Georgia Department of Human Services
Division of Aging Services

GEORGIA
STATE PLAN ON AGING
2024 - 2027

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Heart of Georgia Region Toll Free: 888.367.9913 Counties served: Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis , Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	**Southern Georgia Region** Toll Free: 888.732.4464 Counties served: Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware
Central Savannah River Region Toll Free: 888.922.4464 Counties served: Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	**River Valley Region** Toll Free: 800.615.4379 Counties served: Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster
Southwest Georgia Region Toll Free: 800.282.6612 Counties served: Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	**Northeast Georgia Region** Toll Free: 800.474.7540 Counties served: Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton
Three Rivers Region Toll Free: 866.854.5652 Counties served: Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson	**Coastal Region** Phone: 800.580.6860 Counties served: Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
Georgia Mountains Region Toll Free: 800.845.5465 Counties served: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	**Northwest Georgia Region** Phone: 706.295.6485 Counties served: Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
Middle Georgia Region Toll Free: 888.548.1456 Counties served: Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson	**Atlanta Region** Phone: 404.463.3333 Counties served: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale

Statewide Independent Living Council of Georgia Inc.
315 West Ponce de Leon Ave., Suite 660
Decatur, GA 30030

770-270-6860

Centers for Independent Living

Access 2 Independence Phone: 706-405-2393 Serves the following counties in West Central Georgia: Chattahoochee, Harris, Marion, Muskogee, Quitman, Stewart, Talbot, Taylor, Webster	**Northwest Georgia Center for Independent Living** Phone: 706-314-0008 Serves the following counties in Northwest Georgia: Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker, Whitfield
BAIN (Bainbridge Advocacy Individual Network) Phone: 229-246-0150 Serves the following counties in Southwest Georgia: Atkinson, Baker, Berrien, Brooks, Calhoun, Clay, Clinch, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Lanier, Lee, Lowndes, Miller, Mitchell, Randolph, Seminole, Terrell, Tift, Thomas, Worth	**LIFE (Living Independence for Everyone)** Phone: 912-920-2414 Serves the following counties in Southeast Georgia: Bryan, Bulloch, Camden, Chatham, Effingham, Evans, Glynn, Liberty, McIntosh, Tattnall, Toombs
Disability Connections Phone: 478-741-1425 Serves the following counties in Central Georgia: Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Wilkinson	**Multiple Choices** Phone: 706-850-4025 Serves the following counties in Northeast Georgia: Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe, Walton
Disability Resource Center Phone: 706-778-5355 Serves the following counties in North Georgia: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	**Walton Options for Independent Living** Phone: 706-724-6262 Serves the following counties in East Georgia: Burke, Columbia, Emanuel, Jefferson, Jenkins, Johnson, Lincoln, Richmond, Screven, Washington
disABILITY Link Phone: 404-687-8890 Serves the following counties in Metro Atlanta: Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Newton, Rockdale	

Mission, Vision, Values

MISSION

The Georgia Department of Human Services' (DHS) Division of Aging Services (DAS) supports the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families, and caregivers to achieve safe, healthy, independent, and self-reliant lives.

VISION

Living Longer, Living Safely, Living Well.

VALUES

A Strong Customer Focus
We are driven by customer – not organizational – need. We consider customers' input and preferences in all decision-making.

Accountability and Results
We are good stewards of the trust and resources placed with us. We base our decisions on data analysis and strive for quality improvement.

Teamwork
We do business through teamwork and collaboration. We practice shared decision-making, and everyone's contribution is valued.

Open Communication
Our communication is open and responsive. We listen to our customers and partners and provide them accurate, timely information.

A Proactive Approach
We envision the future needs of our customers and the changing service network. We lead and advocate with innovation.

Dignity and Respect
We respect the rights and self-worth of all people.

Our Workforce
Our workforce, including volunteers, is our best asset. We maintain a learning environment with opportunities to increase professional growth, share knowledge and stimulate creative thinking.

Trust
Compassion and integrity drive what we do and who we are.

Diversity
We value a diverse workforce; it broadens our perspective and enables us to better serve our customers.

Empowerment
We support the right of our customers and workforce to make choices and assume responsibility for their decisions.

Signed Verification of Intent

The State Plan on Aging covers the period of federal fiscal years (FFY) 2024 through 2027. It includes all assurances and plans to be conducted by the Georgia Department of Human Services' (OHS) Division of Aging Services (DAS) under the State Unit on Aging and the provisions of the Older Americans Act (OAA) as amended. The state agency named above has been authorized to develop and administer the State Plan on Aging in accordance with all requirements of the OAA, including the development of comprehensive and coordinated systems for the delivery of supportive services, such as multipurpose senior centers and nutrition services. DAS, under the guidance of OHS, serves as the State of Georgia's effective and visible advocate for older individuals, at-risk adults, and persons with disabilities. DAS also serves as an *effective* and visible advocate for the families and caregivers of those served.

The State Plan on Aging, developed in accordance with all federal statutory and regulatory requirements and approved by the Governor, is hereby submitted.

The State Plan's approval by the Governor constitutes authorization to proceed with activities under the State Plan upon approval by the Assistant Secretary on Aging.

Executive Summary

The Georgia Department of Human Services' (DHS), Division of Aging Services (DAS) is the designated State Unit on Aging, in accordance with the Older Americans Act and Georgia Code, Chapter § 49-6-2, 5. The mission of DAS is to support the larger goals of DHS by assisting older individuals, at-risk adults, persons with disabilities, their families, and caregivers to achieve safe, healthy, independent, and self-reliant lives. The intent of the Older Americans Act (OAA) was to create a robust continuum of home and community-based services to help older adults maintain independence and age in place.

The Division of Aging Services prepares a State Plan on Aging as required by the Administration for Community Living under the U.S. Department of Health and Human Services. The plan guides us to lay the foundation for a robust, equitable continuum of community-based care. DAS partners with a collaborative network of public and private state, local, and community-based providers and agencies that create Georgia's aging services network.

The network is made up of Area Agencies on Aging (AAA), Centers for Independent Living (CILs), providers, non-profit organizations, advocates, and stakeholders. In addition, DAS encourages cross collaboration and partnerships with other state agencies, public and private entities, and non-traditional partners to ensure that the network remains nimble, avoids service duplication, and innovates to meet the needs of the aging population.

The Georgia DAS goals for FFY 2024 through 2027 are:

GOAL 1: Provide long-term services and supports that enable older Georgians, their families, caregivers and persons with disabilities to fully engage and participate in their communities for as long as possible.

GOAL 2: Ensure older Georgians, persons with disabilities, caregivers and families have access to information about resources and services that is accurate and reliable.

GOAL 3: Strengthen the aging network to enable partners to become viable and sustainable, and develop a robust network of aging service partners.

GOAL 4: Prevent abuse, neglect, and exploitation while protecting the rights of older Georgians and persons with disabilities.

GOAL 5: Utilize continuous quality improvement principles to ensure the State Unit on Aging operates efficiently and effectively.

The goals set forth in this State Plan will continue to advance Georgia's service delivery system and allow for a higher quality of service and potentially increase the number of services available for the growing number of older adults, adults with disabilities, their unpaid caregivers, and their families. DAS will continue to deploy innovative methodologies to expand capacity, foster collaboration, and drive cost efficiencies to deliver a comprehensive system of programs and services to assist Georgians in living longer, living safely, and living well while remaining efficient, effective, and nimble.

Introduction and Context

As Americans and Georgians live longer and healthier lives, the DAS must commit to strengthening existing partnerships and developing new ones to improve quality of life, reduce disparities, and support family caregivers. The Georgia State Plan on Aging reflects the focus areas outlined by the United States Department of Health and Human Services Administration for Community Living (ACL), including continued COVID-19 recovery, advancing equity, expanding access to home and community-based services (HCBS), and ensuring a robust caregiver infrastructure. In addition, public input sessions identified priorities for health and wellness, aging in place, safety and protection, and workforce. Realizing success in achieving these additional priority areas for the senior and vulnerable adult populations will require multiagency and multidisciplinary collaboration and investment from federal and state funders. Without the participation of a wide network of community members and organizations, including state and local leadership, the private sector, major health care systems, faith-based and non-profit organizations, and older adult advocates, a major risk to addressing the current and future needs of our consumers will widen. DAS is committed to strengthening existing partnerships and developing new ones to improve the lives of older adults, reduce disparities, and support family caregivers.

In 2022, 14.6% of Georgia's population was 65 and over, up from 12.7% in 2019. Georgia ranks seventh amongst states older adults are moving to. According to census.gov, over 75% of older Georgians receive Social Security and more than 2 million older adults (10.7%) live in poverty. In Georgia, 14.3% of the population speaks a primary language other than English, and over 10% are born outside of the U.S. Almost 9% of people in Georgia under age 65 live with at least one disability. According to a 2019 UCLA/Gallup poll, approximately 6% of Georgians over age 65 identify as LGBT.

With the Georgia General Assembly's investment, DAS has been able to focus on addressing caregivers and individuals affected by Alzheimer's and other dementias. According to the Alzheimer's Association, the prevalence of Alzheimer's in Georgia is expected to increase by 26.7% between 2020 and 2025. Additionally, there are 343,000 unpaid dementia caregivers in Georgia, providing 657 million hours of care annually, valued at more than $9 billion. This state plan includes goals and strategies designed for our state to become more dementia capable.

We are increasing access to early and accurate diagnosis, developing a dementia-capable aging network, and ensuring the provision of quality, person-centered programs and services for people living with dementia and their caregivers.

The State Plan on Aging lays out robust strategies to meet the goals and objectives to drive innovation in our aging services network. We have included comprehensive metrics to measure the performance of our network to ensure the best possible outcomes for older Georgians, persons living with disabilities, and their caregivers. Overall, the State Plan on Aging will ensure that all older adults can live with dignity, independence, and the support they need to thrive by advancing equity, increasing access to home and community-based services, becoming dementia-capable, and creating a robust caregiving infrastructure.

CORE PROGRAMS AND SERVICES

DAS serves as the lead on providing programs and services to Georgia's aging population. As the State Unit on Aging (SUA), DAS administers OAA programs and services through funding from ACL. SUAs administering funds under Titles III and VII of the OAA of 1965, as amended, are required to develop and submit to the Assistant Secretary on Aging, a State Plan for approval under Section 307 of the OAA. DAS has adopted a four-year State Plan on Aging for the period extending from October 1, 2023, through September 30, 2027. In accordance with the act, DAS targets persons age 60 and older, with the greatest economic or social need, particularly low-income and minority persons, older individuals with limited English proficiency, and older persons residing in rural areas.

MAJOR PROGRAMS AND INITIATIVES

Aging & Disability Resource Connection	Links seniors and adults with disabilities to resources that promote independence.

Adult Protective Services	Provides investigations of abuse, neglect, and exploitation to adults with disabilities (age 18 and older) and older adults (age 65 and older) who are not residents of long-term care facilities.
Assistive Technology	Helps clients identify tools and aids that assist them with activities of daily living.
Dementia Capability	Drive dementia capability through implementation of the Georgia Alzheimer's and Related Dementias State Plan; development of programs like Dementia Care Specialists, Dementia Friends, Memory Screening, Brain Health Education, and collaboration with other state agencies and partners to create a robust dementia-capable service delivery network.
Elderly Legal Assistance Program	Provides legal representation, counseling, and education to seniors.
Forensic Special Initiatives Unit	Provides training, support, and technical assistance to law enforcement, social services, medical professionals, prosecutors, victim service providers, and all other local, state, and federal partners who serve elder and disabled adults.
Georgia State Health Insurance Assistance Program (SHIP)	Provides one-on-one, unbiased Medicare counseling to seniors and their families.
Options Counseling	Provides enhanced planning for long-term care including support and services for seniors in the community and in nursing homes.
Money Follows the Person	Assists older adults and adults and children with physical disabilities and/or traumatic brain injuries in moving out of long-term care facilities and into the community of their choice. (Federally-funded program)
Nursing Home Transitions	Assists older adults in moving out of long-term care facilities and into the community of their choice. (State-funded program)
Non-Medicaid Home and Community-Based Programs (HCBS)	Provides long-term support and services as specified by the Older Americans Act.
Caregiver Services Program	Provides support and services for family and informal caregivers of older individuals and persons with dementia, as well as for older relative caregivers of children and adults with disabilities.
Senior Employment Program	Serves unemployed low-income persons who (age 55 and older) who have poor employment prospects by training them in part-time community service assignments and by helping them learn skills to facilitate their transition to unsubsidized employment.

OTHER STATE PLANS

In addition to managing the State Plan on Aging, DAS is responsible for managing several other strategic plans. These plans were developed with a variety of community stakeholders and are dependent on a collaborative effort to achieve the goals outlined in each plan. DAS plays a major role in coordinating and facilitating those activities. The stakeholders and partners meet on a regular basis to strategize and evaluate their progress. Links to these plans are available on the DAS' website: **aging.georgia.gov**.

Georgia Alzheimer's & Related Dementias State Plan Collaborative
Provides a blueprint to address the growing challenge of dementia in Georgia.
Read more: **aging.georgia.gov/get-involved/georgia-alzheimers-related-dementias-state-plan**

Georgia State Plan to Address Senior Hunger
Provides a framework by which the state can work to address senior hunger through five focus areas outlined in the plan. The plan includes background on senior hunger nationally and in the state with key recommendations to advance senior hunger work in Georgia.
Read more: **aging.georgia.gov/get-involved/senior-hunger**

Title V State Plan - Senior Community Service Employment Program
Serves low-income persons who are age 55 and older and have poor employment prospects. Eligible individuals are placed in part-time community service positions with a goal of transitioning to unsubsidized employment.
Read more: **aging.georgia.gov/document/document/scsep-state-plan-2020-2023/download**

ACL AND OTHER DISCRETIONARY GRANTS

DAS seeks ACL discretionary grants and other grants to implement new programs, strengthen the aging network in Georgia, and better serve Georgia's elderly and disabled populations. This is a list of current initiatives funded by discretionary grants:

BankSafe Grant	Educates frontline bank employees on how to identify red flags for financial exploitation.
State Health Insurance Program	Provides free, unbiased, and factual information and assistance to beneficiaries and their caregivers about Medicare, Medicaid, and related health insurance issues including long-term care insurance and prescription drug assistance programs.
Medicare Improvement for Patients and Providers	Provides valuable support at the state and community levels for organizations involved in reaching and aiding people who may be eligible for the Low-Income Subsidy Program (LIS), Medicare Savings Program (MSP), and the Medicare Part D Prescription Drug Program.
The National Center on Advancing Person-Centered Practices and Systems	Provides technical assistance to DAS and network partners to develop a common operational definition of person-centered service delivery and data points to measure progress.
Public Health Workforce Grant	Aims to increase the number of public health professionals within the State Health Insurance Assistance Program (SHIP) and aging and disability networks to address the unique needs of individuals through the support of wages and benefits for these professionals. Professionals supported through this program provide a wide range of public health services and support.

State Agency on Aging Operations Overview

DAS has developed a comprehensive delivery system of services to older adults, individuals with disabilities, and their families. This delivery system encompasses AAAs and contracted service providers. Key customers, partners, collaborators, and stakeholders have the same key requirements and expectations of DAS.

Key Customer Groups	Key Requirements / Expectations
· Older adults	· Accurate information and reliable services
· People with disabilities	· Consistency of delivery and choice
· Families	· Knowledgeable providers
· Caregivers	· Affordable service options
· Advocates	· Available/accessible service options
· Pre-retired adults	· Able to live independently in the community
· Persons in Long-Term Care Facilities	· Trustworthy service providers and safety assurances
· Persons Under Guardianship	· Respectful treatment

Through an annual budget planning process and mid-year review meetings with each Area Agency on Aging, DAS reaffirms the key customers, partner, and stakeholder groups along with market requirements, and then adjusts its plans as needed.

DAS' most important partners are AAAs, CILs, and the provider network. All three entities work in coordination to achieve our common goal: delivering high-quality services to customers. DAS believes that a successful partnership requires a clear understanding of the roles of and benefits to all parties. As such, DAS has specific requirements and expectations of AAAs, and in turn, the AAAs have specific requirements and expectations of providers.

DAS allocates federal and state funds to the Planning and Service Areas (PSA) using an ACL approved Intrastate Funding Formula for most of its contracted services. The weighted funding formula takes into consideration the following eight factors: persons 60 years of age and older; persons 75 years of age or older; low-income minority population 65 years of age and older; low-income population 65 years of age and older;estimated rural population 60 years of age and older; limited English-speaking population 65 years of age and older;disabled adults 65 years of age and older; and living alone 65 years of age and older.

The OAA requires that AAAs provide local matching funds for some programs. DAS ensures that all funds are spent in accordance with applicable state and federal requirements and with sound fiscal management practices. In the last quarter of the fiscal year (FY), if there is the possibility of lapsing dollars which would otherwise benefit key customers, DAS may choose to move funds from one AAA to another through a contract amendment. DAS monitors AAA contracts and provides technical assistance, including a Uniform Cost Methodology (to assist in accurately identifying actual costs for specific services), for providers. Prior to contracting with an AAA, DAS reviews its Area Plan, including its budget. If DAS identifies gaps or problems in an Area Plan, staff work with the AAA to resolve these prior to DAS approval of the Area Plan and execution of the contract.

DAS monitors AAAs annually via monitoring visits and customer satisfaction surveys. Desk reviews were implemented during Covid as well as Temporary Operating Procedures for APS and PGO. DAS works in the field with AAA staff and providers, observing operations, reviewing progress on expenditures, monitoring for potential lapse of dollars, and providing technical assistance to improve the quality of services.

DAS provides AAAs with allocation amendments throughout the year as various funding is received (e.g., federal fund disbursements, grant awards). DAS and AAAs amend contracts as needed to reflect changing needs and expenditures in the Planning and Service Area (PSA).

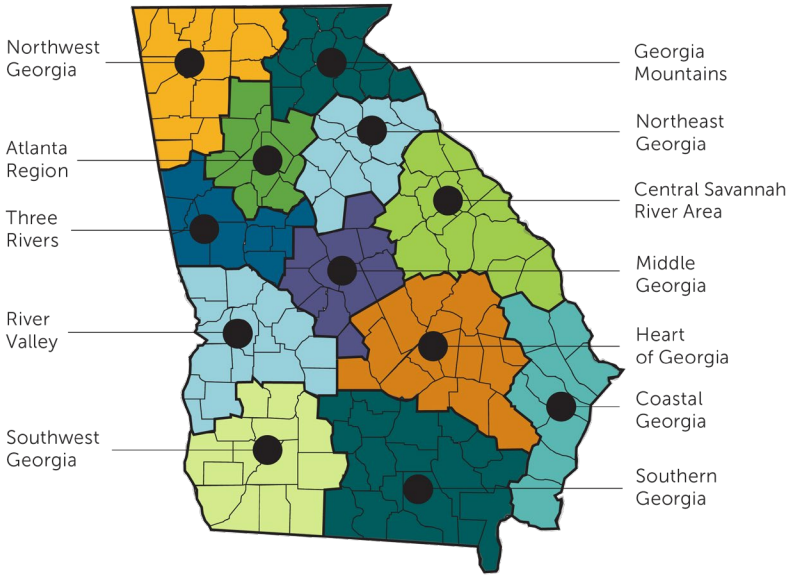
Providers and partners coordinated through the AAAs determine the needs of the senior and vulnerable adults we serve. They directly provide services to consumers, including meals and other nutrition services, in-home services, legal services, employment assistance, and ombudsman services.

GEORGIA'S AGING NETWORK

DAS collaborates with a variety of community partners and agencies to deliver services throughout the state. These partners include 12 AAAs, CILs, home and community-based service providers, and other state agencies.

In Georgia, DAS has designated 12 Planning and Service Areas (PSAs). All community-based services for older adults are coordinated through the designated AAAs for each specific PSA. Ten of the AAAs are housed within Regional Commissions (RCs), which are units of special purpose local government. The remaining two AAAs are freestanding, private nonprofit organizations, both of which have 501(c)(3) status with the Internal Revenue Service.

Planning and Service Areas



The AAAs are responsible for:

- Assuring the availability of an adequate supply of high-quality services using contractual arrangements with service providers, and for monitoring their performance.
- Local planning, program development and coordination, advocacy, and monitoring.
- Developing the Area Plan on Aging and area plan administration, and resource development.
- Working with local business and community leaders, the private sector, and locally elected officials to develop a comprehensive and coordinated service delivery system.
- Establishing and coordinating the activities of an advisory council, which will provide input on development and implementation of the area plan.

- Assisting in conducting public hearings, and reviewing and commenting on all community policies, programs and actions affecting older persons in the area.

GEORGIA COUNCIL ON AGING

In 1977, the Georgia General Assembly created the Georgia Council on Aging (GCOA). The Governor, Lieutenant Governor, Speaker of the House, and the Commissioner of the Department of Human Services appoint Council members. The Council has 20 members, including ten consumers at least 60 years of age and ten service providers. Members represent all older Georgians and ensure that minorities, low-income, rural, urban, public, and private organizations are included.

GCOA's primary mission is to:

- Advocate with and on behalf of aging Georgians and their families to improve their quality of life.
- Educate, advise, inform, and make recommendations concerning programs for the elderly in Georgia.
- Serve in an advisory capacity on aging issues to the Governor, General Assembly, DHS, and all other state agencies.

Coalition of Advocates for Georgia's Elderly (CO-AGE) is led by GCOA. The coalition is meant to be:

- A forum to identify and address concerns of older Georgians.
- A vehicle for bringing broad-based input on aging issues from across the state.
- A diverse group of organizations, individuals, consumers, and providers interested in "aging specific" and intergenerational issues.
- A unifying force communicating the importance of providing supportive communities and adequate services and programs for older Georgians.

GEORGIA ALZHEIMER'S & RELATED DEMENTIAS STATE PLAN

The Georgia Alzheimer's and Related Dementias (GARD) State Plan is designed to ensure that people living with dementia, their families, and caregivers have ready access to reliable information, support, and services that are delivered as effectively and efficiently as possible. The GARD State Plan establishes goals around the state's current and future ability to provide necessary services and programs for Georgians impacted by cognitive decline and recommends strategies to catalyze movement toward dementia capability.

The GARD advisory council and collaborating organizations continue to make advancements in the plan's priority areas. Experts and stakeholders from academia, government, nonprofit, health care, and those with lived experience serve on workgroups in the GARD collaborative. GARD plan goals fall into the following six areas:

- Research and Data
- Workforce Development
- Service Delivery
- Public Safety
- Outreach and Partnerships
- Policy

GEORGIA MEMORY NET

Georgia Memory Net (GMN) is a statewide program developed in partnership with Emory University dedicated to driving early diagnosis and treatment of Alzheimer's and related dementias. The goals of the program are to:

- Establish and sustain a network of Memory Assessment Clinics (MACs) across the state to increase patient access to accurate diagnoses.
- Engage statewide primary care clinicians to improve screening for cognitive impairment, increase referrals to GMN MACs, and provide support in their ongoing care of Georgians diagnosed with memory loss.
- Connect patients to critical community services.
- Provide oversight and evaluation of project performance.

During GMN's first year, MACs were established and training for healthcare providers and other professionals was conducted around the state. In state fiscal year (SFY) 2018, over 500 providers were informed about the project, a workflow was established, and MACs began seeing patients. The MACs are currently located at Augusta University in Augusta, Grady Health in Atlanta, Navicent Health in Macon, and Phoebe Putney Health in Albany.

In FY 2023, the Georgia legislature invested an additional $3 million in the GMN program, which will lead to expansion of the number of memory assessment clinics and telehealth capability. By the second quarter of FY 2024 there will be seven Memory Assessment Clinics across the state to include three new clinics to serve the coast, south Georgia, and north Georgia. These clinics will provide state-of-the-art diagnostic assessments of cognitive impairment at Savannah Neurology Specialists in Savannah, Memorial Health Meadows Adult Primary Care in Vidalia, and Northeast Georgia Physicians Group in Gainesville. By adding these new MACs, there will be increased access to early and accurate diagnosis and care planning across Georgia. This strong statewide infrastructure is groundbreaking and will serve as a model to other states as the first disease modifying drugs become available to those who are diagnosed in the early stage of Alzheimer's disease.

Telehealth sites are available in Dooly and Emanuel counties in partnership with the Georgia Department of Public Health.

In efforts to provide patients with community support services, strengthen clinician education, and raise awareness, GMN has engaged numerous partners across the state. Partnerships include the Rosalynn Carter Institute for Caregiving, the Alzheimer's Association Georgia Chapter, and the Area Agencies on Aging.

DEMENTIA CARE PROGRAM

The Dementia Care Program will fund a dementia care specialist (DCS) beginning in SFY 2023 in each of the twelve Area Agency on Aging (AAA) regions. In addition, the legislation allows for a full-time program lead in the Division of Aging Services to ensure program quality and integrated data collection across the program to maximize impact.

The DCS will:

- Drive collaboration among stakeholders in their local communities.
- Increase the frequency of memory screenings by reducing stigma.
- Support families impacted by dementia by strengthening the capabilities of the aging network.

The DCS will be the local catalyst for dementia care in their communities and, as such, will strengthen existing partnerships and forge new ones as they support their communities in becoming more dementia capable. The result will be greater collaboration throughout the state among partners, stakeholders, and families impacted by dementia.

To increase concern, awareness, and early detection, the DCS will offer community education and memory screenings, thereby promoting efforts to reduce stigma related to memory screening and dementia diagnosis.

Lastly, the DCS will provide targeted dementia-specific case management and support to caregivers while improving care coordination and transitions. As a specialized dementia coordinator within the AAAs, the DCS will ensure a seamless transition among services, including Georgia Memory Net and other health care providers. Overall, the Dementia Care Program will mobilize dementia-specific community resources and support services to better serve persons living with dementia and their families.

DEMENTIA FRIENDS

In 2019, GARD's Dementia Friendly Strategy Group launched Dementia Friends, a dementia information session that teaches attendees signs and symptoms of dementia and tips for communicating with people living with dementia. Since then, over 2,000 Georgians have become Dementia Friends.

PUBLIC HEALTH WORKFORCE

This program aims to increase the number of public health professionals within the State Health Insurance Assistance Program (SHIP) and aging and disability networks to address the unique needs of individuals through the support of wages and benefits for these professionals. Professionals supported through this program provide a wide range of public health services, including provision of culturally affirmative and linguistically accessible information, access assistance for vaccines and boosters, transition and diversion from high-risk congregate settings to community living, provision and connections to health and wellness programs, activities that address social isolation and social determinants of health, provision of education and outreach to ensure access to health insurance and benefits, and other activities that support the public health and well-being of individuals.

DAS was awarded three public health workforce grants that provide for four staff positions:

A **public health outreach specialist** was brought on to support the outreach work of the Georgia State Health Insurance Assistance Program (SHIP) and Aging & Disability Resource Connection (ADRC). The work of the outreach specialist includes:

- Serving as an organization resource related to COVID-19 testing, vaccine, and booster access.
- Developing and delivering training related to COVID-19 testing, vaccine, and booster access.
- Coordinating the dissemination of information and marketing materials related to COVID-19 testing, vaccine, and booster access with Aging and Disability Resource Connection/No Wrong Door System (ADRC/NWD) partners.

- Offering a monthly calendar of outreach and education events for Georgia SHIP and ADRC.

Two **social isolation program specialists** will help develop the telephone reassurance program across the state. Currently, there are four Area Agencies on Aging and one university conducting telephone reassurance. The Division of Aging Services has a goal of all twelve AAAs offering telephone reassurance services, as this has shown to reduce social isolation. The two specialists with the state will provide policies and technical assistance to the AAAs as they develop their programs.

According to the CDC:

- Social isolation significantly increases a person's risk of premature death from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.
- Social isolation is associated with about a 50% percent increased risk of dementia.
- Poor social relationships (characterized by social isolation or loneliness) are associated with a 29% increased risk of heart disease and a 32% increased risk of stroke.
- Loneliness is associated with higher rates of depression, anxiety, and suicide.

An **epidemiologist** will use existing and new data related to the DHS COVID-19 response for analysis, demonstration of readiness and/or gaps in the network's COVID-19 response and prepare recommendations to make the network more ready to respond appropriately in the event of a future public health emergency. Additionally, demographic analysis of who received services related to COVID-19 (i.e. if most clients were OAA target populations, living alone, low-income, rural, etc.) is being conducted and DAS is developing outreach plans to ensure that these populations are better identified/served in a future public health emergency and will propose mitigation strategies targeted to these underserved populations.

QUALITY MANAGEMENT

DAS uses the Baldrige Excellence Framework to systematically improve quality throughout the organization. During the next State Plan cycle, DAS will create a conflict-free delivery system.

An annual self-assessment and quarterly reviews of performance metrics allow DAS to ensure that key outcomes for both customers and the aging network are achieved and sustained. The Baldrige criteria encompasses an overview of the organization's leadership, strategy, customers, measurement analysis and knowledge management, workforce, operations, and results.

DAS uses comparative data as available to examine organizational performance and improvement opportunities. DAS' quality assurance activities include quarterly review of performance measures of operational and service effectiveness and efficiency, quarterly and annual compliance reviews of contractors, and annual customer and workforce satisfaction surveys.

DAS has implemented the DAS Data System (DDS) as the statewide information management system for documentation of client and provider data. The DDS compiles service delivery and financial data for all DAS programs. The DDS has enhanced the aging network's ability to collect meaningful data and to demonstrate the need for additional resources to meet the growing demand for long-term services and support statewide. Our continued development of DDS will help improve measures of outcomes for the clients we serve.

ASSISTIVE TECHNOLOGY PROGRAM

The Assistive Technology (AT) program was initiated in SFY 2015. Funding for this program provided each of the 12 AAAs and the Centers for Independent Living with a demonstration lab. The purpose of the AT labs is to showcase commonly used AT devices to assist older adults in living and working independently in the community of their choice. Additional funding was provided to all 12 AAAs in SFY 2019 to expand AT services in Georgia. During the COVID-19 pandemic, funding for AT services included the provision of Claris tablets to older adults to keep them engaged in physical activity and socially connected with their loved ones. Provision of AT devices is used to mitigate and minimize the risk of social isolation and loneliness.

GEORGIA SENIOR HUNGER INITIATIVE

The key goal of this initiative is to raise awareness and seek solutions in addressing senior hunger in Georgia, principally done through the execution of Georgia's State Plan to Address Senior Hunger implemented in December 2017. The plan consists of five focus areas in addressing senior hunger: Today's Seniors, Health Impact, Food Access, Food Waste and Reclamation, and Meeting the Community's Needs. Georgia has accomplished many of the recommendations of the first state plan and broader initiative goals that include:

- Annual conference participation to include Senior Hunger sessions (SFY19-SFY22).
- Hired a Senior Hunger/Nutrition Coordinator (SFY19).
- Developed 12 regional senior hunger coalitions (SFY19).
- Established a Senior Hunger Interagency Council (SHIC) (SFY22).
- Began coordinating data collection and analysis across agencies (SFY21).
- Began developing and providing education and training (SFY19).
- Expanded the What a Waste Program (SFY20).
- Began providing entrepreneurial mini grants (SFY19).
- Transitioned Senior Hunger Summit Committee to Senior Hunger Advisory Council (SHAC) (SFY22).
- Developed State Senior Hunger Toolkit and launched on initiative website (SFY22).

CONFLICT-FREE SERVICE DELIVERY NETWORK

In recent years, DAS has redesigned its HCBS case management program to focus on assessment and service planning for consumers with a high risk of institutionalization or who have complex needs that jeopardize their ability to live independently. DAS is currently convening a workgroup with representatives from the AAAs to reimagine Georgia's Access to Services system in light of shrinking resources and a growing population of older adults, persons with disabilities, and caregivers in need. Each AAA has identified the degree to which it operates a conflict-free service delivery system and the firewalls each has in place to mitigate conflict when funding is inadequate to implement a fully conflict-free system.

During the next State Plan cycle, DAS will continue to work to create a more conflict-free system. This will include convening additional workgroups, exploring pilot projects with AAAs, and identifying opportunities to maximize the role of the ADRC while segregating the functions of screening, eligibility determination, and assessment/service planning. DAS will utilize research from the National Senior Citizens Law Center and best practices from other states (including Arizona, Minnesota, Ohio, Vermont, Washington, and Wisconsin).

PERSON-CENTERED PLANNING

Person-Centered Planning (PCP) is a process that develops an individual support plan driven by the goals, strengths, and preferences of the person or client. The goal of PCP is to identify the needs of the client from their own perspective. and/or private pay options.

It affirms that each person is the expert in his/her own life and facilitates an informed choice of public and/or private pay options. This approach to service delivery acknowledges that a person's goals, preferences, strengths, and challenges change over time and that the system of care should support those changes.

The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) awarded DAS a three-year technical assistance grant to support development of an operational definition of person-centered service delivery that can be tracked over time. During the previous state plan cycle, DAS worked with state and local partners, as well as subject matter experts from around the country, to develop a common definition of person-centered service delivery in Georgia that spans multiple service agency systems (including aging, developmental disabilities, and behavioral health) and criteria to regularly evaluate our movement toward promoting person-centered support to individuals across the lifespan. This definition is as follows:

Georgia promotes a person-centered approach in the delivery of services to individuals and families that is based on:

- A holistic approach that acknowledges the individual and their loved ones to be the experts in their own lives that centers on the individual/family; that explicitly includes their strengths, interests, values, assets and challenges, and that is trauma-informed and culturally aware and competent.
- Flexible and collaborative plans of care that explicitly define roles of all members of the support team that allow for multiple pathways for success and that account for and mitigate challenges.
- Intentional conversations and actions that support individuals/families on their journey toward life goals that encourage them to dream and explore possible futures and that build their resilience.
- A system of care that aligns services to ensure the individual has maximum access to the benefits of living in the community and that facilitates the individual achieving his/her desired outcomes.

As we continue to promote the use of person-centered practices in all aspects of service delivery, DAS will seek to expand funding and use of consumer-directed services and move from a service-centric waiting list for services (in which waiting lists are maintained by service) to a person-centered waiting list (in which waiting lists are maintained by a consumer's impairment and need).

BEHAVIORAL HEALTH

According to the National Institute of Mental Health, nearly one in five U.S. adults lives with a mental illness, and 4.2% of adults live with a serious mental illness. The prevalence of mental illness in persons aged 50 and older is 15% and the prevalence of serious mental illness in that age group is 2.5%. The Centers for Disease Control and Prevention (CDC) estimates that 20% of people aged 55 years and older experience some type of mental health concern. The most common conditions include anxiety and mood disorders such as depression and bipolar disorder. Older men have the highest suicide rate of any age group. Depression is the most prevalent behavioral health condition affecting older adults and can result in declines in physical health, socialization, and the ability to live and function independently in the community. Behavioral health issues also negatively impact the ability to manage chronic medical conditions.

DHS works with numerous agencies and coalitions to improve access to behavioral health services for older adults, persons with disabilities, and caregivers. These include, but are not limited to, the Georgia Coalition on Older Adults and Behavioral Health, Department of Behavioral Health and Disabilities (DBHDD), Department of Public Health (DPH), Department of Community Health (DCH), NAMI Georgia, Georgia Mental Health Consumer Network, Georgia Council on Substance Abuse, Georgia Council on Developmental Disabilities (GCDD), Statewide Independent Living Council of Georgia (SILC), Georgia Advocacy Officer (GAO), Rosalynn Carter Institute for Caregiving (RCI), Fuqua Center for Late-Life Depression at Emory University, and the Carter Center's Mental Health Program.

These partnerships have worked in recent years to expand access to behavioral health resources and services for older adults across Georgia, including:

- Improving local and statewide coordination and collaboration among behavioral health services, AAAs, Adult Protective Services (APS), and the Public Guardianship Office (PGO).

- Advocating for improvements in service delivery for older adults who experience severe or persistent mental illness.
- Facilitating improved access to the continuum of care related to older adults who have a behavioral health diagnosis or substance use disorder.
- Developing opportunities for staff and stakeholder agencies to gain knowledge, education, and training in order to provide more effective trauma-informed support for older adults and their caregivers.

In January 2023, the DAS ADRC Program Manager assumed the role of chairperson for the Georgia Coalition on Older Adults and Behavioral Health. Serving in this capacity will enhance opportunities for partner agencies and advocacy organizations will continue to work together with the understanding that social determinants of health impact the screening, diagnosis, and treatment of behavioral health issues in older adults. The Coalition's goals moving forward include increasing screening capacity and competence within the Aging network (training on screening tools, mental health first aid, and suicide prevention), and enhancing coordination and access among local aging and behavioral health services providers.

TRANSPORTATION/ACCESS

Experts, including the National Association of States United for Aging and Disability (NASUAD), the American Public Transit Association, and the National Association of Area Agencies on Aging, often cite transportation as one of the most pressing issues facing older adults. DHS contracted with the Georgia Health Policy Center at Georgia State University to inform DHS about these issues in Georgia. In its report presented in November 2018, the Center noted that:

- Older adults will outlive their driving ability by 11 years for women and six years for men.
- Based on estimates of the 2016 population, more than 263,000 Georgians aged 70 and older had ceased driving.
- An estimated 200,000 Georgians aged 70 and older may have unmet transportation needs.

Because lack of transportation has a significant effect on quality of life for older adults, including increased depression, increased social isolation, and decreased access to goods and services, DHS is placing high importance on this issue over the next four years. However, DAS believes that the issue is broader than transportation; therefore, DAS will focus its efforts using the broader context of improving access to services for older adults. These strategies will include improving use of scarce resources and implementing creative approaches (like increasing quality of life trips) to both getting seniors to services they need and desire and getting services to the seniors.

State and Area Plan Alignment

Section 305. (a)(1)(A) of the Older Americans Act, as amended through P.L. 114-144, enacted April 19, 2016, requires that the state agency shall be primarily responsible for the planning, policy development, administration, coordination, priority setting, and evaluation of all State activities related to the objectives of the Act.

Section 307. (a)(1) of the Act requires that the state plan mandate that each designated area agency develop an area plan for submission to and approval by the state agency, and that the state plan be informed by and based on such area plans.

In compliance with both sections, DAS has established a four-year planning cycle such that area plans are developed in the first year and amended as required in the succeeding three years. State plan development is accomplished in the fourth year of the schedule and uses area plan information and performance data as the basis against which compliance with standard assurances, evaluation of regional capacity, effectiveness of service delivery, and the degree to which target populations are served are measured. Based on area plans from the previous State Plan cycle, the state plan establishes statewide goals and objectives for the next area plan cycle to which area agencies must align new area plans developed in the new planning cycle. Area agencies are provided the option to include area specific targets appropriate to serve regional needs absent conflicts with statewide direction.

Goals, Objectives, and Measures

In compliance with the OAA requirements, DAS has developed clear, measurable goals and objectives that meet the ACL's focus areas. The goals embrace person-centered and consumer-directed approaches to improve service delivery, strengthen the aging network and increase safety for older Georgians and people with disabilities.

GOAL 1: Provide long-term services and supports that enable older Georgians, their families, caregivers, and persons with disabilities to fully engage and participate in their communities for as long as possible.

GOAL 2: Ensure older Georgians, persons with disabilities, caregivers, and families have access to information about resources and services that is accurate and reliable.

GOAL 3: Strengthen the aging network to enable partners to become viable and sustainable; and develop a robust network of aging service partners.

GOAL 4: Prevent abuse, neglect, and exploitation while protecting the rights of older Georgians and persons with disabilities.

GOAL 5: Utilize continuous quality improvement principles to ensure the SUA operates efficiently and effectively.

Program Key:

ADRD
Alzheimer's Disease & Related Dementias

ADRC
Aging & Disability Resource Connection

ADMIN
DAS Administration

PI
Program Integrity

APS
Adult Protective Services

FSIU
Forensic Special Initiatives Unit

SHIP
Georgia SHIP

ELAP
Elder Legal Assistance Program

LTCO
Long-Term Care Ombudsman

PGO
Public Guardianship Office

HCBS
Home and Community Based Services

MFP
Money Follows the Person

NHT
Nursing Home Transitions

GOAL 1

Provide long-term services and supports that enable older Georgians, their families, caregivers, and persons with disabilities to fully engage and participate in their communities for as long as possible.

	Objective	Measure	Program	Focus Area
1.1	Increase the number of clients who receive Options Counseling (OC) services from certified Options Counseling staff by 5% each year.	Number of AAA staff who have completed the Options Counseling certification statewide.	ADRC	Advancing Equity

Strategies
- Identify roles at each AAA that need OC certification and enroll staff needing OC certification in Boston University training
- Ensure certified OCs participate in OC certification refresher courses
- Ensure workflow identifies clients needing options counseling and those clients are then referred to certified OCs

	Objective	Measure	Program	Focus Area
1.2	Develop a more dementia capable aging network.	Assess the number of active clients with a formal or self-reported dementia diagnosis and establish a baseline to measure the number of memory screenings per year per AAA. The memory screenings will take place at the local level (at the AAA/in the community).	ADRD	Building a Caregiving Infrastructure

Strategies
- Establish the workflow for the dementia care specialist (DCS) role
- Assess the number of active clients with a formal or self-reported dementia diagnosis and establish a baseline to measure the number of memory screenings per year per AAA
- DCS will provide quarterly dementia training for AAA staff, providers, and partners
- 75% of AAA staff will participate in at least two Dementia Care Specialist and two Georgia Memory Net training sessions annually
- Have 1-2 AAA staff members attend the annual GMN Summit, Quarterly CSE Education Webinar, and/or other GMN-related events

	Objective	Measure	Program	Focus Area
1.3	After receiving meals, the number of clients with low or very low food security will decrease by 5%.	Food security impact report will show how many clients have a food security survey score of 2 or more beginning on July 1, 2021 (SFY22). Establish baseline in 2022. By 2027, the goal will be to decrease baseline by 5%.	HCBS	Advancing Equity

Strategies
- Develop and expand targeted efforts to increase access to food and financial resources for vulnerable seniors to reduce senior hunger in Georgia.
- Target reasons for why clients are low or very low food security (share info about SNAP education/application guidance, nutrition counseling, increase meal provision, etc.)

	Objective	Measure	Program	Focus Area
1.4	Decrease the number participants who are reinstitutionalized in the Nursing Home Transition Program each year.	Number of AAA staff who have completed the Options Counseling certification statewide.	NHT	Supports Advancing Equity

Strategies
- AAAs will participate and engage in training and technical assistance opportunities provided by Division of Aging Services staff for the NHT program.
- Facilitating a discharge meeting to assess the broader needs of the client and anticipate risks for reinstitutionalization
- Develop report in DDS

	Objective	Measure	Program	Focus Area
1.5	Reduce social isolation of HCBS clients in Georgia.	Increase initial assessments and service referral documentation in DDS data %.	HCBS	COVID-19 Recovery

Strategies
- Establish policy/guidance for AAA network
- Baseline number clients who are socially isolated by SFY 2024
- By 2025, increase opportunities for social engagements with internal and external entities (I.e. home delivered meals, universities' telephone reassurance programs, etc.)
- Institute a multi-disciplinary advisory group that includes relevant divisions and strategic system-level stakeholders to provide support and guidance on matters related to activities and services within the aging community
- Provide data, technical assistance on systems processing information, and staff training under DAS (Lubben 6-itemand UCLA 3-item Assessment Scales)Increase initial assessments and service referral documentation in DDS data

	Objective	Measure	Program	Focus Area
1.6	Increase the number of participants completing 365 days in the MFP transition program.	Number of completed transitions	MFP	Supports Advancing Equity

Strategies
- AAAs will conduct meaningful outreach to organizations, agencies, professionals, and other individuals that serve older adults and individuals with disabilities (i.e. hospitals, nursing homes, senior centers, Long-term Care Ombudsman, etc.) in order to provide information and education on the MFP program
- AAAs will participate and engage in training and technical assistance opportunities provided by Division of Aging Services staff for the MFP program
- Use Data Source: MFP/NHT Enrollment Report (reviewed weekly) and the Monthly Transition Reports (submitted monthly by AAAs)

	Objective	Measure	Program	Focus Area
1.7	Increase the length of time older adults remain in their homes while receiving HCBS services.	Length of time in HCBS service	HCBS	Supports Expanding Access to HCBS

Strategies
- Focus on targeting assistive technology to individuals
- Encourage more home modification services using Title IIIB funds

GOAL 2

Ensure older Georgians, persons with disabilities, caregivers, and families have access to information about resources and services that is accurate and reliable.

	Objective	Measure	Program	Focus Area
2.1	Develop a more dementia capable aging network.	Year 1: define the metrics for a dementia capable network. Year 2: establish baseline. Years 3 and 4: measure utilizing PDCA model.	ADRD	Supports Building a Caregiver Infrastructure

Strategies
- Establish the workflow for the DCS role
- Assess the number of active clients with a formal or self-reported dementia diagnosis and establish a baseline to measure the number of memory screenings per year per AAA
- DCS will provide quarterly dementia training for AAA staff, providers, and partners
- AAA staff will participate in at least two Dementia Care Specialist and two Georgia Memory Net training sessions annually
- Have 1-2 AAA staff members attend the annual GMN Summit, Quarterly CSE Education Webinar, and/or other GMN-related events

	Objective	Measure	Program	Focus Area
2.2	To widen access by OAA priority client groups.	Years 1-4: translate two existing publications to languages other than English each state fiscal year. Year 2: establish a baseline for utilization (downloads in specific languages, requests for printed booklets, distribution by providers) of education booklets in languages other than English. Years 3 and 4: assess how many OAA priority client groups receive education booklets in languages other than English through specific outreach.	ELAP	Expanding Access to HCBS

Strategies
- Update existing ELAP publications
- SLSD will review and improve publications to decrease access barriers
- Per FY, the SLSD will have two existing publications translated to languages other than English

	Objective	Measure	Program	Focus Area
2.3	After receiving meals, the number of clients with low or very low food security will decrease by 5%.	Number of first-time contacts	ADRC	Expanding Access to HCBS

Strategies
- AAAs will conduct meaningful outreach to organizations, agencies, professionals, and other individuals that serve older adults and individuals with disabilities (i.e. hospitals, nursing homes, senior centers, faith-based organizations, etc.) to provide information and education on the resources available through ADRC
- AAAs will utilize their ADRC Advisory Council as a resource for building new partnerships and for expanding access to ADRC resources

	Objective	Measure	Program	Focus Area
2.4	Increase referrals to the AAAs to provide services to clients with unmet needs.	Increase by 10% each year through SFY 2027	APS	Advancing Equity

Strategies
- Training will be provided to the AAAs and APS staff
- Managers will check monthly the referral status to the AAAs

	Objective	Measure	Program	Focus Area
2.5	Increase the number of Georgia SHIP client contacts by 3% statewide.	Number of client contacts	SHIP	Supports Advancing Equity
2.6	Increase the number of individuals served at Georgia SHIP outreach and education events by 3% statewide annually.	Number of individuals served at outreach and education events	SHIP	Supports Advancing Equity
2.7	Increase the number of Georgia SHIP low-income, rural, and non-native English clients served by 3% statewide annually.	Increase the number of hard to reach contacts	SHIP	Supports Advancing Equity
2.8	Increase the number of first-time contacts to ADRC by 5% each successive year.	Number of first-time contacts	ADRC	Advancing Equity

Strategies
- AAAs will participate and engage in training and technical assistance opportunities provided by Division of Aging Services staff around data entry in the DDS
- AAAs will ensure that ADRC staff receive ongoing education and skill-building opportunities around motivational interviewing to improve the quality of intakes and screenings that are completed

GOAL 3

Strengthen the aging network to enable partners to become viable and sustainable; and develop a robust network of aging service partners.

	Objective	Measure	Program	Focus Area
3.1	The aging network will have a conflict-free service delivery system by SFY 2028.	All 12 AAAs will have a conflict-free service delivery system by SFY 2028	HCBS	Advancing Equity

Strategies
- Convene statewide workgroup inclusive of all AAAs
- Each AAA will develop operational plan to ensure assessment process is conflict free
- Ensure provider networks are prepared to participate in conflict free delivery system
- SUA provide technical assistance and training and the AAAs will follow/do the same

	Objective	Measure	Program	Focus Area
3.2	Ensure legal information and services are available to, accessible by, and tailored to OAA priority client groups	Years 1 and 2: develop new community education booklets that address the unique legal issues faced by OAA priority client groups. Year 3: establish a baseline for utilization (downloads, requests for printed booklets, distribution by providers) of education booklets that address the unique legal issues faced by OAA priority client groups. Year 4: assess how many OAA priority client groups receive education booklets through specific outreach.	ELAP	Advancing Equity
3.3	Increase the number of staff who have NAPSA Certification.	70% of eligible APS staff will be certified by SFY 2028	APS	Expanding Access to HCBS

Strategies
- New staff will be identified and scheduled for training within three months from hiring
- Six trainings assigned upon hiring that must be completed during the prior to New Worker Training and one training assigned every month thereafter
- Assures that all trainings have been completed by the completion of year 2 of employment
- Process in place to help determine the progress of each new staff member

	Objective	Measure	Program	Focus Area
3.4	Increase the number of CACTS Specialists by 10% annually	Number of CACTS specialists trained	FSIU	Supports Advancing Equity, Expanding Access to HCBS, and Covid-19 Recovery

Strategies
- Conduct focused and targeted marketing
- Continue offering hybrid training
- Require all At-Risk Adult MDT members to attend the training
- Maintain a presence at Prosecuting Attorneys' Council conferences
- Host informational MDT/Task Force meetings quarterly

	Objective	Measure	Program	Focus Area
3.5	Strengthen and increase partnerships among AAA staff and community partners across the state in dementia programming	Year 1: identify local partners, convene, or join a local dementia collaborative, and establish baseline for joint programs offered. Years 2-4: expand local dementia collaboratives, host regular meetings, and increase number of joint programs offered.	ADRD	Building a Caregiver Infrastructure and Expanding Access to HCBS

Strategies
- Every DCS will initiate and/or participate in a community dementia collaborative
- All AAAs will submit two progress reports (using form generated by DAS) each year (mid-year and annual review) detailing efforts/accomplishments
- All AAAs will ensure at least two staff or community partners serve on two different GARD Collaborative workgroups each SFY
- Identify local health department partners, establish working relationships, and create joint programming

	Objective	Measure	Program	Focus Area
3.6	Develop a more dementia-capable aging network *(Communities, including service organizations, businesses, faith communities, and health care providers, that recognize and understand the signs and impact of dementia and offer support to people living with dementia and their families)*	Year 1: define the metrics for a dementia capable community. Year 2: establish baseline. Years 3 and 4: measure utilizing PDCA model.	Dementia	Expanding Access to HCBS

Strategies
- Year 1: DCS will plan two community or family dementia education programs
- Years 2-4: add an additional community-based dementia education program each year per AAA
- Every AAA will identify a staff or volunteer Dementia Friends Champion who will host two Dementia Friends information sessions a year (to include 1-2 slides on GMN at the end of presentation as resource) to four unique community businesses or organizations

	Objective	Measure	Program	Focus Area
3.7	Increase the number of outreaches by 10% each year through 2027	Increase % each year through 2027	APS	COVID-19 Recovery

Strategies
- Outreaches will be recorded in DDS under providers' tab
- Managers will review the activity log monthly
- Training is available on how to access and pull the activity log

	Objective	Measure	Program	Focus Area
3.8	AAAs and providers will document collaborative planning, objectives, and strategies for providing services to OAA priority client groups. All AAAs will submit to DAS via the State Legal Services Developer a copy of the collaborative planning, objectives, and strategies document.	All AAAs will submit to DAS via the State Legal Services Developer (SLSD) a copy of the collaborative planning, objectives, and strategies document.	ELAP	Advancing Equity

Strategies

- Through annual meetings, AAAs and providers will document collaborative planning, objectives, and strategies for providing services to OAA priority client groups
- Collaborative planning, objectives, and strategies documents submitted to SLSD for review
- Annually, SLSD presents to AAAs and providers the outcomes of the objectives and provides technical support for meeting objectives

	Objective	Measure	Program	Focus Area
3.9	Develop professional competencies of Public Guardianship Office staff through trainings, meetings, and conference opportunities.	Number of monthly in-service trainings	PGO	Expanding Access to HCBS

Strategies

- PGO staff will participate in a minimum of one monthly in-service training
- Training will be identified and scheduled by PGO Policy Specialist and Training and Development staff
- Completed trainings will be recorded in DDS under Activity Log

GOAL 4

Prevent abuse, neglect, and exploitation while protecting the rights of older Georgians and persons with disabilities.

	Objective	Measure	Program	Focus Area
4.1	Staff a minimum of 20 cases with DBHDD and APS a year to determine if an alternative to Guardianship is appropriate or other persons are involved who could serve as guardian.	Number of cases reviewed with DBHDD and APS	PGO	Expanding Access to HCBS

Strategies
- Submit or provide assistance with filing 10 petitions annually for restoration, successor guardianship
- Staff will document in DDS when client is assessed and found appropriate for restoration, or a successor found
- Client's case closure reason will be captured in DDS if restoration or successor guardianship occurs

	Objective	Measure	Program	Focus Area
4.2	By SFY 2028, develop basic 1-2 hour ANE courses for identified professionals outside of the aging network (health care, Medical Examiners, criminal justice-based victim advocates, and others).	Number of persons trained for each course; number of courses developed	FSIU	Covid-19 Response, Expanding Access to HCBS, and Advancing Equity

Strategies
- Build various courses for each specified discipline using state training platform
- Courses can be accessed on demand
- Market courses state-wide

	Objective	Measure	Program	Focus Area
4.3	Increase the number of attendees for the new ANE courses by 10% annually once deployed.	Number of individuals trained	FSIU	Covid-19 Response, Expanding Access to HCBS, and Advancing Equity

Strategies
- Market training via FSIU newsletter
- Partner with other local and state agencies to market training opportunities
- Explore making certain training offerings mandatory

	Objective	Measure	Program	Focus Area
4.4	Increase the number of attendees for REACT Mandated Reporter online training by 10% annually	Number of people who complete the course	FSIU	Covid-19 Response, Expanding Access to HCBS, and Advancing Equity

Strategies
- Partner with colleges and universities to offer course as extra credit for Social Work, Psychology, Public Health, and Gerontology students
- Market the course state-wide
- Partner with the AAAs to offer asynchronous training

	Objective	Measure	Program	Focus Area
4.5	Increase number of restorations and successor guardianships by 20%.	Number of restorations and successor guardianships	PGO	Expanding Access to HCBS

Strategies

- Submit or provide assistance with filing 10 petitions annually for restoration, successor guardianship
- Staff will document in DDS when client is assessed and found appropriate for restoration, or a successor found
- Client's case closure reason will be captured in DDS if restoration or successor guardianship occurs

GOAL 5

Utilize continuous quality improvement principles to ensure the State Unit on Aging operates efficiently and effectively.

	Objective	Measure	Program	Focus Area
5.1	Implement the Bakas Caregiving Outcomes Scale (BCOS) assessment for all family caregivers receiving respite care statewide.	Percentage of In-Home Respite Care and Out-of-Home Respite Care clients with a completed BCOS assessment in their DDS client record (Building a Caregiving Infrastructure) Baseline 2023 – 81.40%.	HCBS	Building a Caregiving Infrastructure

Strategies
- Provide technical assistance to the AAAs on the BCOS assessment
- State will monitor the data/assessment entry into the DAS data system

	Objective	Measure	Program	Focus Area
5.2	By SFY 2028, develop basic 1-2 hour ANE courses for identified professionals outside of the aging network (health care, Medical Examiners, criminal justice-based victim advocates, and others).	Number of judicial circuits served/MDT and Task Force meetings attended *(COVID-19 Recovery).*	FSIU	Supports Advancing Equity and Expanding Access to HCBS

Strategies
- Build various courses for each specified discipline using state training platform
- Courses can be accessed on demand
- Market courses state-wide

	Objective	Measure	Program	Focus Area
5.3	Increase collaboration with judicial circuits/Technical Assistance for At-Risk Adult MDTs.	Number of judicial circuits served/MDT and Task Force meetings attended *(COVID-19 Recovery).*	FSIU	Expanding access to HCBS

Strategies
- Partner with colleges and universities to offer course as extra credit for Social Work, Psychology, Public Health, and Gerontology students
- Market the course statewide
- Partner with the AAAs to offer asynchronous training

	Objective	Measure	Program	Focus Area
5.4	Senior centers update, modernize, and implement emergency preparedness plans.	All AAAs will provide annual summary report of plan submissions to SUA.	HCBS	Expanding Access to HCBS

Strategies
- All senior centers will have a written emergency plan which includes a plan for when older adults cannot get to the senior center by SFY 2028
- All AAAs and senior centers will conduct one emergency drill a year and will submit any after action report developed after the drill to the AAA and DAS
- Senior center directors will increase their knowledge of emergency preparedness by participating in SUA sponsored trainings
- Senior center manager onboarding including annual review of the plan
- 100% of senior center directors will complete the Senior Center Community College course on emergency preparedness by SFY 2028

	Objective	Measure	Program	Focus Area
5.5	85% clients served meets at least one OAA target criteria by SFY 2028.	Number of clients meeting at least 1 OAA target criteria	HCBS	Expanding Access to HCBS

Strategies
- Collaboration between ADRC and HCBS program staff to collect targeting data

	Objective	Measure	Program	Focus Area
5.6	Maintain a 90% accuracy rate on data collection for key demographic data elements annually.	Accuracy Rate Percentage	ADRC	Supports Expanding Access to HCBS

Strategies
- AAAs will participate and engage in training and technical assistance opportunities provided by DAS staff around data entry in the DDS
- AAAs will ensure that ADRC staff receive ongoing education and skill-building opportunities around motivational interviewing to improve the quality of intakes and screenings that are completed
- Data Source: DDS Missing Data Elements Report

	Objective	Measure	Program	Focus Area
5.7	Maintain 90% accuracy rate of investigation case record reviews.	Accuracy Rate Percentage	APS	Supports Expanding Access to HCBS

Strategies
- Identify areas for training where reviews indicate a need, to ensure key data elements are documented during the investigation
- Managers will provide coaching on key data elements
- Training will be provided when a need is identified

ATTACHMENTS

Attachments

State Plan Guidance

Attachment A

HOLD SPACE FOR STATE PLAN ASSURANCES

State Plan Guidance

Attachment B

INFORMATION REQUIREMENTS

IMPORTANT: States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (d) requires each State Plan must include a description of how greatest economic need and greatest social need are determined and addressed by specifying:

(1) How the State agency defines greatest economic need and greatest social need, which shall include the populations as set forth in the definitions of greatest economic need and greatest social need, as set forth in 45 CFR § 1321.3; and

(2) The methods the State agency will use to target services to such populations, including how OAA funds may be distributed to serve prioritized populations in accordance with requirements as set forth in 45 CFR § 1321.49 or 45 CFR § 1321.51, as appropriate.

"Greatest economic need" means "the need resulting from an income level at or below the Federal poverty level and as further defined by State and area plans based on local and individual factors, including geography and expenses" (45 CFR § 1321.3).
"Greatest social need" means the need caused by the following noneconomic factors as defined in 45 CFR § 1321.3.

A State agency's response must establish how the State agency will:

(1) identify and consider populations in greatest economic need and greatest social need;
(2) describe how they target the identified the populations for service provision;
(3) establish priorities to serve one or more of the identified target populations, given limited availability of funds and other resources;
(4) establish methods for serving the prioritized populations; and
(5) use data to evaluate whether and how the prioritized populations are being served.

RESPONSE: DAS defines Greatest Economic Need and Greatest Social Need as follows:
Greatest Economic Need: Need resulting from an income level at or below the federal poverty level.
Greatest Social Need: Need caused by non-economic factors that restrict the individual's ability to perform normal daily tasks or threatens the capacity of the individual to live independently, and may include:

- Physical and mental disabilities, including sensory impairments
- Limited English proficiency or other language barriers
- Cultural, social, or geographical isolation, including isolation caused by racial or ethnic status
- Rural
- Lives alone
- Isolation caused by other factors (for example: religious affiliation, sexual orientation, gender identity, or any other population identified by the PSA based on its particular environment).

DAS will continue to use its approved Intrastate Funding Formula (IFF) to ensure preference in providing services to older individuals with greatest economic need and older individuals with greatest social need. In the IFF, emphasis is placed on low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. See DAS' IFF in Attachment 'D.' DAS and Georgia's AAAs follow policy in Manual 5300 Section 114 and 118 to ensure clients with Greatest Economic Need and Greatest Social Need are targeted and prioritized for service.

Native Americans: Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (g):
Demonstration that the determination of greatest economic need and greatest social need specific to Native American persons is identified pursuant to communication among the State agency and Tribes, Tribal organizations, and Native communities, and that the services provided under this part will be coordinated, where applicable, with the services provided under Title VI of the Act and that the State agency shall require area agencies to provide outreach where there are older Native Americans in any

planning and service area, including those living outside of reservations and other Tribal lands.

RESPONSE: Georgia has no Title VI grantees and two-tenths of one percent (0.21%) of Georgian's aging population are reported as American Indian or Alaska Native, numbering an estimated 2,611 individuals. These individuals are encompassed under DAS' definition of Greatest Social Need as they may experience cultural, social, or geographical isolation due to racial or ethnic status. DAS continues to pursue numerous activities to assure older Georgians who are American Indian or Alaska Native have access to Title III funded services.

Activities to Increase Access and Coordination for Native American Older Adults

OAA Section 307(a)(21): The plan shall —
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

45 CFR § 1321.53:
(a) For States where there are Title VI programs, the State agency's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in § 1322.13(a), must explain how the State's aging network, including area agencies and service providers, will coordinate with Title VI programs to ensure compliance with sections 306(a)(11)(B) (42 U.S.C. 3026(a)(11)(B)) and 307(a)(21)(A) (42 U.S.C. 3027(a)(21)(A)) of the Act. State agencies may meet these requirements through a Tribal consultation policy that includes Title VI programs.
(b) The policies and procedures set forth in (a) of this provision must at a minimum address:
(1) How the State's aging network, including area agencies on aging and service providers, will provide outreach to Tribal elders and family caregivers regarding services for which they may be eligible under Title III and/or VII;
(2) The communication opportunities the State agency will make available to Title VI programs, to include Title III and other funding opportunities, technical assistance on how to apply for Title III and other funding opportunities, meetings, email distribution lists, presentations, and public hearings;
(3) The methods for collaboration on and sharing of program information and changes, including coordinating with area agencies and service providers where applicable; How Title VI programs may refer individuals who are eligible for Title III and/or VII services;
(4) How services will be provided in a culturally appropriate and trauma-informed manner; and
(5) Opportunities to serve on advisory councils, workgroups, and boards, including area agency advisory councils, as set forth in § 1321.63.

RESPONSE: Georgia has no Title VI grantees. Two-tenths of one percent (0.21%) of Georgian's aging population are reported as American Indian or Alaska Native, numbering an estimated 2,611 individuals. DAS will pursue numerous activities to assure older Georgians who are American Indian or Alaska Native will have access to Title III funded services. DAS will provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible. Additionally, they will also have the opportunity to review the DAS State Plan and other documents made available for public comment.

Low Income Minority Older Adults

OAA Section 307(a)(14):
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low- income minority older individuals with limited English proficiency.

RESPONSE: DAS' IFF breaks this into two separate variables, with differing weights. Total statewide 65+ low income minority population considered for the preceding fiscal year was 50,148, and the variable has the assigned weight of 10%. Older individuals with limited English proficiency numbered 34,079, and the variable has a weight of 4%. In an effort to meet the needs of low-income minority older individuals, and individuals with limited English proficiency, DAS and the Area Agencies shall provide them access to community resources and/or assist them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

Rural Areas – Hold Harmless

OAA Section 307(a)(3): The plan shall—
...
(B) with respect to services for older individuals residing in rural areas—
(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:
(i)For each fiscal year of this State Plan, DAS will not expend less than the amount expended for services for older individuals residing in rural areas than expended in fiscal year 2000.

(ii)During the beginning of each state fiscal year, DAS issues a budget allocation. At this time, DAS does not project allocations. However, with each allocation, older individuals residing in rural parts of each service area receive funding. A key attribute of DAS' IFF is the allocation of funds for individuals 60 and older residing in rural areas. There is fifteen percent weighted variable for individuals who are 60 and older residing in rural areas.

(iii) DAS utilizes several tools to help determine the location of the older individuals residing in rural areas in Georgia. Some include mapping, census data and analysis through DAS' data management system. AAAs then target these individuals and utilize a person centered approach to service delivery designed to support older adults and individuals with disabilities to live longer, safely and well.

Rural Areas – Needs and Fund Allocations

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

RESPONSE: DAS' IFF provides a greater weighted variable (15%) for individuals who are age 60 and older and reside in rural areas, in addition to a lesser 10% weighted variable for individuals who are 60 and older. Sixty and older rural for the previous fiscal year numbered 457,199, while population ages 60 and older (non-rural) was 1,528,041. Georgians ages 60 and older both in rural and non-rural areas are having their needs met by providing them access to community resources and/or assisting them in identifying and securing resources or services in order to enhance wellness and remain in the community for as long and as safely as possible.

Assistive Technology

OAA Section 306(a)(6)(I):
Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the area agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE: DAS coordinates with the State assistive technology entity (Ga Tech Tools for Life) to provide assistive technology (AT) options for older adults in many ways. Tools for Life was an integral partner when DAS set up AT labs in the 12 AAAs and the Centers for Independent Living around the state. Tools for Life also sets up a demo room annually at the Healthy Communities Summit, a statewide conference for those in the aging and disability network. We are also working collaboratively on a "decision tree", which will match up AT while an ADRC counselor does the DON-R assessment on a client.

Minimum Proportion of Funds

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

RESPONSE: Title IIIB includes funding to meet the minimum required maintenance of effort for the Long Term Care

Ombudsman, and above that level, any amount deemed necessary by the State Unit Director to carry out an effective statewide ombudsman program. Georgia exceeds the required LTCO maintenance of effort. Georgia required that a minimum of 5% of Title IIIB funds be expended by region for Elder Legal Assistance. Maintenance of Effort – Each Area Agency shall provide an adequate proportion of funding received through Title III-B of the Older Americans Act, as amended, for supportive services in the Act. Calculation of the minimum percent is based on the pre-shift amount of the Title III-B allocation for the appropriate fiscal year. Adequate proportions of funding for supportive services shall include each of the following supportive services categories and their designated services. Access Services. Services associated with access to other services, such as transportation, outreach, information and assistance, and case management services. The Area Agency shall provide a minimum of 12% of funding for this category overall. In-home services. Supportive services such as homemaker, home health assistance, visiting and telephone assurance, chore maintenance, and supportive services for families of older persons with Alzheimer's disease and related disorders with neurological and organic brain dysfunction. The Area Agency shall provide a minimum of 5% of funding for this category overall. Legal Assistance. This includes legal representation, legal counseling, and the provision of information. The area agency shall provide a minimum of 5% of funding, or $60,000, whichever is greater, for this category overall. NOTE: Of this required minimum for Legal Assistance, the 5% of Title IIIB funds cannot be waived, but the remainder of the minimum funding level may be from any other source(s).

Assessment of Statewide Service Delivery Model

OAA Section 307(a)(27):
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services

RESPONSE: DAS does and will continue to monitor annual US Census population estimates as well as state research institution analysis of population shifts to assess statewide changes in the elderly population. Annual aging network needs assessments will also be reviewed to determine gaps in service delivery including informing any new programming requirements.

Funding Allocation – Ombudsman Program

45 CFR Part 1324, Subpart A:
How the State agency will coordinate with the State Long-Term Care Ombudsman and allocate and use funds for the Ombudsman program under Title III and VII, as set forth in 45 CFR part 1324, subpart A.

RESPONSE: Georgia DAS uses the allocation methodologies outlined in Administrative Manual Section 2003 to distribute funds for the Ombudsman Program under Title III and VII. This allocation formula is approved by the State Long Term Care Ombudsman, which is provided the authority to manage funds designated for the LTCOP, as per the Georgia Long-Term Care Ombudsman Program Policies and Procedures Part II Chapter 301.1.

Funding Allocation – Elder Abuse, Neglect, and Exploitation

45 CFR § 1321.27 (k):
How the State agency will allocate and use funds for prevention of elder abuse, neglect, and exploitation as set forth in 45 CFR part 1324, subpart B.

RESPONSE: Title VII Allotments will be used for the following:
Educating the public on how to prevent, recognize, and respond to elder and disabled adult abuse. Program activities include training, public education and outreach, and coordinating elder abuse prevention services with adult protective services, law enforcement, courts, medical professionals, and other entities.
Collaborating with local partners in the public and private sectors to provide services and technical assistance to develop, strengthen, and implement programs for the prevention, detection, assessment, and treatment of elder abuse. Utilizing cross-sector networking to address gaps in the response to elder abuse, develop potential partnerships and joint initiatives to meet

needs and fill gaps.
Establishing the Department as the clearinghouse of efforts to stop ANE by centralizing available resources and facilitating public awareness of all programs. Leveraging communication within and across the aging network, DHS, and other state agencies through regular meetings and by sharing data and information about elder abuse issues.

Monitoring of Assurances

45 CFR § 1321.27 (m):
Describe how the State agency will conduct monitoring that the assurances (submitted as Attachment A of the State Plan) to which they attest are being met.

RESPONSE: As outlined in Ch. 3000, Section 3021, AAAs must be able to provide documentation validating they are adhering to the assurances upon request and/or as part of Division monitoring. AAAs are required to include these assurances in their Area Plans, as noted in the Area Plan Format and Instructions.

State Plans Informed By and Based on Area Plans

45 CFR § 1321.27 (c):
Evidence that the State Plan is informed by and based on area plans, except for single planning and service area States.

RESPONSE: As outlined in Ch. 1000, Section 1070, DAS utilizes Area Plan content to develop its State Plan. This policy details the State Plan development process, in which the Area Plans from the prior cycle are reviewed in order to determine State Plan goals, objectives, outcomes, and strategies. The SUA also seeks feedback from the AAAs throughout the State Plan development process.

Public Input and Review

45 CFR § 1321.29:
Describe how the State agency considered the views of older individuals, family caregivers, service providers and the public in developing the State Plan, and how the State agency considers such views in administering the State Plan. Describe how the public review and comment period was conducted and how the State agency responded to public input and comments in the development of the State Plan.

RESPONSE: Georgia Division of Aging Services (DAS), partnered with the University of Georgia's Carl Vinson Institute of Government to gather stakeholder input for the 2024–2027 state plan. Please see Attachment D: Stakeholder Input Report for the 2024-2027 Georgia State Plan on Aging for detailed descriptions of public input and review process for the State Plan. Additionally, Georgia DAS also conducted outreach to obtain public input on the State Plan Amendment. To obtain input on the State Plan Amendment, Georgia DAS posted the Amendment to the website for virtual comments, held an in-person public hearing, and distributed the drafted Amendment email to various stakeholders, including but not limited to AAAs, Providers, and Advocacy Groups.

Program Development and Coordination Activities (Optional, only for States that elect to pursue this activity)

45 CFR § 1321.27 (h):
Certification that any program development and coordination activities shall meet the following requirements:
(1) The State agency shall not fund program development and coordination activities as a cost of supportive services under area plans until it has first spent 10 percent of the total of its combined allotments under Title III on the administration of area plans;
(2) Program development and coordination activities must only be expended as a cost of State Plan administration, area plan administration, and/or Title III, part B supportive services;
(3) State agencies and area agencies on aging shall, consistent with the area plan and budgeting cycles, submit the details of proposals to pay for program development and coordination as a cost of Title III, part B supportive services to the general public for review and comment; and
(4) Expenditure by the State agency and area agency on program development and coordination activities are intended to have a direct and positive impact on the enhancement of services for older persons and family caregivers in the planning and service area.

RESPONSE: The Division of Aging Services (DAS) certifies that all program development and coordination activities meet the requirements listed in 45 CFR § 1321.27 (h). Copies of DAS policies for program development and coordination activities can be found in Manual 5600: Sections 3019, 3076, 3077, and Appendix F: Taxonomy of Services.

Legal Assistance Developer

45 CFR § 1321.27 (l):
How the State agency will meet responsibilities for the Legal Assistance Developer, as set forth in part 1324, subpart C.

RESPONSE: The Division of Aging Services (DAS) employs a full-time legal assistance developer (LAD) who manages the Title IIIB legal assistance program and fulfills Title VII legal assistance development duties.
As manager of the Title IIIB Elderly Legal Assistance Program (ELAP), the LAD develops program policies, provides area agencies on aging (AAA) technical assistance and tools for legal assistance provider monitoring, and collects statewide input on program operations and needs through regular contact with AAAs and ELAP providers.

The LAD ensures timely submission of federally required program data and assists DAS' Program Integrity section with annual Older Americans Act Programs System reporting. The LAD reviews data to verify that program resources are used for serving older Georgians with the greatest economic and social need and that the legal matters handled by ELAP are within the listed Older Americans Act priority areas.

The LAD leads DAS' Title VII, chapter 4, legal assistance development efforts. The LAD uses collaboration and education to help older Georgians, and those who serve them, know and exercise their rights. The LAD provides regular legal education trainings to internal and external stakeholders.

Within DAS, to promote protection of the rights and autonomy of persons under guardianship, the LAD lends subject matter expertise to the Public Guardianship Office's (PGO) policy and training teams. The LAD offers case consultations to public guardianship and adult protective services (APS) staff to help identify legal issues and suggest resources for addressing the legal needs of persons served by PGO and APS.

The LAD consistently provides trainings and technical assistance to other Older Americans Act program staff.
The LAD is strongly allied with the State Long-Term Care Ombudsman program (LTCO). In 2025, the LAD and LTCO will add to the existing memoranda of understanding and second memoranda will provide for better coordination between ELAP and LTCO. The LAD and ELAP providers routinely train LTCO staff and volunteers.

The LAD enjoys great support from the private elder law bar. The private bar The LAD maintains a speaker bank of elder law attorneys who also deliver legal education presentations to the aging network and stakeholders.

The LAD contributes to several initiatives aimed at preventing unnecessary adult guardianships. The LAD serves on Georgia's disability protection and advocacy agency's advisory council on supported decision-making and also provides legal information to the Coalition of Advocates for Georgia's Elderly supported decision-making workgroup.

The LAD authors several publications on various topics in elder law, ranging from public benefits, alternatives to adult guardianship, and issues in death, dying, and burial.

In 2025, jointly with DAS' Forenscis Special Initiatives Unit, the LAD will conduct a needs assessment and environmental scan to assess the status of elder rights sources, initiatives, and issues in Georgia. Combining quantitative surveys with qualitative on-site interviews, the results will be used to assist AAAs with advancement or development of elder rights goals and initiatives.

Emergency Preparedness Plans – Coordination and Development

OAA Section 307(a)(28):
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE: See DAS' Emergency Planning and Management in Attachment "F."

Emergency Preparedness Plans – Involvement of the head of the State agency

OAA Section 307(a)(29):
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE: See DAS' Emergency Planning and Management in Attachment "F." DAS' Division Director is responsible for reviewing and approving all Emergency Preparedness policy and procedures. She or her designee are also responsible for implementing said policies and procedures.

State Plan Guidance Atachment C

INTRASTATE (IFF) FUNDING FORMULA REQUIREMENTS

Requirements Applicable to IFF Revisions:

OAA, Sec. 305(a)(2)(C)

"*States shall,*

(A) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account-

(i) the geographical distribution of older individuals in the State; and

(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

OAA, Sec. 305(d)

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Requirements Applicable to all IFFs Generally

All IFFs must contain the following:

- A descripve statement of the formula.

- A list of the data used by planning and service area.
- A descrip✁ve statement of each factor (i.e., 70+ living alone – number of people who are 70 and older that live alone) and weight/percentage used for each factor (i.e., 70+ living alone = 5%).
- Alloca✁ons of funds by planning and service area based on the IFF segmented by Part of Title III (e.g., chart of PSA X, IIIB Suppor✁ve Services, $900,000).
- States must provide the source of the data used to run in the IFF. States must use the "best available data." In most cases, the best available data is the most current US Census. A state also may use more recent US Census es✁mates from the American Community Survey; other more recent data of equivalent quality available in the State also may be considered.
- A numerical/mathema✁cal statement of the formula is required for Parts B, C, D and E.
- A separate descrip✁ve and numerical/mathema✁cal statement may be provided for Title III Part D – Evidence Based Disease Preven✁on and Health Promo✁on Services, to target the medically underserved and which there are a large number of older individuals who have the greatest economic need for such services, per Sec✁on 362 of the OAA. If a separate formula is used for Part D, a separate descrip✁ve and numerical/mathema✁cal statement is required.
- A statement explaining how NSIP funds are distributed.
- States may use a base amount in their IFFs to ensure viable funding across the en✁re state.
- Statement that discloses if, prior to distribu✁on under the IFF to the AAAs, funds are deducted from Title III funds for: State Plan Administra✁on, Area Plan Administra✁on, and/or Long-Term Care Ombudsman alloca✁ons.
- The IFF should include informa✁on on how the formula affects funding to each planning and service area.

Requirements Applicable to Single Planning and Service Area States

A numerical/mathema✁cal statement is not required for Single Planning and Service Area states. However, Single Planning and Service Areas must include a descrip✁ve statement as to how the state determines the geographical distribu✁on of the Title III funding and how the state targets the funding to reach individuals with greatest economic and social need, with par✁cular aten✁on to low-income minority older individuals.

The Older Americans Act requires the SUA, in consultation with AAA, to develop a formula for allocation of funds within the State that takes into account the geographic distribution of older individuals within the State and the distribution among PSAs of low-income minority older individuals with the greatest economic and social need.

The Intrastate Funding Formula (IFF) is used by State Units on Aging to distribute funds to AAA for Titles III and VII of the Older Americans Act. The Older Americans Act requires in Title III Section 305(a)(2)(C), 42 U.S.C. that the SUA:

"States shall,

(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account--

(i) the geographical distribution of older individuals in the State; and

(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals."

DAS revises the Intrastate Funding Formula decennially (every ten years) based upon demographics and population changes from the most current Census data. The last revision to the DAS IFF was on 2014. Yearly, estimates released by the Census Bureau for factors in the DAS formula are applied to subsequent allocations to account for any funding impact to AAAs related to population changes.

DAS utilizes the following factors to distribute OAA funds by Planning and Service Area (PSA). The current formula provides a specific weight for each of the following populations: persons age 60 years of age and older, persons age 75 years of age or older, low-income minority population age 65 and older, low-income 65 and older population, estimated rural population 60 years of age and older, limited English speaking population 65 years of age and older, disabled adults 65 years of age and older, and living alone 65 years of age and older.

Definitions for each population are indicated below:

60+ population

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

75+ population

Number of persons in the age group 75 and above.

Low-income minority 65+ population

The numbers of persons in the age group 65 and above who are minorities (non-white) and are below the poverty level, as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents "special attention to low income minority older individuals" as required by the OAA.

Low-income 65+ population

Numbers of persons in the age group 65 and above who are at or below the poverty level as established by the Office of Management and Budget in Directive 14 as the standard to be used by federal agencies for statistical purposes. This factor represents economic need as defined by the OAA.

Estimated rural 60+ population

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

Limited English speaking 65+ population

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

Disabled 65+ population

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

Living Alone 65+

Number of persons in the age group 65 and above who live alone

Factors and Weights:

Population 60+	**10%**
Population 75+	**30%**
Low Income Minority 65+	**10%**
Low Income 65+	**13%**
Rural 60+	**15%**
Disabled 65+	**10%**
Limited English Speaking 65+	**4%**
Living Alone 65+	**8%**

The above factors have been incorporated into a mathematical formula for administration as reflected below. In addition to these factors and weights, the Division of Aging Services incorporates a 6 percent funding base for parts B, C1, C2, and E of Title III of the OAA, not to exceed $200,000 annually.

Intrastate Funding Formula

Y=((.10(X)(%60))+((.30(X)(%75))+((.10(X)(%LIM))+((.13(X)(%LI))+
((.15(X)(%RUR))+((.10(X)(%DIS))+((.04(X)(%LES))+((.08(X)(%LA))

Factors:

Y	The service allocation for a Planning and Service Area (PSA)
(X)	The total services allocation amount for the state.
%60	The PSA percentage of the State total population ages 60 and above.
%75	The PSA percentage of the State total population ages 75 and above
%LIM	The PSA percentage of the State total population ages 65 and above who are low income and are minorities
% LI	The PSA percentage of the State total population age 65 and above who are low income
% RUR	The PSA percentage of the State total population age 60 and above who live in rural areas
%DIS	The PSA percentage of the State total population who are age 65 and above and are disabled
%LES	The PSA percentage of the State total population age 65 and above and have limited English speaking ability
%LA	The PSA percentage of the State total population who are 65 and above and living alone

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Stakeholder Input Report for the 2024–2027 Georgia State Plan on Aging

Prepared for the Georgia Department of Human Services Division of Aging Services

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Project Overview

The Older Americans Act of 1965 as amended established the Administration for Community Living's Administration on Aging (ACL's AoA) to oversee state and area agencies on aging (AAAs). This act expanded social services for older individuals and people with disabilities. To receive federal funding, states must develop and implement multiyear state plans. The state plan is a comprehensive planning document that articulates information about innovations in addressing aging society challenges, state long-term care reform efforts, service best practices, and strategies to expand consumer choice and evidence-based prevention. State plans should also include information about current ACL priorities: COVID-19 recovery, advancing equity, expanding access to home and community-based services, and building a caregiving infrastructure. ACL's AoA requires that state units on aging seek feedback during the state plan development process, including from older adults, area agencies on aging, caregivers, Title VI grant recipients,[1] and other interested parties.[2]

Georgia's state unit on aging, the Division of Aging Services (DAS), partnered with the University of Georgia's Carl Vinson Institute of Government to gather stakeholder input for the 2024–2027 state plan. Feedback sessions were held virtually in each of Georgia's 12 planning and service areas from April to June 2022. Two sessions were held in Atlanta, for a total of 13 sessions. Sessions were facilitated by staff from the Institute of Government and DAS. Session feedback was gathered using Zoom chat logs; Slido, a real-time response software; facilitator notes from small-group conversations; and an online feedback form.

The sessions were advertised via DAS's website, the network of each AAA, and social media to service providers, advocates, caregivers, older adults, and other interested parties in each service region. This report discusses the stakeholder input process and themes that emerged from stakeholder input. This information, along with ACL state plan guidance, will inform the development of Georgia's state plan on aging. Data collected may also be useful in AAAs' regional planning efforts.

The feedback sessions involved a main session that solicited general feedback on DAS, and small-group breakout sessions that focused on top issue areas. The top issues were selected via attendee polling from the following: aging in place, health & wellness, COVID-19, equity, caregiving, safety & protection, and workforce. Session participation ranged from 12 to 73 individuals with more than 400 participants across all sessions. During three listening sessions,

[1] Title VI grant recipients refers to ACL nutrition and supportive services for Native Americans.
[2] Administration for Community Living. (2021). *Guidance for developing state plan on aging*. Retrieved from KM_C364e-20180920105928 (acl.gov)

participants from area senior centers joined as a group. The feedback form allowed room for further top issue commentary.

A total of 135 feedback form responses were received. Common themes arising from the sessions and feedback form include affordability, awareness, and accessibility of aging services in Georgia. Adequate funding and workforce capacity were also discussed due to concerns about continuity of care and waitlists. Program flexibility, particularly in relation to consumer choice in aging services, was another common theme. Overall, stakeholders appreciated the variety of aging programs available in Georgia but would like to see further funding and workforce growth so that services can reach more consumers. Three specific topics emerged frequently as important for consideration over the next four years: affordable housing, transportation, and mental health. The remainder of this report discusses top issues and provides insights from the feedback sessions and feedback form.

Feedback Sessions

SESSION OVERVIEW

DAS partnered with UGA's Carl Vinson Institute of Government to collect stakeholder and consumer feedback to guide the development of Georgia's next State Plan on Aging. Due to the progression of COVID-19, a total of 13 sessions (one in each area agency on aging [AAA] region and two in the Atlanta region) were held virtually between April and June of 2022. The Institute of Government developed a session facilitation guide and trained Institute and DAS staff who assisted with facilitating small-group conversations during the sessions. The sessions were advertised via DAS's website, the network of each AAA, and social media to service providers, advocates, caregivers, older adults, and other interested parties. See Appendix A for an example of one of the event flyers. The goal was to gather diverse perspectives on how DAS can best support Georgia's older adults in living longer, living safely, and living well over the next four years.

The sessions also aimed to educate stakeholders about DAS's responsibilities and Georgia's aging system. Information was provided about DAS's role in state governance, federal expectations from the Older Americans Act, the funding process, state plan expectations, service awareness, and more. Attendees were able to ask questions and share their experiences with DAS programming. Networking information was also shared with stakeholders seeking additional guidance. Stakeholder feedback was gathered using Zoom chat logs; Slido, a real-time response software; and facilitator notes. See Appendix B for an example of the form used to gather facilitator notes during the small-group listening sessions.

SESSION STRUCTURE

Each virtual feedback session began with an overview of the purpose of the session. After that, the facilitators and attendees introduced themselves, including name, role, county, and reason for attendance. A DAS representative then provided an overview of DAS's vision and mission, agency structure, and services. Time was then given to stakeholders to ask the DAS representative questions. After that, the sessions were divided into two periods: DAS service reflections and top issue reflections. The DAS service reflections were done as one large group, during which attendees could respond via the Zoom chat function or Slido. For the top issue reflections, attendees were divided into smaller breakout groups with facilitator leads, who reported the findings to the main group afterward. Lastly, each session included a discussion of DAS funding via the intrastate funding formula, which will be detailed in a later report.

PARTICIPANT INFORMATION

Session participation ranged from 12 to 73 individuals, with more than 400 participants across all sessions. During three listening sessions, participants from area senior centers joined as a group. Attendees represented 55 of Georgia's 159 counties. Of those that responded to a question about current county of residence, Fulton County was represented most often, followed by Richmond and DeKalb.

Additional information was collected from attendees about the planning and service area (PSA) region in which they currently live and levels of service usage. The responses are presented in the tables below.

Session Participation by PSA Region (N = 392)

PSA Region	Percent	Number of Participants
Southern Georgia	6.9%	27
River Valley	6.1%	24
Heart of Georgia	6.9%	27
Legacy Link	7.9%	31
Northwest Georgia	8.2%	32
Central Savannah River	4.9%	19
Northeast Georgia	10.0%	39
Coastal Georgia	6.6%	26
Atlanta Region (May 26)	6.4%	25
Atlanta Region (June 1)	4.6%	18
Middle Georgia	3.1%	12
Three Rivers	10.0%	39
Southwest Georgia	18.6%	73

Note: N refers to the number of respondents per question. Participants could only choose one response. A total of 392 individuals participated in the Slido polls.

What is your primary role with aging and adult services? (N = 137)

Response	Percent	Frequency
Consumer (older adult/person with disability)	3.7%	5
Caregiver	2.2%	3
Service Provider	32.1%	44
Advocate	11.0%	15
AAA Staff	29.9%	41
DAS Staff	21.2%	29

Note: N refers to the number of respondents per question. Participants could only choose one response.

DAS SERVICE REFLECTIONS

During the DAS service reflections portion, stakeholders were asked about their experiences with DAS services. The tables below summarize participant responses to the following questions.

- What aging services have you or someone you know used?
- What does DAS do well with aging and adult services?
- What might require more attention from DAS in the years to come?

What aging services have you or someone you know used? (N = 134)

Response	Percent	Frequency
Help at home	23.1%	31
Nutrition & wellness	30.6%	41
Caregiver programs	11.2%	15
Protected rights & safety	5.2%	7
Medicare & insurance answers	19.4%	26
Other services	10.4%	14

Note: N refers to the number of respondents per question. Participants could only choose one response.

What does DAS do well with aging and adult services?

Response Themes	Further Explanation
Adaptability	Responses included the following: adaptable to community needs, multiyear plan with accountability metrics, and receptive to new ideas.
Passionate and committed staff	N/A
Variety of service offerings	N/A
In-depth screening tools for levels of care assessments	N/A
Meals, socialization for seniors, and prevention of elder abuse	Attendees wanted further support for congregate senior centers and the programs offered there.
Collaborating with partners for variety in expertise	N/A
Wellness checks, follow-ups, and emergency management	DAS shows a commitment to outreach and expediting of specialists, Adult Protective Services, and social workers when needed.
Technical assistance, education and advocacy, communication about offerings, and referrals	Attendees specifically mentioned reporting of key aging facts and support for AAAs.
Prioritizing those most in need and a commitment to recognizing the diverse needs of older Georgians	N/A

What does DAS do well with aging and adult services?

Response Themes	Further Explanation
Delivery and management of home- and community-based services	Discussion included in-home services, waivers, caregiver support, equipment support, etc.

Note: Participant text responses to the question were organized into overall response themes. The further explanation column paraphrases attendee comments and provides additional insights about some themes.

What might require more attention from DAS in the years to come?

Response Themes	Further Explanation
Increased attention to mental health	Comments included funding and awareness for services, education about mental health, and ensuring the state has enough physicians and caregivers to provide needed care.
Grandparents raising grandchildren	More and more children are supported by their grandparents. More support is needed for both the aging adult and their management of the home.
Transportation for seniors	Many seniors are limited by lack of vehicle access and struggle to cross county lines. Attendees encouraged multisectoral partnerships as well as more attention given to transportation access for seniors with mobility aids like wheelchairs or walkers.
Pay increase and benefits for direct care staff and funding for caregivers	While there are many committed staff, turnover is still a problem. This impacts continuity and quality of care. Waitlists were a concern.
Resource information hub, legal assistance, and streamlining of applications	While attendees generally had positive remarks about information access once they found the correct contact, they would like a county resource hub, organized by aging issue. Session attendees also wanted simplified applications for service renewals.
More support and awareness for delivery of incontinence products, groceries, and Meals on Wheels	N/A
Resources for those who do not meet the age or income requirement	Some seniors are not quite old enough or have an income level that makes service access more complicated.
More education and access to affordable housing, intensive in-home services, technology, insurance options, and hospice care	Suggestions included options for hybrid services for a growing population with limited funds for aging services. Overall, attendees expressed a desire for flexibility in services based on unique client needs.

What might require more attention from DAS in the years to come?

Response Themes	Further Explanation
Rural advocacy	Overall, attendees suggested that more attention should be directed to service access and funding of rural populations.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases attendee comments and provides additional insights for some themes.

TOP ISSUE REFLECTIONS

To gather additional insights into aging services priorities, attendees at each session were asked to identify two top issues for further discussion. The top issues were selected via polling from the following: aging in place, health & wellness, COVID-19, equity, caregiving, safety & protection, and workforce. Aging in place and health & wellness were the most popular issues selected in the sessions, followed by workforce, caregiving, a tie between safety & wellness and equity, and COVID-19. Thematic insights from top issue reflections are detailed later in the report, as there was significant overlap with the feedback form responses.

Online Feedback Form

FEEDBACK FORM OVERVIEW

The Institute of Government created an online feedback form in partnership with DAS to assist in the state plan development process. The purpose of the feedback form was to gather more input, both from feedback session attendees and from people who were not able to attend a session. The feedback form was available between April and July 2022. A total of 135 people filled out and returned the feedback form.

FEEDBACK FORM METHODS

The feedback form was hosted in Qualtrics. The form was advertised on the DAS website and on social media. All feedback session attendees were encouraged to fill out the form and were provided with a link. The feedback form gathered demographic information and asked both prompted and open-ended questions. See Appendix C for the feedback form instrument.

DEMOGRAPHIC INFORMATION

The feedback form collected demographic information, which is summarized below.

Did you attend one of the virtual feedback sessions? (N = 132)

Response	Percent	Frequency
No	35.6%	47
Yes	39.4%	52
I am planning to	25.0%	33

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your primary role with aging and adult services? (N = 135)

Response	Percent	Frequency
Consumer (older adult/person with disability)	14.8%	20
Service provider	37.0%	50
Advocate	12.6%	17
Caregiver/paid professional	0.74%	1
Caregiver/family who is unpaid	14.0%	19
Other	20.7%	28

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your age? (N = 70)

Response	Percent	Frequency
Under 40	10%	7
41–50	24.3%	17
51–60	18.6%	13
61–70	37.1%	26
71–80	8.6%	6
81–90	1.4%	1
91+	0%	0

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your gender? (N = 70)

Response	Percent	Frequency
Female	90%	63
Male	10%	7
Other	0%	0
Prefer not to say	0%	0

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your sexual orientation? (N = 70)

Response	Percent	Frequency
Heterosexual or straight	87.1%	61
Gay or lesbian	0%	0
Bisexual	1.4%	1
Prefer not to answer	11.4%	8

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your race or ethnicity? (N = 74)

Response	Percent	Frequency
Caucasian or White	60.8%	45
African American or Black	29.7%	2
Asian or Pacific Islander	0%	0
American Indian or Alaska Native	1.4%	1
Hispanic or Latino	4.1%	3
Other	0%	0
Prefer not to answer	4.1%	3

Note: N refers to the number of respondents per question. Respondents could check all that apply.

What is your highest level of education? (N = 70)

Response	Percent	Frequency
Less than high school	0%	0
High school graduate or equivalent	5.7%	4
Some college (no degree)	10.0%	7
Associate or technical degree	5.7%	4
Bachelor's degree	42.9%	30
Graduate degree (Master's, PHD, MD, etc.)	35.7%	25
Prefer not to answer	0%	0

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your current annual income? (N = 70)

Response	Percent	Frequency
$25,000 or less	8.6%	6
$25,001–$50,000	30%	21
$50,001–$75,000	14.3%	10
$75,001–$100,000	14.3%	10
More than $100,000	12.9%	9
Prefer not to answer	20.0%	14

Note: N refers to the number of respondents per question. Respondents could only choose one response.

What is your marital status? (N = 70)

Response	Percent	Frequency
Single	14.3%	10
Married	64.3%	45
Divorced	17.1%	12
Widow	1.4%	1
Prefer not to answer	2.9%	2

Note: N refers to the number of respondents per question. Respondents could only choose one response.

Do you live alone? (N = 69)

Response	Percent	Frequency
No	72.5%	50
Yes	26.1%	18
Prefer not to answer	1.5%	1

Note: N refers to the number of respondents per question. Respondents could only choose one response.

Are you a veteran? (N = 70)

Response	Percent	Frequency
No	90.0%	63
Yes	8.6%	6
Prefer not to answer	1.4%	1

Note: N refers to the number of respondents per question. Respondents could only choose one response.

Do you currently consider yourself to have a disability? (N = 70)

Response	Percent	Frequency
No	60.0%	42
Yes	35.7%	25
Prefer not to answer	4.3%	3

Note: N refers to the number of respondents per question. Respondents could only choose one response.

Geography

Forty of Georgia's 159 counties were represented in the 66 responses to a question asking for the respondent's current county of residence. Two responses were from people residing out of state. The most-common Georgia county was Fulton, followed by DeKalb, and then a tie between Floyd and Dougherty. A total of 58 respondents provided their current zip code, representing 52 different zip codes.

FEEDBACK FORM CATEGORICAL RESPONSES

Respondents answered questions that focused on four categories: top issue reflections, awareness and knowledge, DAS service usage, and suggestions for living longer, living safely, and living well.

TOP ISSUE REFLECTIONS

Feedback form respondents were asked to identify which top three aging priorities DAS should focus on over the next four years. The top issues were selected from the following: aging in place, health & wellness, COVID-19, equity, caregiving, safety & protection, and workforce. Of the 324 responses, 29.6% chose aging in place, 19.75% chose health & wellness, 16.1% chose caregiving, 11.7% chose safety & protection, 11.42% chose workforce, 7.7% chose equity, and 3.7% chose COVID-19. The feedback form included open-ended questions about each of these topics; thematic insights on the top issues are provided in the Top Issue Summary section of this report.

AWARENESS AND KNOWLEDGE

Respondents were asked about their personal awareness of DAS services as well as their perception of DAS's awareness and support of client needs.

How would you rate your awareness of aging and adult services? (N = 115)

Response	Percent	Frequency
I know a lot about available services.	50.4%	58
I know something about available services.	41.7%	48
I know nothing about available services.	7.8%	9

Note: N refers to the number of respondents per question. Participants could only choose one response.

How would you rate your knowledge of who to call if you need information about services? (N = 115)

Response	Percent	Frequency
Very knowledgeable	50.4%	58
Somewhat knowledgeable	41.7%	48
Not knowledgeable	7.8%	9

Note: N refers to the number of respondents per question. Participants could only choose one response.

How would you rate DAS's awareness of the needs of older adults and persons with disabilities? (N = 115)

Response	Percent	Frequency
Extremely aware	47.8%	55
Moderately aware	33.9%	39
Slightly aware	12.2%	14
Not at all aware	6.1%	7

Note: N refers to the number of respondents per question. Participants could only choose one response.

How would you rate DAS's current services to address the needs of older adults and persons with disabilities? (N = 115)

Response	Percent	Frequency
Excellent	21.7%	25
Good	43.5%	50
Fair	27.0%	31
Poor	7.8%	9

Note: N refers to the number of respondents per question. Participants could only choose one response.

CONSUMER SERVICE USAGE

If respondents selected that their primary role with aging and adult services as consumer, they were redirected to the following questions about consumer service usage.

Do you currently use any of the following services? (N = 24)

Response	Percent	Frequency
Senior center	33.3%	8
Adult day care	0%	0
Caregiver support	4.2%	1
In-home support	4.2%	1
Meals (at senior center or delivered)	20.8%	5
Transportation services	8.3%	2
Respite care	0%	0
Do not use any of these services	29.2%	7
Prefer not to answer	0%	0

Note: N refers to the number of respondents per question. Participants could check all that apply. This question appeared if respondents answered “consumer” as their primary role with aging and adult services.

How much assistance does the person receiving aging and adult services require? (N = 18)

Response	Percent	Frequency
No assistance	55.6%	10
Occasional assistance	27.8%	5
Frequent assistance	5.6%	1
Continuous assistance	11.1z%	2
Don’t know/unsure	0%	0
Prefer not to answer	0%	0

Note: N refers to the number of respondents per question. Participants could only choose one response. This question appeared if respondents answered “consumer” as their primary role with aging and adult services.

LIVING LONGER, LIVING SAFELY, LIVING WELL

DAS's mission is to assist older individuals, at-risk adults, persons with disabilities, their families, and caregivers in achieving safe, healthy, independent, self-reliant lives. This mission is expressed in the DAS vision statement of living longer, living safely, and living well. Thus, respondents were asked open-ended questions about how DAS can best meet these goals.

In your current aging role, what is your greatest concern regarding the ability to remain independent in aging?

Response Themes	Further Explanation
Caregiving for a spouse	Navigating relationship dynamics, in addition to health needs, can be difficult.
Costs	Respondents expressed concerns about access to flexible payment plans, cost-sharing opportunities, Medicaid waivers, affordable health insurance, housing, nutrition, etc.
Technology	Technology keeps advancing rapidly, and some older Georgians struggle to integrate it into their lives without support.
Access to support groups	Finding community/guidance, whether as a caregiver or recipient of care, is essential.
Health and safety	Modifications are needed to prevent falls and other sources of injury, and access to adequate health care is essential to overall well-being. Large medical bills were a major concern, as was elder abuse and neglect.
Pandemic influences and inflation	Many are worried about the long-lasting impact of COVID-19 on supply chains, service access, financial institutions, and public health in general. Respondents wanted help navigating these changes.
Rising housing costs	Affordable housing was one of the most frequently mentioned issues on the feedback form. Rental assistance and finding extra ways to make income were suggested.
Cognitive and physical impairments	Support for assistive services, accessible applications, and technology is needed. Memory decline and services to navigate it were a major concern. Respondents want ways to support physical activity and mental health amidst aging.
Waiting lists and transportation	Respondents expressed concerns about access to services due to workforce shortages. When services are available, do seniors have access to transportation to appointments?

In your current aging role, what is your greatest concern regarding the ability to remain independent in aging?

Response Themes	Further Explanation
Rural access	Many seniors in rural areas do not have adequate access to services and physicians.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases comments and provides additional insights about the themes.

What do you think would be most helpful in supporting older Georgians remain in their homes or communities?

Response Themes	Further Explanation
Support from government officials	Respondents expressed a desire for an enhanced culture of supporting older Georgians, a goal that needs support from state leaders.
More in-home health care, shopping services, adult day cares, and home modifications	Support for routine tasks and health services should remain a high priority. This support decreases the chance of injury, encourages preventative care, and keeps spaces livable.
More education about elder abuse/neglect and support for investigations	Preventing exploitation is critical to keeping elders safe in their communities. More awareness and intervention are needed.
Subsidized services	Utilities reductions, tax adjustments, a sliding scale for payment services, grants, and more are all very helpful for those most in need.
Affordable housing and transportation	Seniors without transportation cannot access many places. Housing prices are high, pushing some out of communities due to the rising cost of living. Business and government partnerships were suggested to combat these issues.
Caregiver support services and streamlined service applications/assessments/processes	Caregivers (paid and unpaid) can get burnt out. They need funding, mental health support, and assistance in accessing services for clients. Respondents expressed some frustration at the difficulty of finding information on services, application processes, and inflexible home- and community-based service requirements to meet client needs. Respite care for caregivers was also emphasized.
Raising program eligibility requirements based on income	Some individuals are in a coverage gap, making too much for lower-income services but too little to reliably cover aging costs.
Culturally sensitive policies and services	Recognition of the varied backgrounds of older Georgians and how services can be more equitable and inclusive is valuable.

What do you think would be most helpful in supporting older Georgians remain in their homes or communities?

Response Themes	Further Explanation
More access to physical and cognitive specialists	N/A

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases attendee comments and provides additional insights about some of these themes.

What programs would you like to see in Georgia to meet the aging needs for older Georgians?

Response Themes	Further Explanation
Mental health programming	Respondents encouraged more funding and greater availability of mental health services. COVID-19 heightened social isolation and slowed access to physicians who monitor cognitive and behavioral decline. Support groups for caretakers and elders were suggested.
Homemaking services	Respondents requested more funding and advertisement of in-home services to help older Georgians manage their homes. Examples include lawn-care services, meals, home delivery services, and house tidying .
Education and entertainment	Respondents requested more access to educational programs on a variety of topics, such as caregiving, technology, elder abuse, health and wellness, etc. Respondents also wanted more support of adult day care programs around Georgia and more in-person and virtual programming to keep older adults engaged in activities.
Mobility aids and home modifications	Funding support to help more seniors access mobility aids and home modifications was frequently mentioned. Many leave their communities when their range of movement is limited.
Medical assistance	Delivery and maintenance of medical supplies was emphasized, as was affordability of medications. Respondents encouraged enhanced funding and access to cost-sharing initiatives, waivers, etc. Medicare/Medicaid does not cover some large medical purchases. The need for senior reminder services to order and take medicines and food was also mentioned.
Transportation and housing	Access to affordable housing and reliable transportation was mentioned repeatedly. Respondents encouraged flexible partnerships

What programs would you like to see in Georgia to meet the aging needs for older Georgians?

Response Themes	Further Explanation
	with agencies like HUD and Uber to help people remain in their communities.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases attendee comments and provides additional insights about each theme.

For caregivers, what could the state do better to support you in your role as a caregiver?

Response Themes	Further Explanation
Extend programs for longer coverage	Extending program coverage would help maintain continuity of care.
Payment of family members to take care of their family member	Such pay helps older adults remain in their communities and prevents families from going into debt.
More community-based day options	Not everyone is ready for a transition to full-time care, but caregivers still need help for part of the day.
Improve clarity of available services	Respondents wanted explanations of available services to be more comprehensive and easier to access. Some felt that they had to chase information all over the place to support the one they are caring for.
Grant availability and awareness	Grants are useful in supporting the wellness of those being cared for, so the need for further advertisement and more application opportunities was emphasized.
Respite services for caregivers, including those not on Medicaid	Caretakers need the ability to rest so that they can provide the quality of care the client deserves.
Caregiving mentors	Some respondents indicated that understanding all available aging services, how to access them, and some caregiving tasks are quite complicated. Mentorship programs would help with these processes.
Funding support for caregiving	Developing sources of funding was mentioned frequently to support access to caregiving services for elders.

Note: Participant text responses to the question were organized into overall themes. The further explanation column paraphrases attendee comments and provides additional insights about these themes.

Please provide any other comments you may have regarding the needs and priorities of older adults and individuals with disabilities in Georgia?

Response Themes	Further Explanation
Specialist copays and medical purchases	Some respondents were concerned about the cost of seeing medical specialists as well as medical purchases not covered by Medicaid. More support for lower-income access to these areas and for preventative care was mentioned.
Elder abuse	Respondents expressed a need for more education about and prevention of elder abuse/neglect, including cybercrimes.
Disability	Respondents requested more attention to the needs of disabled seniors. Quality of life can be improved by attention to accessibility in DAS services, such as modifications for visual impairments.
Employment of seniors	Some respondents wondered if DAS has a unit dedicated to employment of seniors. Demand for elder employment services is growing.

Note: Participant text responses to the question were organized into overall themes. The further explanation column paraphrases attendee responses related to each theme.

Top Issue Summary

OVERVIEW

DAS and the Institute of Government worked together to identify seven broad categories that encompass aging priorities: aging in place, health & wellness, COVID-19, equity, caregiving, safety & protection, and workforce. The stakeholder input process included both listening sessions and feedback form questions to gather input on each of these key issues. Participants were encouraged to reflect on their previous experiences with aging services, their own aging needs, and how they think each of these priority areas will differ in four years. Feedback from the sessions and details from the feedback form were combined to address three overarching questions.

- What is working well?
- What is not working well?
- What suggestions were there for the next four years for each topic?

How were each of the top issues described?

Top Issue	Description
Aging in place	Older adults choosing to remain in their homes (or residence of their choice) and able to access activities of daily living • Client direction and choice, services and support, housing, transportation
Health & wellness	Overall goal is to engage in activities that promote human longevity, which are key to good physical, emotional, cognitive, social, and spiritual aging • Mental, behavioral, emotional, physical, cognitive, and social health, wellness education
COVID-19	Virus can cause a variety of symptoms in humans resulting in illnesses ranging from mild respiratory infections like the common cold to serious illnesses, such as pneumonia • Social isolation, services availability, COVID communication/access, mobility and transportation availability
Equity	The practice of being fair, impartial, and conscious of the challenges experienced by older adults grounded in race, socioeconomic status, and other forms of discrimination • Cultural awareness and competence, targeting most in-need consumers, access to services and providers
Caregiving	Care provided to people who need some degree of regular, ongoing assistance with everyday tasks provided by individuals who may be paid or unpaid (family, friend, or provider) • Caregiving support, caregiver education, grandparents raising grandchildren
Safety & protection	The concern for the physical, mental, emotional, social, and financial well-being of older adults within the areas where they live, learn, work, and play • Elder Justice Act, Elderly Legal Assistance Program, Adult Protective Services, and Public Guardianship

How were each of the top issues described?

Top Issue	Description
Workforce/employment	Paid work for older adults, providing opportunities for inclusion and greater independence within their communities • Availability, turnover of provider staff, turnover of AAA staff

Note: DAS and the Institute of Government identified these areas as top issues to be covered in the feedback sessions and feedback form. This table describes each of these topics.

AGING IN PLACE

The purpose of the aging in place discussion was to collect feedback on how DAS can best support older adults in remaining in their homes or a residence of their choice in their community. The goal is to preserve older adults' autonomy by providing resources necessary to age in place, such as housing access, housing modifications, transportation access, and more.

What is working well?

Response Themes	Further Explanation
Systems in place for in-home care assistance	In-home services help many remain in the home when they otherwise would be in a nursing home or assisted-living facility.
Screening tools for personal support services via assessments	These assessments are beneficial for matching clients with the best support for their needs.
Georgia Money Follows the Person (MFP) Program	Stakeholders appreciated the flexibility this program provides older Georgians as they transition from in-patient to community-based care. They are less restricted by funding requirements.
Connection to legal services	Services to help older Georgians manage their assets can prevent exploitation and displacement of older adults.
Matching programs to client needs and continued education to family and seniors	Stakeholders praised the variety of services and education efforts to match clients with the best programs for their needs. Some shared that education also supports preventative care as clients age in place.
Partnership with the Aging and Disability Resource Center	Disabled older adults valued the long-term services and counseling provided by ADRC.
Home-delivered meals	Stakeholders noted these meals are cost-effective and support nutrition for older Georgians who struggle to continue cooking.

What is working well?

Response Themes	Further Explanation
Transportation to congregate senior centers and medical appointments	Access to transportation for some is the difference between living at home and living in a nursing home/assisted-living facility.
Agency staff communication and attentive service providers	Stakeholders noted that communication between upper DAS staff and AAA staff supports overall program efficiency and quality.
Assistance finding housing and waivers for a variety of services/items	This assistance is especially helpful for low-income Georgia residents.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

What is not working well?

Response Themes	Further Explanation
Not enough affordable homes for seniors and disabled Georgians	Older adults are being pushed out of their communities due to inflation, the influx of short-term rentals, tax hikes, and rising home prices.
Limited options for transportation services	AAAs lack funding for flexible transportation options.
Not enough funding for home repairs and modifications	Some older adults live in dilapidated and inaccessible homes due to lack of funds.
Some areas dropped GeorgiaCares program	Stakeholders noted this was a valuable rural resource.
Not enough preparation for future public health crises	Social isolation makes aging in place especially difficult emotionally and logistically as service availability changes.
Somewhat disjointed contact information for services	Some stakeholders reported that program information can be cumbersome to find, particularly phone numbers.
Not enough mental health services	Social isolation and lack of support for mental health issues makes remaining at home less sustainable.
Not enough funding for supplemental services and waivers	This includes items like incontinence products, nutrition supplements, fall-prevention monitors, and low- or no-cost services for vulnerable adults.
Income limits for services	Stakeholders noted a coverage gap among people that make too much money for Medicaid but not enough for private programs.
Rural Georgia transportation and service variety	Fewer programs, service providers, and transportation options are available in rural areas,

What is not working well?

Response Themes	Further Explanation
	severely limiting some seniors' ability to stay at home.
Not enough caregivers to provide services and not enough money to pay them well	Inadequate in-home support services means fewer people are able to age in place.
Not enough attention to the overlap in generational caregiving needs	Some older caregivers struggle to work due to their need to provide total care for an older loved one. Significant financial stress complicates community living.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to aging in place?

Response Themes	Further Explanation
Allow AAAs to use funds allocated to DHS transportation for volunteer programs and private entities like Uber and Lyft	Extra program flexibility helps accommodate more people as they age in place.
Partnerships with Habitat for Humanity, HUD, housing authorities, and other contractors for more senior living options	A greater variety of senior living options based on finances and level of care needs can help people stay in or closer to their communities.
More inspectors for individual and congregate settings for reviews when families are not allowed or available	Stakeholders noted that more inspectors would be helpful during public health events to make sure care quality and client condition remain stable.
More family training and education with seniors	Additional training would provide families with multiple tools for and awareness of different service needs. Feedback from older adults enhances personal choice, which increases the likelihood they will feel empowered to age in place.
Statewide transportation initiative and partner network	Stakeholders noted that accessibility needs to be a top priority for such an initiative, as older adults may have service dogs, mobility aids, and more that they need to transport.
Housing specialist in each region of the state that exclusively works with the AAAs	This position could help with the affordable housing search process, outreach for grants, and housing ordinance oversight.
More mental health screenings and support for treatment	Catching and treating mental health issues or cognitive decline is essential to someone's ability to physically and emotionally remain in their community.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to aging in place?

Response Themes	Further Explanation
A single website that summarizes contacts for service by county and then by aging top issues	Some stakeholders shared that it is difficult to track down the right number and that one central resource hub would be useful.
More trainings and incentives to limit provider turnover and improve service quality	Policy training and rewards improve caregiver confidence, slim service waitlists, and support consistent care quality, which bolsters older adults' ability to age in place.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

HEALTH & WELLNESS

The purpose of discussing health and wellness was to gain feedback on how the state can support human longevity, including the physical, emotional, cognitive, social, and spiritual aging of older Georgians.

What is working well?

Response Themes	Further Explanation
Nutrition programs and physical wellness programs	Diet and exercise are two critical components of overall wellness, and stakeholders highlighted several instances in which these programs have supported older adults in these areas.
Programs are evidence based	Stakeholders appreciated that programs for their loved ones or themselves are based on the latest medical knowledge and technology.
Telehealth opportunities and virtual education about health and wellness subjects	Especially in light of COVID-19, having both virtual and in-person options for health and wellness resources was appreciated.
When it is available, transportation	Stakeholders were strong supporters of services to help older adults get to their appointments and programs.
Multidisciplinary partnerships and partnerships that promote health initiatives around the state	Examples of such partnerships stakeholders gave include the Department of Behavioral Health and Developmental Disabilities and Aging & Disability Resource Connection (ADRC).
Program variety	Stakeholders value a holistic approach to wellness and appreciate how aging services attempts to match clients to programs that best fit their needs.

What is working well?

Response Themes	Further Explanation
Vaccination availability	N/A

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for some themes.

What is not working well?

Response Themes	Further Explanation
People who need health and wellness services may not be participating	It is difficult to figure out how to further engage older adults in the services.
Public knowledge about services	Awareness and participation are both key parts of statewide health and wellness improvements, and stakeholders felt that more outreach can be done to reach more populations.
Mental health services	Stakeholders felt mental health services in the state are quite limited.
Less robust and lower quality programs in poorer counties and rural areas	Stakeholders felt that poorer and rural communities have worse health and wellness outcomes than their higher-income and urban counterparts.
Not enough preventative medicine	Stakeholders felt that preventative medicine efforts should be expanded to enhance the quality of life for older adults.
Unclear training schedules and certification dates	This feedback was provided by caregivers who have experienced lapses in their ability to provide care.
Not enough transportation to health and wellness services	People are foregoing care due to their inability to drive.
Not enough primary care physicians or other caregiver points of contact	This leads to long wait lists or simply not accessing services altogether.
Not enough health and wellness–related counseling and legal services	Stakeholders noted that health issues can be traumatic and hard to learn how to manage. They also mentioned consistent legal support for insurance issues and power-of-attorney concerns.
Not enough coordination between services providers and public health agencies	Stakeholders specifically spoke of communication breakdowns during the COVID-19 pandemic.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about these themes.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to health and wellness?

Response Themes	Further Explanation
More disease identification training	Prevention and early treatment support longevity and the ability to age in place.
More access to meal services, in-home physical therapy, and expanded transportation for those that do leave the home for services	N/A
Recruiting more health care students from colleges to support senior center care	This suggestion addresses workforce shortages in many health care settings.
Insurance transition support	Stakeholders shared that more counseling on options and coverage levels is beneficial.
Technology education	Stakeholders indicated that some older adults need technology education to fully engage with health care resources in virtual formats.
More flexibility to develop health and wellness partnerships in the community	Stakeholders referenced private sources, grants, and referral programs.
Spotlights on communities doing noteworthy work in health and wellness initiatives	Models of good programs motivate improved services around the state.
More screenings for abuse and increased trauma-related training	Stakeholders raised concerns that elder abuse increased during the pandemic and went unreported.
Advertise health and wellness services offered by AAAs in local news and places seniors frequent	Examples cited include libraries, places of worship, and senior activity centers.
Offer more support groups	Stakeholders noted that support groups allow more ideas to be shared between providers, caregivers, and clients.
More cognitive programming for those with memory issues	N/A
Buddy programs	Buddy programs can help older adults consistently access resources and appointments when other programs are not available.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to health and wellness?

Response Themes	Further Explanation
More attention to accessibility of services for disabled individuals	Several people shared that services would be even stronger if they were consistently accessible.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and additional insights about some themes.

COVID-19

COVID-19 was selected for discussion due to its lasting impacts on the health and well-being of older Georgians. Social isolation, service availability, COVID-19 communication, and transportation availability will remain important over the next four years of service delivery.

What is working well?

Response Themes	Further Explanation
Availability of services with walk-in and drive-up options	N/A
Availability of vaccines	N/A

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme, if any.

What is not working well?

Response Themes	Further Explanation
Workforce	Staffing levels for services still have not recovered, and older Georgians seeking employment have additional health and safety concerns.
Lack of mobile vaccination units and other aging services for home-bound or bed-bound patients	Wait lists, staffing shortages, and additional health and safety concerns were mentioned.
COVID-19 test accessibility for blind Georgians	Some with visual impairments may live alone and do not have technology to assist in test checking.
Lack of transport	COVID-19 significantly disrupted transportation to and from services, appointments, stores, etc.
Social isolation	Stakeholders routinely stressed the toll that social isolation has had on seniors' mental health.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to COVID-19?

Response Themes	Further Explanation
Brainstorm and implement efforts to address social isolation	Stakeholders were interested in more virtual connection opportunities as well as more in-person opportunities with safety precautions.
More public health preparation	Some stakeholders would like providers to develop clearer service provision plans and trainings in case another pandemic occurs.
Partnerships for public health communications	Stakeholders wanted options other than the internet to find the latest public health resources and statistics.
More service access for home-bound patients	Stakeholders wanted more resources dedicated to adding and retaining service providers, as well as partnerships with disability support services.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

EQUITY

Equity was discussed to determine how the state can best be fair, impartial, and conscious of the challenges experienced by older adults relating to race, socioeconomic status, and other forms of discrimination. The goal was to learn how the state can develop cultural awareness and competence, target most in-need consumers, and expand access to services and providers.

What is working well?

Response Themes	Further Explanation
Considerate providers of services	Several stakeholders expressed that the providers they have interacted with have been fair, impartial, and committed to service delivery.
Expansion of services	Some stakeholders noted that DAS and the AAAs continue to expand access to services and providers.
Support groups based on different factors such as race, age, ethnicity, and more	Some stakeholders noted that these groups are especially useful in connecting to the correct aging and caregiving services.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases attendee comments and provides additional insights for each theme.

What is not working well?

Response Themes	Further Explanation
Not enough cultural awareness and competence	Stakeholders indicated that it is hard for seniors to feel systems are fair and impartial if providers have less cultural awareness and tools to expand services in those areas. This includes access to interpreters.
Not enough funding and awareness for accessibility services	Some stakeholders expressed concerns about insufficient funding and awareness for home modifications and accessibility devices.
Distribution of resources to those most in need	Some stakeholders were worried that funding dollars are primarily funneled into high-population communities instead of areas with those most in need. Some areas of concern were those who are uninsured, without broadband, without cars, and low income.
Long wait lists for services	Stakeholders felt that wait lists mean that their challenges are not being addressed. Some even felt that their position on the wait list was not impartially decided.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to equity?

Response Themes	Further Explanation
More education and training programs	Stakeholders expressed the need for more education and training for cultural competence purposes as well as to maintain staffing levels to expand services.
TV ads and billboards about DAS services in different languages	N/A
Public education campaign about the aging services website	Some stakeholders noted that the aging services websites are a bit intimidating and overwhelming, and a public overview may help connect more consumers to services.
Broadband everywhere and technology assistance	Stakeholders noted that it is hard in today's world to stay connected to programs without access to technology.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about some themes.

CAREGIVING

Caregiving was discussed to determine how the state can best support Georgians who need ongoing assistance with everyday tasks, whether provided by a family member, friend, or a paid service. Other important aspects of this issue include grandparents raising grandchildren and expansion of caregiver education.

What is working well?

Response Themes	Further Explanation
Respite care	Stakeholders appreciated the structured ability to have breaks from caregiving responsibilities.
Meal delivery programs	Stakeholders shared that older Georgians consistently having access to meals is essential to maintaining quality of life and remaining in the home.
Continued feedback opportunities, support services, and support groups	It helps stakeholders to have resources to turn to for caregiving needs and avenues to report strengths and weaknesses of services.
Network of caregiving providers	Stakeholders appreciated the variety of service connection points, especially for complex caregiving needs like Alzheimer's Disease.
Online and in-person caregiver education programs	Both providers and consumers benefit from awareness about programming and client needs.
Adult daycare options and assisted living	Stakeholders appreciated these options for intermediate levels of caregiving needs.
Material aid and Home and Community Based Services (HCBS)	Stakeholders strongly supported grants to continue providing caregiving materials to consumers and their caregivers in their communities.
Medicaid Long-term care programs such as EDWP (Elderly & Disabled Waiver Program) and Georgia SOURCE	Resources for vulnerable older adults in Georgia are a priority to many stakeholders.
Support provided by the Georgia Caregivers Act-HB1304	Stakeholders valued resources for caregivers to manage the client transition period from hospital back to home care.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

What is not working well?

Response Themes	Further Explanation
Awareness and education	Throughout the feedback sessions and on the feedback form, stakeholders expressed that it is sometimes difficult for older adults and their families to learn about caregiving services in their area. Some individuals do not even realize they are a caregiver or that they need a caregiver. Thus, more education is needed.
Funding	Stakeholders expressed concerns that some older Georgians are falling through the cracks due to not enough financial support for services. Some stakeholders reported there are not enough grants to grow programs.
Grandparents raising grandchildren	Stakeholders expressed that this is becoming more and more prevalent without enough resources dedicated to supporting older adults in these roles.
Limited service hours and options for long-term care programs	Some adults have limited windows in which they can access caregiving services, and limited funds if they are not eligible for Medicaid.
Compensation and not enough respite care for caregivers	Stakeholder expressed concern about insufficient compensation and wellness support for caregivers, which puts stress on the well-being of both the provider and consumer.
Program communication coordination	Some stakeholders remarked that they appreciate the variety of services but that the coordination between programs can be confusing. Specifically, inconsistencies in program communication (verbal and written) can lead to duplications or gaps in both service awareness and ease of program access.
Cultural, mental, and physical fitness	Respondents raised concerns about Georgia not having enough programs for physical activity, mental health care, or cultural heritage.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to caregiving?

Response Themes	Further Explanation
More hours for services	Extended service hours for programs and caregivers can help improve the lives of older Georgians.
Stricter ramifications for elder abuse, neglect, and abandonment	COVID-19 compounded social isolation, which made some older Georgians more vulnerable to neglect, abuse, and cyber-attacks. Stakeholders would like to see more deterrence.
Continue to grow support systems (financial and emotional) for family caregivers	Aging in place with or near loved ones can be beneficial for seniors, but families need extra help to remain stable. One suggestion was TANF and SNAP benefits.
Work across organizational silos to coordinate services	Better service coordination would help avoid duplications and service gaps.
Limit reporting requirements for those caring for grandchildren who get no income other than SS/SSI	This was suggested to stabilize finances in the home.
More funding for Home and Community Based Services (HCBS)	Stakeholders encouraged continued support of services within older Georgians communities when possible.
More virtual options for caregiving education	Virtual options are useful for those with limited transportation, with busy schedules, or who live in rural areas.
Utilize more partnerships for public awareness	Stakeholders stressed the importance of using a variety of media formats to reach a wider audience: news stations, newspapers, church announcements, radio, congregate centers, etc.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

SAFETY & PROTECTION

The goal of the safety and protection discussion was to reflect on the physical, mental, emotional, social, and financial well-being of older adults within the areas where they live, learn, work, and play. Important connections to this issue include the Elder Justice Act, the Elderly Legal Assistance Program, Adult Protective Services, and Public Guardianship.

What is working well?

Response Themes	Further Explanation
Elder rights education	Resources on the rights of elders help stakeholders keep seniors safe.
Adult Protective Services (APS) partnership	Some stakeholders shared that the AAAs and APS have a solid relationship that supports safety and protection initiatives.
Legal aid	Stakeholders appreciated robust legal aid to prevent elders from being taken advantage of.
Reporting system	When there are concerns about safety/well-being, stakeholders appreciated having a system through which to report those concerns.
Government communication	Stakeholders appreciated when the government communicates to older Georgians about contemporary safety and protection concerns.
Multidisciplinary teams for services	Stakeholders benefit from teams built to address a variety of safety concerns, e.g., social, mental, physical, and more.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each of these themes.

What is not working well?

Response Themes	Further Explanation
Staffing for legal assistance	While stakeholders appreciated existing legal aid, some stakeholders felt more accessible and affordable aid is needed to preserve the safety of older Georgians.
Patients being abandoned at hospitals	Stakeholders are concerned about older Georgians being abandoned without repercussions for those responsible.
Lack of a central directory	Especially when it comes to safety and protection, stakeholders wanted to instantly connect with the correct resource instead of chasing information.
Efforts to combat cyber crime	Stakeholders raised concerns about the sheer volume of scams and not enough preventative education and support after attacks occur.
Not enough support with wills, estate planning, getting titles cleared	Some stakeholders were worried about older Georgians being taking advantage of and wanted more help in preserving financial assets and homes.
Not enough staff solely focused on elder rights	Some stakeholders expressed interest in more experts/ advocates for elder rights in each service area. There was a demand for legal, social, and medical support.
Possibly not enough APS resources	Stakeholders expressed a need for potentially more resources, such as staffing and outreach, to guard against elder exploitation.
Not enough volunteers	Stakeholders desired more community involvement in programs that enhance the safety of older adults, in both home and community settings.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights about each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to safety and protection?

Response Themes	Further Explanation
Funding	More funding was requested to expand safety/protective resources, education, and program advertisement.
Clarify and streamline reporting forms	Some stakeholders found reporting safety issues to be confusing and cumbersome.
Partnerships with law schools	One stakeholder suggested partnering with university law schools to connect consumers and caregivers with safety/protection resources.
County-wide cybercrime units	Some stakeholders wanted their immediate communities to dedicate more resources to cybercrime prevention and punishment when applicable.
Streamlining and clarification of emergency protocol	Some respondents wanted support for swift resolutions during emergencies like dementia crises, especially for seniors with no personal advocates.
Advertisements	Stakeholders expressed interest in more advertisement of safety and protection programs in sources older adults tend to use, like radio and newspapers.
More feedback from seniors themselves	Consumers wanted to know that their specific safety/protection concerns were being considered.
Support to expand multidisciplinary teams	Stakeholders talked about county-wide support for the most vulnerable seniors, including more resources for teams that address complex safety and aging needs.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

WORKFORCE

The workforce discussion centered on two issues: (1) turnover of caregiving staff, service provider staff, and AAA staff, and (2) paid work for older adults to provide opportunities for inclusion and greater independence within their communities.

What is working well?

Response Themes	Further Explanation
Passionate AAA staff and service provider staff	The available staff care about what they do and their clients.
Commitment to awareness of workforce deficits	There are gaps in the workforce and in payment, but stakeholders valued opportunities to discuss these issues and potential solutions.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

What is not working well?

Response Themes	Further Explanation
Low pay for professional and family caregivers	Low pay is putting a lot of stress on providers who must support their own lives while helping others.
Worker turnover and low staffing levels	Low pay is one factor that leads to consistent worker turnover and low staffing levels, which in turn creates longer waitlists for services. This was considered especially troubling for in-home services.
Not enough forums for caregiver appreciation	Along with limited pay, some stakeholders were concerned about limited emotional support available to caregivers.
Not enough education for older adults who want to work	Some older adults indicated that they do not know how working affects Social Security payments. There were also concerns about finding work placements and skill advancement opportunities that align with shifting culture and technology.
Not enough support for difficulty of work	Some caregivers expressed concerns about the ability to do their job fully due to lack of resources, and consumers and providers alike desired more training for services.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

As the state works to develop its state plan on aging for the next four years, what suggestions or ideas do you have related to workforce?

Response Themes	Further Explanation
Flexibility and funding at the local level	Stakeholders noted this would be useful for further development of workforce retention programs with a variety of training schedules and working environments (remote, hybrid, etc.) Local funding flexibility could increase efficiency and coordination.
More professional development opportunities and work-from-home opportunities	Such opportunities can help caregivers and older Georgians feel like they are still advancing positively in their lives and work.
Partnerships with hospital associations	Partnerships may be useful to streamline care needs in areas with a limited workforce, such as a certified nursing assistant shortage.
Quality health insurance and paid leave	If salaries are slow to grow, some stakeholders felt that benefits should improve to compensate. This could potentially slow turnover.
Dedicated rural outreach and recruitment	Several stakeholders highlighted the difficulty of attracting talent to rural areas, suggesting that more outreach is needed if services are going to be consistently available to consumers.
More visibility for Senior Community Service Employment Program (SCSEP)	This could help seniors with concerns about re-entering the workforce.
Consistent training manuals and policies	Some staff remarked that training information and agency policies sometimes conflict and that changes are not always communicated until a problem has occurred. Stakeholders suggested feedback sessions when policy/training manual revisions occur.
Quarterly events in support/appreciation of caregivers	Such events could boost morale.
A strategic plan for the next spike in retirement	Due to the high number of Baby Boomers retiring or about to retire, dedicated efforts for recruitment and transition were deemed necessary.

Note: Participant responses to the question were organized into overall themes. The further explanation column paraphrases participant comments and provides additional insights for each theme.

Conclusion

The 13 feedback sessions and response to the online feedback form provided information about the priorities of stakeholders invested in Georgia's aging services. The feedback provided insights from a diverse group of stakeholders, including consumers, caregivers, service providers, aging advocates, AAA staff, DAS staff, and family members. Older adults were well represented in the feedback, with 65.71% of feedback form respondents being 51 years or older. The largest age group was the 61–70 age range, or 37.14% of feedback form respondents. Additionally, older adults from three senior centers attended the feedback sessions that were hosted by DAS and the Institute of Government. This feedback will guide the creation of Georgia's next state plan on aging. Overall, the feedback was positive, with most areas for improvement connected to a desire for expansion and refinement of programs.

Five overriding themes appeared consistently throughout the feedback.

Affordability: Stakeholders supported creative efforts to make aging services more affordable, such as grants, community and business partnerships, volunteer programs, and waiver programs.

Awareness of Services: Stakeholders encouraged more advertisement of services, with additional emphasis in locations frequented by older adults, families, and caregivers.

Accessibility: Stakeholders supported streamlined reporting systems and applications to make programs more accessible to consumers. Stakeholders also wanted to see more investments in home modifications and accessibility equipment for disabled older adults.

Continuity of Care: Stakeholders wanted to see more efforts to address workforce shortages and turnover. People are experiencing long waitlists that are interrupting their ability to get care. Stakeholders were interested in grants and resources to increase service availability.

Program Flexibility: Stakeholders valued the variety of aging programs but wanted more flexibility in locations, funding requirements, and partnerships.

Additionally, three specific needs were mentioned so frequently during the sessions and feedback form that they are noted below:

Affordable Housing: A variety of economic conditions are making affordable housing scarce. Stakeholders said that this issue will affect aging in place in the coming years and that heavy investments and multisectoral partnerships will be needed to address it.

Transportation: Stakeholders supported more investment in transportation services for older adults. They also recommended the creation of a statewide network of partnerships so older Georgians can easily identify a provider in their region.

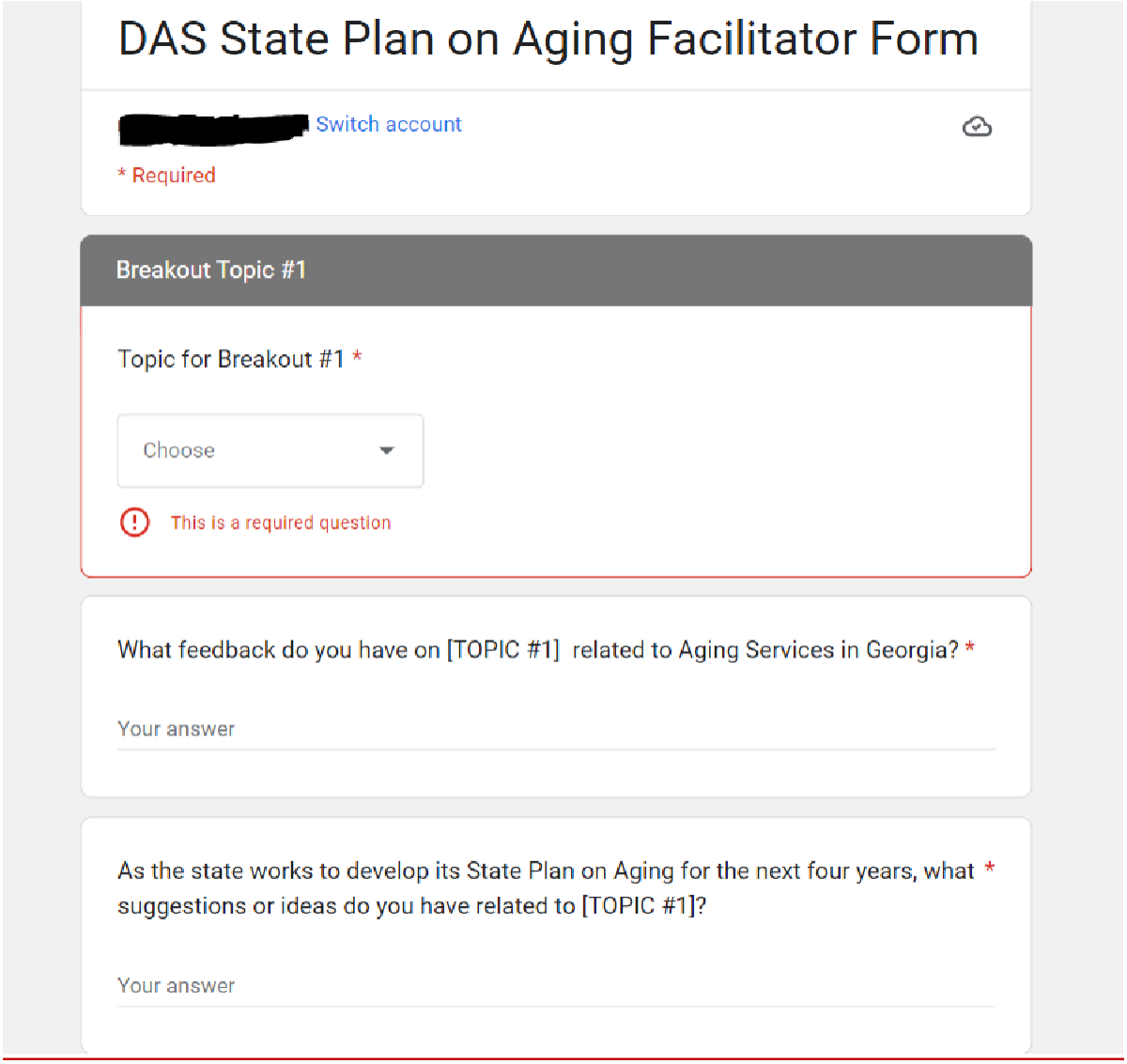
Mental Health: Stakeholders felt that mental health support is one issue that Georgia needs to invest heavily in, especially considering the lingering effects of COVID-19.

Appendix A: Feedback Session Flyer

Below is an example of a flyer advertising the online feedback sessions. The graphic was customized for each AAA and posted on the DAS website and advertised on AAA social media accounts.

Appendix B. Feedback Session Facilitator Note Template

During each feedback session, facilitators took notes on participant feedback. After the sessions, they filled out the online form below. The form had space for notes on each of the top issues as well as a miscellaneous option for any additional feedback from the breakout sessions.



DAS State Plan on Aging Facilitator Form

[redacted] Switch account

* Required

Breakout Topic #1

Topic for Breakout #1 *

Choose

This is a required question

What feedback do you have on [TOPIC #1] related to Aging Services in Georgia? *

Your answer

As the state works to develop its State Plan on Aging for the next four years, what suggestions or ideas do you have related to [TOPIC #1]? *

Your answer

Appendix C: Feedback Form Instrument

DAS Feedback

This is the instrument that was hosted on Qualtrics to garner feedback.

Thank you for your interest in providing feedback on Aging Services in Georgia. The Division of Aging Services has partnered with the University of Georgia's Carl Vinson Institute of Government to assist with collecting aging services feedback statewide. This short form seeks to collect input from Georgia stakeholders to inform the upcoming State Plan on Aging. Your responses will be used to help shape strategies and focus areas for Georgia's Aging Services for the next several years.

Did you attend one of the virtual listening sessions hosted by the Division of Aging Services and the local AAA?

- ○ Yes
- ○ No
- ○ I am planning to attend one in the near future

What is your primary role with aging and adult services?

- ○ Consumer (older adult/person with disability)
- ○ Service provider
- ○ Advocate
- ○ Caregiver/paid professional
- ○ Caregiver/family who is unpaid
- ○ Other _____

Consumer Question—The following question was only displayed for respondents selecting their primary role as consumer)

Do you currently use any of the following services? (check all that apply)

- ☐ Senior Center
- ☐ Adult Day Care
- ☐ Caregiver Support
- ☐ In-home Support
- ☐ Meals (at senior center or delivered
- ☐ Transportation Services
- ☐ Respite Care
- ☐ Do not use any of these services
- ☐ Prefer not to answer

Consumer Question—The following question was only displayed for respondents selecting their primary role as consumer)

How much assistance does the person receiving aging and adult services require?

- ○ No assistance
- ○ Occasional assistance
- ○ Frequent assistance
- ○ Continuous assistance
- ○ Don't know/unsure
- ○ Prefer not to answer

How would you rate your awareness of aging and adult services?

- ○ I know a lot about available services
- ○ I know something about available services
- ○ I know nothing about available services

How would you rate your knowledge of who to call if you need information about services?

- ○ Very knowledgeable
- ○ Somewhat knowledgeable
- ○ Not knowledgeable

How would you rate the Division of Aging Services' awareness of the needs of older adults and persons with disabilities?

- ○ Extremely aware
- ○ Moderately aware
- ○ Slightly aware
- ○ Not at all aware

How would you rate the Division of Aging Services' current services to address the needs of older adults and persons with disabilities?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

Caregiver Question—The following question was only displayed for respondents selecting their primary role as a caregiver)

What could the state do better to support you in your role as a caregiver?

_____

_____

_____

_____

_____

Please select three (3) priority areas you think the Division of Aging Services should focus on over the next four years:

☐ Aging in Place (Client Direction/Support/Choice, Services and Support, Housing, Transportation, Paid Family Caregiving)

☐ Health and Wellness (Mental, Behavioral and Physical Health, Wellness Education)

☐ COVID-19 (Social Isolation, Services Availability, COVID Communication/ Access, Mobility and Transportation Availability)

☐ Equity (Cultural Awareness Competence, Targeting most at need Consumers, Access to Services and Providers)

☐ Caregiving (Caregiving Support, Caregiver education, Grandparents Raising Grandchildren)

☐ Safety and Protection (Elder Justice Act, Elderly Legal Assistance Program, Adult Protective Services, Public Guardianship)

☐ Workforce (Availability, Turnover of Provider Staff, Turnover of AAA Staff)

You will be asked to provide additional information regarding the areas you selected on the following page.

Please tell us more about Aging in Place (Client Direction/Support/Choice, Services and Support, Housing, Transportation, Paid Family Caregiving)

What is working well?

_____

_____

_____

_____

_____

What is not working well?

_____

_____

_____

_____

_____

What ideas would you like to share about this area?

_____

_____

_____

_____

_____

These same questions were repeated for the following top issues.

- **Health and Wellness** (Mental, Behavioral and Physical Health, Wellness Education)
- **COVID-19** (Social Isolation, Services Availability, COVID Communication/ Access, Mobility and Transportation Availability)
- **Equity** (Cultural Awareness Competence, Targeting most at need Consumers, Access to Services and Providers)
- **Caregiving** (Caregiving Support, Caregiver education, Grandparents Raising Grandchildren)
- **Safety and Protection** (Elder Justice Act, Elderly Legal Assistance Program, Adult Protective Services, Public Guardianship)
- **Workforce** (Availability, Turnover of Provider Staff, Turnover of AAA Staff)

In your current aging role, what is your greatest concern regarding the ability to remain independent in aging?

What do you think would be most helpful in supporting older Georgians remain in their homes or communities?

What programs would you like to see in Georgia to meet the aging needs for Older Georgians?

Please provide any other comments you may have regarding the needs and priorities of older adults and individuals with disabilities in Georgia.

Please provide some demographic data so we can better understand the needs of our respondents.

How old are you?

- ○ Under 40
- ○ 41-50
- ○ 51-60
- ○ 61-70
- ○ 71-80
- ○ 81-90
- ○ 91-100
- ○ 100+

What is your gender?

- ○ Male
- ○ Female
- ○ Other
- ○ Prefer not to say

Do you consider yourself to be?

- ○ Heterosexual or straight
- ○ Gay or lesbian
- ○ Bisexual
- ○ Prefer not to answer

Which race/ethnic categories describe you (check all that apply):

- ☐ Caucasian or White
- ☐ African American or Black
- ☐ Asian or Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ Other
- ☐ Prefer Not to Answer

What is the highest level of education you have completed?

- ○ Less than high school
- ○ High school graduate or equivalent
- ○ Some college (no degree)
- ○ Associate or technical degree
- ○ Bachelor's degree
- ○ Graduate degree (Masters, PhD, MD, etc.)
- ○ Prefer not to answer

What is your current annual income?

- ○ $25,000 or less
- ○ $25,001-$50,000
- ○ $50,001-$75,000
- ○ $75,001-$100,000
- ○ More than $100,000
- ○ Prefer not to answer

Are you a veteran?

- ○ No
- ○ Yes
- ○ Prefer not to answer

Do you live alone?

- ○ No
- ○ Yes
- ○ Prefer not to answer

Do you currently consider yourself to have a disability?

- ○ No
- ○ Yes
- ○ Prefer not to answer

What county do you live in? What is your current home ZIP code?

_____

What is your marital status?

- ○ Single
- ○ Married
- ○ Divorced
- ○ Widow
- ○ Prefer not to answer

SECTION 2003 – Allocation Methodologies

POLICY STATEMENT:	The Division of Aging Services (DAS) adheres to federal and state policy, rules, grant requirements and appropriation intent in allocating funds to the Area Agencies on Aging and other contractors
ALLOCATION METHODOLOGIES, OAA:	The following methodology is used in allocating Older Americans Act funds:
Title IIIA	AAA Administration: 10% of total, including part D and is the maximum available for all direct and indirect administrative charges. This fund source requires a 25% local match. No Administration may be charged to Part D.
Title III B, C1, C2, & E	Six percent base or maximum $200,000 annually statewide, allocated equally to all regions. Remainder allocated by approved Intrastate Funding Formula (IFF). There are minimum III-B requirements for Access to Services, In-home Services and Legal Assistance. Refer to Section 2006 of this manual. State funds provide 5% matching funds; 10% local match required.
Title IIIB LTCO	Funding distributed to all regions according to the formula used for VII-2 described below in this section.
Title III D	Fifty percent base; remainder allocated by approved IFF. State funds provide 5% matching funds; 10% local match required.
Title V	SCSEP: Allocated to AAAs by an equitable distribution formula determined by the U.S. Department of Labor, which authorizes the number of positions (slots) statewide. 10 % local match required. Not all AAAs receive Title V funding.
Title VII-2	Long-Term Care Ombudsman (LTCO): allocated directly to LTCO contractors
Title VII-3	Elder Abuse Prevention. These funds are retained by the State Unit on Aging for statewide programming. Refer to Section 2006 of this manual for minimum requirements and maintenance of effort. Refer to Section 2002 of this manual for information on the Intra State Funding Formula.

SECTION 2005 – Matching Federal Funds

POLICY STATEMENT:	The Georgia Department of Human Services, Division of Aging Services follows federal requirements regarding the matching of federal funds.
REQUIREMENTS for MATCH:	
Service Match	In order to fulfill the match requirements of the Older Americans Act, 1965, as amended, Area Agencies and their service providers shall provide a minimum of 10% non-federal match funds for the cost of Older American Act Services. Area Agencies also shall provide local matching funds for allocations from the Social Services Block Grant, in amounts/percentages established by the Division. The local share of service funding shall be in the form of cash or non-cash (in kind.) The value of non-cash match shall be based on a fair market value of the services and goods supplied in support of the service or activity provided. Agencies shall document the value of staff time used as non-cash match by time sheets signed by the paid staff or volunteer. Agencies will report cash and non-cash match by submitting DHS/DAS Form 5215, "Report of Certified Costs" monthly.
Administrative Match	In order to fulfill the match requirements of the Older Americans Act, as amended, Area Agencies shall provide a minimum of 25% non-federal match funds for the cost of administration of area plans. The non-federal share shall be cash or non-cash. The value of non-cash match shall be based on a fair market value of the services and goods supplied in support of the service or activity provided. Agencies shall document the value of staff time used as non-cash match by time sheets signed by the paid staff or volunteer.

SECTION 2006 – Maintenance of Effort

POLICY STATEMENT:	The Georgia Department of Human Services, Division of Aging Services follows federal requirements for maintenance of effort.
REQIREMENTS for MAINENANCE of EFFORT (MOE)	
OAA Priority Services	Each Area Agency shall provide an adequate proportion of funding received through Title III-B of the Older Americans Act, as amended, for supportive services in the Act. Calculation of the minimum percent is based on the pre-shift amount of the Title III-B allocation for the appropriate fiscal year. Adequate proportions of funding for support services shall include each of the following support services categories and their designated services: • Access services. Services associated with access to other services, such as transportation, outreach, information and assistance, and case management services. The Area Agency shall provide a minimum of 12% of funding for this category overall. • In-home services. Supportive services such as homemaker, home health assistance, visiting and telephone assurance, chore maintenance and supportive services for families of older persons with Alzheimer's disease and related disorders with neurological and organic brain dysfunction. The Area Agency shall provide a minimum of 5% of funding for this category overall. • Legal assistance. This includes legal representation, legal counseling, and the provision of information. The area agency shall provide a minimum of 5% of funding, or $60,000, whichever is greater, for this category overall. NOTE: Of this required minimum for Legal Assistance, the 5% of Title IIIB funds cannot be waived, but the remainder of the minimum funding level may be from any other fund source(s).

REQIREMENTS for MAINENANCE of EFFORT (MOE), cont.

OAA Priority Services, cont.

An Area Agency may request a waiver from the Division for expending an adequate proportion of Title III-B funding for supportive services, if it meets the following criteria:

- The Area Agency holds at least one public hearing on the area plan or area plan update or amendment, containing a request for waiver of the adequate proportion requirement. The Agency shall notify all interested parties in the area of the public hearing and provide with an opportunity to testify.
- The Area Agency provided acceptable justification to demonstrate that an adequate supply of a specified support service is available to meet the needs of the service area.
- The Area Agency will submit separate waiver requests for each category of support service for which a waiver is sought.

LTCO

The State shall meet the requirements for maintenance of effort of funding as defined in the Older Americans Act, §306(a)(11). Title IIIB funds required to meet the maintenance of effort requirement are allocated to LTCO regions per the established LTCO funding formula.

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Carl Vinson
Institute of Government

Intrastate Funding Formula Feedback and Options Summary

Prepared for the Georgia Department of Human Services Division of Aging Services

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Acknowledgements

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Georgia's Intrastate Funding Formula Review Project

The Georgia Department of Human Services Division of Aging Services (DAS) partnered with the University of Georgia's Carl Vinson Institute of Government to provide technical assistance on the state's Intrastate Funding Formula (IFF). The IFF is used to allocate federal and state funds for aging services to the state's planning and service areas. The state must develop its IFF in accordance with federal statutes and regulations.[1] The IFF formula must consider the "geographical distribution of older individuals in the state" and the distribution of "older individuals with greatest economic need and older individuals with great social need, with particular attention to low-income minority older individuals."[2]

Georgia's IFF comprises eight elements, each with an assigned weight. The current elements are 60+ population, 75+ population, low-income minority 65+ population, low-income 65+ population, estimated rural 60+ population, limited English speaking 65+ population, disabled 65+ population, and living alone 65+.[3] Table 1 provides additional details on each IFF element.

The IFF project is part of DAS's continuous quality improvement efforts. The main goal of the project was to explore the current IFF processes and identify strengths and areas for improvement. This was accomplished through stakeholder interviews and feedback sessions, compliance research on Older Americans Act and Administration for Community Living guidelines, an IFF data input analysis, data profiles of older adults in Georgia, and a scan of other states' formulas. Additionally, DAS and the Institute of Government developed options for potentially revising the rural element of the IFF.

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[1] See 45C.F.R1321.37,42 U.S.C.3025, 42U.S.C.3027, 45C.F.R.1321.17, 45C.F.R.1321.19, and 45C.F.R.1321.43.

[2] 42U.S.C.3025(a)(2)(C).

[3] See Attachment D in the Georgia State Plan on Aging 2020–2023 for additional information on Georgia's current IFF formula: aging.georgia.gov/document/document/2020-2023-state-plan/download

Table 1. Georgia Current Intrastate Funding Formula (IFF)

Formula Element	Weight	Description	Data Source
60+ population	10%	The number of Georgians age 60 and older	ACS 5-year estimates
75+ population	30%	The number of Georgians age 75 and older	ACS 5-year estimates
Low-income-minority 65+ population	10%	The number of minority (non-white) Georgians age 65 and older whose income falls below the federal poverty level	ACS 5-year estimates
Low-income 65+ population	13%	The number of Georgians age 65 and older whose income falls below the federal poverty level	ACS 5-year estimates
Estimated rural 60+ population	15%	The number of Georgians that reside in a rural area as defined by the US Census Bureau	Decennial census (% population residing in rural areas) and ACS 5-year estimates (60+ population)
Limited English-speaking 65+ population	4%	The number of Georgians 65 and older who speak a language other than English and speak English not well or not at all	ACS 5-year estimates
Disabled 65+ population	10%	The number of Georgians age 65 and older who have a mobility or self-care limitation disability	ACS 5-Year Estimates
Living alone 65+	8%	The number of Georgians age 65 and older who live alone	ACS 5-year estimates

Note: ACS = American Community Survey from the US Census Bureau.

Considerations for Altering Intrastate Funding Formula Factors

Georgia typically updates its IFF formula (i.e., revising elements and weights) once every 10 years. It was last updated in 2014. In 2022, the state again considered IFF changes and partnered with the Institute of Government to evaluate the current formula. DAS leadership asked the Institute of Government to consider three focus areas:

1. Alignment with Older Americans Act (OAA) requirements and Administration for Community Living (ACL) priorities
2. Data access (regularly collected, ease of access, available at the correct geographic level, reliability)
3. Stakeholder and consumer feedback

OAA AND ACL ALIGNMENT

The Institute of Government evaluated OAA and ACL requirements for the IFF and found that Georgia's current formula appears to align with the requirements and vision of both. To ensure consideration of key OAA and ACL priorities, the Institute of Government produced two reports as part of the IFF project. The *Data Profile on Older Individuals in Georgia* examined current and projected demographic and economic trends impacting older Georgians. The second report, the *Georgia Intrastate Funding Formula Analysis and Review*, details the results of the IFF review project.

DATA UPDATE PROCESS

To comply with the OAA mandate to utilize the best available data, Georgia periodically updates the formula inputs, which are the various statistics for each formula element. These updates ensure that federal and state dollars for aging services are allocated based on the current data that best reflect the goals of the current IFF formula. The DAS Program Integrity Unit is charged with updating the data inputs for the IFF formula elements. All data utilized for the Georgia IFF rely on US Decennial Census data and five-year US Census Bureau American Community Survey estimates. The Institute of Government recommends consistently using the latest five-year-estimates data, usually released each December, to ensure that the IFF reflects the most recent data. Doing so will avoid large swings in funding distributions that could occur if data are not regularly updated to reflect demographic shifts.

As part of Georgia's IFF review process, researchers from the Institute of Government reviewed the current process for downloading, processing, and organizing the data inputs for the IFF formula elements. The research team developed an automated script to enhance data collection efforts in the future. Additional information on the data update process and the Institute of Government's data recommendations are presented in the *Georgia Intrastate Funding Formula Analysis and Review* report.

STAKEHOLDER AND CONSUMER FEEDBACK

According to federal statutes, potential changes or updates to the IFF must be guided by the input of Area Agencies on Aging (AAA) leadership, consumers, and other stakeholders with a vested interest in older individuals in Georgia.[4] The Institute of Government engaged stakeholders about the IFF through virtual feedback sessions and interviews. In addition, a more general feedback form and feedback voicemail number were mentioned to stakeholders at the feedback sessions where they could provide more IFF feedback if desired.

DAS and the Institute of Government began by conducting virtual interviews with leadership from AAAs across the state. The 12 Georgia AAA regions are Southern Georgia, River Valley, Heart of Georgia, Legacy Link Georgia Mountains, Northwest Georgia, Central Savannah River Region, Northeast Georgia, Coastal Georgia, Atlanta Regional Commission, Middle Georgia, Three Rivers, and Southwest Georgia. Due to scheduling conflicts, virtual interviews were not possible for Northeast Georgia, the Central Savannah River Region, or Middle Georgia. During the nine interviews, researchers gathered feedback on the current formula and the formula implementation process.

Next, DAS and the Institute of Government held 13 virtual feedback sessions with consumers, providers, and other interested stakeholders. These sessions were held for each of the AAA regions, and included a dedicated feedback portion on the IFF. The next two sections present detailed feedback information from the interviews and feedback sessions.

[4] See 42 U.S.C 3015 and 45 C.F.R 1321.37

Area Agencies on Aging Leadership Interviews

INTERVIEW OVERVIEW

AAAs coordinate and deliver services to older adults in Georgia, putting them on the front lines of IFF funding distributions. Thus, DAS partnered with the Carl Vinson Institute to collect feedback from leadership at each of the AAAs. The goal was to gather leadership perspectives on the current IFF and suggestions for potential needed updates. Nine virtual interviews were conducted in December 2021. The interviews took place on Zoom and were advertised internally to the AAAs by DAS leadership. DAS leadership provided attendees with an overview of IFF expectations from OAA and ACL guidelines, a review of the funding process, and an explanation of the formula and its weights. Attendees could view the formula and ask questions, share their experiences with existing DAS funding levels, and provide specific formula commentary. Feedback was gathered using Zoom chat logs and verbally, which was then converted into notes by session facilitators from the Institute of Government.

INTERVIEW STRUCTURE

The virtual interviews were attended by one to two leaders from the AAAs, as well as by a few DAS representatives and facilitators from the Institute of Government. Feedback was shared using the Zoom chat function or verbally. Each of the interviews lasted 30 minutes. The interviewees were given Institute of Government contact information if they had additional feedback. Each interview began with an overview of the interview purpose and brief attendee introductions. A DAS representative then provided a PowerPoint presentation that covered the formula's purpose, formal guidance from the OAA and the ACL, a visual representation of the formula, and an overview of how the funding gets allocated to AAAs. After each formula weight was described in further detail, the interviewees could then ask questions and note IFF pros, cons, and areas for improvement. The following three guiding questions were used.

- What do you like about the current Intrastate Funding Formula?
- Where does the current Intrastate Funding Formula fall short?
- What suggestions do you have for DAS leaders as they review the current formula and consider any needed updates?

AAA leadership responses are presented in the tables that follow.

INTRASTATE FUNDING FORMULA REFLECTIONS

What do you like about the current Intrastate Funding Formula?

Response Themes	Further Explanation
Dedicated 75+ factor	Several AAA leaders shared that the 75+ population typically has increased needs and that the AAAs value dedicated funding support at a high percentage for this population.
Dedicated factor for 60+ rural population	Several AAAs serve rural Georgia regions. Though service availability is sometimes limited in rural locations, they appreciated that the rural factor attempted to serve the greatest number of rural older adults by using a 60+ cutoff rather than 65.
2 factors emphasizing low-income populations	Several AAA leaders identified low-income as a key population served in their regions. They valued having two sources of dedicated funding.
Feedback sessions before IFF rollout	AAA leadership appreciated the opportunity to provide input during the formula update process.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

Where does the current Intrastate Funding Formula fall short?

Response Themes	Further Explanation
Not enough funding for 60+	Some AAA leaders shared that they are starting to see decreased life expectancies and increased needs at ages 60+. Thus, some believed 60+ should receive a higher percentage.
Gaps in rural funding effectiveness	Some AAA leaders shared that while there is dedicated funding for rural populations, the actual availability of services is limited. Additionally, some areas are between rural and metropolitan in size. They wondered if there is a way to more effectively implement the funding to increase service availability.
Unclear rationale for formula weights	Several AAA leaders wanted more transparency about how the IFF factors and weights are decided. They were interested in DAS providing documentation explaining the process and more continuous funding updates.
Specificity of minority factor	Some AAA leaders noted that the current factor focuses on low-income minorities. Thus, some were worried about minorities' ability to access services if they do not meet the low-income qualification.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

What suggestions do you have for DAS leaders as they review the current formula and consider any needed updates?

Response Themes	Further Explanation
Clear definition for rural factor and increased percentage for rural	Some AAA leaders wanted clarification on the definition of "rural" to better understand which parts of their region were eligible for rural funding distributions. In addition, some shared a desire for increased funding for rural Georgians, particularly to help increase service availability.
Increase the percentage for low-income	The low-income demographic was a key population in AAA discussions. Additional funding was suggested because AAAs experience high demand for affordable services.
Increase the percentage for disabled	AAA leaders shared that disabled and home-bound individuals are often at high risk, and extra funding could help improve quality of life for these older Georgians.
Include a more general minority factor	Some AAA leaders were concerned that the current factor focuses too specifically on low-income minorities. Minorities may have unique needs not being met due to funding being limited to the subset of those with low income.
Factor to address transportation and caregivers	Some AAA leadership discussed the critical need for reliable access to transportation and caregivers/caregiver support. They suggested adding a dedicated IFF factor or a statewide fund for these issues.
More transparency about the formula	The majority of AAA leaders in the sessions wanted more information about the formula decision-making process, access to information on the data used for IFF decisions, the rationale for factor changes, and information about future initiatives to give IFF feedback.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

Consumer Feedback Sessions

SESSION OVERVIEW

DAS partnered with UGA's Carl Vinson Institute of Government to collect stakeholder and consumer feedback to guide the development of Georgia's next State Plan on Aging and Intrastate Funding Formula. Due to the progression of COVID-19, a total of 13 sessions (one in each AAA region and two in the Atlanta region) were held virtually between April and June of 2022. Session participation ranged from 12 to 73 individuals, with more than 400 participants across all sessions. A portion of each of these sessions was dedicated to gathering consumer feedback on the Intrastate Funding Formula. The sessions were advertised via DAS's website, the network of each AAA, and social media to service providers, advocates, caregivers, older adults, and other interested parties. The goal was to gather diverse perspectives on how DAS can best support Georgia's older adults in living longer, living safely, and living well.

The sessions also aimed to educate stakeholders about Georgia's Intrastate Funding Formula and DAS's responsibilities pertaining to it. Information was provided about DAS's role in state governance, federal formula requirements from the Older Americans Act, the funding process, the meaning of formula weights, and the formula's relevance to state plan expectations. Attendees were able to ask questions about the formula and share their experiences with existing DAS programming and funding levels. Networking information was also shared with stakeholders seeking additional guidance. Consumer feedback was gathered using Zoom chat logs; Slido, a real-time response software; and facilitator notes.

SESSION STRUCTURE

Each virtual feedback session began with an overview of the purpose of the session. After that, the facilitators and attendees introduced themselves, including name, role, county, and reason for attendance. A DAS representative then provided an overview of DAS's vision and mission, agency structure, and services. Time was then given to stakeholders to ask the DAS representative questions. Next, the sessions were divided into three periods: DAS service reflections, top issue reflections, and IFF reflections. Additional information about the DAS service reflections and top issue reflections can be found in the Stakeholder Input Report for the 2024–2027 Georgia State Plan on Aging.

The purpose of the IFF reflections portion was to educate the attendees about the formula and to gather feedback on perceived pros, cons, and suggestions for improvement. The formula session began with a PowerPoint presentation from DAS leadership that provided basic information about the formula's purpose and formula guidance from the OAA and the ACL. Then, DAS leadership showed the visual representation of Georgia's Intrastate Funding Formula to stakeholders and explained each of the weights and how they pertained to funding for services. Stakeholders were then given the opportunity to ask questions about the formula and to note pros, cons, and areas of improvement for the formula and its weights. Feedback was shared aloud or using the Zoom chat function. The following three questions were used to guide the conversation.

- What do you like about the formula?
- What do you not like about the formula?
- How should the State of Georgia fairly and efficiently allocate limited aging resources?

INTRASTATE FUNDING FORMULA REFLECTIONS

What do you like about the formula?

Response Themes	Further Explanation
Variety of categories	Stakeholders valued that the formula factors attempted to cover a variety of demographics in the aging population.
Representation	Several stakeholders noted the importance of inclusion, particularly the factors for disabled, limited English, and minority populations.
Higher percentage for those 75+	Several stakeholders discussed the increased support needs of adults ages 75+, especially those trying to age in place in their communities. Thus, the extra funding for advanced age support was a plus to many stakeholders at the sessions.
Includes limited English factor	Some stakeholders discussed the importance of making services accessible to those with English as a second language.
Includes living-alone factor	Living alone was considered a risk factor to consumers, caregivers, and other service providers during the sessions, so a dedicated funding source was appreciated.
Includes rural factor with a larger percentage	Many stakeholders came from rural areas, and the funding emphasis outside of metropolitan areas was appreciated.
In line with OAA and ACL guidance	Stakeholders liked the references to the OAA and ACL and how DAS incorporated them both in the formula review process.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

What do you not like about the formula?

Response Themes	Further Explanation
Lack of clear definition for the rural factor	Several stakeholders seemed concerned about how "rural" is defined, such as which data sources are used and how that impacts communities at a funding level.
Funding percentage for rural factor too low	While there was limited concern that the funding percentage for rural was too high, far more stakeholders at the sessions were concerned that it was too low. Some suggested that their communities fell between rural and metropolitan sizes.
Funding percentage for living-alone factor too low	Several stakeholders discussed aging in place in their communities with limited caregiver access or support systems. Some felt that this factor could be further funded.
Funding percentage for 60+ population factor too low	Several stakeholders shared concerns about decreased lifespans in some regions and increases in service needs prior to age 65. Thus, some were worried about a significant gap in service access for in-need older adults.
Accuracy of the census data unclear	Some stakeholders were unsure about which census estimates were used. Several stakeholders were concerned that underreporting might lead to deflated population estimates in their regions and thus less funding.
Complicated formula without a detailed key	Several stakeholders wished there had been a comprehensive written pamphlet or key prepared prior to the sessions explaining the IFF and its factors in much greater detail. Some stakeholders found it hard to follow the conversation.
Does not include a factor for clients under age 60 who are disabled and otherwise eligible for services	Some stakeholders discussed the demand from other older adults not yet in their 60s who could benefit from service access.
Funding percentage for disabled factor too low	Stakeholders noted that numbers of disabilities are on the rise and increased funding may help older Georgians.
Currently, no factor captures transportation and caregiver needs	Several stakeholders talked about caregiver burnout, including older adults who are also caregivers. Limited funding for and access to transportation was also a concern.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

How should the State of Georgia fairly and efficiently allocate limited aging resources?

Response Themes	Further Explanation
More funding for living-alone factor	This was suggested due to increased risks and to provide greater support for aging in place.
More funding for disabled factor	Stakeholders noted rising rates of disability and a potential need for greater funding to best meet the needs of these older adults.
More funding for low-income factor	Several stakeholders were concerned about the affordability of services for many Georgians and, consequently, funding to keep services available to those with limited financial resources.
Move the minimum age to 60 for each factor	This was suggested frequently by stakeholders because of a potential service coverage gap.
Dedicate a portion of lottery funds to aging services	Some stakeholders seemed interested in supplementing IFF dollars with other state dollars such as lottery funds or a dedicated tax for aging services.
Consider factors for transportation, affordable housing, and caregiving support	Several stakeholders felt that transportation, affordable housing, and caregiving support are critical aging issues in need of immediate additional advocacy and funding.
Base the allocations on need in area instead of population	Stakeholders wondered if there is a way to conduct needs assessments around the state to help allocate funds rather than using census population estimates. This was mainly due to concerns about census participation.
Remove barriers to access such as language barriers and complicated forms to access services	Some stakeholders mentioned that some services require program enrollment to receive funding, and there were concerns of accessibility issues limiting enrollment.

Note: Participant responses to the question were organized into overall themes, listed in the left column. The right column paraphrases participant comments and provides additional insights about each of these themes.

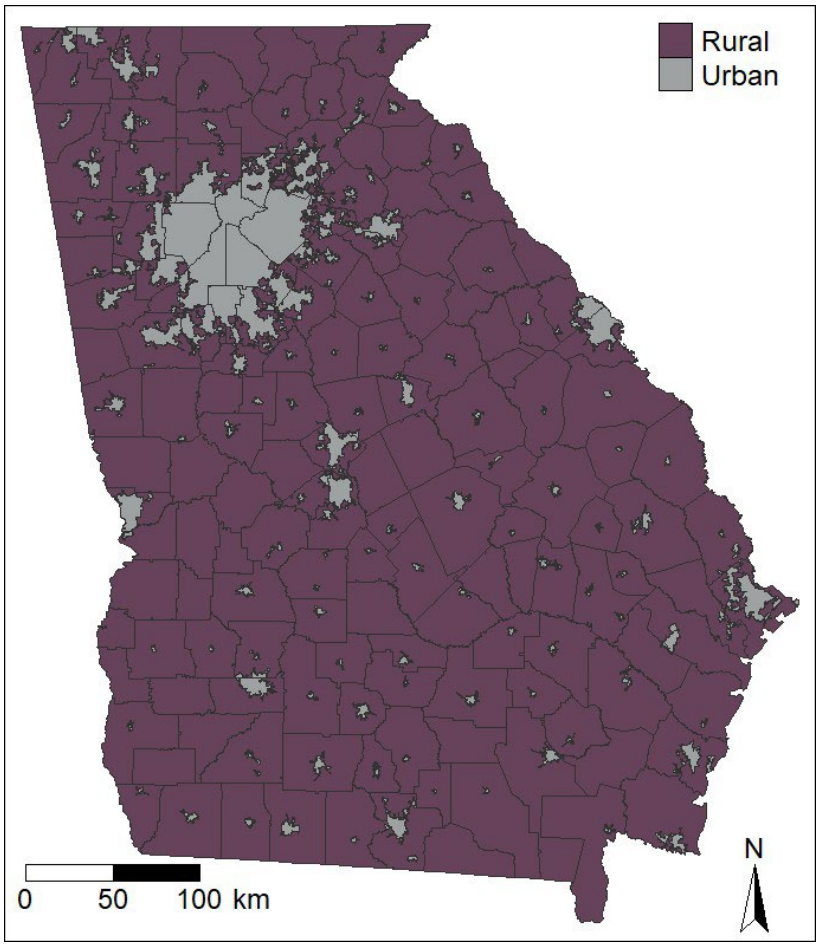
Options for Revising the Rural Factor

Based on the analysis of data on older Georgians, a scan of other intrastate funding formulas, stakeholder feedback, and guidance from DAS leadership, the Institute of Government developed options for revising the rural factor in the funding formula. The sections that follow outline five calculation options for Georgia's rural factor for review and consideration by DAS senior leadership. Appendix A contains estimates of financial impacts under each of these options.

OPTION 1: DECENNIAL CENSUS (CURRENT DEFINITION)

The first option is the status quo. "Rural" would continue to be defined based on the decennial census urbanized area measure. However, this option has some unknowns. The Census Bureau has announced a new definition for "urban" in the 2020 census data.[5] Additionally, population projections indicate continued demographic shifts in Georgia's 60+ and 75+ populations. These changes will result in Title III funding shifts, even if the formula stays the same. Figure 1 depicts urban/rural areas in Georgia based on the current definition and 2010 data.

Figure 1. Decennial Census Current Definition, Based on 2010 Census Data

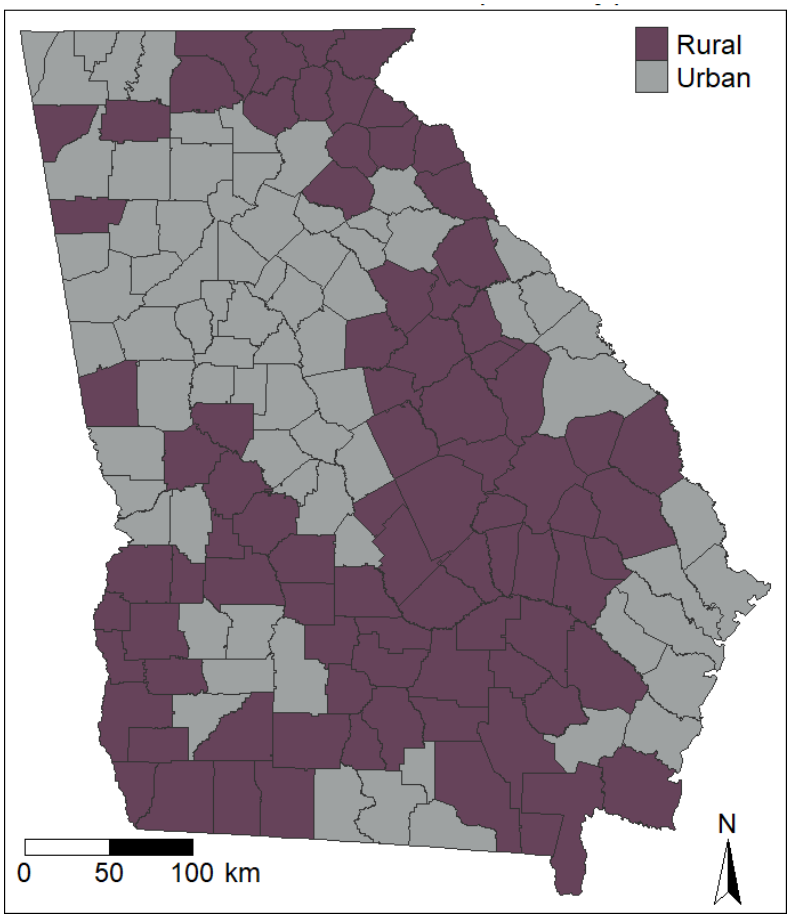


[5] See www.federalregister.gov/documents/2022/03/24/2022-06180/urban-area-criteria-for-the-2020-census-final-criteria for additional information.

OPTION 2: RUCC

The second option is to use Rural Urban Continuum Codes (RUCC), which is a county-based measure from the US Department of Agriculture's Economic Research Service. This classification system is based on the population of each county. The RUCC codes are generated from a combination of county population size and adjacency to the 2013 census-defined metropolitan areas. (The US Census Bureau last updated its metropolitan area definitions in 2013.) Counties are first distinguished as metro or nonmetro, following Office of Management and Budget guidelines.[6] Metro counties are then divided into three categories based on population size. Nonmetro counties are divided first into urban-size categories based on population, and then subdivided by whether the county is adjacent to one or more metro areas.[7] For IFF purposes, all nonmetropolitan counties would be classified as rural. Figure 2 shows which counties in Georgia would be considered rural versus urban for IFF distributions.

Figure 2. Rural Urban Continuum Codes (RUCC) Definition



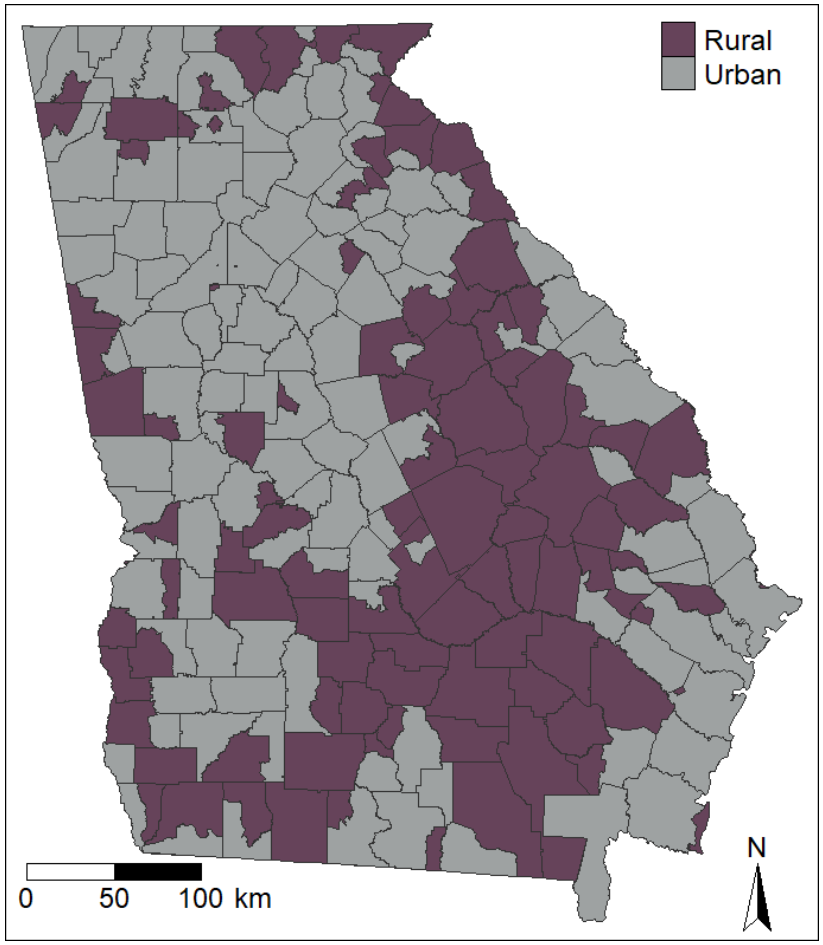
[6] See obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf

[7] See www.ers.usda.gov/data-products/rural-urban-continuum-codes/documentation/

OPTION 3: RUCA1

The third rural definition option is RUCA1, or Rural-Urban Commuting Area Code Option #1. This option uses census-tract-level classifications of urban and rural. RUCA1 defines a tract as urban if 30% of its employed population commutes to a metropolitan urbanized area (e.g., Atlanta, Albany, Chattanooga, Valdosta). This definition is based on the ACL Title III guidance for the OAA Performance System.[8] Figure 3 shows which census tracts in Georgia would be considered rural versus urban for IFF distributions.

Figure 3. Rural-Urban Commuting Area Code Option #1 (RUCA1) Definition

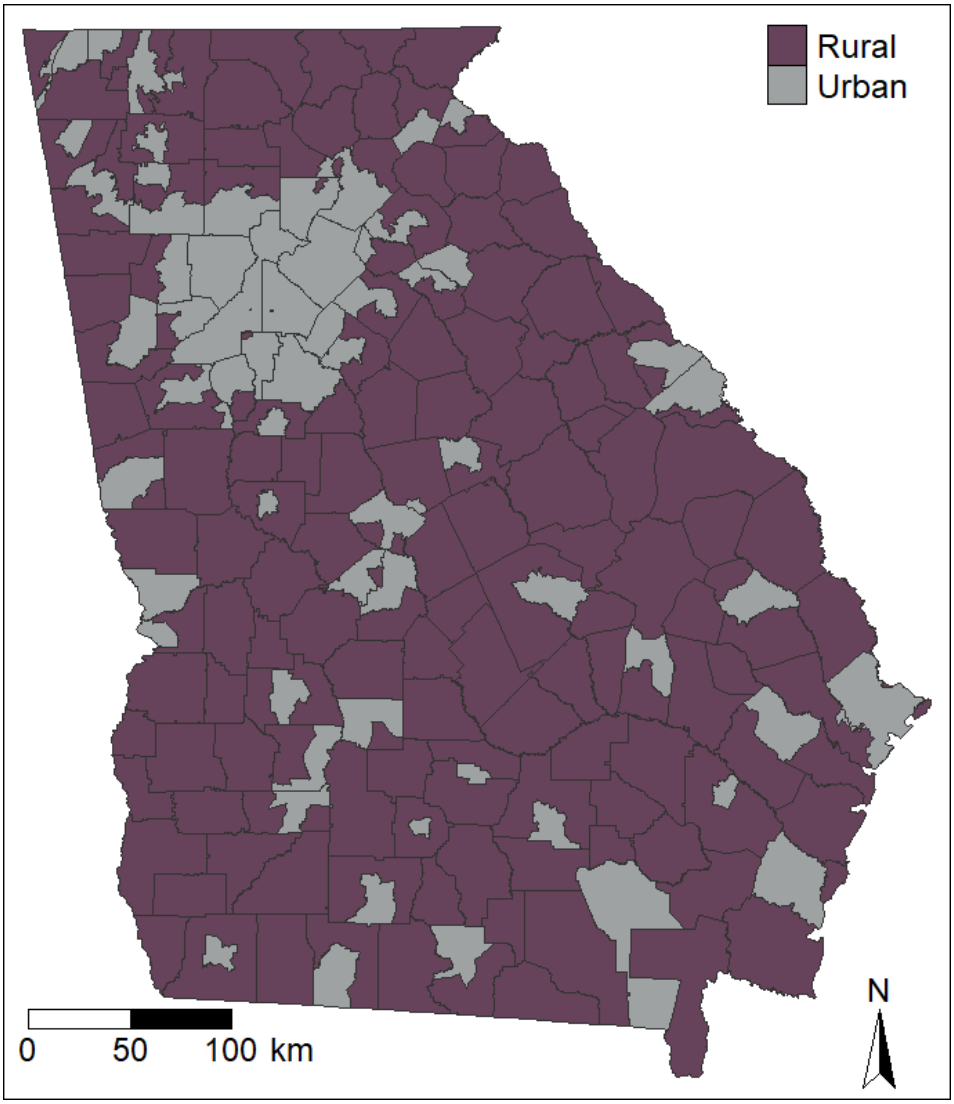


[8] See www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation/

OPTION 4: RUCA2

The fourth rural definition option is RUCA2, or Rural-Urban Commuting Area Code Option #2. This option uses another census-tract-level classification of urban and rural. However, it differs from RUCA1 in that the urban definition includes only places where the majority of commutes occur within metropolitan or micropolitan urbanized areas. Figure 4 shows which census tracts in Georgia would be considered rural versus urban for IFF distributions under RUCA2.

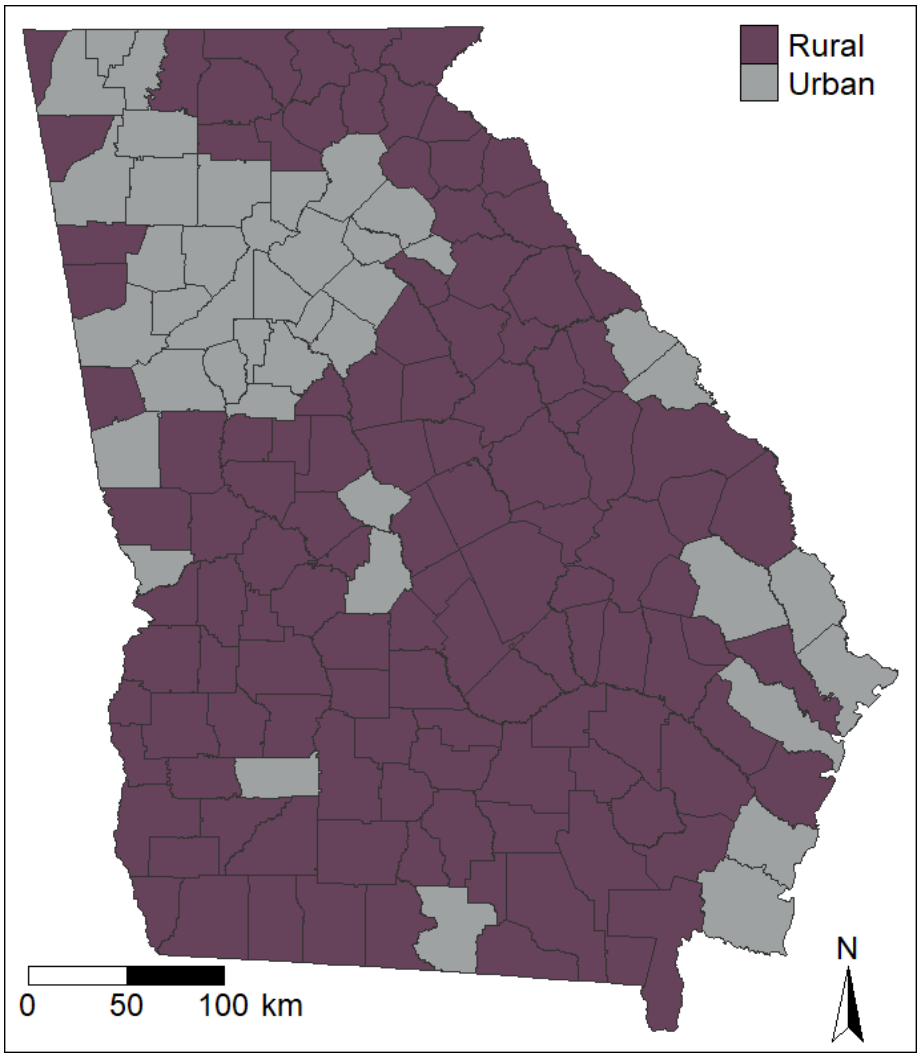
Figure 4. Rural-Urban Commuting Area Code Option #2 (RUCA2) Definition



OPTION 5: RHOAA

The fifth rural definition option, RHOAA, is based on the Rural Hospital Organization Assistance Act of 2017. It is a county-level classification of urban and rural based on the definitions in Georgia Code § 31-7-94.1 (2019). Counties with a population of at least 50,000 are considered urban, and the rest are rural. Figure 5 shows which counties in Georgia would be considered rural versus urban for IFF distributions.

Figure 5. Rural Hospital Organization Assistance Act of 2017 (RHOAA) Definition



Appendix A. Estimated Financial Impacts of Revised Rural IFF Factor

The Institute of Government estimated the financial impacts of options 2–5 against the current formula (option #1).

RUCC IMPACTS

PSA_NAME	Funds_Census	Funds_RUCC	
NWGA AAA	$ 3,017,426	$ 2,794,959	($222,468)
Legacy Link	$ 2,371,602	$ 2,531,815	$160,213
ARC Aging Division	$ 9,440,950	$ 9,218,640	($222,309)
Three Rivers AAA	$ 1,712,978	$ 1,521,738	($191,239)
NEGA AAA	$ 1,900,277	$ 1,717,277	($183,001)
River Valley AAA	$ 1,406,581	$ 1,484,154	$77,572
Middle Georgia AAA	$ 1,796,254	$ 1,689,564	($106,690)
CSRA AAA	$ 1,652,684	$ 1,618,779	($33,905)
Heart of Georgia AAA	$ 1,301,561	$ 1,665,071	$363,510
SOWEGA AAA	$ 1,427,721	$ 1,606,687	$178,966
Southern GA AAA	$ 1,570,785	$ 1,783,467	$212,682
Coastal GA AAA	$ 1,896,114	$ 1,862,783	($33,332)

RUCA1 IMPACTS

PSA_NAME	Funds_Census	Funds_RUCA1	
NWGA AAA	$ 3,017,426	$ 2,778,620.25	($238,806)
Legacy Link	$ 2,371,602	$ 2,302,437.85	($69,164)
ARC Aging Division	$ 9,440,950	$ 9,221,243.16	($219,706)
Three Rivers AAA	$ 1,712,978	$ 1,650,144.96	($62,833)
NEGA AAA	$ 1,900,277	$ 1,638,767.61	($261,510)
River Valley AAA	$ 1,406,581	$ 1,457,148.36	$50,567
Middle Georgia AAA	$ 1,796,254	$ 1,722,742.55	($73,512)
CSRA AAA	$ 1,652,684	$ 1,715,502.74	$62,819
Heart of Georgia AAA	$ 1,301,561	$ 1,770,034.29	$468,474
SOWEGA AAA	$ 1,427,721	$ 1,651,476.09	$223,755
Southern GA AAA	$ 1,570,785	$ 1,836,357.40	$265,572
Coastal GA AAA	$ 1,896,114	$ 1,750,458.75	($145,656)

RUCA2 IMPACTS

PSA_NAME	Funds_Census	Funds_RUCA2	
NWGA AAA	$ 3,017,426	$ 2,966,001	($51,425)
Legacy Link	$ 2,371,602	$ 2,360,338	($11,264)
ARC Aging Division	$ 9,440,950	$ 9,297,723	($143,227)
Three Rivers AAA	$ 1,712,978	$ 1,745,603	$32,625
NEGA AAA	$ 1,900,277	$ 1,946,563	$46,286
River Valley AAA	$ 1,406,581	$ 1,396,196	($10,386)
Middle Georgia AAA	$ 1,796,254	$ 1,777,374	($18,880)
CSRA AAA	$ 1,652,684	$ 1,675,175	$22,491
Heart of Georgia AAA	$ 1,301,561	$ 1,341,272	$39,711
SOWEGA AAA	$ 1,427,721	$ 1,430,297	$2,576
Southern GA AAA	$ 1,570,785	$ 1,583,208	$12,422
Coastal GA AAA	$ 1,896,114	$ 1,975,185	$79,070

RHOAA IMPACTS

PSA_NAME	Funds_Census	Funds_RHOAA	
NWGA AAA	$ 3,017,426	$ 2,821,140	($196,287)
Legacy Link	$ 2,371,602	$ 2,431,596	$59,994
ARC Aging Division	$ 9,440,950	$ 9,218,640	($222,309)
Three Rivers AAA	$ 1,712,978	$ 1,540,232	($172,746)
NEGA AAA	$ 1,900,277	$ 1,772,725	($127,552)
River Valley AAA	$ 1,406,581	$ 1,513,284	$106,702
Middle Georgia AAA	$ 1,796,254	$ 1,880,743	$84,489
CSRA AAA	$ 1,652,684	$ 1,674,106	$21,422
Heart of Georgia AAA	$ 1,301,561	$ 1,517,568	$216,007
SOWEGA AAA	$ 1,427,721	$ 1,622,835	$195,114
Southern GA AAA	$ 1,570,785	$ 1,760,435	$189,650
Coastal GA AAA	$ 1,896,114	$ 1,741,631	($154,483)

ALLOCATION METHODOLOGIES, OAA, cont.	
Nutrition Services Incentive Program (NSIP)	NSIP funds are allocated according to Regional percentages of the number of meals served statewide in the previous year as reported in the DAS Data System, consistent with federal methodology for allocating NSIP to the states. State and federal funds appropriated to supplement NSIP are allocated in the same way.
ALLOCATION METHODOLOGIES, STATE FUNDS	State funds are used to match federal funds and are also allocated to conform to legislative intent.
Alzheimer's Services	Funds for the Alzheimer's Program are allocated using the East Boston "Harvard Study", with prevalence rate projections updated with the latest census data by the CDC, including prevalence rates of other dementias. Additional Community Based Services state funds are "set aside" for Alzheimer's Services.
Aging and Disabilities Resource Connection (ADRC)	State Funds are distributed evenly to the 12 AAAs. Any grant funds are distributed according to grant requirements.
Community Based Services (CBS)	State funds include "set asides" to reflect legislative intent or to ensure policy compliance for the following programs: <u>Alzheimer's Services:</u> allocated via the funding methodology described above in this section. <u>ELAP:</u> Allocated by the approved IFF <u>GeorgiaCares:</u> This set aside is to support the SHIP. Refer to GeorgiaCares methodology below in this section. <u>Respite Services:</u> Allocated by the approved IFF. <u>Non-Medicaid HCBS Case Management:</u> Allocated by the approved IFF. The remaining CBS funds are distributed using the six percent base and the IFF.

ALLOCATION METHODOLOGIES, STATE FUNDS, cont.	
LTCO Supplemental	The supplement is distributed to all regions according to the formula used for VII-2 described above in this section.
Nutrition Services Incentive Program (NSIP) Supplemental	State and federal funds appropriated to supplement NSIP are allocated according to Regional percentages of the number of meals served statewide in the previous year as reported in the DAS Data System, consistent with federal methodology for allocating NSIP to the states.
State Nursing Home Transitions	State funds appropriated for nursing home transmissions are allocated to sub-recipients. Contracted transitions are funded at $5,100 per transition for transition services.
ALLOCATION METHODOLOGIES, OTHER FUNDS	
GeorgiaCares	GeorgiaCares funding is primarily from the SHIP federal grant. The methodology used for allocating these funds mirrors the approach used by the Centers for Medicare and Medicaid Services (CMS) in allocating to the states. State funds also support this program. A base of combined CMS and CBS funds is distributed to each of the 12 regions. 75% of the remaining funds are allocated based upon the % of total Medicare beneficiaries in each region and 15% are allocated based on the % of rural Medicare beneficiaries in each region. Additional grant funds for this program, if available, are allocated according to grant requirements.

ALLOCATION METHODOLOGIES, OTHER FUNDS, cont.

Social Services Block Grant (SSBG)

Funds are distributed to specified programs as follows:

Home and Community Based Services: Six percent base; remainder allocated by approved IFF; 12% local match required.

Long Term Care Ombudsman (LTCO): Funds are allocated following the methodology for OAA Title VII-2 as described above in this section.

Money Follows the Person Transition Coordination:
A base us distributed evenly to all 12 AAAs.

NSIP: SSBG funds appropriated by the General Assembly to supplement NSIP are allocated according to Regional percentages of the number of meals served statewide in the previous year as reported in the DAS Data System, consistent with federal methodology for allocating NSIP to the states.

Income Tax Check off

The Georgia Fund for Children and Elderly "Income Tax Check off" funds are received by the Department of Revenue (DOR). After deducting an administrative fee, the DOR sends 50% of the remainder to the Department of Public Health and 50% to the Division of Aging Services. The funds to DAS are restricted for use on meals and transportation.

DAS distributes to the AAAs a six percent base and the remainder by current IFF.

Nutritional Supplement Incentive Program (NSIP)

NSIP funds are allocated to the AAAs according to Regional percentages of the number of meals served statewide in the previous year as reported in the DAS Data System, consistent with federal methodology for allocating NSIP to the states.

ALLOCATION METHODOLOGIES, OTHER FUNDS, cont.

Money Follows the Person

The Department of Community Health contracts with DAS to administer a portion of the Money Follows the Person grant from CMS. DAS allocates the funds to the 12 AAAs for specific purposes as follows:

MFP Transition Coordination:
50% of the funding is distributed by AAA based upon the percent of nursing home beds in the planning and service area.
25% of the funding is distributed by AAA based upon the percent of the incoming caseload (pipeline) for the current fiscal year in the planning and service area.
25% of the funding is distributed by AAA based upon the percent of the current caseload for the current fiscal year in the planning and service area.

MDSQ Options Counseling: Funds are distributed evenly between 11 AAAs with the Atlanta Regional Commission receiving a double share.

Non-Medicaid HCBS Case Management

DAS established a $1.4 million state fund set-aside from existing funds for non-Medicaid HCBS Case Management in the HCBS Manual Transmittal 2007-03 (MAN 5300, April 2007). This set-aside is allocated based on the current Intrastate Funding Formula. This set-aside is reflected in the Allocation Issuances effective with the 2016-01 Allocation. The set aside is intended to be a minimum for non-Medicaid HCBS Case Management; Area Agencies on Aging may additionally fund non-Medicaid HCBS Case Management by any allowable fund source.

PROCEDURES

Allocations are issued in the form of an EXCEL workbook, which is locked. The workbook is locked to limit the opportunity for fraud, since the allocation is the basis for AAA budgets and contracting.

The Allocation workbook contains a summary sheet for each AAA and sub-contractor, a “Consolidated Totals” page which is the statewide allocation and multiple supporting fund source pages. While most of the funds allocated to an AAA are found on their summary page, some fund sources are

PROCEDURES, cont.

only shown on the fund source page. The Allocation Issuance Memorandum, which accompanies the workbook, will indicate where to look for the funds in the workbook.

The Business Operations Section Manager will draft the allocation for review by DHS/Office of Budget Administration, Section Managers, as appropriate, and the Director and Deputy Director. One time fund sources are not included in the planning allocation.

Allocations for each State Fiscal Year are enumerated/named using the four digit state fiscal year and issuance number. The planning allocation is designated with "P". Examples:

Planning Allocation = 2014-P
Initial issuance for SFY 2014 = 2014-01
Subsequent issuance for SFY 2014 = 2014-02, 2014-03, etc.

Planning Allocation

A locked copy of the Allocation workbook and memorandum is filed on the DAS shared drive in the ALLOCATION ISSUANCES folder by state fiscal year.

A planning allocation is sent to the AAAs prior to the start of the Area Plan process. This is usually in the second quarter of the current fiscal year. Refer to Section 3021 of this manual for information on the Area Plan.

Initial Allocation for SFY

The AAA will use the planning allocation to develop their budget for the upcoming State Fiscal Year. Refer to Section 3022 of this manual for information on budget submission.

The initial allocation for the state fiscal year is sent to the AAAs before July 15.

Subsequent Allocations for SFY

The AAA will submit their budget revision by the deadline set forth in the Allocation Memorandum.

Subsequent Allocations for the state fiscal year will be issued at the discretion of the DAS Director. Reasons for subsequent allocations include, but are not limited to:

- New or changes in federal funding levels
- New or changes in state funding levels
- New or changes in grant funds
- Redistribution of funds as a result of potential lapse of funds by a AAA

Subsequent Allocations for SFY, cont.	The AAA will submit their budget revision by the deadline set forth in the Allocation Memorandum.
TITLE III FUND TRANSFERS	
AAA Transfer	Area Agencies on Aging may shift up to 30% of their allocation for Title III-C1 or Title III-C2 to the other. The shift must be requested and approved as part of the Area Plan/budget process. Area Agencies on Aging may transfer up to 20% of their combined budget for Title III-C to Title III-B or 20% of Title III-B to Title III-C. The shift must be requested and approved as part of the Area Plan/budget process.
SUA Transfer	The Division is responsible for final, statewide transfers in a federal fiscal year. Allowable transfers are as follows: • 40% between Titles III-C1 and III-C2 • 30% between Titles III-B and the Nutrition Programs under Title III-C The U.S. Assistant Secretary for Aging may disapprove the transfer if it is determined that the transfer is not consistent with the objectives of the OAA, as amended.
REFERENCES	MAN 5600, Section 2002, Interstate Funding Formula MAN 5600, Section 2005, Matching Federal Funds MAN 5600, Section 2006, Maintenance of Effort MAN 5600, Section 3021, Area Plan MAN 5600, Section 3022, Budget Revisions, Contract Amendments and Reporting Requirements AoA PI 07-03; Older Americans Act, Sections 308 (b)(4)(A), 308 (b)(4)(B), 308 (b)(5)(A), and 308 (b)(4)(C), As Amended

TABLE IV - 6
SFY 2024 State Program Allocations by PSA

PSA	PSA Name	IFF%	Title III Admin Totals	Title IIIB	Title IIIC1	Title IIIC2	Title III Part D Wellness	Title IIIE	Other Funds Total*	Grand Total
1	Northwest Georgia	9.8831500%	$412,596	$943,329	$1,531,712	$781,681	$52,667	$364,786	$4,373,329	**$8,460,100**
2	Georgia Mountains	8.1092400%	$343,275	$782,660	$1,270,829	648544	$47,538	$307,054	$3,672,112	**$7,072,012**
3	Atlanta Region	32.9455600%	$1,320,001	$3,032,173	$4,923,434	$2,512,584	$119,345	$1,176,940	$12,496,001	**$25,580,478**
4	Three Rivers	5.7448200%	$249,850	$568,506	$923,101	$471,087	$40,701	$219,841	$2,823,714	**$5,296,800**
5	Northeast Georgia	6.6556500%	$285,670	$651,003	$1,057,053	$539,448	$43,336	$251,742	$2,984,142	**$5,812,394**
6	River Valley	4.5806000%	$204,066	$463,059	$751,882	$383,709	$37,337	$179,064	$2,447,041	**$4,466,158**
7	Middle Georgia	5.7926500%	$251,731	$572,839	$930,136	$474,678	$40,841	$221,516	$2,835,126	**$5,326,867**
8	Central Savannah River	5.5643500%	$243,194	$552,160	$896,560	$457,542	$40,182	$217,920	$2,303,004	**$4,710,562**
9	Heart of Georgia Altamaha	4.3107100%	$193,890	$438,614	$712,191	$363,453	$36,556	$174,012	$2,386,489	**$4,305,205**
10	Southwest Georgia	4.9230000%	$217,530	$494,071	$802,239	$409,407	$38,326	$191,058	$2,553,733	**$4,706,364**
11	Southern Georgia	5.7448200%	$223,103	$505,891	$821,431	$419,202	$38,704	$200,028	$2,641,069	**$4,849,428**
12	Coastal	6.4367700%	$277,502	$631,179	$1,024,864	$523,020	$42,703	$248,476	$3,047,168	**$5,794,912**
	State Total	**100.00%**	**$4,222,408**	**$9,635,484**	**$15,645,432**	**$7,984,355**	**$578,236**	**$3,752,437**	**$44,562,928**	**$86,381,280**

NOTE: Other funds includes SSBG, Community based services, Alzheimer's, LTCO state supplemental, Income tax check off, NSIP, and Transition Programs funding. Title VIII funds are not allocated through AAAs.

NSIP funds are allocated according to Regional percentages of the number of meals served statewide in the previous year as reported in the DAS Data System, consistent with federal methodology for allocating NSIP to the states. State and federal funds appropriated to supplement NSIP are allocated in the same way. We will add it to the IFF attachment.

PSA IFF Factors

PSA_NAME	POP_60	POV_NW_65	POV_65	RURAL_60	DIS_65	LIM_ENG_65	LIV_ALONE_65	POP_75
ARC Aging Division	816382	29635	47168	30959	165890	25207	139708	198385
Coastal GA AAA	141846	4365	8878	34601	35875	1048	25501	38658
CSRA AAA	109645	5022	8003	36266	28689	784	21441	29086
Heart of Georgia AAA	67391	2827	8255	43321	18168	231	13632	19767
Legacy Link Georgia Mountains AAA	163587	1730	9978	78040	40818	2618	24242	47579
Middle Georgia AAA	112115	4996	9042	39945	29420	277	21045	30674
NEGA AAA	132195	3607	8732	60961	33269	1156	21187	35732
NWGA AAA	200513	2203	13813	93437	52118	1966	35301	55151
River Valley AAA	80489	4736	7943	30188	22799	437	16636	21996
Southern GA AAA	85986	3517	9431	45191	21127	310	17756	24358
SOWEGA AAA	81738	4814	8318	38982	22319	522	16217	23398
Three Rivers AAA	110777	3004	7746	53259	30352	601	20108	30285
Totals	**2102664**	**70456**	**147307**	**585150**	**500844**	**35157**	**372774**	**555069**

IFF CY2023 - County Breakdown

PSA_NAME	COUNTY	POP_60	POV_NW_65	POV_65	RURAL_60	DIS_65	LIM_ENG_65	LIV_ALONE_65	POP_75
ARC Aging Division	Cherokee	54034	239	2109	9241	11074	365	7577	12825
ARC Aging Division	Clayton	43449	2241	3040	386	8713	2082	7061	8638
ARC Aging Division	Cobb	138117	2767	6218	340	27105	3164	21504	33861
ARC Aging Division	DeKalb	137583	7071	8891	362	31213	3605	27311	34687
ARC Aging Division	Douglas	25000	413	1340	3939	5895	303	3456	5979
ARC Aging Division	Fayette	30078	370	942	5468	6024	271	4492	8303
ARC Aging Division	Fulton	181501	10636	13875	1956	36801	3308	40674	46729
ARC Aging Division	Gwinnett	146419	4482	8239	711	25476	11317	17690	32951
ARC Aging Division	Henry	40184	1002	1645	5567	8692	493	7076	9800
ARC Aging Division	Rockdale	20017	414	869	2989	4897	299	2867	4612
		816382	**29635**	**47168**	**30959**	**165890**	**25207**	**139708**	**198385**
Coastal GA AAA	Bryan	6157	49	322	3223	1762	44	824	1718
Coastal GA AAA	Bulloch	13235	420	808	6390	3285	9	2862	3459
Coastal GA AAA	Camden	10400	267	724	3270	2212	0	1529	2709
Coastal GA AAA	Chatham	63167	2207	3731	2846	16369	779	12165	17888
Coastal GA AAA	Effingham	11108	122	851	7448	2738	0	1416	2559
Coastal GA AAA	Glynn	22830	439	1067	4695	5526	82	4252	6690
Coastal GA AAA	Liberty	8862	643	890	2052	2345	120	1411	2095
Coastal GA AAA	Long	2174	34	123	1768	743	14	369	522
Coastal GA AAA	McIntosh	3913	184	362	2908	895	0	673	1018
		141846	**4365**	**8878**	**34601**	**35875**	**1048**	**25501**	**38658**
CSRA AAA	Burke	5653	328	488	4240	1320	10	1361	1406
CSRA AAA	Columbia	29545	363	1240	4794	7377	456	4479	7619
CSRA AAA	Glascock	683	0	75	683	178	0	138	211
CSRA AAA	Hancock	2394	311	315	1474	569	0	539	791
CSRA AAA	Jefferson	3764	211	354	3036	1119	0	772	1111
CSRA AAA	Jenkins	2618	178	290	1731	733	0	587	578
CSRA AAA	Lincoln	2672	137	203	2672	719	0	536	765
CSRA AAA	McDuffie	5466	156	334	3332	1188	49	813	1512
CSRA AAA	Richmond	43011	2408	3274	3964	11847	201	9194	10853
CSRA AAA	Screven	3544	140	261	2797	1036	0	730	993
CSRA AAA	Taliaferro	519	73	96	519	174	0	73	245
CSRA AAA	Warren	1621	136	205	1621	383	8	263	500
CSRA AAA	Washington	5158	399	505	3384	1203	60	1046	1419
CSRA AAA	Wilkes	2997	182	363	2019	843	0	910	1083
		109645	**5022**	**8003**	**36266**	**28689**	**784**	**21441**	**29086**
Heart of Georgia AAA	Appling	4503	122	420	3217	1330	0	754	1262
Heart of Georgia AAA	Bleckley	2997	62	200	1546	866	0	492	1005
Heart of Georgia AAA	Candler	2589	131	254	1734	697	31	576	769
Heart of Georgia AAA	Dodge	5068	245	1081	3661	1627	55	861	1452
Heart of Georgia AAA	Emanuel	5001	181	550	3345	1527	0	1022	1382
Heart of Georgia AAA	Evans	2353	142	284	1442	454	0	511	675
Heart of Georgia AAA	Jeff Davis	3096	44	428	2152	859	0	607	836
Heart of Georgia AAA	Johnson	2436	133	236	1593	773	0	632	653
Heart of Georgia AAA	Laurens	11652	641	1610	6600	2799	17	2361	3605
Heart of Georgia AAA	Montgomery	1967	100	289	1942	547	0	390	572
Heart of Georgia AAA	Tattnall	4358	268	733	2974	1487	51	1056	1391

IFF CY2023 - County Breakdown

PSA_NAME	COUNTY	POP_60	POV_NW_65	POV_65	RURAL_60	DIS_65	LIM_ENG_65	LIV_ALONE_65	POP_75
Heart of Georgia AAA	Telfair	3164	123	328	1487	561	43	440	899
Heart of Georgia AAA	Toombs	6271	316	632	3202	2062	33	1671	1916
Heart of Georgia AAA	Treutlen	1627	82	170	958	581	0	355	475
Heart of Georgia AAA	Wayne	6751	100	471	3911	1517	1	1191	1801
Heart of Georgia AAA	Wheeler	1541	83	327	1541	231	0	353	447
Heart of Georgia AAA	Wilcox	2017	54	242	2017	250	0	360	627
		67391	**2827**	**8255**	**43321**	**18168**	**231**	**13632**	**19767**
Legacy Link Georgia Mountains AA	Banks	4190	46	580	3931	1432	27	727	1138
Legacy Link Georgia Mountains AA	Dawson	7263	0	272	5833	1581	29	1223	1847
Legacy Link Georgia Mountains AA	Forsyth	40799	355	1665	4048	7720	1060	4784	11255
Legacy Link Georgia Mountains AA	Franklin	5836	55	575	5190	1905	74	895	1821
Legacy Link Georgia Mountains AA	Habersham	11276	44	1037	6626	3625	212	2034	3335
Legacy Link Georgia Mountains AA	Hall	41562	721	2478	8544	10022	1097	5823	12144
Legacy Link Georgia Mountains AA	Hart	7738	272	669	5762	2862	55	1349	2442
Legacy Link Georgia Mountains AA	Lumpkin	7960	2	489	6682	1688	4	1217	2236
Legacy Link Georgia Mountains AA	Rabun	6072	17	258	4814	1582	1	954	1928
Legacy Link Georgia Mountains AA	Stephens	7141	124	553	4182	2140	50	1270	1890
Legacy Link Georgia Mountains AA	Towns	5290	0	461	5290	1113	0	808	1805
Legacy Link Georgia Mountains AA	Union	10300	49	685	10300	2911	0	1998	3255
Legacy Link Georgia Mountains AA	White	8160	45	256	6838	2237	9	1160	2483
		163587	**1730**	**9978**	**78040**	**40818**	**2618**	**24242**	**47579**
Middle Georgia AAA	Baldwin	9715	331	818	3414	2806	14	1805	2661
Middle Georgia AAA	Bibb	34041	2360	3501	4905	9144	88	6858	9653
Middle Georgia AAA	Crawford	3404	114	349	3404	996	1	500	774
Middle Georgia AAA	Houston	30061	864	1406	2995	7472	125	5022	7668
Middle Georgia AAA	Jones	6910	243	615	4679	1820	0	1232	1951
Middle Georgia AAA	Monroe	6919	159	408	5551	1555	0	1326	1956
Middle Georgia AAA	Peach	6099	315	686	2331	2108	44	1375	1670
Middle Georgia AAA	Pulaski	2818	166	292	1880	862	0	475	968
Middle Georgia AAA	Putnam	7150	112	397	5788	1306	5	1412	1924
Middle Georgia AAA	Twiggs	2521	185	269	2521	854	0	532	712
Middle Georgia AAA	Wilkinson	2477	147	301	2477	497	0	508	737
		112115	**4996**	**9042**	**39945**	**29420**	**277**	**21045**	**30674**
NEGA AAA	Barrow	14708	124	626	4421	3765	376	2379	3552
NEGA AAA	Clarke	20188	874	1513	1183	4964	238	4697	5446
NEGA AAA	Elbert	5612	224	586	3963	1585	0	1240	1639
NEGA AAA	Greene	7205	208	376	5962	1469	13	1263	1972
NEGA AAA	Jackson	15259	270	992	9158	3614	164	2128	4156
NEGA AAA	Jasper	3520	67	317	2878	1009	0	317	932
NEGA AAA	Madison	6703	267	616	6159	1963	90	818	1954
NEGA AAA	Morgan	5341	192	332	4025	1370	9	796	1579
NEGA AAA	Newton	20873	934	1380	6522	5565	46	2736	5291
NEGA AAA	Oconee	8797	42	304	4426	1885	107	1258	2281
NEGA AAA	Oglethorpe	3587	46	209	3560	762	0	619	1068
NEGA AAA	Walton	20402	359	1481	8703	5318	113	2936	5862
		132195	**3607**	**8732**	**60961**	**33269**	**1156**	**21187**	**35732**
NWGA AAA	Bartow	21635	363	1662	7622	4902	201	3236	5619

IFF CY2023 - County Breakdown

PSA_NAME	COUNTY	POP_60	POV_NW_65	POV_65	RURAL_60	DIS_65	LIM_ENG_65	LIV_ALONE_65	POP_75
NWGA AAA	Catoosa	16267	23	738	4571	4481	31	2759	4779
NWGA AAA	Chattooga	6251	86	540	3598	1696	64	1596	1821
NWGA AAA	Dade	4243	0	373	3060	1194	0	738	1222
NWGA AAA	Fannin	9662	21	733	9662	2911	4	1830	2807
NWGA AAA	Floyd	21909	309	1309	8067	5878	52	4274	6483
NWGA AAA	Gilmer	10120	10	835	8869	2703	37	1651	2815
NWGA AAA	Gordon	12161	135	1294	6270	2809	85	2405	3292
NWGA AAA	Haralson	6939	62	558	5368	2258	8	1171	1877
NWGA AAA	Murray	8139	40	452	5708	2110	45	1500	2109
NWGA AAA	Paulding	26933	429	1161	5401	6185	204	3389	6131
NWGA AAA	Pickens	9640	8	579	7047	2417	0	1514	2576
NWGA AAA	Polk	9499	131	591	4885	2914	154	1852	2585
NWGA AAA	Walker	17029	100	1166	7468	5010	59	3356	5199
NWGA AAA	Whitfield	20086	486	1822	5840	4650	1022	4030	5836
		200513	**2203**	**13813**	**93437**	**52118**	**1966**	**35301**	**55151**
River Valley AAA	Chattahoochee	499	0	14	147	123	0	84	133
River Valley AAA	Clay	934	53	83	934	391	0	307	333
River Valley AAA	Crisp	5390	125	420	2535	1740	0	1043	1479
River Valley AAA	Dooly	3279	104	183	1760	950	0	521	873
River Valley AAA	Harris	9079	72	328	8778	2239	0	1004	2018
River Valley AAA	Macon	3108	278	450	1653	905	0	588	674
River Valley AAA	Marion	2007	106	166	2007	685	0	386	582
River Valley AAA	Muscogee	39571	2457	4213	1178	10993	306	9326	10876
River Valley AAA	Quitman	1012	32	61	740	296	0	215	311
River Valley AAA	Randolph	1796	308	340	909	540	0	490	611
River Valley AAA	Schley	955	100	135	955	232	0	135	295
River Valley AAA	Stewart	956	89	125	956	278	6	218	348
River Valley AAA	Sumter	7112	670	840	2972	1907	92	1287	2089
River Valley AAA	Talbot	2078	112	211	1951	677	4	493	559
River Valley AAA	Taylor	2197	166	304	2197	646	29	369	635
River Valley AAA	Webster	516	64	70	516	197	0	170	180
		80489	**4736**	**7943**	**30188**	**22799**	**437**	**16636**	**21996**
Southern GA AAA	Atkinson	1639	42	181	1639	478	67	324	356
Southern GA AAA	Bacon	2268	32	267	1571	834	0	584	649
Southern GA AAA	Ben Hill	4144	147	477	1409	990	8	891	1177
Southern GA AAA	Berrien	4348	72	513	3311	1356	0	818	1239
Southern GA AAA	Brantley	4278	50	395	4254	716	0	1174	1090
Southern GA AAA	Brooks	4528	203	508	3217	1037	5	937	1225
Southern GA AAA	Charlton	2778	164	244	1417	777	6	427	799
Southern GA AAA	Clinch	1376	81	251	832	411	0	141	401
Southern GA AAA	Coffee	8393	194	942	5588	2432	75	1735	2056
Southern GA AAA	Cook	3855	132	731	2290	1095	0	722	1145
Southern GA AAA	Echols	799	63	94	799	221	0	124	225
Southern GA AAA	Irwin	2335	120	233	1511	423	31	606	772
Southern GA AAA	Lanier	1858	56	452	1322	415	0	471	554
Southern GA AAA	Lowndes	19704	1228	2016	5360	4291	35	4275	5711
Southern GA AAA	Pierce	4594	104	380	3645	1367	0	813	1403

IFF CY2023 - County Breakdown

PSA_NAME	COUNTY	POP_60	POV_NW_65	POV_65	RURAL_60	DIS_65	LIM_ENG_65	LIV_ALONE_65	POP_75
Southern GA AAA	Tift	8276	348	672	3375	1924	45	1952	2331
Southern GA AAA	Turner	2297	124	268	1142	663	0	341	624
Southern GA AAA	Ware	8516	357	807	2507	1697	38	1421	2601
		85986	**3517**	**9431**	**45191**	**21127**	**310**	**17756**	**24358**
SOWEGA AAA	Baker	1072	130	205	1072	278	0	237	229
SOWEGA AAA	Calhoun	1279	115	123	1279	346	0	197	345
SOWEGA AAA	Colquitt	9562	416	1185	5637	2556	175	2099	2769
SOWEGA AAA	Decatur	6611	256	521	3734	1774	17	1195	1951
SOWEGA AAA	Dougherty	19209	1861	2266	2682	5585	55	4585	5311
SOWEGA AAA	Early	2757	186	348	1818	643	0	653	844
SOWEGA AAA	Grady	6131	330	605	3823	1832	62	1437	1973
SOWEGA AAA	Lee	6213	99	305	2251	1316	95	831	1467
SOWEGA AAA	Miller	1641	69	233	1641	404	0	365	608
SOWEGA AAA	Mitchell	5304	435	702	2891	1364	41	1024	1466
SOWEGA AAA	Seminole	2759	121	316	1891	785	0	378	783
SOWEGA AAA	Terrell	2434	219	324	1267	656	0	521	705
SOWEGA AAA	Thomas	11236	378	744	5171	3226	77	1810	3353
SOWEGA AAA	Worth	5530	199	441	3825	1554	0	885	1594
		81738	**4814**	**8318**	**38982**	**22319**	**522**	**16217**	**23398**
Three Rivers AAA	Butts	5396	31	291	4206	1365	27	999	1477
Three Rivers AAA	Carroll	22392	418	1716	9365	6144	101	3919	6007
Three Rivers AAA	Coweta	29151	390	1151	9600	7272	402	4575	7374
Three Rivers AAA	Heard	2595	27	283	2595	988	0	550	681
Three Rivers AAA	Lamar	4263	213	335	2595	1207	0	1111	1155
Three Rivers AAA	Meriwether	5719	206	696	4763	2033	2	1058	1713
Three Rivers AAA	Pike	3860	50	223	3820	898	0	726	1178
Three Rivers AAA	Spalding	16152	628	988	6722	3948	43	3063	4738
Three Rivers AAA	Troup	14394	550	1121	6376	4369	17	2450	3951
Three Rivers AAA	Upson	6855	491	942	3216	2128	9	1657	2011
		110777	**3004**	**7746**	**53259**	**30352**	**601**	**20108**	**30285**

INTRA-STATE FUNDING FORMULA CALCULATIONS USING 2017-2021 AMERICAN COMMUNITY SURVEY (ACS) AND CENSUS (CEN) 2010 DATA 2016 REV-1 FORMULA

NEW FORMULA = (10% x %60+ POP)+(10% x %65+ MIN POV)+(13% x %65+ POV)+(15% x %60+ RURAL)+ (10% x %65+ DISABLED)+(4% x %65+ LIM ENG)+(8% x %65+ ALONE)+(30% x %75+ POP)

WEIGHT: **10%**	**ACS 60+ POP**	% of total 60+ POP	
County			WEIGHT
ARC Aging Division	816,382	38.826080%	10%
Coastal GA AAA	141,846	6.746014%	10%
CSRA AAA	109,645	5.214575%	10%
Heart of Georgia AAA	67,391	3.205029%	10%
Legacy Link Georgia Mountains AAA	163,587	7.779988%	10%
Middle Georgia AAA	112,115	5.332045%	10%
NEGA AAA	132,195	6.287024%	10%
NWGA AAA	200,513	9.536141%	10%
River Valley AAA	80,489	3.827953%	10%
Southern GA AAA	85,986	4.089384%	10%
SOWEGA AAA	81,738	3.887354%	10%
Three Rivers AAA	110,777	5.268412%	10%
Total	**2,102,664**	100%	

WEIGHT: **4%**	**ACS 65+LIM ENG**	% of total 65+LIM ENG	
County			WEIGHT
ARC Aging Division	25207	71.698382%	4%
Coastal GA AAA	1048	2.980914%	4%
CSRA AAA	784	2.229997%	4%
Heart of Georgia AAA	231	0.657053%	4%
Legacy Link Georgia Mountains AAA	2618	7.446597%	4%
Middle Georgia AAA	277	0.787894%	4%
NEGA AAA	1156	3.288108%	4%
NWGA AAA	1966	5.592058%	4%
River Valley AAA	437	1.242996%	4%
Southern GA AAA	310	0.881759%	4%
SOWEGA AAA	522	1.484768%	4%
Three Rivers AAA	601	1.709475%	4%
Total	**35,157**	100%	

WEIGHT: **10%**	**ACS 65+ MIN POV**	% of total 65+ MIN POV	
County			WEIGHT
ARC Aging Division	29635	42.061712%	10%
Coastal GA AAA	4365	6.195356%	10%
CSRA AAA	5022	7.127853%	10%
Heart of Georgia AAA	2827	4.012433%	10%
Legacy Link Georgia Mountains AAA	1730	2.455433%	10%
Middle Georgia AAA	4996	7.090950%	10%
NEGA AAA	3607	5.119507%	10%
NWGA AAA	2203	3.126774%	10%
River Valley AAA	4736	6.721926%	10%
Southern GA AAA	3517	4.991768%	10%
SOWEGA AAA	4814	6.832633%	10%
Three Rivers AAA	3004	4.263654%	10%
Total	**70,456**	100%	

WEIGHT: **8%**	**ACS 65+ ALONE**	% of total 65+ ALONE	
County			WEIGHT
ARC Aging Division	139708	37.477936%	8%
Coastal GA AAA	25,501	6.840874%	8%
CSRA AAA	21,441	5.751742%	8%
Heart of Georgia AAA	13,632	3.656907%	8%
Legacy Link Georgia Mountains AAA	24,242	6.503136%	8%
Middle Georgia AAA	21,045	5.645512%	8%
NEGA AAA	21,187	5.683605%	8%
NWGA AAA	35,301	9.469813%	8%
River Valley AAA	16636	4.462758%	8%
Southern GA AAA	17,756	4.763208%	8%
SOWEGA AAA	16217	4.350357%	8%
Three Rivers AAA	20,108	5.394153%	8%
Total	**372,774**	100%	

WEIGHT: **13%**	**ACS 65+ POV**	% of total 65+ POV	
County			WEIGHT
ARC Aging Division	47168	32.020203%	13%
Coastal GA AAA	8878	6.026869%	13%
CSRA AAA	8,003	5.432871%	13%
Heart of Georgia AAA	8255	5.603943%	13%
Legacy Link Georgia Mountains AAA	9,978	6.773609%	13%
Middle Georgia AAA	9,042	6.138201%	13%
NEGA AAA	8732	5.927756%	13%
NWGA AAA	13813	9.377015%	13%
River Valley AAA	7943	5.392140%	13%
Southern GA AAA	9431	6.402276%	13%
SOWEGA AAA	8318	5.646711%	13%
Three Rivers AAA	7746	5.258406%	13%
Total	**147,307**	100%	

WEIGHT: **30%**	**ACS 75+ POP**	% of total 75+ POP	
County			WEIGHT
ARC Aging Division	198,385	35.740602%	30%
Coastal GA AAA	38,658	6.964540%	30%
CSRA AAA	29,086	5.240069%	30%
Heart of Georgia AAA	19,767	3.561179%	30%
Legacy Link Georgia Mountains AAA	47,579	8.571727%	30%
Middle Georgia AAA	30,674	5.526160%	30%
NEGA AAA	35,732	6.437398%	30%
NWGA AAA	55,151	9.935882%	30%
River Valley AAA	21,996	3.962751%	30%
Southern GA AAA	24,358	4.388283%	30%
SOWEGA AAA	23,398	4.215332%	30%
Three Rivers AAA	30,285	5.456078%	30%
Total	**555,069**	100%	

WEIGHT: **15%**	**ACS/CEN 60+ RURAL**	% of total 60+ RURAL	
County			WEIGHT
ARC Aging Division	30,959	5.290780%	15%
Coastal GA AAA	34,601	5.913185%	15%
CSRA AAA	36,266	6.197727%	15%
Heart of Georgia AAA	43,321	7.403401%	15%
Legacy Link Georgia Mountains AAA	78,040	13.336751%	15%
Middle Georgia AAA	39,945	6.826455%	15%
NEGA AAA	60,961	10.418012%	15%
NWGA AAA	93,437	15.968042%	15%
River Valley AAA	30,188	5.159019%	15%
Southern GA AAA	45,191	7.722977%	15%
SOWEGA AAA	38,982	6.661882%	15%
Three Rivers AAA	53,259	9.101769%	15%
Total	**585,150**	100%	

WEIGHT: **10%**	**ACS 65+DISABLED**	% of total 65+DISABLED	
County			WEIGHT
ARC Aging Division	165,890	33.122090%	10%
Coastal GA AAA	35,875	7.162909%	10%
CSRA AAA	28,689	5.728131%	10%
Heart of Georgia AAA	18,168	3.627477%	10%
Legacy Link Georgia Mountains AAA	40,818	8.149843%	10%
Middle Georgia AAA	29,420	5.874085%	10%
NEGA AAA	33,269	6.642587%	10%
NWGA AAA	52,118	10.406035%	10%
River Valley AAA	22,799	4.552116%	10%
Southern GA AAA	21,127	4.218280%	10%
SOWEGA AAA	22319	4.456278%	10%
Three Rivers AAA	30,352	6.060170%	10%
Total	**500,844**	100%	

SECTION 304 - Nutrition Service Program Guidelines and Requirements

304.1 SUMMARY STATEMENT	This section establishes requirements for Area Agencies on Aging and their subcontractors in the administration and provision of a comprehensive program of nutrition services to older adults.
304.2 SCOPE	These requirements apply to all congregate and home delivered nutrition services contracted and provided through or by the Area Agency on Aging, supported by any and all non-Medicaid sources of funding.
304.3 DEFINITIONS	Nutrition Assessment An evaluation of nutritional status at a given point in time, which may include estimation of nutritional requirements and care plan with measurable goals. Nutrition Counseling The provision of individualized guidance by a qualified professional on appropriate food and nutrient intakes for those with special nutrition needs, taking into consideration health, cultural, socioeconomic, functional and psychological factors. Nutrition counseling may include: advice to increase, decrease, or eliminate nutrients in the diet, to change the timing, size or composition of meals, to modify food textures, and/or to change the route of administration-from oral to feeding tube to intravenous. Nutrition Education The provision of information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve their nutritional status. Nutrition Screening The process of using characteristics known to be associated with nutrition problems to identify individuals who are nutritionally at risk. Therapeutic Diet A diet ordered by a physician as part of treatment for a disease or clinical condition, or to eliminate, decrease, or increase specific nutrients in the diet.

304.4 LAWS AND CODES	Each nutrition service program site shall be operated in compliance with all federal, state, and local laws and codes that govern facility operations, specifically related to fire safety, sanitation, insurance coverage, and wage requirements.
304.5 NUTRITION PROGRAMS	The congregate nutrition program promotes better physical and mental health for older adults through the provision of nutritious meals and opportunities for social contact. The home delivered meal program promotes better health for older adults and eligible members of their households through the provision of nutritious meals; nutrition screening, education and counseling; and opportunities for social contact. Both types of nutrition services shall be part of a system of services that promotes independent living for older adults.
304.6 SERVICE OUTCOMES	At a minimum: • To identify persons at nutritional risk and/or with food insecurity and delay the decline in health/nutrition status through nutrition screening, assessment, and referrals; • To reduce identified nutritional risk and food insecurity among program participants through the provision of nutritious meals, education and counseling; • To reduce isolation of program participants through socialization.
304.7 ELIGIBILITY AND PRIORITY FOR SERVICES	Eligible persons are: • Aged 60 and over, or a spouse (regardless of age) of a person aged 60 or over; • Persons with disabilities who are residents of housing facilities occupied primarily by older adults at which congregate nutrition services are provided; or • Volunteers, staff and guests age 60 and above (Approved conditionally upon AAA policies). AAAs shall give priority to those: • In greatest social and economic need, • Show moderate to high nutrition risk status, as indicated by the NSI

	• High functional impairment levels and unmet need, as documented on the DON-R instrument (Home Delivered Meals ONLY) • And as indicated by the Food Security Survey. Providers may offer a meal to the spouse/caregiver(s) of a homebound eligible person if the provision of the meal supports maintaining the person at home. Providers may also offer meals to the non-elderly or persons with disabilities who reside in the household of an older adult (60 years or older) and are dependent on them for care.
304.8 REQUIREMENTS FOR MEALS	Each meal shall comply with provisions in the Older Americans Act, Title III, Subpart 3, Section 339, concerning compliance with Dietary Guidelines for Americans. Meals will focus not only on the nutrition content, but also color, texture and flavor. Variety in the meal pattern is important to meal satisfaction. Therefore, there are no requirements that any specific food be served (example: milk), or any requirements that a meal pattern be followed (example: 3oz meat, 2 ½-cup vegetables, dessert, roll). Standardized recipes will be used to analyze and prepare meals. The food that is served will be the same as analyzed, to the fullest extent possible. A caffeine free and sugar free beverage must be offered as part of a complete meal. Providers will develop a plan to offer choice in meals. Providers will be capable of serving a therapeutic diet based on a doctor's recommendation. See 304.3k for further explanation.
304.9 MENU CYCLES	Providers shall follow at a minimum a twenty day (four week) menu cycle, which can be repeated during the quarter.
304.10 NUTRIENT CONTENT	Nutrient content of meals is determined by the application of the Dietary Reference Intakes (DRI) guidelines and the Dietary Guidelines for Americans. To allow for regional preferences, the nutrient content of meals must:

	• Use the targets outlined in Appendix 304-B "Georgia Nutrition Program Nutrient Targets for Meals". • The nutrition analysis will show these targets are met over an average of one menu cycle (minimum of twenty days), within +/-10%.
304.11 NUTRIENT ANALYSIS	The provider shall obtain and maintain documentation of nutrient analysis for each meal per menu cycle. If the AAA allows the use of alternative protein sources, the procurement documents must clearly state how frequently alternative protein may be used on a monthly basis and to what degree.
304.12 MEAL TYPE	Hot, frozen, dehydrated, chilled, and shelf-stable meals shall be prepared and served in accordance with Division of Aging Services requirements. The AAA or provider will be responsible for assessing the ability of the home delivered meal recipient to store and prepare meals. Appendix 304-A contains instructions to determine appropriate meal type. A hot meal is not required for congregate or home delivered programs. However, each individual should be assessed and given the type of meal that is determined to be the most appropriate, or that the individual requests.
304.13 THERAPEUTIC DIETS	Therapeutic diets shall be provided as required by the participant's special needs and medical condition, providing: • The nutrition service provider obtains a physician prescription for each participant needing a therapeutic meal and maintains documentation of specific guidance on meal modification; • The therapeutic diet is planned in accordance with the Georgia Dietetic Association Manual, is approved by a Registered Dietitian, and is submitted on a quarterly basis along with the regular menu.
304.14 MENU APPROVAL	A qualified dietitian shall certify menus in each cycle as meeting the dietary guidelines and providing recommended dietary allowances. The AAA shall submit copies of certified menus and nutrition analyses to the Division of Aging Services' Chief Nutritionist on a quarterly basis, at least two weeks before implementation.

	The AAA shall assure that the services of a registered dietitian are available for menu review and certification. This dietitian shall not be employed by the commercial food vendor that provides meals for the planning and service area, if the provider subcontracts meal preparation. The certified menus are subject to the audit process and are to be retained for a minimum of six years, according to state record retention requirements.
304.15 REGISTERED DIETITIANS	The AAA is responsible for assuring compliance with the Older Americans Act, which states that the nutrition program be administered with the advice of dietitians or individuals with comparable expertise. The AAA may employ directly the dietitian(s) or contract for consultation services. Nutrition service providers may also employ or contract the services of a dietitian in fulfillment of this requirement.
304.16 DUTIES OF THE DIETITIAN	Duties of the dietitian include, but are not limited to: 1. Menu Planning The development of (or oversight of the development of) regular four week cycle menus (20 day minimum) which will change quarterly with consideration of input from program participants and staff. The dietitian shall convene quarterly menu planning meetings with senior center managers, individual representatives and on-site kitchen staff or commercial food vendor staff. The dietitian shall assure that the menus conform to DAS' nutrient content requirements. 2. Development of Standardized Recipes and Nutritional Analysis The dietitian shall develop, select, and/or approve standardized recipes and provide full nutritional analysis for all proposed menus. 3. Nutrition Screening and Intervention The dietitian shall assist the AAA staff in implementation of the NSI-D, including assisting with developing protocols and mechanisms to provide access to Level I Screening (or higher) and assessments, or referrals to appropriate health care providers for individuals identified as being at high nutritional risk. Upon reassessment, if there is no change to the NSI score, the dietitian will have the option, based on the individual's needs, to provide additional education and/or counseling. 4. Nutrition Education The dietitian shall develop and/or disseminate approved nutrition education materials to food service personnel (for use with kitchen staff) and to senior center managers (for use with congregate and home delivered meals program participants).

	5. Nutrition Counseling The dietitian shall provide, oversee and/or develop resources for the provision of individualized nutrition counseling for persons identified as being at high nutrition risk, including developing protocols for targeting individual groups and priorities for using available resources. The counseling may include referral to other services and assistance and follow-up. The dietitian shall coordinate service referrals with case managers, if present. 6. Training The dietitian shall develop and/or disseminate quarterly (or more frequently as needed) in-service training to on-site kitchen staff and senior center staff on such topics as: food sanitation and safety, portion control, special nutrition needs of older adults, and health related topics. 7. Program Monitoring, Planning, and Evaluation The dietitian shall oversee or assist as needed with the program monitoring and evaluation; the analysis of programmatic data; oversee or assist in the development of bid specifications; and oversee or assist in developing the Area Plan with regard to meal service and nutrition program initiatives. The dietitian will coordinate with Wellness Program staff, Care Coordinators, and other staff in the implementation and promotion of Wellness Program activities. 8. Technical Assistance The dietitian shall provide technical assistance in the areas of food service management and nutrition program management to AAA staff, nutrition program personnel and food service personnel. The dietitian will provide technical assistance to food vendors to offer flexibility and choices for program participants. 9. Quality Assurance It is the responsibility of the dietitian to assure that: • Meals served in the OAA program meet the dietary standards. • The vendor/provider has used standardized recipes. • The menu items used for nutrient analysis and the food products provided to participants are the same. • Program participants have an opportunity to provide input in the development of menus.
304.17 **MEAL PACKING**	1. Providers shall use supplies and carriers that allow for packaging and transporting hot foods separately from cold foods. 2. Providers shall use meal carriers of appropriate design, construction, and materials to transport trays or containers of potentially hazardous food, and

	other hot or cold foods. Carriers shall be enclosed to protect food from contamination, crushing or spillage, and be equipped with insulation and/or supplemental sources of heat and/or cooling as is necessary to maintain safe temperatures. 3. Providers shall clean and sanitize meal carriers daily or use carriers with inner liners that can be sanitized. 4. Meals packaging, condiments, and utensils must meet the following criteria: • Be sealed to prevent moisture loss or spillage to the outside of the container while also meeting the current standards for oxygen transfer rates; • Be designed with compartments to separate food items for maximum visual appeal and minimize leakage between compartments; and • Be easy for the participant to open or use. 5. Providers must make every effort to provide assistive devices or modified utensils to persons who need them. 6. Package labeling must be legible and show: • the packaging date, • list of food items, • storage instructions, and • instructions for preparation of safe thawing and reheating, or reconstituting.
304.18 MEAL SERVICE REQUIREMENTS	Nutrition service providers shall use procedures that provide for the safety, sanitation, accessibility and convenience of participants, and efficiency of service, and shall include the following: 1. Using correct portion sizes (and utensils) as specified on approved menus; 2. Adherence of staff and volunteers to food sanitation requirements, as prescribed by applicable Federal, State and local rules and regulations. County health departments have the right of amendment to add requirements to State rules and regulations. The higher of the two sets of standards shall apply;

	3. Taking and recording food temperatures daily to document that safe temperatures are maintained; 4. To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed and sanitized after each use and following any interruptions of operations during which contamination may have occurred; 5. Food shall be available to participants for at least 30 minutes after serving begins; 6. Providers shall make available to people with disabilities food containers and utensils appropriate for their needs; 7. After offering additional servings to participants if appropriate, program providers *may* donate unconsumed food products to other charitable community social service of public service organizations. Providers that make such donations shall obtain a "hold harmless" agreement from the receiving organization, that protects the provider from any liability (see Appendix 304-C "Hold Harmless Guidance"); 8. Providers shall not arrange for or provide covered dish meals at nutrition sites or other locations, using any funds which are administered through the contract with the AAA to support the cost of such activities.
304.19 ALTERNATIVE MEALS	Picnic, special occasion, holiday and weekend meals must meet the nutrient targets outlined in Appendix 304-B; meet temperature requirements for hot and cold foods; and must be prepared in a commercial food service or on-site kitchen. Shelf-stable, dehydrated, chilled, and frozen meals must meet the nutrient targets outlined in Appendix 304-B; and applicable temperature standards. Package labeling must be legible and show: • the packaging date, • list of food items, • storage instructions, and • instructions for preparation of safe thawing and reheating, or reconstituting.

304.20 FOOD STORAGE AND SAFETY	All rules and regulations governing food service stated by the Georgia Department of Public Health (511-6-1) shall apply for congregate and home delivered meal programs. Refer to references section for web link.
304.21 HOLDING TIME	Providers shall assure that holding times for hot foods do not exceed four (4) hours from the final stage of food preparation until the meal is served to the participants, including delivery to the homes of home delivered meal participants.
304.22 MEAL DELIVERY	Providers shall develop and implement procedures for assuring safe meal delivery in accordance with applicable food service and safety rules and DAS requirements for holding times. Meals shall not be left in coolers or other containers outside the house or dwelling as proper temperatures may not be possible in this environment.
304.23 NUTRITION SCREENING	Nutrition screening begins at the AAA with the administration of the Nutrition Screening Initiative DETERMINE (NSI-D) Checklist as part of the intake and screening process. The AAA may allow congregate meal sites with no waiting lists to perform initial applicant intake and screening directly. Congregate meal providers shall complete the checklist thirty (30) days after services begin, and at a minimum, annually thereafter, or at any time a change in the participant's condition or circumstances warrants. The AAA and provider(s) jointly (or case management, if used) shall develop protocols to assure that applicants/recipients whose NSI-D score is 6 or greater receive or are referred for: • a comprehensive nutrition assessment, when indicated; • nutrition counseling, if indicated; • their primary health care provider(s) for follow-up; and • any other assistance or services needed
304.24	Area Agencies and nutrition service providers are to work collaboratively to identify or develop resources for the provision of nutrition assessments for

NUTRITION ASSESSMENT	persons at high nutrition risk and/or those with low food security. Registered Dietitians and other qualified professional (example: Dietetic Technician, Registered) may conduct nutrition assessments.
304.25 NUTRITION EDUCATION **CONGREGATE** **HOME DELIVERED**	Each provider shall develop written nutrition education programming, including a calendar, documentation of subject matter, presenters, and materials to be used, in accordance with requirements below. The RD may develop a single educational curriculum that may be used by multiple sites. The provider may develop curriculum, however the RD will review and approve all nutrition education content and materials. The RD is not required to approve nutrition education from reliable sources (USDA, Universities, etc.) Providers shall assure that nutrition education content and materials are developed to be consistent with the nutritional needs, literacy levels, and vision and hearing capabilities, as well as the multi-cultural composition of participating older adults. Providers shall make available print materials that are sufficiently large (14 point or larger), use clear and common typefaces (such as Arial, Verdana, Georgia, or Times New Roman), and in language that is appropriate for the educational levels and cultural backgrounds of the participants. Each nutrition service provider shall maintain written documentation of programs presented to verify that the requirements are met. Sessions shall be provided at least once monthly consisting of a session of not less than 15 minutes in length. Education materials will be included with the meal delivery at least once per month.
304.26 NUTRITION COUNSELING	The AAA or provider (or case management, if used) shall develop protocols to determine those participants with special nutrition needs who would benefit from individual counseling and assure that such counseling is made available by qualified professionals. Individual counseling may not be indicated, regardless of the level of nutritional risk if the person would not benefit from the counseling due to: • cognitive impairments or otherwise could not participate in the development of a nutrition care plan, or

	• the documented opinion of a social service or health care professional that the person would not comply with a nutrition care plan.
304.27 SERVICE ACTIVITIES	In addition to identifying, assessing and referring individuals to a nutrition program, the following service activities are meant to enhance the core services and allow individuals to remain independent in the community. 1. The provision of meals, wellness activities, and nutrition education in a group setting at a nutrition site, senior center, or multipurpose senior center, and ongoing outreach to the community; 2. Access by participants to nutrition screening and assessment, nutrition education, and counseling on an individual basis, when appropriate; 3. Access to the congregate site through transportation services; 4. Shopping assistance, and increasing access to healthy foods; 5. Evidence-based wellness programs, and; 6. Appropriate referrals to other services/resources.
304.28 SCHEDULE OF SERVICE	The service provider shall provide home delivered meals as proscribed by contract and in accordance with the frequency requirements in the Older Americans Act Section 336 (42 U.S.C. §3030f). Individual meal service and frequency shall be based on the determined needs of each individual.
304.29 TEMPORARY HOME DELIVERED MEALS FOR REGISTERED CONGREGATE MEAL PARTICIPANTS	Temporary home delivered meal service may be provided to registered congregate meal site participants who are ill, incapacitated, or temporarily homebound, at the discretion of the AAA. An additional provider assessment for home delivered eligibility is not required for this service. Funding for these temporary home delivered meals should be charged to the congregate meal program. When providing this service, only the meal cost and cost of delivery are to be included. An eligible homebound congregate meal participant may receive up to twenty (20) consecutive home delivered meals. Receipt of more than 20 consecutive home delivered meals shall require: • an assessment of the individual's need for continued home delivered meal service and • their corresponding placement on the waiting list (if needed) and/or

	• referral to gateway for additional resources (if appropriate).
304.30 WEATHER-RELATED EMERGENCIES, FIRES, AND OTHER DISASTERS	The provider agency shall make facilities, equipment, and services available to the fullest extent possible in emergencies and disasters, according to the AAA regional emergency/disaster plan. The provider agency shall develop and implement written procedures to provide for the availability of food to participants in anticipation of and during emergencies and disasters, including contingency planning for delivery vehicle breakdowns, inclement weather, shortages in deliveries, food contamination, spoilage, etc. Minimum implementation guidelines include: 1. Creating a functional matrix that plots out key emergency functions and responsible parties. 2. Spelling out actions in the matrix that apply to events and hazards most likely to occur in the service area (natural and human-made events like weather emergencies, chemical spills, major power outages, disease outbreaks, etc). 3. Specifying conditions for adapting the plan as needed to meet unforeseen circumstances. 4. Planning for federal disaster takeover. The guidelines and sample plan from Meals On Wheels Association of America can be used. http://www.mowaa.org/Document.Doc?id=38
304.31 FACILITY ACCESS AND SAFETY	All nutrition sites shall comply with the Americans with Disabilities Act requirements, and with any other relevant DAS standards or program requirements relating to access and safety. Facility requirements for senior centers which house congregate meal programs are found in DAS Manual 5300 Section 200, Chapter 206.
304.32 MENU MONITORING	Each nutrition service provider shall retain on file each menu with meals as served, for monitoring purposes. If providing services at multiple sites, each site must have a copy of the menus with meals as served.
304.33	Providers shall conduct outreach activities with emphasis on identifying potential program participants who are among those in greatest social and

NUTRITION OUTREACH	economic need. Providers shall refer potential participants to the Area Agency for intake and screening, when appropriate, according to the procedures developed by the AAA. Outreach strategies and contacts will be documented.
304.34 CONDITIONS FOR REFERRAL TO OTHER SERVICES	When appropriate, service providers shall work with the AAA (or case management, if available) to refer participants to other service resources that may be able to assist with remaining independent and safe in the home, and/or to assist caregivers with maintaining their own health and well-being.
304.35 ADMINISTRATIVE RESPONSIBILITIES OF NUTRITION SERVICE PROVIDERS	All providers shall comply with all provisions for nutrition services contained in the Older Americans Act, as amended.
304.36 COMPLIANCE WITH OTHER LAWS AND REGULATIONS	Each provider agency shall use procedures that comply with all applicable state and local fire, health, sanitation, and safety laws and regulations. All food preparation, handling and serving activities shall comply with applicable requirements as found at 290-5-14 of the Administrative Rules and Regulations of the State of Georgia (website in References).
304.37 FOOD BORNE ILLNESS COMPLAINTS	The provider shall report to local health authorities within 24 hours of receiving complaints involving two or more persons with symptoms of food borne illness within a similar time frame after consuming food supplied through the nutrition service program. Providers shall report any complaints regarding food borne illness to the contracting AAA within two business days of receipt.
304.38 MANAGEMENT AND OVERSIGHT OF THE NUTRITION PROGRAM	The provider shall identify an individual who is responsible for the overall management of nutrition services and compliance with performance standards, requirements, and procedures. This person, and any other employee(s) responsible to food service management, shall be ServSafe certified, as required by the state. www.servesafe.com

304.39 STAFF ORIENTATION AND TRAINING	The service provider shall assure that orientation and ongoing training for administrative and direct service staff and volunteers shall be adequate to5 provide safe, appropriate, and efficient services to older adults, and compliance with all applicable requirements and procedures. Providers shall document and maintain records of all content and dates of orientation and training for monitoring purposes. Providers may offer additional topics.
304.40 HEALTH INSPECTIONS	It is the responsibility of the nutrition service provider to obtain required health inspections and certificates from the appropriate local health authorities, and post the annual certificates in each facility. Any facility that handles food in any capacity (cooking, warming, plating, etc) must have a current health inspection.
304.41 RECORD KEEPING AND REPORTING	Providers shall comply with all record keeping and reporting and retention requirements as prescribed by DAS in MAN5600, Section 3012. Documentation requirements specific to food service include, but are not limited to: • Daily records documenting persons who receive meals; • Perpetual and physical inventory records for all foods, if meals are prepared on site; • Food cost records, including raw food costs for eligible NSIP meals; • Documentation of daily temperature checks for congregate meals and bi-weekly checks for home delivered meals; • Documentation of daily meal reports; • Documentation of participant feedback, and the method used to obtain feedback on a routine basis.
304.42 CONTRIBUTIONS	Providers shall allow participants the opportunity to make voluntary contributions in support of the program, in a manner that protects their confidentiality. Refer to Manual5600, Sections 2025, 2026, 2027, and 2028 for full guidance.
304.43 NUTRITION SERVICES	The purpose of NSIP in part, is to reduce hunger and food insecurity, promote socialization, promote health and well-being, and delay adverse health conditions for older individuals.

INCENTIVE PROGRAM (NSIP)	NSIP funding is to be used exclusively to purchase domestically produced food. AAAs shall use the raw food cost from the uniform cost methodology for reimbursement. Meals eligible for NSIP funding are those that: 1. Meet the nutrition targets outlined in Appendix B (unless the meal has been modified for medical reasons, as prescribed by a physician); 2. Are served to eligible individuals; and 3. Are served by a nutrition service provider that is under the jurisdiction, control, management, and audit authority of the State Unit on Aging or the AAA.
304.44 PROVIDER QUALITY ASSURANCE AND PROGRAM EVALUATION	Each nutrition program provider shall develop and implement an annual plan to evaluate and improve the effectiveness of operations and services to ensure continuous improvement in service delivery. The evaluation process shall include: • A review of the existing program; • Satisfaction survey results from participants, staff, and volunteers; • Program modifications made that responded to changing needs or interests of participants, staff or volunteers; and • Proposed program and administrative improvements Each provider shall prepare and submit to the AAA annually (no later than September 30th) a written report that summarizes the evaluation findings, improvement goals, and implementation plan for each site. Providers that also operate senior centers shall incorporate the evaluation of the nutrition program into the annual senior center program evaluation.
304.45 MONITORING BY SERVICE PROVIDER	Each provider will monitor and document daily that temperatures of hot or cold food received from vendors are within acceptable ranges upon delivery to the site. Providers will monitor no less than twice per month and document the temperature of the last meal delivered on a given delivery route to assure that holding times, safe temperatures, and quality of meals are maintained.

	Providers shall select routes randomly for monitoring. Providers will maintain this documentation in accordance with DAS policy, MAN 5600, Section 3015.
304.46 INDIVIDUAL'S RIGHTS AND RESPONSIBILITIES AND COMPLAINT RESOLUTION	Nutrition service providers, including AAAs, if applicable, shall assure that participants, or their caregivers/representatives, receive written notice of their rights and responsibilities upon admission to the program, according to Manual5300, Chapter 202, General Service Requirements. For ongoing participants, the information may be provided at the next re-assessment.
304.47 AAA RESPONSIBILITIES FOR THE NUTRITION SERVICES PROGRAM	The AAA shall develop and implement any necessary additional policies and procedures for the following: • Compliance with the Older Americans Act, with regard to the older adult nutrition program • Program evaluation activities, including conducting periodic evaluations of assessment, reassessment and nutrition risk information for congregate and home delivered meals participants to assure that those persons in greatest need are being served and that desired outcomes are achieved • Verification that all providers comply with NSIP funding rules; only eligible meals are funded through NSIP; and that cash will be used to purchase only food grown or commodities produced in the United States. • The election to allow providers to provide meals to volunteers, guests, and staff
304.48 COMPLIANCE REQUIREMENTS	AAAs are responsible for: 1. Assuring that all meals served meet requirements (see Requirements for Meals earlier in the document); 2. Establishing procedures for consistent AAA management of waiting lists and communications with nutrition providers regarding referrals to and openings in the program; 3. Assuring that service provider staff has made appropriate arrangements for providing meals in emergency situations or disasters, with emphasis on plans for providing services during periods of inclement weather, particularly to people residing in geographically remote areas.

304.49 STAFFING FOR NUTRITION PROGRAM CONTRACT MANAGEMENT DUTIES	The AAA shall designate one or more staff to manage the nutrition service contracts or obtain the services of consultants to coordinate with staff for the management of nutrition service contracts. The minimum qualifications for staff or consultants shall be: • Satisfactory completion of a DAS-approved course in food safety, food protection, or equivalent (ServSafe); or • Licensure through the state of Georgia as a registered dietitian. Refer to Manual5600, Section 3014: AAA Contract Management Requirements
304.50 COMPLIANCE MONITORING	The AAA shall monitor each nutrition service provider and individual provider site at least once annually within the first six months of the contract year, placing additional emphasis on monitoring more often those sites that continue to demonstrate substantial non-compliance for the previous year, or new provider(s)/site(s). Monitoring forms provided from DAS are the preferred tool. If an AAA uses its own forms, all information on the DAS forms must be included. Refer to Manual5600, Section 3015: AAA Monitoring and Evaluation of Service Providers
304.51 NEGOTIATION OF CONTRACTS	Using the Uniform Cost Methodology and principles or performance-based contracting to procure congregate and home delivered meal services, AAAs shall assure that potential subcontractors establish a base meal cost. AAAs shall base reimbursement rates on actual cash costs, excluding estimates of volunteer time, and the value of contributed goods and services. The base meal cost shall be the basis for negotiation between the AAA and any respondents to requests for proposals. Area Agencies may waive the use of the Uniform Cost Methodology by food vendors if the vendor provides a meal unit cost with similar food cost categories. Costs of services other than the base meal rate must be accounted for in other service categories. The AAA has the authority to renegotiate reimbursement rates during the contract period, based on documentation from the provider that identifies additional costs and the rationale for including any additional costs as necessary and reasonable to the provision of meals.

	Refer to Manual5600, Section 3014: AAA Contract Management Requirements
304.52 PROGRAM PLANNING AND EVALUATION	On an annual basis, the AAA shall analyze individual and cost data, in addition to compliance monitoring results, to identify necessary program improvements. The AAA shall involve the provider(s) in the evaluation process and provide written feedback regarding required corrective actions or program improvement initiatives.
304.53 AAA QUALITY ASSURANCE AND PROGRAM EVALUATION	Area Agencies shall assure that each nutrition program provider develops and implements an annual plan to evaluate and improve the effectiveness of operations and services to ensure continuous improvement in service delivery. The evaluation process shall include: • A review of the existing program (including retention rates); • Satisfaction survey results from participants, staff, and volunteers; • Program modifications made that responded to changing needs or interests of participants, staff or volunteers; and • Proposed program and administrative improvements. Each provider shall prepare and submit to the AAA annually (no later than September 30th) a written report that summarizes the evaluation findings, improvement goals, and implementation plan for each site. Providers that also operate senior centers shall incorporate the evaluation of the nutrition program into the annual senior center program evaluation.
304.54 FISCAL MANAGEMENT	Contractors providing nutrition services shall practice sound and effective fiscal management and planning, financial and administrative record keeping and reporting. Contractors will use the Uniform Cost Methodology to analyze, evaluate and manage the costs of the program on an annual basis. Refer to MAN 5600, Appendix G
REFERENCES	http://www.nal.usda.gov/fnic/foodborne/wais.shtml , maintained by the USDA Food and Nutrition Service for information and resources on food safety.

	Websites which may assist in the development of nutrition education materials include http://www.livewellagewell.info/, http://www.uri.edu/ce/ceec/food/consumer.html http://extension.uga.edu/food/ Georgia Department of Public Health Rules and Regulations Governing Food Service http://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/EnvHealthFinalFoodRules.pdf ServSafe http://www.servsafe.com MOWAA Disaster Planning Sample and Guide http://www.mowaa.org/Document.Doc?id=38 Dietary Guidelines for Americans 2015-2020 http://health.gov/dietaryguidelines/2015/guidelines/appendices/

Appendix 304-A

Evaluation of Individuals for Appropriate Meal Type

When considering providing a meal to homebound individuals, as either a routine method of meeting part of their nutritional needs or in planning for continuity of services in emergencies, Area Agencies and/or provider staff are responsible for assessing the appropriateness of meal types for each person who will need them. These types include hot, frozen, chilled, or shelf stable meals.

Such meal types may not be appropriate if:

- The individual's home lacks proper appliances for food storage and preparation, and adequate space for proper storage of multiple meals, if a supply for an extended period of time is planned.

- The individual has physical or cognitive impairments that limit his/her ability to prepare or safely reheat the meals, and/or eat without assistance.

The Determination of Need-Revised (DON-R) assessment at the time of intake provides information about the person's functional abilities, specifically in the area of eating and meal preparation. It also provides indicators of possible cognitive impairment which may affect the person's functional capacity.

The assessor will use this information, as well as additional information on the physical conditions of the home, to determine the appropriateness of the alternate meal type. The assessor will make a home visit to visually inspect the cooking facilities and availability and condition of equipment and utensils.

The assessor will document the evaluation findings in the individual's file, using the following form, or otherwise capturing the required data. Staff responsible for periodic individual reassessment will re-verify and document the individual's status and continuing appropriateness for alternate meals, if such meals are part of the ongoing care plan.

Individual/Home Evaluation for Alternate Meal Types

Individual Name: _____Evaluation Date: _____

Client ID: _____

Agency Name: _____

Evaluation Completed By_____

Eating:

Is the individual able to feed himself/herself? Assess the individual's ability to feed him/herself using routine or adapted table utensils and without frequent spills. Address the individual's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages.

Score *0* – The individual can eat, with or without an assistive device.

1 -- The individual can eat, with or without an assistive device, but requires some verbal or physical assistance in some or all components of the activity.

2 -- The individual cannot eat, even with an assistive device, and/or requires a great deal of verbal and/or physical assistance.

3 -- The individual cannot perform any of the tasks of eating.

Availability of assistance with eating. If the individual scores at least (1) in impairment level, determine whether someone is available to assist and/or motivate the individual in eating.

Need for assistance with eating

Score *0* -- The individual's need for assistance is met to the extent that there is no risk to health or safety if current level of assistance is maintained or no other assistance is added.

1-- The individual's need for assistance is met most of the time, or there is minimal risk to the individual's health or safety is additional assistance is not acquired

2-- The individual's need for assistance is not met most of the time; or there is moderate risk to the individual's health/safety if additional assistance is not acquired;

3-- The individual's need for assistance is seldom or never met; or there is severe risk to the health and safety of the individual.

Who, if anyone, is available to provide assistance? _____

How often will assistance be provided? _____

Preparing Meals

Is the individual able to prepare a meal, including re-heating frozen or chilled meals? Assess the ability to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing any utensils used in preparing or eating the meal.

Score *0* – The individual can prepare a meal, with or without an assistive device.

1 -- The individual can prepare a meal, with or without an assistive device, but requires some verbal or physical assistance in some or all components of the activity.

2 -- The individual can prepare a meal, even with an assistive device, and/or requires a great deal of verbal or physical assistance.

3 -- The individual cannot perform any of the tasks of preparing a meal.

Be specific about impairments_____

Need for assistance with meal preparation

If the individual scores at least (1) in this area, evaluate the appropriateness of the meal type being proposed.

Score *0* -- The individual's need for assistance is met to the extent that there is no risk to health or safety if current level of assistance is maintained or no other assistance is added.

1-- The individual's need for assistance is met most of the time, or there is minimal risk to the individual's health or safety is additional assistance is not acquired

2-- The individual's need for assistance is not met most of the time; or there is moderate risk to the individual's health/safety if additional assistance is not acquired;

3-- The individual's need for assistance is seldom or never met; or there is severe risk to the health and safety of the individual.

Who, if anyone, is available to provide assistance? _____ How often?_____

Equipment for Meal Preparation and Storage and Utensils

The individual has in proper working condition:	Yes	No	Not Needed for Meal Type
Refrigerator	_____	_____	_____
Freezer or freezer compartment	_____	_____	_____
Oven	_____	_____	_____
Microwave	_____	_____	_____
Toaster Oven	_____	_____	_____
The individual has an adequate supply of:			
Appropriate utensils for serving and eating	_____	_____	
Towels/Hot pads or mitts for handling hot food items	_____	_____	_____
The individual has an adequate amount of refrigerator/freezer space to store multiple meals if needed.	_____	_____	_____

Type of meal recommended: Hot_____ Shelf stable ____ Frozen_____ Chilled _____

Appendix 304-B

Georgia Nutrition Program Nutrient Targets for Meals

Nutrient Targets: Targets may be met as a monthly average, +/-10%

Table 304-F-1

Nutrient	**Target Value**
*Calories	600
*Protein	17 grams
*Fat	Up to 35% of total calories:
*Saturated Fat	Up to 10% of total calories
*Calcium	400 milligrams
*Sodium	766 milligrams
*Potassium	1566 milligrams
*Magnesium	123 milligrams
*Zinc	3.2 micrograms
*Vitamin A	300 micrograms
*Vitamin B_6	0.57 micrograms
*Vitamin B_{12}	0.8 micrograms
*Vitamin D	5 micrograms
*Vitamin E	5 milligrams
*Folate	133 micrograms
*Fiber	$\geq$ 8 grams
*Vitamin C	$\geq$ 27 milligrams

*Targets based on 2015-2020 Dietary Guidelines for Americans averaged for Females 51+ and Males 51+

Appendix 304-C

Hold Harmless Guidance

Hold Harmless

You may have a hold harmless provision in a contract presented to you. You may also choose to include a hold harmless provision in a contract you present to others.

Definition of a hold harmless agreement: A contractual agreement whereby one party assumes the liability inherent in a situation, thereby relieving the other party of responsibility.

Purpose of a hold harmless agreement: To save another party from all legal consequences or from the outlay of any money for defense costs, damages, etc.

Ultimately, a hold harmless agreement transfers the risk from one party to another.

You should include a hold harmless provision in most contracts dealing with contractors or vendors.

Hold Harmless Sample: You should consult your attorney for specific language to meet your specific needs. Additionally, you should refer to your general liability policy for any specific requirements.

"To the fullest extent permitted by law, the (contractor/vendor) agrees to defend (including attorney's fees), pay on behalf of, indemnify, and hold harmless the (entity), its elected and appointed officials, employees and volunteers and others working on behalf of the (entity) against any and all claims, demands, suits or loss, including all costs connected therewith, and for any damages which may be asserted, claimed or recovered against or from the (entity), its elected and appointed officials, employees, volunteers or others working on behalf of the (entity), by reason of personal injury, including bodily injury or death and/or property damage, including loss of use thereof, which arises out of or is in any way connected or associated with this contract."
-Sample taken from page 16, Risk Transfer Manual, published by C.M. Althoff Co. 1999.

Mutual Hold Harmless Sample
Each party shall defend any third party claim against the other party arising from the death of or physical injury to any person or damage to the indemnified party's property to the extent proximately caused by the negligence of the indemnifying party or its agents or employees, and indemnify and hold harmless the other party and its respective officers, directors and employees from and against damages, liabilities and reasonable costs and expenses, including reasonable legal fees incurred in connection therewith.

GARD

Georgia Alzheimer's and Related Dementias Advisory Council

State Plan

2020-2023

Prepared by the Georgia Alzheimer's Disease and Related Dementias State Plan Collaborative Members and Advisory Council

Version Date: 10/28/2020

Georgia Alzheimer's Disease and Related Dementias

State Plan

The GARD State Plan was developed by the GARD Collaborative and GARD Advisory Council and will be housed by the Georgia Department of Human Services as the administrative body.

I, the undersigned, express support for the State Plan for Alzheimer's Disease and Related Dementias. The State Plan's approval by the governor constitutes authorization to proceed with activities under the State Plan.

Lynne Reeves

Date 12/16/2020

Lynne Reeves, Director
Area Agency on Aging of Northwest Georgia

Chairman, Georgia Alzheimer's Disease and Related Dementias State Plan Advisory Council

Date 12/16/2020

MaryLea Boatwright Quinn, Director of Government Affairs
Alzheimer's Association, Georgia Chapter
Co-Vice Chairman, Georgia Alzheimer's Disease and Related Dementias State Plan Advisory Council

Date 12/16/2020

Abby Cox, Director
Georgia Department of Human Services
Division of Aging Services

Co-Vice Chairman, Georgia Alzheimer's Disease and Related Dementias State Plan Advisory Council

Date

Brian Kemp, Governor
State of Georgia

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ACKNOWLEDGEMENTS

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- **Lynn Ross, LMSW**, Person Living with Dementia
- **Kathleen E. Toomey, MD, MPH**, Commissioner and State Health Officer, Georgia Department of Public Health
- **Senator Ben Watson, MD**, Chairman, Senate Health and Human Services Committee

EXECUTIVE SUMMARY

Introduction

This is the 2020 update to the Georgia Alzheimer's Disease and Related Dementias (GARD) State Plan. In 2013, the Georgia General Assembly created a multidisciplinary task force to assess the state's current and future ability to provide necessary services and programs for Georgians impacted by cognitive decline and dementia and recommend steps to catalyze movement toward dementia capability. Those recommendations, developed through extensive research and input from diverse experts and stakeholders, formed the foundation of the inaugural GARD State Plan, which was signed into action in 2014 by Gov. Nathan Deal. Established by Senate Bill 444, the task force became the GARD Advisory Council, and the 17-member group continues to lead GARD's efforts today.

The 2014 GARD State Plan identified the following six priority areas, and work within each area is currently carried out by six corresponding work groups:

- Research and Data;
- Workforce Development;
- Service Delivery;
- Public Safety;
- Outreach and Partnership; and
- Policy.

The initial plan established goals for each area accompanied by potential strategies designed to promote advancement toward each goal. Since the inaugural plan was developed, stakeholders have made significant progress within each priority area, and new opportunities to further the work have arisen. Consequently, GARD leadership determined a need to update the plan and continue to do so on a four-year cycle.

Update process

The 2014 GARD State Plan was updated through a series of facilitated conversations with each work group, as well as input gathered through asynchronous exchanges with work group chairpersons, members, and GARD leadership. Through this process, progress on the initial goals and strategies was documented, feedback was gathered to inform revisions and identify gaps, and, ultimately, updated goals and strategies were formulated that reflect current needs and align with the groups' capacity and available resources. This updated version then underwent further review by the GARD Advisory Council and leadership and was revised based on this feedback before it was finalized and approved.

Call to Action

The 2020 GARD State Plan update proposes an ambitious undertaking. Progress on the goals and strategies set forth in this plan are dependent upon multiple factors, including consistent, coordinated efforts and support from stakeholders across sectors; available funding; and the capacity of each GARD work group. The ability of the collaborative to effect timely, meaningful change for all Georgians and reduce health disparities also requires the participation of individuals with a range of experiences. It is critical that many perspectives, especially those representing underserved communities, inform this work to ensure our approach is equitable and culturally responsive. All Georgians are welcome and encouraged to join in this effort.

Goals for 2020-2023

Research and Data

RD1: Champion and strengthen existing research and data collection related to cognitive decline and dementia diagnosis, care, and support.

RD2: Identify and pursue opportunities to expand research and data collection of dementia-related surveillance, care, and support.

RD3: Support analysis, translation, and dissemination of available dementia-related research and data for sharing with multiple audiences.

Workforce Development

WD1: Develop a person-centered, dementia-capable, culturally responsive workforce.

WD 2: Develop and implement a tiered career and training model for Georgia's direct-care workforce to improve job quality and quality of care.

WD3: Improve job quality and retention of the dementia workforce.

Service Delivery

SD1: Increase the availability of health and social services tailored for individuals living with dementia and their families.

SD2: Support efforts that provide training for care partners and volunteers in person-centered care.

SD3: Improve consumer access and experience with the service delivery system, focusing on informal service networks not already captured by the Area Agencies on Aging network, public health departments, and health care systems.

SD4: Improve consumer and care partner access to needed services and information, including identifying eligibility criteria for different services.

SDS: Strengthen care partners' (family, professional, and/or volunteer) capacity to deliver high-quality services for persons living with dementia and their families.

Public Safety

PS1: Ensure public safety and financial organizations are prepared to assure the safety of persons living with cognitive decline and dementia who are at risk of abuse, neglect, and/or exploitation.

PS2: Reduce rates of injury and enhance legal protections for people living with cognitive decline and dementia.

PS3: Ensure the inclusion of people living with cognitive decline and dementia and considerations for their unique needs in the state's emergency preparedness plans.

Outreach and Partnership

OP1: Initiate and maximize opportunities to disseminate accurate, comprehensive, and timely information about dementia risk factors, protective elements, and management to the public.

OP2: Educate the public and organizations to become more "dementia-friendly" and dementia-inclusive across all types of dementia.

OP3: Expand Georgia's capacity to promote brain health and address the needs of persons living with cognitive decline and dementia, their care partners, and their families through strategic partnerships and resource sharing, the leveraging of existing funding, and accessing new resources.

Policy

P1: Inform state budgetary, legislative, and regulatory actions that impact individuals living with dementia and their care partners.

P2: Promote awareness and implementation of local-level policies that support dementia inclusion and dementia friendliness.

INTRODUCTION

During the 2013 session of the Georgia General Assembly, legislators created the Georgia Alzheimer's and Related Dementias (GARD) State Plan Task Force, a multidisciplinary group convened to improve dementia research, awareness, training, and care. Starting in June of that year, the six task force members and dozens of experts in diverse fields formed committees, conducted research, and made detailed recommendations. The recommendations formed the core of the GARD State Plan. The document described current demographics, prevalence statistics, and existing resources; analyzed the state's capacity to meet growing needs; and presented a roadmap to create a more dementia-capable Georgia. In June 2014, Gov. Nathan Deal signed the first Georgia Alzheimer's and Related Dementias State Plan.

The GARD Task Force ultimately became the 17-member GARD Advisory Council with membership specified by Senate Bill 444 and appointed by the governor. The GARD Advisory Council is prepared to call for the early, accurate detection of dementia; willing to battle stigma and misinformation; and able to provide an incomparable web of support to families that need it. To support the work of the GARD Advisory Council and Collaborative, a state plan coordinator position was designated within the Georgia Department of Human Services, Division of Aging Services. Continuing with the recommendations from the task force, Georgia's GARD State Plan addresses research and data, workforce development, service delivery, public safety, outreach and partnership, and policy. And undergirding all of these areas is the importance of partnerships — creating a deeply coordinated statewide team of agencies, nonprofits, businesses, and organizations.

Since the inaugural plan was developed, considerable work has transpired and new opportunities have arisen. Thus, with an update required by Georgia Code section 49-6-90 and guidance from the GARD Advisory Council chairpersons, it was determined that an update to the GARD State Plan was necessary. Utilizing the experience, wisdom, and guidance of GARD leadership, a process for updating the state plan was developed, guiding principles were carefully chosen, and a four-year renewal cycle was established. Feedback was gathered from the GARD Advisory Committee and Collaborative in February and May 2020. From March to August 2020, the GARD work groups have worked to document accomplishments to date and identify high-level goals and specific strategies that will serve as the guide for their work through 2023.

This plan does not purport to address all of the obstacles experienced by individuals living with cognitive decline and dementia and their care partners or the complexities of the public health issues of early detection, risk reduction, and brain health. The intent was to identify the greatest needs, opportunities, and strategies at this time that will continue to build on the foundation that has been established. At its core, the contributors to the update to the state plan seek to clarify the purpose and strategy for each work group in the short- and mid-term. Ultimately, this is an ambitious state plan that seeks to make transformative change and will need to draw on the active engagement of public and private-sector stakeholders. In some cases, implementation of the identified strategies will be dependent on the availability of resources and collaboration of the many partners that it will take to act on these opportunities.

LEGISLATION

Senate Bill 444

By: Senators Unterman of the 45th, Hufstetler of the 52nd, Watson of the 1st, Burke of the 11th, Kirkpatrick of the 32nd and others

AS PASSED

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 6 of Title 49 of the Official Code of Georgia Annotated, relating to services for the aging, so as to create the Georgia Alzheimer's and Related Dementias State Plan Advisory Council; to provide for legislative declaration; to provide for definitions; to provide for membership; to provide for duties and reporting requirements; to provide for a short title; to provide for related matters; to provide an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

This Act shall be known and may be cited as the "Senator Thorborn 'Ross' Tolleson, Jr., Act."

SECTION 2.

Chapter 6 of Title 49 of the Official Code of Georgia Annotated, relating to services for the aging, is amended by adding a new article to read as follows:

"ARTICLE 8

49-6-90.

The General Assembly having declared that Alzheimer's disease and related dementias is a looming state and national public health crisis and having found that it is in the best interest of the state and its citizenry to address this issue created a Georgia Alzheimer's and Related Dementias State Plan for the purpose of developing a strategy to mobilize a state response. The provisions of this chapter are enacted to further the intention of the State of Georgia to become a more dementia-friendly and dementia-capable environment for the citizens of Georgia with Alzheimer's disease and related dementias. To further that purpose, the Georgia Alzheimer's and Related Dementias State Plan Advisory Council is

created to ensure that focus remains on implementing and amending as needed the goals set forth in the Georgia Alzheimer's and Related Dementias State Plan.

49-6-91.

As used in this article, the term:

(1) 'Advisory council' means the Georgia Alzheimer's and Related Dementias State Plan Advisory Council as created and authorized by this article.

(2) 'Alzheimer's' means having characteristics of Alzheimer's disease, a progressive and degenerative brain disease that causes impairment or change in memory, thinking, or behavior.

(3) 'Commissioner' means the commissioner of human services.

(4) 'Dementia' means any disease from a class of degenerative brain disorders that cause impairment or changes in memory, thinking, or behavior that are progressive and irreversible. Such diseases include, but are not limited to, Alzheimer's disease, Lewy Body dementia, frontotemporal dementia, and vascular dementia.

(5) 'Department' means the Department of Human Services.

(6) 'State plan' means the Georgia Alzheimer's and Related Dementias State Plan, as amended, created pursuant to legislation for the purpose of analyzing state demographics, prevalent statistics, and existing resources to gauge the state's capacity to meet growing needs and to present a roadmap for creating a more dementia-capable Georgia.

49-6-92.

(a) There is established the Georgia Alzheimer's and Related Dementias State Plan Advisory Council which shall consist of the following members:

(1) Eleven individuals are standing members due to their position in government agency, organization, or elected office:

(A) The commissioner of human services or his or her designee;

(B) The director of the Division of Aging Services;

(C) The President of the Georgia Association of Area Agencies on Aging or his or her designee;

(D) The commissioner of community health or his or her designee;

(E) The commissioner of public health or his or her designee;

(F) The commissioner of behavioral health and developmental disabilities or his or her designee;

(G) The chairperson of the Senate Health and Human Services Committee or his or her designee;

(H) The chairperson of the House Committee on Health and Human Services or his or her designee;

(I) The chairperson of the House Committee on Human Relations and Aging or his or her designee;

(J) A representative of the Georgia Chapter of the Alzheimer's Association; and

(K) A representative of the Georgia Council on Aging.

(2) The Governor shall appoint one individual from around the state in each topical area below, chosen for his or her expertise or experience in one of the following six specific fields:

(A) A provider of residential, health care, or personal care services to those living with dementia;

(B) A social gerontologist or clinical researcher in an education or clinical setting with expertise in dementia;

(C) An advocate with a not-for-profit or state agency whose role is to improve services for older adults or those living with dementia;

(D) A medical professional with an active practice specializing in geriatrics, neurology, or other field closely related to dementia;

(E) A caregiver, current or past, for a family member with dementia who has experience navigating health care service options; and

(F) A person who has been diagnosed with dementia.

(b) The advisory council shall serve in an advisory capacity to the Governor, the General Assembly, the Department of Human Services, and all other state agencies on matters relating to the Georgia Alzheimer's and Related Dementias State Plan. The advisory council shall review and make recommendations regarding progress toward the goals of the state plan and on progress in implementing resources and services to serve individuals with dementia related diseases around Georgia in the future. Such review and recommendations shall include, but not be limited to, the following:

(1) Selecting current priorities for state plan work groups to focus on;

(2) Examining the current laws, rules and regulations, and policies of the various agencies that interact with services for individuals with dementia and making recommendations to improve the navigation of and provision of care services for those with dementia and their caregivers;

(3) Proposing legislative or administrative changes to policies and programs needed for furtherance of the state plan;

(4) Examining state and federal funding into the areas of the state plan and reviewing how to work interdisciplinarily to ensure the most efficient and effective use of available resources;

(5) Locating and assisting departments or partner agencies in applying for new funding sources and new opportunities in furtherance of the goals of the state plan; and

(6) Amending the state plan at least every three years and submitting the amended state plan to the Governor for authorization.

(c) The advisory council shall annually elect a chairperson and vice chairperson from among its membership. The advisory council may elect such other officers and establish committees as it considers appropriate. Until a chairperson and vice chairperson are elected or if the chairperson or vice chairperson is unavailable, the director of the Division of Aging Services shall serve temporarily in that role until a new election can be held by the advisory council. The advisory council shall create and vote on bylaws and policies as needed.

(d) The terms of those individuals appointed by the Governor pursuant to paragraph (2) of subsection (a) of this Code section shall serve for an appointment of two years, with the exception of the first year of existence of the advisory council. For the purpose of staggering term appointments, in the first appointment of the individuals in paragraph (2) of subsection (a) of this Code section, the Governor shall appoint three appointees for a one-year first term and three appointees for a two-year first term. All subsequent appointments or reappointments shall be for terms of two years. If an appointee resigns or is otherwise unable to complete the appointed term, the Governor shall appoint a new individual whose expertise or experience satisfies the vacated position within 90 days.

(e) The advisory council shall meet at least quarterly and at such additional times as it shall determine necessary to perform its duties. The advisory council shall also meet on the call of the chairperson, the vice chairperson, the commissioner, or the Governor. All meetings shall contain updates from each work group and presentations on any developed proposals for furtherance of the state plan goals. At or before the summer quarterly meeting, the advisory council shall take a formal vote on any proposals or recommendations under consideration.

(f) Starting on January 1 of the year after this article takes effect and repeating every three years after that date, the advisory council shall submit to the Governor for his or her approval and thereafter make available to the General Assembly a report on the work of the advisory council. This report shall include a summary of the progress report toward implementation of the state plan and recommendations for amendments to the state plan. If the advisory council determines that amendments need to be made to the state plan, an amended Georgia Alzheimer's and Related Dementia State Plan may be presented to the Governor for review and approval.

(g) The department shall staff a position for the Georgia Alzheimer's and Related Dementias State Plan; such position shall be the state plan coordinator. The state plan

coordinator shall assist the chairperson and advisory council on council related activities, coordinating the advisory council meetings, and coordinating and serving as a liaison between the work groups and the advisory council, and other associated duties as assigned by the department. The state plan coordinator shall ensure that the progress report is published pursuant to subsection (f) of this Code section.

(h) The advisory council members shall serve in one or more of the Georgia Alzheimer's and Related Dementias State Plan work groups as described in the goals of the state plan. These work groups are to be composed of volunteers and individuals interested in dementia and shall meet between the quarterly meetings to develop the priorities from paragraph (1) of subsection (b) of this Code section to present recommendations to the full advisory council at its quarterly meetings.

(i) Members shall serve without compensation, although each member of the advisory council shall be reimbursed for actual expenses incurred in the performance of his or her duties from funds available to the advisory council; provided, however, that any legislative member shall receive the allowances authorized by law for legislative members of interim legislative committees and any members who are state employees shall be reimbursed for expenses incurred by them in the same manner as they are reimbursed for expenses in their capacities as state employees."

SECTION 3.

This Act shall become effective on July 1, 2018.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.

GUIDING PRINCIPLES

The GARD State Plan update was guided by six principles:

(1) Seek opportunities to optimize and grow resources to ensure access to coordinated, evidence-informed services systemwide.

(2) Recognize the value of a collaborative approach to the work; encourage participation, support, and leadership from public and private entities.

(3) Consistently assess progress and make changes to policies, systems, and environments that will transform the way we approach cognitive decline and dementia.

(4) Prioritize the needs and desires of persons living with and at risk for dementia and their care partners, and engage them in the design, implementation, and evaluation of the strategies.

(5) Embrace a life course and person-centered philosophy that recognizes both social and medical needs and values diversity.

(6) Actively seek to include voices that have been left out in decision-making in an effort to create meaningful outcomes for underserved populations.

STATE PLAN 2020-2023

RESEARCH AND DATA

GOAL RD1: Champion and strengthen existing research and data collection related to cognitive decline and dementia diagnosis, care, and support.

Rationale: Research, surveillance, and data collection are central to advancing our understanding of dementia, developing and ensuring linkage to effective treatments, and improving the quality of care for people living with cognitive decline and dementia and their families.

Strategies

RD1a: Provide and maintain a database of key referral sources as a resource for community physicians to support screening, diagnosis, and management of cognitive decline and dementia.

Time Frame and Measurable Outcomes:

- Complete scan of existing databases to establish whether a referral database is already available for use by January 2021.
- Disseminate information about database of key referral sources by May 2021.

Key Stakeholders: Georgia Department of Public Health; Georgia institutes of higher education; Georgia Memory Net; Georgia Primary Care Association; Georgia Division of Aging Services

Cost Implications: Dissemination of communication materials could have a cost if printed.

RD1b: Develop and maintain a catalog of existing surveillance data sources on dementia in the state of Georgia, such as the Alzheimer's Disease and Related Dementias Registry and Behavioral Risk Factor Surveillance System's Cognitive Decline and Caregiver modules.

Time Frame and Measurable Outcomes: Complete initial catalog of data sources on dementia by January 2022.

Key Stakeholders: Georgia Department of Public Health; Georgia institutes of higher education; Georgia Memory Net; Georgia Division of Aging Services; Alzheimer's Association, Georgia Chapter

Cost Implications: None anticipated.

RD1c: Develop a protocol by which to provide guidance on the use of Alzheimer's Disease and Related Dementias Registry data to support the enhancement and adoption of quality reporting.

Time Frame and Measurable Outcomes: Publish Alzheimer's Disease and Related Dementias registry guidance by January 2023.

Key Stakeholders: Georgia Department of Public Health; Georgia institutes of higher education; Georgia Memory Net; Georgia Division of Aging Services

Cost Implications: None anticipated.

GOAL RD2: Identify and pursue opportunities to expand research and data collection of dementia-related surveillance, care, and support.

Rationale: Enhanced funding and collaboration can accelerate research progress, improve data collection, and create opportunities for testing and adopting service innovations.

Strategies

RD2a: Promote the use of the Behavioral Risk Factor Surveillance System's Cognitive Decline and Caregiver modules data with health-related outcome and/or quality measures.

Time Frame and Measurable Outcomes: Disseminate data briefs using Behavioral Risk Factor Surveillance System's Cognitive Decline and Caregiver modules data to promote increased funding for data collection by November 2021

Key Stakeholders: GARD Outreach and Partnership Work Group; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter

Cost Implications: Minimal to no cost anticipated.

RD2b: Collaborate with the GARD Policy Work Group to review potential legislative and policy changes proposed to enhance Alzheimer's disease and related dementias data collection, usage, and dissemination among state agencies and engage appropriate advocacy partners as needed.

Time Frame and Measurable Outcomes: Complete review of relevant legislation and policy and identify needed revisions by November 2022.

Key Stakeholders: GARD Policy Work Group; Georgia Department of Public Health; Georgia Council on Aging; Alzheimer's Association, Georgia Chapter

Cost Implications: None anticipated.

RD2c: Develop a process to coordinate existing resources and seek additional resources to expand dementia-related research and evaluation.

Time Frame and Measurable Outcomes: Conduct a feasibility assessment for obtaining funding that will enable expanded data collection using the Behavioral Risk Factor Surveillance System's Cognitive Decline and Caregiver modules.

Key Stakeholders: Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications**:** None anticipated.

GOAL RD3: Support analysis, translation, and dissemination of available dementia-related research and data for sharing with multiple audiences.

Rationale: Data synthesis and dissemination are critical to informing decision-making, ensuring the infusion of innovations, and promoting the adoption of best practices among stakeholders. This is especially important to identify and serve higher burdened populations.

Strategies:

RD3a: Promote the sharing of surveillance data to state agencies, regional commissions, and other planning agencies to encourage and inform data-driven approaches to prevention and services.

Time Frame and Measurable Outcomes: Publish a brief tailored to inform community planning efforts related to dementia by August 2023.

Key Stakeholders: GARD Outreach and Partnership Work Group; Georgia Department of Public Health; Georgia regional commissions; Alzheimer's Association, Georgia Chapter

Cost Implications: Dissemination of the brief could have a cost if printed.

RD3b: Evaluate and advocate for enhancement of the extent to which cognitive decline and dementia content is infused in curricula at secondary and post-secondary institutions of higher education in Georgia.

Time Frame and Measurable Outcomes: Collaborate with the GARD Outreach and Partnership Work Group to advocate for enhancement of the extent to which cognitive decline and dementia content is infused in curricula at secondary and post-secondary institutions of higher education in Georgia in 2021.

Key Stakeholders: Georgia institutes of higher education.

Cost Implications: None anticipated.

RD3c: Develop outcome measures to inform the implementation of the GARD State Plan and assess the impact of GARD activities.

Time Frame and Measurable Outcomes: Publish and disseminate guidance to key stakeholders by January 2022.

Key Stakeholders: Georgia Department of Public Health; Georgia Division of Aging Services
Cost Implications: None anticipated.

WORKFORCE DEVELOPMENT

GOAL WD1: Develop a person-centered, dementia-capable, culturally responsive workforce.

Rationale: A workforce that is designed to proactively work with people living with cognitive impairment and dementia, including Alzheimer's disease, is better poised to serve persons living with cognitive decline and dementia and their care partners.

Strategies

WD1a: Determine the size, education/training level, and capacity of the existing workforce.

Time Frame and Measurable Outcomes: Complete determination by August 2022.

Key Partners: GARD Research and Data Work Group; Office of Workforce Development; the Georgia Department of Public Health; the Georgia Department of Community Health; the Georgia Department of Behavioral Health and Developmental Disabilities; the Georgia Division of Aging Services

Cost Implications**:** None anticipated.

WD1b: Encourage/develop person-centered, dementia-specific continuing education for a variety of occupations.

Time Frame and Measurable Outcomes: Ongoing

Key Partners: Georgia Department of Labor; Georgia institutes of higher education; Alzheimer's Association, Georgia Chapter; Lewy Body Dementia Association (LBDA), frontotemporal dementia (FTD) advocates; other consumers; appropriate professional societies; Southern Gerontological Society; Georgia Gerontology Society

Cost Implications: Supported through partnerships and individual Continuing Education Unit (CEU) fees

WD1c: Explicitly develop connection to the GARD Outreach and Partnership Work Group and the GARD Service Delivery Work Group to support cross-pollination and ensure the use of similar language and focus on inclusion of people living with dementia and their care partners.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: GARD Outreach and Partnership Work Group; GARD Service Delivery Work Group

Cost Implications: None anticipated.

WD1d: Develop a "hospital packet" with education and tips for people living with dementia, their care partners, and long-term services and support workers about prevention and hospitalization.

Time Frame and Measurable Outcomes: Complete and disseminate "hospital packet" by August 2022

Key Stakeholders: GARD Outreach and Partnership Work Group

Cost Implications: None anticipated with the exception of print materials if determined necessary.

GOAL WD2: Develop and implement a tiered career and training model for Georgia's direct-care workforce to improve job quality and quality of care.

Rationale: Job quality and quality of care remain large issues for Georgia. By developing and implementing a career model that can be used for the direct-care workforce, we will be able to ensure quality in both areas.

Strategies

WD2a: Partner with workforce investment boards to support new entrants to direct-care workforce.

Time Frame and Measurable Outcomes:

- Create partnerships by August 2021.
- Implement pilot training model by August 2023.
- Recommend statewide model by 2024.

Key Stakeholders: Georgia Health Care Association; LeadingAge Georgia; workforce investment boards; Georgia community and technical colleges; Alzheimer's Association, Georgia Chapter

Cost Implications: Seeking grant funds for pilot; braided resource strategy with workforce investment dollars

WD2b: Partner with employers/employer associations to encourage and support use of high-quality dementia education/programming.

Time Frame and Measurable Outcomes:

- Create partnerships by August 2021.
- Promotion and support will be ongoing.

Key Stakeholders: GARD Service Delivery Work Group

Cost Implications: Supported through partnerships and individual or employer-based fees

WD2c: Develop statewide registry of high-quality, person-centered, and vetted training.

Time Frame and Measurable Outcomes: Statewide registry developed by September 2023

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Labor; Georgia Department of Community Health; LeadingAge Georgia; Alzheimer's Association, Georgia Chapter

Cost Implications: To be determined

WD2d: Partner with Dementia Friendly Georgia to support workforce training to build community awareness and dementia inclusive competencies.

Time Frame and Measurable Outcomes: Support will be ongoing.

Key Stakeholders: Dementia Friendly Georgia; Georgia Gerontology Society; Georgia Division of Aging Services

Cost Implications: None anticipated.

GOAL WD3: Improve job quality and retention of the dementia workforce.

Rationale: In order to best serve the dementia workforce, it will be important to improve the quality of jobs and retention efforts, as well as increase the attractiveness of this work to potential new entrants.

Strategies

WD3a: Implement statewide turnover data collection for long-term services and supports in Georgia.

Time Frame and Measurable Outcomes: Implement data collection tool by August 2023

Key Stakeholders: Georgia Department of Public Health; Georgia Department of Community Health

Cost Implications: $25,000 per year for design of tool to be implemented with annual licensure and analysis.

WD3b: Support and disseminate "employer of choice" strategies to help employers improve jobs and increase recruitment and retention ("employer of choice" refers to workplaces that are favored by potential employees due to their advantageous workplace practices).

Time Frame and Measurable Outcomes: Support and dissemination efforts will be ongoing.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Georgia Health Care Association; LeadingAge Georgia; long-term care services and supports employers; Georgia

institutes of higher education

Cost Implications: None anticipated.

WD3c: Educate Georgia workforce commission within the state-level office of the Department of Labor about person-centered, dementia-capable, culturally responsive workforce across occupational categories.

Time Frame and Measurable Outcomes: Share information by August 2021

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; workforce investment boards; Alzheimer's Association, Georgia Chapter

Cost Implications: None anticipated.

SERVICE DELIVERY

GOAL SD1: Increase the availability of health and social services tailored for individuals living with dementia and their families.

Rationale: Support for individuals living with dementia should include building support systems for families.

Strategies

SD1a: Assess the current availability of tailored health and social services for individuals living with dementia and their families to determine gaps and needs.

Time Frame and Measurable Outcomes: Complete assessment by August 2022.

Key Partners: GARD Research and Data Work Group; Georgia Office of Workforce Development; the Georgia Department of Public Health; the Georgia Department of Community Health; the Georgia Department of Behavioral Health and Developmental Disabilities; the Georgia Division of Aging Services

Cost Implications: None anticipated.

SD1b: Develop a strategy to address identified health and social service gaps and needs that applies best practices.

Time Frame and Measurable Outcomes: Strategy defined by September 2023.

Key Partners: Georgia Department of Labor; GARD Research and Data Work Group; Alzheimer's Association, Georgia Chapter; Area Agencies on Aging network; Family Caregiver Alliance; Georgia Department of Community Health; Georgia Memory Net

Cost Implications: None anticipated.

SD1c: Collaborate with the GARD Research and Data Work Group to pursue opportunities to identify and address gaps in dementia-related service capacity, access, and quality in Georgia.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: GARD Research and Data Work Group

Cost Implications: None anticipated.

SD1d: Assess the current landscape of dementia-friendly telehealth in the state of Georgia, documenting best practices and identifying opportunities for development.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: Georgia Memory Net; Georgia hospitals; Alzheimer's Association, Georgia Chapter; Georgia Department of Public Health; Emory Goizueta Alzheimer's Disease Research Center

Cost Implications: None anticipated.

GOAL SD2: Support efforts that provide training for care partners and volunteers in person-centered care.

Rationale: Optimal support for individuals living with cognitive decline and dementia includes efforts to support volunteers, care partners, and professional caregivers, specifically around person-centered care.

Strategies

SD2a: Guide/support efforts to promote the adoption of and training on person-centered best practices for care partners and volunteers across settings.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: Georgia Department of Labor; the Alzheimer's Association, Georgia Chapter; Culture Change Network of Georgia; Georgia Memory Net; Area Agencies on Aging network

Cost Implications: None anticipated.

SD2b: Promote the most effective and current care partner education for care partners of individuals living with dementia.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: Rosalynn Carter Institute for Caregiving; Eden Alternative; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Area Agencies on Aging network; Emory Goizueta Alzheimer's Disease Research Center

Cost Implications: None anticipated.

SD2c: Collaborate with the GARD Workforce Development Work Group to ensure consistent and available person-centered care training for volunteers, care partners, and staff.

Time Frame and Measurable Outcomes: Ongoing

Key Stakeholders: GARD Workforce Development Work Group

Cost Implications: None anticipated.

GOAL SD3: Improve consumer access and experience with the service delivery system, focusing on informal service networks not already captured by the Area Agencies on Aging network, public health departments, and health care systems.

Rationale: Consumer access and experience with service providers is related to uptake of services. In order to increase customer uptake, access and experience need to be addressed.

Strategies

SD3a: Identify best practices for improved connectivity between organizations within the service delivery system.

Time Frame and Measurable Outcomes: Best practices identified and shared within the network by September 2022.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Area Agencies on Aging network; Georgia Memory Net

Cost Implications: None anticipated.

SD3b: Identify best practices for ensuring services are accessible for individuals living with dementia.

Time Frame and Measurable Outcomes: Best practices identified and shared within the network by September 2022.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Georgia Department of Community Health; Alzheimer's Association, Georgia Chapter; Area Agencies on Aging network; Georgia Memory Net

Cost Implications: None anticipated.

SD3c: Develop guidance or sample protocols as necessary for service providers that promote improved consumer experience.

Time Frame and Measurable Outcomes: Outline for guidance and sample protocols developed by August 2021; delivery of guidance and sample protocols ongoing.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Georgia Memory Net; Area Agencies on Aging network

Cost Implications: Minimal cost anticipated.

GOAL SD4: Improve consumer and care partner access to needed services and information, including identifying eligibility criteria for different services.

Rationale: Consumer and care partner access to dementia-related services and information continues to be an issue for Georgians. Access can be increased by aligning with current efforts around expanding access, addressing transportation challenges, and assessing current data around service uptake.

Strategies

SD4a: Encourage and support efforts to enhance access to information about dementia and dementia-related services, and support dementia awareness efforts.

Time Frame and Measurable Outcomes: Identify current efforts around expanding access to information by September 2021; support will be ongoing.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; GARD Outreach and Partnership Work Group; Georgia Memory Net; Area Agencies on Aging network; Georgia Department of Community Health; Georgia Department of Driver Services; Georgia Department of Transportation

Cost Implications: None anticipated.

SD4b: Examine and respond to transportation challenges that individuals living with cognitive decline and dementia and/or their care partners face in accessing services.

Time Frame and Measurable Outcomes:

- Identify transportation challenges for individuals living with cognitive decline and dementia and their care partners by September 2022.
- Develop response by September 2023.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Georgia Memory Net; Area Agencies on Aging network; Georgia Department of Human Services Coordinated Transportation; Georgia Department of Community Health

Cost Implications: Minimal

SD4c: Collaborate with the GARD Research and Data Work Group to examine and document how many people access services that are funded by Medicaid to help inform future services that could be provided. Identify financial barriers to access.

Time Frame and Measurable Outcomes: Initial collaboration and data pull by August 2021; ongoing collaboration.

Key Stakeholders: GARD Research and Data Work Group; Georgia Department of Community Health

Cost Implications: None anticipated.

GOAL SD5: Strengthen care partners' (family, professional, and/or volunteer) capacity to deliver high-quality services for persons living with dementia and their families.

Rationale: Care partners are often the first point of contact for persons living with cognitive decline and dementia. By building their capacity to respond to challenges and provide referrals, care partners are better able to care for persons living with dementia and navigate available services.

Strategies

SD5a: Evaluate access to and quality of services available for volunteers and care partners along with issues of access to those services using standardized measures where possible.

Time Frame and Measurable Outcomes:

- Identify available services for volunteers and care partners by September 2021.
- Document issues of access by August 2023.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Georgia Memory Net; Area Agencies on Aging network

Cost Implications: None anticipated.

SD5b: Promote evidence-informed materials that provide additional, informal supports for volunteers and care partners.

Time Frame and Measurable Outcomes: Ongoing.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Alzheimer's Association, Georgia Chapter; Georgia Memory Net; Area Agencies on Aging network

Cost Implications: None anticipated.

PUBLIC SAFETY

Goal PS1: Ensure public safety and financial organizations are prepared to assure the safety of persons living with cognitive decline and dementia, who are at risk of abuse, neglect, and/or exploitation.

Rationale: Older adults living with cognitive decline and dementia may be at high risk for abuse, neglect, and exploitation. Implementation of programs to educate and prepare public safety and financial organizations will increase awareness of public safety and financial professionals, enhance collaborative processes, and improve outcomes.

Strategies

PS1a: Support the development of specialized regional multidisciplinary teams to (1) respond to and investigate crimes against at-risk adults, including individuals living with cognitive decline and dementia, and (2) relocate victims when needed**.**

Time Frame and Measurable Outcomes:

- Assess the state and document where multidisciplinary teams exist and where there is particular interest in creating one by April 2021.
- Using the expertise of existing regional multidisciplinary teams, share information and support the development of at least one new regional multidisciplinary team by October 2021.
- Continue supporting information sharing to develop new regional multidisciplinary teams through 2023.

Key Stakeholders: Local law enforcement; first responders; local elder abuse task forces; financial institutions; Georgia Bureau of Investigation; Area Agencies on Aging network; Georgia Division of Aging Services, Forensic Special Initiatives Unit

Cost Implications: None anticipated.

PS1b: Designate and maintain an at-risk adult subject matter expert in each Georgia Bureau of Investigation region to focus on combating crime and providing technical assistance to local law enforcement.

Time Frame and Measurable Outcomes:

- Support training efforts where needed, ongoing.
- Provide mechanisms for information sharing related to building awareness and knowledge among public safety organizations, ongoing.

Key Stakeholders: Georgia Bureau of Investigation; local law enforcement agencies; Georgia Division of Aging Services, Forensic Special Initiatives Unit

Cost Implications: None anticipated.

PS1c: Develop brief, accessible training videos for organizations that may identify and provide assistance to persons living with cognitive decline and dementia who are at risk of abuse, neglect, and/or exploitation.

Time Frame and Measurable Outcomes:

- Engage members of the GARD Public Safety Work Group and seek representation from all of the target audiences to serve as advisers by March 2021.
- Create a list of training topics that could be addressed with brief videos that includes the target audience by June 2021. Topic examples include Mattie's Call, signs of dementia, how to respond to a person presenting with signs of dementia; target audiences include law enforcement, first responders, financial professionals, and Adult Protective Services staff.
- Prioritize the list of topics by July 2021.
- Collaborate with the GARD Outreach and Partnership Work Group regarding GARD messaging, process for producing the videos, and funding by July 2021.
- Assess available funding from stakeholder agencies and external sources by September 2021.
- Monitor and reassess availability of funding on a semiannual schedule based on the topics prioritized.
- Video production schedule and production based on available funding by 2023.

Key Stakeholders: Local law enforcement; first responders; financial professionals; GARD Outreach and Partnership Work Group; Alzheimer's Association, Georgia Chapter

Cost Implications: Approximately $2,000 - $6,000 per video.

PS1d: Promote existing and emerging opportunities to educate financial professionals about cognitive decline and dementia; risks, prevention, and mitigation of possible financial exploitation and abuse; their authority to report suspected abuse; and the protections for those who report.

Time Frame and Measurable Outcomes:

- Connect with the Georgia Division of Aging Services' financial forensic expert regarding existing training and reach with financial institutions by February 2021.
- Promote current training through the GARD collaborative and externally, ongoing.
- Identify additional opportunities to support education of financial professionals, ongoing.

Key Stakeholders: Area Agencies on Aging network; Alzheimer's Association, Georgia Chapter; the Governor's Office of Consumer Protection; the Georgia Bureau of investigation; the Medicaid Fraud Control Unit; the U.S. Department of Health and Human Services; the U.S. Office of Inspector General;

GARD Outreach and Partnership Work Group; and the Georgia Division of Aging Services, Forensic Special Initiatives Unit, Adult Protective Services, and Senior Medicare Patrol project

Cost Implications: None anticipated.

Goal PS2: Reduce rates of injury and enhance legal protections for people living with cognitive decline and dementia.

Rationale: Persons living with dementia are at increased risk of hospitalization if in an automobile accident, unsafe or erratic driving, and victimization. These risks can be mitigated through the prioritization of individual rights and utilization of tools, practices, and regulations known to prevent and avoid injury.

Strategies

PS2a: Evaluate existing policies and practices regarding the assessment of driving ability for persons living with cognitive decline and dementia.

Time Frame and Measurable Outcomes:

- Review and assess existing policies and practices regarding the assessment of driving ability for persons living with cognitive decline and dementia by January 2022.
- Review policies and practices utilized in other states, evidence-informed recommendations from organizations such as the Centers for Disease Control and Prevention by April 2022.
- Work with the GARD Policy Work Group to recommend changes to existing driving assessment policies and practices that would increase safety of the public and reduce injuries of persons living with cognitive decline and dementia by June 2022.

Key Stakeholders: Georgia Department of Public Health; Georgia Department of Driver Services; GARD Policy Work Group

Cost Implications: None anticipated.

PS2b: Evaluate state laws regarding powers of attorney and guardianship and make recommendations that will increase autonomy and decrease fraud, abuse, neglect, and self-neglect of persons living with cognitive decline and dementia.

Time Frame and Measurable Outcomes:

- Review and assess the state's powers of attorney and guardianship laws and practices by May 2021.
- Review other states' laws and practices regarding powers of attorney and guardianship by August 2021.

- Review recommendations from organizations such as the American Bar Association and the National Guardianship Association by August 2021.
- Work with the GARD Policy Work Group to recommend changes to existing laws and practices that would support autonomy and reduce the likelihood of abuse, neglect, and exploitation of persons living with cognitive decline and dementia by November 2021.

Key Stakeholders: GARD Policy Work Group; Georgia Division of Aging Services, Adult Protective Services; elder law attorneys; Prosecuting Attorneys' Council of Georgia

Cost Implications: Minimal to no cost

PS2c: Increase awareness and utilization of programs and devices that seek to locate individuals prone to wandering.

Time Frame and Measurable Outcomes:

- Review available programs and devices available throughout the state by January 2022.
- Develop a compendium of information related to wandering that can be shared with medical providers, people living with dementia, and care partners by June 2022.
- Share information with the GARD Advisory Council and relevant stakeholders about identified opportunities or gaps related to the availability of programs and devices in the state by August 2022.
- Collaborate with GARD Service Delivery Work Group and GARD Outreach and Partnership Work Group regarding increasing access to programs and devices among medical providers to reduce injuries and deaths related to wandering among individuals living with cognitive decline and dementia by November 2022.

Key Stakeholders: Local law enforcement; Area Agencies on Aging network; local elder abuse task forces; Alzheimer's Association, Georgia Chapter; Adult Protective Services; Georgia Bureau of Investigation; GARD Outreach and Partnership Work Group; GARD Service Delivery Work Group

Cost Implications: None anticipated with the exception of print materials if determined necessary.

Goal PS3: Ensure the inclusion of people living with cognitive decline and dementia and considerations for their unique needs in the state's emergency preparedness plans.

Rationale: There is great diversity and disparity in emergency and disaster preparedness plans and communications. There is a need for intensified outreach efforts educating care partners and persons living with cognitive decline and dementia on how to plan and prepare for disasters. Further, improved disaster preparedness planning and coordination among relevant agencies and organizations is needed.

Strategies

PS3a: Engage partners to develop guidance for state and local emergency management agencies. Guidance should help to ensure that the needs of individuals living with cognitive decline and dementia will be met during evacuation, transportation, and sheltering during a disaster.

Time Frame and Measurable Outcomes:

- Review and document learnings acquired through the response to COVID-19 and other emergencies as it relates to the plans and response related to the unique needs of individuals living with cognitive decline and dementia by February 2021.
- Review best practices and plans from other states by May 2021.
- Engage a group of stakeholders that includes representatives from the organizations involved in emergency management to discuss the opportunity to integrate information into existing plans and develop guidance for emergency management agencies by September 2021.
- Recommend changes to emergency management plans and agencies to better address the unique needs of individuals living with cognitive decline and with dementia by December 2021.

Key Stakeholders: State and local emergency management planning agencies; Georgia Division of Aging Services; Georgia Department of Public Health; Georgia Department of Community Health; Georgia Health Care Association; Alzheimer's Association, Georgia Chapter

Cost Implications: None anticipated.

OUTREACH AND PARTNERSHIP

GOAL OP1: Initiate and maximize opportunities to disseminate to the public accurate, comprehensive, and timely information about dementia risk factors, protective elements, and management.

Rationale: Enhancing public awareness of cognitive decline and dementia is essential to reducing public misconceptions and stigma, as well as encouraging families to seek assessment, care management, and support resources.

Strategies

OP1a: Conduct an environmental scan to identify and organize information from existing needs assessments of populations that are underserved and not connected to resources in the state.

Time Frame and Measurable Outcomes:

- Complete environmental scan by August 2023.
- Synthesize and organize data to inform material design and outreach strategy development by November 2023.

Key Partners: GARD Research and Data Work Group; Georgia Division of Aging Services; Georgia Department of Public Health; Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications: Environmental scan could involve a cost if conducted by an external contractor.

OP1b: Catalog, brand, and regularly update existing GARD outreach and educational materials and ensure current versions, as well as links to relevant materials from other entities, are available through the GARD website.

Time Frame and Measurable Outcomes: Complete cataloging, branding, and updating of GARD materials and website by July 2021.

Key Partners: Georgia Division of Aging Services; Georgia Department of Public Health; Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications: Dissemination of communication materials could have a cost if printed.

OP1c: Increase efforts to involve people living with cognitive decline and dementia and their care partners in activities to raise public awareness about risk and protective factors and resources and to reduce stigma.

Time Frame and Measurable Outcomes: Connect with support groups, senior centers, faith-based organizations, and other potential stakeholders to engage people living with cognitive decline and dementia and their families in outreach and education efforts by December 2022.

Key Stakeholders: Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter

Cost Implications: None anticipated.

GOAL OP2: Educate the public and organizations to become more "dementia-friendly" and dementia-inclusive across all types of dementia.

Rationale: Dementia-friendly and dementia-inclusive communities help to ensure people living with dementia and their families are supported, feel respected and engaged, and experience the highest possible quality of life.

Strategies

OP2a: Conduct an environmental scan to identify learnings from Dementia Friends communities in other states and disseminate learnings to support local planning and implementation efforts.

Time Frame and Measurable Outcomes: Conduct interviews with state, community, and organizational leaders engaged in Dementia Friends initiatives by August 2021.

Key Stakeholders: Georgia Division of Aging Services; Georgia Gerontology Society; Dementia Friends network; Alzheimer's Association, Georgia Chapter

Cost Implications: No cost anticipated.

OP2b: Identify and support opportunities to advance progress in communities engaged in dementia-friendly initiatives.

Time Frame and Measurable Outcomes: Compile a list of the contact information for community leads engaged in dementia-friendly or dementia-inclusive initiatives in Georgia by March 2021.

Key Stakeholders: Georgia Division of Aging Services; Georgia Gerontology Society; Georgia Department of Public Health; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; GARD Policy Work Group; communities implementing dementia-friendly initiatives

Cost Implications: No cost anticipated.

OP2c: Recommend strategies to improve/sustain ongoing work in dementia-friendly communities and address gaps related to the development of new dementia-friendly communities across the state.

Time Frame and Measurable Outcomes: Produce and begin to disseminate a Dementia Friends brief that includes community success stories by November 2022.

Key Stakeholders: Georgia Division of Aging Services; Georgia Department of Public Health; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; GARD Policy Work Group; Georgia Gerontology Society

Cost Implications: Dissemination of the brief could have a cost if printed.

OP2d: Collect stories that highlight the impact of dementia-friendly and dementia-inclusive communities to inform advocacy and funding efforts within the state.

Time Frame and Measurable Outcomes:

- Develop a template to use for the collection of stories by January 2021.
- Establish a centralized method of storing collected stories by January 2021.
- Complete first wave of story collection by August 2021.

Key Stakeholders: Georgia Gerontology Society; Georgia institutions of higher education; Alzheimer's Association, Georgia Chapter; AARP

Cost Implications: Dissemination of communications materials could have a cost if printed.

GOAL OP3: Expand Georgia's capacity to promote brain health and address the needs of persons living with cognitive decline and dementia, their care partners, and their families through strategic partnerships and resource sharing, the leveraging of existing funding, and accessing new resources.

Rationale: Building and maintaining strategic partnerships, sharing information and resources, and pursuing new resource opportunities are vital to the progress and sustainability of GARD's work.

Strategies

OP3a: Identify funding opportunities from federal agencies, corporate entities, and foundations to apply for with partners.

Time Frame and Measurable Outcomes: Complete initial scan by September 2021.

Key Stakeholders: GARD Research and Data Work Group; Georgia Division of Aging Services; Georgia Department of Public Health; Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications: None anticipated.

OP3b: Identify and promote strategies to engage private-sector organizations to assist in implementing GARD objectives.

Time Frame and Measurable Outcomes:

- Collect data on dementia-related main objectives and current activities of public and private entities by February 2021.
- Create and maintain a centralized grid of data on relevant entities to identify commonalities and gaps by May 2021.

Key Stakeholders: GARD Research and Data Work Group; Georgia Division of Aging Services; Georgia Department of Public Health; Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications: None anticipated.

OP3c: Develop an action plan to promote public awareness of the objectives of the state and national plan.

Time Frame and Measurable Outcomes:

- Complete action plan by August 2021.
- Initiate engagement in promotion activities by December 2022.

Key Stakeholders: GARD Research and Data Work Group; Georgia Division of Aging Services; Georgia Department of Public Health; Rosalynn Carter Institute for Caregiving; Culture Change Network of Georgia; Alzheimer's Association, Georgia Chapter; Georgia institutes of higher education

Cost Implications: Dissemination of communication materials could have a cost if printed.

POLICY

Goal P1: Inform state budgetary, legislative, and regulatory actions that impact individuals living with cognitive decline and dementia and their care partners.

Rationale: There is a significant opportunity to address the needs of Georgians living with cognitive decline and dementia and their care partners through state-level public policy efforts.

Strategies

P1a: Develop a selection process for the determination of the annual state-level policy platform.

Time Frame and Measurable Outcomes:

- Draft a process by November 2020 for feedback and testing in preparation of the subsequent legislative session.
- Share the process with members of the GARD Collaborative during the November 2020 collaborative meeting and receive feedback.
- Test the process in preparation of the 2021 legislative session from November 2020 to March 2021.
- Refine and update the process by June 2021.

Key Stakeholders: GARD Policy Work Group; GARD Collaborative; Georgia Council on Aging

Cost Implications: None anticipated.

P1b: In partnership with GARD work groups, develop a state-level policy platform that seeks to promote effective interventions and best practices to protect brain health, support individuals living with cognitive decline and dementia, and meet the needs of care partners.

Time Frame and Measurable Outcomes:

- Receive policy issues submitted by members of the GARD Collaborative and members of the work groups annually by November.
- Utilizing the process developed, select the state-level policy platform annually by December.
- In coordination with the GARD Outreach and Partnership Work Group, develop and disseminate communications materials that provide information regarding the state-level policy platform for the GARD website, sharing with stakeholders, and informing policymakers.

Key Stakeholders: GARD Collaborative; Georgia Division of Aging Services; Georgia Department of Public Health

Cost Implications: Development of communication materials provided by Georgia Department of Human Services, Division of Aging Services staff. Dissemination of communication materials could have a cost if printed.

P1c: Educate state-level policymakers on the basics of cognitive health and impairment, the impact of cognitive decline and dementia on care partners and communities, and the role of state government in addressing this priority issue.

Time Frame and Measurable Outcomes:

- Identify policymakers in committees and positions of relevance annually to share information and resources by January.
- Work with committee members and Advisory Council members to educate policymakers throughout each legislative session.

Key Stakeholders: Members of the Georgia General Assembly; GARD Advisory Council

Cost Implications: None anticipated.

P1d: Collaborate with GARD work groups to identify and advance state-level budgetary, legislative, and regulatory issues that are identified through the activities of the work groups.

Time Frame and Measurable Outcomes:

- Meet with members of other work groups quarterly or on an ad hoc basis to discuss issues that could be reviewed and considered for the annual policy platform or other initiatives.

Key Stakeholders: GARD work groups; GARD Advisory Council; Georgia Council on Aging

Cost Implications: None anticipated.

Goal P2: Promote awareness and implementation of local-level policies that support dementia inclusion and dementia friendliness.

Rationale: County and municipal governments have an opportunity to foster dementia-inclusive and –dementia-friendly communities in ways that can support individuals living with dementia and their families to thrive.

Strategies

P2a: Review and assess leadership offered by associations and organizations that provide information and resources related to dementia for county and municipal governments.

Time Frame and Measurable Outcomes:

- Complete an environmental scan that includes key associations and organizations to determine the existing availability of information and resources available by June 2021.
- Identify and share gaps and opportunities for the work group with the members of the GARD Policy Work Group and state plan coordinator by July 2021.

Key Stakeholders: Organization and association representatives; county and municipal government elected officials and staff; GARD Outreach and Partnership Work Group

Cost Implications: None anticipated.

P2b: Develop and make accessible materials and guidance that support county and municipal government elected officials and staff in the journey to dementia inclusion and dementia friendliness.

Time Frame and Measurable Outcomes:

- Utilizing the information learned through the environmental scan, develop a strategy for sharing existing resources by September 2021.
- Utilizing the information learned through the environmental scan, prioritize and address three gaps that could be addressed quickly through the development of resources such as white papers, model policies, and sample resolution language by November 2021.
- Continue to address additional opportunities to provide guidance through adding three new white papers or model policies annually.

Key Stakeholders: Organization and association representatives; county and municipal government elected officials and staff; GARD State Plan coordinator; GARD Outreach and Partnership Work Group

Cost Implications: None anticipated.

RESOURCES

The following is a brief list of key state and national resources addressing the needs of persons living with dementia, their families, and care partners. In acknowledgement that this list does not include all existing organizations due to the continually changing landscape of dementia research and resources, this list is limited to the most current and relevant organizations.

Aging and Disability Resource Connection (ADRC), State of Georgia
https://www.georgiaadrc.com/
Tel: 866-552-4464 (Select Option 2)

The Aging and Disability Resource Connection (ADRC) partners with multiple agencies at both the state and local levels to streamline access to long-term services and supports by serving as a one-stop shop for consumers' aging and disability-related information, counseling, referral, and planning needs.

Area Agencies on Aging (AAA), State of Georgia
https://aging.georgia.gov/locations

Designated as Aging and Disability Resource Connections by the Georgia Division of Aging Services, Area Agencies on Aging support individuals and family members who are aging or living with a disability by alleviating the need for multiple calls and/or visits to receive services. AAAs provide a range of options that allow older individuals and people with disabilities to choose home and community-based services and living arrangements that are best for them. There are 12 regional AAAs across Georgia.

American Parkinson Disease Association, Georgia Chapter
https://www.apdaparkinson.org/community/georgia/
Tel: 404-325-2020

The Georgia Chapter provides educational programs featuring topics that relate to Parkinson's disease and to caregivers. The organization's target audience is people diagnosed with Parkinson's disease and their caregivers, and its goal is also to serve the medical community and the community at large by raising awareness of the disease and the treatments and support available.

The Association for Frontotemporal Degeneration (AFTD)
https://www.theaftd.org/
Tel: 866-507-7222

The Association for Frontotemporal Degeneration (AFTD) is a nonprofit organization that provides information, education, and support to those living with frontotemporal dementia and their caregivers.

The Alzheimer's Association, Georgia Chapter
https://www.alz.org/georgia?set=1
Tel: 1-800-272-3900 (24-hour helpline)

The Alzheimer's Association, Georgia Chapter, is a volunteer health organization in Alzheimer's disease care serving 159 counties in Georgia, with offices in Atlanta, Augusta, Columbus, Dalton, Macon, Savannah, and Tifton. The chapter has been serving Georgia communities since 1982 by providing local support groups, education classes, and other local resources.

Creutzfeldt-Jakob Disease Foundation
https://cjdfoundation.org/
Tel: 800-659-1991

The Creutzfeldt-Jakob Disease Foundation is a nonprofit organization that offers support, information, and guidance to those dealing with Creutzfeldt-Jakob disease.

Family Caregiver Alliance (FCA)
https://www.caregiver.org/taxonomy/term/69
Tel: 800-445-8106

The mission of Family Caregiver Alliance (FCA) is to improve the quality of life for family caregivers and the people who receive their care. For over 40 years, FCA has provided services to family caregivers of adults living with physical and cognitive impairments, such as Parkinson's, stroke, Alzheimer's, and other types of dementia. Services include assessment, care planning, direct care skills, wellness programs, respite services, and legal/financial consultation vouchers.

Georgia Department of Community Health (DCH)
https://dch.georgia.gov/
Tel: 404-656-4507

As it relates to Alzheimer's and related dementias, this agency of state government provides rules, regulations, and guidelines for facilities and programs serving a wide array of individuals, including those living with dementia. Such facilities and programs include adult day programs, assisted living communities, nursing homes, and home health agencies.

Georgia Department of Public Health (DPH)
https://dph.georgia.gov/
Tel: 404-657-2700

The Georgia Department of Public Health (DPH) helps raise awareness and provides education regarding Alzheimer's and related dementias, conducts a survey providing Georgia agencies and other stakeholders with key information to help shape policy and service for those living with Alzheimer's and related dementias, and is a prime coordinator of stakeholders and partners for the Alzheimer's Disease and Related Dementias (ADRD) Registry.

Georgia Memory Net
https://gamemorynet.org/
Tel: 404-727-1568

The Georgia Memory Net is a statewide early diagnosis and treatment program for Alzheimer's disease and related disorders and dementias, supported by the Georgia Department of Human Services (DHS) and Georgia Alzheimer's Project (GAP). The Georgia Memory Net has five regional Memory Assessment Clinics (MACs) to improve Georgians' access to early and accurate diagnosis of Alzheimer's disease and related disorders, and to improve long-term care and outcomes for patients and caregivers.

Huntington's Disease Society of America (HDSA)
https://hdsa.org/
Tel: 800-345-4372 or 770-286-1547

The Huntington's Disease Society of America (HDSA) Georgia Chapter provides educational programs featuring topics that relate to Huntington's disease. The organization's target audience is people living with Huntington's disease and their families. Its goal is also to serve the medical community and the community-at-large by raising awareness of the disease, treatments, research opportunities, and support available locally.

Lewy Body Dementia Association (LBDA)
https://www.lbda.org/
Tel: 800-539-9767

Lewy Body Dementia Association (LBDA) is a nonprofit organization providing information and assistance to individuals living with the disease, caregivers, and medical professionals.

The Rosalynn Carter Institute for Caregiving (RCI)
https://www.rosalynncarter.org/

The Rosalynn Carter Institute for Caregiving (RCI) establishes local, state, and national partnerships committed to building quality, long-term, home and community-based services. RCI focuses on providing caregivers with effective supports to promote caregiver health, skills, and resilience. RCI focuses on helping caregivers coping with chronic illness and disability across the lifespan. RCI's overall goal is to support caregivers — both family and professional — through efforts of advocacy, education, research, and service.

GLOSSARY

Georgia Alzheimer's and Related Dementias State Plan glossary of terms as they relate to this state plan.

Aging and Disability Resource Connection (ADRC) — This statewide coordinated system of partnering organizations is managed by the Georgia Department of Human Services, Division of Aging Services. ADRC provides information about publicly and privately financed long-term supports and services, offers a consumer-oriented approach to learning about the availability of services in the home and community, alleviates the need for multiple calls and/or visits to receive services, and supports individuals and family members who are aging or living with a disability, including those living with Alzheimer's and those who care for them.

Alzheimer's Disease Research Center (ADRC) — The National Institute on Aging funds Alzheimer's Disease Research Centers (ADRCs) at major medical institutions across the United States. Researchers at these centers work to translate research advances into improved diagnosis and care for people living with Alzheimer's disease, and work to find a treatment or way to prevent Alzheimer's and other types of dementia.

Alzheimer's disease — Alzheimer's (AHLZ-high-merz) is a type of dementia that causes problems with memory, thinking, and behavior. Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks. Alzheimer's accounts for 50 to 80 percent of dementia cases, making it the most common form of dementia (Alzheimer's Association, 2016a).

Assisted Technology — Assisted technology includes person-specific technology or devices that help individuals with activities of daily living. As it applies to those with Alzheimer's or a related dementia, assisted technology can be used to trigger memory or to perform routine tasks.

Creutzfeldt-Jakob disease (CJD) — Creutzfeldt-Jakob (CROYZ-felt YAH-cob) disease is the most common human form of a group of rare, fatal brain disorders known as prion diseases. Misfolded prion protein destroys brain cells, resulting in damage that leads to rapid decline in thinking and reasoning as well as involuntary muscle movements, confusion, difficulty walking, and mood changes (Alzheimer's Association, 2016a).

Georgia Division of Aging Services (DAS) — This division of the Georgia Department of Human Services is the State Unit on Aging for Georgia, which carries out service planning functions as detailed in the Older Americans Act of 1965 as amended. DAS performs this function in collaboration with other members of Georgia's aging network — namely 12 Area Agencies on Aging and numerous service providers throughout the state. As it relates to Alzheimer's and related dementias, the Georgia Alzheimer's and Related Dementias State Plan will be managed by the Georgia Division of Aging Services.

Georgia Department of Community Health (DCH) — DCH is one of Georgia's four health agencies serving the state's growing population. DCH provides numerous health care programs and services that benefit the citizens of Georgia, including some of the state's most vulnerable and underserved populations. As it relates to Alzheimer's and related dementias, this agency of state government provides rules, regulations, and guidelines for facilities and programs serving a wide array of individuals,

including those living with dementia. Such facilities and programs include adult day programs, assisted living communities, nursing homes, and home health agencies.

Dementia — Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities (Alzheimer's Association, 2016a).

Dementia-Capable — Dementia-capable means being able to help people living with dementia and their caregivers. More specifically, being dementia-capable means being skilled in identifying people with possible dementia and working effectively with them and their caregivers, being knowledgeable about the kinds of services needed, and being able to inform or refer to agencies and individuals that provide such services (Alzheimer's Association, 2016b).

Dementia with Lewy bodies (DLB) — Dementia with Lewy bodies is a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function due to abnormal microscopic deposits that damage brain cells (Alzheimer's Association, 2016a).

Georgia Department of Public Health (DPH) — DPH is a lead agency in Georgia in preventing disease, injury, and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. As it relates to Alzheimer's and related dementias, DPH helps raise awareness and provides education regarding Alzheimer's and related dementias. DPH's Epidemiology Section conducts a survey providing Georgia agencies and other stakeholders with key information to help shape policy and service for those living with Alzheimer's and related dementias. DPH is a prime coordinator of stakeholders and partners for the Alzheimer's Disease and Related Dementias (ADRD) Registry.

Down Syndrome — Down syndrome dementia develops in people born with extra genetic material from chromosome 21, one of the 23 human chromosomes. As individuals with Down syndrome age, they have a greatly increased risk of developing a type of dementia that's either the same as or very similar to Alzheimer's disease (Alzheimer's Association, 2016a).

Early Stage Alzheimer's — The stage of Alzheimer's where a person may function independently. He or she may still drive, work, and be part of social activities. Despite this, the person may feel as if he or she is having memory lapses, such as forgetting familiar words or the location of everyday objects. Friends, family, or others close to the individual begin to notice difficulties (Alzheimer's Association, 2016a).

Younger-Onset — Younger-onset Alzheimer's affects people younger than age 65. Many people with younger-onset are in their 40s and S0s (Alzheimer's Association, n.d.).

Frontotemporal dementia (FTD) — Frontotemporal dementia (FTD) is a group of disorders caused by progressive cell degeneration in the brain's frontal lobes (the areas behind the forehead) or its temporal lobes (the regions behind the ears) (Alzheimer's Association, 2016a).

GARD — This acronym stands for Georgia Alzheimer's and Related Dementias. GARD can refer to the GARD State Plan, the GARD Task Force, the GARD Advisory Council, or the GARD Collaborative.

Home and Community-Based Services (HCBS) — HCBS provide in-home and community-based care that allows older adults and individuals with disabilities, including individuals with Alzheimer's disease and related dementias, to stay independent and close to family and friends (CMS, 2006).

Healthy Brain Initiative — A partnership between the Centers for Disease Control and Prevention and the Alzheimer's Association to examine how best to bring a public health perspective to the promotion of cognitive health. Resulted in the creation of the publication, *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health,* published in 2007, with the most recent update being published in 2018. Some of the specific recommendations contained in the state plan come as a result of this publication (Alzheimer's Association & CDC, 2018).

Huntington's disease (HD) — Huntington's disease dementia is a progressive brain disorder caused by a defective gene. It causes changes in the central area of the brain, which affect movement, mood, and thinking skills (Alzheimer's Association, 2016a).

Long-Term Services and Supports (LTSS) — A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities (CMS, 2006).

Mattie's Call — Mattie's Call is a safety alert program first established by the city of Atlanta, then subsequently adopted across the country as the Silver Alert. Local public safety agencies send out alerts through A Child Is Missing organization to seek community assistance in finding a missing adult with the goal of returning the individual safely to his/her family.

Mild Cognitive Impairment (MCI) — Mild cognitive impairment (MCI) causes a slight but noticeable and measurable decline in cognitive abilities, including memory and thinking skills. A person with MCI is at an increased risk of developing Alzheimer's or another dementia (Alzheimer's Association, 2016a).

Mixed dementia — Mixed dementia is a condition in which abnormalities characteristic of more than one type of dementia occur simultaneously. Symptoms may vary, depending on the types of brain changes involved and the brain regions affected, and may be similar to or even indistinguishable from those of Alzheimer's or another dementia (Alzheimer's Association, 2016a).

Normal pressure hydrocephalus (NPH) — Normal pressure hydrocephalus is a brain disorder in which excess cerebrospinal fluid accumulates in the brain's ventricles, causing thinking and reasoning problems, difficulty walking, and loss of bladder control (Alzheimer's Association, 2016a).

Older Americans Act (OAA) — The Older Americans Act (OAA) of 1965, as amended, calls for a range of programs that offer services and opportunities for older Americans, especially those at risk of losing their independence. The Older Americans Act focuses on improving the lives of older people in areas of income, housing, health, employment, retirement, and community services. Individuals with Alzheimer's and related dementias benefit from many of these services targeted at keeping individuals in their communities longer.

Parkinson's disease (PD) — Parkinson's disease dementia is an impairment in thinking and reasoning that many people with Parkinson's disease eventually develop. As brain changes gradually spread, they often begin to affect mental functions, including memory and the ability to pay attention, make sound judgments, and plan the steps needed to complete a task (Alzheimer's Association, 2016a).

Person-Centered — Person-centered care is a mindset that sees the people using health and social services as equal partners in planning, developing, and monitoring care to make sure it meets their needs. This means putting people and their families at the center of decisions and seeing them as experts, and working alongside professionals to get the best outcome. Plans and services are developed with attention to each person's unique preferences, skills and abilities, and needs (HIN, 2016).

Vascular Dementia (VaD) — Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of vital oxygen and nutrients. These changes sometimes occur suddenly following strokes that block major brain blood vessels. It is widely considered the second most common cause of dementia after Alzheimer's disease (Alzheimer's Association, 2016a).

Wernicke-Korsakoff syndrome — Wernicke-Korsakoff is a chronic memory disorder caused by severe deficiency of thiamine (vitamin B-1). It is most commonly caused by alcohol misuse, but certain other conditions can also cause the syndrome (Alzheimer's Association, 2016a).

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APPENDIX: STRATEGY ARCHIVE

The 2014 GARD State Plan Strategies were examined through facilitated discussion with each work group. Many strategies were revised and included in the update, while those listed below were archived. Strategies were archived to maintain the historical knowledge of the collaborative, commemorate the achievements of the work groups to date, and to preserve ideas for incorporation into subsequent state plan updates. The 2014 strategies laid the foundation for this initiative and can continue to serve as a resource as the work progresses. Minor wording changes were made to some of the strategies to incorporate positive language that includes words and phrases that address people with dignity and respect.

Research and Data Work Group

Archived Strategy	Status
Implement a State Alzheimer's Disease and Related Disorders Registry to be housed in the Georgia Department of Public Health.	Completed
Add comorbidities to the death certificate to better enable tracking of dementia incidence.	Completed
Destigmatize dementia and encourage individuals to explore concerns about memory problems with their physicians.	Archived for future consideration
Identify and promote culturally appropriate strategies designed to increase public awareness about dementia.	Archived for future consideration
Recognize cognition as a "vital sign" and assess all Medicare patients during the Annual Wellness Visit under Medicare.	Archived for future consideration
Develop a plan to have the diagnosis of dementia routinely recorded in medical records.	Archived for future consideration
Develop a plan for high-risk populations such as persons with mental illness and developmental disabilities to be screened for dementia and, when diagnosed, to have the diagnosis routinely recorded in medical records.	Archived for future consideration
Provide public health awareness, education, and resource information through the Georgia Department of Public Health and other agencies, with website information and media releases.	Archived for future consideration
Pursue public, private, corporate, and philanthropic funding for broad-based statewide educational campaigns.	Archived for future consideration
Promote positive images of people living with dementia and their caregivers to combat stigma.	Archived for future consideration
Identify and promote strategies designed to increase awareness about dementia, reduce conflicting messages, decrease stigma, and promote early diagnosis.	Archived for future consideration
Coordinate efforts to disseminate evidence-based messages about risk reduction for preserving cognitive health.	Archived for future consideration

Ensure that local Aging and Disability Resource Centers as well as Area Agencies on Aging are aware of and promote existing training and informational materials available to family caregivers, especially those located in rural areas.	Archived for future consideration
Integrate Alzheimer's and related dementias awareness training into existing heart, stroke, and diabetes education programs as the risk factors are interconnected — via managing the numbers (blood pressure, pulse, cholesterol, and blood sugar). Integrate into the training that what is good for the heart is good for the brain.	Archived for future consideration
Adopt the 16 action items from the Healthy Brain Initiative Road Map that are relevant to immediate implementation to assist states in becoming dementia capable.	Archived for future consideration
Develop protocols and a corresponding training module to help ensure professionals recognize the role of care partners in the care coordination of persons living with dementia.	Archived for future consideration
Increase awareness among health care professionals about care partner health and its importance in maintaining the health and safety of the person living with dementia.	Archived for future consideration
Develop and implement quality standards for dementia care in state-funded services such as Medicaid State Plan services, HCBS waivers, personal care, and nursing homes.	Archived for future consideration
Require that all state contracts providing services to older adults, including those with developmental disabilities and/or mental illness and comorbid dementia, include quality measures specific to dementia-capable care.	Archived for future consideration
Review HCBS waivers and modify as necessary to provide person-centered care for people living with dementia as well as to expand caregiver support services to family members providing care to people living with dementia.	Archived for future consideration
Evaluate the cost and feasibility of developing state and/or federally funded caregiver support programs for caregivers who do not currently qualify for Medicaid services.	Archived for future consideration
Provide care coordination to people living with dementia and their caregivers upon diagnosis to improve access to information on options and resources.	Archived for future consideration
Establish quality care measures with system benchmarks for facility- and community-based care for persons living with Alzheimer's disease and other dementias.	Archived for future consideration
Identify and promote wide use of evidence-based practices through the development of an evidence-based practice guide specific to Alzheimer's care.	Archived for future consideration

Workforce Development Work Group

Archived Strategy	Status
Survey professionals, utilizing information on licensed professionals from the secretary of state's office, the Georgia Board for Physician Workforce, and other entities as necessary.	Completed
Project the future supply of the workforce and estimate future shortages or surpluses.	Completed

Develop and implement an evidence-based training curriculum and implementation strategies for targeted audiences.	Completed
Recognize agencies and/or organizations that work toward enhancing the wages of the direct-care workforce, the professionalization of direct-care workers, effective coaching, the promotion of direct-care workers' vital role in interdisciplinary teams, and the effective engagement of direct-care workers in care transitions and health IT.	Archived for future consideration
Develop residencies or fellowships for the training of geriatric psychiatrists, geriatricians, and other geriatric specialists.	Archived for future consideration
Develop a specific track on dementia and dementia-related diseases for medical students and residents.	Archived for future consideration
Evaluate the feasibility of a "Bucks for Brains" program to recruit and train geriatric psychiatrists, geriatricians, and other geriatric specialists.	Archived for future consideration
Universities and colleges throughout Georgia, including public entities governed by the Board of Regents and the Technical College System of Georgia, should evaluate existing social, health, and allied health curriculums to ensure adequate basic information is provided on an aging population and Alzheimer's disease and related dementias.	Archived for future consideration
Develop emergency-room specific protocols on appropriate treatment for people living with dementia — including behavior management strategies.	Archived for future consideration
Ensure that these emergency providers understand the role and partnership of the care partner in the emergency care of the person living with dementia.	Archived for future consideration

Public Safety Work Group

Archived Strategy	Status
The Georgia Bureau of Investigation, Prosecuting Attorney's Council, and DAS collaborated on the development of HB 803. The purpose of HB 803 is to prohibit trafficking of an older or disabled adult and to provide for elements of the crime and punishment.	Completed
Georgia Bureau of Investigation and Forensic Special Initiatives Unit have conducted multiple classes of "Responding to Alzheimer's for Public Safety" for approximately 300 public safety officials. The class provides information about issues regarding Alzheimer's and other dementias to increase awareness for public safety officials who encounter adults with dementia.	Completed
Create a network of housing options, personal support services, and other needed services for at-risk adults in need of safe emergency housing due to dangerous situations, such as the absence of a caregiver, wandering, or exposure to potential abuse, neglect, and/or exploitation. The system should have an infrastructure to facilitate access to resources 24/7.	Archived for future consideration

Provide state-approved forms such as the Georgia Advance Directive for Healthcare, Physician Orders for Life Sustaining Treatment (POLST), and other documents at no cost to the consumer via public libraries, resource centers, and easily accessible websites.	Archived for future consideration
Create a 24/7 emergency access line to Adult Protective Services so that law enforcement and other key community safety net agencies/organizations can reach them during the evening, weekends, and holidays.	Archived for future consideration
Implement an educational program for medical providers to increase the use of the STEADI screening tool — Stopping Elderly Accidents, Deaths, and Injuries. This evidence-based practice developed by the Centers for Disease Control and Prevention reduces falls, driving injuries, and other accidents experienced by persons with dementia and other at-risk individuals.	Archived for future consideration
Increase awareness of driving assessment programs in Georgia — to both physicians and families.	Archived for future consideration
Promote programs that (1) ensure home safety through falls prevention programs, home safety assessments, and home monitoring devices; (2) help people with dementia and their families prepare for care and services in the event of a disaster or emergency; and (3) develop employer-supported dementia caregiver training and other employer-supported programs.	Archived for future consideration
Educate caregivers on the importance of home modifications to prevent injury. (Recommendation also noted in Outreach and Partnerships section.)	Archived for future consideration

Service Delivery Work Group

Archived Strategy	Status
Fund a pilot to demonstrate expanded person-centered, evidence-based best practices in long-term care and community-based facilities caring for individuals living with dementia, specifically focused on creating small units (six to 10 residents) based on The Netherlands model.	Completed
Establish criteria which define an effective Alzheimer's/related dementias service delivery system, using other state plans as models, and compile a comprehensive statewide catalog and assessment of Georgia's current service delivery which measures the current system against the proposed established criteria. Funding is necessary to conduct the assessment.	Archived for future consideration
Assign/procure dedicated staff persons or consultants to develop and conduct the assessment.	Archived for future consideration
Identify potential recommendations from other states' plans for consideration (including recommendations that could be implemented prior to completion of the assessment). Resources needed include technical and financial resources to analyze the assessment and implement recommendations.	Archived for future consideration

Raise awareness that individuals with younger-onset Alzheimer's need services targeted to their specific needs.	Archived for future consideration
Recognize self-determination at all stages and allow persons living with dementia to contribute to and control their lives as much as possible.	Archived for future consideration
Work with professional licensing and certification entities to require dementia-specific training in relevant licensing, certification, and continuing education initiatives for health care providers.	Archived for future consideration
Train facility staff to view behavioral "problems" as behavioral expressions that are a way for a person living with dementia to communicate. Train care providers to identify the root cause of behavioral expression and then address the cause through an individualized approach focusing on the strengths and preferences of the individual.	Archived for future consideration
Work with professional licensing and certification entities to require dementia-specific training in relevant licensing, certification, and continuing education initiatives for health care providers.	Archived for future consideration
Develop and make small-scale adult day programs more accessible by offering them through existing service providers.	Archived for future consideration
Create policy within facilities that serve people living with dementia to enforce best practice in design, color, texture, lighting, air change ratio, and sound, thereby promoting the safety, security, and well-being of persons living with dementia.	Archived for future consideration
Educate architects and engineers about the impact of architecture and engineering, reflected through design, color, texture, lighting, air change ratio, and sound on the safety, security, and well-being of persons living with dementia. Educate these professionals through preservice and in-service training.	Archived for future consideration
Provide funding and implement innovative models to increase caregivers' access to respite that is provided through in-home respite providers, adult day services organizations, volunteer-based respite programs, and other sources.	Archived for future consideration
Assure that an appropriate discharge plan is developed for each patient being discharged from a hospital, skilled nursing facility, or emergency room. The plan should be made in collaboration with the individual and family, the physician, and the provider.	Archived for future consideration
Assure that all discharge planners in hospitals, skilled nursing facilities, and emergency rooms have access to region-specific resources, including websites and written literature.	Archived for future consideration
Ensure that discharge planners provide families with access to resource information before discharge occurs.	Archived for future consideration
Fund, implement, and enforce adult day services licensure in order to ensure the quality of providers. Legislation must be passed to secure funding for enforcement of licensure.	Archived for future consideration
Establish and enforce quality care measures related to personalized practices (person-centered care) for facility- and community-based care for persons with Alzheimer's disease and other dementias.	Archived for future consideration

Outreach and Partnership Work Group

Archived Strategy	Status
Provide training modeled after the Dementia Friends program in Japan and the United Kingdom.	Completed
Develop a marketing and media plan with a message that helps reduce stigma and fear related to dementia. Include the developmental disability community in the target population. Determine branding and implement the plan statewide.	Archived for future consideration
Promote advance care planning and advance financial planning to care partners, families, and individuals living with dementia in the early stages before function declines.	Archived for future consideration
Develop a strategic plan that supports faith- and community-based organizations in their efforts to provide early detection, education, and resources for individuals and families experiencing symptoms of memory loss and dementia. Make training programs available for all faith- and community-based organizations.	Archived for future consideration
Engage organizations as repositories that are currently serving in this capacity.	Archived for future consideration
Create funding mechanisms to support family caregivers to keep their family member living with dementia at home longer by providing reimbursement for personal care services, specialized medical supplies, and respite, for example.	Archived for future consideration
Leverage enhanced funding available through the Balancing Incentive Program to increase access to home and community-based services.	Archived for future consideration

Georgia State Plan to Address Senior Hunger

Georgia Department of Human Services

Division Of Aging Services

December 18, 2017

Table of Contents

Executive Summary

Food insecurity is influenced by multiple factors and impacts a person's health, well-being, and quality of life. A 2016 report places Georgia ninth in the nation for the prevalence of food insecurity among people ages 60 and older. The number of older adults in Georgia who currently face the threat of hunger is more than 300,000.

> Georgia defines food insecurity as a person or household facing the threat of hunger, lacking safe and adequate food to sustain health and quality of life, and unsure of the accessibility of or the capability to obtain suitable foods in socially acceptable ways.

Good nutrition is a key factor for older adults to maintain well-being and an independent, healthy lifestyle, and in recovering from an illness or an injury. Reasonably priced, wholesome foods are not always accessible to older adults because of the lack of transportation, health problems and disabilities, and the lack of food stores within close proximity for shopping. One-third of Georgia is a food desert, which makes it problematic for older adults living in these areas to obtain fresh, nutrient-dense food.

The projected growth of older adults aged 65 and over in Georgia is expected to increase 17% by 2032. This rate of growth will push the state's older adult population to over 2 million, which will place the prevalence of food insecurity at more than 360,000 people if the state maintains its current 17.8% growth in older adults facing the threat of hunger. Food insecurity increases negative health outcomes by contributing to and exacerbating disease conditions, and increases medical costs and hospitalizations.

This issue is worthy of attention considering 80% of older adults have at least one chronic disease and 68% have at least two. A person who is not eating a balanced diet with the recommended amounts of calories, protein and essential micronutrients is at a greater risk of

malnutrition, especially if the person has a chronic disease. Adequate nutrition and physical activity are well-documented in the role of the prevention and management of chronic health conditions and malnutrition.

Five areas of impact are selected to address and remedy food insecurity issues in Georgia. These areas are: a) Today's Seniors, b) Health Impact of Senior Hunger, c) Food Access, d) Food Waste and Reclamation, and e) Meeting the Community's Needs. Changing the direction of food insecurity in Georgia requires the coordination, cooperation and communication of health care professionals, faith-based and civic groups, communities, government and other resources all working together for the common good of the state's older adult population.

Glossary

Activities of Daily Living (ADLs): Basic activities of daily living refer to those activities and behaviors that are the most fundamental self-care activities to perform and are an indication of whether the person can care for one's own physical needs. The activities and behaviors are; eating, bathing, grooming, dressing, transfer in and out of a bed/chair, and bowel/bladder continence. (Determination of Need-Revised (DON-R) Training Manual 1998 Georgia Training and Deployment)

Chronic health condition: Those conditions lasting a year or more and requiring ongoing medical attention or limiting activities of daily living. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults, p. 10)

Comorbidities: The simultaneous presence of two or more chronic medical conditions or diseases that are additional to the initial diagnosis (Mosby's Medical Dictionary)

Cost-related medication nonadherence: Taking less medication than prescribed by a health care professional due to cost (Bengle, *et al,* 2010, p. 171)

Disability: A disability attributable to a mental and/or physical impairment that results in substantial functional limitation in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, cognitive functioning, and emotional adjustment. (Older Americans Act, Section 102(8))

Food bank: A nonprofit, charitable organization that collects donated or surplus foodstuffs and distributes it free or at a low cost to programs or organizations that are serving people in need of assistance. (Compilation of e-dictionaries)

Food desert: a neighborhood or rural town that lacks access to fresh, healthy and reasonably priced food or in which food sources are not within a reasonable proximity to the resident's home.

Food insecurity (United States Department of Agriculture [USDA]): "Food insecurity is a household-level economic and social condition of limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways." (Economic Research Service of the USDA)

Food insecurity (Georgia's working definition): A person or household is considered food insecure when facing the threat of hunger and lacking safe and adequate food to sustain health and quality of life, and is unsure of access or the capability to obtain suitable foods in socially acceptable ways.

Hunger: "Hunger is an individual-level physiological condition that may result from food insecurity. It refers to a potential consequence of food insecurity that, because of prolonged, involuntary lack of food, results in discomfort, illness, weakness, or pain that goes beyond the usual uneasy sensation." (Economic Research Service of the USDA)

Instrumental Activities of Daily Living (IADL): The more complex activities associated with daily life, which are essential to being able to live independently in the community. The IADLs include; managing money, telephoning, preparing meals, laundry, housework, outside home,

routine health, special health and being alone. (Determination of Need-Revised (DON-R) Training Manual 1998 Georgia Training and Deployment)

Malnutrition: A state of deficit, excess, or imbalance in energy, protein or nutrients that adversely impacts an individual's own body form, function, and clinical outcomes. (National Blueprint: Achieving Quality Malnutrition Care for Older Adults)

Obesity: ≥ 30 BMI. Weight that is higher than what is considered healthy for a given height is described as overweight or obese. Body Mass Index, or BMI, is used as a screening tool for overweight or obesity. It is not an indicator of a person's overall health. (CDC.gov)

Quality of Life (QoL): The degree to which a person is able to function at a usual level of activity without -- or with minimal -- compromise of routine activities; QoL reflects overall enjoyment of life, sense of well-being, freedom from disease symptoms, comfort and ability to pursue daily activities. (McGraw-Hill Concise Dictionary of Modern Medicine, 2009)

Seniors/Older Adults: Individuals who are aged 60 years of more are considered older adults for the majority of Older American's Act programs. However, some programs begin this designation at 55 and others at 65. For the purpose of the Georgia Senior Hunger State Plan, 60 years old or older is the designation.

Undernutrition: A form of malnutrition characterized by a lack of adequate calories, protein or other nutrients needed for tissue maintenance and repair.

Brief National Overview of Senior Hunger

Growth of older adult population and most common health conditions

It is well-documented that the U.S. population is aging in greater numbers than ever before in history. By the year 2030, the number of adults age 65 and older is expected to reach 74 million (Avalere & Defeat Malnutrition, 2017). (See Appendix I)

The older adult population is projected to reach 82.3 million (21.7% of the total population) by the year 2040 (Administration for Community Living [ACL], 2016, p. 6). (See Appendix II)

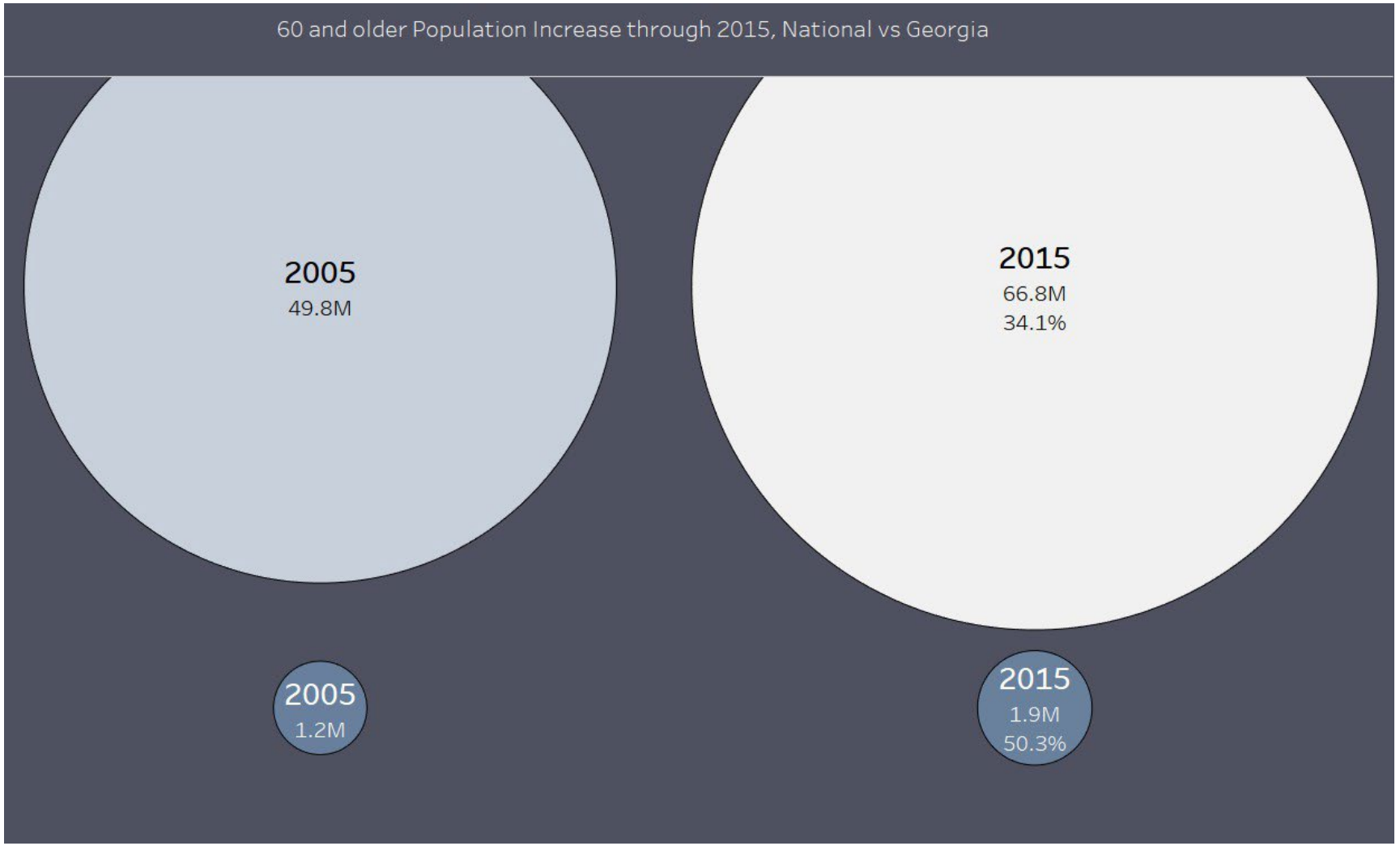
The report compiled by ACL, "A Profile of Older Americans: 2016," provides the following data regarding the growth of the older adult population in the United States:

- About 1 in 7 -- or 14.9% -- of Americans are age 60 or older.
- Between 2005 and 2015, this population increased 34% -- from 49.8 million to 66.8 million. It is projected to be 98 million by 2060. (See Figure 1)
- The number of Americans age 45 to 64 who will reach 65 over the next two decades increased by 14.9% between 2005 and 2015.
- Adults reaching age 65 have an average life expectancy of an additional 19.4 years (20.6 years for women and 18 years for men.)

This change in demographics is noteworthy, considering that most older adults have at least one chronic health problem, and many have multiple health conditions. The 2016 Profile shows that seniors spend a larger proportion (12.9%) of their total expenditures on personal health care compared with other age groups. A compilation of data and reports indicate the health problems frequently increased when coupled with food insecurity in the older adult population are:

- Depression (233%)
- Hypertension (Men 72%, Women 80%)
- Diabetes (22%)
- Any cancer (32%),

Figure 1



Profile of Older Americans: 2016, Administration on Community Living (ACL) (See Appendix 2)

- Diagnosed arthritis (53%)
- All types of heart disease (35%)
- Limitations in activities of daily living (32%)
- Asthma (2%),
- Poor gum health (68%)
- Malnutrition (46%)

(ACL, 2016; Centers for Disease Control and Prevention [CDC], 2016; Kaiser et al., 2010; Ziliak & Gundersen, 2014)

The prevalence of food insecurity exacerbates these health problems. Food insecurity has been linked to inadequate nutrition and worsening of disease. Seniors with low intake of calories, protein and essential micronutrients are at a greater risk for an increase in osteoporosis, infections, an undesirable weight, restricted physical activity, cognitive impairment and malnutrition. The lack of adequate nutrition negatively affects diseases that can be effectively managed with diet and medication, and it may lead to unforeseen health crises. Heart disease, high blood pressure and diabetes are examples of conditions that can be managed with balanced diet and appropriate medication.

Food insecurity often leads to undesirable behaviors such as medication nonadherence, which in turn may lead to early hospital readmission and extended hospital stays. Food insecurity potentially has greater consequences for older adults when health status and disease are considered. Authorities on healthy lifestyle choices recognize and support the role that nutrition and physical activity play in the management and prevention of chronic health conditions and malnutrition.

Impact of food insecurity on individual health and health care system

Prior to 1995, the terms hunger, poverty and unemployment were used interchangeably in public policy and public health discussions even though they addressed different problems. The Task Force on Food Assistance appointed in 1983 by President Ronald Reagan concluded that hunger referred to the physiological condition and was separate and distinct from food insecurity. The current standardized measure of food insecurity was developed in 1995 and is

used in official publications and most other research on this topic. The Economic Research Service (ERS) of the U.S. Department of Agriculture (USDA) defines hunger and food insecurity as follows:

> *Hunger* is an individual-level physiological condition that may result from food insecurity. It refers to a potential consequence of food insecurity that, because of prolonged, involuntary lack of food, results in discomfort, illness, weakness or pain that goes beyond the usual uneasy sensation. (ERS USDA)

> *Food insecurity* is a household-level economic and social condition of limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. (ERS USDA)

The number of seniors experiencing food insecurity in 2016 exceeded 15%, more than 10 million people. This was 600,000 more people than in 2013, according to the June 2016 annual report, “Hunger in America in the Senior Population,” prepared for NFESH (Ziliak & Gundersen, 2016). (See Appendix IV)

Households with limited resources and food insecurity are forced to choose between the basic necessities of food, housing, medical care and medications. Routine visits to the doctor may be postponed until the individual is in a health crisis, and must therefore be seen in acute care or the emergency room, or potentially is admitted to the hospital. Cost-related medication nonadherence behaviors, such as skipping or reducing doses, delaying medication refills or avoiding filling new prescriptions, can lead to a health crisis for an individual and the exacerbation of disease. These situations result in detrimental health consequences and an increase in health care costs, which place an increased burden on the health care system. The costs associated with food insecurity warrant examination considering three-fourths of people

age 65 or older have a chronic health condition (Avalere & Defeat Malnutrition Today, 2017). (See Appendix I, p.10)

Food Insecurity National Demographics

Research has identified multiple risk factors associated with senior food insecurity. These include: race, ethnicity, employment status, age, gender, metropolitan versus non-metropolitan, income, having a disability, and marital status. Older adults who live alone are at a greater risk for food insecurity. Reports indicate that at least 1.2 million seniors in the U.S live alone. The possibility of an older adult being food insecure increases when the person lives in a rural area. A grandchild living in the household with an older adult increases food insecurity to more than twice that of a household without a grandchild, because the grandchild is given priority for having food. Ziliak and Gundersen's 2014 report revealed that food insecurity among people between ages 60 and 64 are approximately 50% higher than those over age 80. Seniors living in the South and the Southwest are consistently at greater risk for food insecurity. Food insecurity is shown to be 8.3% when at least one member of the household is age 65. Racial or ethnic minorities, people with a high school education or less, households with lower incomes and people with a disability are most likely at risk to be food insecure. However, Ziliak and Gundersen's 2016 report reveals that food insecurity also occurs in households with incomes above the poverty line and is present in all races.

Senior Hunger in Georgia

The 2017 Ziliak and Gundersen report "The State of Senior Hunger in America 2015" places Georgia as tenth in the nation for the prevalence of a threat of hunger in older adults. This report compares aspects of hunger and food insecurity across the nation. It has been produced annually in partnership with the National Foundation to End Senior Hunger since 2008. (See Appendix IV, p. 6) Georgia considers food insecurity a priority for current and future public health at large, program developers, health care professionals and policy makers. The state recognizes the consequences of food insecurity and is developing a state plan to end senior hunger in Georgia. At the initiation of this project Georgia was ranked ninth in the nation (Ziliak and Gunderson 2016)

Georgia Senior Hunger Initiative Definitions: Food Insecurity and Seniors

The USDA food insecurity definition is just one of many in use by various agencies and organizations. Here is how the Georgia Senior Hunger initiative defines food insecurity:

> A person or household is considered food insecure when facing the threat of hunger and lacking safe and adequate food to sustain health and quality of life, and is unsure of access or the capability to obtain suitable foods in socially acceptable ways.

NFESH annual reports characterize food insecurity into the following categories:

- Fully food secure
- Threat of hunger
- Risk of hunger
- Facing hunger

The category of food insecurity in a household is determined by the number of affirmative responses to questions on the Core Food Insecurity Module (CFSM). (See Appendix IV, p. 3)

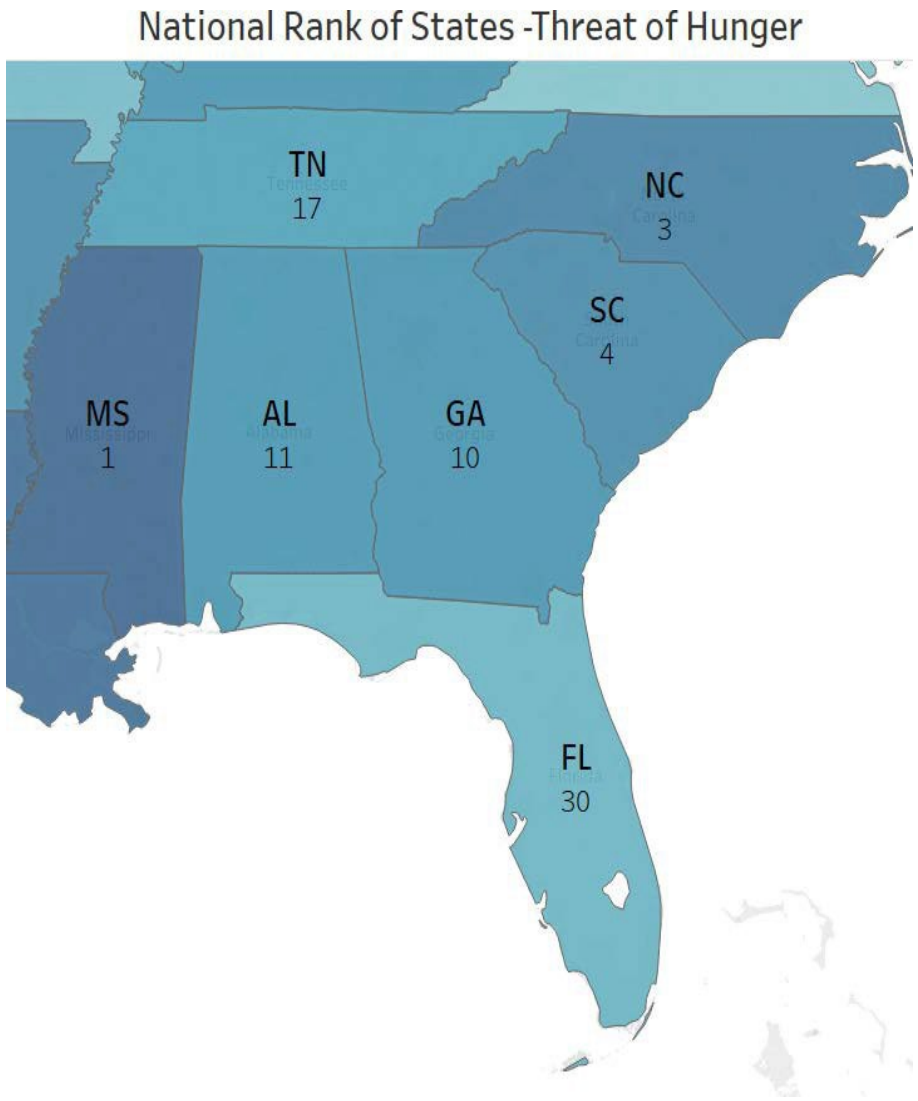
The CFSM is considered the standard tool for measuring household food insecurity rates. Georgia utilizes the CFSM 6-item battery of questions. (See Appendix V). For example, a person who answers yes to one or more questions on the CFSM is in the marginally food insecure category of facing the threat of hunger. Georgia defines the terms “senior” and “older adult” as age 60 and over and uses the threat of hunger throughout the proposed Georgia Senior Hunger plan to designate a person food insecure.

Georgia’s Senior Population and Food Insecurity

Georgia currently ranks fourth in growth rate of older adults age 65 and older when comparing the state’s population in 2010 with 2015 based on the Census Bureau American Community Survey data. Utilizing the same data source, the projected growth of the same demographic group is 17% by 2032 and 18.9% by 2050. The 2009 Ziliak and Gundersen report that examined hunger in rural and urban areas on behalf of the Meals on Wheels Association of America Foundation (MOWAAF), revealed Georgia as one of the top five Southern states with the highest average rates of food insecurity over a six-year data collection time-period (2001 to 2007). (See Appendix VI, p. 21) (See Figure 2)

When compared nationally with other states in 2015, Georgia’s 65-and-older population ranked 14th (9.7%) in poverty, 17th (36.5%) in 65-and-older individuals with at least one disability, and sixth (7%) for 60-and-older grandparents living with grandchildren.

Three risk factors for food insecurity are: low income, disability, and grandchildren living in the household. Combining two or more of these risk factors within a single household has a



Ziliak, J.P., Gundersen, C. (2017). The state of senior hunger in America 2015: An annual report. Report submitted to the National Foundation to End Senior Hunger. *Lexington, KY: UK Center for Poverty Research, University of Kentucky*.

multiplier effect, increasing a person's risk for being food insecure. According to the 2015 American Community Survey (ACS) Census data, 11.3% (191,610) of 60-and-older adults in Georgia live in poverty. Overall, 33% (559,561) of Georgia's 60-and-older population have at least one disability. Seniors who are living below the poverty line and are responsible for grandchildren is 23.7%. Of this population, 34% of grandparents 60 and older have a disability. Disabilities add a special constraint to the ability to gain access to and prepare food.

Social isolation is also recognized as a factor that increases the risk of food insecurity. The 2015 ACS Census data for Georgia indicates that 300,000 adults age 65 and older live alone, more than a quarter of that population. (See Appendix VII). The same report revealed that more than 15.7% (186,900) live in rural areas. In 2017, the percentages of people living below the federal poverty level ranges from 12.3% to 30.3%. The percentage of people living at 100% to 200% of the poverty level were 27.8% and 48.1%, respectively. (See Appendix VII)

The Georgia maps indicate people living in poverty are primarily in the rural areas and not in major cities.

Isolation affects the ability to obtain food, as the area may not have available transportation or an easily accessible grocery store with reasonably priced, wholesome foods. Neighbors or family members may not live close by to assist with food shopping or meal preparation for an older adult who is not well or has a disability and is unable to cook. A person is less likely to prepare food and eat alone if another person who lived in the household has died or no longer lives there. Ziliak and Gundersen's 2008 report reveals that social isolation created by the loss of access to emotional and financial support due to changes in life events increases the "likelihood of being at-risk of hunger that is of comparable magnitude to living in poverty" (p. 41). (See Appendix VIII)

Health Impact of Food Insecurity in Georgia

Food insecurity influences a person's well-being and health care from multiple perspectives. Older adults in food insecure households often use medication nonadherence as a coping strategy. Bengle, *et al.* (2010) conducted a statewide study of low-income food insecure individuals who reported cost-related medication nonadherence, and found that the percentage of adherence range between 42.9% for those with drug coverage insurance and 52.6% among those without coverage. A significant number had a previous diagnosis of diabetes and coronary heart disease. Food insecurity exacerbates these chronic conditions, for which expensive prescriptions and dietary treatments are required.

A balanced, nutritious diet, appropriate exercise, a suitable medication regimen and good medical care affect heart disease and diabetes, both of which are leading causes of death in Georgia. Frequently, obtaining foods that provide the required nutrients is problematic for food-insecure households due to lack of accessibility to grocers and/or reasonably priced wholesome foods. The available low-cost food choices are commonly limited to high-calorie, low-nutrient dense foods. The prolonged intake of high-calorie, nutritionally inadequate foods leads to weight gain and establishes an undesirable food intake pattern. A nutritionally inadequate diet may leave a person without enough energy to exercise or complete routine daily tasks. A consistent lack of exercise combined with steady weight gain can lead to obesity, which is frequently seen in low-income populations. Multiple adverse health conditions such as diabetes, arthritis, hypertension, heart and cardiovascular diseases and physical disabilities are prevalent in persons who are obese. It is important to recognize that obesity does not equate to nutritional adequacy or the overconsumption of food.

The combination of disease and food insecurity can increase the risk of or add to the already existing condition of malnutrition that is frequently seen in the older adult population. Diseases can cause lack of absorption, a decrease in appetite, and a decline in the ability to obtain and prepare food for oneself. Medications can have side effects such as nausea,

vomiting and altered taste sensation so a person loses the desire to eat. A person who is malnourished does not have the proper nutrients required to maintain health, to heal from an injury or to recover from an illness. Malnutrition increases the chance of infections, worsening diseases and disability. It also increases the possibility of an emergency room visit or hospitalization.

Cost Impact of Food Insecurity in Georgia

A study conducted by Goates, Braunschweig and Arensberg (2016) estimated Georgia's direct medical cost of disease-associated malnutrition for 65-and-older adults at $125,373,000. Protein/calorie malnutrition increases the cost of a hospital stay by approximately $25,200, based on 2016 prices. A malnourished older adult who is admitted to the hospital has a four- to six-day longer length of stay, more comorbidities, a 50% higher readmission rate, and five times the likelihood of death compared with hospital stays of adults without malnutrition.

Recognizing the rise in costs when a malnourished older adult is admitted to the hospital, the Centers for Medicare and Medicaid Services have proposed to adapt the 2017 recommendations of the Malnutrition Quality Improvement Initiative (mqii.today) into a future Hospital Inpatient Quality Reporting Program. "A Profile of Older Americans: 2016" showed Medicare as the primary method of payment for health-care-related expenditures for adults 65 and older. (See Appendix II, p. 13)

Older adults with chronic diseases and/or malnourishment use Medicare more than people who are healthy. Recent research strongly suggests that "up to one out of every two older Americans is at risk for malnutrition" (See Appendix I, p. 11). Addressing the risk factors that perpetuate food insecurity, a decreased quality of life, malnutrition and escalating health care costs within the state's communities, and improving the programs and policies that influence these risk factors, are necessary measures to bring an end to the detrimental conditions that an estimated 307,983 older adults living in Georgia are facing.

Gaining a Statewide Perspective

To ensure that this plan reflects Georgia both regionally and as a unified state, four groups of stakeholders participated in collecting data. Those groups are: the Senior Hunger Summit Planning Committee, the Senior Hunger Fighter Workgroups, the participants in 12 regional listening sessions and conference attendees at two statewide aging conferences.

The Senior Hunger Summit Planning Committee initiated the work. The committee represented multiple areas of the state and different aspects of the provision of nutrition services. The group included meal service providers, food banks, directors of Area Agencies on Aging, advocates, county-based agencies, and staff from the Department of Human Services Division of Aging Services (DHS DAS). This group reviewed the state and national research and decided upon the five primary focus areas:

- Access to food
- Impact of senior hunger on health
- Food waste and reclamation
- Today's seniors
- Meeting the needs of the community

The group also worked to develop the senior hunger summit agenda and ensure that outreach was as broad as possible.

During the first Georgia Senior Hunger Summit, the Senior Hunger Fighter Workgroups convened as the final session facilitated discussion groups, and the information was recorded and disseminated to the group. Meetings and conference calls were held for each of the five workgroups reviewing and developing the information. A final conference call was held to distill the initial information into some actionable recommendations. (See Appendix IX)

Following the Senior Hunger Summit in 2016, 12 listening sessions were conducted across the aging network planning and service areas through a partnership with the North Highland consulting group and the Georgia Area Agencies on Aging (AAAs). (See Appendices X, XI, XII). Each AAA publicized and hosted the event. Copies of the five topic areas were provided to the attendees ahead of time. The North Highland consultants conducted the listening sessions using multiple methods to capture the information (computer recording of the conversations, Post-it note collections from the participants and follow-up survey).

The final outreach and data collection was held at two statewide aging conferences -- the Aging and Disability Resource Connection (ADRC) Healthy Communities Summit 2017, and the Georgia Gerontology Society Annual Conference 2017. During these two sessions, the five focus areas were presented along with emerging themes from the listening sessions. The session attendees were then able to add their comments, concerns and ideas to the information collected. (See Appendices XIII, XIV)

Common Themes in Each Focus Area

Food Access	
Transportation	Door-through-door service is needed for more frail seniors.
	Transportation availability is lacking in urban and rural areas.
	Communication between resources needs improvement.
Food Deserts	
	Some rural counties are lacking grocery stores.
	Distance to grocery stores for seniors without cars is too great.
	Alternatives such as general/convenience markets with healthy options need to be explored.
	Food delivery services are an option.

	Farmers markets and other agricultural options to meet needs.

Today's Seniors	
	We need to have an understanding of who is considered a senior for various programs and what generational differences exist.
	Many seniors care for grandchildren and may defer to their nutritional needs first.
	Services tend to be offered during week days. Today's seniors need more options.

Food Waste and Reclamations	
	Clear and consistent policy is needed.
	Stronger outreach for food collection agencies is needed.
	Enhancing partnerships may allow for greater reach.

Meeting the Needs of the Community	
	Better communication of available services needed to prevent duplication.
	Better communication and partnership with the faith-based community is needed.
	Partnerships with schools could be helpful.

Five Impact or Focus Areas

Five areas of focus were selected by the Senior Hunger Summit Planning Committee. These areas were selected after review of the national hunger reports with the purpose of creating actionable items for Georgia. They are: Today's Seniors, Impact of Senior Hunger on Health, Food Access, Food Waste and Reclamations, and Meeting the Needs of the Community.

Today's Seniors

One significant challenge that communities, agencies and program administrators working with the older adult population face are the differences in needs/requirements and likes/dislikes among various generations. The young-old (ages 60 to 69) and middle-old (70-79) may have different dietary and health needs than the oldest-old, (80 and older). Advances in health care are allowing people to live longer but not always independently. Even though some of the oldest-old are very active and healthy, many others are dependent on someone for transportation, meal preparation and more. The young-old also may be taking care of an aging parent while continuing to work and run a household.

Rural areas are experiencing a migration of youth away from small towns to larger cities. This creates a shortage of people in rural areas and small towns to take care of and help older adults who are dependent on assistance. Food stores may be in near proximity, but an older adult may not be physically able to grocery shop or to prepare meals if groceries are available.

Georgia's growing cultural diversity also affects food security. Older adults who come from other countries and cultures may not be familiar with available local foods and may not know how to prepare them, creating a situation of food insecurity for them. Food stores catering to a specific culture may not be in the area. Communication can be limited if there is not a common language between older adults and the people helping them. Agencies or

organizations distributing food to those in need may not be able to accommodate the culturally diverse needs of the older population.

There are vast differences in interest and skill level in technology among older adults. The younger-old are more likely to have the interest and the skills to utilize computers to order food items online, whereas the oldest-old may not.

Health Impact of Senior Hunger

It is well-documented that nutrition affects a person's health. Heart disease, diabetes and kidney disease are influenced by diet. The only choices a food-insecure person may have available are high-salt, high-fat, high-sugar, low-nutrient dense foods if resources for fruits, vegetables, and quality protein are limited or not accessible in the area. Special dietary requirements are usually recommended by a health care professional as one component of treating the patient. Frequently, the professional does not consider whether the special dietary requirements are within the patient's finances or whether the special items are available where the patient buys food. The professional may not be aware of community resources to recommend to the older adult when assistance is needed in acquiring the proper food.

Disease conditions become more complex when an individual is obese. Georgia ranks 19th in the nation for prevalence of obesity. A food-insecure older adult might be limited to high-calorie, nutrient-deficient foods, which can contribute to obesity. Obesity can lead to arthritis and other joint problems which affects the ability to perform IADLs, such as grocery shopping and food preparation.

Older adults who are food insecure are not eating sufficient amounts of calories, protein and micronutrients, which can contribute to frailty. Calcium, magnesium, vitamin D and iron are micronutrients required to maintain muscle strength and bone integrity. Muscle weakness, osteoporosis and weight loss are often found in frail individuals. This, in turn, can lead to the inability to perform IADLs, an increase in falls, disability, the worsening of diseases and

hospitalizations. Frailty and the risk of falling are concerns for older adults. Falls are the leading cause of injury-related emergency room visits, hospitalizations and deaths for Georgians 65 and older. Falls affect quality of life and are costly in terms of well-being, cost and time spent recuperating.

Older adults who are food insecure are 60% more likely to experience depression. Worry, anxiety and stress associated with threat of hunger and lack of suitable foods to sustain health have negative outcomes on well-being, quality of life and mental health for older adults. Seniors who are food insecure self-reported poor or fair health when compared to food-secure seniors. Fruits and vegetables are commonly lacking in food-insecure households. Fruits and vegetables contain the micronutrients vitamin C, vitamin B, iron and a form of vitamin A. These nutrients are known to be effective against depression and to enhance overall well-being.

Food Access

The availability of local food sources strongly impacts food insecurity. Neighborhoods and rural areas with limited access to food make it difficult for older adults to obtain nutritionally rich foods for a healthy diet. Areas that are void of food sources within a reasonable distance to an individual's home are called food deserts. Georgia food deserts occur both in urban and rural settings. A food desert is defined as a neighborhood or rural town that lacks access to fresh, healthy and reasonably priced food, and food sources are not within a reasonable proximity to the resident's home. Georgia considers a half-mile as reasonable proximity. One-third of Georgia is considered food desert.

For older adults, transportation can be a significant barrier to food access. Even when food resources such as congregate meal sites, community gardens, food banks or farmers' markets are in their area, older adults may not be able to drive, and public transportation is often not available in rural or less-populous areas. In a low-income neighborhood or for an older adult who is frail or has a disability, public transportation may be available but not manageable. The

cost of a private taxi service or ownership of a vehicle may be prohibitive when there are financial constraints in the household. Many communities do not have services that provide transportation at a reduced cost for older adults.

Many seniors are eligible for the Supplemental Nutrition Assistance Program (SNAP) benefits but do not sign up because the enrollment process for the program can be confusing or difficult to an older adult. Enrollment is available online, but that is not a viable option if the older adult does not have internet access, does not own a computer, or does not have computer skills. Many older adults do not apply for SNAP benefits even if they are eligible because they view them as degrading and a form of dependency.

Food Waste and Reclamation

Food is wasted daily in communities. For example, grocery stores that have strict “sell by” dates throw food away, as do restaurants that have unserved leftovers. Crops are plowed under and left to rot in the fields by farmers who have more than they can sell or personally use. Local schools discard opened cases of canned goods rather than donating the items to food-insecure households. Each of these sources could provide food to people in need. Unfortunately, businesses and organizations do not have a clear understanding of the laws addressing the donation of food, so they hesitate to do so out of concern for liability.

Federal laws exist to encourage and support the donation of unused food that is kept at proper temperatures and is safe to consume. The Bill Emerson Good Samaritan Food Donation Act provides liability protection to donors of food and grocery products to qualified nonprofit organizations. The Internal Revenue Code 170(e)3 provides tax deductions to businesses that donate wholesome food to qualified nonprofit organizations serving the poor and needy. Gleaning programs can be implemented to collect fresh foods from farms, gardens, and farmer’s markets. The food is then distributed to food-insecure households.

Communities may have farmers or businesses willing to donate food, but the appropriate transportation may not be available. Certain food items must to be transported under refrigeration to keep them safe for consumption. An appropriate vehicle may be available during "off hours," but the farmer or business may not be aware of the availability.

It is important for individuals, organizations and community groups to work together to support efforts in eliminating senior hunger. Collaboration is also critical to avoid duplication of services to food-insecure households while other people in need of food are overlooked.

Meeting the Community's Needs

Addressing food insecurity is a community affair. Communication and coordination among businesses with food to donate, agencies distributing food, transportation businesses and officials, health care professionals, public safety officials, policy makers and the faith-based community are key in assuring a healthy, food-secure future for older adults. Different types of community organizations may be addressing the same issue while unaware of each other's programs. Faith-based groups, civic groups, colleges, universities, neighborhoods and local government all have resources that may overlap while some areas go unserved. Improved communication and partnerships may be in order to share resources and identify service gaps.

Recommendations

- **Develop Regional Coalitions** in 12 regions of the state to bring together the aging network with for-profit, nonprofit, faith-based, civic, health care and other organizations, older adults and their caregivers. These coalitions would address a number of concern areas found during the data collection phase and would track the number of deliverables each year, including but not limited to:
    - Reduction of duplication of services
    - Conducting community needs assessments
    - Shared knowledge of regional and local issues
    - Shared knowledge of regional and local resources
    - Locally designed interventions such as community gardens, pantry programs and volunteer transportation services
    - Hold a minimum of four meetings each year
    - Annual report
    - Daylong pre-conference intensive at the ADRC Healthy Communities Summit

- **Establish DHS DAS Senior Hunger Position** to perform the following duties at a minimum:
    - Coordinate the 12 regional coalitions
    - Coordinate a Policy Review Council
    - Develop and disseminate nutrition education and other education resources
    - Develop toolkits for statewide use
        - Assistive Technology to help with food needs
        - Outreach to community programs
        - FAQs and “How to talk” about the issue
    - Coordinate with Universities and other partners for data analysis and other hunger prevention projects
    - Coordinate waste prevention initiatives and ongoing best practice sharing
    - Coordinate the Senior Hunger Track at the Healthy Communities Summit
    - Manage implementation of the State Plan for Senior Hunger

- **Establish Policy Review Council** to review policy that impacts a variety of aspects of senior hunger, from food reclamation to information sharing. This recommendation addresses the following concern areas; better communication across programs, consistent policy development to support state plan initiatives, adaptation as needed in a changing environment. This council would include state departments and divisions such as DHS DAS and the departments of Public Health, Community Health and Agriculture
    - Meet quarterly to review issues that arise in regional coalition meetings
    - Review current and proposed policy to suggest changes to allow great efficiency in food processes
    - Share enrollment in state programs to alleviate some of the paperwork for older adults across SNAP, Public Housing, Senior Community Programs, etc.

- **Coordinate Data Collection and Analysis** to measure the success of the state plan on senior hunger across organizations
    - Health Care Utilization Data
    - The Food Security Survey (expand to other agencies using the six-question survey for consistency)
    - Total number of food-insecure seniors current vs. projected
    - Rural vs. urban needs and resources
    - Return on investment for health impact
    - Ensuring service delivery to those in the greatest need
    - Others…

- **Develop and Provide Education and Training for Agencies, Stakeholders and Individuals across a variety of topics**
    - WebEx trainings and discussions held regularly
    - Regular nutrition education meetings to develop and disseminate senior appropriate nutrition education
    - Healthy Communities Summit Pre-Conference Intensive and Senior Hunger Track
    - Meeting in Macon at the DHS training center to keep conversations moving and idea-sharing open annually
    - Host workshops
        - Review state statistics
        - Review state and federal policies
        - Develop understanding of the current issue and programs in need of expansion

- **Continue and Expand the What a Waste Program with the National Foundation to End Senior Hunger.** This recommendation addresses the food waste and reclamation focus area and allows better use of the resources already available.

- **Provide Entrepreneurial Mini-Grants** to support creative initiatives that alleviate the issues of senior hunger, food deserts and isolation. These would be small grants designed to stimulate local problem solving at the local level
    - Food Mobile Ideas
    - Others…

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Appendices Table of Contents

SECTION 3017 – Emergency Planning and Management

POLICY STATEMENT:	Area Agencies on Aging (AAA) are responsible for identifying themselves to and consulting with local (county and regional) emergency management agencies; public utilities; law enforcement authorities; other community service providers; state, county and municipal governments; and any other entities or organizations which have an interest or role in meeting the needs of the elderly in planning for, during and after natural, civil defense or other man-made disasters.
REQUIREMENTS:	AAAs are expected to • Designate a staff person to have primary responsibility for emergency management planning and coordination; • Participate in state, regional, county and/or municipal planning activities with other human service agencies and entities and organizations charged with the responsibility of meeting the needs of disaster victims; • Assist in identifying "at risk" elderly in the planning and service area, including but not limited to current consumers of contracted services; • Require by contract provision that service providers develop plans for emergency management that fit the scope of their individual operations; • Assure by annual review that service providers' policies, procedures and capabilities are adequate to meet the needs of the elderly in their areas prior to, during and after emergencies; • Provide periodic training to providers regarding emergency management resources and activities; • Upon request, provide information to the Division of Aging Services (DAS) regarding the impact of emergencies on the elderly population in the planning and service area; • Provide authorized services to the elderly victims of disasters;

REQUIREMENTS, cont:

- Collect data necessary to submit reimbursement requests for services provided during the emergencies, which may be covered by other sources of funding available outside the aging program contract for disaster assistance;

- Participate in initial meetings of FEMA and GEMA on-site teams to assist in establishing recovery operations when appropriate.

SCOPE OF EMERGENCY PLANS and ACTIVITIES

AAA plans will address four categories of activity: preparation, immediate response and stabilization, recovery and evaluation.

Preparation

AAA emergency plans will address at a minimum:

- the types of natural disasters prevalent in the planning and service area (those that reasonably can be anticipated);

- the AAA's capabilities and limitations in addressing such incidents;

- ongoing maintenance and updating of resource databases;

- AAA emergency policies and procedures, including:

    - staff duties and responsibilities, including specific chain of command and alternates, if agency leadership is unavailable;
    - alert procedures for working and non-working hours;
    - procedures for providing for alternate communications channels and equipment;
    - locations of operations centers and alternates when primary offices are affected;
    - assuring availability of office supplies for alternate locations, staff identification badges, and the like.
    - roles of various relief organizations operating in and primarily responsible for relief authority in the area;
    - strategies for maintaining contact with staff, local organizations, and the Division if essential public services, such as communications and transportation, are limited or unavailable;

SCOPE OF EMERGENCY PLANS and ACTIVITIES, cont.

Preparation, cont.

- current disaster response systems and the Area Agency's linkages to, for example, county law enforcement and public safety agencies, emergency management agencies;
- community education to alert first responders/other entities to special needs of the elderly and the Area Agency resources;
- identification and mapping, if feasible, of heavy concentrations of elderly, including those residing in institutions, and households in which seniors reside alone, including apartments, and mobile homes;
- demographic profiles of elderly in the area for targeting of specialized recovery assistance.

Response

The initial reaction to ensure safety, hygiene/sanitation, and security, either in advance of an impending emergency or immediately following, will include:

- initiation of planned communications strategies and determination of impact of disaster on staff;
- assignment of duties;
- contact with key providers;
- initiation of disaster-specific record-keeping, including but not limited to records of :
  - staff time, including overtime;
  - supplies used;
  - documentation of contacts with seniors;
  - type and amount of services provided;
  - personal expenses;
  - specific telephone logs.

SCOPE OF EMERGENCY PLANS and ACTIVITIES, cont.

Response, cont.

- preliminary assessment of scope of impact, including, but not limited to:
    - geographic scope and numbers of affected elderly/other target populations and their short and long term needs;
    - kinds of services needed, including impact on transportation resources;
    - identification of service gaps
    - provision of information to DAS.
- employment, training and deployment of field and outreach workers.
- follow-up contacts with all seniors/others initially assisted to determine additional needs which have developed, appropriateness of additional available resources, and need to advocate for additional resources.

Recovery

Recovery involves sustained care over a longer period of time, for the purpose of assisting people in re-establishing as normal a life as possible. Recovery includes:

- shifting from emergency response to providing answers to more complex, long-range and long term problems, including arranging for psychological/mental health services for disaster victims;
- providing access to increased resources that have become available;
- participation in long range planning and coordination with other agencies;
- maintaining contact and providing services, including meeting non-immediate needs identified during the response phase.

SCOPE OF EMERGENCY PLANS and ACTIVITIES, cont.	
Evaluation	Evaluation involves analysis of the effectiveness of an emergency plan once deployed and provision of input and feedback to staff, volunteers and other community organization, following response and recovery phases. Evaluation results will drive improvements in emergency planning.
EMERGENCY MANAGEMENT SERVICES	AAAs and their subcontract service providers are authorized to provide the following services to manage the emergency needs of the elderly: • expansion of information and assistance services on a 24-hour basis, including escort assistance; • special outreach activities to encourage elderly disaster victims to apply for benefits at federal emergency disaster assistance centers (DACs) as soon as they are established; • special transportation for elderly disaster victims to DACs, doctors, clinics, shopping and such essential travel in the event that vehicles are not readily available. Since FEMA funds may be available to fund this service, the Area Agency will consult with the on-site federal coordinating officer prior to expending Older Americans Act or state funds on this service; • assistance by case managers acting as disaster assistance advocates to older persons in the DACs in the benefits application process, including follow up to assure older victims receive approved grants and services and are protected from unscrupulous contractors for housing and other repairs; • handyman and chore services, including clean-up, in the event that FEMA cannot provide these services in sufficient volume through volunteer efforts; • licensed appraiser services to assist elderly disaster victims in arriving at realistic estimates of losses incurred;

EMERGENCY MANAGEMENT SERVICES, cont.

- legal services, only when scope of the primary elderly legal assistance program must be expanded to address insurance and disaster grant assistance settlements;
- assistance to move elderly disaster victims from temporary housing back to their own places of residence;
- other Older Americans Act services, including meals, when assessments indicate that disaster related needs are unresolved by federal, state, or voluntary disaster assistance programs.

REIMBURSEMENT PROCEDURES FOR EMERGENCY SERVICES

Reimbursement for the services specified above are authorized by the Older Americans Act, §310, as amended. AAAs shall forward requests for reimbursement to DAS within 30 business days of the date that disaster recovery operations are completed.

AAAs will prepare the reimbursement requests as follows:

- Sort the expenses for which reimbursement is requested into categories by service, as listed in the preceding section.
- Provide a narrative for each category, which documents the number of units provided and the number of elderly served. This will be the cover page for each set of reimbursement documentation materials.
- Enclose the billing documentation, such as paid bills and invoices, with the narrative for each category of service provided.
- Attach a description of the cause and scope of the disaster.
- Attach the certificate of non-duplication of services provided by the FEMA office, if it is available.

DAS will review all reimbursement requests, seek any additional information or clarification needed, and forward to the Administration on Community Living for payment.

ATTACHMENT G – Abbreviaons

AAA	Area Agencies on Aging
ACL	Administraon for Community Living
ACT	Adult Crime Taccs
ADRC	Aging and Disability Resource Connecon
AIMS	Aging Informaon Management System
ANE	Abuse/Neglect/Exploitaon
APS	Adult Protecve Services
CCSP	Community Care Services Program
CILS	Centers for Independent Living
CLP	Community Living Program
CMS	Centers for Medicare and Medicaid Services
CO-AGE	Coalion of Advocates for Georgia's Elderly
CQI	Connuous Quality Improvement
DAS	Georgia Division of Aging Services
DCH	Department of Community Health
DD	Developmental Disabilies
DFCS/DFACS	Georgia Department of Family and Children Services
DHS	Department of Human Services
DON-R	Determinaon of Need - Revised
DPH	Georgia Department of Public Health
ELAP	Elderly Legal Assistance Program
FSIU	Forensic Special Invesgaons Unit
G4A	Georgia Associaon of Area Agencies on Aging
GCOA	Georgia Council on Aging
HCBS	Home and Community Based Services
HDM	Home Delivered Meals
HFR	Georgia Healthcare Facility Regulaon
IFF	Intra-State Funding Formula
LIS	Low-Income Subsidy
LTCO	Long Term Care Ombudsman
LTCOP	Long Term Care Ombudsman Program
MAPs	Measurement and Analysis Plan (performance indicators)
MDS	Minimum Data Set
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Paents and Providers Act
MSP	Medicare Savings Program
NAPIS	Naonal Aging Program Informaon System
NCI –AD	Naonal Core Indicators – Aging and Disabilies
NH	Nursing Home
NHT	Nursing Home Transions
OAA	Older Americans Act

PGO	Public Guardianship Office
PSA	Planning and Service Area; Personal Support Aide
QOL	Quality of Life
RC	Regional Commission
RD	Regional Director
PSS	Personal Support Services
SCSEP	Senior Community Service Employment Program
SMP	Senior Medicare Patrol (See SHIP)
SNAP	Supplemental Nutri&#xFFFD;on Assistance Program
SFY	State Fiscal Year (July 1 through June 30)
SLTCO	State Long Term Care Ombudsman
SUA	State Unit on Aging

ATTACHMENT H – Document Links

Georgia Alzheimer's State Plan
https://aging.georgia.gov/document/document/2020-gard-state-plan/download

Georgia State Plan to Address Hunger
https://aging.georgia.gov/document/document/georgias-state-plan-address-senior-hunger/download

Senior Community Service Employment Program State Plan

https://aging.georgia.gov/document/document/2021-scsep-directory/download