A NEW LIFE
State of Georgia
Olmstead Strategic Plan
Governor Sonny Perdue
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A NEW LIFE (HOME PAGE INTRO)

A new life.

For many Georgians who are either aging or have mental illness or developmental disabilities, the chance to live in a community setting rather than an institution represents a new lease on life. The State of Georgia is dedicated to providing services for people with disabilities and the aging population in the most appropriate, integrated settings.

This site outlines Georgia's **Olmstead Plan**, including the State's strategies and achievements in improving the delivery of behavioral health and disability services to Georgians. This update to Georgia's Olmstead Plan is consistent with the Voluntary Compliance Agreement between the State and the U.S. Department of Health and Human Services Office for Civil Rights to improve access to community-based services for people with disabilities.

Georgia's Olmstead Plan represents a partnership between individuals, their families, communities, and state agencies to combine resources to achieve real community-based solutions for Georgians.

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I. HISTORY

Introduction

The legacy of institutionalized care for people with mental illness and developmental disabilities is not unique to Georgia. For decades, state hospitals were the primary source of care and services throughout the United States, with many hospitals reaching maximum populations by the 1960s and 1970s.

In Georgia, Central State Hospital in Milledgeville reached a population of nearly 13,000 patients by the 1960s – making it one of the largest institutions in the United States. Since that time, services for people with mental illness and developmental disabilities have increasingly focused on community-based solutions.

- Over the decades, Georgia has moved from one state asylum to several state hospitals to a growing reliance on community treatment (**see Section V., Achievement Report**, for more information about Georgia's work to transition people to community settings).

Home and Community-based services for **individuals with developmental disabilities** began in the late 1980s with the Home and Community-based Waiver. This waiver allowed the federal funds used to pay for institutional placement to be used to purchase home and community-based services and support with the stipulation that the average cost of a waiver not exceed the average cost of a person in institutionalized care. These services were expanded with the addition of another Home and Community-based Waiver program developed as a result of the closure of a facility in the late 1990s that served people with developmental disabilities.

These waiver programs provided the community-based services and supports that allowed for the transition of residents with developmental disabilities to the community. Since 1996, Georgia has closed three institutions for individuals with developmental disabilities:

- River's Crossing (37-bed facility for children with developmental disabilities)
- Brook Run (326-bed facility)
- Bainbridge (100-bed facility)

The growth of Georgia's **older adult** population has significantly outpaced the national average. Georgians are living longer on average and an increasing number are either elderly or have disabilities. Given the decline in family caregivers and the need for community housing and supports, Georgia faces a growing challenge in meeting the long-term care needs of older adults.

Since the early 1980s, the Community Care Service Program (CCSP) waiver has existed to help physically and functionally impaired elderly and disabled individuals live dignified and reasonably independent lives – either in their own home or with relatives or caregivers – through various community-based services. Since many older Georgians desire to live at home or with their families for as long as possible, the Georgia General

Assembly has recognized the need for a continuum of care that assures Georgians aged 60 and older have the least restrictive environment suitable to their needs. In addition, the General Assembly has recognized the need to maximize existing community social and health resources to prevent the unnecessary placement of individuals into long-term care facilities.

Olmstead v. L.C.

The *Olmstead v. L.C.* case, which involved two Georgia citizens with disabilities living in a state institution, held that "undue institutionalization qualifies as discrimination" under the Americans with Disabilities Act (ADA). The United States Supreme Court issued the *Olmstead v. L.C.* decision on June 22, 1999, ruling that unnecessary segregation of individuals in institutions may constitute discrimination based on disability.

The case recognized Georgia's need to maintain a range of services to support people with a variety of disabilities, including services that are community-based. The U.S. Supreme Court's decision suggested that a state could establish compliance with ADA if:

- It demonstrated it had a comprehensive, effective plan for placing eligible persons with disabilities in less restrictive settings.
- It kept a waiting list, subsequently called the Olmstead List **(****see Section III, Georgians Affected by the Olmstead Plan**, for more information**)**, that moves at a reasonable pace given available resources and that is not controlled by any attempt to keep state institutions fully populated.

Blue Ribbon Task Force

In response to *Olmstead v. L.C.*, the state undertook a number of initiatives to shape the development of Georgia's Olmstead Plan. The first of these was a Blue Ribbon Task Force on Home and Community-Based Services that convened in December 1999. The task force recognized that health and human services was moving away from institutionalized care in favor of community-based services and supports that prevent early and unnecessary institutionalization.

Blue Ribbon Task Force Recommendations

The Task Force, comprised of consumers, family members, advocates and professionals, presented a final report in January 2001 detailing the following key issues:

- The need for community-based services
- Barriers preventing access to existing community-based services
- Funding recommendations based on current actual funding and limited new funding
- Prioritization of services
- Possible criteria for waiting lists if funding is fixed or limited

The Task Force report included the following **behavioral health recommendations**:

Recommendation 1*: Commission a study that examines and quantifies Georgia's behavioral health needs, including identifying unmet needs.*

Recommendation 2: *Implement full behavioral health parity in all state insurance plans.*

Recommendation 3*: Create flexibility for consumers in the method of payment and treatment options.*

Recommendation 4*: Determine the number of children and adolescents with serious emotional disturbances (SED) who need services from the public sector.*

Recommendation 5*: Develop "safe havens" that provide treatment and care to homeless people with mental illness that can act as alternatives to crisis services and/or hospitalizations.*

Recommendation 6: *Encourage service providers to use best practices that emphasize the contributions of individuals with mental illness.*

Recommendation 7*: Strengthen employment services and vocational training for individuals with mental illness so more people can move off disability rolls and reduce demand for state-funded services and social programs.*

The Task Force report included the following **developmental disability recommendations**:

Recommendation 1*: Implement a multi-year funding plan for the developmental disability waiting lists.*

Recommendation 2: *Address reimbursement for the Mental Retardation Waiver Program (MRWP) services, which are still based on 1993 cost reports.*

Recommendation 3*: State grant-in-aid dollars in the mental retardation service system should not be supplanted by Social Services Block Grant (SSBG) dollars.*

Recommendation 4*: Develop and implement a major information, education and outreach initiative.*

Recommendation 5*: Strengthen and expand family support services.*

Recommendation 6: *Change eligibility and program names from Mental Retardation to Developmental Disabilities.*

Recommendation 7*: Seek grants to assist with transition planning.*

Recommendation 8*: Document how existing funds are allocated and used.*

Olmstead Planning Committee

In 2000, Georgia established an **Olmstead Planning Committee.** The Department of Human Resources (DHR), acting as the lead state agency, applied for and received a grant from the Center for Health Care Strategies that enabled the **Olmstead Planning Committee** to be established. This committee included:

- Consumers of services
- Members of consumers' families
- Advocates
- Service providers for people with disabilities
- Leaders of the Department of Community Health (i.e., Medicaid) and the Department of Human Resources (i.e., Division of Mental Health, Developmental Disabilities and Addictive Diseases; Division of Aging Services, Division of Family and Children Services, and the Office of Regulatory Services).

The Olmstead Planning Committee and its various workgroups met between February and October of 2001 to incorporate and extend the work of the Blue Ribbon Task Force. The Committee's final report and recommendations, completed in November 2001, were presented to the DHR Commissioner and DCH Commissioner on January 30, 2002.

Role of Olmstead Planning Committee

The **Olmstead Planning Committee (OPC)** is created by the Governor by executive order and housed under the Governor's Office. Chaired by the **Olmstead Coordinator**, the OPC is composed of individuals with mental illness, developmental disabilities, and/or addictive diseases; their families; advocates; community-based providers; and state agency representatives. The Governor selects and funds the OPC.

The key functions of the OPC include:

- Approving Georgia's Olmstead Plan.
- Soliciting and including the views of a cross-section of stakeholders in community services for institutionalized individuals.
- Addressing all issues pertinent to creating a comprehensive and effective Olmstead Plan, including:
    - Data collected by the State to assess the need for community services
    - State resources for providing community services and determining how resources can be better utilized
    - Determining whether the State's policies are consistent with Olmstead goals and the Voluntary Compliance Agreement (and if not, what policy changes are necessary to meet obligations)
    - Any other issues the OPC believes are important to the Olmstead Plan effort
- Reviewing regular progress reports on meeting the Olmstead Plan goals.

- Issuing an annual Olmstead Report each December to the public that details the State's progress in achieving the Olmstead Plan goals. The annual Olmstead Report includes:
    - Policy proposals
    - Recommended funding for initiatives and resources
    - Assessment of the State's community service needs
    - Solicitations for stakeholder comments and concerns

Olmstead Planning Committee Recommendations

The Olmstead Planning Committee's final report included a set of **recommendations** for the process of identification, education, assessment, planning and movement of institutionalized individuals organized by different populations. In addition, the Committee had recommendations for systems capacity and resources for housing and transportation infrastructure, service expansion, provider development and workforce development.

Behavioral Health Gap Analysis

Background

In 2004, Georgia commissioned the first Gap Analysis of its behavioral health delivery system. The findings of the analysis, requested by Georgia's federally mandated Mental Health Planning and Advisory Council, were released in 2005.

The Georgia Mental Health Gap Analysis revealed the following priority resources that were inadequate to meet the needs of adults with serious mental illness or children and adolescents with serious emotional disorders in Georgia.

- State spending on public behavioral health services was not keeping pace with Georgia's population growth or demand for community-based services.
- Public behavioral health services reached less than a third of those estimated to have a serious mental illness or a serious emotional disturbance who would be eligible for publicly funded services.
- The behavioral health system struggled to serve special populations, such as transitional youth (aged 17 to 24), individuals with limited English proficiency or sensory impairment, certain minorities, and older adults, in Georgia.
- Despite high numbers of Georgians needing services, many were not receiving the intensity of care their condition required.
- Community providers had inadequate staffing ratios to meet the minimum needs for services.
- A fragmented infrastructure for financing, accounting and managing information did not support the goal of measuring utilization, trending and planning for system needs.
- State hospitals appeared to be overburdened trying to make up for the lack of community-based services.

- Focus groups and surveys revealed a fragmented vision for an improved behavioral health system.

The Georgia Mental Health Gap Analysis also identified areas where Georgia had excelled despite several barriers.

- In 1999, Georgia obtained approval from the Centers of Medicaid and Medicare (CMS) to offer several innovative community-based services. In fact, Peer Supports was pioneered in Georgia as a Medicaid billable service that is nationally recognized.
- At the local level, there were positive examples of innovative programming, collaboration across agencies and technologically advanced solutions that resulted in quality care and high consumer satisfaction.

Developmental Disability Gap Analysis

Background

In 2005, Georgia became the 26th state to join the National Core Indicators (NCI) Consortium, sponsored by the Human Services Research Institute. The resulting NCI survey identified gaps in Georgia's service delivery for people with developmental disabilities by benchmarking the State's efforts with other NCI states.

Georgia's NCI developmental disability gap analysis revealed that Georgia families perceived the following gaps in community services compared to other NCI states:

- Less involvement in their plan development
- Fewer Individual Service Plans reflecting personal preferences
- Less participation in choosing their providers of services
- Less participation in choosing their support workers
- Less control in hiring staff
- Less understanding on how mental retardation and developmental disability finances are spent

Georgia used the NCI results above to rewrite its Home and Community Based Waivers for Persons with Developmental Disabilities targeting the specific areas needing improvement.

Voluntary Compliance Agreement

In 2005, the Office of the Governor and the Department of Human Resources began negotiations with the U.S. Department of Health and Human Services Office for Civil Rights, which led to the signing of a Voluntary Compliance Agreement (VCA) on July 1, 2008, between the State of Georgia and the U.S. Department of Health and Human Services Office for Civil Rights. The provisions of this agreement are described in the following sections.

According to the agreement's preamble, the parties agreed that:

- Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the basis of disability and require public entities (including state governments) and recipients of federal financial assistance to administer services, programs and activities **in the most integrated setting appropriate to the needs of qualified individuals with disabilities**.
- Unnecessary institutionalization of individuals with disabilities can constitute discrimination under the ADA when the state's treatment professionals determine that community-based treatment is appropriate and the affected individual does not oppose it.
- **A state's responsibility is not "boundless."** States can weigh the needs of others with disabilities, including people requiring institutional levels of care.
- The Georgia Department of Community Health (DCH) and the Georgia Department of Human Resources (DHR) recognize an independent obligation under Georgia law to provide community-based services to people with intellectual and developmental disabilities (DD) and/or people with behavioral health disabilities (MH).
- DCH and DHR want state-operated facilities to adopt a treatment goal to treat qualified individuals with disabilities in the most integrated setting that:
    - Reflects their needs and their choice.
    - Ensures their care is directed toward acquiring skills and abilities that promote as much independence, autonomy, and development as possible.
- Certain public interest organizations that advocate for the rights of persons with disabilities (i.e., Georgia Advocacy Office, the Atlanta Legal Aid Society Inc., the Georgia Legal Services Program and the Disability Law Policy Center of Georgia Inc.) filed class complaints with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) alleging that the Respondents (i.e., DCH, DHR, Gracewood State School and Hospital, and Region 12 MH/MR/SA) failed to treat qualified persons with developmental disabilities and/or mental illnesses in the most integrated setting appropriate in violation of Title II of the ADA.
- **The State** (i.e., DCH, DHR and the Governor's Office through the Olmstead Coordinator) **denies any violation of the ADA or Section 504, and does not admit to any such violation by entering into the agreement**.
- The State wants to clarify how it will organize and make available federal, state and local resources to ensure qualified persons with DD and/or MH receive services in the most integrated setting appropriate to their needs and in full compliance with the spirit, intent, and letter of the ADA and Section 504.
- OCR would suspend its investigation of the Georgia class complaints while the State cooperated with OCR to increase the delivery of services in the community.

Key Planning Provisions of the Voluntary Settlement Agreement

<u>Olmstead Coordinator</u>

One of the key provisions of the Voluntary Compliance Agreement between Georgia and U.S. Department of Health and Human Services Office for Civil Rights is the creation of an Olmstead Coordinator.

The Olmstead Coordinator:

- Reports directly to the Governor of Georgia
- Receives reports from State agencies with Olmstead obligations about their Olmstead activities
- Develops and implements all Olmstead Plan objectives
- Addresses all concerns related to the implementation of the plan

Assessing Statewide Need for Community Services

The Olmstead Coordinator, Department of Human Resources and Department of Community Health will collect data to estimate the need for community services in Georgia for individuals with developmental disabilities or mental illness who are currently institutionalized or at risk of institutionalization. The data will include the number of institutionalized people determined appropriate for community services, as well as the number of people at risk of institutionalization due to lack of services. The data will be published annually as part of Georgia's Annual Olmstead Report and be used to assess the need for community services.

Revising the State Olmstead Plan

A provision of the Voluntary Compliance Agreement requires Georgia to develop a new draft of its multi-year Olmstead Plan within seven months of the agreement's effective date.

This revised plan must include:

- An annual schedule of anticipated discharges of institutionalized individuals with developmental disabilities and mental illness without identifying their names.
- A comprehensive and effective plan to treat all institutionalized persons having a preference to be served in the community
- Information on obtaining and maintaining necessary community services for individuals at risk of being institutionalized.
- Approval by the **Olmstead Planning Committee**.

Implementation of the Voluntary Compliance Agreement

The State of Georgia follows a **timeline** to implement the goals of the Voluntary Compliance Agreement (VCA). Each step represents a significant advance toward achieving the plan and ensuring more Georgians are able to transition into community settings.

Georgia must accomplish the following:

- Designate Olmstead Coordinator (**See Section I, History**, for more information) (effective 7/14/2008)

- Issue Executive Order appointing members of Olmstead Plan Committee (effective 9/27/2008)
- Publish online list of community service programs for all interested persons (effective 9/3/2008).

Georgia must accomplish the following key behavioral health goals:

- Implement a procedure for conducting monthly tours of State-operated behavioral health facilities to examine individual Person Centered Transition Plans (**see Section III, Georgians Affected by the Olmstead Plan** for information) and assessments of individuals determined not appropriate for community service (effective 7/14/08).
- Assess all individuals with mental illness institutionalized more than 60 days (as of 7/1/2008) who have not already been determined appropriate for community services (effective 11-28-08).
- Provide to U.S. Department of Health and Human Services Office for Civil Rights a dated list of all individuals on the Behavioral health Olmstead List (effective 11/28/2008).
- Review a sample of Person Centered Transition Plans of individuals with mental illness to assess competent assessments, reasonable discharge dates and conditions related to discharge dates (effective 12-31-08).
- Collect after-care data to determine if behavioral health Person Centered Transition Plans are efficient and provide policies to Office for Civil Rights for review prior to implementations (12-31-08).

Georgia must accomplish the following key behavioral health goals on a monthly basis:

- Provide Olmstead Coordinator with monthly progress report specifying:
    - Number of individuals with mental illness newly admitted or readmitted to State-operated facilities
    - Number of individuals receiving services by the discharge date specified in their Person Centered Transition Plan
    - Number of individuals not receiving community services by discharge date and the length of their delays
    - Number of individuals awaiting community services longer than 60 days after discharge
- Review Monthly Progress Reports and compliance concerns raised by Office for Civil Rights.
- Assess whether individuals with mental illness hospitalized longer than 60 days are ready to transition into community.
- Review samples of completed behavioral health assessments of individuals deemed not appropriate for community placement and individuals whose transition is planned. Treatment professionals will be consulted if there is disagreement; if no agreement is reached, Olmstead Coordinator will review.
- Conduct monthly tours of State-operated behavioral health facilities (one hospital per month) to examine individual Person Centered Transition Plans and assessments of individuals determined not appropriate for community placement.

Treatment teams for other State facilities will participate by telephone in each tour.

Georgia must accomplish the following key developmental disability goals:

- Implement a procedure for conducting monthly tours of State-operated developmental disability facilities (one per month) to examine individual Person Centered Descriptions (**see section III, Georgians Affected by the Olmstead Plan**, for more information), Transition Plans and assessments of individuals determined not appropriate for community service. Treatment teams from other State facilities will participate by telephone for each tour (effective 7/14/2008).
- Conduct Person Centered Planning (**see Section III, Georgians Affected by the Olmstead Plan**, for more information) process for all institutionalized persons with developmental disabilities yet to go through the process (effective 11/28/2008).
- Provide to Office for Civil Rights a data list of all individuals on the Developmental Disabilities Olmstead List (**see section III, Georgians Affected by the Olmstead Plan**, for more information) (effective 11/28/2008).
- Create developmental disability community training plan and submit with any accompanying training materials to Office for Civil Rights for comment (effective 12/31/2008).
- Collect developmental disability after-care data to determine if transition plans are efficient and provide policies to Office for Civil Rights for review prior to implementations (effective 12/31/2008).
- Review a sample of individual developmental disability transition plans (effective 12/31/2008).

Georgia must accomplish the following key developmental disability goals <u>on a monthly basis</u>:

- Provide Olmstead Coordinator with monthly progress report specifying:
    - Number of individuals with developmental disabilities newly admitted or readmitted to facilities
    - Number of individuals receiving services by their discharge date specified in their transition plan
    - Number of individuals not receiving community services by their discharge date and the length of their delays
    - Number of individuals awaiting community services longer than 60 days after their discharge
- Conduct monthly tours of State-operated Developmental disability facilities (one per month) to examine individual Person Centered Descriptions, transition plans and assessments of individuals not appropriate for community placement. Treatment teams from other State facilities will participate by telephone in each tour.

Complete Text of the Voluntary Compliance Agreement

Please follow the links below to access any section of full text of the Voluntary Compliance Agreement.

II. PURPOSE AND GOALS OF THE OLMSTEAD PLAN

Purpose

The purpose of the Olmstead Plan is to create a comprehensive, effective plan for assisting eligible persons to live in less restrictive settings. Eligible people include:

- **People with developmental disabilities** currently in State-operated facilities for longer than 60 days who are eligible for appropriate community services in the most integrated setting appropriate to their needs and who do not oppose community services.
- **People with behavioral health conditions** currently in State-operated facilities for longer than 60 days who are eligible for appropriate community services in the least restrictive setting appropriate to their needs, who do not oppose community services and who can lively safely with such services.
- **Older adults** currently living in institutions who are eligible for appropriate community services in the least restrictive setting appropriate to their needs, who do not oppose community services and who can live safely with such services.

Guiding Principles for Georgia's Olmstead Plan

- **Person-Centered Focus –** Eligible individuals are the focus and, along with their family and significant others, have an active role in the planning, delivery and evaluation of their services. Person-centered focus includes awareness and appreciation of cultural diversity.
- **Valuing Diversity –** Communities benefit from people with disabilities in many ways, including from their cultural diversity. It is a privilege and a responsibility for Georgia to assist these individuals in engaging in meaningful lives in the community. In doing this, the State compassionately understands the challenges that these individuals are facing.
- **Consistency of Services** – Service systems will be designed to ensure services are timely, consistent, dependable and appropriate.
- **Available and Accessible Services** – Individuals have access to the services they need.
- **Most Integrated Setting Appropriate to Individual Needs** –Individuals make informed choices about service options in order to have meaningful lives in the community.
- **Collaboration with Stakeholders** – We collaborate and create partnerships with individuals receiving services, their families; advocacy groups; faith-based organizations; nonprofit organizations; public and private entities; and federal, state and local agencies.
- **Equitable Allocation of Resources** – Because the State must support with appropriate services a large and diverse population of people with disabilities, available resources should be allocated in as equitable a manner as possible,

taking into account the needs of persons already being served and those waiting for services.

Goals

The goals of Georgia's Olmstead Plan are to:

1. Create a practical structure for reviewing, providing public input and making recommendations for implementing the Olmstead Plan.
2. Identify ways to improve the delivery of integrated community services and resources for older adults and other people with disabilities in a holistic approach.
3. Ensure individuals served, family members, and other stakeholders are essential contributors to the ongoing process of improving integrated community services.
4. Establish sustainable processes for identifying, assessing and planning with eligible individuals in Georgia.
5. Utilize the annual budget planning process to support agency operational plans related to the Olmstead Working Plan.
6. Establish a philosophical and practical framework that provides direction for state agency operational strategies to address Olmstead.
7. Provide information and education regarding the rights of older adults and other people with disabilities to live in integrated community settings.

III. GEORGIANS AFFECTED BY THE OLMSTEAD PLAN

In accordance to the Olmstead ruling, Georgians affected by the Olmstead Plan include qualified individuals with a disability who meet the criteria established under the Americans with Disabilities Act (ADA), and who:

- Have a recommendation for a less-restrictive placement from their treatment professionals.
- Do not oppose the recommended placement.
- Do not require the State to make fundamental alterations of its services and programs that impact other persons in need of service.

Georgia's Olmstead Plan specifies guidelines for assessing and identifying qualified individuals with disabilities, as well as ensuring these individuals can make informed choices. These qualified individuals include:

- Children and adults with serious mental illness and/or serious emotional disturbances
- Children and adults with mental retardation and/or developmental disabilities
- Children and adults with physical disabilities and/or motor impairments (i.e., hearing impaired, visually impaired, Spina Bifida, etc.)
- Older adults with functional limitations and/or disabilities
- Adults with traumatic brain injury

Individuals in the groups identified above include:

- People who reside in State-operated psychiatric hospitals
- People who reside in State-operated and private intermediate care facilities and skilled nursing facilities
- People who reside in nursing homes
- People who are in acute-care hospitals
- People at risk of institutionalization

Several State agencies (including the Department of Human Resources and the Department of Community Health) are responsible for the services and supports for those disabled Georgians who meet the above criteria. The ongoing collaboration of these agencies is necessary to further Georgia's efforts to meet the needs of this population.

Olmstead Lists

Georgians affected by the Olmstead Plan, including those who reside in State-operated facilities and those who meet certain criteria, make up the **Behavioral Health Olmstead List** and the **Developmental Disabilities Olmstead List**.

Behavioral Health Olmstead Lists

There are two behavioral health lists. The larger list is the **Behavioral Health Olmstead List**, which includes individuals in state hospital behavioral health units who:

- Have met criteria for the Behavioral health Planning List
- Are not on a forensic legal status
- Do not object to community placement (or in cases of a legal guardian, the guardian does not object).

The Behavioral Health Planning List is a subset of the Behavioral Health Olmstead List and includes individuals in State hospital behavioral health units who:

- Have been hospitalized for more than 60 days
- Have been assessed by clinical criteria and determined by the treatment team to be appropriate for transition to a less restrictive environment with appropriate supports.

Developmental Disabilities Olmstead List

The **Developmental Disabilities Olmstead List** includes all individuals with developmental disabilities residing in State institutions who do not oppose (or their legal guardian does not oppose) being transitioned from the hospital to receiving services in the community. Individuals in State institutions who indicate a desire to live in the community are considered to have the highest priority for community placement. For those individuals unable to communicate their preference, the perspective of family or representative regarding the desire for the individual to live in the community is

considered. Children are considered a priority for transitioning to the community. When referring to "older adults," the term usually refers to individuals who are aged 60 years or older.

The **Developmental Disabilities <u>Transition</u> List** is created annually. This list identifies the specific individuals on the Developmental Disabilities Olmstead List who the Department of Human Resources plans to discharge to the community within the fiscal year.

NOTE: "Older Adults" generally refers to individuals who are aged 60 and older, as defined by the Aging Network for federal Older Americans Act and other state or local programs.

Person Centered Planning

While the Olmstead Plan mainly focuses on the individuals being transitioned from institutions to community life, their families, representatives and significant others are vital participants in the process. The Person Centered Planning process includes two kinds of plans – the **Person Centered Transition Plan (PCTP)** and the **Person Centered Description (PCD)**.

Person Centered Transition Plan (PCTP)

The Olmstead Plan requires that a Person Centered Transition Plan (PCTP) be developed for every person on the Behavioral Health Olmstead List. The plan includes an individual's preferences, service needs and anticipated discharge date from the hospital.

Person Centered Description (PCD)

The Olmstead Plan requires that a Person Centered Description (PCD) be developed for every person on the Developmental Disabilities Olmstead List. The PCD identifies the individual's preferences, strengths, capacities, needs and desired outcomes. This information is used with a transition plan that includes the anticipated discharge date from the hospital.

IV. NEW LIFE: INDIVIDUAL PROFILES

The transition from institutional care to receiving community services represents many personal stories of exciting new beginnings. People faced with a wide variety of disabilities have embraced a new life in their communities after months or years in institutionalized care. Each Olmstead profile puts a human face on Georgia's mission to provide services that ensure a meaningful life in the community for older Georgians and persons with mental illness and developmental disabilities.

The Art of Living

Walter P. Norman, Jr., is quick to describe himself as a famous artist.

It's easy to see why. His original works are on display at Creative Expressions Studio & Gallery at the Baldwin County Service Center in Milledgeville, Georgia. Known as the "Art House," the studio specializes in original paintings, drawings, jewelry, wreaths and other creative works by former residents of Central State Hospital. Walter was discharged from Central State in July 2007. He now lives in a community home and works at the Baldwin Service Center.

Walter's life has been enriched since he was able to transition back into the community. And his art career has taken off. Walter was selected to be a featured self-taught artist in an exhibit sponsored by the Middle Georgia Art Association.

V. ACHIEVEMENTS and CHALLENGES

This section of Georgia's Olmstead Plan provides an overview of what Georgia has accomplished toward the goals of the Olmstead Plan. Georgia's effort to assist individuals with disabilities to transition from institutions to community settings predates the U.S. Supreme Court's *Olmstead v. L.C.* decision and has continued since the decision.

Accomplishments include:

- **Dedicated staff for Olmstead Plan** – Since 2004, 233 staff positions have been added to support transitioning individuals with developmental disabilities to community services. In fiscal year 2007, seven new Case Expeditor positions were added. Case Expeditors assist with the transition of individuals out of state hospitals and into the community.
- **Increased hours of active treatment within State hospitals** – This has contributed to the reduced length of stay for most individuals who enter hospitals.
- **Easier access to information and services** – the 24-hour, seven-days-a-week **Georgia Crisis and Access Line** (GCAL) provides a single point of entry to behavioral health, addictive diseases and crisis services throughout Georgia
- **Nationally recognized peer support services for individuals in recovery** – Georgia is recognized nationally as a model for peer support services. These services include peer support centers focused on recovery and staffed by certified peer specialists. In addition, there are Peer Mentors, Double Trouble in Recovery Facilitators, Trauma-Informed Peers, and peer staffing of wellness initiatives
- **New waivers for persons with developmental disabilities** have been approved by the federal government. These waivers define eligibility, types of services and supports, methodology for determining allocation and rates.
- **Reimbursement to providers of community developmental disabilities services** increased by 3% over the 2006 rates.

- **A multi-year funding commitment was developed** by the Department of Community Health (DCH) and the Department of Human Resources (DHR) to unlock the waiting list for home and community-based services. This plan addressed the waiting list and substantial progress has been made.
- **Statewide family forums** on the new Home and Community-based Waiver Programs, the New Options Waiver and the Comprehensive Supports Waiver. These forums described available services in these programs and provided information on how to access these services.
- **Training on self-directed services and best practices for developmental disability services**. The State developed websites informing families of available services and access to these services.
- **Information provided to individuals in nursing homes and developmental disability facilities** about available community services.
- Partnering with the Governor's Council on Developmental Disabilities to **develop a statewide network of family support services**. Georgia added Natural Support Enhancement services to its Home and Community-based Waiver Program in 2002. The ability to self-direct these services was added in 2006. The New Options Waiver and Comprehensive Supports Waiver, both effective in 2008, are providing increased opportunity and choice in services that support families, including enhanced opportunities for self-direction of waiver services.
- **Obtaining four grants from the Centers of Medicare and Medicaid Services** that assisted with transition planning. Grant-funded projects included:
    - Transition planning for individuals in nursing homes, housing and workforce development.
    - Enhancing peer support to help people transition from institutions to community services.
    - Improving communications to consumers and their families and across agencies.
    - Planning for the implementation of self-direction of home and community-based services.
- **New funding for people with developmental disabilities for community services** totaling $157 million - resulting in 3,000 additional people receiving services in fiscal years 2006, 2007 and 2008. It is expected that an additional 350 people will receive services in fiscal year 2009.
- **Participating in the federal Money Follows the Person** initiative to move 600 people from Georgia institutions to community supports and services before fiscal year 2013.

Georgia has also worked on behalf of older adults and people with physical disabilities. Highlights of these accomplishments include:

- **Easier access to information and services** – The Department of Human Resources (DHR) Division of Aging Services (DAS) works to ensure that outreach, information and assistance regarding home- and community-based services are available to older Georgians. In conjunction with the Area Agencies on Aging (AAAs), DAS created the Gateway information system for this purpose. Gateway receives federal and state funding to provide accurate information on

available resources and access to home- and community-based services for older and disabled adults, their families and caregivers.

- **Standardized screening and assessment** – The Gateway system uses a standardized process to assess an individual's impairment level, unmet needs and what services are required to keep that person in the community. In addition, waiting lists for both the Community Care Services Program (CCSP) and non-Medicaid Home and Community Based Services are maintained.
- **Investments in Aging and Disability Resource Connection** – Georgia has approved state funds to build on a federal Aging and Disability Resource Connection (ADRCs) grant. ADRCs are a partnership of the Division of Aging Services (DAS) and the Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) which establishes no wrong door for individuals with disabilities of any age to receive information, assistance and referral to available long term care supports or services in the community.
- **Increased provider reimbursement rates** – Reimbursement to service providers has increased 14 percent under the Community Care Services Program (CCSP).
- **Increased focus on quality assurances to enroll qualified providers.** Georgia has developed monitoring and quality assurance tools to focus on encouraging qualified providers.
- **More informed selection of long-term care options** – The Georgia Department of Community Health (DCH) developed an easy-to-read booklet that highlights eligibility requirements and point of entry for the Home and Community-based Waiver programs, including the Money Follows the Person Initiative. To date, more than 130,000 booklets have been distributed with primary distribution points including all admissions to nursing homes, all individuals admitted to waiver programs, hospitals and in public forums, and events throughout Georgia. Additionally, DAS continues to provide public information about a wide variety of services through its Gateway information, assistance and referral operation, including services available through Medicaid waivers and in the community.
- **Shifting resources to the community –** Georgia has used **Nursing Home Transition Grants** in the past to identify individuals who wish to leave institutions and supports their living in the community. The state participates in the Nursing Home Diversion Modernization Grants project – a federal competitive grants opportunity designed to assist individuals at risk of nursing home placement to receive home and community-based services that enable them to continue to live in the community.
- **Improving consumer services** – Georgia funds the **Aging and Disability Resource Connection (ADRC)** that provides outreach, benefits counseling and information that allows individuals with disabilities, their families and caregivers to make more informed decisions about addressing their long term care needs. In addition, ADRC web sites have been established to make it easier to access information about home and community based alternatives to institutional services.
- **Depression screening and intervention** – DAS, in partnership with the Fuqua Center on Late-Life Depression at Emory Healthcare and the Area Agencies on Aging, continues to provide depression screening for CCSP participants.

Intervention measures include identifying at-risk individuals at the local level, identifying needed behavioral health services, training care coordinators to recognize depression symptoms and obtaining resources to provide services.

Monthly Olmstead Progress Report

According to the Voluntary Compliance Agreement between Georgia and the U.S. Department of Health and Human Services Office for Civil Rights, the State must report on the status of Olmstead activities to the **Olmstead Coordinator (**see Section I, History, for more information about Olmstead Coordinator**)** on a monthly basis.

The Olmstead Coordinator reviews the Monthly Progress Reports and any compliance concerns raised by the Office for Civil Rights. If deadlines are not met or progress is insufficient, the Olmstead Coordinator will convene a meeting with the affected State agencies within a month to determine what policy, administrative, resource, and budgetary changes are necessary in the upcoming quarter to achieve the required progress toward the State's Olmstead Plan.

This section provides the Olmstead Progress Report for the latest month available.

Behavioral Health Monthly Progress Report

		Sept 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	March 2009	April 2009	May 2009	June 2009	July 2009	Aug 2009
1	Individuals admitted to state hospitals												
2	Individuals placed on Olmstead List												
3	Individuals removed from Olmstead List												
4	Olmstead List readmissions												
5	Individuals on state hospital census at end of month												
6	Individuals on Olmstead List at end of month												
7	Individuals discharged from state hospitals												

		Sept 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	March 2009	April 2009	May 2009	June 2009	July 2009	Aug 2009
8	Individuals on Olmstead List discharged												
9	Individuals on Olmstead List discharged to community services												
10	Number of individuals on Olmstead List not receiving services by planned discharge date												
11	Average number of days waiting for community services												
12	Median number of days waiting for community services												
13	Number of individuals on Olmstead List waiting > 60 days past planned discharge date for community services												
14	Number of individuals on Olmstead List waiting > 90 days past planned discharge date for community services												

DESCRIPTION OF DATA ELEMENTS

1. Unduplicated count of individuals admitted to adult behavioral health units during specified period
2. Unduplicated count of individuals placed on Olmstead List during specified period (These individuals may have previously been on Olmstead list but were removed.)
3. Individuals removed from Olmstead List during specified period because they no longer met discharge criteria

4. Number of individuals previously on Olmstead List who were discharged but later readmitted to state hospital (These individuals may be counted in #2.)
5. Census on adult behavioral health units on last day of month
6. Individuals on Olmstead List on last day of month
7. Unduplicated count of individuals discharged from adult behavioral health units during specified period
8. Number of individuals on Olmstead List discharged during specified period (They may or may not be discharged to community services.)
9. Number of individuals on Olmstead List discharged to community services during specified period (Individuals also included in #8)
10. Number of individuals on the Olmstead list during specified period who remained in the hospital past their planned discharge date
11. For individuals in #10, the average number of days between planned discharge date and actual discharge date/last day of month
12. For individuals in #10, the median number of days between planned discharge date and actual discharge date/last day of month
13. For individuals in #10, the number of individuals where the difference between planned discharge date and actual discharge date /last day of month is > 60 days
14. For individuals in #10, the number of individuals where the difference between planned discharge date and actual discharge date /last day of month is > 90 days (Consent agreement requires description of barriers to discharge and a Corrective Action Plan.)

Developmental Disabilities Monthly Progress Report

		Sept 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	March 2009	April 2009	May 2009	June 2009	July 2009	Aug 2009
1	Individuals admitted to state hospitals												
2	Individuals placed on Olmstead List												
3	Individuals removed from Olmstead List												
4	Olmstead List readmissions												
5	Individuals on state hospital census at end of month												
6	Individuals on Olmstead List at end of month												
7	Individuals discharged from state hospitals												

		Sept 2008	Oct 2008	Nov 2008	Dec 2008	Jan 2009	Feb 2009	March 2009	April 2009	May 2009	June 2009	July 2009	Aug 2009
8	Individuals on Olmstead List discharged												
9	Individuals on Olmstead List discharged to community services												
10	Number of individuals on Olmstead List not receiving services by planned discharge date												
11	Average number of days waiting for community services												
12	Median number of days waiting for community services												
13	Number of individuals on Olmstead List waiting > 60 days past planned discharge date for community services												
14	Number of individuals on Olmstead List waiting > 90 days past planned discharge date for community services												

DESCRIPTION OF DATA ELEMENTS

1. Unduplicated count of individuals admitted to developmental disability units during specified period
2. Unduplicated count of individuals placed on Olmstead List during specified period (These individuals may have previously been on the Olmstead list but removed).
3. Individuals removed from Olmstead List during specified period because they no longer met discharge criteria

4. Number of individuals previously on Olmstead List who were discharged but later readmitted to state hospital (These individuals may be counted in #2, above.)
5. Census on developmental disability units on last day of month
6. Individuals on Olmstead List on last day of month
7. Unduplicated count of individuals discharged from developmental disability units during specified period
8. Number of individuals on Olmstead List discharged during specified period (They may or may not be discharged to community services)
9. Number of individuals on Olmstead List discharged to community services during specified period (Individuals also included in #8)
10. Number of individuals on the Olmstead list during specified period who remained in the hospital past their planned discharge date
11. For individuals in #10, the average number of days between planned discharge date and actual discharge date/last day of month
12. For individuals in #10, the median number of days between planned discharge date and actual discharge date/last day of month
13. For individuals in #10, the number of individuals where the difference between planned discharge date and actual discharge date /last day of month is > 60 days
14. For individuals in #10, the number of individuals where the difference between planned discharge date and actual discharge date /last day of month is > 90 days (Consent agreement requires description of barriers to discharge and a CAP).

Challenges to Achieving the Olmstead Plan

In its ruling on *Olmstead v. L.C.*, the U.S. Supreme Court recognized a state's responsibility is not "boundless" to provide community alternatives to institutionalized care. States can weigh the needs of others with disabilities, including people requiring institutional levels of care.

Like any state, Georgia faces challenges in implementing the Olmstead Plan. This section outlines some of those challenges.

Budget

Georgia's ability to provide community services is defined by specifically appropriated State funds and federal funding that can be leveraged with these State funds. As a result, Georgia's efforts to assist individuals to have meaningful lives in the community are impacted by available resources.

Like many states, Georgia has an annual budget process and a balanced budget constitutional requirement. While budgetary changes impact the State's ability to achieve the goals of the Olmstead Plan, Georgia remains committed to the Olmstead goals.

Behavioral Health

Several challenges exist in assisting individuals with mental illness to transition from hospitals to community settings. Key challenges include the lack of:

- Programs in some areas of state with behavioral health staff that are available on site 24 hours a day, seven days a week
- Available nursing and other medical supports in the community for persons with medical conditions
- Sufficient numbers of community providers who are capable and willing to support individuals with histories of physical aggression
- Adequate resources to fund specialized supports for individuals in the community
- Community services and supports for individuals with histories of sexually inappropriate behavior
- Resources for expanding innovative new approaches that promote recovery and independence
- Supported employment and housing

Developmental Disabilities

In recent years the Georgia legislature has appropriated significant resources supporting persons with developmental disabilities to live in their own community. The 2008 **State of the States in Developmental Disabilities** shows Georgia moving to 9th in the nation for increasing resources to move people with developmental disabilities from state hospitals to less restrictive community settings.

Despite this progress, several challenges remain:

- It often takes substantial amounts of time to plan for and arrange the necessary services and supports for people with medical and/or behavioral challenges to successfully transition from state hospitals to community life.
- In many areas of the state, individuals and their families do not have an adequate selection of developmental disability providers from which to choose.
- There is a lack of community services and supports for individuals with histories of sexually inappropriate behavior.
- There is a lack of supported employment and housing.

Older Adults with physical disabilities often face many of the same challenges as other populations that need long-term care. These challenges include the lack of:

- Resources or access to housing in the community
- Financial resources to support community-based services
- Adequate transportation services to sustain community living
- Adequate resources for diagnosis, access to services and treatment for older adults with mental illness or developmental disabilities.
- Adequate community supports to serve frail and physically impaired older adults

VI. ACTION PLAN

The Action Plan sets the strategic direction and broad parameters for addressing Georgia's community service delivery. The plan consists of **goals** and **actions** the State will take to achieve the desired outcomes.

State Planning and Oversight

State-level planning and oversight is required to address Georgia's community service delivery needs.

State Planning and Oversight Goal 1: *Input from individuals with disabilities, family members and stakeholders is included in Olmstead planning and implementation.*

Actions:

- Georgia has established an Olmstead Planning Committee that includes people with disabilities, advocates and other stakeholders in the ongoing planning and implementation of the Olmstead Plan.

State Planning and Oversight Goal 2*: State agencies and divisions, including the Department of Community Health; the Division of Mental Health, Developmental Disabilities and Addictive Diseases; and the Division of Aging Services, collaborate to achieve successful outcomes.*

Actions*:*

- State agencies are engaged in the planning to overcome barriers to community living. This collaboration addresses the long-term needs of Georgians impacted by the Olmstead Plan.

State Planning and Oversight Goal 3*: Effective leadership is identified to provide State-level oversight to implement the Olmstead Plan.*

Actions*:*

- The Governor designated the Olmstead Coordinator to provide State-level implementation oversight.

Identification and Assessment of Eligible Individuals

A process is required to identify and assess the eligibility of individuals. To that end, Georgia is utilizing a process that defines the services and supports a person needs and the preferences they have expressed in order to live successfully in a community setting.

Identification and Assessment of Eligible Individuals Goal*: Steps are taken to prevent future premature or inappropriate institutionalization of older adults and individuals with disabilities.*

Actions:

- Identify individuals in state hospitals who may be ready to benefit from community services.
- Identify individuals with behavioral health needs or developmental disabilities, and older adults who live in nursing homes and who may be ready to benefit from community services.
- Identify individuals who have lived in institutions for six months or longer for inclusion in the Money Follows the Person Initiative.
- Through the Aging Network, individuals who have been placed or are at risk of being placed in a nursing home will continue to be assessed. Also, the Aging Network will continue providing education, outreach and assistance through the Gateway system and the ADRCs to provide access to services.
- Evaluating individuals at risk of institutionalization for their ability to be served with community services.
- Identifying individuals living in state institutions longer than 60 consecutive days for inclusion on the **Behavioral Health Olmstead List** or **Developmental Disabilities Olmstead List**.

Assurance of Individual Choice

Georgians impacted by the Olmstead Plan make informed choices about how their needs can best be met in community and institutional settings. The State ensures that individuals and their families have opportunities to learn about different services and supports that allow them to live in the most integrated and least-restrictive setting.

Assurance of Individual Choice Goal: *Older adults and people with disabilities have the right information to make informed choices.*

Actions:

- Using available funds, Georgia has the capacity to meet with individuals in state hospitals who are recommended for community placement. The meetings focus on available community options and the individual's preferences with regard to those options. The meetings will also be used to determine if the individuals are opposed to a community placement.
- The State primarily includes individuals in making decisions about their community services and supports. Family members, legal representatives and caregivers are encouraged to participate in the decision-making process, when appropriate.
- The State ensures that individuals at risk of institutionalization are able to make informed choices about their treatment.
- The State keeps an inventory of available community resources and informs individuals about their options.
- Using available funds, Georgia develops the capacity to meet with those individuals in nursing homes who are recommended for community placement.

These meetings focus on available community options and determine if individuals are opposed to community placement.

Management of Olmstead Lists

Georgia has a growing population of older adults and individuals with disabilities. Although demand for services exceeds immediately available resources, Georgia will move individuals from Olmstead lists as the resources necessary for a successful transition can be made available.

Olmstead Lists Operation Goal*: Georgia continues to act in a timely manner to assess the needs of individuals with disabilities and older adults.*

Actions*:*

- The State has adopted policies for identifying individuals who are deemed appropriate for the **Behavioral health Olmstead List** and the **Developmental Disabilities Olmstead List.**

Individual Plan Development and Implementation

The State works with individuals (as well as their families, representatives, or treatment professionals) to move from institutional settings to community living through individualized transition planning. This planning:

- Reflects the individual's needs, choices and preferences
- Includes appropriate and necessary measures to support the individual in the community
- Ensures the equitable distribution of limited State resources
- Begins before an individual is moved from an institution to the community and continues after transition by ensuring an adequate support system

Individual Plan Development and Implementation Goal*: Older adults, individuals with disabilities and their families or representatives are included in individual plan development and implementation.*

Actions*:*

- Transition planning reflects the needs and preferences of the individual to ensure successful community integration within available resources.
- Support systems are identified to ensure individualized plans are comprehensive and effective.
- Families, State agencies and others determine their respective roles in providing services and supports for the individual.
- Transition planning with individuals who are placed on the Olmstead list is **person-centered**. The planning is based on an individual's own preferences and addresses all areas of that person's life necessary to support a meaningful life in

the community. Such services include but are not limited to health, human services, employment, functional abilities, interpersonal relationships, community involvement and family relations.

Current Availability of Community Services

Developmental Disabilities

Georgia has several home and community-based waiver programs. Although different Medicaid waiver programs include different services, they have some services in common. Each program offers core services, including:

- Service coordination
- Personal support (assistance with daily living activities)
- Home health services (nursing and occupational, physical and speech therapy)
- Emergency response systems and respite care (caregiver relief).

In addition, other federal and state funding supports community-integrated service programs. These programs include:

- **Community Care Services Program (CCSP) –** Provides home and community-based services to the functionally impaired or disabled. It helps eligible recipients remain in their own homes, the homes of caregivers, or in other community settings as long as possible.
- **Independent Care Waiver Program (ICWP)** – Helps a limited number of adult Medicaid recipients with physical disabilities remain in their own homes or in the community. Services are also available for people with traumatic brain injuries.
- **Community Habilitation and Support Services Program (CHSS)** – A home and community-based waiver for people with mental retardation. Developed after closure of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) in Atlanta. Serves individuals who have transitioned from institutions and those on community waiting lists.
- **Mental Retardation Waiver Program (MRWP)** – A home and community-based waiver for people diagnosed with mental retardation or other developmental disabilities (e.g., autism, cerebral palsy or epilepsy) requiring a level of care provided in an intermediate care facility for the mentally retarded.
- **Service Options Using Resources in Community Environments (SOURCE) –** Provides community-based services along with primary care-focused case management with the goal of improving the health outcomes of individuals with chronic conditions.
- **Georgia Pediatric Program (GAPP) –** Members must be medically fragile with multiple diagnoses and require continuous skilled nursing care or skilled nursing care in shifts.
- **Home and Community Based Supports** for individuals with Developmental Disabilities.

Services Overview:

- **Adult Occupational Therapy** – Addresses the occupational therapy needs of the adult participant that result from his or her developmental disabilities.

- **Adult Physical Therapy** – Addresses the physical therapy needs of the adult participant that result from his or her developmental disabilities.

- **Adult Speech and Language Therapy** – Addresses the speech and language therapy needs of the adult participant that results from his or her developmental disabilities.

- **Behavioral Supports Consultation** – Professional-level services that assist the participant with significant, intensive challenging behaviors that interfere with activities of daily living, social interaction, work or similar situations.

- **Community Access** – Designed to assist the participant in acquiring, retaining, or improving self-help, socialization and adaptive skills required for active participation and independent functioning outside the participant's place of residence.

- **Community Guide** – Designed only for participants who opt for participant direction. Assists them with defining and directing their own services and supports and meeting the responsibilities of participant direction.

- **Community Living Support** – Individually tailored supports that assist with the acquisition, retention, or improvement in skills related to a participant's continued residence in his or her family home.

- **Community Residential Alternative** – Targeted for people who require intense levels of residential support in small group settings of four or less, foster homes, or host home/life sharing arrangements and include a range of interventions with a particular focus on training and support in one or more of the following areas: eating and drinking, toileting, personal grooming and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time.

- **Environmental Accessibility Adaptation** – Physical adaptations to the participant's family's home that ensure the health, welfare and safety of the individual - or that enable the individual to function with greater independence in the home.

- **Financial Support Services** – Provided to ensure that participant directed funds outlined in the Individual Service Plan are managed and distributed as intended.

- **Prevocational Services** – Prepare a participant for paid or unpaid employment and include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

- **Specialized Medical Equipment** – Consists of devices, controls or appliances specified in the Individual Service plan that enable participants to increase their abilities to perform daily living activities and interact more independently with their environment.

- **Specialized Medical Supplies** – Includes food supplements, special clothing, diapers, bed-wetting protective chunks and other authorized supplies that are specified in the Individual Service Plan.

- **Support Coordination** – A set of interrelated activities for identifying, coordinating and reviewing the delivery of appropriate services with the objective of protecting the health and safety of participants while ensuring access to needed waiver and other services.

- **Supported Employment** – Supports that enable participants for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to work in a regular work setting.

- **Transportation** – Enables participants to gain access to waiver and other community services, activities, resources and organizations typically utilized by the general population but do not include transportation available through Medicaid non-emergency transportation or as an element of another waiver service.

- **Vehicle Adaptation** – Includes adaptations to the participant's or family's vehicle approved in the Individual Service Plan, such as a hydraulic lift, ramps, special seats and other modifications to allow for access into and out of the vehicle as well as safety while moving.

- **Shepherd Care Demonstration** – Provides primary care through an outreach program managed by advanced practice nurses who coordinate medical care for individuals with disabilities through the Shepherd Center in Atlanta.

- **Model Waiver** – Services include private duty nursing and medical day care for individuals under age 21 who depend on respirators or oxygen.

- **Service Options Using Resources in a Community Environment (SOURCE)** – Available in limited areas of Georgia, SOURCE is an intensive service coordination demonstration project linking primary care with an array of long-term health services in a person's home or community. This reduces or eliminates

the need for preventable hospital and nursing home care, and serves older adults and individuals with disabilities eligible for Medicaid and SSI disability coverage.

- **Non-Medicaid Home and Community-based Services for People with Developmental Disabilities** – Provides family support and respite services, room and board, day habilitation services and specialized employment services for people with developmental disabilities. Funded by state and federal Social Services Block Grant.

- **Adult Behavioral Health Community Treatment Services** – Serves adults with severe mental illness and a reduced level of functioning. Funded by the Medicaid Rehabilitation Option, federal Behavioral health Block Grant and state funds.

- **Child and Adolescent Community Behavioral health Treatment Services** – Serves children and adolescents up to 17 years of age with serious emotional disturbances. Funded by the Medicaid Rehabilitation Option, federal Behavioral health Block Grant and state funding.

- **Non-Medicaid Home and Community-based Services (HCBS) for Older Adults** – Provides State funds for senior centers, home-delivered meals, homemaker services, respite care services, transportation and adult day care.

Community Services Availability Goal*: Enhance the availability of community-based services.*

Actions*:*

- The State consistently reviews availability and adequacy of community-based services for older adults and individuals with disabilities.
- The State consistently reviews all funding sources, including Medicaid, to increase the availability of community-integrated services.
- The State utilizes demonstration grants to learn new strategies for moving youth out of institutional settings or preventing their admission to an institutional setting.
- The State communicates and collaborates with other agencies and stakeholders regarding current community-integrated services and initiatives.

Behavioral Health

Core customers, based on individual preferences and customized recovery plans, have access to the following services:

- Behavioral Health Diagnostic and Functional Assessments
- Community Support
- Crisis Intervention Services
- Individual, family and group counseling and training
- Nursing assessments and health services
- Psychiatric treatment and medication management

- Pharmacy and laboratory services
- Substance abuse and co-occurring disorders treatments

In some areas of Georgia, consumers also have access to specialty services, including:

Adult Specific Specialty Services

- Assertive Community Treatment
- Psychosocial Rehabilitation (Day treatment)
- Mobile Crisis Services
- Crisis Stabilization Programs
- Residential Services
- Supported Employment
- Peer Services

Youth Specific Specialty Services

- Intensive Family Interventions
- Behavioral Supports
- Peer Services
- Crisis Stabilization Programs
- Residential Services
- Mobile Crisis Services
- PRTF Waiver

Georgia's system of community behavioral health services is being developed as a recovery focused, community based, peer supported system with a goal of reducing the inappropriate reliance on hospital level care. When consumers need acute care services they should be able to receive them in community settings as close to home as possible. The Georgia Crisis and Access Line is a point of entry where consumers can receive telephonic triage which triggers an appropriate referral across the spectrum of care from mobile crisis intervention to a routine appointment within 7 days depending on the services available in the consumer's area.

Older Adults and Physically Disabled

- Community Care Services Program (CCSP) waiver services
- SOURCE waiver services
- Independent care waiver services
- Non-Medicaid home and community-based services
- Older Adult Peer Support project to train older adult peers to assist older adults with mental illness
- Initiatives for caregivers, such as Grandparents Raising Grandchildren
- Benefits counseling

Addictive Diseases

- Behavioral Health and Diagnostic Assessments
- Community Support – Individual
- Crisis Intervention Services
- Individual, family and group counseling and training
- Nursing assessments and health services
- Psychiatric treatment and medication management
- Pharmacy and laboratory services
- Substance abuse and co-occurring disorders treatments

In some areas of Georgia, consumers also have access to specialty services, including:

- Inpatient, Residential, and Ambulatory Substance Use Detoxification
- Opioid Maintenance Treatment
- Assertive Community Treatment
- Psychosocial Rehabilitation (Day treatment) – adult only
- Mobile Crisis Services
- Crisis Stabilization Programs
- Residential Services
- Supported Employment – adult only
- Substance Abuse Day Treatment
- Peer Services
- Intensive Family Interventions – child and adolescent only
- Behavioral Supports – child and adolescent only

Behavioral Health Service Packages

Currently in Georgia, waivers exist for older adults and people with either developmental or physical disabilities – but not for people with mental illness. However, **Georgia seeks to maximize potential funding opportunities in order to offer a comprehensive package of services** to support individuals with mental illness who are either transitioning from institutionalization or are at risk of institutionalization.

Two components of such a package would be **Supported Employment** and **Psychosocial Rehabilitation/Substance Abuse Day Treatment.** Employment is already a part of treatment planning even before an individual transitions out of institutionalization. Georgia has adopted the Individual Placement and Support model of supported employment services, which makes eligibility based on consumer choice. No one is excluded who wants to participate in supported employment. However, because some individuals do not believe they are ready for supported employment, another option is Psychosocial Rehabilitation, which teaches life skills such as community living, vocational readiness, and social and recreational pursuits.

The following subsection, **Potential Behavioral Health Packages**, provides cost estimates for all necessary supports for either a Supported Employment or Psychosocial Rehabilitation/Substance Abuse Day Treatment service package.

Potential Behavioral Health Packages

Olmstead Consumers with Supported Employment

Total Annual Cost per Consumer (State and Federal Funds)

Consumers funded with state funds only	ranges from $61,288 to $94,288
Consumers with Medicaid	ranges from $47,316 to $80,316

Services (Cost by Unit/Annual)

Psychiatrist	$39.64 (monthly); $475.68 (annually)
Nursing assessment and health services	$24.44 (monthly); $293.28 (annually)
Supported Employment	$410 (monthly); $4,920 (annually)
Medication	$1,300 (monthly); $15,600 (annually)
Residential support	ranges from $40,000 to $73,000 annually

Olmstead Consumers with Psychosocial Rehabilitation or Substance Abuse Day Treatment

Total Annual Cost per Consumer (State and Federal Funds)

Consumers funded with state funds only	ranges from $69,724 to $102,724
Consumers with Medicaid	ranges from $36,289 to $69,289

Services (Cost by Unit/Annual)

Psychiatrist	$39.64 (monthly); $475.68
Nursing assessment and health services	$24.44 (monthly); $293.28
Psychosocial Rehab or SA Day Treatment	$11.13 (hourly); $13,356 (annually)
Medication	$1,300 (monthly); $15,600 (annually)
Residential support	ranges from $40,000 to $73,000 annually

Education/Outreach

Many Georgians qualify for publicly funded services, but may be unaware of the available programs, the eligibility requirements or how to access them. Knowing where to get information and support is a concern for some persons with disabilities, especially those who do not live near services.

Education/Outreach Goal*: Education and outreach activities inform Georgians on how to access and receive publicly funded services.*

Actions*:*

- The State of Georgia works to enhance education and outreach efforts that inform people with behavioral health and developmental disabilities on how to access and receive available services. Outreach is done in a manner that is sensitive to cultural and individual differences.

Planned Transitions, Service Expansions and Special Initiatives

In addressing the needs of individuals affected by the Olmstead Plan, Georgia's planning considers both people in institutions and people at risk of institutionalization. Planning takes into account available resources and Georgia's responsibility for all people receiving publicly supported disability services.

Georgia's annual budgets are influenced by fluctuations in the economy, unforeseen disasters, changes in state and federal laws and regulations, and the priorities of state citizens, among other considerations.

Planned Transitions, Service Expansion and Special Initiatives Goal*: The State facilitates the movement of individuals affected by the Olmstead Plan into community-based services.*

Actions*:*

- The State provides Developmental Disability services based on the allocations approved by the legislature. The Legislature approved 750 services in fiscal year 2006, 1,500 in fiscal year 2007, 1,500 in fiscal year 2008, and 500 in fiscal year 2009.
- The State includes individuals from the Developmental Disabilities Olmstead List on the Transition List, as indicated in the Voluntary Compliance Agreement. The Official Developmental Disability Olmstead List, based on hospitalized individuals as of July 1, 2008, is 873 individuals. In fiscal year 2009, 175 of the individuals on the Olmstead List will be added to the Annual Transition List. 175 people will be added in fiscal years 2010, 2011 and 2012, and 173 will be added in 2013.
- The State will develop Person Centered Transition Plans for all individuals on the Behavioral Health Olmstead List within 30 days of them being placed on the list. The official Behavioral Health Olmstead List provided to the Office of Civil Rights lists 87 individuals who were hospitalized for more than 60 days and met all criteria for placement on the list on July 1, 2008. The State will make every effort to successfully transition all 87 individuals on the list to the community during the term of the Voluntary Compliance Agreement.
- The State of Georgia collects data that informs State budgetary and planning processes.
- The State continues to seek grant funding to help individuals transition to the community.
- The State has written new home and community-based waivers, effective November 1, 2008.
- The State is utilizing preference data to help determine which individuals have priority to transition to the community.
- The State created and maintains reporting on Olmstead Lists for both Mental Health and Developmental Disabilities.

- The State is continually monitoring and proactively addressing barriers to successful community living.
- Utilizing the State's budget process to identify needs and request funding to enable implementation of proposed solutions.
- Marshalling resources and aligning existing resources to maximize their benefit to individuals in need.

Infrastructure and System Capacity

The Olmstead Plan requires improvements in **infrastructure** and **system capacity**. State agencies need to develop infrastructure to expand community-based services. The goals and actions for each area are outlined below.

Service Provider Capacity
The State's ability to transition individuals to community-based services requires adequate service provider capacity. Expanding that capacity requires an increase in the numbers, types and quality of providers and the services they provide.

Service Provider Capacity Goal*: Georgia strives to develop a sufficient service provider capacity.*

Actions*:*
- The State develops plans and strategies to expand the capacity and quality of current service providers and attract new service providers to the system.
- A fee for service system for child and adolescent services
- The State has Home and Community-Based Waiver Programs that now include options and infrastructure for consumer self-directed care, which contributes to enlarging the provider capacity.
- State planning for provider capacity includes the development of community services by existing institutions such as state hospitals and nursing homes.

Access to Services
Georgia's service delivery system works to respond to individual preferences and choice of appropriate services and supports. Helping individuals to transition from institutional to community settings sometimes requires the development of new and different services.

Access to Services Goal*: Effective services and supports are consistently available to assist individuals to have meaningful lives in the community.*

Actions:
- The state uses demographic, survey, and other data to help estimate the need for community services for individuals who have been institutionalized or are at risk of institutionalization.
- The State coordinates services and programs that meet the multiple needs of individuals who are institutionalized or at risk of institutionalization.

- The State identifies and addresses regulatory and policy obstacles to community based service delivery and accessibility.
- When the State has identified gaps in services and resources that require additional resources, requests for new funding are made through the state budgetary process, federal funds, grants, and other available options.
- The State maximizes the use of existing consumer, family, and agency resources and identifies opportunities for additional funding for services.
- The State encourages the use of consumer/family/private/public partnerships to support service development.
- The State makes available a toll free 24-hour phone line which provides access to service appointments. This phone line is provided by an entity that can offer a consumer an unbiased choice of provider.
- The State provides a toll free 24-hour telephonic response to mitigate crisis and enhance linkage to community supports.

Workforce Development

Georgia, like the rest of the nation, is experiencing shortages of health care professionals and related community services workers who support the long-term care and community-based service delivery system. Georgia continues to develop and implement strategies to address those shortages.

The collaboration of multiple partners – including education, business, providers, affected individuals and their families – is essential to the State's ability to address workforce shortage issues.

Workforce Development Goal*: Maintain a stable and skilled workforce.*

Actions*:*

- The State makes relevant workforce shortage issues a high priority in strategic planning.
- The State develops and implements retention, recruitment, training, financing, and other strategies to ensure a diverse, stable, and *skilled* workforce.
- The State provides training for those serving persons with mental health and developmental disabilities in the community and in institutions, in order to expand their skills to serve consumers. Click on links below for Training Information: **MHDDAD Olmstead Training Plan**, **MHDDAD Olmstead Training Reports**, **MHDDAD Training Calendars**, and **Looking Ahead to the Next Quarter's Training Activities**
- The State encourages public/private partnerships to address workforce shortage issues.
- The State builds upon its certified peer specialist workforce model to enhance its workforce.
- The State develops special initiatives and certification programs to enhance its workforce.

- The State seeks to obtain changes in regulatory and professional standards when such changes are determined to be necessary in order to expand availability of appropriate and available services for persons with disabilities.

Housing
Across the United States and in Georgia, there is a critical shortage of affordable and accessible housing. Housing is essential to transitioning individuals from institutions to community-based settings. In order to succeed in a community setting, each individual needs a decent, stable, safe, and desirable place to live.

Housing Goal*: Increase access to and availability of decent, stable, safe, and desirable housing for older adults and other individuals with disabilities.*

Actions:
- The State promotes change in housing policies that increase housing options.
- The State utilizes effective strategies for state and federally subsidized housing programs.
- State agencies partner to implement strategies to address the housing needs of older adults and individuals with disabilities.
- The State encourages consumer/family/private/public partnerships to address the housing needs of older adults and individuals with disabilities.

Transportation
Adequate transportation is vital to successful community integration and participation. Individuals affected by the Olmstead Plan need ways to access services and supports, recreation, employment, worship, shopping and other community activities.

Most of Georgia's transportation programs are either geared to the general public or are too specialized to meet the needs of older adults and individuals with disabilities. Public transportation is not widely available throughout the state, and does not adapt to meet individuals schedules, locations for pick up, or other needs that are essential for individuals with disabilities to utilize public transportation.

Transportation Goal*: Adequate transportation services to support successful community integration and participation of individuals with disabilities and older adults is available.*

Actions:
- The State will review and modify policies and practices that inhibit people's access to transportation resources.
- The State will encourage its agencies to partner with one another and others in the development and implementation of strategies to address the transportation needs of older adults and individuals with disabilities.

Older adults and individuals with disabilities need a variety of transportation options that allow them to fully participate in community life. Transportation options that would allow full integration and participation:

- Transportation system that provides for varied needs of consumers.
- Token Systems or purchased transport that allows individuals to use public transportation for themselves and an attendant, if needed.
- Non Emergency Transportation not covered for reimbursement, such as trips to the grocery store, pharmacy, church, social outings, etc…

Assistive Technology
Older adults and people with disabilities often need assistive technology to perform basic activities that people without disabilities take for granted – such as communicating with others (add more here). The State promotes the use of available technology that increases the independence for people with disabilities.

Examples of assistive technology include: (add more examples of tech that is used for broader needs)

- Computerized talking boards
- Scanning communicators
- Speech amplifiers
- Electronic telephone systems such as Personal Emergency Response Systems
- Home modifications

Assistive Technology Goal*: Assistive technology is available to older adults and individuals with disabilities who can benefit from the technology.*

Actions:

- The State requires that individuals who potentially need assistive technology receive an assessment as part of the planning process.
- The State maximizes existing resources and identifies opportunities for additional funding for assistive technology.

Coordination/Partnerships
Georgia's Olmstead Plan requires more coordination and partnerships between consumers, families, advocacy groups, faith-based organizations, nonprofit organizations, public and private entities, and federal, state and local agencies. Although Georgia has already begun coordinating its planning and resources to enhance its community-integrated service delivery system, additional collaborative opportunities will be identified.

Coordination/Partnerships Goal*: The State promotes coordination and partnerships to maximize resources.*

Actions*:*

- The State identifies and supports coordination and partnerships needed for implementation of its plan.
- Expand the ADRC network to cover the entire state.

Monitoring/Oversight Capacity

Expanding Georgia's service delivery system requires increased monitoring and oversight capacity to ensure the health and safety of individuals moving to the community. In addition, the quality and effectiveness of the services they receive are monitored. This includes such activities as:

- Licensure and certification of providers
- Monitoring and oversight of service delivery
- Technical assistance for providers
- Development and maintenance of standards and policies
- Involvement of individuals receiving services, families, community stakeholders, and representative bodies

Monitoring/Oversight Capacity Goal*: The State has sufficient capacity to provide monitoring and to establish service delivery guidelines in support of the Olmstead Plan.*

Actions:

- The State ensures adequate monitoring and oversight capacity to meet the demand.
- The State establishes practice guidelines and enhances service coordination in order to prevent institutionalization.

Increased Technology

The incorporation of information technology into planning, implementation and evaluation processes will promote the success of Georgia's Olmstead Plan. Information technology enables the State to increase efficiency and effectiveness in the following areas:

- Consumer tracking
- Outcome measurement
- Utilization management
- Data analysis for planning and decision support

Comprehensive and coordinated information technology systems are essential for Georgia to evaluate its effectiveness in identification, assessment, planning and transition of affected individuals.

Increased Technology Goal: *The State effectively utilizes information technology in implementing the Olmstead Plan.*

Actions:

The State will review the capacity of existing information technology and then develop strategies for making necessary improvements in order to support implementing the Olmstead Plan.

State Administrative Capacity

The State recognizes that the state agencies involved in implementing the plan need adequate administrative capacity to do so.

State Agency Capacity Goal*: State agencies have the administrative resources they need to successfully implement the Olmstead Plan.*

Actions:

- Identify current capacity and gaps in resources required for agencies to successfully implement the Olmstead Plan.
- Utilize the State's budget process to request needed resources.

Quality Improvement, Data Management and Evaluation

Achieving the goals of the Olmstead Plan requires ongoing monitoring and evaluation of the system and the care provided to individuals. Data management and evaluation of the State's service delivery system supports efforts to continuously improve the quality of outcomes and the processes used to achieve them throughout the implementation of the plan.

Quality Improvement, Data Management and Evaluation Goal*: The State collects and utilizes data to provide the information needed to improve processes and outcomes in order to implement the Olmstead Plan.*

Actions:

- The State gathers and analyzes data to examine the quality and effectiveness of processes and services.
- The State utilizes quality improvement processes to improve service delivery systems.
- The State shares data and reports about Olmstead implementation progress with the public.

VII. HOW TO PROVIDE FEEDBACK ON GEORGIA'S OLMSTEAD PLAN

Anyone interested in providing comments about Georgia's Olmstead Plan is encouraged to submit their comments utilizing the Olmstead feed back form. The form should be submitted via email to: **OlmsteadPlan@dhr.state.ga.us.**

VIII. HOW TO ACCESS SERVICES IN GEORGIA

Mental Health, Developmental Disabilities, and Addictive Diseases Services

For information about Mental Health, Developmental Disabilities, and Addictive Diseases services go to http://mhddad.dhr.georgia.gov.

To access behavioral health and addictive diseases services, contact Georgia's Crisis and Access Line (GCAL) at 1-800-715-4225.

Aging Services

For information about Aging Services in Georgia, go to http://www.aging.dhr.georgia.gov. To access Aging Services in Georgia, contact 1-866-55-AGING.

Notes from 12/29 Olmstead Meeting, need to add the following information

Financing Sections

1. Look at the sufficient services within five years
2. Come up with a behavioral health comp. package (rehab and non-rehab)
3. Description of the DD
4. Hospital game plan (right sizing and reinvesting)
5. Efforts to maximizing federal funding.

Right Sizing of State Hospital

1. Determining Target population
2. Use of regional hospitals (Virginia Plan)

Nursing Requirements

1. More efficient use of resources by allowing lay people to do g-tubes and medication (changes to nurse practice act)
2. Provider training and certification on appropriate supports when non-nursing are used to provided.
3. Continuous quality improvement
4. Grave out for individual's transition out of institutions or at high risk of institutional care. (Get with new nursing chair and Karen Green-Macowin to about the OK statute)

Training Section (Outline training require as specified by VCA)

1. Hospital, Division and regional staff
2. Families
3. Consumers
4. Provider

Put policies after VCA will link to the policy i.e. notification policy

Method of monitoring reentries with under 60 days length of stays