</p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
By FY2015, at least 80% of consumers receiving Options Counseling through the Coastal AAA will report increased knowledge of community living supports and services and long-term care	At least 80% of clients receiving Options Counseling through the Coastal ADRC will report an increased knowledge of service options evident by annual consumer satisfaction surveys.	<ul style="list-style-type: none"> <li>The Options Counselor will handle MDSQ referrals in the order received. Referrals will be generated through SNF's, LTCO's, consumers and caregivers.</li> <li>The Options Counseling will visit nursing homes</li> </ul>	

services.		<p>throughout the region, meet with NH residents, and conduct educational sessions for NH staff.</p> <ul style="list-style-type: none"> <li>• During 3<sup>rd</sup> quarter, the AAA will attempt to survey all consumers receiving OC during the fiscal year to determine if consumers report increased knowledge of community living and long-term care service options.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<p>By FY2015, at least 80% of consumers receiving Options Counseling through the Coastal AAA will report increased knowledge of community living supports and services and long-term care services.</p>	<p>At least 80% of clients receiving Options Counseling through the Coastal ADRC will report an increased knowledge of service options evident by annual consumer satisfaction surveys.</p>	<ul style="list-style-type: none"> <li>• The Options Counselor will handle MDSQ referrals in the order received. Referrals will be generated through SNF's, LTCO's, consumers and caregivers.</li> <li>• The Options Counseling will visit nursing homes throughout the region, meet with NH residents, and conduct educational sessions for NH staff.</li> <li>• During 3<sup>rd</sup> quarter, the AAA will attempt to survey all consumers receiving OC during the fiscal year to determine if consumers report increased knowledge of community living and long-term care service options.</li> </ul>	

**GOAL 1: Administration on Aging - Empower older people, their families, and other consumers to make informed decisions about, and to easily access, existing health and long-term care options.**

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

SFY 2012 Goal 1 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
			<p>The Coastal AAA released an RFP for the MFP Program during 2<sup>nd</sup> quarter FY12. Through the bid process two qualified candidates were identified. The contract was awarded to one provider.</p> <p>In December 2011, the AAA contracted with B&amp;B Care Services to provide Transition Services Coordination for the MFP Program. To date the provider has transitioned 4.5 clients. The AAA will evaluate the provider during 4<sup>th</sup> quarter FY12.</p> <p><b>To date there has been 9 transitions completed for MFP</b></p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Expand the use of Transition Services through the MFP Program by transitioning at least 45 individuals from institutional settings into a community setting by	Transition at least 15 individuals from an institutional setting into a community setting during FY13.	<ul style="list-style-type: none"> <li>Throughout the fiscal year the TC will work with Gateway and the Options Counselor to identify appropriate candidates for the MFP Program.</li> <li>The TC will coordinate</li> </ul>	<p><b>As of January 2013, Coastal has transitioned 13 clients. Given our current trending, Coastal will meet and surpass the FY2013 performance measure.</b></p>

FY2015.		<p>transitional services for MFP clients and assist said clients with application for waiver programs.</p> <ul style="list-style-type: none"> <li>• TC will provide monthly status reports to the AAA regarding all client transitions.</li> <li>• TC will assist AAA in outreach efforts to educate community about MFP Program.</li> <li>• Monthly TC will work with LTCO provider to conduct outreach in the nursing homes.</li> <li>• Quarterly TC will attend CCSP networking meetings to collaborate with CCSP providers on MFP outreach.</li> <li>• AAA will conduct mid-year review of provider's performance towards meeting contract deliverables.</li> </ul>	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Expand the use of Transition Services through the MFP Program by transitioning 45 individuals from institutional settings into a community setting by FY2015.	Transition at least 15 individuals from an institutional setting into a community setting during FY14.	<ul style="list-style-type: none"> <li>• Throughout the fiscal year the TC will work with Gateway and the Options Counselor to identify appropriate candidates for the MFP Program.</li> <li>• The TC will coordinate transitional services for MFP clients and assist said clients</li> </ul>	

		<p>with application for waiver programs.</p> <ul style="list-style-type: none"> <li>• TC will provide monthly status reports to the AAA regarding all client transitions.</li> <li>• TC will assist AAA in outreach efforts to educate community about MFP Program.</li> <li>• Monthly TC will work with LTCO provider to conduct outreach in the nursing homes.</li> <li>• Quarterly TC will attend CCSP networking meetings to collaborate with CCSP providers on MFP outreach.</li> <li>• AAA will conduct mid-year review of provider's performance towards meeting contract deliverables.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Expand the use of Transition Services through the MFP Program by transitioning 45 individuals from institutional settings into a community setting by FY2015.	Transition at least 15 individuals from an institutional setting into a community setting during FY15.	<ul style="list-style-type: none"> <li>• Throughout the fiscal year the TC will work with Gateway and the Options Counselor to identify appropriate candidates for the MFP Program.</li> <li>• The TC will coordinate transitional services for MFP clients and assist said clients with application for waiver programs.</li> </ul>	

		<ul style="list-style-type: none"> <li>• TC will provide monthly status reports to the AAA regarding all client transitions.</li> <li>• TC will assist AAA in outreach efforts to educate community about MFP Program.</li> <li>• Monthly TC will work with LTCO provider to conduct outreach in the nursing homes.</li> <li>• Quarterly TC will attend CCSP networking meetings to collaborate with CCSP providers on MFP outreach.</li> <li>• AAA will conduct mid-year review of provider's performance towards meeting contract deliverables.</li> </ul>	
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**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

**Name of Service or Program: Community Care Services Program**

SFY 2012 Goal 2 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Increase supports for caregivers providing primary care for CCSP clients.	<ul style="list-style-type: none"> <li>• <b>Maintain the number of caregivers of CCSP clients served with TCARE in in FY12 as compared to the numbers</b></li> </ul>	<ul style="list-style-type: none"> <li>• During 3<sup>rd</sup> quarter FY12, train additional CCSP care coordinators in TCARE.</li> <li>• Throughout the fiscal year</li> </ul>	<b>Chatham County Board of Health has six CCSP Care Coordinators certified as TCARE Care Managers.</b>

	served in FY11, a total of 6.	<p>market TCARE and Powerful Tools for Caregivers to caregivers of CCSP clients.</p> <ul style="list-style-type: none"> <li>Continue to follow TCARE protocol with existing caseload, reassessment, care plan review, etc.</li> </ul>	<p>The CCSP Program Manager participates in monthly TCARE/CCSP conference calls with the AAA and DAS.</p> <p>Our CCSP Provider is currently serving five family caregivers with TCARE. They anticipate adding four more by the end of this fiscal year; for a total of nine.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase supports for caregivers providing primary care for CCSP clients by utilizing TCARE with at least 12 family caregivers by FY2015.	<ul style="list-style-type: none"> <li>Increase number of caregivers of CCSP clients receiving TCARE by 2 in FY13 over the numbers served in FY11.</li> </ul>	<ul style="list-style-type: none"> <li>During 1<sup>st</sup> quarter, certified TCARE Care managers will review their CCSP caseloads to identify families that might benefit from TCARE.</li> <li>By 2<sup>nd</sup> quarter, 1-2 additional family caregivers will be identified and offered TCARE services.</li> <li>Throughout the fiscal year, market evidence based wellness programs and caregiver support services to caregivers of CCSP clients.</li> <li>Train additional staff in TCARE. Training dates to be announced.</li> <li>Continue to follow TCARE protocol with existing caseload, reassessment, care plan review, etc.</li> </ul>	<p>During FY2013, Coastal's CCSP provider has served 5 family caregivers using TCARE. Coastal's in-house care managers have served an additional 8 family caregivers of CCSP clients using TCARE.</p> <p>During FY13 a total of 13 family caregivers with care receivers on CCSP have been case management utilizing the TCARE protocol. Performance measure met.</p>

SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase supports for caregivers providing primary care for CCSP clients by utilizing TCARE with at least 12 family caregivers by FY2015.	<ul style="list-style-type: none"> <li>Increase the number of caregivers of CCSP clients receiving TCARE by 2 in FY14 over those served in FY13.</li> </ul>	<ul style="list-style-type: none"> <li>During 1<sup>st</sup> quarter, certified TCARE Care managers will review their CCSP caseloads to identify families that might benefit from TCARE.</li> <li>By 2<sup>nd</sup> quarter, 1-2 additional family caregivers will be identified and offered TCARE services.</li> <li>Throughout the fiscal year, market evidence based wellness programs and caregiver support services to caregivers of CCSP clients.</li> <li>Train additional staff in TCARE. Training dates to be announced.</li> <li>Continue to follow TCARE protocol with existing caseload, reassessment, care plan review, etc.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase supports for caregivers providing primary care for CCSP clients by utilizing TCARE with at least 12 family caregivers by FY2015.	<ul style="list-style-type: none"> <li>Increase the number of caregivers of CCSP clients receiving TCARE by 2 in FY15 over those served in FY14.</li> </ul>	<ul style="list-style-type: none"> <li>During 1st quarter, certified TCARE Care managers will review their CCSP caseloads to identify families that might benefit from TCARE.</li> <li>By 2nd quarter, 1-2 additional family caregivers will be identified and offered TCARE services.</li> </ul>	

		<ul style="list-style-type: none"> <li>• Throughout the fiscal year market TCARE and Powerful Tools for Caregivers to caregivers of CCSP clients.</li> <li>• Continue to follow TCARE protocol with existing caseload, reassessment, care plan review, etc.</li> </ul>	
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**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

**Name of Service or Program: HCBS In-Home Category**

SFY 2012 Goal 2 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objectives
Increase funding for In-Home Services in the Coastal Region.	<ul style="list-style-type: none"> <li>• Increase funding for in-home services by 10% by FY13 and by 15% in FY15 over funding allocated for in-home services in FY11. Baseline data for Fy11, \$297,190.</li> </ul>	<ul style="list-style-type: none"> <li>• Throughout the fiscal year research grants opportunities and additional funding sources for in-home services.</li> <li>• Explore grant opportunities for CARE-Nets to leverage funding for in-home services.</li> <li>• Continue work on branding and marketing for agency to attract sponsors and private pay clients.</li> <li>• During 3<sup>rd</sup> and 4<sup>th</sup> quarter, AAA management staff will meet with county and city officials to leverage additional local dollars to support in-</li> </ul>	<p><b>AAA staff hosted CARE-Net meetings quarterly during FY2012. Coastal CARE-Net Members identified increased funding for services as a priority/ goal.</b></p> <p><b>During 3<sup>rd</sup> and 4<sup>th</sup> quarter AAA staff are pursuing increased funding through Care Transitions grant opportunities. Scheduled meeting with AOA staff during 3<sup>rd</sup> quarter to receive technical assistance on Care Transitions grant proposal.</b></p>

SFY 2013	SFY 2013	SFY 2013	SFY 2013
By 2015, increase funding for In-Home Services in the Coastal Region by 15% over the allocated funding for in-home services in FY11.	<ul style="list-style-type: none"> <li>Increase funding for in-home services by 5% by FY13 over funding allocated for in-home services in FY11.</li> </ul>	<p>home services.</p> <ul style="list-style-type: none"> <li>Throughout the fiscal year research grants opportunities and additional funding sources for in-home services and explore grant opportunities for CARE-Nets to leverage funding for in-home services.</li> <li>During 1<sup>st</sup> quarter, submit proposal for Care Transitions Grant funding.</li> <li>Continue to conduct quarterly CARE-Net Meetings.</li> <li>During 2<sup>nd</sup> quarter, provide training and workshops on grant writing for contract providers.</li> <li>During 3<sup>rd</sup> quarter meet with city and county officials to leverage additional local dollars for in-homes services.</li> </ul>	<b>Goal is discontinued due to projected budget cuts.</b>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase client satisfaction with HCBS In-Home Services.	<ul style="list-style-type: none"> <li>Increase client satisfaction by 5% during FY2014, specifically related to the reliability of Homemaker and Personal Care Services.</li> </ul>	<ul style="list-style-type: none"> <li>Use client satisfaction data from FY2013 to determine a baseline.</li> <li>Share survey data with In-Home Service Providers and ask for best practices from each provider agency.</li> <li>Develop a mechanism for sharing best practices with provider network.</li> </ul>	

		<ul style="list-style-type: none"> <li>• During 2<sup>nd</sup> quarter, convene an In-Home Services work group to identify specific areas for improvement and develop a plan of action.</li> <li>• 3<sup>rd</sup> and 4<sup>th</sup> quarters implement plan of action and monitor results.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase client satisfaction with HCBS In-Home Services.	<ul style="list-style-type: none"> <li>• Maintain increased client satisfaction level during Fy2015.</li> </ul>	<ul style="list-style-type: none"> <li>• 1<sup>st</sup> quarter survey program participants receiving in-home services during FY2014.</li> <li>• Share survey results with in-home services providers and workgroup members.</li> <li>• Determine success of action plan based on survey data. If FY2014 performance measure is met, act to hold the gain. If the measure is not met, reconvene workgroup to tweak the action plan. Then implement revised plan.</li> <li>• Repeat survey process.</li> </ul>	

**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

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

SFY 2012 Goal 2 - Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Through a screening and referral process the AAA will link at risk individuals with Alzheimer’s Disease and related disorders to Alzheimer’s Association for safety driving assessments.	<ul style="list-style-type: none"> <li>The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY12, increasing referrals by 10% in FY13, 25% in FY14 and by 50% FY15, over the baseline established in FY12.</li> </ul> <p>* An increase in referrals is anticipated due to a marketing campaign launched in FY11 targeting caregivers of persons with dementia or related disorders.</p>	<ul style="list-style-type: none"> <li>Throughout the fiscal year, Gateway I&amp;A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders.</li> <li>Refers will be made to the Alz. Association by the I&amp;A Specialist as appropriate.</li> <li>The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals and the need for additional services.</li> </ul> <p>*All action steps are ongoing throughout the fiscal year.</p>	<p><b>Staff will continue screening older at risk adults in the region and make appropriate referrals for those with Alz Disease and related disorders.</b></p> <p><b>Developed an internal referral tracking system to track referrals made to the Alzheimer’s Association.</b></p> <p><b>Caregiver Specialist will refer Alzheimer’s clients or those with memory disorder to Alzheimer’s for safety driver assessments. To date no referrals have been made. Caregivers have declined assessments or expressed no interest in pursuing a driving assessment. Most caregivers reported handling the transportation needs of their care receivers.</b></p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013

<p>Through a screening and referral process the AAA will link 25 at risk individuals with Alzheimer’s Disease and related disorders to Alzheimer’s Association for safety driving assessments by 2015.</p>	<ul style="list-style-type: none"> <li>• The AAA will refer a minimum of 5 clients to Alz. Association or other service agency for a safety driving assessment in FY13.</li> </ul>	<ul style="list-style-type: none"> <li>• Throughout the fiscal year, Gateway I&amp;A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders.</li> <li>• Refers will be made to the Alz. Association by the I&amp;A Specialist as appropriate.</li> <li>• The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals and the need for additional services.</li> <li>• *All action steps are ongoing throughout the fiscal year.</li> </ul>	<p><b>To date no referrals have been made. This goal was established as a deliverable in an Alzheimer’s Innovation Grant that ended earlier in the fiscal year. The Coastal AAA is considering discontinuing the goal, as there have been no referrals made for safety driving assessments to date. Currently Gateway I&amp;A Specialists continue to identify at risk individuals appropriate for referral and provide information about the safety driving assessments provided through the Alz. Association.</b></p>
<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>
<p>Through a screening and referral process the AAA will link 25 at risk individuals with Alzheimer’s Disease and related disorders to Alzheimer’s Association for safety driving assessments by 2015.</p>	<ul style="list-style-type: none"> <li>• The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY14.</li> </ul>	<ul style="list-style-type: none"> <li>• Throughout the fiscal year, Gateway I&amp;A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders.</li> <li>• Refers will be made to the Alz. Association by the I&amp;A Specialist as appropriate.</li> <li>• The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals</li> </ul>	

		<p>and the need for additional services.</p> <ul style="list-style-type: none"> <li>*All action steps are ongoing throughout the fiscal year.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<p>Through a screening and referral process the AAA will link 25 at risk individuals with Alzheimer’s Disease and related disorders to Alzheimer’s Association for safety driving assessments by 2015.</p>	<ul style="list-style-type: none"> <li>The AAA will refer a minimum of 10 clients to Alz. Association or other service agency for a safety driving assessment in FY15.</li> </ul>	<ul style="list-style-type: none"> <li>Throughout the fiscal year, Gateway I&amp;A Specialist will screen older adults in the coastal region and identify potentially at risk clients with Alz. Disease and related disorders.</li> <li>Refers will be made to the Alz. Association by the I&amp;A Specialist as appropriate.</li> <li>The AAA will work with the Alz. Association and other service agencies to track the outcome of these referrals and the need for additional services.</li> <li>*All action steps are ongoing throughout the fiscal year.</li> </ul>	

**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

**Name of Service or Program: Caregiver/ T-Care Case Management – Caregiver Assistance Program (CAP)**

SFY 2012	SFY 2012	SFY 2012	SFY 2012
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Goal 2 – Objective #4	Annual Performance Measure	Action Steps	Annual Update on Objectives
Expand the use of TCARE protocol with family caregivers in the Coastal region.	<ul style="list-style-type: none"> <li>Maintain an average caseload of 60 clients during FY12.</li> <li>Offer TCARE in nine-counties in by FY15 vs. five counties served during FY11.</li> </ul>	<ul style="list-style-type: none"> <li>Hire additional in-house case managers to expand program to nine-counties.</li> <li>Schedule TCARE Training courses by 2<sup>nd</sup> quarter FY12.</li> <li>Identify additional caregivers from waitlist to enroll in CAP.</li> <li>Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.</li> </ul>	<p>One CAP case manager was hired in July.</p> <p>One TCARE Training was conducted in October, and another one is scheduled in March.</p> <p>FY2012 has been a transition year for CAP, as the program was moved in-house and is no longer contracted out to a service agency. Our in-house CAP Care Manger worked during 1<sup>st</sup> and 2<sup>nd</sup> quarter to clean up the existing caseload. Hence the performance measure for FY12 has been tweaked to focus on maintaining the existing caseload with increases in the following fiscal years.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Expand the use of TCARE protocol with family caregivers in the Coastal region by utilizing TCARE with 15 family caregivers over the SFY12 baseline by FY2015.	<ul style="list-style-type: none"> <li>Increase numbers served in SFY13 by 5 caregivers over SFY12 baseline. SFY12 baseline will be determined by June 30, 2012.</li> </ul> <p><b>Baseline is 37 at fiscal year-end 2012.</b></p>	<ul style="list-style-type: none"> <li>Identify potential caregivers from waitlist. Conduct TCARE screen to determine eligibility for CAP.</li> <li>Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.</li> <li>By 3<sup>rd</sup> quarter, develop expansion plan to bring CAP into additional counties.</li> </ul>	<p><b>During FY2013, Coastal AAA has provided case management to 43 family caregivers using the TCARE protocol. The FY2013 performance measure is met.</b></p>

		<ul style="list-style-type: none"> <li>Train additional Master Trainers for TCARE; training dates to be announced.</li> </ul>	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Expand the use of TCARE protocol with family caregivers in the Coastal region by utilizing TCARE with 15 family caregivers over the SFY12 baseline by FY2015.	<ul style="list-style-type: none"> <li>Increase numbers served in FY14 by 5 over numbers served in FY13.</li> </ul>	<ul style="list-style-type: none"> <li>Identify potential caregivers from waitlist. Conduct TCARE screen to determine eligibility for CAP.</li> <li>Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.</li> </ul> <p>*Action steps are ongoing.</p>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Expand the use of TCARE protocol with family caregivers in the Coastal region by utilizing TCARE with 15 family caregivers over the SFY12 baseline by FY2015.	<ul style="list-style-type: none"> <li>Increase numbers served in FY15 by 5 over numbers served in FY14.</li> </ul>	<ul style="list-style-type: none"> <li>Identify potential caregivers from waitlist. Conduct TCARE screen to determine eligibility for CAP.</li> <li>Assess clients enrolled in CAP program each 6 months to determine effectiveness of program.</li> </ul>	

**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

**Name of Service or Program: HCBS Case Management – (Care Transitions Program)**

SFY 2012 Goal 2 – Objective #5	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Provide case management	<ul style="list-style-type: none"> <li>By FY15, 90% of clients served</li> </ul>	<ul style="list-style-type: none"> <li>AAA will develop/update</li> </ul>	Due to a delay and difficulty

<p>to older adults in the Glynn County area following hospitalization and Emergency Room visits to promote a seamless transition home.</p>	<p>through the Aftercare Program will report an improved ability or confidence in maintaining their health as a result of care received through the Aftercare Program as evident by pre and post questionnaires.</p>	<p>marketing/outreach materials for the AfterCare Program.</p> <ul style="list-style-type: none"> <li>• In-home Care Manager will work with hospital discharge planners in Glynn County to develop a referral process to link recent discharges to the Aftercare Program.</li> <li>• Care Coordination Supervisor will identify or develop an assessment process to measure the client's confidence with managing their health condition.</li> <li>• In-Home Care Manger will administer said assessment at intake to and discharge from the AfterCare Program.</li> <li>• QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that AfterCare program guidelines and the hospital standards for discharge are adhered to.</li> </ul>	<p>filling the In-home Care Manager and Care Coordination Supervisor positions, we were not able to initiate these actions steps. A Case Management Supervisor was hired in October. A new HCBS/AfterCare Case Manager has been hired and is undergoing training. We plan to meet with hospital discharge planners and social workers in Glynn County to develop a referral process and to further open up the lines of communication.</p>
<p>SFY 2013</p>	<p>SFY 2013</p>	<p>SFY 2013</p>	<p>SFY 2013</p>
<ul style="list-style-type: none"> <li>• By FY15, 90% of clients served through the Care Transitions Program will report an improved ability or confidence in</li> </ul>	<ul style="list-style-type: none"> <li>• Establish a baseline in FY2013.</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter, in-home Care Manager will work with hospital staff in Glynn County to establish a referral process to link recent discharges to</li> </ul>	<p><b>Case Management staff were trained on the Bridge Model and developed a program outline for a Care Transition</b></p>

<p>maintaining their health as a result of care received through the Care Transitions Program as evident by pre and post questionnaires.</p>		<p>the Care Transitions Program.</p> <ul style="list-style-type: none"> <li>• Care Manager will develop pre and post questionnaire by 1<sup>st</sup> quarter FY13.</li> <li>• In-Home Care Manager will administer questionnaire at intake and discharge from the Care Transitions Program.</li> <li>• QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that Care Transitions program guidelines and the hospital standards for discharge are adhered to.</li> </ul>	<p><b>Program.</b></p> <p>During 1<sup>st</sup> quarter Fy2013, Coastal AAA presented the program model to stakeholders at the Southeast Georgia Health System (SGHS). A MOU was signed with the local hospital (SGHS) and a Care Transitions Team was established with representation from the AAA and SGHS.</p> <p>In December 2012, the Coastal AAA Care Transitions Program began accepting referrals. In January 2013, 4 clients were successfully completed the 30 day program. To date, another 12 clients are enrolled in the program. 100% of the program participants completing the end of program assessment reporting feeling more confident in managing their own health.</p>
<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>
<ul style="list-style-type: none"> <li>• By FY15, 90% of clients served through the Care Transitions Program will report an improved</li> </ul>	<ul style="list-style-type: none"> <li>• During FY2014, 80% of clients served through the Care Transitions Program will report an improved ability or</li> </ul>	<ul style="list-style-type: none"> <li>• In-home Care Manager will work with hospital staff in Glynn County to improve the referral process to link recent</li> </ul>	

<p>ability or confidence in maintaining their health as a result of care received through the Care Transitions Program as evident by pre and post questionnaires.</p>	<p>confidence in maintaining their health as a result of care received through the Care Transitions Program as evident by pre and post questionnaires.</p>	<p>discharges to the Care Transitions Program.</p> <ul style="list-style-type: none"> <li>• In-Home Care Manger will administer questionnaire at intake and discharge from the Care Transitions Program.</li> <li>• QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a review of the referral process to ensure that Care Transitions program guidelines and the hospital standards for discharge are adhered to.</li> </ul> <p>*Action steps are ongoing.</p>	
<p>SFY 2015</p>	<p>SFY 2015</p>	<p>SFY 2015</p>	<p>SFY 2015</p>
<ul style="list-style-type: none"> <li>• By FY15, 90% of clients served through the Care Transitions Program will report an improved ability or confidence in maintaining their health as a result of care received through the Care Transitions Program as evident by pre and post questionnaires.</li> </ul>	<ul style="list-style-type: none"> <li>• By FY15, 90% of clients served through the Care Transitions Program will report an improved ability or confidence in maintaining their health as a result of care received through the Care Transitions Program as evident by pre and post questionnaires.</li> </ul>	<ul style="list-style-type: none"> <li>• In-home Care Manager will work with hospital staff in Glynn County to improve the referral process to link recent discharges to the Care Transitions Program.</li> <li>• In-Home Care Manager will administer questionnaire at intake to and discharge from the Care Transitions Program.</li> <li>• QA Specialist will evaluate program annually to monitor progress towards program outcomes. Program evaluation will include a</li> </ul>	

		<p>review of the referral process to ensure that Care Transitions program guidelines and the hospital standards for discharge are adhered to.</p> <p>*Action steps are ongoing.</p>	
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**GOAL 2: Administration on Aging - Enable seniors to remain in their own homes with high quality of life for as long as possible through its provision of home and community based services, including supports for family caregivers.**

**Name of Service or Program: Adult Day Care (ADC)/ Mobile Adult Day Care Services**

SFY 2012 Goal 2 – Objective #6	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
<ul style="list-style-type: none"> <li>Expand ADC services in the Coastal region.</li> </ul>	<ul style="list-style-type: none"> <li>Baseline for FY11 is 130 clients served. Maintain the 130 ADC clients served in SFY11.</li> </ul>	<ul style="list-style-type: none"> <li>AAA Director will pursue additional funding sources for HCBS services.</li> <li>AAA Director will explore establishing foundation through CARE-NETs to leverage funds for caregiver services.</li> <li>AAA will seek potential ADC providers in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties.</li> <li>AAA lead staff will meet with city and county officials in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties to plan for</li> </ul>	<p>Coastal AAA staff has met with local county and city officials throughout the fiscal year. Further the Coastal CARE-NET is meeting quarterly with a focus on securing additional service dollars. During third quarter the Coastal AAA is exploring additional funding for Care Transition Services.</p>

		the expansion and enhancement of aging services in their county.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
<ul style="list-style-type: none"> <li>Expand ADC services in the Coastal region to serve 145 clients by FY2015.</li> </ul>	<ul style="list-style-type: none"> <li>Increase the number of clients served through ADC by 5 in FY13 over baseline in FY11. Baseline for FY11 is 130 clients served.</li> </ul>	<ul style="list-style-type: none"> <li>AAA Director will pursue additional funding sources for HCBS services.</li> <li>By 1<sup>st</sup> quarter FY12, AAA will identify a service provider in Camden, Bryan, Bulloch, Long, McIntosh or Effingham County to establish an ADC Program.</li> <li>AAA will work with said provider to development a service plan and budget for the ADC program.</li> </ul>	<b>Goal is discontinued due to projected budget cuts.</b>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
<ul style="list-style-type: none"> <li>Expand ADC services in the Coastal region to serve 145 clients by FY2015.</li> </ul>	<ul style="list-style-type: none"> <li>Increase the number of clients served through ADC by 5 FY14 over number of clients served in Fy2013.</li> </ul>	<ul style="list-style-type: none"> <li>AAA Director will pursue additional funding sources for HCBS services.</li> <li>AAA will seek potential ADC providers in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties.</li> <li>AAA lead staff will meet with city and county officials in Camden, Bryan, Bulloch, Long, McIntosh and Effingham counties to plan for the expansion and enhancement of aging services in their county.</li> <li>During 4<sup>th</sup> quarter FY14, AAA</li> </ul>	

		<p>will identify a service provider in Camden, Bryan, Bulloch, and Long, McIntosh or Effingham County to establish an ADC Program.</p> <ul style="list-style-type: none"> <li>• AAA will work with said provider to development a service plan and budget for the ADC program.</li> <li>• QA Specialist will evaluate effectiveness of new ADC program.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<ul style="list-style-type: none"> <li>• Expand ADC services in the Coastal region to serve 145 clients by FY2015.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the number of clients served through ADC by 5 in FY15 over the numbers served in Fy2014.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA Director will continue to pursue funding and resources to sustain new ADC programs.</li> <li>• AAA staff will provided continued technical assistance to providers.</li> <li>• QA Specialist will evaluate effectiveness of new ADC programs.</li> </ul>	

**GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.**

**Name of Service or Program: Nutrition Program – Congregate Meals**

SFY 2012 Goal 3 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase variety and diversity in menu items provided through	<ul style="list-style-type: none"> <li>• Target one senior center with an onsite kitchen to pilot a “client choice” menu offering a</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of survey on current clients to determine options meal selections</li> </ul>	Met with DAS Nutritionist and received technical assistance on

<p>congregate meal programs promoting client choice and healthy eating habits by SFY2015 at two sites</p>	<p>hot meal and 1-2 alternate meal choices daily.</p>	<ul style="list-style-type: none"> <li>• Develop two alternative of menu selections that meet 1/3 DRI/ RDA</li> <li>• By 4<sup>th</sup> quarter the Wellness Program Manager will evaluate the program to determine client satisfaction and progress towards program outcomes.</li> </ul>	<p>developing an implementation plan and timeline.</p> <p>Currently, researching “choice menus” and senior centers that have implemented “consumer choice” options through state funded nutrition programs.</p> <p>Developing a survey to solicit input from congregate meal participants, incorporating specific questions relating to “choice menus” meals</p> <p>Identified the first pilot site, the City of Brunswick Multipurpose Center. In the process of scheduling meetings discuss choice menus, survey, and logistics of choice menus.</p>
<p>SFY 2013</p>	<p>SFY 2013</p>	<p>SFY 2013</p>	<p>SFY 2013</p>
<p>Increase variety and diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits by SFY2015 at two sites.</p>	<ul style="list-style-type: none"> <li>• Start a diversified menu at initial pilot site with a “client choice” menu offering a hot meal and 1-2 alternate meal choices daily.</li> </ul>	<ul style="list-style-type: none"> <li>• Analyze survey of results to determine meal choices.</li> <li>• <del>Survey current clients to determine options meal selections</del></li> <li>• During 2<sup>nd</sup> quarter begin serving choice meal at first pilot site.</li> <li>• Continue using the two alternative menus selections</li> </ul>	<p><b>A “Choice Meal” pilot site has been identified; the City of Brunswick Multi-Purpose Center. Several meetings have occurred with the City of Brunswick MPC director and center staff to discuss choice options, process of implementation and a start</b></p>

		<p>that meet 1/3 DRI/ RDA</p> <ul style="list-style-type: none"> <li>• By 4<sup>th</sup> quarter FY2013, the Wellness Program Manager will share an overview of the project to other congregate site managers.</li> <li>• AAA will identify another site to implement pilot project during SFY14.</li> </ul>	<p>date.</p> <p>The Brunswick MPC has decided to implement “Choice Meals” by offering Choice desserts two to three times during the month. The choice dessert option will be an option of fresh fruit or dessert. The participants will have to sign-up through the meal reservation process. The “Choice Dessert” option was first offered in December 2012 and is ongoing. The pilot site will provide a project summary report to the Wellness Manager (AAA) at the end of June 2013.</p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase variety and diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits by SFY2015 at two sites.	<ul style="list-style-type: none"> <li>• Continue diversified menu at initial pilot site with a “client choice” menu offering a hot meal and 1-2 alternate meal choices daily.</li> <li>• In SFY14 start a diversified menu at a second senior center with on-site kitchen.</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of survey current clients to determine options meal selections</li> <li>• Continue using the two alternative menus selections that meet 1/3 DRI/ RDA</li> <li>• 4<sup>th</sup> quarter the Wellness Program Manager will evaluate the program to determine client satisfaction and progress towards program outcomes.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Increase variety and	<ul style="list-style-type: none"> <li>• Continue diversified menu at</li> </ul>	<ul style="list-style-type: none"> <li>• Survey current clients to</li> </ul>	

<p>diversity in menu items provided through congregate meal programs promoting client choice and healthy eating habits by SFY2015 at two sites.</p>	<p>two pilot sites with a “client choice” menu offering a hot meal and 1-2 alternate meal choices daily.</p>	<p>determine options meal selections</p> <ul style="list-style-type: none"> <li>• Continue using the two alternative menus selections that meet 1/3 DRI/ RDA</li> <li>• By 4<sup>th</sup> quarter, the Wellness Program Manager will share an overview of the project to other congregate site managers.</li> </ul>	
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### GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare

#### Name of Service or Program: Wellness Program – Matter of Balance

SFY 2012 Goal 3 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase knowledge of health and wellness concepts amongst older adults participating in wellness programs at three senior centers and/or sites where seniors congregate by SFY 2015	<ul style="list-style-type: none"> <li>80% of Matter of Balance (MOB) class participants at each site will report increased confidence in regaining stability after a fall and wellness concepts related to fall prevention, as evidenced by pre and post surveys</li> </ul>	<ul style="list-style-type: none"> <li>Pre and post surveys will be administered by MOB Master Trainers by Sept 2011.</li> <li>Coaches will be trained to administer pre and post- tests by Jan of 2012</li> <li>Post tests administered by June of 2012</li> </ul>	<p>Currently Matter of Balance has been offered in Glynn County at a provider site; the City of Brunswick Multipurpose Center. Fourteen participants attended the 8-wk class. During session eight, workshop participants were surveyed. 86% reported confidence in regaining stability after a fall. The MOB classes did have a positive impact on older adults at the City of Brunswick MPC related to prevent falls.</p> <p>Yes the same 14 people were administered the pre and post survey.</p> <p>McIntosh Co. is the next county where we will implement MOB by the end 2012.</p>
SFY 2013`	SFY 2013	SFY 2013	SFY 2013
By 2015, increase	<ul style="list-style-type: none"> <li>During FY2013 70% of Matter</li> </ul>	<ul style="list-style-type: none"> <li>Program coordinators will</li> </ul>	<b>Currently, Matter of Balance</b>

confidence in regaining stability amongst 80% of older adults with recent falls participating in the Matter of Balance Program at three (3) senior centers and/or sites where seniors congregate by 2015.	of Balance (MOB) class participants at each site will report increased confidence in regaining stability after a fall,, as evidenced by pre and post surveys.	compile and report data for 2012 annual wellness report <ul style="list-style-type: none"> <li>• Pre testing Jan 2013</li> <li>• Post testing June 2013</li> <li>• Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients.</li> <li>• Implement MOB in 2<sup>nd</sup> county.</li> </ul>	<b>(MOB) an evidence based program will be implemented in Camden County at the Camden County Senior Center. MOB will begin on February 20, 2013. The evidence based program will be open to the public. Those participating in the February MOB workshop will provided pre and post surveys to determine the effectiveness of MOB in increasing the workshop attendee's confidence.</b>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
By 2015, lincrease knowledge of health and wellness concepts confidence in regaining stability amongst 80% of older adults with recent falls participating in wellness programs at three senior centers and/or sites where seniors congregate by 2015 the Matter of Balance Program.	<ul style="list-style-type: none"> <li>• During FY2014, 75% of Matter of Balance (MOB) class participants at each site will report increased confidence in regaining stability after a fall, as evidenced by pre and post surveys.</li> </ul>	<ul style="list-style-type: none"> <li>• Program Manager will compile and report data for 2013 annual wellness report</li> <li>• Pre testing Jan 2014</li> <li>• Post testing June 2014</li> <li>• Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients.</li> <li>• Plan and facilitate training for MOB lay-leaders.</li> <li>• Implement MOB in 3<sup>rd</sup> county.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
By 2015, increase knowledge of health and	<ul style="list-style-type: none"> <li>• During FY2015, 80% of Matter of Balance (MOB) class</li> </ul>	<ul style="list-style-type: none"> <li>• Implement Matter of Balance Program in 3 Coastal Counties</li> </ul>	

<p>wellness concepts confidence in regaining stability amongst 80% of older adults with recent falls participating in wellness programs at three senior centers and/or sites where seniors congregate by 2015 the Matter of Balance Program.</p>	<p>participants at each site will report increased confidence in regaining stability after a fall, as evidenced by pre and post surveys.</p>	<p>by 2015, Glynn, Camden and McIntosh.</p> <ul style="list-style-type: none"> <li>• Program coordinators will compile and report data for 2014 annual wellness report</li> <li>• Pre testing Jan 2015</li> <li>• Post testing June 2015</li> <li>• Program Manager will work with community partners to provide health and wellness education opportunities that meet the needs of the clients.</li> </ul>	
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**GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare**

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

SFY 2012 Goal 3 – Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
<p>Provide 28 Chronic Disease Self-Management Program (CDSMP) evidence-based health and wellness workshops to older adults in the Coastal region by SFY 2015.</p>	<ul style="list-style-type: none"> <li>• Offer 7 CDSMP workshops and increase knowledge of health and wellness concepts.</li> </ul> <p><u>Comment:</u> One workshop consists of 6 classes.</p>	<ul style="list-style-type: none"> <li>• Complete surveys by participants in the CDSMP workshops by Sept 2011.</li> <li>• Train 24 lay leaders by Jan of 2012</li> <li>• Obtain volunteer agreements from LL's to maintain certification.</li> <li>• Compile data and report in AIMS, NCOA database, monthly CDSMP report, and quarterly narrative.</li> </ul>	<p>Currently, Coastal has 220 CDSMP participant completers.</p> <p>The AAA has planned and facilitated 4 Lay Leaders Trainings; two in Glynn Co., one in Liberty Co. and one in Chatham County. Two more are planned before the ARRA grant ends in March. 2012</p> <p>Currently, we have 32 Lay Leaders;</p>

			<p>all have signed a volunteer agreement.</p> <p>In September 2011 AAA hired a Wellness Assistant temporary for duration of the project.</p> <p>Currently 41 CDSMP Workshops are planned before the end of March 2012.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
<p>Provide 28 ongoing Chronic Disease Self-Management Program (CDSMP) evidence-based health and wellness workshops to older adults in the Coastal region by SFY 2015.</p>	<ul style="list-style-type: none"> <li>• During FY2013, offer 7 CDSMP workshops.</li> </ul> <p><u>Comment:</u> One workshop consists of 6 classes.</p>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter, the Wellness Program Manager will draft a wellness activities calendar for the fiscal year to include potential CDSMP workshops.</li> <li>• The AAA will market CDSMP workshops throughout the fiscal year.</li> <li>• Program Manager will continue to work with community partners to provide health and wellness education opportunities that meet the needs of the clients. Workshops will be offered throughout the Coastal region.</li> <li>• Provide a refresher training to current CDSMP LL by</li> </ul>	<p><b>The CDSMP/ Living Well Coastal is an ongoing evidence based program. The Coastal AAA currently has implemented five of the seven projected 6-week workshops in the coastal region. The two remaining workshops are scheduling to begin in March and April 2013.</b></p> <p><b>We have three (3) Master Trainers on Staff(MT) and we currently have a database of twenty-seven(27) CDSMP Lay Leaders in our region all of which have been trained through the Coastal AAA. The AAA will offer two CDSMP Refresher one-day training</b></p>

		December 2012	sessions in the spring; during March and May 2013.
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Provide 28 ongoing Chronic Disease Self-Management Program (CDSMP) evidence-based health and wellness workshops to older adults in the Coastal region by SFY 2015.	<p>During FY2014, offer 7 CDSMP workshops.</p> <p><u>Comment:</u> One workshop consists of 6 classes.</p>	<ul style="list-style-type: none"> <li>• During 1st quarter, the Wellness Program Manager will draft a wellness activities calendar for the fiscal year to include potential CDSMP workshops.</li> <li>• The AAA will market CDSMP workshops throughout the fiscal year.</li> <li>• Coordinate with community partners to provide health and wellness education opportunities that meet the needs of the clients.</li> <li>• Train additional lay leaders by June of 2014</li> <li>• Obtain volunteer agreements from LL's to maintain certification.</li> <li>• Plan and facilitate training for CDSMP lay-leaders.</li> <li>•</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Provide 28 ongoing Chronic Disease Self-Management Program (CDSMP) evidence-based health and wellness workshops to older adults in the Coastal region by	<ul style="list-style-type: none"> <li>• During FY2015, offer 7 CDSMP workshops.</li> </ul> <p><u>Comment:</u></p> <ul style="list-style-type: none"> <li>• One workshop consists of 6</li> </ul>	<ul style="list-style-type: none"> <li>• During 1st quarter, the Wellness Program Manager will draft a wellness activities calendar for the fiscal year to include potential CDSMP workshops.</li> </ul>	

SFY 2015.	classes.	<ul style="list-style-type: none"> <li>• The AAA will market CDSMP workshops throughout the fiscal year.</li> <li>• Volunteer Coordinator will continue recruitment of volunteers to serve as CDSMP lay leaders.</li> <li>• CDMSP Master Trainers will offer lay leaders training by 3<sup>rd</sup> quarter SFY15.</li> <li>• Obtain volunteer agreements from LL's to maintain certification.</li> <li>• Program coordinator will compile and report data for 2014 annual wellness report.</li> </ul>	
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**GOAL 3: Administration on Aging Goal - Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare**

**Name of Service or Program: Nutrition - Senior Centers**

SFY 2012 Goal 3 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Offer more engaging and diverse activities and programming through senior centers in the Coastal region.	<ul style="list-style-type: none"> <li>• In FY12, increase the number of planned actives offered through Coastal senior centers by 50% compared to FY11, as evidenced on monthly activity calendars and required in provider contract.</li> </ul>	<ul style="list-style-type: none"> <li>• By 1<sup>st</sup> quarter FY12, provider contracts will be revised to increase the required amount of planned programming in senior centers (3 hours).</li> <li>• The Wellness Coordinator will plan an annual workshop for senior center managers to offer ideas on programming</li> </ul>	During FY12 contract renewals, contracts for senior center/ congregate meals were revised to increase the number of planned activities to 3 hours daily in addition to the meal. Each month service providers send a copy of their activity calendars to the AAA for

		<p>and enhancing senior centers.</p> <ul style="list-style-type: none"> <li>• The AAA will assist providers in identifying new funding sources and resources to enhance their programs.</li> <li>• The QA Specialist will monitor center activities monthly and offer feedback to providers on programming.</li> <li>• During 2<sup>nd</sup> quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.</li> </ul>	<p>review. All Coastal senior centers have increased hours of planned activity to at least 3 hours per day.</p>
SFY 2013	SFY 2013	SFY 2013	SFY 2013
<p>Offer at least 6 hours/ daily of engaging and diverse activities and programming through senior centers in the Coastal region by FY2015.</p>	<ul style="list-style-type: none"> <li>• In FY13, increase the number of planned actives offered through Coastal senior centers to 4 hours daily, as evidenced on monthly activity calendars and required in provider contract.</li> </ul> <p>The baseline in FY2011 is 2 hours of planned activities daily.</p> <p>(Planned activities should be concurrent and will not require program hours to be extended.)</p>	<ul style="list-style-type: none"> <li>• By 1st quarter FY13, provider contracts will be revised to increase the required amount of planned programming in senior centers (4 hours).</li> <li>• The AAA will assist providers in identifying new funding sources and resources to enhance their programs.</li> <li>• Lead staff at the AAA will identify additional workshops and training opportunities for providers to enhance their programming.</li> <li>• The QA Specialist will monitor center activities monthly and offer feedback to providers on programming.</li> <li>• During 2<sup>nd</sup> quarter, the QA</li> </ul>	<p><b>During FY13 contract renewals, contracts for senior center/ congregate meals will be revised to increase the number of planned activities to 4 hours daily in addition to the meal.</b></p> <p><b>The AAA will continue instructions to review the providers' activity calendars monthly. The AAA is providing the senior centers on going technical assistance regarding to programming via quarterly provider trainings.</b></p>

		Specialist will survey center participants to measure their level of satisfaction with center programming.	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Offer at least 6 hours/ daily of engaging and diverse activities and programming through senior centers in the Coastal region by FY2015.	<ul style="list-style-type: none"> <li>In FY14, increase the number of planned actives offered through Coastal senior centers to 5 hours daily, as evidenced on monthly activity calendars and required in provider contract.</li> </ul> <p>(Planned activities should be concurrent and will not require program hours to be extended.)</p>	<ul style="list-style-type: none"> <li>By 1st quarter FY14, provider contracts will be revised to increase the required amount of planned programming in senior centers (5 hours).</li> <li>The AAA will assist providers in identifying new funding sources and resources to enhance their programs.</li> <li>Lead staff at the AAA will identify additional workshops and training opportunities for providers to enhance their programming.</li> <li>The QA Specialist will monitor center activities monthly and offer feedback to providers on programming.</li> <li>During 2<sup>nd</sup> quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Offer at least 6 hours/ daily of engaging and diverse activities and programming through senior centers in the	<ul style="list-style-type: none"> <li>In FY15, increase the number of planned actives offered through Coastal senior centers to 6 hours daily, as evidenced on monthly activity calendars</li> </ul>	<ul style="list-style-type: none"> <li>By 1st quarter FY15, provider contracts will be revised to increase the required amount of planned programming in senior centers (6 hours).</li> </ul>	

Coastal region by FY2015.	<p>and required in provider contract.</p> <p>(Planned activities should be concurrent and will not require program hours to be extended.)</p>	<ul style="list-style-type: none"> <li>• The AAA will assist providers in identifying new funding sources and resources to enhance their programs.</li> <li>• Lead staff at the AAA will identify additional workshops and training opportunities for providers to enhance their programming.</li> <li>• The QA Specialist will monitor center activities monthly and offer feedback to providers on programming.</li> <li>• During 2<sup>nd</sup> quarter, the QA Specialist will survey center participants to measure their level of satisfaction with center programming.</li> </ul>	
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**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation**

**Name of Service or Program: GeorgiaCares SHIP**

SFY 2012 Goal 4 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase access to services offered through GeorgiaCares Program through development of a regional volunteer base.	<ul style="list-style-type: none"> <li>• Establish 36 volunteers in the Coastal region trained to provide services and information specific to the GeorgiaCares Program by FY15.</li> </ul>	<ul style="list-style-type: none"> <li>• Gateway Manager will work with Volunteer Coordinator to develop a training program for GeorgiaCares Program and to recruit potential volunteers. Training curriculum will cover SHIP programs.</li> </ul>	<p>Coastal AAA hired a Volunteer Services Manager in December 2011.</p> <p>Volunteer Coordinator streamlined the GeorgiaCares training program by utilizing the SMP online</p>

		<ul style="list-style-type: none"> <li>Continue development of marketing plan to attract volunteers.</li> <li>GaCares Coordinator will schedule outreach events throughout the region to attract potential volunteers and heighten awareness about GeorgiaCares Program.</li> </ul>	<p>training.</p> <p>Volunteer Outreach material has been created and disseminated at all outreach events the GeorgiaCares Coordinator attends.</p> <p>Advertising and recruitment for volunteers for the GeorgiaCARES program has been ongoing and will continue until the program has a significant volunteer coverage which may very well pass the goal of 20 volunteers by SFY2015</p> <p>The GA CARES Coordinator conducted at least one outreach event in every county quarterly to attract potential volunteers</p>
SFY 2013 Goal 4 – Objective #1	SFY 2013 Annual Performance Measure	SFY 2013 Action Steps	SFY 2013 Annual Update on Objective
By the end of SFY 2015 GeorgiaCares we will have 20 volunteers trained to provide GeorgiaCares services on a regular schedule throughout our region.	<ul style="list-style-type: none"> <li>Baseline: Volunteer2 software database - as of May 2012 our agency has 8 trained GeorgiaCares volunteers.</li> <li>By June 2013, increase the number of trained GeorgiaCares volunteers by 4.</li> </ul>	<ul style="list-style-type: none"> <li>Set weekly meetings between GeorgiaCares Coordinator and Volunteer Services Manager beginning first QTR SFY2013 to discuss updates and strategic planning for volunteer recruitment and training.</li> <li>On a regular basis, continue advertisement/recruitment plan for GeorgiaCares volunteer.</li> <li>Present quarterly updates on</li> </ul>	<p><b>Restructuring of the GACares program occurred first QTR SFY2013. We eliminated the full time GACares staff and combined the Volunteer Services Manager along with a part-time GACares Counselor. The Volunteer Services Manager will lead the program, recruit volunteers while the GACares Counselor will provide training and</b></p>

		<p>the progress of GeorgiaCares program at quarterly CCSP meeting, Nutrition Providers meeting and the Area Agency Advisory Board</p> <ul style="list-style-type: none"> <li>• Set up quarterly webinar trainings beginning June 2012 with GeorgiaCares volunteers to discuss updates and receive feedback.</li> <li>• Distribute volunteer satisfaction survey to volunteers 2x per year in October and March</li> </ul>	<p>administrative tasks.</p> <p>Performance measures 2<sup>nd</sup> QTR resulted in an average 500% increase in program activities related to client contacts and numbers of clients served, compared to 1<sup>st</sup> QTR.</p> <p>GACares program has already exceeded the anticipated number of trained GACares Volunteers by 1, for a total of 13.</p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014 Annual Update on Objective
By the end of SFY 2015 GeorgiaCares we will have 20 volunteers trained to provide GeorgiaCares services on a regular schedule throughout our region.	<ul style="list-style-type: none"> <li>• By June 2014, increase the number of trained GeorgiaCares volunteers by 4.</li> </ul>	<ul style="list-style-type: none"> <li>• Continue weekly meetings with GeorgiaCares Coordinator and Volunteer Services Manager beginning first QTR SFY2014 to discuss updates and strategic planning for volunteer recruitment and training</li> <li>• On a regular basis, continue advertisement/recruitment plan for GeorgiaCares volunteer.</li> <li>• Present updates on the progress of GeorgiaCares program at quarterly CCSP meeting, Nutrition Providers meeting and the Area Agency Advisory Board</li> </ul>	

		<ul style="list-style-type: none"> <li>• Set up quarterly webinar trainings beginning June 2012 with GeorgiaCares volunteers to discuss updates and receive feedback.</li> <li>• Distribute volunteer satisfaction survey to volunteers 2x per year in October and March</li> <li>• Recognize a GeorgiaCares volunteer each month in the CRC-AAA Volunteer Voice newsletter</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
By the end of SFY 2015 GeorgiaCares we will have 20 volunteers trained to provide GeorgiaCares services on a regular schedule throughout our region.	<ul style="list-style-type: none"> <li>• By June 2015, increase the number of trained GeorgiaCares volunteers by 4.</li> </ul>	<ul style="list-style-type: none"> <li>• Continue weekly meetings between GeorgiaCares Coordinator and Volunteer Services Manager beginning first QTR SFY2015 to discuss updates and strategic planning for volunteer recruitment and training</li> <li>• On a regular basis, continue advertisement/recruitment plan for GeorgiaCares volunteer.</li> <li>• Present updates on the progress of GeorgiaCares program at quarterly CCSP</li> </ul>	

		<p>meeting, Nutrition Providers meeting and the Area Agency Advisory Board</p> <ul style="list-style-type: none"> <li>• Set up quarterly webinar trainings beginning June 2012 with GeorgiaCares volunteers to discuss updates and receive feedback.</li> <li>• Distribute volunteer satisfaction survey to volunteers 2x per year in October and March.</li> <li>• Recognize a GeorgiaCares volunteer each month in the CRC-AAA Volunteer Voice newsletter</li> </ul>	
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**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation**

**Name of Service or Program: GeorgiaCares Senior Medicare Patrol (SMP)**

SFY 2012 Goal 4 – Objective #2	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase services offered through SMP Program through community	<ul style="list-style-type: none"> <li>• Coordinate 2 community education events during Open Enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter, Georgia Cares Coordinator will develop an outreach plan for</li> </ul>	In December 2011 Coastal AAA developed an outreach plan and GA Cares Coordinator maintains

outreach.		<p>SMP that includes at a minimum the following components: marketing, volunteer recruitment, volunteering training, and community education events.</p> <ul style="list-style-type: none"> <li>• Georgia Cares Coordinator will work with Volunteer Coordinator to recruit volunteers and develop a training program/ curriculum for SMP volunteers.</li> <li>• GeorgiaCares Coordinator will schedule and coordinate 2 community education events during Open Enrollment with a focus on empower consumers to make informed decisions concerning health insurance options and increasing understanding of Medicare.</li> <li>• During 3<sup>rd</sup>- 4<sup>th</sup> quarter Quality Assurance Specialist and Gateway Program Manager will conduct an annual evaluation of the SMP program to determine effectiveness of outreach activities.</li> </ul>	<p>monthly an outreach calendar for SMP.</p> <p>The GA CARES Coordinator conducted at least one outreach event in every county quarterly.</p> <p>Throughout the fiscal year the GA CARES Coordinator has continued to recruit and train volunteers to assist with community education and outreach.</p> <p>During FY12, Coastal AAA added a part-time GA Cares staff and full-time VISTA worker to assist with SMP program activities.</p>
SFY 2013 Goal 4 – Objective #2	SFY 2013 Annual Performance Measure	SFY 2013 Action Steps	SFY 2013 Annual Update on Objective
	<ul style="list-style-type: none"> <li>• Baseline: there is no active SMP</li> </ul>	<ul style="list-style-type: none"> <li>• In July 2012 GeorgiaCares</li> </ul>	<p><b>The SMP Committee met for</b></p>

<p>Develop a region wide active SMP committee by SFY2015.</p>	<p>committee at this time.</p> <ul style="list-style-type: none"> <li>• By end of SFY 2013 we will have 10 active members,(a minimum of 1 representative from each county in our service area) on the Coastal SMP Committee.</li> </ul>	<p>Coordinator and volunteer services manager will host the 1<sup>st</sup> annual SMP Elder Abuse Summit and begin recruitment of SMP members at that summit.</p> <ul style="list-style-type: none"> <li>• GeorgiaCares coordinator and Volunteer Services Manager will address the Area Agency Advisory Board about SMP and the development of a SMP committee in August 2012.</li> <li>• First meeting for SMP Committee will be held by December 2012. <ul style="list-style-type: none"> <li>○ Goals will be set for SMP Committee</li> <li>○ List-serv and membership list will be created</li> <li>○ Fraud and abuse updates will be provided continuously through that list-serve throughout the year.</li> </ul> </li> </ul>	<p>the first time in January 2013, approximately 10 members. The committee members primarily reside in Chatham County. The next meeting will be held in March 2013 and will incorporate representation from more of the region. The SMP committee will coordinate efforts with the Chatham County SALT Counsel.</p> <p>Beginning January 2013, SMP updates will be provided in the Advisory Board minutes that are sent out monthly.</p> <p>SMP updates are also provided at monthly ADRC meetings and in our monthly GACares on-line newsletter.</p>
<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>
<p>Develop a region wide active SMP committee by SFY2015.</p>	<ul style="list-style-type: none"> <li>• By the end of SFY 2014 the SMP Committee will be the lead planner in the 2<sup>nd</sup> annual region wide Medicare Fraud and abuse summit</li> </ul>	<ul style="list-style-type: none"> <li>• GeorgiaCares coordinator and Volunteer Services Manager will provide updates on SMP at the Area Agency Advisory Board, CCSP and nutrition</li> </ul>	

	<ul style="list-style-type: none"> <li>By the end of SFY 2014 the SMP Committee will have met at least bi-annually</li> </ul>	<p>providers meetings each QTR.</p> <ul style="list-style-type: none"> <li>SMP Committee will meet minimally bi-annually (October and March) discussing fraud and abuse updates</li> <li>October 2013, SMP Committee will be the lead on the annual SMP summit and begin planning the event for July 2014.</li> </ul>	
SFY 2015	SFY 2015	SFY2015	SFY 2015
Develop a region wide active SMP committee by SFY2015.	<ul style="list-style-type: none"> <li>By the end of SFY 2015 the SMP Committee will be the lead planner in the 3rd annual region wide Medicare Fraud and abuse summit</li> <li>By the end of SFY 2014 the SMP Committee will have met at least bi-annually</li> </ul>	<ul style="list-style-type: none"> <li>GeorgiaCares coordinator and Volunteer Services Manager will provide updates on SMP at the Area Agency Advisory Board, CCSP and nutrition providers meetings each QTR.</li> <li>SMP Committee will meet minimally bi-annually (October and March) discussing fraud and abuse updates</li> <li>October 2014, SMP Committee will be the lead on the annual SMP summit and begin planning the event for July 2015</li> </ul>	

## GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation

### Name of Service or Program: Elderly Legal Assistance Program

SFY 2012 Goal 4 – Objective #3	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Increase the number of Hispanic/Latino clients served through ELAP.	<ul style="list-style-type: none"> <li>Increase the number of Hispanic/Latino clients served by 20% in FY15, compared to numbers served in FY11. Baseline data for FY11 is six.</li> </ul>	<ul style="list-style-type: none"> <li>The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency.</li> <li>The provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period.</li> <li>Provider will disseminate marketing materials and publications in English and Spanish.</li> <li>Provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers.</li> <li>AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.</li> <li>AAA and service provider will explore adding a Spanish voice mail option so that</li> </ul>	<p>During 1<sup>st</sup> quarter FY12, our ELAP provider's Spanish speaking attorney resigned leaving the agency without bilingual staff. The position was filled during 2<sup>nd</sup> quarter. However, the lag time in filling the position may have contributed the decline in the number of Hispanic/Latino clients served thus far in FY12. The provider has maintained their commitment to providing bilingual staff (Hispanic speaking attorney) and continues to offer printed literature in Spanish and English. Despite budget restraints, the Coastal AAA and ELAP provider continue to explore adding Spanish voicemail options to our phone system.</p>

		resulting new clients don't reach a communications roadblock after hours.	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Increase the number of Hispanic/Latino clients served by 100% in FY15, compared to numbers served in FY11.	<ul style="list-style-type: none"> <li>Increase the number of Hispanic/Latino clients served by 33% in FY13, compared to numbers served in FY11. Baseline data for FY11 is six.</li> </ul>	<ul style="list-style-type: none"> <li>The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency.</li> <li>Ongoing, the provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period.</li> <li>Quarterly, provider will disseminate marketing materials and publications in English and Spanish.</li> <li>At least quarterly, provider will continue to draft articles on legal issues for Spanish Language publications/newspapers.</li> <li>Ongoing, the AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.</li> </ul>	To date the ELAP service provider has served 3 Hispanic/Latino clients, 50% of the FY2013 performance measure. During 4 <sup>th</sup> quarter FY2012, the provider launched a Spanish Intake Program to provide Spanish speaking clients assistance by phone. The provider continues outreach efforts to Hispanic/Latino communities.
SFY 2014	SFY 2014	SFY 2014	SFY 2014
Increase the number of Hispanic/Latino clients served by 100% in FY15,	<ul style="list-style-type: none"> <li>Increase the number of Hispanic/Latino clients served by 66% in FY14, compared to</li> </ul>	<ul style="list-style-type: none"> <li>The provider will utilize funding secured through Goizuetta funded outreach</li> </ul>	

<p>compared to numbers served in FY11.</p>	<p>numbers served in FY11. Baseline data for FY11 is six.</p>	<p>program to increase resources for serving clients with limited English proficiency.</p> <ul style="list-style-type: none"> <li>• Ongoing, the provider will maintain bilingual staff or easy-access to interpreter services throughout the contract period.</li> <li>• Quarterly, provider will disseminate marketing materials and publications in English and Spanish.</li> <li>• At least quarterly, provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers.</li> <li>• Ongoing, the AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.</li> </ul>	
<p>SFY 2015</p>	<p>SFY 2015</p>	<p>SFY 2015</p>	<p>SFY 2015</p>
<p>Increase the number of Hispanic/Latino clients served by 100% in FY15, compared to numbers served in FY11.</p>	<ul style="list-style-type: none"> <li>• Increase the number of Hispanic/Latino clients served by 100% in FY15, compared to numbers served in FY11. Baseline data for FY11 is six.</li> </ul>	<ul style="list-style-type: none"> <li>• The provider will utilize funding secured through Goizuetta funded outreach program to increase resources for serving clients with limited English proficiency.</li> <li>• Ongoing, the provider will maintain bilingual staff or easy-access to interpreter services throughout the</li> </ul>	

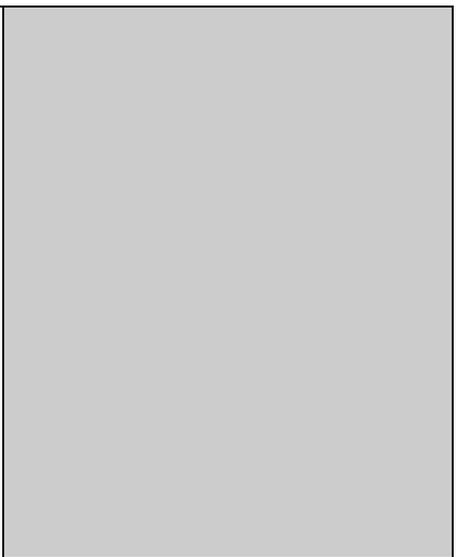
		<p>contract period.</p> <ul style="list-style-type: none"><li>• Quarterly, provider will disseminate marketing materials and publications in English and Spanish.</li><li>• At least quarterly, provider will continue to draft articles on legal issues for Spanish Language publications/ newspapers.</li><li>• Ongoing, the AAA will work with provider agency to target and identify older adults with limited English proficiency in need of legal services.</li></ul>	
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**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

**Name of Service or Program: Long-term Care Ombudsman**

SFY 2012 Goal 4 – Objective #4	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
<p>Increase the use of volunteers used to provide LTCO Services.</p>	<ul style="list-style-type: none"> <li>Increase the volunteer base by 50% in FY13 and by 75% in FY15 over the baseline in FY11.</li> </ul>	<ul style="list-style-type: none"> <li>During 1<sup>st</sup> quarter Fy12, Volunteer Services Manager and QA Specialist will work with LTCO provider to identify volunteer opportunities through LTCO program and develop training process for volunteers.</li> <li>AAA will include LTCO Program in marketing, outreach and recruitment activities for volunteers, ongoing.</li> <li>LTCO staff will provide oversight of program volunteers and ongoing training that is program-specific.</li> <li>By 4<sup>th</sup> quarter, Volunteer Services Manager and LTCO staff will evaluate the effectiveness of using volunteers in LTCO Program and establish ideas for increasing volunteerism.</li> </ul>	<p>The Volunteer Services Manager was hired in December 2011. During 3<sup>rd</sup> and 4<sup>th</sup> quarters, the Volunteer Services Manager is working with AAA staff and providers to learn the different aging services and programs and determine strategies for recruiting and training volunteers.</p> <p>The LTCO Program continues to utilize volunteers accompanying ombudsmen on routine site visits and assisting with outreach.</p> <p>During SFY2012, the AAA Volunteer Services Manger focused on surveying LTCO's to determine the program's volunteer needs. No volunteers have been referred from the AAA to the LTCO program during SFY2012.</p>

SFY 2013 Goal 4 – Objective #4	SFY 2013 Annual Performance Measure	SFY 2013 Action Steps	SFY 2013 Annual Update on Objective
The Area Agency Volunteer Services and the LTCO provider in the coastal region will develop a coordinated plan of entry for ombudsman volunteers by SFY 2015.	<ul style="list-style-type: none"> <li>• <b>Baseline</b> data for SFY2012: As of May 2012 we have not developed a plan for a coordinated plan of entry for ombudsman volunteers.</li> <li>• By the end of SFY2013 the Area Agency and the LTCO provider will have developed a plan for a coordinated plan-of-entry for ombudsman volunteers.</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> quarter SFY13, Volunteer Services Manager and QA Specialist will work with LTCO provider to identify volunteer opportunities at LTCO program and develop training process for volunteers.</li> <li>• AAA and LTCO provider will develop marketing plan for LTCO volunteers and recruit partners for plan implementation in SFY2014.</li> </ul>	<p><b>Volunteer Services Manager and QA Specialist have met several times with LTCO provider on identifying volunteer opportunities. The next meeting is set for April 2013. A plan is expected to be finalized and implemented June 2013.</b></p> <p>Currently the Coastal LTCO program has 18 volunteers, a 38% increase over the 13 volunteers assisting with the program during FY2012.</p>
SFY 2014	SFY 2014	SFY 2014	SFY 2014
The Area Agency Volunteer Services and the LTCO provider in the coastal region will develop a coordinated plan of entry for ombudsman volunteers by SFY 2015.	<ul style="list-style-type: none"> <li>• Refer a minimum of 5 volunteers a year to the LTCO provider in Coastal Georgia.</li> </ul>	<ul style="list-style-type: none"> <li>• During 1<sup>st</sup> qtr, implement LTCO volunteer plan.</li> <li>• Implement marketing, outreach and recruitment plan first QTR SFY2013.</li> <li>• Communicate monthly with LTCO provider on updates and progress of coordinated plan-of entry at the AAA side.</li> <li>• Refer volunteers to LTCO program, ongoing.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015

<p>The Area Agency Volunteer Services and the LTCO provider in the coastal region will develop a coordinated plan of entry for ombudsman volunteers by SFY 2015.</p>	<ul style="list-style-type: none"> <li>• Refer a minimum of 5 volunteers a year to the LTCO provider in Coastal Georgia.</li> </ul>	<ul style="list-style-type: none"> <li>• Refer volunteers to LTCO program, ongoing.</li> <li>• Continue marketing plan for volunteer recruitment, ongoing.</li> <li>• Volunteer Services Manager and LTCO staff will distribute a self-assessed volunteer satisfaction survey to each LTCO volunteer</li> <li>• Recognize LTCO volunteer in AAA Volunteer Voice newsletter and at Volunteer Appreciation Luncheon.</li> </ul>	
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**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

**Name of Service or Program: Elder Abuse and Consumer Fraud Prevention (Elder Rights Team Goal)**

SFY 2012 Goal 4 – Objective #5	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
See Elder Rights Plan		•	
SFY 2013	SFY 2013	SFY 2013	SFY 2013
See Elder Rights Plan		•	
SFY 2014	SFY 2014	SFY 2014	SFY 2014
See Elder Rights Plan		•	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
See Elder Rights Plan		•	

**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

**Name of Service or Program: AAA Advocacy**

SFY 2012 Goal 4 – Objective #6	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Establish an Advocacy Academy (AA) to produce graduates/ affiliates to advocate for issues relevant to older adults and the aging network.	<ul style="list-style-type: none"> <li>Establish a program that will offer potential advocates the resources and skills needed to effectively advocate for senior issues.</li> </ul>	<ul style="list-style-type: none"> <li>Special Projects Coordinator will research successful models of advocacy programs and develop a program description and implementation plan for the Advocacy Academy.</li> <li>AAA Director and Special Projects Coord. will seek funding and resources to</li> </ul>	<p>The advocacy academy curriculum has been developed and is based off the Oklahoma Senior Advocacy Training. Partnerships with 2 Colleges, College of coastal Georgia and the Armstrong Atlantic State University</p> <p>The development of an Advocacy Committee is</p>

		<p>support the project.</p> <ul style="list-style-type: none"> <li>• QA Specialist and Special Projects Coord. will develop program outcomes.</li> </ul>	<p>currently in the early stages and will be operated primarily by the Advisory Board. Advisory members have been educated on the advocacy academy and members who presented interest in assisting with the plan have been placed on the committee list.</p> <p>Also, the development of an advocacy newsletter has been developed and will be ready for distribution early June.</p>
SFY 2013 Goal 4 – Objective #6	SFY 2013 Annual Performance Measure	SFY 2013 Action Steps	SFY 2013 Annual Update on Objective

<p>By SFY 2015 the Area Agency will establish a region wide Advocacy Academy in which 40 advocates will be educated on senior issues by 2015.</p>	<ul style="list-style-type: none"> <li>• <b>Baseline:</b> A comprehensive Curriculum for the Advocacy Academy has been developed</li> <li>• By the end of SFY 2013 a minimum of 20 graduates will have completed the first Coastal Advocacy Academy</li> </ul>	<ul style="list-style-type: none"> <li>• AAA Director and Volunteer Services Manager will seek funding and resources to support the project.</li> <li>• Advisory members who presented an interest will be contacted and 1<sup>st</sup> advocacy academy planning meeting will be set by July 2012</li> <li>• Presenters for curriculum will be recruited by October 2012.</li> <li>• First Advocacy Academy will be completed before the end of 2012</li> <li>• Advocacy graduates will complete an advocacy strategic plan</li> <li>• Advocacy graduates will attend senior week in 2013</li> <li>• Volunteer Services Manager will recruit potential speakers to complete the AAA curriculum by April 2013.</li> </ul>	<p><b>15 advocates attended the Advocacy Academy in October 2012. The Advocacy members have agreed on advocating for the pass of the state Alzheimer's plan. A partnership with the Alzheimer's Association has provided an opportunity for our Advocacy members to participate alongside the Alzheimer's Association at the 2013 Senior Week. A total of 29 Coastal Advocates were recruited for the Alzheimer's Advocacy Campaign.</b></p>
<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>
<p>By SFY 2015 the Area Agency will establish a region wide Advocacy Academy in which 40 advocates will be educated on senior issues by 2015.</p>	<ul style="list-style-type: none"> <li>• AAA curriculum will be offered at least once during FY14 with at least 10 graduates.</li> <li>• Review of advocacy efforts will be conducted in order to evaluate the advocacy efforts of the previous year.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA will set date and market the advocacy academy region wide</li> <li>• Presenters for curriculum will be recruited.</li> <li>• Second Advocacy Academy will be implemented before the end of 2013</li> </ul>	

		<ul style="list-style-type: none"> <li>• Advocacy graduates will complete an assessment of the previous year's advocacy efforts along with the current years advocacy strategic plan</li> <li>• Advocacy graduates will attend senior week in 2014.</li> <li>• Volunteer Services Manager will recruit potential speakers to complete the AA curriculum by April 2014.</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
By SFY 2015 the Area Agency will establish a region wide Advocacy Academy in which 40 advocates will be educated on senior issues by 2015.	<ul style="list-style-type: none"> <li>• AA curriculum will be offered at least once during FY15 with at least 10 graduates.</li> <li>• Review of advocacy efforts will be conducted in order to evaluate the advocacy efforts of the previous year.</li> </ul>	<ul style="list-style-type: none"> <li>• AAA will set date and market the advocacy academy region wide</li> <li>• Presenters for curriculum will be recruited.</li> <li>• Second Advocacy Academy will be implemented before the end of 2014</li> <li>• Advocacy graduates will complete an assessment of the previous year's advocacy efforts along with the current years advocacy strategic plan</li> <li>• Advocacy graduates will attend senior week in 2015</li> </ul>	

## GOAL 5: Engage older adults in healthy and meaningful activities that improve their quality of life.

### Name of Service or Program: AAA Volunteer Coordination

SFY 2012 Goal 5 – Objective #1	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
<p>Develop a volunteer program through the AAA that is attractive, engaging and easy to access and provides support to the aging network.</p>	<ul style="list-style-type: none"> <li>• Increase number of active volunteers by 25% in FY12 over those volunteering through the AAA in FY11. Increase the volunteer pool by an additional 10% in FY13, FY14, and FY15. Baseline data for FY11 is 25.</li> <li>• 85% of active volunteers will rate the AAA volunteer program as good or better.</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteer Services Manager will work with the AAA Director to develop a marketing campaign to attract volunteers.</li> <li>• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate volunteer opportunities.</li> <li>• Volunteer Services Manager will meet with community agencies and service providers to determine their workforce needs and identify volunteer opportunities. If AAA volunteers are placed with these agencies, the agencies will be included in the program's evaluation process.</li> <li>• Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program.</li> <li>• Third quarter FY12, Volunteer</li> </ul>	<p>Hired a Volunteer Services Manager in December 2011. A brochure and handbook have been developed for the Volunteer Services Program. During 3<sup>rd</sup> quarter, the Volunteer Services Manager met with the Coastal HCBS and CCSP Providers to discuss developing a regional volunteer program.</p> <p>A survey of the senior center sites was conducted and reported that almost 80% of the sites have the evidence based CDSMP program implemented but only 20% of the sites had a GeorgiaCares volunteer.</p>

		<p>Services Manager, AAA Director and QA Specialist will develop an evaluation process for the volunteer program that will include feedback from active volunteers.</p> <ul style="list-style-type: none"> <li>• Volunteer Services Manager will track # of active volunteers and volunteer hours provided throughout region.</li> </ul>	
SFY 2013 Goal 5 – Objective #1	SFY 2013 Annual Performance Measure	SFY 2013 Action Steps	SFY 2013 Annual Update on Objective
By the end of SFY2015 the Area Agency will have developed a respite volunteer program with at least 10 active respite volunteers to provide support to the overstressed caregivers and high risk populations identified in the needs assessment. .	<ul style="list-style-type: none"> <li>• <b>Baseline:</b> currently the Area Agency does not have any active respite volunteer program</li> <li>• By the end of SFY 2013 the Area Agency will have developed the training and program standards for the volunteer respite program.</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteer Services Manager will review existing respite programs nationally</li> <li>• Volunteer Services Manager will meet with staff, community agencies and service providers to determine their respite needs and training requirements.</li> <li>• Conduct a risk assessment and develop training for respite program by partnering with appropriate agencies</li> </ul>	<b>The Volunteer respite program is focusing primarily on the <i>LifeSpan Respite</i> program administered in North Carolina. The program will be evaluated and adapted to fit the needs of the Coastal Area Agency on Aging.</b>
SFY 2014	SFY 2014	SFY 2014	SFY 2013
By the end of SFY2015 the Area Agency will have developed a respite volunteer program with at	<ul style="list-style-type: none"> <li>• Recruit minimally 5 respite volunteers by the end of SFY 2014</li> <li>• Survey respite volunteer</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate respite volunteer.</li> </ul>	

<p>least 10 active respite volunteers to provide support to the overstressed caregivers and high risk populations identified in the needs assessment.</p>	<p>satisfaction reaching for a 100% self-reported satisfaction rate</p>	<ul style="list-style-type: none"> <li>• Volunteer Services Manager will communicate on a continual bases with the agencies in need of respite assistance the programs progress and referrals</li> <li>• Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program.</li> <li>• Collect outputs for respite: hours and tasks completed</li> </ul>	
SFY 2015	SFY 2015	SFY 2015	SFY 2015
<p>By the end of SFY2015 the Area Agency will have developed a respite volunteer program with at least 10 active respite volunteers to provide support to the overstressed caregivers and high risk populations identified in the needs assessment.</p>	<ul style="list-style-type: none"> <li>• Recruit minimally 5 respite volunteers by the end of SFY 2015</li> <li>• Survey respite volunteer satisfaction reaching for a 100% self-reported satisfaction rate</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteer Services manager will conduct interviews with each volunteer recruit to identify skills and match to appropriate respite volunteer.</li> <li>• Volunteer Services Manager will communicate on a continual bases with the agencies in need of respite assistance the programs progress and referrals</li> <li>• Volunteer Services Manager will conduct/ attend outreach events to increase visibility of AAA volunteer program.</li> <li>• Conduct respite training</li> <li>• Collect outputs for respite: hours and tasks completed</li> <li>• Distribute self-reported survey that measures</li> </ul>	

		volunteer satisfaction with LTCO.	
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## LOCATION OF SERVICES CHART –

### ATTACHMENT B-1: Home and Community Based Services Provided in Each County Chart

	Counties → Services ↓	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	Adult Day Care				X		X			
2.	Adult Day Care – Mobile							X		
3.	Congregate Meals	X	X	X	X	X	X	X	X	X
4.	Home Delivered Meals	X	X	X	X	X	X	X	X	X
5.	Homemaker Services	X	X	X	X	X	X	X	X	X
6.	Personal Care	X	X	X	X	X	X	X	X	X
7.	Respite Care Services	X	X	X	X	X	X	X	X	X
8.	Caregiver Services		X		X	X	X			X
9.	CCSP Care Coordination	X	X	X	X	X	X	X	X	X
10.	DHS Coordinated Transportation	X	X	X	X	X	X	X	X	X
11.	ADRC	X	X	X	X	X	X	X	X	X
12.	HCBS Case Management	X	X		X	X	X			X
13.	Health Promotion / Wellness	X	X	X	X	X	X	X	X	X
14.	Chronic Disease Self-Management Education	X	X	X	X	X	X	X	X	X
15.	Information & Assistance	X	X	X	X	X	X	X	X	X

**ATTACHMENT B-2: Access, Elder Rights and LTCO Services Provided in Each County Chart (Form)**

	Counties Services	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	GeorgiaCares SHIP	X	X	X	X	X	X	X	X	X
2.	GeorgiaCares SMP	X	X	X	X	X	X	X	X	X
3.	Elderly Legal Assistance Program	X	X	X	X	X	X	X	X	X
4.	Long-term Care Ombudsman	X	X	X	X	X	X	X	X	X
5.	Elder Abuse and Consumer Fraud Prevention Program (optional)	X	X	X	X	X	X	X	X	X

**ATTACHMENT B-3: Community Care Services Provided in Each County Chart (CCSP)**

	Counties Services	Bryan	Bulloch	Camden	Chatham	Effingham	Glynn	Liberty	Long	McIntosh
1.	Adult Day Health	X	X		X			X		
2.	Alternative Living Services	X	X	X	X	X	X	X	X	X
3.	Emergency Response System	X	X	X	X	X	X	X	X	X
4.	Home Delivered Meals	X	X	X	X	X	X	X	X	X
5.	Home Delivered Services	X	X	X	X	X	X	X	X	X
6.	Personal Support Services	X	X	X	X	X	X	X	X	X
7.	Personal Support Services Extended	X	X	X	X	X	X	X	X	X
8.	Respite Care – Out of Home	X	X	X	X	X	X	X	X	X
9.	Skilled Nursing Services	X	X	X	X	X	X	X	X	X

## C. COMPLIANCE DOCUMENTS

### ATTACHMENT C-1: REQUEST FOR ADVANCE/BOND

Not Applicable

## C. COMPLIANCE DOCUMENTS:

### 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 identify 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 describe 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 State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals 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 VIII/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;

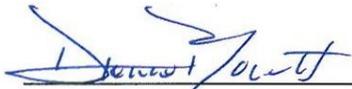
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under 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 Coastal Regional Commission Area Agency on Aging is in compliance and will maintain compliance with all aforementioned Standard Assurances.



Dionne Lovett

3/1/13

Date

Area Agency on Aging Director



Walter Gibson, CRC Council Chairman

3-1-13

Date

Coastal Regional Commission

**C. COMPLIANCE DOCUMENTS:**

**ATTACHMENT C-3: LETTER REQUESTING WAIVER OF STANDARD ASSURANCES**

C. COMPLIANCE DOCUMENTS:

ATTACHMENT C-4 - BOARD RESOLUTION -

## Resolution

**Whereas**, Federal law and the Georgia Department of Human Service/ Division of Aging Services rules require each Area Agency on Aging to prepare an *Area Plan for Aging Services for FY 2012-2015*; and

**Whereas**, the document known as the *Area Plan for Aging Services of Coastal Georgia FY 2012 – 2015* was submitted to the Coastal Area Agency on Aging Advisory Council for review and comment on January 29, 2013; and

**Whereas**, the Coastal Area Agency on Aging Advisory Council unanimously approved the *Area Plan for Aging Services of Coastal Georgia for FY 2012-2015* on January 29, 2013; and

**Whereas**, the Georgia Department Human Resources/Division of Aging Services requires that the document be presented to the Council for final adoption;

**Now therefore, be it resolved**, that the Coastal Regional Commission Council hereby adopts the *Area Plan for Aging Services FY 2012- 2015 of Coastal Georgia*.

**Adopted** this 13<sup>th</sup> day of February, 2013.



By: Walter C. Gibson  
Walter Gibson, Chairman

**Attest:**

By: [Signature]  
Allen Burns, Executive Director

**D. REQUIRED PLANS:**

**ATTACHMENT D-1 – ANNUAL ELDER RIGHTS PLAN**

# COASTAL AAA ELDER RIGHTS PLAN

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Coastal AAA and its service providers and partner agencies have always been responsive to the needs of older adults and individuals with disabilities in the Coastal region. AAA staff and providers are trained to identify signs of abuse and exploitation and receive regular information and updates from the Aging Services Coordinator and Resource Specialist regarding programs, services and resources available to victims of abuse. AAA lead staff dialogue with service providers and staff about the dynamics of elder abuse on an on-going basis. Providers and staff are required to follow-up on client complaints, trained to look for changes in client behavior and encouraged to stay current on preventive techniques and practices that help to safeguard the clients we serve.

During October 2008, the AAA obtained a \$10,000 grant from the Nation Center for the Prevention of Elder Abuse (NCPEA) to develop a new coalition to work on Elder Abuse issues in the community. Elder Abuse, particularly financial exploitation, is the biggest cross-cutting issue for all Elder Rights Programs. This Coalition meets monthly and has established a Strategic Plan, projects, committees and an 'extranet' site. Although the grant required that the Coalition be viable for at least one year, the AAA has continued to facilitate monthly meetings of the Coastal Alliance for the Protection of Elders (CAPE), a multi-disciplinary approach to educate the community about the growing epidemic of Elder Abuse. CAPE became stagnant in FY11 after the loss of the Elder Rights & Advocacy Program Manager. To revitalize

CAPE in FY12 the Coastal AAA partnered with the College of Coastal Georgia to utilize interns through the college's Business Leadership Program. Interns from the program will be used to market the Elder Rights Team, plan advocacy activities and assist with quarterly meetings. During FY2012 the Elder Right Team hosted Coastal's 1<sup>st</sup> walk-a-thon to heighten awareness regarding elder abuse. The event themed, "Stomp Out Elder Abuse," was a huge success with 200+ attendees. Activities are being planned for World Elder Abuse Awareness Day 2013. In June, Coastal AAA will host a second walk-a-thon to recognize the issues facing vulnerable older adults.

In addition, Elder Rights program staff is participating in other coalitions throughout the region including the Chatham County S.A.L.T. Council, the Chatham County Multi-disciplinary Team and the Glynn County Task Force Against Family Violence. Many of our cross-cutting issues identified by our Elder Rights Team are the focus of these Coalitions (Elder Abuse, Domestic Violence, Financial Fraud, Elder Shelters, etc.).

## **Elder Rights team:**

The Coastal Elder Right's Team is led by the AAA and co-led by our Elder Legal Assistance Program provider, Georgia Legal Services. The AAA solicits input from our ELAP provider, SALT and CAPE members in the development of the Elder Rights Plan. These groups collectively make up Coastal's Elder Rights Team and their input and recommendations drive the Team's activities and events.

POTENTIAL ELDER RIGHTS TEAM MEMBERS			
√	AAA staff	√	Georgia Legal Services
	AARP Chapter Representative	√	Health Department
	Adult Protective Services Representative	√	Hospitals
	Chiropractors		Judge or Clerks
	Community/Service Groups (Lions Club, Kiwanis Club Elks Club, etc.)	√	Law Enforcement
	Council on Aging	√	Local Attorneys
	Domestic Violence Advocates	√	Long-term care Ombudsman
	Dentists	√	Mental Health Professionals
	EMS/Paramedics		Neighborhood Watch Programs
√	Elderly Legal Assistance Provider	√	Older Persons who is an advocate
	Financial Institutions Employees		Rape Crisis Center Representative
	Faith based leaders	√	Solicitor or District Attorney
√	Gateway/ADRC Representative	√	Triad/SALT Council Representative
√	GeorgiaCares		Victim Witness Assistants
√	Other (describe): Adult Protective Services		Other (describe):

During 3<sup>rd</sup> quarter FY13 and leading up to World Elder Abuse Day 2013, lead staff from the AAA will be scheduling meetings with other agencies throughout the Coastal region identified as important partners for the Elder Rights Team. These meetings will be used to introduce new agencies to the issues being addressed by the Elder Rights Team as well as the team's purpose and goals. Interested agencies will be encouraged to join the Elder Rights Team and assigned activities towards accomplishing the team's FY14 goals and objectives.

We further anticipate participation on Coastal's Elder Rights Team will be positively impacted by the AAA's new approach to marketing and branding, as well as impacted by new

partnerships developed in FY12 as new programs and initiatives have been implemented.

**c) Describe the process for determining the cross cutting priority issue.**

**1. How and why was this issue chosen?**

During planning cycle FY2012-15, Coastal has used various methods to gather input from team members on the most relevant areas impacting our target population and the providers that serve them, such as group discussions, webinars, and on-line surveys. Further, Coastal AAA conducted a comprehensive needs assessment in 2010 to identify the needs

of older adults in the Coastal region. Public hearings are heard annually to further solicit input from the communities we serve about issues impacting vulnerable older adults. Through these processes, we have recognized that the need for increased awareness, funding, training, volunteers and resources remain the primary areas of focus. Thus the Elder Rights Team further recognizes the need to develop long-term goals that address multiple areas for improvement with objectives, that when accomplished, will offer lasting improvements to the service systems we operate under.

*2. Describe the envisioned role of each Elder Rights Team member will play in addressing this issue.*

Members of the Elder Rights Team work collectively to increase public awareness around elder abuse. Member organizations offer workshops and community education sessions on topics of consumer fraud and elder abuse. Further, team members and the agencies they represent partner with the AAA to host annual awareness events to increase outreach and educate the community about elder abuse. Team members will work with the AAA's Volunteer Coordinator to help identify volunteers that work with the team on plan activities. Lastly, the Elder Rights Team will assist the AAA in the development of the Advocacy Academy Program to further identify volunteers and advocates to work on elder rights issues.

**GOAL 4: Administration on Aging - Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

**Name of Service or Program: Elder Abuse and Consumer Fraud Prevention**

SFY 2012 Goal 4 – Objective #5	SFY 2012 Annual Performance Measure	SFY 2012 Action Steps	SFY 2012 Annual Update on Objective
Heighten public awareness amongst the community professionals in the aging network about elder abuse and consumer fraud for SFY 2012 – SFY 2015.	<ul style="list-style-type: none"> <li>In FY12, FY13, FY14 and FY15, the AAA will collaborate with other agencies to host at least one public-awareness event with a focus on elder abuse and consumer fraud prevention. At least 80% of those attending the event and completing a post event evaluation will report increased awareness about elder abuse.</li> <li>Use self-reporting measures utilizing surveys from at least 80% of those attending the event and completing a post event evaluation to report increased awareness about elder abuse.</li> </ul>	<ul style="list-style-type: none"> <li>The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event.</li> <li>During 4<sup>th</sup> quarter the AAA will host an awareness event on World Elder Abuse Awareness Day, June 15.</li> </ul>	On June 15, 2012, the Coastal Regional Commission of Georgia’s Area Agency on Aging along with the Coastal Alliance for the Protection of Elders (CAPE) celebrated community senior citizens by presenting their first annual World Elder Abuse Awareness Day Walkathon: “Let’s Stomp-Out Elder Abuse!” at the Glynn Place Mall in Brunswick. The event hosted over three hundred participants from the coastal region including sponsors, partners and presenters. In support of the public awareness, a website was created for the Coastal Alliance for the Protection of Elders (CAPE), <a href="http://www.protectcoastalelders.org">www.protectcoastalelders.org</a> .
SFY 2013	SFY 2013	SFY 2013	SFY 2013
Heighten public awareness amongst the community professionals in the aging network about elder abuse	<ul style="list-style-type: none"> <li>In FY12, FY13, FY14 and FY15, the AAA will collaborate with other agencies to host at least one public-awareness event</li> </ul>	<ul style="list-style-type: none"> <li>The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and</li> </ul>	<b>The AAA will host the 2<sup>nd</sup> Annual Walkathon: “Let’s Stomp Out Elder Abuse” to commence on June 14<sup>th</sup>.</b>

<p>and consumer fraud for SFY 2012 – SFY 2015.</p>	<p>with a focus on elder abuse and consumer fraud prevention. At least 80% of those attending the event and completing a post event evaluation will report increased awareness about elder abuse.</p> <ul style="list-style-type: none"> <li>• Use self-reporting measures utilizing surveys from at least 80% of those attending the event and completing a post event evaluation to report increased awareness about elder abuse.</li> </ul>	<p>other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event.</p> <ul style="list-style-type: none"> <li>• During 4<sup>th</sup> quarter the AAA will host an awareness event on World Elder Abuse Awareness Day, June 15.</li> </ul>	<p><b>Planning stages have begun for volunteer recruitment, sponsors and venue.</b></p> <p><b>The event was hosted on June 14<sup>th</sup> and attended by approximately 350 older adults, providers, advocates and other members of the community. The AAA is in the process of following up with all attendees via mail, email and by phone to solicit feedback on the event and to survey attendees on the effectiveness of the event. A summary report will be available in August.</b></p>
<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>	<p>SFY 2014</p>
<p>Heighten public awareness amongst the community professionals in the aging network about elder abuse and consumer fraud for SFY 2012 – SFY 2015.</p>	<ul style="list-style-type: none"> <li>• In FY12, FY13, FY14 and FY15, the AAA will collaborate with other agencies to host at least one public-awareness event with a focus on elder abuse and consumer fraud prevention. At least 80% of those attending the event and completing a post event evaluation will report increased awareness about elder abuse.</li> <li>• Use self-reporting measures utilizing surveys from at least 80% of those attending the event and completing a post</li> </ul>	<ul style="list-style-type: none"> <li>• The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event.</li> <li>• During 4<sup>th</sup> quarter the AAA will host an awareness event on World Elder Abuse Awareness Day, June 15.</li> </ul>	

	event evaluation to report increased awareness about elder abuse.		
SFY 2015	SFY 2015	SFY 2015	SFY 2015
Heighten public awareness amongst the community professionals in the aging network about elder abuse and consumer fraud for SFY 2012 – SFY 2015.	<ul style="list-style-type: none"> <li>In FY12, FY13, FY14 and FY15, the AAA will collaborate with other agencies to host at least one public-awareness event with a focus on elder abuse and consumer fraud prevention. At least 80% of those attending the event and completing a post event evaluation will report increased awareness about elder abuse.</li> <li>Use self-reporting measures utilizing surveys from at least 80% of those attending the event and completing a post event evaluation to report increased awareness about elder abuse.</li> </ul>	<ul style="list-style-type: none"> <li>The Special Projects Coordinator will work with CAPE, local elder abuse prevention coalition, and other local advocacy groups, such as SALT, FLETC Task Force for Prevention of Family Violence, to develop a plan for an annual public awareness event.</li> <li>During 4<sup>th</sup> quarter the AAA will host an awareness event on World Elder Abuse Awareness Day, June 15.</li> </ul>	

## D. REQUIRED PLANS: ATTACHMENT D-2 – LONG-TERM CARE OMBUDSMAN (LTCO) ANNUAL PLAN

### Georgia Community Long-Term Care Ombudsman Program

#### Annual Plan State Fiscal Year 2014

Community LTCO Program: *As of January 14, 2013 Ward Management gave notice to the State Long-Term Care Ombudsman Program and the Coastal Georgia Area Agency on Aging to terminate their contract on March 31, 2013. Due to this unforeseen circumstance, the Coastal LTCOP Coordinator is moving forward to make plans to submit a proposal for the program and enter into a contract to provide services for the Ombudsman Program. The staffing projections below indicate what staffing hours will be in FY 2014.*

Name of LTCO Director & Coordinator : Pam Lipsitz

#### A. General Program Information

##### I. Long-Term Care Ombudsman staff

How many hours are in a full-time work week in your agency? 40

List LTCO staff (certified or pending certification) and the hours per week they spend working for the LTCO Program<sup>1</sup>:

Ombudsman Program Director & Coordinator:	40
LTCO Assistant Program Coordinator:	40
Ombudsman Staff position:	40

List any non-certified LTCO staff (providing clerical assistance, but not directly serving residents through routine visits or complaint processing) and the hours per week they spend working for the LTCO Program:

Ms. Marcia Berens is a volunteer visitor who volunteers approximately 1-2 hours per month.

Al Ward is a program consultant who provides tech support and administrative support approximately 5 hours per month.

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<sup>1</sup> Indicate all hours worked to benefit the LTCO Program, including direct services to residents and LTCO program administration, such as staff supervision, volunteer management, and data entry.

The following volunteers all serve as non-certified volunteer visitors and are Student volunteers from South University and average volunteering 1-2 hours per month:

- |                     |                   |
|---------------------|-------------------|
| Morgan Bargstadt    | Allison Landing   |
| Amber Brown         | Levi Moore        |
| Marquivia Clark     | James O'Neal      |
| Jesse Decker        | Robert Raybon     |
| Christopher Dribble | Shirleen Thornton |
| Sheri Holland       | Megan Wright      |
| Jared Johnson       | John York         |
| Bill Johnson        |                   |

II. Volunteers<sup>2</sup>

- 0 LTCO Volunteers (Certified)
- 17 Volunteer Visitors
- 1 Volunteers who contribute in other ways
- 18 TOTAL (if a volunteer fits in more than one category above, include them only once in the total)

III. Facilities and Beds

- 28 Nursing Facilities
- 2628 Nursing Facility Beds
  
- 91 Personal Care Homes
- 1458 Personal Care Home Beds

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<sup>2</sup> This number should not include individuals whose sole volunteering role is serving on an advisory council or whose contribution to the LTCOP is related to their employment (e.g., guest speaker at an in-service training.)

## **Program Plan Mandatory Program Components**

### **A. Complaint Processing**

Indicate Program plans to provide prompt responses to complaints and confidential access to an ombudsman, including when ombudsman staff are not immediately available (for example, when staff are in the field, attending conferences, or on leave, or when positions are vacant).

Complaint processing is our program's top priority and complaints are resolved to the satisfaction of the resident as delineated in our program standards. The Coastal LTCOP will continue to meet the standards through the following measures:

1. Prompt responses to complaints will be assured by initiating responses and investigations from complaints received in person, by phone, fax or email as follows:

Abuse complaints in which the resident may be at risk will be responded to on the same day or by the next working day.

Abuse complaints in which there is no reason to believe the resident is at risk will be addressed within three working days, but not exceeding three calendar days when possible. Transfer and discharge complaints will be responded to within 5 working days if possible or by the last day of a bed hold or last day for filing an appeal. All other complaints will be processed within seven working days.

2. Adequate staff and telephone coverage is assured as follows: All staff has access to a voice mail system in which

they can retrieve messages in a timely manner. Our phone system is equipped with a toll-free phone number and fax number. All staff has access to email in order to communicate with each other as well as receive and send messages from the public and other professionals. Staff can also be located through Internet web sites such as NCCNHR, COCO and SLTCOP. An assigned LTCO staff will cover calls and cases due to other staff absences.

3. The Ombudsman staff will handle any complaints received in a confidential manner, unless the complainant authorizes them to disclose particular information. In some cases, complaints or issues are addressed without identifying the individual who made the complaint. The Ombudsman staff will ask the complainant and the resident how they want their complaint handled. Confidential information will not be disclosed without the express permission of the complainant or the resident. LTCO are also available to meet with complainants and residents (within the guidelines of our policies) in confidential meeting spaces. LTCO staff safety is of utmost concern when agreeing to meet any individuals in a private location. Staff may pair up for these visits and agree to meet individuals within a location that is mutually agreed upon.
4. Note: With the anticipated change in provider agencies, Ward Management and Coastal ConnectedCare have given the phone/internet service provider permission to transfer the account directly to Coastal ConnectedCare, Inc. Thus, we anticipate (without any errors by the provider company in the transfer) that the main phone number, toll-free number, fax number and email addresses will remain the same. In addition, our business address will remain the same.

Other information related to complaint processing:

1. The Coastal LTCOP has developed and utilizes a fact sheet that contains information about state and local resources that complainants may find helpful when pursuing resolutions to the issues or problems they are experiencing.
2. Referrals are made to DCH: Healthcare Facility Regulation Unit and Georgia Legal Services when appropriate.
3. Coastal staff discusses cases as needed in the processing of complaints. All staff may also call the SLTCOP for guidance and assistance.

Applicable Standards: Complaint processing is the highest priority service.

Adequate staff and telephone coverage must be available to assure prompt responses to complaints, within the standards of promptness.

Confidential access to an ombudsman must be available for individuals seeking assistance.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-101.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

## B. Information and Assistance

Indicate Program plans to provide prompt responses to requests for information and assistance and confidential access to an ombudsman, including when ombudsman staff are not immediately available (for example, when staff are in the field, attending conferences, or on leave, or when positions are vacant).

All information and assistance requests is responded to during the same day when possible and, in all cases, within two working days. The access procedures apply with I & A as described with complaint processing.

The Coastal Area Ombudsman Program will respond to phone requests for assistance within two (2) working days and answering machines will take messages while LTCO are working in the field. Also, LTCO staff will be reimbursed at the basic monthly rate for cell phone service, so that they may respond to calls while in the field.

Applicable Standards:

Respond to request for I&A during the same day whenever possible and, in all cases, within two (2) working days.

Adequate staff and telephone coverage must be available to assure prompt responses to I&A requests.

Confidential access to an ombudsman must be available for individuals seeking assistance.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-102.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

### C. Routine Visits

Indicate Program plans for routine visits as follows:

- 28 Current number of nursing homes
- 28 Number that will be visited during each calendar quarter (112 annual visits)
  
- 91 Current number of personal care homes
- 91 Number of personal care homes that will be visited during each calendar quarter ( 364 annual visits)

Routine visits will be conducted in order to create LTCO presence in facilities as frequently as possible. The minimum standards will be met when visiting each classification of long-term care facilities. At minimum, quarterly visits will be made to nursing homes and personal care homes. Problematic facilities

will be visited more frequently when possible. Routine visits are unannounced and staggered so that facility staff cannot predict the time of a visit. When routine visits are not needed between required visitation standard, consultations to facilities, phone calls to residents or resident council presidents/or families may be used to keep in contact with facility staff and residents and their representatives.

In addition, the Coastal LTCOP currently has 46 CLA facilities in the area with a total of 180 beds. Even though routine visits are not mandatory, complaint processing remains a priority. Therefore, LTCO staff will process complaints and incur routine visits in CLA facilities as needed. When visits are possible they will be made as well as facility consultations.

Applicable Standards:

LTCO presence in facilities should be as frequent as possible.

LTCO presence should be increased in facilities with a history of serious or frequent complaints.

Every nursing home in the services area shall be visited at least one time per quarter and the Program shall make every effort to make more frequent visits.

Every personal care home in the services area shall be visited at least one time per quarter and the Program shall make every effort to make more frequent visits.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-103.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### D. Issues Advocacy

Indicate what issue(s) the Program plans to address in SFY 2014 and what types of activities the Program plans to pursue in order to address the issue(s).

The Coastal Area Ombudsman Program will continue to address issues related to long-term care residents.

Locally, an area of advocacy that the Coastal LTCOP was heavily involved in was the funding of a special prosecutor of elder abuse in the Chatham county District Attorney's office. Our program will collaborate with the DA's office on elder abuse cases when appropriate and advocate as needed to continue the funding for this position. After a recent election, a new District Attorney has been elected and is continuing to support the special prosecutor on elder abuse cases.

Our program is planning to continue to focus on the issue of elder abuse. We plan to educate ltc consumers and families about elder abuse laws and our dedicated prosecutor in the Chatham county DA's office handling adult crimes. Our program will collaborate with the ADA assigned to elder abuse

cases and our Elder Abuse Multi-Disciplinary Team members on the successful case management, referrals to appropriate agencies, and prosecution of crimes against our elderly and disabled in long-term care facilities.

Other advocacy efforts may be coordinated as needed.

Applicable Standards:

The LTCOP is expected to identify issues impacting residents and participate in and appropriate advocacy activities to promote the interests of residents.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-104.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### E. Resident Councils

Calculate the minimum activities required for your area:

Resident Councils = 28 nursing homes x 100% = 28 (Note: 2 are TCUs in Hospitals and do not have resident councils or family councils). Therefore 26 nursing homes have resident councils.

Family Councils = 3 currently active nursing home family councils x 30% = 1

Indicate Program activities planned related to resident councils and family councils.

It is projected that the Coastal Area will have involvement in 100% of the 26 nursing facilities with resident councils in the service area, thus, 26 contacts with resident council activities will be provided. These contacts may be provided by: attending resident council meetings, visiting with the resident council presidents, reviewing minutes of the resident council meetings or writing to councils regarding our services.

To meet the standard for Family Council Involvement, there should be involvement with family councils in 30% of the active family councils. There are very few active family councils in the Coastal Area estimated to be 3 family councils, thus, 1 contact of family council activities will be provided. LTCO staff may attend family council meetings or provide other assistance to families such as: visiting with the president or officers of the council, planning a session with families on organizing a council, or providing telephone, email or mail information and assistance to families, staff or residents about family councils.

Applicable standards:

Involvement with resident councils in 100% of the nursing facilities in the services area.

Involvement with family councils in 30% of the active nursing home family councils.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-105 (for Resident Councils) and currently III – 203 (for Family Councils) to be changed to III-108 in proposed Policy Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### F. Volunteer Management

Indicate Program plans to recruit, train, retain, and/or manage volunteers.

There are currently eighteen volunteers utilized in the Coastal GA Area. We have been working with volunteers in the South University Pharmaceutical Program since 2005. They are primarily serving as volunteer visitors, but may pursue special projects as well.

Volunteers will be recruited as the need arises. Training of volunteers is carried out in accordance with the Volunteer Training Manual for the Long Term Care Ombudsman Program. Volunteers must be certified in order to handle complaint investigations. Volunteer visitors would only be allowed to make routine visits to nursing homes, personal care homes, and community living arrangements, but must bring any complaints

back to be handled by a certified ombudsman. They may assist with limited functions with supervision.

The Coastal LTCOP will provide recognition events or other recognition efforts for volunteers, as the budget will allow. In addition, the Coastal LTCOP will provide some incentives for volunteers as budgeted such as providing refreshments at volunteer recruitment sessions or meetings; sending out thank you cards to volunteers; and providing awards, certificates and plaques when appropriate.

Applicable standard:

The LTCOP shall utilize volunteers to maximize its resources to benefit residents.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-106.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### G. Nursing Home Pre-Survey Information

Indicate Program plans related to providing nursing home pre-survey information.

The Coastal LTCOP will provide pre-survey information for 100% of the surveys in the Coastal area for which the program receives timely notice. The Coordinator will retrieve survey information from the State LTCOP and relay it to the staff. In her absence, staff will retrieve the survey information. It is each staff person's responsibility to submit his or her pre-survey form to the SLTCOP by the due date. All Coastal Staff will ask for written verification from the SLTCOP of having received pre-survey information. The pre-survey form and verification fax or email notice stating that the form was received will be kept in the file for that facility.

Applicable standards:

The LTCOP shall provide nursing home pre-survey information to the Healthcare Facility Regulation Division of the Department of Community Health prior to 100% of surveys for which the Program received timely notice.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual §III-107.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### H. Community Outreach and Education

Indicate Program plans for community education sessions, media contacts (including press releases), exhibits, and/or other outreach activities.

Calculate the minimum community outreach activities required for your area:

Total LTCO staff work hours per week = 120 divided by 40 hours per full-time work week = 3.0 full-time equivalent (FTE)

$3.0 \text{ FTE} \times 4 = 12$  minimum community outreach activities required.

In FY 2014, the Coastal LTCOP will plan to meet the standard of 12 sessions of community education presentations, but strive to exceed this number, if possible. There are three FTE staff LTCO that will provide 4 sessions each for a total of 12 sessions.

Community education is shown by the activity codes for a community education session (3a) or other community education (3b) which includes presentations, program exhibits and special events for residents.

Work with Media and Press Releases are recorded as an activity for each LTCO, and can now be counted as community outreach or education. So, the Coastal LTCOP staff will count any media

press releases (20), interviews or discussions (19) as a community outreach and education unit. Press releases may be sent out around Resident's Rights Week or Older Americans Month, as an example.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual currently III – 201 to be changed to III-109 in proposed Policy Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### I. In-Service Education to Facilities

Indicate Program plans for in-service education to facilities.

Calculate the minimum education session required for your area:

$28 \text{ nursing homes} \times 50\% = 14$

In FY 2014, we plan to provide 14 sessions of in-service education to nursing facilities. This number is equal to 50% of the number of facilities in the Coastal area. One of these sessions will be made available to a larger number of personal care home providers in our service area.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual currently §III-202 to be changed to III-110 in proposed Policy Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### J. Interagency Coordination

Indicate Program activities planned related to interagency coordination.

Applicable standards:

The LTCOP shall develop relationships with other programs and agencies with resources, services and/or interests which could benefit residents and/or the Program.

In Chatham County, attendance at monthly Chatham County S.A.L.T. (Seniors and Law Enforcement Together) and Elder Abuse MDT (Multi-Disciplinary Team) meetings is made whenever possible. One staff member in Glynn County will attend the Glynn County CAPE (Coastal Advocates for the Protection of the Elderly) meetings, if active, whenever possible. Other staff continues to work with CCSP/Care-Net interagency meetings.

In addition to these planned goals, the Coastal staff will continue to serve in the following organizations: Georgia Council of Community Ombudsmen (Coordinator is serving as President); National Consumer Voice; Council of Advocates for Georgia's Elderly; and the Greater Savannah Coalition on Aging.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual currently §III-204 to be changed to III-111 in proposed Policy Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

#### K. Home Care Ombudsman

Indicate Program activities planned related to Home Care Ombudsman

Visits:

For those residents that transition under the Money Follows the Person Program and agree to have the Coastal LTCOP staff provide Home Care Ombudsman services, the first face to face (F2F) visit to each resident will be made within 30 days of discharge. Two additional face to face (F2F) visits will be made within the 6<sup>th</sup> month and 11<sup>th</sup> month of each residents return to the community. The LTCO staff will provide monthly phone contacts during the other months of the year of service under the MFP program. The MFP participant has the right to

suspend and resume these contacts during the 365 demonstration period.

Notes:

In addition to any confidential notes kept for each MFP participant, a case note will document each contact unit and kept in the MFP participant's file with a copy of the MFP Vendor Payment form for purposes of auditing.

Applicable standards:

The LTCOP shall contact at least monthly Face to Face (F2F) or phone call in accordance with MFP policies and procedures and the person's plan for services) each Money Follows the Person (MFP) participant assigned to the program; at least three of the monthly visits must be face to face in accordance with the Department of Community Health MFP Policies and Procedures which requires a F2F visit during the first 30 days post transition, at 6 months and again before the 11<sup>th</sup> month.

In addition to the confidential notes kept for each MFP participant, a case note is required to document each contact and shall be kept in the MFP participant's file with a copy of the MFP Vendor Payment form for purposes of auditing.

Reference: Proposed Georgia Long-Term Care Ombudsman Policies and Procedures Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? Yes

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

## II. Other Program Components

### Advisory Council

Indicate Program activities planned related to a Program advisory council.

The Advisory Component is considered "other" or "optional" and at this time. The Coastal LTCOP does not plan to have an advisory council.

Applicable standards: (Proposed Policy)

The LTCOP shall develop an active community LTCOP advisory council providing advice regarding the planning and operation of the community LTCOP.

Reference: Georgia Long-Term Care Ombudsman Policies and Procedures Manual currently §III- 205 to be changed to III-112 in proposed Policy Manual revisions.

Do the anticipated activities meet or exceed the applicable standards? No; the standard is not required.

NOTE: If the anticipated activities do not meet or exceed the applicable standards, the Program must request approval of a modified standard (please refer to Appendix I for guidance).

### M. Other Activities

Provide any additional information regarding planned program activities (such as special initiatives or projects, or program needs or barriers).

Currently, the Coastal LTCOP has no planned additional program activities.

**D. REQUIRED PLANS:**

**ATTACHMENT D-3 – SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM REQUEST FOR PROPOSAL**

**Not Applicable**

## E. AIMS BUDGET DOCUMENTS:

### ATTACHMENT E

Title III Federal Allocation and Match Analysis (Separate Excel spreadsheet)

AIMS Area Plan – Budget Fund Source Summary

AIMS Area Plan – Budget Service Summary

AIMS Area Plan – Provider Site List