Division of Aging Services

Home and Community Based Services (HCBS)

2026-01-21

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MAN 5300 Home and Community-Based Services (HCBS)

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		Revised:	**05/10/2023**
		Next Review:	**01/31/2024**

100 Administrative Guidelines and Requirements for Area Agencies on Aging

110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs

	Georgia Division of Aging Services **Home and Community-Based Services Manual**			
	Chapter:	100	**Effective Date:**	02/15/2016
	Section Title:	Grievance Procedures for Individuals in Non-Medicaid Home and Community Based Services Programs	**Reviewed or Updated in:**	MT 2015-11
	Section Number:	110	**Previous Update:**	MT 2015-11

110.1 Summary Statement

The Older Americans Act (OAA) requires Area Agencies on Aging (AAA) to provide grievance procedures for older individuals and persons with disabilities who are dissatisfied with or denied services. Further, the OAA requires the State Unit on Aging to issue guidelines to AAAs regarding grievance procedures.

This chapter provides guidance to AAAs in developing and implementing policies and procedures for handling grievances of individuals who are dissatisfied with or denied services. AAAs and providers will ensure that all program participants are informed of their right to file a grievance and of the process to be used at the time of application for services and upon admission to services.

Any written materials provided to applicants/recipients are to be concise, in sufficiently large print (14-point font or larger) for ease in reading, and in language the individuals/recipients use and best understand. Unless specific circumstances suggest otherwise, materials should be written at an 8th grade reading level.

110.2 Scope

Redress of grievances will be available to all applicants for and recipients of services provided through all non-Medicaid fund sources administered by the AAA.

A consumer can file a complaint for any action or inaction that a AAA and the AAA's contracted ser-

vice providers may take. The AAA will establish formal written procedures for handling complaints within its network.

However, only adverse actions, defined as the denial, reduction, or termination of services, are subject to appeal. Examples of adverse actions include, but are not limited to:

Denial:

- A decision that the applicant is not eligible for a program or service
- A decision not to provide initial or additional services

> **NOTE** The Division does not interpret the placement of individuals for service into waiting list status as a denial of service.

Reduction:

- A decision that results in diminished amount, extent, or number of services, excluding changes in service providers and/or funding streams when the same level of service(s) provided to the consumer is maintained

Termination:

- A decision that a consumer is no longer eligible for a program
- A decision following a service suspension brought about by an unsafe situation for agency or direct provider staff that a consumer cannot or will not resolve within a reasonable established time frame

The following actions are not subject to appeal:

1. An applicant is placed on a waiting list when services cannot be provided due to insufficient funding
2. A consumer is terminated due to non-payment of cost share, ensuring that Older Americans Act guidelines and MAN 5600 3090 Fee for Service System Overview and 3091 Cost Share are followed.

110.3 Concept of Due Process

Due process entails the implementation of specific procedures designed to safeguard the legal rights of individuals and to assure maximum fairness in decision making. Grievance and complaint policies and procedures will assure older adults, persons with disabilities, and their families that their concerns will be considered in a fair and timely manner, regardless of the ultimate legitimacy of the claim.

110.4 Individuals' Rights in Filing a Grievance or Complaint

Individuals in non-Medicaid home and community-based services that are funded in part or in whole by OAA and other federal and state funds have the right to file grievances or complaints regarding specific actions or activities affecting their participation in the program or the conduct of

the program as it relates to all individuals at a given site or location without fear of reprisal.

The applicant/recipient has the right to be represented by a friend, advocate, or attorney, at his/her own expense.

Prior to a grievance hearing, the individual and his/her chosen representative may request access to information regarding the service case, including individual records, intake and screening forms, eligibility determination forms, or any other documentation that was used to make the decision regarding denial, reduction, suspension, or termination of services.

110.4A Presentation of the Grievance

An authorized representative, including a caregiver, may present a grievance on behalf of an individual. If the individual chooses this option, s/he shall accompany the representative to every meeting at which the complaint is discussed, unless the individual is so functionally impaired that s/he cannot reasonably attend or participate in a meaningful way. If necessary, the meeting will be held in the individual's home if his/her condition limits mobility outside the home.

110.4B Resolution

Every effort will be made to resolve grievances at the lowest level of authority to avoid the ineffective use of staff time, time, and resources of the individual, and burdensome documentation. Grievances will be directed as appropriate to the situation to the following authorities in the order indicated:

1. Site Manager or Director or Case Manager
2. Program Director or Project Director
3. Agency Director of the subcontract agency
4. Area Agency on Aging Director

Once a grievance reaches the AAA level, the AAA is encouraged to select one or more impartial reviewers who have not been directly involved in the initial determination of the adverse action to participate in the review of the appeal. The decision of the AAA shall be the final decision.

110.4C Additional Redress

This policy does not remove the right of the individual to pursue other avenues of redress, such as filing with the Office of Civil Rights of the U.S. Department of Health and Human Services.

110.4D Time Frames for Filing

Grievances must be filed within thirty calendar (30) days of the action that is the basis of the grievance or upon thirty calendar (30) days of receipt of notification of the action which is the basis of the grievance, whichever is later. A waiver or extension of the time frame to file a grievance may be requested based upon proving good cause, including but not limited to serious illness, hospitalization, or other reasonable extenuating circumstances.

110.5 Forms and Content of Grievances

Individuals may file grievances orally or in writing and must state in sufficient detail the basis for the complaint and the reasons the individual objects to the action or circumstances in question. AAAs and providers shall supply a written outline to prepare for the oral filing to assure the coverage of the following points:

1. The notice, document, policy, situation, or event that is the reason for the complaint.
2. Significant dates pertaining to the complaint.
3. The names of organizations and individuals involved.
4. Reference to any provision of the Older Americans Act or other laws, regulations, or policies believed to have been violated by site management, subcontract agency, or AAA.
5. The action or decision desired by the individual to resolve the issue.

110.6 Disposition of Grievances

The following timeline and process will be followed to ensure prompt and thorough resolution of grievances:

1. The responsible authority will investigate the grievance, make any changes necessary to attempt to resolve the grievance, and notify the individual(s) of the resolution in writing within thirty (30) calendar days of receipt of the written grievance.
2. If the Manager's or Service Provider Director's response is not satisfactory to the individual, the individual may forward the matter for further consideration to the next higher authority as specified in 110.4B Resolution. Such intent must be received by the Manager/Director within ten (10) calendar days of the date of the written response to the grievance.
3. At each level at which the grievance/complaint is not resolved, the individual must notify the agency representative (orally or in writing) of the desire for a continuing grievance action within ten (10) calendar days of the date of the most recent written response to the grievance action. The agency representative will develop a memorandum detailing the circumstances of the grievance, attach all pertinent documentation regarding the findings and actions taken at the level of authority and forward it to the next level with a request for a meeting of the parties concerned with the issue. Each level of authority must attempt to resolve the grievance and notify the individual within thirty (30) calendar days of the receipt of the individual's request.
4. An individual may withdraw a grievance at any time. Failure by an individual to comply with required time frames will be considered withdrawal of a grievance unless compliance with time frames creates a hardship for the individual.
5. When the grievance is resolved, all parties will provide joint written notification of having reached agreement to each level of authority involved.

110.8 Mitigation of Grievances and Complaints

The AAA will assure that each individual or recipient of services is notified of his/her right to file a grievance/complaint and that reasonable attempts are made to resolve them at the lowest level of authority possible.

The following actions are suggested to mitigate the quantity and/or duration of grievances and complaints:

1. Ensure that all staff, especially staff having direct contact with a consumer either by telephone or in person, are trained in DAS and agency policies and procedures. Focus should be made on policies related to eligibility, individual prioritization, screening and assessment, and aspects of service delivery.
2. Ensure that all staff who have responsibility for screening and/or assessing individuals and recipients are thoroughly trained and, when applicable, certified to administer the required assessment instruments.
3. Ensure that all staff who have direct contact with a consumer, either by telephone or in person, are trained in proper documentation techniques.
4. Ensure that staff who have responsibility for any part of determining eligibility or appropriateness for services are trained in how to match specific domains of assessments to service needs and goals of consumers.
5. Ensure that all staff who have direct contact with a consumer either by telephone or in person are trained in customer service, with attention to methods for communicating policy to consumers in a clear, concise, and understandable manner.
6. Provide a robust quality assurance program to identify areas for improvement and additional training in the topics listed above and other topics identified by the AAA.

110.9 Review of Resolution and Appeal Logs

The AAA will develop a process for internal review of the procedures used in resolving each grievance/complaint to determine whether the local authorities at all levels adhered to the process and correctly followed the prescribed steps. If necessary, the AAA will implement corrective action plans to ensure compliance with grievance policy and protocols.

The AAA will maintain logs of all actions for which appeals or grievances were filed within its network that include, at a minimum:

1. Date of appeal or grievance
2. Name of person filing appeal
3. Summary of findings
4. Resolution of appeal or grievance
5. Date of resolution

The Appeal Logs shall be made available upon request to the Division for quality assurance or monitoring purposes.

References

MAN 5300, Chapter 202
MAN 5600, Chapter 2025
MAN 5600, Chapter 2026
MAN 5600, Chapter 3016

114 Guidelines for Client Assessment

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Guidelines for Client Assessment	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	114	**Previous Update:**	

114.1 Purpose

This chapter establishes the guidelines for quality service and accountability for Area Agencies on Aging (AAAs), Area Agency contractors, and subcontracting service providers when conducting client assessments for non-Medicaid Home and Community Based Services (HCBS).

This chapter also establishes the guidelines for using specified assessment instruments during both telephonic assessment and face-to-face assessment.

114.2 Scope

Client assessment encompasses those activities that directly relate to telephone assessment and periodic reassessment of persons by the Area Agency on Aging through its Aging and Disability Resource Connection (ADRC) program. Client assessment also encompasses those activities that directly relate to face-to-face assessment and periodic reassessment of persons by the AAA through a designated case management organization or its provider network.

These standards provide guidance to AAAs in achieving the following goals:

1. Eliminate the duplication of assessment and reassessment activities
2. Assure timely completion of assessment and reassessment activities
3. Assure that assessments are conducted accurately and consistently within each AAA and statewide
4. Assure the most effective targeting of resources to persons who need and can benefit from home and community-based services
5. Assure that the process of assessment and periodic reassessment reflects changes over time in clients' conditions and circumstances
6. Assure that the services planned, ordered, and provided are appropriate for a client's situation and condition on a continuous basis; and
7. Provide the basis for evaluating the effectiveness of service planning, measuring service quality, and documenting outcomes of the service delivery system

114.2A Definitions

Moved to MAN 5600, Appendix E (January 2021)

114.3 Objectives

The purpose of assessment is to document the capacities, needs, and functioning of the consumer in a holistic approach that results in a Care Plan tailored to that consumer. We never assess for a specific service.

The primary objectives of initial face-to-face assessments are to expand upon the information obtained at telephone assessment including functional impairment level, unmet need for care, level of nutrition risk, and other various individual needs of a consumer for services, and to obtain a more thorough evaluation of eligibility, when appropriate.

The goal is the development of an individualized Care Plan in collaboration with the consumer and caregivers when present, through which care needs will be met by one or more service providers and/or other community resources, including those resources within the consumer's support network.

The primary objective of periodic reassessment is to review all criteria related to initial and subsequent reassessment findings, so that any necessary adjustments in service planning and delivery may be made, based on the client's most recent status and situation.

114.4 Determining Eligibility and Target Populations

The Older Americans Act states that persons are eligible for Older Americans Act services at age 60, with additional criteria for recipients of Title III-C and Title III-E services.

If funds are not enough to serve all persons who are eligible based on age requirements, the Older Americans Act (see References) requires that services are provided with particular attention to targeted populations including but not limited to:

- Older individuals with greatest social need
- Older individuals with greatest economic need (including low-income minority individuals)
- Older individuals at risk for institutional placement
- Older persons who are frail

AAAs will ensure that limited resources are used to serve older adults, persons with disabilities and their caregivers in greatest need based on assessment information and based on ongoing information obtained through periodic utilization review and/or reassessment (see Appendix 114-H and Appendix 114-I) and through information and observation provided by both formal and informal service providers. See MAN 5300, 118 Prioritizing Clients for additional information.

Following AAA telephone triage, and subject to the availability of services, the AAA will refer clients in need of HCBS services to appropriate providers (CMO or provider agency) for a comprehensive initial face-to-face assessment.

In instances deemed to be an emergency, AAAs may refer clients to appropriate providers and authorize them to begin services prior to the completion of an initial face-to-face assessment.

Either the Case Management Organization (CMO) or the provider will complete the initial face-to-face assessment within ten calendar days of service initiation. AAAs that exercise this option must

assure that providers adjust services to appropriate levels based on the face-to-face assessment. The AAA will establish protocols to ensure that providers do not accept clients who are found to be inappropriate for any reason for the original service requested and will work with providers to ensure such consumers are referred to appropriate resources.

114.5 Assessment

The Division approaches the process of assessment and reassessment in a holistic manner, seeking to identify client needs and resources across a spectrum of domains. Specific domains to be assessed are described in Appendix 114-A Domains of Comprehensive Assessment.

The Division will periodically review the need to establish additional assessment domains, instruments, and data sets. Refer to the Appendices at the end of this chapter for an overview of the various assessments.

Because assessments track consumer changes over time and are the foundation of ensuring appropriateness and effectiveness of services, staff must not copy assessment scoring, comments, or notes between subsequent assessments.

114.5A Assessment Instruments

Required Assessments - The Division requires that specific assessments be completed on all applicants for all services, unless otherwise noted below. These include:

1. Determination of Need – Revised (DON-R)
2. Nutrition Screening Initiative DETERMINE Checklist (NSI-D)
3. Food Security Survey
4. NSI – Appendix D (if response to question #5 in NSI-D is affirmative)

DAS encourages but currently does not require use of the Risk Assessment Tool (RAT).

Specialized Assessments - The Division has adopted specific assessments that are to be completed based on indicators in the RAT and/or based on professional judgment of the assessor. These include:

1. Montreal Cognitive Assessment (MoCA) and MoCA-BLIND for cognitive impairment
2. STEADI Falls Risk Assessment
3. GAD-7 for anxiety
4. PHQ-9 for depression
5. Bakas Caregiving Outcomes Scale (BCOS)
6. AUDIT-10 for substance abuse
7. CDC Check for Safety: A Home Fall Prevention Checklist for Older Adults
8. NSI Appendix B

The use of the DON-R and specialized assessment instruments listed above are not required for the following services, though they may be helpful in some situations:

1. Senior Centers (MAN 5300, §206)
2. Congregate Meals (MAN 5300 §304)
3. Transportation (MAN 5300 §218)
4. Home modification/repair (MAN 5300 §314)
5. Emergency response installation/emergency response monitoring
6. Assistive technology

Each AAA is responsible for determining the placement of specialized assessments within its service delivery network and that staff identified as responsible for completing specialized assessments are trained and competent to do so.

DAS strongly encourages that staff performing assessments identify whether a consumer exhibits cognitive impairments prior to beginning assessment activities to determine the need for an informant to assist with gathering information, consistent with a person-centered approach to service delivery.

114.5B DON-R

The Determination of Need – Revised (DON-R) is the functional assessment for the State of Georgia and is the initial assessment for all individuals who are to be screened for services, except as noted in 114.5A Assessment Instruments. It is also used in reassessment to determine the change or continuation in services. It is used to determine an individual's level of impairment in 15 domains as well as his/her level of unmet need.

See Appendix 114-B for the complete DON-R guide and instructions.

114.5C NSI-DETERMINE and NSI Appendix B

The Nutrition Screening Initiative-DETERMINE is one of the three core assessments used in Georgia. It will be used on all individuals being screened for services and receiving a home and community-based service. It is used to identify individuals who are at nutrition risk.

For any individual who responds affirmatively for Item #5 "I have tooth or mouth problems that make it difficult to eat" staff must administer the NSI Appendix B.

See Appendix 114-C Nutrition Screening Initiative – DETERMINE (NSI-D) for information about the NSI and the NSI Appendix B and their administration.

114.5D Food Security Survey

The Food Security Survey is one of the three core assessments and will be used on all individuals being screened for services and on those receiving a home and community-based service. It is used to identify those at nutritional risk due to food insecurity.

See Appendix 114-D for information about the Food Security Survey and its administration.

114.5E Risk Assessment Tool (RAT)

DAS encourages use of the Risk Assessment Tool (RAT) Assessment on all individuals being assessed

for services and on those receiving a home and community based service. It is used to identify persons who are at risk of institutionalization. The RAT will categorize individuals into three risk levels of High, Moderate, Low, which will dictate the frequency of reassessment. In certain instances, staff may determine that assessing only specific domains of the RAT are necessary to identify the potential of risk(s) to the consumer's health and safety.

See Appendix 114-E for information about the Risk Assessment Tool and its administration.

114.5F Montreal Cognitive Assessment (MoCA and MoCA BLIND)

See Appendix 114-F for information about the Montreal Cognitive Assessment (MoCA) and its administration, and Appendix 114-G for information about the Montreal Cognitive Assessment – Blind version (MoCA BLIND) and its administration.

114.5G STEADI Toolkit / Falls Risk Assessment

See Appendix 114-H for information about the STEADI Toolkit Falls Risk assessment and its administration.

114.5H PHQ-9

See Appendix 114-I for information about the Patient Health Questionnaire, 9 scale version (PHQ-9) assessment and its administration.

114.5I GAD-7

See Appendix 114-J for information about the Generalized Anxiety Disorder Scale (GAD-7) assessment and its administration.

114.5J AUDIT-10

See Appendix 114-K for information about the AUDIT-10 assessment and its administration.

114.5K Bakas Caregiving Outcomes Scale (BCOS)

See Appendix 114-L for information about the Bakas Caregiving Outcomes Scale (BCOS) assessment and its administration.

114.6 Assessment for Caregiver Services

If the consumer is identified to be in need of services based on his/her relationship as a caregiver to another eligible consumer, priority will be based on the level of caregiver burden, using the Bakas Caregiving Outcomes Scale (BCOS). To receive caregiver services, the caregiver must be present/available to provide periodic or ongoing care, and the AAA must document that the caregiver will likely benefit from the services to be provided. Staff may assess the care receiver (using the DON-R, RAT, etc.) to help determine appropriate interventions.

Numerous funds sources may be used to provide caregiver services; however, the caregiver MUST be the identified client.

114.7 Initial Assessment and Follow Up

Each AAA will implement a process to ensure that variations in DON-R scores between ADRC and the face-to-face assessment that exceed ten points, as well as any other factors that may impact eligibility determination or redetermination, are communicated back to ADRC.

Follow-up. The AAA will designate appropriate staff to provide telephone follow up with clients/caregivers no later than the end of the first sixty (60) calendar days of service delivery to determine the degree of client/caregiver satisfaction with services and whether the services are meeting the needs identified by the assessment process. The designated staff should support the AAA's conflict-free system (See §114.14).

During the 60-day follow-up staff should identify whether the level of impairment or unmet need for care has changed in the relevant domains for which services were initiated. Staff should re-administer the DON-R during this follow-up. It is not necessary for staff to enter comments for domains in which no changes have been detected but comments are required for domains in which a change has occurred.

114.8 Utilization Review and Continued Service Delivery

Redeterminations of client status and service delivery are to be completed within specified time frames based on the Level of Risk identified by the RAT, either 6 months, 12 months, or 18 months; or if the RAT is not required by the AAA, no less than annually. This utilization review should include re-administration of the DON-R, NSI, Food Security, RAT, and specialized assessments as indicated.

AAAs will identify in their Area Plan documents whether the function of utilization review is managed through the ADRC system, through case management, a combination of the two, or an alternate method. If an alternate method is chosen, the AAA must explain in its Area Plan how the process is handled independently of the provider of services.

During the utilization review process, the level of services a client receives may remain the same or may be increased, decreased, or terminated based on the information obtained. Changes that result in modifications to service levels will be thoroughly documented in the client's record and clients will be notified of their right to appeal decisions about service levels (see MAN 5300, §202.5D).

114.9 Reassessment

Designated staff will conduct reassessment in accordance with the consumer's individual RAT score (or, if the RAT is not required by the AAA, no less than annually) or whenever there is a significant change in client condition, status, or circumstances that would affect the need for a change in service levels and/or additional services to be provided. Consumers receiving comprehensive case management services may be reassessed at the time of Service Plan reviews, as determined by the case manager.

114.10 Assessment Schedule

To better coordinate the assessment functions among multiple providers, DAS recommends the following order:

1. Assessment of clients
2. Reassessment of clients on waiting lists for HCBS services, when appropriate
3. Determination of eligibility and/or prioritization for services
4. Referral for service(s)
5. Follow-up no later than 60 calendar days following beginning of service delivery, with adjustments as necessary
6. Periodic reassessment and adjustments to service delivery, as needed

The DON-R, NSI, and Food Security Survey are to be completed at the following events:

1. Assessment
2. Reassessment
3. When a significant change has occurred in the consumer's condition or situation

Optional specialized assessment instruments are also to be used as needed and indicated by the client's basic assessments and/or the professional judgment of service providers.

Unless otherwise specified in program policy, service plans and service plan reviews (when required) should coincide with periodic reassessments.

114.11 Standards of Promptness

The initial face-to-face assessment must be completed within ten business days of receipt of referral for service from ADRC. Exceptions to this standard are to be fully documented in the client's case notes. However, in no instance shall the initial attempt to contact the client to schedule the face-to-face assessment exceed two business days.

114.12 Joint Service Provision and Coordination

Primary Assessment: When a client receives both non-Medicaid HCBS and Community Care Service Program (CCSP) services, the CCSP assessment and resulting care plans are primary and must incorporate and reflect the non-Medicaid services. Non-Medicaid HCBS providers have no further responsibility under these policies for assessment/service planning in those cases but will communicate and work with the Care Coordination Agency regarding need for adjustments in service levels and care plans based on their observations over the course of providing services. (Note: Non-Medicaid HCBS providers that are licensed by the State Healthcare Facility Regulation (HFR) Division of the Department of Community Health as private home care providers may have additional requirements for assessment pursuant to those regulations.)

Electronic client records and reporting: To comply with federal and state reporting requirements, AAAs or other designated entities will continue to enter any additional client data required for non-Medicaid services into the DAS data system to document and report each non-Medicaid service provided.

AAAs shall establish protocols and procedures for obtaining from the CMO/provider necessary data from the assessment/care plan information.

114.13 Integration of Client Assessment Activities

The Area Agency shall assure that initial and ongoing client assessments are conducted in a manner that provides maximum coordination and integration with its intake, assessment, and information and assistance processes and with ongoing case management and service delivery, at whatever level that activity occurs.

The Area Agency *may*, through the negotiation of subcontracts, delegate any or all components of client assessment activities.

AAAs shall develop protocols by which clients served by more than one organization do not receive duplicate assessments, and that services provided by several providers are coordinated through a single plan of care. AAAs shall negotiate with contract providers to designate a "lead agency" to coordinate care and services when there are multiple HCBS providers involved with a client.

AAAs are to assure that only one assessment per client per assessment interval and that only one redetermination of eligibility per eligibility interval occurs and is recorded in the DAS data system, except as noted here.

Information about both caregivers and care receivers must be indicated and recorded for the Title III-E National Family Caregiver Support Program, depending on the mix of services provided.

The Division may request documentation at the time of submission of a proposed Area Plan, Area Plan amendment or update; at the time of a program review or quality assurance review; or at any other time the information is needed as a part of program evaluation.

114.14 Conflict-Free Assessment and Firewalls

Optimally, assessment is conflict-free; that is, performed independently by appropriately trained personnel who are not employed by an organization that also contracts with the AAA to provide supportive and other services.

In an optimal system, the AAA utilizes an objective, third-party entity (including the AAA) that provides initial face-to-face assessment and periodic reassessment for those persons deemed appropriate to receive home and community-based services, either on a short-term or long-term basis. The assessment of potential clients and service planning on their behalf is separate from the provision of services.

The AAA will document in its Area Plan (beginning with the SFY 2018 Area Plan documents) its participation in a conflict-free assessment and service delivery system.

If enough resources are not available to implement the optimal system described above, the AAA will ensure use of reasonable firewalls to mitigate conflict between assessment or reassessment and service delivery, including but not limited to:

- Independent and objective ADRC counseling and referral
- When making referrals, the ADRC informs consumers of all service options available, and provides at least three options of service providers, when available
- Independent and objective authorization of services requested by the agency charged with client assessment/reassessment, including review of assessments to ensure accuracy

- Independent and objective desk audits of clients receiving services to ensure accuracy of assessments and appropriateness of the service mix and quantity provided
- AAA approval of all provider requests for increases or decreases in services to a client
- The AAA conducts at least annual monitoring of service providers that includes a review of client records to ensure that services are person-centered, consumer-directed to the extent possible, and that evidence supports that clients (and caregivers and representatives, when present) are included in the determination of service delivery
- The AAA will ensure that each consumer has the right to appeal the results of assessment, eligibility determination, and authorization of services

Providers shall assure that they will not accept clients for whom their services are inappropriate, based on the completed assessment. The AAA will work with providers to establish protocols for having inappropriate referrals re-assessed and referred to appropriate resources.

114.15 Staffing

Area Agencies shall assure that staff performing assessments, at either the AAA or subcontract agency level, are competent, ethical, sufficient in number and qualified by training and/or experience to conduct client and caregiver assessments using the assessments, tools, and data collection/management systems specified by the Division. Staff conducting assessments shall have specialized knowledge of older persons, with particular strength in assessing the variables that affect health and functioning.

Area Agencies are responsible for identifying training needs of both AAA and provider staff and notifying appropriate Division staff if they need technical assistance or assistance with providing training.

For individuals being referred for initial face-to-face assessment for HCBS services who are also active on the CCSP waiting list, the provider worker conducting the assessment must meet any education and experience requirements outlined in CCSP policy and must demonstrate competence administering the DON-R. The AAA may choose to complete the initial face-to-face assessment in lieu of the HCBS provider to meet CCSP policy standards.

114.16 Client Records and Records Management

The entity conducting consumer assessments shall establish for each participant a confidential record in a form designated or authorized by the Division, that is protected from damage, theft, and unauthorized inspection, and that is made available for monitoring and audit purposes.

The record shall contain, at a minimum, the following information in form and format provided by or approved by the Division:

1. Intake and assessment information
2. Documentation of eligibility, assessment, and reassessment
3. Care plans
4. Notes regarding significant client contacts, activities, including care plans
5. Procedures for emergency care

The AAA shall develop and implement written procedures to be followed by staff performing assessments at any level to obtain and document the consent of the consumer for the release of confidential information to other providers when referrals are made.

To ensure consistency and competence in administering assessments, staff must complete required trainings, either online or in person. The AAA must have policy related to any method of completing assessments other than directly into the DAS data system. The AAA must develop written policy to ensure that staff completing assessments on paper have received training in and are competent to administer them regardless of who enters the information into the DAS data system. Contact Division staff if training is needed.

114.17 Referrals to Other Services

When staff discover conditions during the assessment that warrant referral, they shall assist consumers in taking advantage of other services, whether provided through the aging network or through other community, public, private, or fee-for-service agencies. Staff shall document such referrals in the consumer record, and the assistance or services obtained in the care plan, if of an ongoing nature.

114.18 Record Keeping and Reporting

AAAs/subcontractors shall maintain in the manner prescribed by the Division any such records, in addition to consumer records, as may be necessary for overall program management and report in compliance with the Division's policies and procedures. Refer to MAN 5600 §1061 and MAN 5300 §202.5.

114.19 AAA Monitoring

The Area Agency shall conduct periodic (at least annual) reviews of documentation in consumer records of the appropriate use of assessment tools used at the ADRC and may conduct such reviews in tandem with monitoring of the ADRC service. The AAA must select and monitor a reasonable and meaningful sampling of client records that is sufficient in number to ensure compliance with this policy.

The Area Agency shall also conduct periodic (at least annual) reviews of documentation in client records of the appropriate use of assessment tools used by all service providers and may conduct such reviews in tandem with monitoring of the service provider.

The Division may monitor client assessment records at the AAA and subcontract provider levels to assure compliance with all applicable requirements.

114.20 Quality Assurance

The AAA shall periodically, but not less than annually, evaluate the effectiveness of client assessment and of determination and redetermination of eligibility activities (if provided as a stand-alone activity, not as a part of comprehensive case management), to determine the degree of accuracy of assessment and re activities and the degree of correlation of care plans to assessment data (including self-review procedures, if applicable). The AAA shall determine the degree to which the assessment component of case management contributes to the development of care plans which support maintenance or improvement of client status. The AAA will arrange for or provide training and

technical assistance, when indicated, to improve assessment results.

References

Older Americans Act Sec 305(2) (E) "preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas."

DON-R:

Hagopian M, Paveza GJ, Prohaska T, Cohen D: *Determination of Need – Revision Final Report, Volume III*. Chicago, Illinois: University of Illinois at Chicago, 1990.

Paveza GJ, Cohen D, Hagopian M, Prohaska T, Blaser CJ, Brauner D: A Brief Assessment Tool for Determining Eligibility and Need for Community Based Long Term Care Services. *Behavior, Health and Aging 1*: 121-132, 1990a.

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FOOD SECURITY SURVEY:

www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/survey-tools.aspx#six

Appendix 114-A Domains of Comprehensive Assessment

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Domains of Comprehensive Assessment	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-A	**Previous Update:**	

Comprehensive assessment is the process of reviewing the cognitive, emotional, social, health/medical and functional status of an adult to determine if there are deficits in need of support, as well as strengths that can be used to develop plans that support continued independence and/or that support family caregivers. Although the DON-R Assessment is the Level One Assessment for the ADRC, there are many other aspects of a person's life that staff and other professionals will want to con-

sider when working with consumers/families to develop interventions. Following is an overview of other issues that should be considered in care planning.

- **Functional Status** - evaluates how well the adult manages activities and instrumental activities of daily living as measured by the Determination of Need-Revised (DON-R) instrument. Assessment of functional status includes:
  - Activities of Daily Living (ADLs)
  - Instrumental Activities of Daily Living (IADLs)
  - Use of or need for assistive devices or technology
  - Level of assistance required and who provides assistance
- **Cognitive Status** – DAS measures cognitive status by the Montreal Cognitive Assessment (MoCA and the MoCA-BLIND). Establishing a baseline for cognitive status can be critical in designing interventions to assist family caregivers when providing care for a family member with dementia or other cognitive impairments. IADL impairments as noted on the DON-R may also be indicators of cognitive impairment and decline; the DON-R comments section can be used to note concerns regarding cognition issues, absent a formal assessment. See Appendix 114-B for the DON-R with dementia triggers. Assessment of cognitive status includes:
  - Orientation
  - Attention
  - Short-term and longer-term memory
  - Construction
  - Calculation
  - Judgment
- **Behavioral and Emotional Well-being** – includes information about the consumer's past and present coping mechanisms, diagnoses, management of emotional issues, and life changes that may impact functioning or well-being. Issues to be addressed may include:
  - Depression
  - Substance abuse
  - Suicide risk
  - Social stressors
  - Values and preferences
  - Mood
  - Effect
  - Coping mechanisms
  - History of behavior or emotional problems
  - Eating disorders
  - Life satisfaction
- **Social Supports** - includes social networks and supports, including family, friends, formal or paid supports, and the degree and causes of social isolation. The DON-R comments section can

be used to note involvement of family and friends. Assessment of social supports includes:

  - Consumer's current marital status
  - Current living situation
  - Frequency and type of contacts with friends/friends
  - Feelings and causes of isolation or loneliness
  - Availability and duration of care if it was needed
  - Hobbies and interests

- **Environment** – addresses the adequacy of residence, conditions inside the home and surrounding environment, and characteristics of the community. An environmental assessment includes:
  - Architectural barriers that limit access from the outside or that limit access within the environment
  - Accessibility of assistive devices, if used
  - Functionality of structure and design
  - Need for modification or repairs
  - Adequacy of major systems: heating, cooling, wiring, plumbing, overall structural integrity of dwelling
  - Emergency planning
  - Access to local transportation options
  - Neighborhood location and safety
- **Finances and Legal Issues** – assesses the adequacy of income and resources for present and future needs, and includes:
  - Income
  - Assets
  - Expenditures
  - Health insurance
  - Affordability of health care, including medications
  - Eligibility for entitlement programs
  - Presence of guardian or conservator
  - Advance directives and awareness of support system of these
  - Retirement planning or long-term care planning
- **Health status** – assesses the consumer's current physical health status, usage of health care services, health risk factors, and preventive actions, including:
  - Nutritional status (NSI-D and Food Security
  - Medical diagnoses and chronic conditions
    - Effect on functioning
    - Ability to manage

- Health literacy
- Number of hospitalizations and admissions, number of readmissions, and utilization of emergency room for primary care needs
- Current medications including prescribed, OTC, and alternative treatments/therapies
- Need for additional health assessments, medication management assistance or assistance to obtain needed medications
- Experience with health care (self, family and friends)
- Cultural beliefs about illness and treatment
- Access to health care providers, and the ability and means to make and keep appointments as necessary
- Overuse, underuse, or misuse of health care network

- **Risk for Abuse, Neglect, or Exploitation** – assessed current or potential risk for abuse, neglect, or exploitation, and possible intervention of Adult Protective Services, including:
  - Are there signs of injury, such as bruises, burns, teeth marks?
  - Is the person's explanation of how the injuries occurred plausible?
  - Are there signs of physical neglect, such as burning, contractures, decubitus ulcers, dehydration, diarrhea or compaction, urine burns or excoriation?
  - Does neglect appear to be active or passive?
  - Do income resources appear to be adequately and properly used to provide care? Are bills being paid on time and in full, if being handled by another person?

Adapted from:

"Comprehensive Geriatric Assessment, Moving People Down the Road to Continued Independence," training presented to Georgia Aging Network by Gregory J. Paveza, Ph.D., 1999.

Center for Aging & Disability Education and Research at Boston University

"Guidelines for Case Management Practice across the Long-Term Care Continuum, Connecticut Community Care, Inc., November 1994.

Appendix 114-B Determination of Need – Revised (DON-R)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Determination of Need – Revised (DON-R)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-B	**Previous Update:**	

Functional Assessment (ADLs/IADLs)

Introduction

The Determination of Need functional assessment (DON) instrument was originally developed as part of a contract with the Illinois Department of Aging to provide the means for determining eligibility for community-based services. As such, there was a need for the DON to identify those factors that were the best predictors of need for care. Furthermore, there was a need for the instrument to be constructed in a fashion that would permit the state to set funding caps for different levels of impairment, but also allow for adjustment as a care recipient's needs changed. Beginning in 1987 and concluding in 1989, a group of researchers at the Gerontology Center of the University of Illinois at Chicago worked on developing such an instrument. The process involved in the DON's development is well documented in a three-volume final report to the Illinois Department on Aging (Paveza et al., 1989; Prohaska et al., 1989; Hagopian et al., 1990) and in two articles (Paveza et al., 1990a; Paveza et al., 1990b).

Since the DON was developed as part of a state contract the instrument resides in the public domain. The instrument described in this manual represents a modification for use by those wishing to solely assess functional impairment in persons with whom they are working, as well as refinements made to the interpretative process as use of this instrument has evolved over time. Nevertheless, since the original DON was developed under a public contract, this modified DON also resides in the public domain.

The State of Georgia began training on the DON during 1995-1996. Use of the DON was implemented for Home and Community Based Services (HCBS) in 1997 and was subsequently implemented for telephone assessment/Gateway in 2000-2001.

The Determination of Need - Revised (DON-R) defines the factors which help determine a person's level of impairment and the unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on basic Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

The backbone of determining the level of need for care is whether a person can perform activities of daily living. Table 1 presents the list of ADLs included in the DON-R under two categories: BASIC AND INSTRUMENTAL.

DAS does not use the DON-R to determine eligibility for HCBS services; rather its primary purposes are to help prioritize consumers at risk of institutionalization, to develop appropriate service plans to address impairments and unmet needs for care, and to maximize the use of community resources.

<Basic> Activities of Daily Living (ADL)	**Instrumental Activities of Daily Living (IADL) (IADL)**
Eating	Managing Money
Bathing	Telephoning
Grooming	Preparing Meals
Dressing	Laundry
Transferring	Housework
Continence	Outside Home
	Routine Health

<Basic> Activities of Daily Living (ADL)	Instrumental Activities of Daily Living (IADL) (IADL)
	Special Health
	Being Alone

The ADLs 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 his/her physical needs.

The IADLs are the more complex activities associated with daily life and are the functions that are necessary to maintain one's environment. Information regarding both ADLs and IADLs are essential to evaluating whether a person can live independently in the community.

Determination of Need – Revised Functional Assessment Instrument

The DON-R is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular function. Furthermore, it is an ordinal scale with clearly defined meanings for each level of impairment, each level of unmet need for care and each functional activity. Because of its ordinal nature, the instrument permits quantification of scores so that changes in scores represent actual changes in level of impairment and unmet need for care.

Before discussing the specific definitions that describe the functional activities included in the DON-R and the definitions that specify each of the levels of impairment and unmet need for care, some general comments about the DON-R are provided to assist in the completion of the instrument.

Column Rule

If Column A, "level of impairment", is scored "0", then Column B, "unmet need" must also be"0".If a client does not have any impairment in a function, it is not possible to have an unmet need.

1. If Column A is scored greater than "0", then score Column B.
2. If there is a score greater than "0" in Column A/B, a case comment is needed.

The "Case Comments" space to the right of Column B is used to:

- Note the reasons for impairment, e.g. if eating level of impairment is scored as a "1" and the person has rheumatoid arthritis, write down that they are having trouble with cutting food and may benefit from adapted utensils. Or, if the person is having trouble swallowing due to advanced dementia, record that information here as well.
- Note the reasons the person has an unmet need, such as no family nearby or client opposition to caregiver assistance in intimate tasks, such as incontinence, bathing or dressing.
- Describe the type of service, caregiver support or assistive devices that are currently being used or are in place.
- Record the primary caregivers' names or other pertinent information.

Proper notation:

Function	Level of Impairment	Unmet Need	Case Comments
9. Preparing Meals	1	1	Client can open packages and cans; client can use the microwave but has left stove on in past due to mild cognitive impairment; client is able to clean dishes. Family has concern about client possibly leaving stove on.

Improper notation:

Function	Level of Impairment	Unmet Need	Case Comments
9. Preparing Meals	1	1	Client cannot prepare meals like she used to

Determination of Need - Revised Functional Assessment

Function	Column A Level of Impairment	Column B Unmet Need for Care	Case Comments: Identify resources, describe special needs and circumstances that should be considered when developing a care plan
1. Eating	0 1 2 3	0 1 2 3	
2. Bathing	0 1 2 3	0 1 2 3	
3. Grooming	0 1 2 3	0 1 2 3	
4. Dressing	0 1 2 3	0 1 2 3	
5. Transferring	0 1 2 3	0 1 2 3	
6. Continence	0 1 2 3	0 1 2 3	
7. Managing Money	0 1 2 3	0 1 2 3	
8. Telephoning	0 1 2 3	0 1 2 3	
9. Preparing Meals	0 1 2 3	0 1 2 3	
10. Laundry	0 1 2 3	0 1 2 3	
11. Housework	0 1 2 3	0 1 2 3	
12. Outside Home	0 1 2 3	0 1 2 3	
13. Routine Health	0 1 2 3	0 1 2 3	
14. Special Health	0 1 2 3	0 1 2 3	
15. Being Alone	0 1 2 3	0 1 2 3	
Box A: Subtotal Col A, Items 1-6	Box A	Box B	Box B: Subtotal Col B, Items 1-6
Box C: Subtotal Col A, Items 7 - 15	Box C	Box D	Box D: Subtotal Col B, Items 7 - 15
Box E: Subtotal Box A & Box C	Box E	Box F	Box F: Subtotal Box B & Box D
		Box G	Box G: Subtotal Box E & Box F

Column A: Level of Impairment

Each of the basic and instrumental activities of daily living (ADL/IADL) must be discussed in terms of level of impairment. Look for the ability to perform the essential components of all 15 activities listed on the following pages. How the assessor mentions functional impairment is not as important as encouraging the client to report how they accomplish the activity, and any difficulties they may encounter. Sample questions could include:

Are you able to do…?
How do you go about…?
How much difficulty do you have in doing…?

The object is to gather sufficient information through interview and observation to determine the most appropriate score for the level of impairment. If the client uses special adaptive equipment, score the client based on the ability to perform activity with that equipment. **The DON-R is assessing the client's ability to perform the essential components of the activity NOT the client's willingness/desire to do the activity.**

Score 0 – The person performs or can perform **all essential components** of the activity, with or without an assistive device, such that:

- no significant impairment of function remains; or
- activity is not required by the client (Routine and Special Health only); or
- client does not require verbal or physical assistance.

Score 1 – The person performs or **can perform most essential components** of the activity with or without an assistive device, but some impairment of function remains such that the client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- experience minor, intermittent fatigue in performing the activity; or
- take longer than would be required for an unimpaired person to complete the activity; or
- must perform the activity more often than an unimpaired person; or
- require some verbal prompting or physical assistance to complete the task.

Score 2 – The person **cannot perform most of the essential components** of the activity, even with an assistive device, and/or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- experience frequent fatigue or minor exertion in performing the activity; or
- take an excessive amount of time to perform the activity; or
- must perform the activity much more frequently than an unimpaired person; or
- require frequent verbal prompting to complete the task.

Score 3 – The person **cannot perform any essential components of the activity** and requires someone else to perform the task, although client may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care

The purpose of scoring unmet need for care is twofold. The first objective is to assess the consumer's unmet need for care and the assistance available. The second objective is to determine the

impact on the consumer if additional assistance is not provided. In scoring this column, the goal is to obtain information from the client about their perceptions regarding need for care and to use observational skills to determine what the impact might be on the client should care or assistance (or additional assistance) not be provided to the client. The availability of an appropriate caregiver also needs to be assessed. Caregiver availability may be impacted by various factors, including stress/burden, lack of knowledge/skill, etc. The reason for lack of availability should be documented in the comments section. The DONR measures only the availability of the caregiver, not caregiver stress which is assessed via the Bakas Caregiving Outcomes Survey (BCOS).

Questions that might be asked of clients and caregivers are:

Can you tell me if you are getting enough help with…?
Do you think you need more help with …?
Who is helping you with…?

In your own observations, look at the client's mobility, level of clutter, appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The client's **need for assistance is met** to the extent that the client has no risk to health or safety if additional assistance is not acquired; or the client has no need for assistance; or additional assistance will not benefit the client.

Score 1 - The client's need for assistance is **met most of the time**, or there is minimal risk to the health and safety of the client if additional assistance is not acquired.

Score 2 - The client's need for assistance is **not met most of the time**; or there is moderate risk to the health and safety of the client if additional assistance is not acquired.

Score 3 - The client's need for assistance is **seldom or never met**; or there is severe risk to the health and safety of the client that would require acute medical intervention if additional assistance is not acquired.

If assistance with intimate tasks (bathing, dressing, or continence care) is needed and is available but is inappropriate and/or opposed by the client or caregiver, consider the assistance unavailable.

Essential Components of the Functional Domains

The following definitions will list the essential components of each function for assessing level of impairment. Ask yourself "can the person do all, most, not most or none of the components" to help you score.

Eating

A. Is the client able to feed himself/herself?

   Assess the client's ability to feed themselves a meal using routine or adapted table utensils and without frequent spills.

   Essential components of eating are:

- Cutting food into manageable pieces
- Getting food or drink to the mouth
- Chewing
- Swallowing food or drink

When a special diet is needed, do NOT consider the preparation of the special diet when scoring this item (see “Preparing Meals” and “Routine Health” items).

B. Is someone available to assist the client at mealtime?

If the client scores at least one (1) in level of impairment, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating. Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Bathing

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client’s circumstances?

Assess the client’s ability to shower, bathe, or take sponge baths to maintain adequate hygiene and cleanliness. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. If the consumer can give himself or herself periodic baths, but cannot bathe with the frequency needed because of incontinence, assign a higher score accordingly. If the consumer takes sponge baths and that is adequate, score only on getting in/out of the tub.

Essential components of bathing are:

- Getting in and out of the tub or shower
- Getting adequately set up at sink, if sponge bathing
- Turning faucets
- Regulate water temperature
- Wash fully
- Dry off fully

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least one (1) in level of impairment, evaluate the continued availability of resources to assist in bathing. Is there someone available:

- All of the time (score = 0)

- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Grooming

A. Is the client able to take care of his/her personal appearance?

   Assess client's ability to take care of personal appearance, grooming, and hygiene activities. If a professional has instructed the client to visit a podiatrist for toenail care, consider that an impairment.

   Essential components of grooming are:

   - Shaving (facial and/or other body parts if this is the person's custom)
   - Nail care, including toenails
   - Hair care (grooming hair, **not** washing hair)
   - Dental care (brushing teeth or managing dentures)

B. Is someone available to assist the client in personal grooming tasks?

   If the client scores at least one (1) in level of impairment, evaluate the assistance needed for grooming. Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Dressing

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

   Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather or street attire as needed. If the client chooses night wear for day wear as a preference, do not score an impairment; however, if this is because of dexterity, score as mild impairment. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or heavier items such as a winter coat. Do not include style or color coordination.

   Essential components of dressing are:

   - Putting on clothes
   - Taking clothes off
   - Ability to work buttons, zippers, laces

- Clothes are appropriate to weather or activity

B. Is someone available to assist the client in dressing and undressing?

   If the client scores at least one (1) in level of impairment, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Transfer

A. Is the client able to get into and out of bed or other usual sleeping place?

   Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or arm chair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include the ability to adjust the bed or place/remove handrails, if applicable and necessary. **Do not assess mobility around the home in this domain.**

   Essential components of transferring are:

   - Getting in and out of normal sleeping place
   - Get legs over side of bed
   - Sit up; stand up
   - Reach walker or wheelchair, if used
   - Get out of lounger, if that is normal sleeping place

B. Is someone available to assist or motivate the client to get in and out of bed?

   If the client scores at least one (1) in level of impairment, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed. Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Continence

A. Is the client able to take care of bladder/bowel functions without difficulty?

   Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or

other appropriate facility in a timely manner. Consider the need for reminders. If the consumer has a colostomy that is managed properly, consider this as continent in bowel. Also, account for medical conditions (ex: temporary vs. permanent catheter).

Essential components of continence are:

- Recognize the need to go
- Get to the bathroom on time
- Get clothing off to level needed
- Clean up
- Get clothes back on/up

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least one (1) in level of impairment, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions. Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Managing Money

A. Is the client able to handle money and pay bills?

Assess the client's ability to handle money and coins and to pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paperwork (including applications for benefits). Include the ability to read, write and count sufficiently to perform the activity. Do not increase the score based on insufficient funds.

Essential components of managing money are:

- Recognize the difference between paper money and coins
- Understand what a bill is and how to pay it
- Write a check
- Ability to count money

B. Is someone available to help the client with money management and money transactions?

If the client scores at least one (1) in level of impairment, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc. Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)

- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Telephoning

A. Is the client able to use the telephone to communicate essential needs?

   Assess the client's ability to use a telephone to communicate essential needs. Do not consider the absence of a telephone in the client's home. The use of an emergency response system (ERS) device should be considered in the "Being Alone" domain.

   Essential components of telephoning are:

   - Picking up phone
   - Dialing
   - Talking
   - Being Understood and understanding the conversation sufficiently enough to explain the conversation to another person
   - Hanging up the phone

B. Is someone available to assist the client with telephone use?

   If the client scores at least one (1) in level of impairment, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency if client does not have a telephone in the home. Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Preparing Meals

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?

   Assess the client's ability to plan and prepare routine hot and/or cold, nutritionally balanced meals. Do not consider the ability to **plan** therapeutic or prescribed meals. If a client states he or she cannot "cook like they used to", he or she does not necessarily have an impairment score. The impairment score only looks at the level of impairment within the essential components. When in doubt, consider the essential components of preparing food in order for a person to remain healthy and safe.

   Essential components of preparing meals are:

   - Opening packages or cans

- Pouring food into bowl or pot
- Turning knobs on the stove
- Using other kitchen appliances
- Washing and putting away dishes

B. Is someone available to prepare meals as needed by the client?

If the client scores at least one (1) in level of impairment, evaluate the continued availability of resources (including restaurants and home-delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later. Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Laundry

A. Is the client able to do his/her laundry?

Assess the client's ability to do laundry. Include use of coins where needed and use of machines and/or sinks. Only consider ability to access laundry facilities if they are inside the home. The consumer should be able to tell whether or not garments are clean.

Essential components of laundry are:

- Getting to machine, if in home
- Carrying laundry
- Sorting
- Getting clothes in and out of washer and dryer
- Folding
- Putting away

B. Is someone available to assist with performing or supervising the laundry needs of the client?

If the client scores at least one (1) in level of impairment, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc. Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Housework

A. Is the client able to do routine housework?

   Assess the client's ability to do routine housework to maintain basic sanitary, hygienic, and safety conditions in the home. Do NOT include laundry, washing or drying dishes. In most cases, a consumer's refusal to do housework is not considered an impairment.

   Essential components of housework are:

   - Sweep, dust
   - Clean up spills on counter or floor
   - Clean sinks and toilets
   - Cleaning bathtub
   - Vacuuming

B. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards?

   If the client scores at least a one (1) in level of impairment, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, **do not assume** the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and does not measure the maintenance needs of living space occupied by others in the same residence. Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

   If hoarding is suspected as a contributing factor to a consumer's performance in this domain, consider the person completely unable to perform housework. Hoarding is a severe psychological condition for which highly specialized and extensive intervention is required. Resources to remediate this issue may be inadequate, unavailable, or inappropriate.

Outside Home

A. Is the client able to get out of his/her home and to essential places outside the home?

   Assess the client's ability to get to and from essential places outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to plan and secure appropriate and available transportation and to know locations of home and essential places. Lack of appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation. Consider whether there are structural or safety issues with home entries and exits, such as faulty stairs or railings, or uneven surfaces. Consider the consumer's ability to get from one location to another location without becoming

confused or lost.

Essential components of outside home are:

- Able to negotiate porch, stairs, walkways
- Able to get to essential places like grocery store, doctor's office, bank
- Able to drive, or get in and out of car, or use public transit

B. Is someone available to assist the client in reaching needed destinations?

If the client scores at least one (1) in level of impairment, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client.

Is there someone available:

- All of the time (score = 0)
- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Routine Health Care

A. Is the client able to follow the directions of physicians, nurses or therapists, as needed for routine health care?

Assess the client's ability to follow directions from a physician, nurse or therapist, and to manipulate equipment in the performance of routine health care, if needed. Include simple dressings, special diet planning, monitoring of symptoms and vital signs (e.g. blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist. Consider the consumer's ability to understand, recall, and implement the instructions of a health care provider. Score "0" if client has no routine health needs.

Essential components of routine health care are:

- Everyday tasks that don't need close monitoring and supervision by a licensed care professional
- Ability to follow directions e.g. taking medications, weighing self, exercising

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in level of impairment, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions.

Is there someone available:

- All of the time (score = 0)

- Most of the time, slight risk to health and safety (score = 1)
- Not most of the time, higher risk to health and safety (score = 2)
- Rarely, great risk to health and safety (score = 3)

Special Health Care

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

   Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tube feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. If the consumer has diabetes and requires special foot care, she should be assessed for the ability to cooperate with the professional while the care is being provided. Score "0" for clients who have no specialized health care needs.

   Essential components of special health care are:

   - Tasks usually performed by a licensed health care professional
   - Includes complex dressings as in wound care; physical, occupational, or speech therapy; IV therapy

B. Is someone available to assist with or provide specialized health care for the client?

   If the client scores at least one (1) in level of impairment, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

   Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Being Alone

A. Can the client be left alone?

   Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety. Also take into account the consumer's proficiency at making judgments about personal health and safety.

Essential components of being alone are:

- Recognizing an emergency
- Responding to an emergency
- Able to get out of the home in case of an emergency
- Recognize and respond to threats to personal health or safety

B. Is someone available to assist or supervise the client when the client cannot be left alone?

   If the client scores at least one (1) in level of impairment, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider the availability of "watchful oversight" such as friendly visiting, telephone reassurance, and neighborhood watch programs.

   Is there someone available:

   - All of the time (score = 0)
   - Most of the time, slight risk to health and safety (score = 1)
   - Not most of the time, higher risk to health and safety (score = 2)
   - Rarely, great risk to health and safety (score = 3)

Scoring the DON-R

Scoring the DON-R is done by obtaining a series of totals in boxes A, B, C, D, E, F, and G on the bottom of the DON-R form.

Subtotal of Columns A and B

1. Add the scores for the first six functional activities (1-6) of Column A, and enter that score in Box A. Then add the scores for the last nine functional activities (7- 15) and enter that score in Box C. Finally add the scores for Box A and Box C and place that total in Box E.
2. Add the scores for the first six functional activities (1-6) of Column B, and enter that score in Box B. Then add the scores for the last nine functional activities (7- 15) of Column B and enter that score in Box D. Finally add the scores for Box B and Box D and place that total in Box F.
3. Add the scores from Box E and Box F and enter that total in Box G.

Each of these boxes provides specific information about the client. Box A provides a score that represents total impairment in basic Activities of Daily Living, while Box C provides a score that represents total impairment in Instrumental Activities of Daily Living. Box E provides a summary score that represents total functional impairment.

Box B provides a score that represents the total unmet need for care in basic Activities of Daily Living, while Box D provides information about the total unmet need for care in Instrumental Activities of Daily Living. Box F provides a summary score of unmet need for all Activities of Daily Living.

Box G provides a summary score that represents a total care burden and represents both a combination of total impairment and total unmet need for care.

Interpreting the DON-R

When interpreting the DON-R score, it is important to look at all sub scores along with the total score. Totals in boxes A, B, C, and D enable you to delve into the data to more accurately assess a consumer's situation. This also enables you to assess in more detail what the consumer's needs are based on the individual sub score and to develop appropriate service plans to address impairments and unmet needs.

For example, a score of 4 in Total Level of Impairment for Activities of Daily Living would indicate that the consumer has a low level of impairment. On the other hand, a score of 19 in total Unmet Need for Care in Instrumental Activities of Daily Living could indicate that a family member or caregiver is not present, and the consumer could benefit from assistance in the IADLs.

Consider the following two DON-Rs. Both have the same total score but are interpreted differently because they have different sub scores.

DON-R Client Example A has a total level of impairment score of 4 in ADLs and a total level of impairment score of 11in IADLs and a total overall level of impairment of 15. In terms of unmet need, this client has an unmet need for care score of 17 in IADLs. This could indicate that the client has the ability to perform some basic functions but needs some assistance with higher level functions as indicated.

In DON-R Example B, the client has a total level of impairment score of 11 in ADLs and a total level of impairment score of 14 in IADLs. In comparison, this client has an unmet need for care score of 10 for ADLs but an unmet need for care score of 5 for IADLs. This could indicate that there is a caregiver assisting with IADL tasks, but the client needs assistance with ADL functions.

Client Example A		
Function	**Level of Impairment**	**Unmet Need for Care**
1. Eating	0	0
2. Bathing	1	2
3. Grooming	1	2
4. Dressing	1	2
5. Transferring	0	0
6. Continence	1	2
7. Managing Money	2	3
8. Telephoning	1	2
9. Preparing Meals	2	3
10. Laundry	1	2
11. Housework	1	2
12. Outside Home	0	0
13. Routine Health	2	2
14. Special Health	0	0
15. Being Alone	2	3
ADL Total	4	8
IADL Total	11	17
All	15	25
Total Raw Score		**40**
Standardized		
ADL	0.7	1.3
IADL	1.2	1.9
All	1.0	1.7
Total Standardized		**1.3**

Client Example B		
Function	**Level of Impairment**	**Unmet Need for Care**
1. Eating	2	0
2. Bathing	2	3
3. Grooming	2	1
4. Dressing	2	3
5. Transferring	2	0
6. Continence	1	3
7. Managing Money	1	1
8. Telephoning	2	1
9. Preparing Meals	2	0
10. Laundry	2	0
11. Housework	2	0
12. Outside Home	3	2
13. Routine Health	2	1
14. Special Health	0	0
15. Being Alone	0	0
ADL Total	11	10
IADL Total	14	5
All	25	15
Total Raw Score		**40**
Standardized		
ADL	1.8	1.7
IADL	1.6	0.6
All	1.7	1.0
Total Standardized		**1.3**

Standardized Score Interpretation

Another method that is used to interpret the DON-R is the use of standardized scores. Standardized scores can be generated based on the raw totals for ADLs and IADLs for both Level of Impairment and Unmet Need for Care (Boxes A, B, C, and D).

To obtain a standardized score for each of these areas, divide the raw score in each of box by the number of domains added in that total. For example, six domains are added to total the raw score of Level of Impairment in Activities for Daily Living in Box A. Divide the number in Box A by 6 to reach the standardized score.

Similarly, you can arrive at standardized scores for Level of Impairment and Unmet Need for Care, as well as overall, by applying the same calculations to each raw score.

Interpretations can be made from each standardized score. Standardized scores in the boxes will be between 0 and 3, and those numbers are ordinal, meaning that they have a scaled relationship to

one another; just as the scores you assigned for each domain. Scores of 0 to 3 can be interpreted as follows:

0	No Functional Impairment or no Unmet Need for Care
0 – 1.0	Mild Functional Impairment or mild Unmet Need for Care
1.0 – 1.5	Mild to moderate Functional Impairment or mild to moderate Unmet Need for Care
1.5 – 2.0	Moderate Functional Impairment or moderate Unmet Need for Care
2.0 – 2.5	Moderate to severe Functional Impairment or moderate to severe Unmet Need for Care
2.5 – 3.0	Severe Functional Impairment or severe Unmet Need for Care

Conclusions based on standardized scores for each area and overall can help shape a care plan. But first you must consider the meaning of each area individually.

For example, if the total in Box A is 1.7, this would be interpreted to mean that the consumer has mild to moderate impairment in Activities of Daily Living. If the total in Box C is 2.2, this would be interpreted to mean that the consumer has a moderate to severe impairment in Instrumental Activities of Daily Living.

The difference between those two totals indicates that the consumer is having considerable difficulties with IADLs, but not having as much trouble with the basic ADLs. This may lead you to conclusions about how much the consumer's abilities have deteriorated, but it will also give you an understanding of what he or she is still able to handle on his or her own. Likewise, standardized scores in Box D and Box G will indicate in which areas the consumer may or may not have unmet care needs.

Essential Components

Function	Level of Impairment	Unmet Need for Care	Essential Components
1. Eating	0 1 2 3	0 1 2 3	• Cutting food into manageable pieces • Getting the food to your mouth • Chewing • Swallowing • Getting a drink to your mouth and swallowing
2. Bathing	0 1 2 3	0 1 2 3	• Getting in and out of tub or to sink • Turning faucets • Regulating water temperature • Washing entire body • Drying entire body
3. Grooming	0 1 2 3	0 1 2 3	• Fixing hair • Shaving • Fingernail and toenail care • Brushing teeth or dentures

Function	Level of Impairment	Unmet Need for Care	Essential Components
4. Dressing	0 1 2 3	0 1 2 3	• Getting arms and legs into clothing • Getting arms and legs out of clothing • Buttons, zippers, laces • Clothing is appropriate to social situation • Clothing is appropriate to weather
5. Transferring	0 1 2 3	0 1 2 3	• Getting in and out of the normal sleeping place • Get legs over bed • Sit up; stand up • Get out of lounger if that is normal sleeping place
6. Continence	0 1 2 3	0 1 2 3	• Recognize need to go • Get to the bathroom on time • Get clothing off to level needed • Clean up • Get clothes back on/up
7. Managing Money	0 1 2 3	0 1 2 3	• Recognize the difference between paper money and coins • Understand what a bill is and how to pay it • Write a check • Ability to count money
8. Telephoning	0 1 2 3	0 1 2 3	• Picking up phone • Dialing • Talking • Being understood • Hanging up the phone
9. Preparing Meals	0 1 2 3	0 1 2 3	• Opening up packages or cans • Pouring food into bowl or pot • Turning knobs on stove • Using other kitchen appliances • Washing and putting away dishes
10. Laundry	0 1 2 3	0 1 2 3	• Carrying laundry to machine • Sorting • Getting clothes in and out of washer and dryer • Folding • Putting away
11. Housework	0 1 2 3	0 1 2 3	• Sweeping or vacuuming • Dusting • Cleaning up spills on counter or floor • Cleaning sinks and toilets • Cleaning bathtub

Function	Level of Impairment	Unmet Need for Care	Essential Components
12. Outside Home	0 1 2 3	0 1 2 3	• Negotiating porch, stairs, walkways • Getting to and navigating essential places like grocery store, doctor's office, bank • Able to drive or get in and out of car, or use public transportation • Plan trip
13. Routine Health Care	0 1 2 3	0 1 2 3	• Completing everyday tasks that don't need close monitoring and supervision by a licensed care professional • Ability to follow directions (taking medications, weighing self, exercising, special diet planning)
14. Special Health Care	0 1 2 3	0 1 2 3	• Following directions required or performed by a licensed health care professional • Performing complex dressings (wound care, physical therapy, occupational therapy, speech therapy, IV therapy, tube feeding, intravenous care)
15. Being Alone	0 1 2 3	0 1 2 3	• Recognizing an emergency • Responding to an emergency • Able to get out of the home in case of an emergency • Recognizing and responding to threats to personal health or safety

DON-R with Dementia Triggers

Function	Level of Impairment	Unmet Need for Care	Indicators of Possible Cognitive Impairment
1. Eating	0 1 2 3	0 1 2 3	unexplained weight loss, failure to thrive, or vague symptoms (weak, dizzy); difficulty with swallowing
2. Bathing	0 1 2 3	0 1 2 3	poor personal hygiene observed compared to previous
3. Grooming	0 1 2 3	0 1 2 3	inattentive to appearance, unkempt, compared to previous
4. Dressing	0 1 2 3	0 1 2 3	inappropriate dress for climate, weather conditions, or occasion
5. Transferring	0 1 2 3	0 1 2 3	
6. Continence	0 1 2 3	0 1 2 3	
7. Managing Money	0 1 2 3	0 1 2 3	can no longer write checks, pay bills, balance a checkbook, count money/make change;
8. Telephoning	0 1 2 3	0 1 2 3	can no longer recognize/dial numbers properly; has difficulty with verbal expression, following conversations.
9. Preparing Meals	0 1 2 3	0 1 2 3	can no longer operate stove; cannot heat water; fails to turn surface units/oven off; meal preparation tasks are too complex.
10. Laundry	0 1 2 3	0 1 2 3	can no longer operate washer/dryer
11. Housework	0 1 2 3	0 1 2 3	no longer has usual initiative for basic household chores/upkeep; has trouble organizing objects around the house compared to previous

Function	Level of Impairment	Unmet Need for Care	Indicators of Possible Cognitive Impairment
12. Outside Home	0 1 2 3	0 1 2 3	• fails to keep scheduled appointments/comes at wrong time/wrong day • can no longer shop alone for clothing, household or groceries; stays in own room within home • can no longer drive or use transportation alone; impaired sense of direction; gets lost in formerly familiar areas.
13. Routine Health	0 1 2 3	0 1 2 3	repeatedly, and apparently unintentionally, fails to follow instructions for Rx dosages, other healthcare tasks; does not appear to comprehend instructions; cannot learn/retain ability to do new tasks.
14. Special Health	0 1 2 3	0 1 2 3	repeatedly and apparently unintentionally fails to follow instructions for healthcare tasks; does not appear to comprehend instructions; cannot learn/retain ability to do new tasks.
15. Being Alone	0 1 2 3	0 1 2 3	could not identify and respond appropriately to an emergency; seems disoriented. Ability to reason is impaired.

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Appendix 114-C Nutrition Screening Initiative – DETERMINE (NSI-D)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Nutrition Screening Initiative – DETERMINE (NSI-D)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-C	**Previous Update:**	

The Nutrition Screening Initiative (NSI) Checklist is a scored checklist aimed at developing the nutritional awareness of older adults living in the community. The checklist was developed to be either self-administered by the older adult or used by professionals to rate the potential or actual nutrition risk status. The Checklist has been psychometrically tested and found to have acceptable

levels of reliability and validity. The checklist does not provide a clinical diagnosis but does provide an effective initial screen of nutrition risk. Often, people who score high on the checklist have multiple problems, which can be addressed once identified.

The Nutrition Screening Initiative is a project of the American Academy of Family Physicians, The Academy of Nutrition and Dietetics and the National Council on the Aging. Following is a summary of the instrument.

The Nutrition Screening Initiative is a national collaborative effort committed to the identification and treatment of nutritional problems in older persons. Analysis was used to derive item weights that would predict poor nutrient intakes and low perceived health status. Sensitivity and specificity values were reviewed to define low, moderate, and high nutritional risk scores. This resulted in a revised checklist containing 10 yes/no items. Scores of 6 or more points define persons at high nutritional risk, and in a study by Posner, et. al. identified between 36% and 46% of older persons who may be at increased nutritional risk owing to inadequate intakes of essential nutrients or to fair or poor perceived health.

DETERMINE was designed by the American Academy of Family Physicians, the National Council on the Aging and others as part of the Nutrition Screening Initiative. This tool can be used by professionals working with elders to assess their risk for poor nutritional status or malnutrition. The DETERMINE questionnaire can also be used to measure an individual's change in level of nutritional risk over time. If DETERMINE scores taken prior to beginning a new nutrition program are compared with scores later in the program, a decrease in the resulting score would indicate a corresponding decrease in the elder's nutritional risk. In this way, the effectiveness of the program for the individual can be evaluated.

The "DETERMINE" in the name of the assessment is a mnemonic associated with the various factors associated with nutritional risk:

D – disease
E – eating poorly
T – tooth loss/mouth pain
E – economic hardship
R – reduced social contact
M – multiple medications
I – involuntary weight loss
N – needs assistance in self-care
E – elderly

It is important to review responses to each question in addition to the total score to identify appropriate interventions based on those areas of risk.

NSI Appendix B

For any individual who responds affirmatively for Item #5 "I have tooth or mouth problems that make it difficult to eat" staff must administer the NSI Appendix B.

Appendix B focuses on issues related to oral health including:

- Tooth or mouth problems that cause difficulty with eating

- Mouth pain
- Dry mouth
- Specific problems with oral health
- Date of last dentist visit

Based on the results of Appendix B, staff should print the assessment results and provide the report to the individual (or caregiver) for follow-up with an oral health professional, including assisting with referrals and appointments if needed.

Appendix 114-D Food Security Survey

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Food Security Survey	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-D	**Previous Update:**	

The Six-Item Food Security Scale was developed by researchers at the National Center for Health Statistics in collaboration with Abt Associates Inc. and documented in the *American Journal of Public Health*, vol. 89, pp. 1231-34, 1999. The survey has been shown to identify food-insecure households and households with very low food security with reasonably high specificity. The instrument does not directly ask about children's food security, and does not measure the most severe range of adult food insecurity, in which children's food intake is likely to be reduced. The original version asks each question in the relative time period of the last 12 months; however, DAS use a relative time period of the last 30 days.

This survey, six simple questions, will help us determine what areas of the state are the most food insecure, will help us to prioritize our wait lists, will help us to refer the appropriate clients to other nutrition support programs like SNAP, will help us to make our case with legislators, will help us to apply for funding to address this issue and help us to identify those individuals most in need. Here are the six questions: Scores are indicated in {}.

1. During the last 30 days, how often was this statement true: The food that we bought just didn't last, and we didn't have money to get more?
    1. Often {1}
    2. Sometimes {1}
    3. Never {0}
2. During the last 30 days, how often was this statement true: We couldn't afford to eat balanced meals?
    1. Often {1}
    2. Sometimes {1}
    3. Never {0}
3. In the past 30 days, did you or other adults in your household ever cut the size of your meals

because there wasn't enough money for food?

1. Yes {1}
2. No {0}

4. In the past 30 days, did you or other adults in your household ever skip meals because there wasn't enough money for food?
    1. Yes {1}
    2. No {0}
5. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?
    1. Yes {1}
    2. No {0}
6. In the last 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?
    1. Yes {1}
    2. No {0}

Scores of 0-1 indicate High Food Security
Scores of 2-4 indicate Low Food Security
Scores of 5-6 indicate Very Low Food Security

The Food Security Survey is in the DAS data system and will score itself. The survey can be administered over the phone or face to face. It should be administered at the time of intake, six months after receiving services and at annual reassessments.

Appendix 114-E Risk Assessment Tool (RAT)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Risk Assessment Tool (RAT)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-E	**Previous Update:**	

The Older Americans Act (OAA) establishes eligibility based on an individual being 60 years of age or older (with special criteria for caregivers and certain recipients of nutrition services). The Department of Human Services/Division of Aging Services (DAS) sought to operationalize the four additional OAA targeted populations to ensure that persons in greatest need are being served and to maximize the effective use of limited resources:

- Greatest economic need
- Greatest social need
- Frail
- At risk of institutionalization

DAS created the Risk Assessment Tool (RAT) to have a comprehensive overview of individuals requesting Older American Act (OAA) services and improve the accuracy of identifying those who are at highest risk of institutionalization [e.g. nursing home placement (NHP)]. The RAT gives Aging and Disability Resource Connection (ADRC) staff and case managers guidance on which clients to focus on while maximizing flexibility to determine service allocation based on their professional experience.

The Risk Assessment Tool

Members of the statewide Case Management Redesign Work Team identified risk factors for institutionalization based on their extensive field experience. Then, DAS researchers from the Program Integrity and Access to Services Sections conducted research on known risk factors. Staff combined this knowledge into the Risk Assessment Tool (RAT). The section inclusion criteria are based on research-identified risk or topics deemed important but not found in research. Sections that research identified as not contributing risk were excluded. Where risk factors are identified in research, those questions in the RAT are appropriately weighted to calculate Risk Levels (High, Moderate, and Low).

Sections included in the RAT are:

- Functional Status
- Unmet Need
- Health and Wellness
- Unplanned Hospital Visits
- Fall Risk
- Cognitive Impairment
- Depression and Anxiety
- Caregiver Burden
- Substance Abuse
- Risk of Abuse / Neglect / Exploitation
- Social Support
- Environmental
- Access to Services
- Demographics

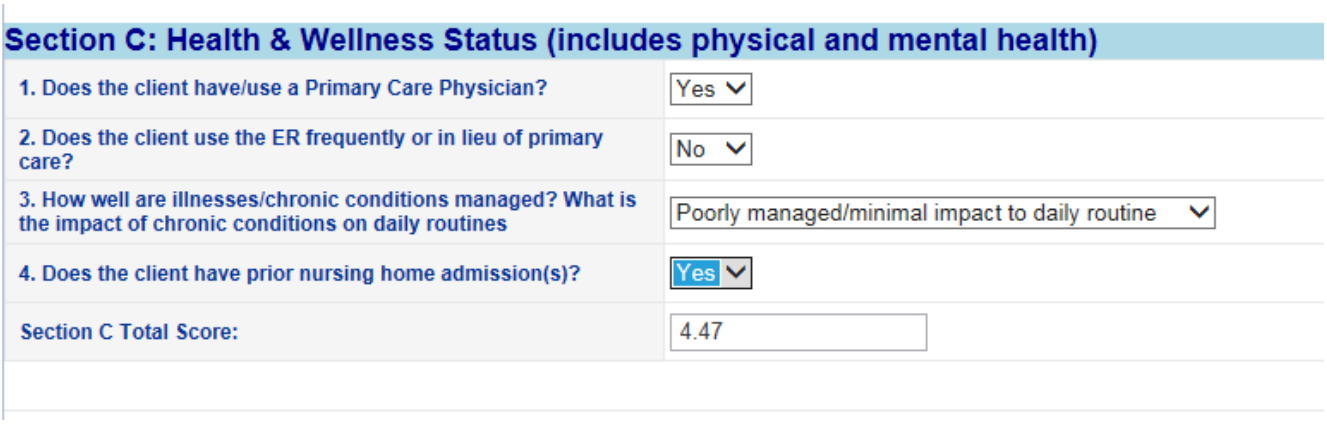
Certain sections contain trigger questions linked to full vetted assessments that properly identify the individual's risk in the category (e.g. Risk of Falls triggers the Stay Independent brochure). The Rosalynn Carter Institute for Caregiving (RCI), in partnership with Emory University's Fuqua Center for Late-Life Depression and the Alzheimer's Research Center, identified the trigger questions (and associated specialized assessment for the domains of cognitive impairment, caregiver burden, depression, and mental health.

Section A and Section B

Section A (DON-R Functional Status Scores) and Section B (DON-R Unmet Need Score) will auto populate from the latest DON-R assessment completed for that client.

Section C

- Questions 1 and 2 require a “Yes” or “No” response
- Question 3 asks about how well illnesses/chronic conditions are managed and the impact of the chronic conditions on daily routines. Possible responses are:
  - Managed well/minimal impact
  - Managed well/significant impact
  - Poorly managed/minimal impact
  - Poorly managed/significant impact
- Question 4 asks whether the client has a prior nursing home admission(s), with a “Yes” or “No” response.



Section D

Section D asks about prior unplanned hospital use. This does not include planned procedures and does include emergency room visits. There are two possible responses:

- No visits
- 1+ visits

If prior visits are reported, inquire whether there were any re-hospitalizations within 30 days of discharge for the same condition. If so, consider a referral to your Care Transitions program.

Section E

Section E documents risk of falls using questions developed by the Centers for Disease Control and Prevention (CDC). Each of the three questions requires a "Yes" or "No" response. If any of the questions is answered "Yes", the score adjusts to show increased risk.

Section F

Section F begins by asking whether the client has a medical diagnosis of cognitive impairment. This must be an actual diagnosis by a medical professional (Alzheimer's disease, Lewy Body Disease, etc.), not a generic statement such as "doctor thinks she is confused." If possible, document the information about the diagnosis in the case notes.

If the answer to this question is "Yes" the section automatically scores.

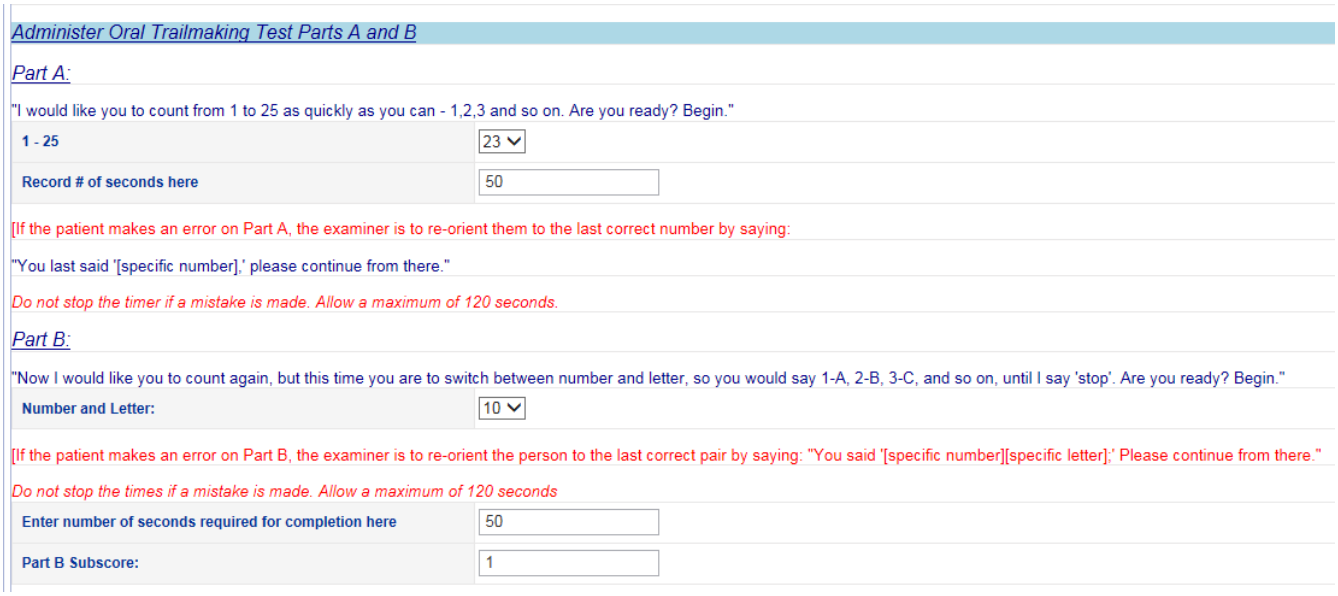
If the answer to this question is "No" then additional questions will display.

Read the script to the client and record his/her ability to repeat the five words during each of two trials.

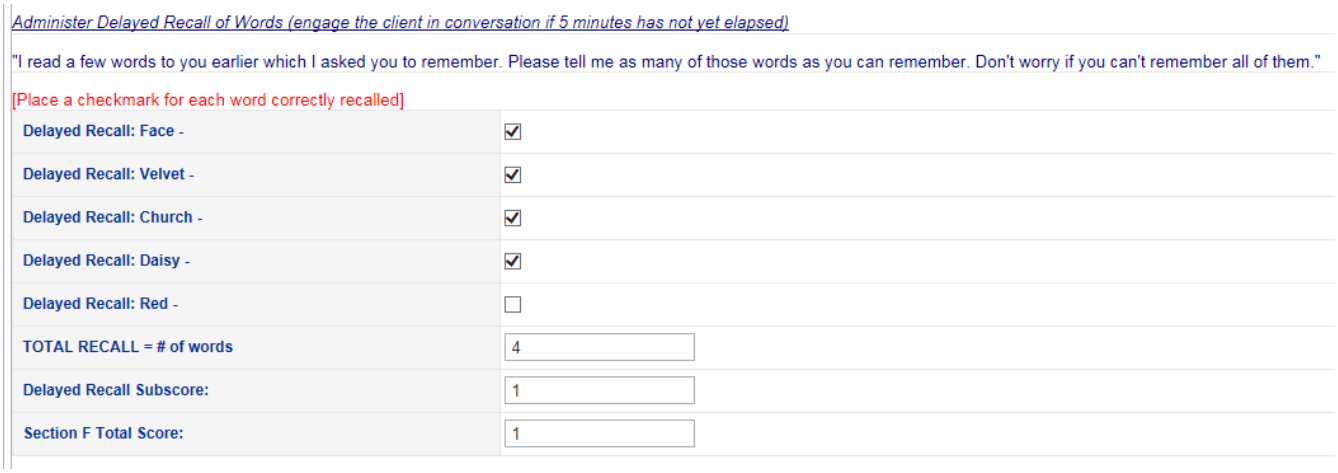
Next, administer the two Oral Trailmaking Tests as described.

- Part A – the client is asked to count from 1 to 25 in a maximum of 120 seconds. If the client counts successfully to 25, record the number of seconds required to complete the task. If the client does not reach 25 in 120 seconds, select the last number correctly stated and note 120 seconds in the time box. Part A is not required and is not calculated in scoring; however, it is a good indicator of rote memory functioning.
- Part B – the client is asked to repeat numbers and letters in alternating fashion within 120 seconds. Note the last number or letter successfully stated in the dropdown and record the number of seconds required in the time box. Part B measures executive functioning.

This sub section automatically scores.



The next section is administration of the delayed recall. Document each of the five words that the client remembers. Manually enter the number of correct responses in the "TOTAL RECALL" box. The system will compute the subscore and the total score for Section F.



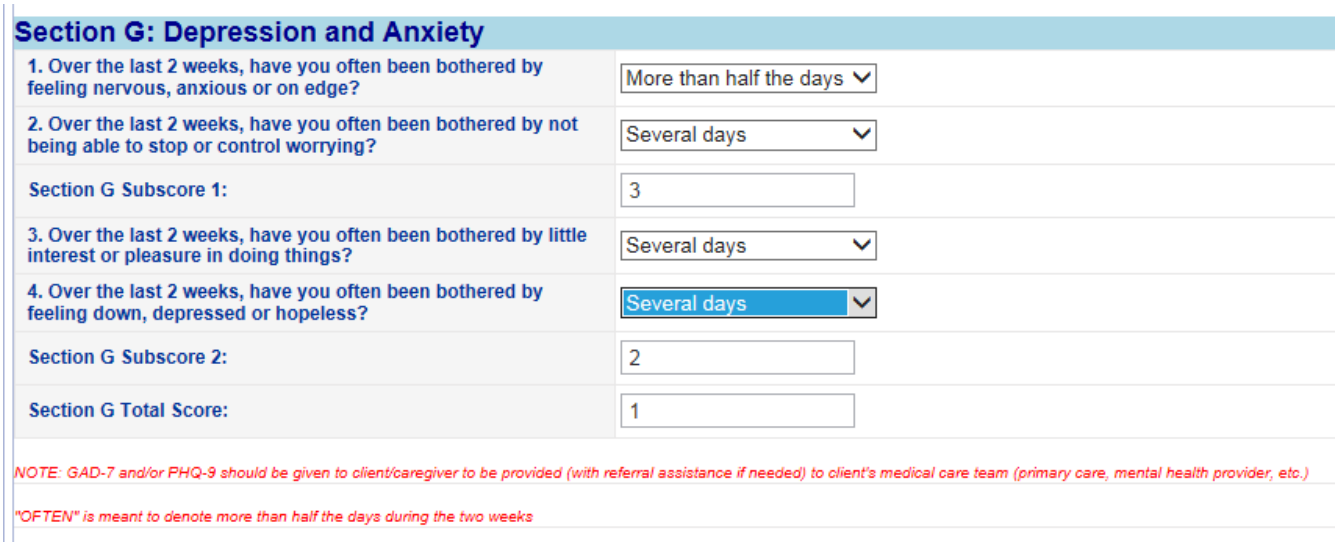
The system calculates scoring based on number of seconds required to complete the tasks and the number of words recalled.

Section G

This section asks four questions about the client's mental health over the past two weeks. The possible responses for each question are:

- Not at all
- Several days
- More than half the days
- Nearly every day

The section is broken into two sub-sections. Subscore 1 relates to anxiety and Subscore 2 relates to depression. Each is scored separately. If the Subscore1 total is 3 or greater, it is recommended that the GAD-7 be administered. If the Subscore2 total is 3 or greater, it is recommended that the PHQ-9 be administered.



Section G: Depression and Anxiety

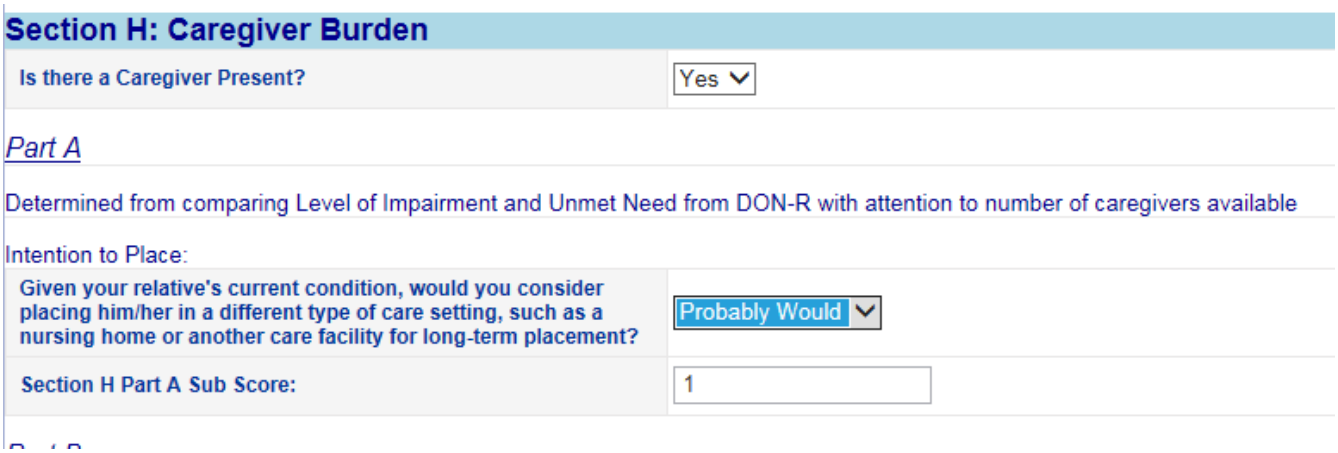
1. Over the last 2 weeks, have you often been bothered by feeling nervous, anxious or on edge?	More than half the days
2. Over the last 2 weeks, have you often been bothered by not being able to stop or control worrying?	Several days
Section G Subscore 1:	3
3. Over the last 2 weeks, have you often been bothered by little interest or pleasure in doing things?	Several days
4. Over the last 2 weeks, have you often been bothered by feeling down, depressed or hopeless?	Several days
Section G Subscore 2:	2
Section G Total Score:	1

NOTE: GAD-7 and/or PHQ-9 should be given to client/caregiver to be provided (with referral assistance if needed) to client's medical care team (primary care, mental health provider, etc.)

"OFTEN" is meant to denote more than half the days during the two weeks

Section H

The first question asks whether a caregiver is present. If not, skip this section. Part A gauges the caregiver's intention to place the care receiver in a nursing home or other long-term care setting. Select the response provided by the caregiver. If the caregiver answers "Probably Would," further assessment using the Bakas Caregiving Outcomes Scale (BCOS) may be helpful. Also, consider a referral to Community Options Counseling.



Section H: Caregiver Burden

Is there a Caregiver Present?	Yes

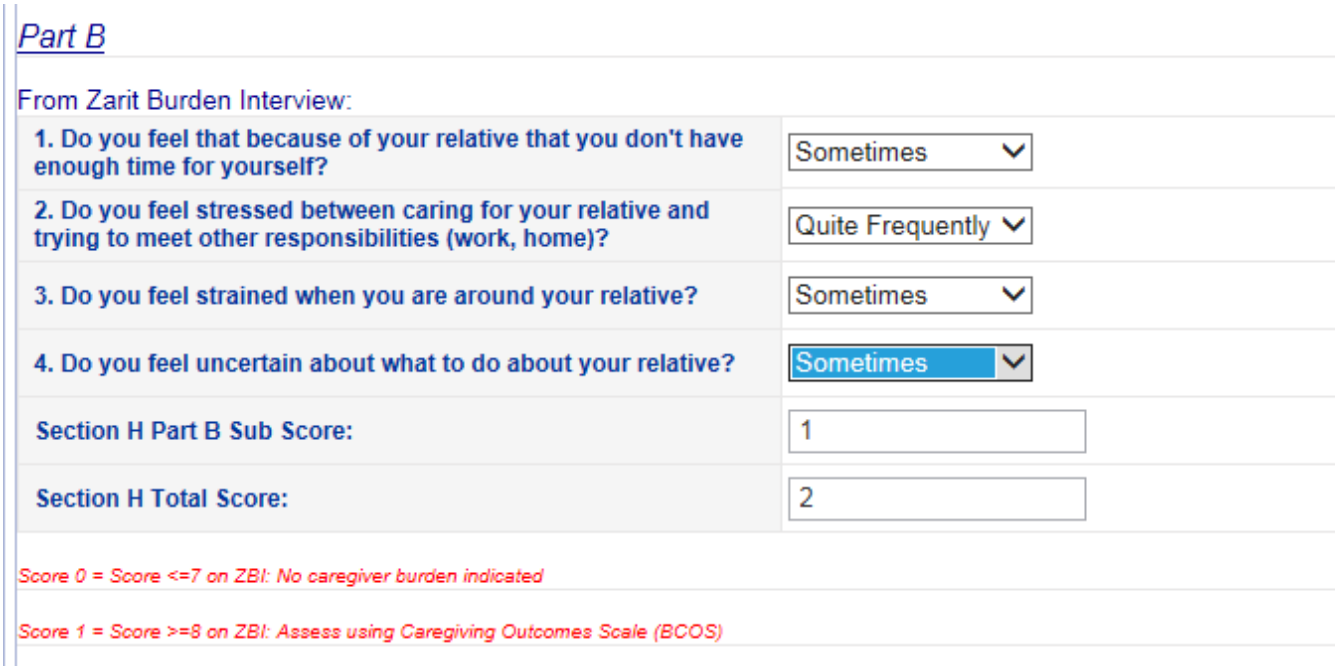
Part A

Determined from comparing Level of Impairment and Unmet Need from DON-R with attention to number of caregivers available

Intention to Place:

Given your relative's current condition, would you consider placing him/her in a different type of care setting, such as a nursing home or another care facility for long-term placement?	Probably Would
Section H Part A Sub Score:	1

Part B is taken from the Zarit Burden Interview and asks four questions about the impact of providing care on the caregiver's life.



Part B

From Zarit Burden Interview:

1. Do you feel that because of your relative that you don't have enough time for yourself?	Sometimes
2. Do you feel stressed between caring for your relative and trying to meet other responsibilities (work, home)?	Quite Frequently
3. Do you feel strained when you are around your relative?	Sometimes
4. Do you feel uncertain about what to do about your relative?	Sometimes
Section H Part B Sub Score:	1
Section H Total Score:	2

Score 0 = Score <=7 on ZBI: No caregiver burden indicated

Score 1 = Score >=8 on ZBI: Assess using Caregiving Outcomes Scale (BCOS)

If the Section H, Part B sub score equals 1, it is recommended that the caregiver be assessed using the Bakas Caregiving Outcomes Scale (BCOS).

Section I

This section asks four questions regarding use of alcohol and drugs (both legal and illegal). Each question requires a response of "Yes" or "No." You should verify that the answers given in this section correspond to the question about "having 3 or more drinks" from the NSI.

Section I: Substance Abuse

Determined from comparing NSI Question: I have 3 or more drinks of beer, liquor or wine almost every day

From CAGE-AID:

1. Have you ever felt you ought to cut down on your drinking or drug use?	No
2. Have people annoyed you by criticizing your drinking or drug use?	Yes
3. Have you felt bad or guilty about your drinking or drug use?	Yes
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	No
Section I Total Score:	1

Score 0 = Score <=1

Score 1 = Score >=2 - Assess using AUDIT-10

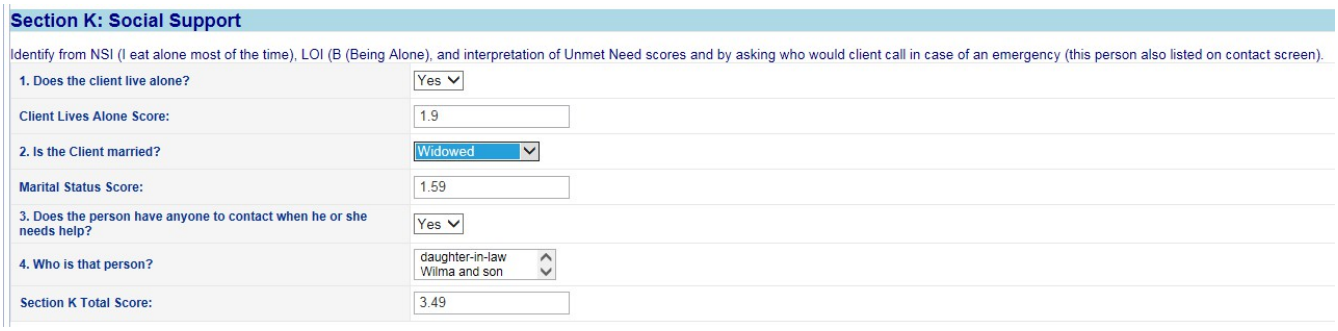
If the total score equals 2 or greater, assess further using the AUDIT-10 assessment.

Section J

This section identifies risk of abuse, neglect, or exploitation. Identify whether there is an active case with Adult Protective Services (APS) and/or whether there is a history of involvement with APS.

Section K

This section identifies the level of social support available to the client. The section asks whether the client lives alone (compare to the NSI question about “eating alone most of the time”, the Level Impairment Score in the domain of Being Alone, and interpretation of unmet need scores), the client’s marital status, and whether the client has someone to contact when help is needed (and the identity of that person – be sure to include in the Contacts screen). The system automatically calculates the weighted score for this section based on the responses.



Section L

This section looks at risks posed by the client’s current living environment, and asks about home ownership. All questions require a response of “Yes” or “No.” If risks are identified, consider conducting a home safety assessment.

Section M

This section documents the degree of access the client has to services, including transportation, whether the client lives in a rural area, the safety of the client’s neighborhood, and whether the client has access to income and/or resources to afford services (compare this information to the Income Worksheet). For question 3, the concerns can be voiced by the client or the caregiver, or can be based on the objective observations of the assessor.

Section M: Access to Services	
1. Does client have access to transportation?	Yes
2. Does client live in a rural area?	Yes
3. Are there any concerns about the safety of the client's neighborhood?	No
4. Does the client have or have access to income and/or resources to afford services?	No
Section M Total Score:	2.45

Section N

The demographic section auto populates from the Demographics tab and calculates the weighted score. If the information in this section is not correct, make the changes on the Demographics tab as well as within Section N.

Appendix 114-F Montreal Cognitive Assessment (MoCA)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Montreal Cognitive Assessment (MoCA)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-F	**Previous Update:**	

Based on the Cognitive Impairment section of the Risk Assessment Tool (Section F) using the word recall and oral trail making tasks, or based on professional judgement, staff may complete the Montreal Cognitive Assessment (MoCA).

Before using the MoCA, staff must complete webinar #26 entitled “Cognitive Status Assessment for Older Adults” on the Rosalynn Carter Institute website. Staff should have a printed copy of the MoCA available before administering the assessment. The time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

The MoCA was created in 1996 by Ziad Nasreddine in Montreal, Quebec and was validated in the setting of mild cognitive impairment, and has subsequently been adopted in numerous other settings clinically. It assesses several cognitive domains: short-term memory recall, visuospatial abilities, executive functioning, language, orientation, and attention/concentration/working memory. A validation test by Nasreddine in 2005 showed that the MoCA was a promising tool for detecting Mild Cognitive Impairment (MCI) and Early Alzheimer’s disease. Because the MoCA assesses multiple cognitive domains, it may be a useful assessment tool for several neurological diseases that affect younger populations.

It is imperative that staff approach any consumer identified as having possible cognitive impairment with a capacity-based mindset – meaning that staff should recognize and emphasize remaining cognitive abilities.

Visuospatial / Executive Tasks

Part 1: Instruct the client as follows: “Please draw a line, going from a number to a letter in ascending order. Begin here (point to 1) and draw a line from 1 then to A then to 2. End here (point to E).” Allocate one point if the client draws the correct pattern (1-A-2-B-3-C-4-D-5-E) without any lines that cross. Select “Yes” or “No” from the dropdown to indicate whether the task was completed.

Part 2: Show the client the picture of the cube and ask the client to copy the picture. You can use the back of the assessment or another piece of paper. One point is allocated for a correctly executed drawing that includes all of the criteria below:

- Drawing must be three-dimensional
- All lines are drawn
- No lines are added
- Lines are relatively parallel and their length is similar (rectangular prisms are accepted)

Select “Yes” or “No” from the dropdown to indicate whether the task was completed.

Part 3: Give the client the following instructions: “Draw a clock. Put in all the numbers and set the time to ten past eleven.” Select “Yes” or “No” from the dropdown to indicate whether each component of the task was completed:

- Contour: the clock face must be a circle with only minor distortion
- Numbers: all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour
- Hands: there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centered within the clock face with their junction close to the clock center.

Naming Task

Beginning on the left, point to each figure and say: “Tell me the name of this animal.” Select “Yes” or “No” from the dropdown to indicate whether the correct response was given.

Memory

Read the following instructions to the client. “This is a memory test. I am going to read to you a list of five words to remember. Listen carefully. When I finish, please tell me as many words as you can remember. It doesn’t matter in what order you say them.” [Read list of words below at the rate of 1 word per second. Client repeats them after the last word is read. Check each word the client recalls in the space below]. [Do a second trial even if the client recalls the word(s) on the first trial.] “I am going to read the same words a second time. Try to remember and tell me as many words as you can, including words you said the first time.” No points are given for Trials One and Two.

Attention

Forward Digit Span: Give the following instruction: “I am going to say some numbers and when I am through, repeat them to me exactly as I said them.” Read the five number sequence at a rate of

one digit per second. Select “Yes” or “No” from the dropdown to indicate whether the task was completed.

Backward Digit Span: Give the following instruction: “Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order.” Read the three number sequence at a rate of one digit per second. Select “Yes” or “No” from the dropdown to indicate whether the task was completed.

Vigilance: Give the following instruction: “I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand.” Read the list of letters at a rate of one per second. Give one point if there is zero to one error (an error is a tap on a wrong letter or a failure to tap on letter A). If there are more than one errors, give no points.

Serial 7 Subtraction: Give the following instruction: “Now I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop.” Give the instruction twice if necessary. This item is scored out of 3 points. Give 0 points for no correct subtractions, 1 point for one correct subtraction, 2 points for two to three correct subtractions, and 3 points if the client successfully makes four or five correct subtractions. Each subtraction is counted independently; that is, if the client responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction.

Language

Sentence repetition: Give the following instructions: “I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: I only know that John is the one to help today.” Following the response, say: “Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: The cat always hid under the couch when dogs were in the room.” Check “Yes” or “No” for each sentence correctly repeated. Repetition must be exact.

Fluency: Give the following instructions: “Tell me as many words as you can think of that begin with a certain letter of alphabet that I will tell you in a moment. You can say any kind of word you want except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix (for example, love, lover, loving). I will tell you to stop after one minute. Are you ready?” [Pause] Now, tell me as many words as you can think of that begin with the letter F [time for 60 seconds]. Stop.” Write the number of words that client generates. The system will automatically compute a score, with 11 being needed to award 1 point.

Abstraction

Ask the client to explain what pairs of words have in common, starting with the example: “Tell me how an orange and a banana are alike.” If the client answers in a concrete manner, then say only one additional time: “Tell me another way in which those items are alike.” If the subject does not give the appropriate response (fruit), say “Yes, and they are also both fruit.” Do not give any additional instructions or clarification. After the practice trial, say: “Now tell me how a train and a bicycle are alike.” Following the response, administer the second trial, saying; “Now tell me how a ruler and a watch are alike.” Do not give any additional instructions or prompts. Select “Yes” or “No” to indicate a correct response for each pair correctly answered. The following responses are acceptable:

- Train-bicycle: means of transportation, means of travelling, you take trips in both

- Ruler-watch: measuring instruments, used to measure

The following responses are not acceptable:

- Train-bicycle: they have wheels
- Ruler-watch: the have numbers

Delayed Recall

Give the following instruction: “I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember.” Select “Yes” or “No” for each word the client correctly remembers.

At this time, do not use the Category cue or the Multiple Choice cue.

Orientation

Give the following instruction to the client: “Tell me the date today.” If the client does not give a complete answer, then prompt accordingly by saying: “Tell me the [year, month, exact date, and day of the week].” Then say: “Now, tell me the name of the place and which city it is in.” Select “Yes” or “No” for whether each component of the question was answered correctly. The client must state the exact date and exact place.

Education

The system will add 1 point for an individual who has 12 years or fewer of formal education.

Scoring

The maximum possible score is 30 points (including the additional point for education). The interpretation of the client’s total score is as follows:

- 26 and above: normal
- 18-26: mild cognitive impairment
- 10-17: moderate cognitive impairment
- Less than 10: severe cognitive impairment

It is recommended that the results from the MoCA be printed and given to the client and/or caregiver to take to his/her physician for further evaluation.

Appendix 114-G Montreal Cognitive Assessment – BLIND (MoCA-BLIND)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Montreal Cognitive Assessment – BLIND (MoCA-BLIND)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-G	**Previous Update:**	

The Montreal Cognitive Assessment (MoCA)-BLIND is an adapted version of the original MoCA that assesses the cognitive domains of attention and concentration, memory, language, conceptual thinking, calculations, and orientation. It contains the same items as the original MoCA except for those requiring visual abilities, which have been removed. The time to administer the MoCA-BLIND is approximately 5-10 minutes. The total possible score is 22 points, with a score of 18 or above considered normal.

Before using the MoCA-BLIND, staff must complete webinar #26 entitled "Cognitive Status Assessment for Older Adults" on the Rosalynn Carter Institute website.

Memory

Read the following instructions to the client. "This is a memory test. I am going to read to you a list of five words to remember. Listen carefully. When I finish, please tell me as many words as you can remember. It doesn't matter in what order you say them." [Read list of words below at the rate of 1 word per second. Client repeats them after the last word is read. Check each word the client recalls in the space below]. [Do a second trial even if the client recalls the word(s) on the first trial.] "I am going to read the same words a second time. Try to remember and tell me as many words as you can, including words you said the first time." No points are given for trials one and two.

Attention

Forward Digit Span: Give the following instruction: "I am going to say some numbers and when I am through, repeat them to me exactly as I said them." Read the five number sequence at a rate of one digit per second. Select "Yes" or "No" from the dropdown to indicate whether the task was completed.

Backward Digit Span: Give the following instruction: "Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order." Read the three number sequence at a rate of one digit per second. Select "Yes" or "No" from the dropdown to indicate whether the task was completed.

Vigilance: Give the following instruction: "I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand." Read the list of letters at a rate of one per second. Give one point if there is zero to one error (an error is a tap on a wrong letter or a failure to tap on letter A).

Serial 7 Subtraction: Give the following instruction: "Now I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop." Give the instruction twice if necessary. This item is scored out of 3 points. Give 0 points for no correct subtractions, 1 point for one correct subtraction, 2 points for two to three correct subtractions, and 3 points if the client successfully makes four or five correct subtractions. Each subtraction is counted independently; that is, if the client responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction.

Language

Sentence repetition: Give the following instructions: "I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: I only know that John is the one to help today." Following the response, say: "Now I am going to read you another sentence. Repeat it after me, exactly as I say it

[pause]: The cat always hid under the couch when dogs were in the room." Check "Yes" or "No" for each sentence correctly repeated. Repetition must be exact.

Fluency: Give the following instructions: "Tell me as many words as you can think of that begin with a certain letter of alphabet that I will tell you in a moment. You can say any kind of word you want except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix (for example, love, lover, loving). I will tell you to stop after one minute. Are you ready?" [Pause] Now, tell me as many words as you can think of that begin with the letter F [time for 60 seconds]. Stop." Write the number of words that client generates. The system will automatically compute a score, with 11 being needed to award 1 point.

Abstraction

Ask the client to explain what pairs of words have in common, starting with the example: "Tell me how an orange and a banana are alike." If the client answers in a concrete manner, then say only one additional time: "Tell me another way in which those items are alike." If the subject does not give the appropriate response (fruit), say "Yes, and they are also both fruit." Do not give any additional instructions or clarification. After the practice trial, say: "Now tell me how a train and a bicycle are alike." Following the response, administer the second trial, saying; "Now tell me how a ruler and a watch are alike." Do not give any additional instructions or prompts. Select "Yes" or "No" to indicate a correct response for each pair correctly answered. The following responses are acceptable:

- Train-bicycle: means of transportation, means of travelling, you take trips in both
- Ruler-watch: measuring instruments, used to measure

The following responses are not acceptable:

- Train-bicycle: they have wheels
- Ruler-watch: the have numbers

Delayed Recall

Give the following instruction: "I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember." Select "Yes" or "No" for each word the client correctly remembers.

At this time, do not use the Category cue or the Multiple Choice cue.

Orientation

Give the following instruction to the client: "Tell me the date today." If the client does not give a complete answer, then prompt accordingly by saying: "Tell me the [year, month, exact date, and day of the week]." Then say: "Now, tell me the name of the place and which city it is in." Select "Yes" or "No" for whether each component of the question was answered correctly. The client must state the exact date and exact place.

Education

The system will add 1 point for an individual who has 12 years or fewer of formal education.

Scoring

A score of 22 or higher is considered normal. Change the status to “Complete” when done.

It is recommended that the results from the MoCA-BLIND be printed and given to the client and/or caregiver to take to his/her physician for further evaluation.

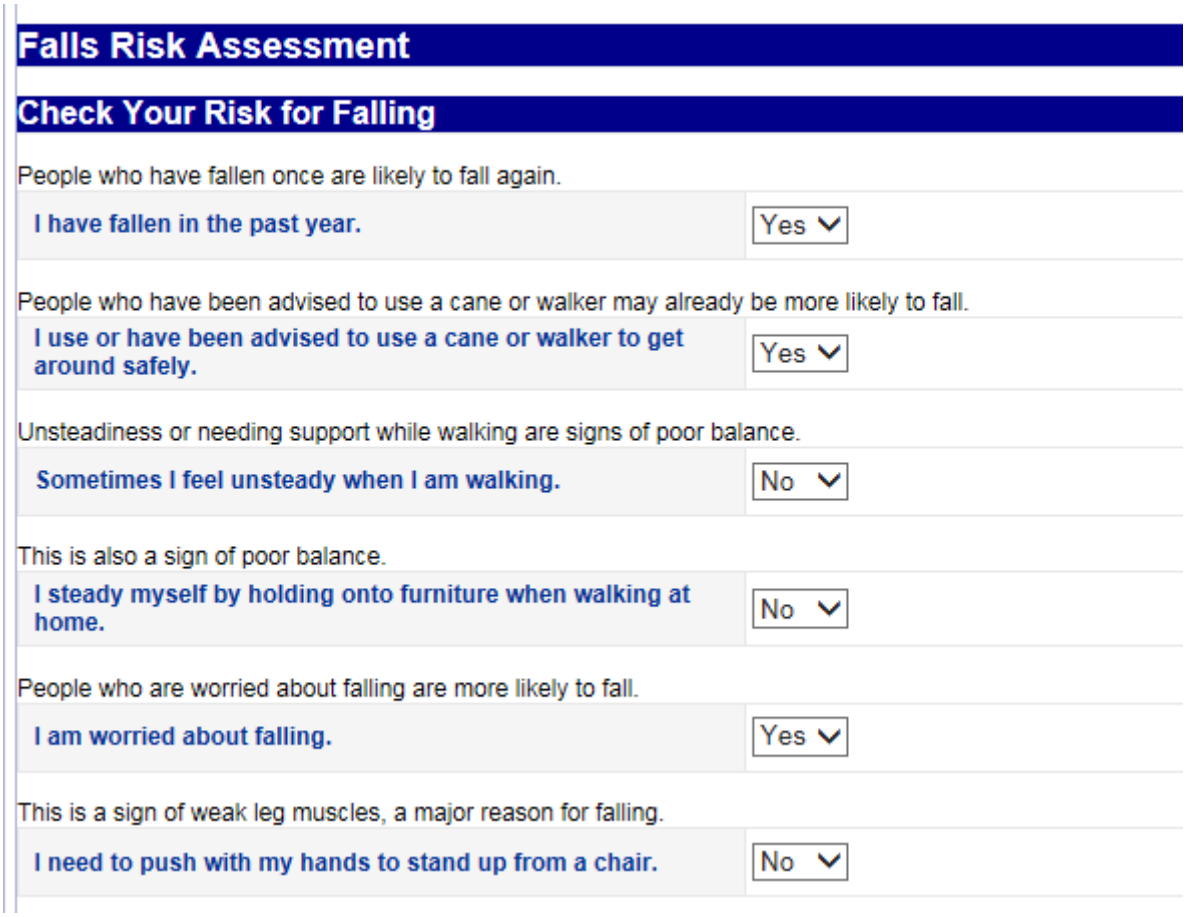
Appendix 114-H STEADI Toolkit

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	STEADI Toolkit	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-H	**Previous Update:**	

Based on the Risk of Falls section of the Risk Assessment Tool (Section E) using the assessment questions developed by the Centers for Disease Control and Prevention (CDC), or based on professional judgement and information gathered from the DON-R in the domains of Transferring and Outside Home, staff may complete the STEADI Falls Risk Assessment.

The STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Initiative has been developed by the CDC as part of a comprehensive approach to prevent falls. The STEADI initiative includes materials for health care providers and older adult patients. The STEADI Took Kit is based on a simple algorithm adapted from the American and British Geriatric Societies’ Clinical Practice Guidelines.

The STEADI Falls Risk Assessment consists of twelve questions, each requiring a “Yes” or “No” response.



Falls Risk Assessment

Check Your Risk for Falling

People who have fallen once are likely to fall again.

I have fallen in the past year.	Yes

People who have been advised to use a cane or walker may already be more likely to fall.

I use or have been advised to use a cane or walker to get around safely.	Yes

Unsteadiness or needing support while walking are signs of poor balance.

Sometimes I feel unsteady when I am walking.	No

This is also a sign of poor balance.

I steady myself by holding onto furniture when walking at home.	No

People who are worried about falling are more likely to fall.

I am worried about falling.	Yes

This is a sign of weak leg muscles, a major reason for falling.

I need to push with my hands to stand up from a chair.	No

If the total score is greater than or equal to 4, the consumer is considered at risk for falling. Staff should send the completed STEADI Falls Risk Assessment to the client or his/her caregiver and suggest that they consult with their health care provider and/or pharmacist. Additional referrals to evidence-based falls prevention programs (Tai Chi for Health, Matter of Balance or OTAGO) may be appropriate.

Appendix 114-I PHQ-9

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Patient Health Questionnaire-9 Item Scale (PHQ-9)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-I	**Previous Update:**	

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders. The 27-item test was found to be a barrier to use in busy clinical settings. In two large studies, a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.

Based on the Depression and Anxiety section of the Risk Assessment Tool (Section G) using the PHQ-2 and GAD-2 screens, or based on professional judgement, staff may complete the PHQ-9 assessment tool.

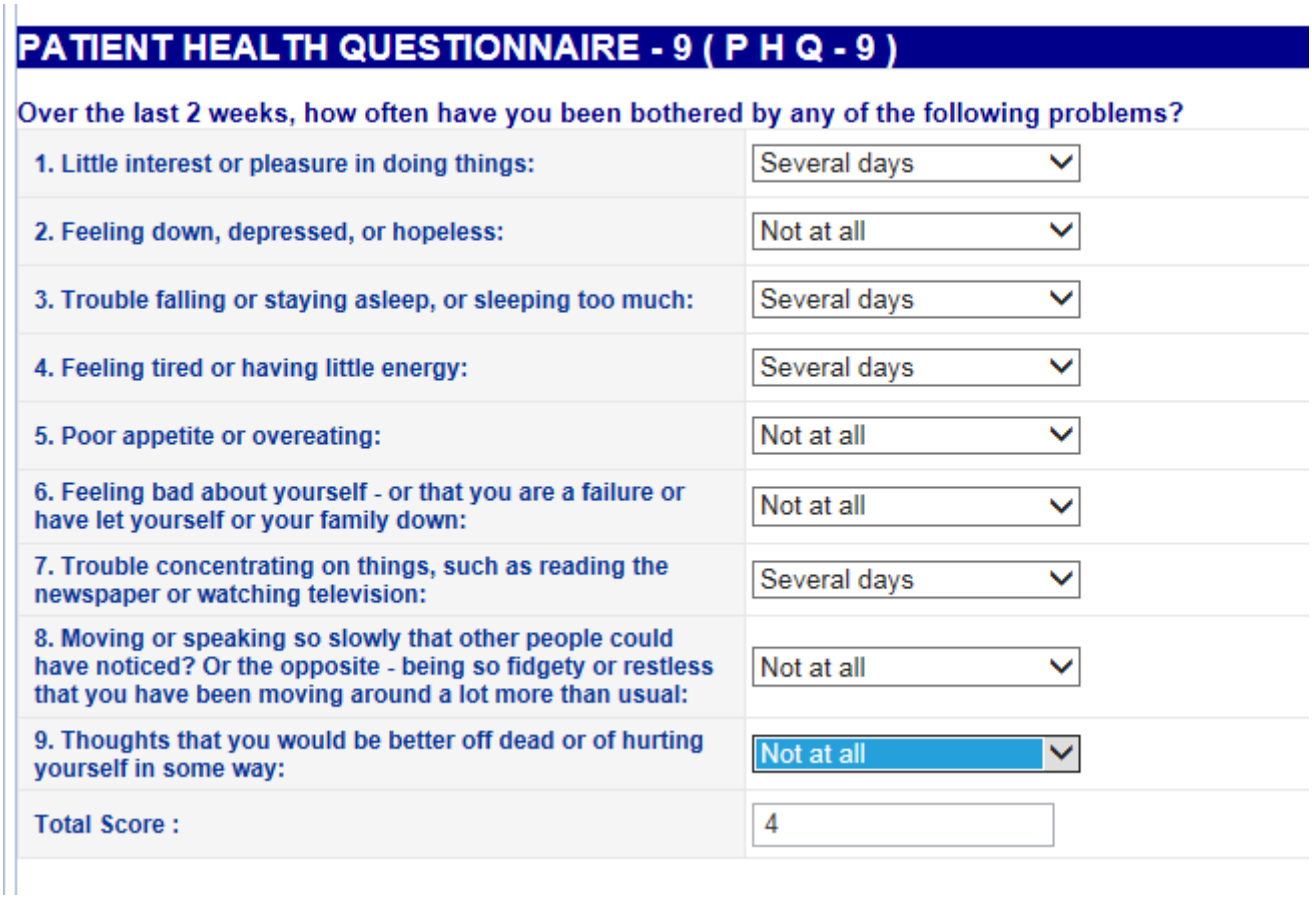
Before using the PHQ-9, staff must complete webinar #24 entitled “Assessment for Depression in Older Adults” on the Rosalynn Carter Institute website.

The PHQ-9 consists of nine questions, each with the following answer options:

- Not at all
- Several days
- More than half the days
- Nearly every day

Ask the client each question, preceded by the statement “Over the last 2 weeks, how often have you been bothered by any of the following problems.” Record the answer by selecting the correct item in the dropdown menu. Alternately, the questionnaire can be printed out and given to the client to complete, then entered into the system.

The first two questions of the PHQ-9 are the same as the two questions asked on the Risk Assessment Tool (the PHQ-2). Depending on the time lapse from when the Risk Assessment Tool was conducted, the first two questions can be scored without repeating those questions. However, it is certainly appropriate to ask all nine questions, in case anything has changed in the client’s situation.

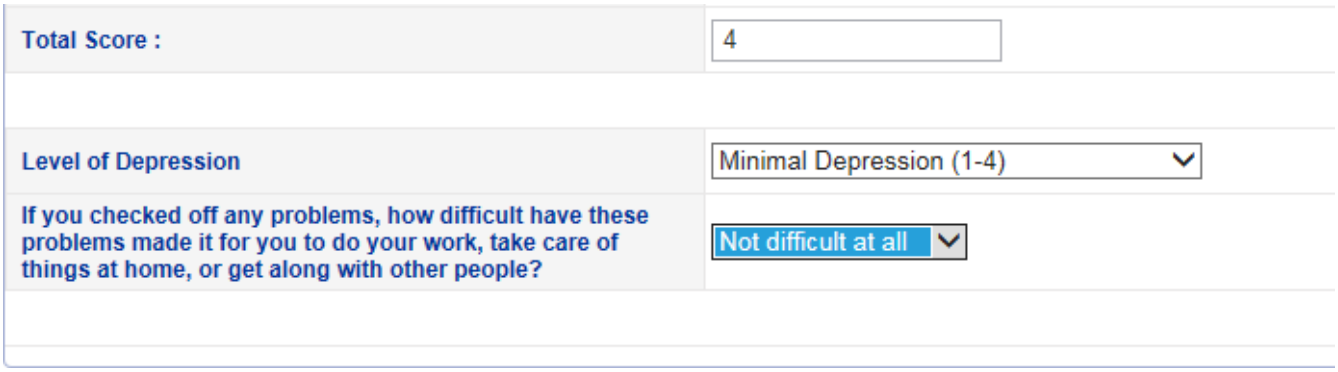


PATIENT HEALTH QUESTIONNAIRE - 9 (P H Q - 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:	Several days
2. Feeling down, depressed, or hopeless:	Not at all
3. Trouble falling or staying asleep, or sleeping too much:	Several days
4. Feeling tired or having little energy:	Several days
5. Poor appetite or overeating:	Not at all
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down:	Not at all
7. Trouble concentrating on things, such as reading the newspaper or watching television:	Several days
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual:	Not at all
9. Thoughts that you would be better off dead or of hurting yourself in some way:	Not at all
Total Score :	4

The system automatically computes a Total Score based on the answers provided by client.



The additional question helps you to identify how significantly the person's level of depression is impacting their daily routines and help them develop strategies to improve his/her quality of life. The response to this question will give an indication of how urgent further evaluation may be and may indicate that a manual "override" of the Risk Level may be appropriate, with input from supervisory staff.

A score of 10 or higher is considered a positive screen for depression and should prompt intervention. It is suggested that staff print out the PHQ-9 for the client and ask him/her to take it to a health care provider or mental health provider. Depending on the severity of the depression as indicated by the score, immediate action may be appropriate. The following are appropriate emergency treatment options:

- 911
- Hospital or Emergency Room
- Primary care physician
- Georgia Crisis and Access Line (G-CAL) at 1-800-715-4225 or www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/

For non-emergency treatment, the following represent appropriate options:

- Medical doctor (primary care or psychiatrist)
- Talk therapist (does not prescribe medication)
  - Psychologist
  - Marriage and family therapist (MFT)
  - Licensed clinical social worker (LCSW)
  - Licensed professional counselor (LPC)

Appendix 114-J GAD-7

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Generalized Anxiety Disorder – 7 Item Scale (GAD-7)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-J	**Previous Update:**	

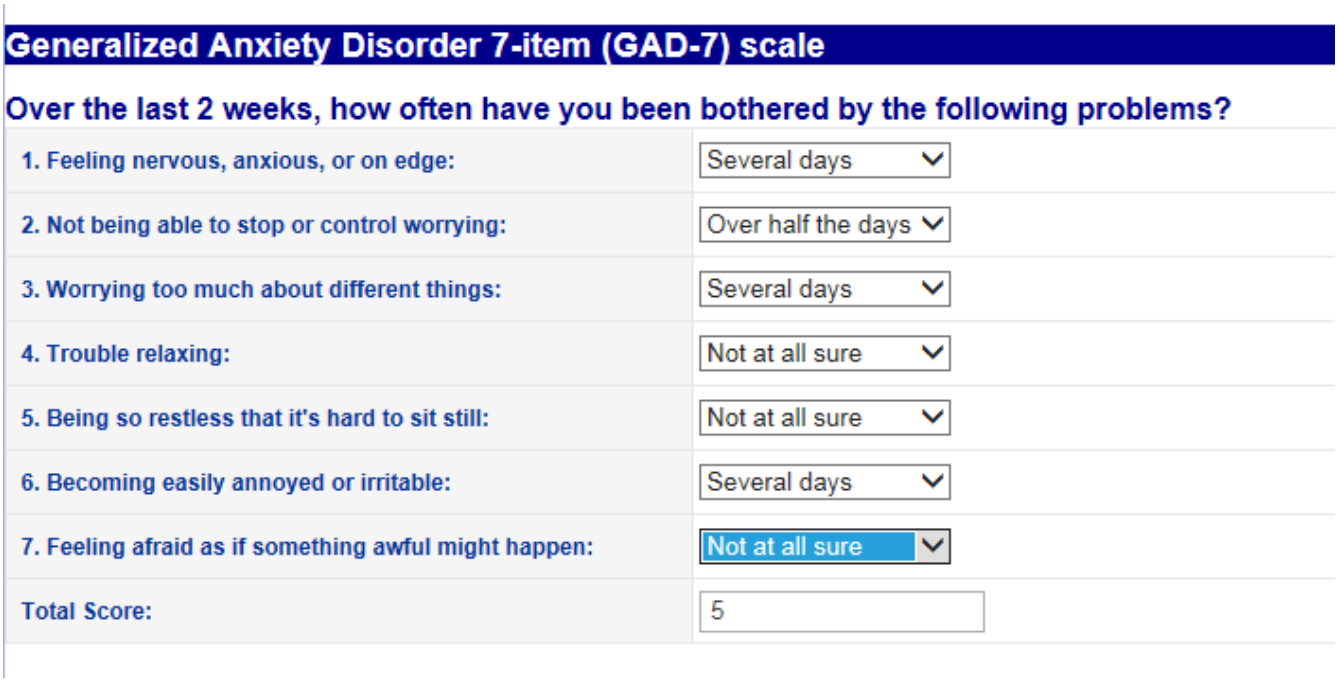
The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders. The 27-item test was found to be a barrier to use in busy clinical settings. In two large studies, a self-administered version of the PRIME-MD called the Generalized Anxiety Disorder scale (GAD-7) was developed and validated. Though originally developed to diagnose generalized anxiety disorder, the GAD-7 also provide to have good sensitivity and specificity as a screener for panic, social anxiety, and post-traumatic stress disorder.

Based on the Depression and Anxiety section of the Risk Assessment Tool (Section G) using the PHQ-2 and GAD-2 screens, or based on professional judgement, staff may complete the GAD-7 assessment tool.

Before using the GAD-7, staff must complete webinar #23 entitled “Assessment for Anxiety in Older Adults” on the Rosalynn Carter Institute website. The GAD-7 consists of seven questions, with each question offering a choice of four responses:

- Not at all sure
- Several days
- Over half the days
- Nearly every day

Ask the consumer each question and record the response.



Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge:	Several days
2. Not being able to stop or control worrying:	Over half the days
3. Worrying too much about different things:	Several days
4. Trouble relaxing:	Not at all sure
5. Being so restless that it's hard to sit still:	Not at all sure
6. Becoming easily annoyed or irritable:	Several days
7. Feeling afraid as if something awful might happen:	Not at all sure
Total Score:	5

The system automatically computes a total score. The Level of Anxiety allows staff to identify the degree to which the consumer indicates anxiety disorder based on the total score:

- None (0-4)
- Mild Anxiety (5-9)
- Moderate Anxiety (10-14)

- Severe Anxiety (15-21)

If the client scores a 10 or higher, refer the client for additional evaluation, either from a primary care physician or mental health professional.

Appendix 114-K Alcohol Use Disorders Identification Test (AUDIT-10)

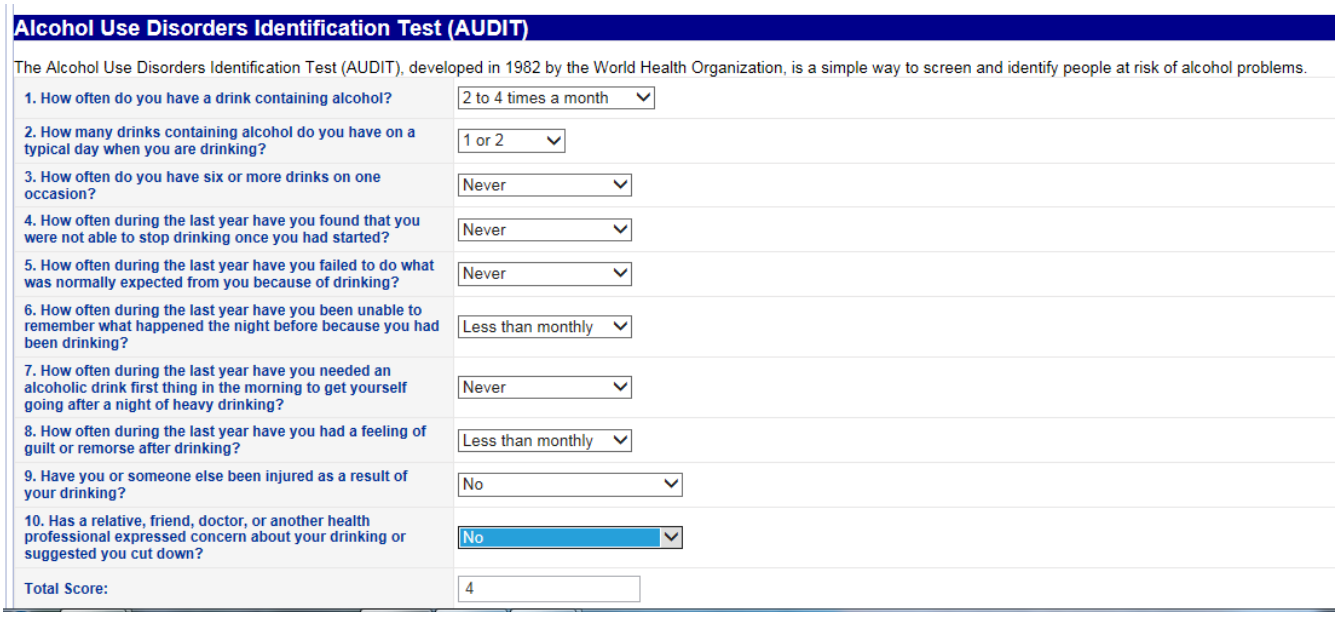
	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Alcohol Use Disorders Identification Test (AUDIT-10)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-K	**Previous Update:**	

According to AARP, about 17% of adults age 60 and older struggle with alcohol or drug addiction. The AUDIT-10 is a 10-item assessment tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Consumers should be encouraged to answer the AUDIT-10 questions in terms of standard drinks. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups.

Based on the Substance Abuse section of the Risk Assessment Tool (Section I) using the CAGE-AID, or based on professional judgement, staff may complete the AUDIT-10 assessment tool.

Before using the AUDIT-10, staff must complete webinar #25 entitled “Assessment for Substance Use in Older Adults” on the Rosalynn Carter Institute website.

The DAS data system automatically scores the answers.



Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?	2 to 4 times a month
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2
3. How often do you have six or more drinks on one occasion?	Never
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never
6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Less than monthly
7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?	Never
8. How often during the last year have you had a feeling of guilt or remorse after drinking?	Less than monthly
9. Have you or someone else been injured as a result of your drinking?	No
10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?	No
Total Score:	4

For a total score of 8 or higher in the general population, further assessment by a professional is indicated. For a total score of 5 or higher among older adults, further assessment by a professional is indicated.

Appendix 114-L Bakas Caregiving Outcomes Scale (BCOS)

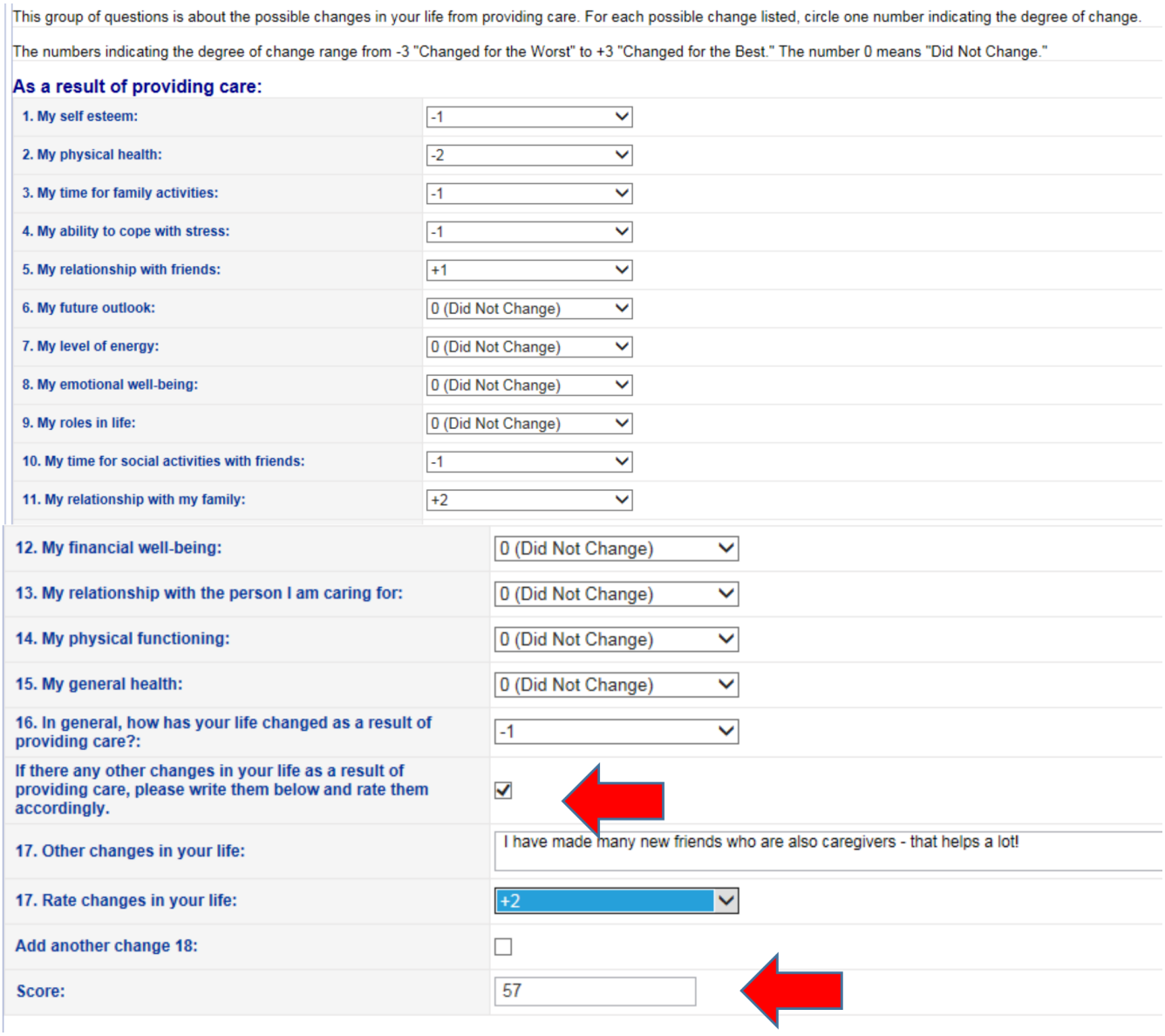
	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	
	Section Title:	Bakas Caregiving Outcomes Scale (BCOS)	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	Appendix 114-L	**Previous Update:**	

The Bakas Caregiving Outcomes Scale (BCOS) was originally developed in 1994 to measure life changes in family caregivers of stroke survivors. The BCOS has been requested for use with a variety of other caregiving populations. The BCOS is copyrighted; however, the Division of Aging Services has obtained written permission from the developer for its use.

Based on the Caregiver Burden section of the Risk Assessment Tool (Section H) using the Zarit Burden Index or based on professional judgement, staff may complete the BCOS assessment tool.

Before using the BCOS, staff must complete webinar #27 entitled “Assessing Caregiver Burden” on the Rosalynn Carter Institute website.

Administer the BCOS by asking each of the first 16 questions and selecting the degree of change experienced by the caregiver from the dropdown menu after each question.



After question #16, there is a question about any other changes in the person's life as a result of providing care. If you check the box, question 17 will appear with a text box to write the changes described by the person and to rate that change. Up to three additional changes can be added. These answers can be critical in identifying areas of concern for the caregiver and lead to interventions that can provide maximum support.

The specific questions allow interventions / referrals / activities to be tailored to that specific area of the caregiver's life with the goal of improving the well-being of the caregiver.

The DAS data system automatically converts the responses to a score and totals each question to get an overall score. Each item #1 - #15 is scored. Items #16 – 19 are not included in the scoring. If all answers are "Changed for the Worst", the total score = 15. If all answers are "Changed for the Best", the total score = 105. Only as a marker, if each item is answered "No Change", the total score = 60.

The BCOS is not intended to score one caregiver against another, but to measure changes in a caregiver's experience over time. While one could postulate that a caregiver with a low score has had a more difficult time coping with caregiving than someone with a higher score, such interpretations and comparisons among clients and potential clients should be made judiciously.

Gayle Alston of the Rosalynn Carter Institute for Caregiving provided the following visual represen-

tation of the domains that relate to each question on the BCOS.

My self esteem		
My physical health		
My time for family activities		
My ability to cope with stress		
My relationship with friends		
My future outlook		
My level of energy		
My emotional well-being		
My roles in life		
My time for social activities with friends		
My relationship with my family		
My financial well-being		
My relationship with the care recipient		
My physical functioning		
My general health		
Quality of Life	Emotional	Physical

118 Prioritizing Clients

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	100	**Effective Date:**	08/15/2019
	Section Title:	Prioritizing Clients	**Reviewed or Updated in:**	MT 2020-02
	Section Number:	118	**Previous Update:**	MT 2020-02

118.1 Summary Statement

While all adults aged 60 and over are eligible for services (except as noted in MAN 5300, CH 202.4A), the Older Americans Act Title III requires programs to prioritize service or give preference to older individuals with the greatest economic and social need, to persons who are frail, and to persons who are at risk of institutionalization. The OAA also identifies as a priority population persons with Alzheimer's disease and related disorders and the caregivers of such individuals. Further, the OAA instructs that particular attention should be given to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.

The ability to effectively target higher-priority persons is particularly critical when available funding is not sufficient to serve all persons who are eligible. In addition to providing guidance for remediating funding reductions, this document provides guidance in the prioritizing services to persons in greatest need.

118.2 Definitions

The following definitions are taken directly or derived from language in the Older Americans Act.

At Risk for Institutional Placement

Unable to perform at least two activities of daily living without substantial assistance (including verbal reminding, physical cueing, or supervision) and is determined by the State involved to be in need of placement in a long-term care facility. DAS measures risk for institutionalization by using the Risk Assessment Tool.

Frail

- Unable to perform at least three activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision (receives a score of 2 or higher in 3 or more ADLs on the DON-R), or
- Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual

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)

118.3 Screening and Admission to Services

The Aging and Disability Resource Connection in each AAA is charged with screening consumers for eligibility for various services. If a consumer meets age requirements, and funding is not sufficient to serve all eligible consumers, staff will use the four Older Americans Act target criteria to prioritize consumers for further assessment and care planning.

The Triage screening tool is based on the OAA target criteria, and specific questions are weighted using research that documents risk of institutionalization based on these factors.

Clients who are determined to be of higher priority are then referred for assessment and care planning to determine appropriate services and service levels. See MAN 5300, 202 Program Guidelines and Requirements and MAN 5300, 114 Guidelines for Client Assessment.

118.4 Prioritizing Clients Due to Funding Restrictions

If the prioritization is due to a reduction in funding, the AAA should evaluate affected services first. If the funding reduction is not specific to a service area (example: Title III-C2) the AAA may identify which service or services to evaluate first; for example, congregate meals or homemaker services. DAS data system reports and the Area Plan documents may give some guidance about these services. Once the services are identified, the AAA may then prioritize the order in which the services will be reviewed, remembering that some clients may receive multiple services.

To ensure that assessments are completed accurately and appropriately, the AAA may require additional training for agency and/or provider staff who will be involved in this process. This training may include use of the DON-R, the NSI, Food Security Survey, as well as any other assessment tools used by the AAA, and/or specific issues of service eligibility or delivery. DAS suggests that such training be scheduled prior to initiating client reviews.

If the prioritization is due to a reduction in funding, the AAA should evaluate affected services first. If the funding reduction is not specific to a service area (example: Title III-C2) the AAA may identify which service or services to evaluate first; for example, congregate meals or homemaker services. DAS data system reports and the Area Plan documents may give some guidance about these services. Once the services are identified, the AAA may then prioritize the order in which the services will be reviewed, remembering that some clients may receive multiple services.

To ensure that assessments are completed accurately and appropriately, the AAA may require additional training for agency and/or provider staff who will be involved in this process. This training may include use of the DON-R, the NSI, Food Security Survey, as well as any other assessment tools used by the AAA, and/or specific issues of service eligibility or delivery. DAS suggests that such training be scheduled prior to initiating client reviews.

Start with clients with lowest total DON-R scores. Reviewing the following data from the client records will assist with prioritizing clients for whom a reduction in services or discharge may be appropriate.

1. Review the begin date and end date for services to confirm accuracy. Do those services accurately adhere to policy? Are there any services that the client is no longer receiving but for which there is no End Date? If so, enter the appropriate End Date and Disposition Code.
2. In the “Assessment” tab, review the latest DON-R in detail. Is the latest DON-R consistent with current services and service levels? For example, a client who has a total DON-R of 3 currently receives 6 hours per week of Homemaker services.
3. Does the domain(s) of Level of Impairment and/or Unmet Need coincide with the current services and service levels provided? For example, a client receives Home Delivered Meals but has no impairment scores in Meal Preparation, Eating, or Going Outside the Home, or is not considered homebound (see MAN 5300, CH 202.4C).
4. In the “Assessment” tab, review at least one prior DON-R in detail. Is the current score consistent, or is there a logical sequence, from prior score to current score? Are the notes for DON-R domains adequate and appropriate?
5. In the “Assessment” tab, review any other assessment (NSI, Food Security Survey, Risk Assessment Tool, Bakas Caregiving Outcomes Scale, etc.) completed on the client and determine their impact on current services and service levels. Each assessment tool is equally important and

staff should pay attention to discrete domains or questions in each assessment tool, rather than making decisions based on total scores.

Identify any policy guidelines that will influence services or service levels (for example, for Title III-E services the caregiver is the identified client and may have a lower DON-R score). Is the client a caregiver? If so, is there a care receiver identified? Do services align with policy?

Identify whether the client is on the waiting list for other service(s).

Identify any other service(s) that the client is receiving. Do those services accurately correspond to the DON-R score? For example, the client's Level of Impairment score is a "1" in Bathing but is only receiving Home Delivered Meals.

Finally, review information in the client record that documents whether he/she is in greatest economic need and/or greatest social need. These factors must be considered in addition to assessment details in determining prioritization.

Review the case notes in the client's record, with attention to the following questions:

1. Are there HCBS Case Notes to indicate activities and, when appropriate, to document the need for services that may not be clearly indicated by the DON-R?
2. Has the client received services consistently, or has there been a lapse or gap in time since services were last received?

The above steps will identify clients who are appropriate for continuing services at current levels and will also identify clients who should be considered for adjustments in the type or frequency of service(s).

For each client identified for reductions or termination of service(s), the AAA must complete a desk audit. This may be done by AAA staff or delegated to a contracted service provider. The person performing the desk audit must be trained in assessment protocols and DAS policy regarding service delivery.

If the desk audit results in questions or concerns for any client, the AAA must ensure that a thorough reassessment is completed, either by telephone or in person before a decision is made about that client's service(s).

If the assessment indicates that current service levels are appropriate, update the Service Plan/Order for the client, or include a case note indicating that current service levels should continue.

Always ensure that services and service levels align to specific domains of the DON-R and with other specialized assessments completed.

If the assessment indicates that any current service(s) is not needed, or that a reduction in any current service(s) is appropriate, follow DAS policy to notify client as described in 202 Program Guidelines and Requirements.

Clients identified for reduction or discharge for services must be offered the option to receive service(s) on a private-pay basis, funded by the client, the client's family, or other resources available

to the client.

Prioritizing Clients in Response to Increase in Funds

Specific strategies for serving clients based on an increase in funds can depend on several factors, including the amount of the increase and the timing of the increase. The following guidance is provided to promote the most effective use of these funds to serve highest priority clients. Any increase in service or service level should correspond to current assessments and service plans.

- Increase existing services to current clients only when such an increase is based on need as demonstrated through proper assessments and care planning.
- Utilize the Tier 1 waiting list to identify consumers who may benefit from services.
- Utilize the Tier 2 waiting list (which is ranked by Triage scores) to identify consumers who may benefit from services.
- Utilize the ability to shift funds sources to maximize the service delivery system.
- Utilize the Area Plan documents related to public hearings and service gaps to identify where additional funds may have the most significant impact.
- Provide outreach to underserved populations that may benefit from services rather than offering services to consumers who have requested services but who do not meet OAA target criteria.
- Utilize the purchase of assistive technology devices or a consumer-directed approach to service delivery.

References

MAN 5300, Chapter 202

MAN 5300, Section 3016

Gaugler, Joseph E., Duval, Sue, et. al. “Predicting nursing home admission in the U.S: a meta-analysis,” BMC Geriatrics 2007, 7:13.Published June 19, 2007.

“Older Americans Act: Options to Better Target Need and Improve Equity.” U.S. Government Accountability Office, November 2012.

“Older Americans Act: Updated Information on Unmet Need for Services.” U.S. Government Accountability Office, June 10, 2015.

“Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services.” U.S. Government Accountability Office, February 2011.

200 General Service Requirements

202 Program Guidelines and Requirements

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	
	Section Title:	Program Guidelines and Requirements	**Reviewed or Updated in:**	MT 2021-09
	Section Number:	202	**Previous Update:**	

202.1 Purpose

The guidelines and requirements contained in this section are to be used by Area Agencies on Aging (AAA) and their subcontract service providers along with any rules or requirements associated with specific fund sources.

202.2 Scope

These rules apply to all services provided under contract and funded in part or in whole with funds provided by the Department/Division under the Older Americans Act (OAA), as amended, or by State general revenue appropriations, or other funding source granted or contracted to the Division of Aging Services (DAS) for use in providing services, or other funds pooled with such funds to meet the costs for services under the Older Americans Act. These rules provide suggested guidelines for services paid for by local funds or through fee-for-service models.

The Title V program, Senior Community Service Employment Program (SCSEP) has specific program criteria and supersedes guidance provided in this chapter. AAAs will use these guidelines for issues not addressed in SCSEP guidelines. Refer to MAN 5300, Section 400 for SCSEP guidelines.

Unless otherwise noted, the policies contained in this chapter apply to all services included in MAN 5300. Specific services or programs may include additional guidelines or requirements as described in the corresponding chapters.

AAAs may add additional requirements for programs provided that such requirements do not conflict with OAA or DAS requirements and are described in the Area Plan.

202.3 Definitions

Moved to MAN 5600, Appendix E.

202.4A Client Eligibility

Except for fund-source specific eligibility criteria, and for specific eligibility criteria for OAA congregate meals, home delivered meals, and caregiver services, AAAs should use the following eligibility criteria for services:

1. any person, age 60 or over, for all services authorized under the Older Americans Act and any such services supported by any other source of State funding; and
2. any person, regardless of age, who is identified as having Alzheimer's disease or a related disorder, and the families and caregivers of those persons, for state-funded Alzheimer's respite and day care services.

If funding is not sufficient to serve all eligible individuals requesting services, the Older Americans Act provides for giving preference to specific persons:

1. Persons in greatest economic need,
2. Persons in greatest social need,
3. Persons who are frail, and
4. Persons who are at risk of institutionalization.

Additionally, AAAs should give particular attention to serving low-income minority individuals within these categories. See MAN 5300, 218 Transportation Services for additional information on Older Americans Act target criteria.

The Older Americans Act defines a "comprehensive and coordinated system" as a system for providing all necessary support services…using available resources efficiently and with a minimum of duplication. All services provided or authorized under the auspices of the Division should reflect no duplication in service delivery across funds sources, providers, and types of service without documented explanation in the client record. Examples of this duplication include, but are not limited to, services provided via waiver programs, the Veterans Administration, and community and faith-based organizations.

An AAA may designate up to 10% of non-Older Americans Act funds to serve persons with disabilities who are under the age of 60 and/or to serve caregivers not eligible under the National Family Caregiver Support Program requirements. The AAA must indicate in its Area Plan how it will allocate funding for services to these populations.

AAAs may develop fee-for-service programs for persons who may not otherwise meet these target criteria. See MAN 5600 2001 Fund Sources, MAN 5600 4010 Targeting Service Delivery, and MAN 5300 118 Prioritizing Clients for additional guidance.

202.4B Client Status

DAS recognizes two categories of client status for purposes of service delivery and reporting of home and community-based services (HCBS):

1. Active – the client is enrolled in and is currently receiving any HCBS service or has received a unit of any HCBS service within 60 calendar days. For clients receiving multiple services, he/she is considered "active" if at least one service meets the definition above.
2. Closed – the client does not currently receive an HCBS service or has not received any service within 60 days. Clients receiving multiple services are considered closed when an end date is entered for the last service received. Staff must enter the correct disposition code each time a service is ended.

202.4C Homebound Clients

DAS targets some services within the delivery system to serve persons who are homebound.

Homebound (as defined by Centers for Medicare and Medicaid Services): An individual is considered homebound only if the following two criteria are met:

1. Criteria One:
    a. Because of illness/disability or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence *OR*
    b. The individual has a condition such that leaving his or her home is medically contraindicated,

    AND.

2. Criteria Two:
    a. There must exist a normal inability to leave home AND leaving home must require a considerable and taxing effort.

Individuals who meet the criteria for homebound will have scored at least a 2 on the DON-R for Level of Impairment in the domain of Outside Home. AAAs should give priority to those individuals who have highest Unmet Need scores in the domain of Outside Home. Homebound individuals will have also scored positively on the NSI in regard to the statement "I am not always physically able to shop, cook, and/or feed myself" regardless of the diagnosis resulting in the inability to perform these tasks.

202.4D Risk Factors

AAAs should consider the following Risk Factors when referring older adults or persons with disabilities for community-based services in order to maximize the effectiveness and efficiency of services and to target services to individuals at greatest risk. Whenever possible, AAAs should prioritize services based on the individual's risk level, and should recommend services based on specific domains of risk.

1. **Functional Status**
    - Persons having significant ADL impairments and/or IADL impairments (a score of 2 or 3 on a domain of the DON-R) based on physical, cognitive, or emotional factors that place them at risk of institutionalization
2. **Unmet Need for Care**
    - Persons who have unmet needs that can be met through the Aging network, other community resources, or through their support system
3. **Health and Medical Status**
    - Persons identified as having acute and/or complex health conditions (including behavioral health conditions)
    - The degree to which the client uses emergency and primary care appropriately
    - The degree to which chronic conditions are managed or impact daily routine
    - Frequent or inappropriate hospital use or re-hospitalizations
    - The presence of medical conditions that demonstrate a trajectory of decline over time
    - The presence of significantly compromised nutritional health status
4. **Prior Unplanned Hospital Use**

- The number of unplanned hospital visits, including emergency room visits, within the last 180 days
- The number of re-hospitalizations within 30 days for the same condition

5. **Risk of Falls**
   - Risk identified from impairments on the DON-R in domains of Bathing, Transferring, and Outside Home
   - The degree to which the individual is at risk for falls as determined by diagnoses, medications, and environmental factors
   - A prior history of falls
6. **Cognitive Impairment**
   - Risk identified in any DON-R domain based on the need for reminding, cueing, or prompting
   - Risk identified during interview involving attention, recall, or processing information
   - Diagnosis of cognitive impairment, or treatment or medication for a cognitive impairment by a medical professional
7. **Depression/Anxiety**
   - Risk identified based on the PHQ-2 and GAD-2 screening
   - Diagnosis of a behavioral health condition, or treatment or medication for a behavioral health condition by a medical professional
8. **Caregiver Burden**
   - Risk identified based on the Zarit Burden Interview, screening version
   - Risk identified from comparing DON-R Levels of Impairment with Unmet Need for Care with attention to the number of caregivers available
   - Caregiver's intention to place the care receiver in an institutional setting
9. **Substance Abuse**
   - Risk identified from NSI question, "I have 3 or more drinks of beer, liquor or wine almost every day."
   - Risk identified from the AUDIT-C questionnaire
10. **Risk of Abuse, Neglect, or Exploitation**
    - The history of prior or current involvement with Adult Protective Services
    - The frequency of APS involvement
    - Whether there is an ongoing investigation at the time of the assessment
    - Identification of factors that place the person at risk of abuse, neglect, or exploitation
11. **Social Supports**
    - Risk identified by response to the NSI question, "I eat alone most of the time."
    - The status of formal and/or informal support system
    - The degree to which the support system is deteriorating and placing the individual at risk of premature or avoidable placement outside the home

- The identity of persons whom the individual would contact in the event of an emergency
- Risk identified by the Lubben Assessment or the UCLA 3-item Loneliness Scale

12. **Environmental Risk**
    - The presence or absence of significant structural or safety concerns in the individual's environment
    - Inappropriate or unhealthy living conditions
    - The absence of utilities
    - The lack of access to working appliances
13. **Access to Services**
    - The individual's degree of difficulty accessing services due to rural location
    - Absence of transportation services
    - Lack of income or resources to afford services
    - Safety of individual's neighborhood

See MAN 5300, 118 Prioritizing Clients for details about prioritizing clients.

202.4E Complex Cases

The level of potential risk and complexity of the presenting problem(s) will in part determine whether an individual should benefit from Community Options Counseling, Care Consultation, Care Transitions, Case Management, or other community-based interventions.

The following situations, though not inclusive, provide indicators in determining whether a case is complex:

1. The presenting problem or situation is vague or ill-defined, or could jeopardize the health or safety of the individual
2. The individual/family has multiple or complex problems
3. The individual has multiple diagnoses or a new diagnosis with complex follow-up requirements
4. The individual/family may need multiple services or coordination of services across multiple programs or agencies
5. Informal supports are missing, inadequate, overwhelmed, neglectful, or abusive
6. The individual's judgment about his/her needs is questionable
7. The individual/family indicates multiple competing needs, or
8. The individual is at high risk of institutionalization or has multiple risk factors

202.4F Conflict-Free Service Delivery

Person-centered approaches and outcomes that are cost-effective for both individuals and the community characterize an efficient service delivery system. Therefore, DAS supports the implementation of a conflict-free service delivery system.

The key elements included in the design of such as system include:

1. The separation of eligibility determination/assessment and care planning from service provision
2. The evaluator of the individual's needs has no relationship to the individual and has no financial interest in any service provider
3. The agency responsible for determining eligibility has firewalls in place to mitigate the risk of potential conflict if eligibility determination/assessment and service provision overlap, and
4. DAS and the AAA have robust monitoring and oversight to reduce potential conflicts

DAS and the AAAs will pursue systematic and deliberate progress toward a conflict-free delivery system.

202.5 Client Records and Activities

AAAs will ensure through contractual requirements that subcontractors maintain complete client information records.

The AAA will establish and implement written policies and procedures for the maintenance and security of client records, including:

1. The person responsible for supervising the maintenance of records
2. The person(s) having custody of record, and
3. The persons/entities to whom records may be released and for what purposes

DAS, or a particular program area, may establish specific criteria for content of client records. In lieu of specific criteria, client records should include all applicable fields in the electronic client database. To the extent possible, the AAA should maximize the use of electronic records and minimize duplication between electronic and paper records. The holder of the client record is required to keep a paper record only of documents that are not available or that cannot be converted to electronic format.

All client records will be maintained pursuant to MAN 5600 1060 Division Reports, Overview, MAN 5600 1061 Older Americans Act Performance System (OAAPS), and MAN 5600 3012 Provision of Services by Area Agencies on Aging.

202.5A Documentation

Documentation ensures accountability, the coordination of services among providers, and high-quality service delivery. The AAA should ensure that all documentation is concise, current, meaningful, and accurate. This can be achieved through orientation, on-going staff development and monitoring. Staff must complete documentation no later than 2 business days after the event, though the AAA may adopt more stringent requirements for timeliness of documentation.

Staff should write documentation with two specific instances in mind:

1. That another staff person or supervisor would be able to read documentation about a consumer and be able to understand the consumer's situation and provide appropriate services or inter-

ventions in the absence of the primary case manager; and

2. That the consumer's record, if received by subpoena or Open Records Request, would adequately, accurately, and professionally reflect the services provided by the AAA.

DAS does not prescribe a specific format for documentation. The AAA may choose a format to be used at its discretion. However, the following general criteria must be used in all documentation:

1. Notes should include:
    a. the specific date of the activity (month, day, and year)
    b. the case manager's name
    c. the type of activity (face-to-face, telephone call, etc.)
    d. the identify of person(s) involved in the interaction, if any
    e. the purpose of the contact; and
    f. significant information or observations.
2. Notes should reflect objective and factual language and should avoid subjective or vague language, including direct quotes when necessary.
3. Notes should avoid opinions and perceptions, unless these are specifically labeled as such and are necessary for the documentation.
4. Notes **not** prepared in electronic format must be legible.

Staff should use acronyms standard to the Division of Aging Services. See Man 5600, Appendix E "Glossary of Terms, Abbreviations and Acronyms."

Monitoring of Documentation – the AAA or supervisory staff should review records periodically to ensure quality by reviewing whether:

1. Assessments and Service Plans are thorough, accurate, timely, and internally consistent.
2. Clients and their caregivers/families were actively involved in making informed choices regarding service delivery.
3. Services provided were appropriate to achieve client outcomes.

See Appendix B for additional information about documentation.

202.5B Confidentiality of and Access to Client Records

AAAs will ensure maintenance of client records according to the following minimum requirements:

1. Staff may not disclose information about a client or obtained from a client in a form that identifies the person without the informed consent of the person or of his legal representative, unless the disclosure is required by court order, by specific law, or for program monitoring. For more detailed information on informed consent and release of information forms, see MAN 5600 2053 Grant Submittal Instructions.
2. Staff will use client information only for the specific purpose outlined in the written consent authorization or for purposes of performing program evaluation by authorized Federal or State personnel, or the AAA as the local monitoring agency.

Staff must include all signed consent for release of information forms in the client record. See MAN 5600, Appendix D for the Authorization for Release of Information form.

Additional guidance regarding confidentiality and access to records can be found in MAN 5600 1060 Division Reports, Overview, MAN 5600 2053 Grant Submittal Instructions, and MAN 5600 2053 Grant Management. Also see 45 C.F.R. § 1321.51.

202.5C Client Rights and Responsibilities

AAAs and provider organizations will assure that all individuals, or their caregivers/representatives, receive written notification of their rights and responsibilities as program/service participants upon their admission to services. See MAN 5300, Appendix E for the Client Rights and Responsibilities form.

202.5D Client Complaint and Incident Procedures

AAAs will ensure that each provider establishes written client complaint procedures that provide all clients and their advocates with the opportunity for communicating those aspects of the service which have negative impact on them.

The provider must document in each client record that the client was given information about his/her right to make such complaints and of the procedures for filing such complaints prior to the beginning of service delivery.

Procedures should include, at a minimum:

1. A description of the manner in which the provider will handle and resolve complaints, including options for submitting complaints either orally or in writing
2. An explanation of how the provider will address and resolve complaints in a timely manner
3. A description of how the specific provider will ensure client access to contact information related to questions or complaints about services

AAAs will maintain the following information related to complaints and incidents:

1. Documentation of any complaints regarding services provided, including documentation of action taken by the provider/AAA to resolve the complaints
2. Documentation of all incident reports or reports of unusual occurrences or critical incidents (such as falls, accidents, etc.) that affect the health, safety and welfare of staff or clients, including documentation of action taken by the provider/AAA to address the incidents or occurrences following guidelines outlined in MAN 5600 5056 Serious Incident Review Team (SIRT) Process, and
3. Documentation of disclosure to the appropriate contract authority (AAA and/or DAS) upon receipt of any complaints or allegations of employee misconduct

202.5E Client Notification

AAAs will ensure that each provider notifies individuals when services begin (including the type and cost of service), when there are any changes in service delivery (including type, frequency, or cost of service), and when the provider intends to terminate services.

The provider will include in each client record a Client Notification Form for each change in service. See MAN 5300, Appendix D for the Client Notification Form.

202.5F Client Appeals and Grievances

AAAs will ensure that each service provider has established written appeals procedures that are consistent with MAN 5300 CH 110 "Grievance Procedures for Participants in Non-Medicaid Home and Community Based Services". These procedures will provide all clients or their advocates with the opportunity to appeal provider decisions concerning the provision of services, including, but not limited to, the initiation or termination of services, and increases or decreases in service levels. The intent of these procedures is to assure client satisfaction with the services provided. It is the responsibility of the service provider to give specific consideration to the client's concerns.

The AAA will ensure that all providers establish and implement policies and procedures through which individuals and providers may file a written grievance that specify:

1. The process by which all parties receive notification of their right to appeal
2. The rights and responsibilities of all parties
3. The time frames under which each party must take action, and
4. The process by which notifications of appeals decisions occur

202.6 Services to Private Membership Prohibited

AAAs will ensure that those subcontractors with contracts to operate facilities such as nutrition sites, senior centers, day care centers or provide other supportive services under the Older Americans Act or other federal or state funding will not limit such facilities and services to membership in a specific private organization, group, association, or fraternal organization, nor show discriminating preference for such membership. However, this does not preclude AAAs from establishing membership-based senior centers.

202.7 Agency Records

AAAs will maintain proper records related to client activities, personnel, criminal records investigations, reports of complaints, and incidents at both the agency level and the provider level.

AAAs are responsible for ensuring that each service provider maintains agency records according to MAN 5600 3012 Provision of Services by Area Agencies on Aging.

202.7A Personnel Records

The AAA will ensure that providers maintain separate written records for each employee including the following:

1. Identifying information including name, address, telephone number, emergency contact(s)
2. Employment history
3. Documentation of qualifications such as transcripts, diplomas, licenses, or certificates
4. Dates of employment
5. Documentation of results of criminal records investigation, including documentation that the

employee has not been convicted of any charge of abuse, neglect, or exploitation or convicted of any crime (excluding misdemeanors or traffic violations) that would pose a safety or health risk to clients or their families

6. Individual job description or statement of the employee's duties and responsibilities, preferably signed by the employee
7. Documentation of completion of orientation and training requirements, and ongoing staff development activities (see Appendix 202-A Training Requirements for HCBS Staff for list of basic training requirements)
8. Documentation of a performance evaluation conducted at least annually

The Division recognizes that many Aging network staff routinely are in contact with the public. Therefore, each AAA will document that staff have received appropriate preventive measures to protect against the spread of communicable disease. Each AAA may determine local policy, but DAS encourages that employees be current on the required immunization schedule and that they receive annual flu vaccines and tuberculosis screening.

202.7B Criminal Records Investigations

All AAAs will document completion of criminal history investigations in accordance with MAN 5600 3040 Criminal History Investigations on behalf of all employees and volunteers.

202.7C Administrative Appeals

AAAs will ensure that each service provider establishes written appeals procedures that are consistent with MAN 5600 3020 Administrative Appeals.

202.8 Data Collection and Reporting

All AAAs will comply with all requirements of MAN 5600 1060 Division Reports, Overview.

AAAs will make accessible to staff all information needed to initiate and carry out HCBS services, including the DAS data system, as well as any associated hardware and software required to access and operate the system. Whenever possible, the AAA will provide enhanced technology (i.e. laptop computers) to improve program efficiency. The AAA may require additional information systems at its discretion but may not fail to meet the minimal standards required by DAS.

Unless DAS approves a waiver to the AAA, staff must maintain all information gathered on behalf of clients in the DAS data system.

The AAA will use data from the DAS data system, at a minimum, to facilitate quality improvement and data analysis functions in conjunction with other programmatic, client, and cost data.

202.9 Client Contributions, Cost Sharing, and Fee-For-Service

The AAAs will ensure that each service provider establishes written procedures for voluntary contributions, cost sharing, and private pay options. Procedures will correspond to MAN 5600 3090 Fee for Service System Overview, 3091 Cost Share, 3092 Voluntary Contributions, and 3093 Private Pay Services.

Each AAA/provider is encouraged to offer in-home services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In so doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Sections 2025-2028, “Fee for Service System”.

Services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

202.10 Insurance

AAAs are responsible for ensuring that each service provider maintains appropriate types and levels of insurance coverage that protects the health and safety of clients and employees, and that complies with all applicable state and federal statutes.

202.11 Facilities

AAAs will ensure that contractors which operate congregate facilities (such as nutrition sites, senior centers, adult day care facilities or other such facilities) funded by any grant from DAS locate the facility as close as possible to the majority of eligible persons in the specified target group for the service and service area.

AAAs will ensure that such facilities operate in compliance with all federal, state, and local laws and codes that govern facility operations, including but not limited to space, heating, ventilation and air conditioning (HVAC), plumbing, lighting systems, fire safety, sanitation, and insurance coverage. Specific program guidelines may contain more specific criteria for operation of facilities.

202.11A Emergency Plan

AAAs will ensure that all contractors that operate congregate facilities (such as nutrition sites, senior centers, adult day care facilities or other such facilities funded by any grant from DAS) have a written emergency plan, to include evacuation in the event of fire, inclement weather, public health emergency, or other emergency, including missing participants. Such plans must be consistent with MAN 5600 3010 Emergency Planning and Management.

Specific program guidelines may include more stringent requirements in addition to those listed in this section.

202.11B No Smoking Policy

The Surgeon General of the United States has determined that the smoking of tobacco constitutes a health hazard. DAS prohibits smoking of tobacco during the hours of operation of senior programs and in facilities / physical plants designated for senior activities funded by DAS.

202.12 Ethical and Legal Practice

AAAs will ensure that all service providers establish, implement, and review with personnel no less than annually procedures that address the ethical and legal framework for the provision of services, and that all providers comply with Division policies on these and related topics.

Certain services may have specific ethical and/or legal guidelines that refine the general scope outlined in this policy and it is the AAA’s responsibility to ensure appropriate staff is adequately trained in them.

General ethical guidelines for all programs should include, at a minimum:

1. Advocacy for individuals' needs and preferences whenever possible and feasible
2. Professional relationships with individuals and their families
3. Resolution of conflicts of interest between among staff, the individual, the service provider, or other entities
4. Business and financial practices and marketing
5. Resolution of potential or perceived lapses in documented quality of care resulting from actions by individuals or their families, staff, service providers, or other entities that affect service delivery;
6. Process by which clients and providers may file grievances or appeals
7. Provision of staff that are adequately screened, trained, and have credentials appropriate to the service provided, and
8. Prohibition of discrimination against a client or a group of clients

General legal guidelines for all programs should include, at a minimum:

1. Scope of practice for staff
2. Laws and procedures affecting client confidentiality and release of information
3. Federal, state, and local laws that impact service delivery, such as Americans with Disabilities Act, Worker's Compensation laws, and other laws protecting individuals and staff
4. Laws regarding reporting of abuse, neglect, and exploitation, and
5. Laws and practice regarding advanced directives

202.13 Prohibited Activities

The AAA will establish a list of prohibited activities when provider staff is in the client's home. These prohibited activities will include, at a minimum:

1. Consumption of clients' food or drink, except for water
2. Use of clients' telephones for personal calls
3. Discussion of one's own or others' personal problems and religious or political beliefs with the client
4. Bringing other persons, including children, not involved in providing care, to the clients' homes
5. Solicitation or acceptance of tips, gifts, or loans in the form of money or goods for personal gain for clients/caregivers
6. Consumption of alcoholic beverages, or use of medicines or drugs for any purpose, other than as ordered or prescribed for medical treatment, in the clients' homes or prior to being present in the home to provide services
7. Smoking in clients' homes
8. Breach of the clients'/caregivers' privacy or confidentiality of information and records
9. Purchase of any item from the client/caregiver, even at fair market value

10. Assuming control of the financial or personal affairs, or both, of the client or his/her estate, including accepting power of attorney or guardianship
11. Taking anything from the clients' home
12. Committing any act of abuse, neglect, or exploitation

202.14 Program Evaluation and Monitoring

Using tools specified by DAS at a minimum, the AAA and its providers will periodically monitor performance to determine the degree to which defined program outcomes and objectives are being achieved (see MAN 5600 3009 Area Agency on Aging Monitoring and Evaluation of Service Providers and MAN 5600, 7001 Compliance with Contractor Responsibilities and Sanctions.

The AAA will monitor for compliance with program requirements and evaluate performance on at least an annual basis and provide written feedback to the provider about its findings and will provide technical assistance for continuous quality improvement. If the AAA is the service provider, it will develop and implement a protocol for self-evaluation and objective review of services.

The AAA will monitor each provider annually, including ensuring appropriate time for notification to and response from each provider prior to June 30. The AAA will forward all monitoring reports completed during a calendar quarter to DAS by the 15th working day of the following month.

The evaluation process will include at a minimum:

1. Review of the existing program
2. Satisfaction survey results from participants, volunteers, families, and referral sources,
3. Program modifications made that responded to satisfaction survey results and/or changes in needs or interests of individuals, and
4. Proposed program and administrative improvements

202.15 Non-Discrimination in Services

All services are to be provided to eligible recipients without regard to race, color, national origin, gender, mental or physical disability, political or religious affiliation, or sexual orientation. Providers may consider age only with regard to eligibility requirements.

202.16 Changes in Service Levels

It is the explicit intent of DAS to serve clients in greatest need and to maximize the efficiency and effectiveness of the Aging Network.

DAS anticipates that during the span of service delivery to an individual, the individual's needs, supports, and resources will change. Based upon the ongoing process of assessment and reassessment, the AAA may determine based on recommendations from its service provider network, that an individual's type of service or quantity of service may be reduced or terminated (see MAN 5300 §114 "Guidelines for Client Assessment" and MAN 5300 §118 "Prioritizing Clients").

Each AAA will develop written guidelines pursuant to MAN 5600 3020 Administrative Appeals ensuring, at a minimum:

1. That individuals are informed prior to beginning services that the type or quantity of service may be changed
2. That individuals will be informed of any changes in a timely manner
3. That individuals are informed of their rights to appeal a decision, and
4. That all information pertinent to the decision, including changes in assessment data, is thoroughly documented

The provider shall provide written notice of reduction or discontinuation of services, including the reason for the action, at least 30 calendar days prior to the effective date of the change to both the individual and the service agencies involved. The written notice will include information about how to appeal the decision if reduction/termination was not a mutual decision between the family and service provider or not initiated by the individual/family.

The individual will continue to receive services during the 30-day period unless continuation of services would place staff at risk of harm. If other supportive services are also being discontinued, the respective service providers will continue services during the 30-day period.

During the 30-day period, the provider will coordinate with the ADRC as needed to arrange for the provision of information and referral to other services, or to assist with transition to other levels of care as appropriate. If the individual is relocating to another part of the state or country, the provider will refer to appropriate services to assist with coordinating the transition.

For some individuals, a provider may recommend an increase in service levels. In such cases, the increase must be clearly documented in the assessment(s) used to determine that an increase in service levels is appropriate, and the AAA must approve the increase. In lieu of approvals of individual cases, the AAA may establish policies or guidelines that providers may use to increase service levels.

In other situations of changes in service (such as change in provider, etc.) the AAA should follow the 30-day notification guidelines. When a 30-day notice is not possible, the AAA should ensure that clients are notified as soon as possible.

202.17 Service Termination and Discharge

The AAA staff shall discontinue services when any of the following conditions exist:

- The individual has moved to a long-term care facility or other community placement for an extended or permanent duration
- The individual is non-compliant with the Service Plan, or the persistent actions of the individual or the family negate the services provided by the various agencies/individuals involved, AND the AAA staff has documented attempts to counsel with the individual/family to encourage compliance prior to discontinuing services
- The family has developed or strengthened a support system that is capable of providing adequate and acceptable care, and the family and other service providers are informed of how to contact the area ADRC if a future need for in-home services arise
- The individual, caregiver, or individual's family threatens service provider staff (including AAA staff), engages in illegal or hostile/threatening activity, or refuses to remediate unsanitary con-

ditions such that the welfare and safety of service provider staff are in jeopardy AND good-faith attempts at corrective action have failed

- The individual has relocated outside the service area and any transition assistance has been provided, including coordination with AAA staff, in the area of relocation
- The individual requests to discontinue in-home services
- The individual has deceased

Situations may arise in which the current level of service provision is inadequate to ensure the safety and health of the individual. In such situations, the AAA staff must document efforts to educate the individual or family about other community resources including more appropriate levels of care, limitations of current services, and the right of the individual to make informed choices. AAA staff should assist wherever possible to ensure a smooth transition from supportive services. AAA staff must comply with MAN 5300, CH 202.17 when discharging clients or reducing levels of service.

AAA staff will coordinate discontinuation of services with individuals and agencies providing supportive services. Discontinuation of one services should not affect the individual's receipt of other support services. The AAA staff will develop procedures for supervisory review of pending closures.

202.18 Client Safety and Well-Being

The AAA and subcontracting organizations will establish and implement policies and procedures to protect the safety of individuals, staff, and volunteers. Such policies will address the AAA's/subcontracting organization's responsibilities to intervene in management of such risks, and will address the following circumstances, at a minimum, as appropriate to their scope of practice:

1. Mandatory reporting of suspected abuse, neglect, or exploitation
2. Protocols for staff and volunteers who interact with clients, and
3. Reporting of incidents

AAAs and AAA providers will maintain reports of incidents that affect the health, safety, and welfare of the clients, for a minimum of six years.

Providers will furnish adequate identification (ID) to any staff that has direct contact with individuals and caregivers. Each employee must carry the identification and either wear it on his/her person or present it to the individual upon request. An adequate ID is one that is made of permanent materials and that shows the provider agency name, and the name, title, and photograph of the employee. The provider will issue the ID at the time of employment and require its return from each employee upon termination of employment.

202.19A Mandatory Reporting of Abuse / Neglect / Exploitation

Staff of all AAAs and contractors for non-Medicaid Home and Community Based Services are considered mandated reporters under O.C.G.A. 30-5-4.

Any person employed by any program or service funded in part or in full by the statewide aging program, who has reasonable cause to believe that a disabled adult age 18 or older, or elder person

age 65 or older, not residing in a long-term care facility, is being abused, neglected, or exploited must report the abuse, neglect, or exploitation situation to DAS of Aging Services Adult Protective Services Central Intake **and** to a law enforcement agency of appropriate jurisdiction. If the adult is a resident of a long-term care facility, the report should be made to the Department of Community Health, Health Care and Facilities Regulation.

Persons making reports must provide the following information, at a minimum:

1. Name, age, and address of the resident
2. Name and address of the person responsible for the care of the client, if available
3. Nature and extent of the elderly or disabled person's condition
4. Basis of the reporter's knowledge
5. The type of maltreatment alleged and identify of alleged perpetrator, and
6. Any other information relevant to an investigation

202.19B Procedures and Protocols for Individuals at Risk of Suicide

AAAs will ensure that procedures and protocols for staff and all volunteers who interact with clients are in place to identify persons at risk of suicide and to provide appropriate interventions to prevent suicide.

Protocols should include, at a minimum:

1. Linking persons at risk with the Behavioral Health Link Service, Georgia's crisis and access line (1-800-715-4225)
2. Facilitating warm transfers when feasible or required by specific program guidelines
3. Completing an incident report to be submitted to a supervisor for follow-up as needed
4. Procedures for reporting incidents that occur in the course of service delivery, whether calls originate from offices or homes; case management practice in agency offices and in other community locations, including individuals' homes. For definitions of what constitutes an incident, see MAN 5600 Section 9000.
5. Using the Serious Incident Review Team (SIRT) Manual as a guideline, the AAA will identify the nature of incidents to be reported and the manner and timeframe for reporting

Effective Date

Upon Issuance. AAAs will assure that staff and providers subject to these guidelines receive copies of this chapter in a timely manner and will allow providers a reasonable period of time in which to make adjustments to comply.

References

Serious Incident Review Team (SIRT) Process

NASW: Guidelines for Social Worker Safety in the Workplace.

Syracuse University School of Social Work "Social Work Safety Tips."

Indiana Department of Child Services, Home Visit Safety Protocol

DAS MAN 1000, Chapter 1060, “Technology and Data Management”

DAS MAN 5300, Chapter 110, “Grievance Procedures for Participants in Non-Medicaid Home and Community Based Services”

DAS MAN 5300, Chapter 114, “Guidelines for Client Assessment”

DAS MAN 5300, Chapter 118, “Prioritizing Clients”

DAS MAN 5300, Appendix D, “Forms and Templates”

DAS MAN 5600, Chapter 1060, “Technology and Data Management”

DAS MAN 5600, Chapter 2025, “Fee for Service Overview”

DAS MAN 5600, Chapter 2026, “Cost Share”

DAS MAN 5600, Chapter 2027, “Voluntary Contributions”

DAS MAN 5600, Chapter 2028, “Private Pay Services”

DAS MAN 5600, Chapter 2051, “Eligibility”

DAS MAN 5600, Chapter 2053, “Confidentiality”

DAS MAN 5600, Chapter 2054, “HIPAA”

DAS MAN 5600, Chapter 3012, “Area Agency on Aging Records”

DAS MAN 5600, Chapter 3016, “Targeting Service Delivery”

DAS MAN 5600, Chapter 3017, “Emergency Planning and Management”

DAS MAN 5600, Chapter 3020, “Administrative Appeals”

DAS MAN 5600, Chapter 3030, “Uniform Cost Methodology:

DAS MAN 5300, Chapter 3036, “Criminal History Investigations”

DAS MAN 5600, Chapter 3050, “Compliance with Contractor Responsibilities, Rewards, and Sanctions”

DAS MAN 5600, Chapter 3025, “Financial Management”

DAS MAN 5600, Chapter 9006, “Serious Incident Review Team (SIRT) Process”

Appendix 202-A Training Requirements for HCBS Staff

For staff whose duties include assessment of individuals, DAS requires that their personnel files include documentation that they completed the following training modules no later than 30 days after beginning their duties:

Scoring the DON-R, Part 1

Dementia Training for Case Managers: the DON-R

Mental Health and the Older Adult: The Assessment

Screening for Substance Abuse in Older Adults

Screening for Depression in Older Adults

Screening for Anxiety in Older Adults

Depression vs. Dementia

For staff whose duties include assessment of caregivers, DAS requires that their personnel files include documentation that they completed the following additional training module no later than 30 days after beginning their duties:

Assessing Caregiver Burden

For staff whose duties include care planning, DAS requires that their personnel files include documentation that they completed the following training modules no later than 30 days after beginning their duties:

Care Planning: A Strengths Perspective

Motivational Interviewing

Coaching for Empowerment

Tailoring Dementia Services to Family and Individual Needs

Identifying and Responding to Mental Health Issues During Assessment and Care Management

Identifying and Responding to Dementia Issues During Assessment and Care Management

Caring for the Family

Progression of Dementia: Stages

For staff whose duties include working with individuals living with dementia and/or families caring

for an individual living with dementia, DAS requires that their personnel files include documentation that they completed the following training modules no later than 30 days after beginning their duties:

Life After a Dementia Diagnosis – Finding the Silver Lining

Stigma: An Added Burden for People Living with Dementia

Living Not so Alone with Dementia

Behavioral Symptoms of Dementia

Home Safety for Individuals with Dementia

Strategies for Managing Problem Behaviors

For provider staff who have direct contact with individuals living with dementia and/or families caring for an individual living with dementia, DAS requires that their personnel files include documentation that they completed the following training modules no later than 30 days after beginning their duties:

Addressing the Stigma of Dementia for Service Providers

Service Providers Recognizing Risk Factors of Dementia

Service Providers Avoiding/Responding to Combative Behaviors Caused by Dementia

Understanding the Different Types of Dementia if You're a Service Provider

Strategies for Managing Problem Behaviors

Legal Issues for People Living with Dementia and their Caregivers

For staff whose duties include care planning, DAS requires that their personnel files include documentation that they completed the following training modules no later than 6 months after beginning their duties:

Mental Health and Dementia Issues

Substance Abuse Among the Older Adult Population

For all Aging and Disability network non-administrative staff DAS requires that their personnel files include documentation that they completed the following additional training module no later than 6 months after beginning their duties:

Alzheimer's Disease 101

Alzheimer's Disease 102

Alzheimer's Disease 103

Recognizing Risk Factors for Dementia

Staff whose duties began prior to this policy revision's publication must complete required trainings within 3 months from the publication date. Some program areas may require additional trainings as described in manual sections.

Appendix 202-B Documentation Guidelines

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	
	Section Title:	Documentation Guidelines	**Reviewed or Updated in:**	MT 2021-09
	Section Number:	Appendix 202-B	**Previous Update:**	

Documentation is the formal record of the agency's work and proves that staff conducted appropriate activities on behalf of the individual. Each case note is the narrative that describes the background/history and activities with or on behalf of the individual and provides an historical and chronological record of interaction with the individual and his/her community. Proper documentation adds credibility to case management decisions or interventions recommended on behalf of the individual. Staff should write case notes in such a manner that any person (including supervision or the Court) will understand exactly what transpired during the agency's work with the individual. Good documentation helps avoid liability and is instrumental in promoting excellent quality assurance practices. The bottom line is this: if it is not documented, it did not occur.

The New York State Society for Clinical Social Work lists the following purposes of documentation (with paraphrasing):

1. To document professional work
2. To serve as the basis for organization and continuity of care
3. To serve as the basis for subsequent continuity of care by recording for use by other practitioners who may serve the individual in the future
4. To protect against lawsuits and complaints and to aid in defending effectively against such lawsuits or complaints
5. To comply with legal, regulatory, and institutional requirements
6. To facilitate quality assurance and utilization review
7. To facilitate coordination of professional efforts by fostering communication and collaboration between agencies serving the individual

Examples of topics to be included in a case note include:

- Presence of a Legal Guardian
- Needs, preferences, or values of the individual
- Cultural awareness
- Options discussed with the individual
- Referrals made on behalf of the individual

- Education provided to the individual
- Advocacy on behalf of the individual

The following guidelines will help to ensure that documentation is appropriate and professional:

1. Case notes should be written in a factual, objective manner. Objective language can be measured, counted, and seen by more than one person. Two people reading the note would have the same understanding of the situation. Examples of information include:
    a. Client activities observed by staff or reported by the client ("The Case Manager saw Mrs. Smith crying and clenching her fists.")
    b. Agency actions ("The agency has suspended Mrs. Smith's service for two weeks because she was admitted to the hospital on 02/01/2014.")
    c. Information from official records or documents ("The report from Dr. Jones dated 08/13/2014 stated that Mrs. Smith has hypertension and diabetes.")
    d. Descriptions of circumstances ("Mrs. Smith stated it is important to her to return to her home to care for her pet cat.")
2. Staff must avoid subjective, judgmental, or vague language
3. Staff must avoid labels such as 'alcoholic', 'schizophrenic', incompetent', 'incapacitated' or 'mentally retarded' unless a certified or licensed professional has documented such a diagnosis
4. Staff must refrain from including personal opinions or perceptions unless clearly labeled as such and factual justification for the opinion is included

The chart below provides examples of poor notes and appropriate notes:

Poor Note	Objective Note
Mrs. Smith will obtain adequate housing.	Mrs. Smith will obtain housing that has running water, electricity, and is accessible for her wheelchair.
Mrs. Smith's family is dysfunctional.	I observed Mrs. Smith, her husband, and her daughter screaming at one another during the face to face meeting.
Mrs. Smith was drunk.	I observed Mrs. Smith having slurred speech, staggered gait, and her breath smelled of alcohol.
Mrs. Smith is an alcoholic.	Mrs. Smith's daughter said, "It is embarrassing to have an alcoholic for a mother."
Mrs. Smith refused services.	Mrs. Smith said, "Leave me alone" and shut the door.
Mrs. Smith could not sit up and obviously needs 24-hour care.	I saw Mrs. Smith struggle to pull herself to a sitting position for our meeting.
Mrs. Smith was rude and unresponsive during my interview.	Mrs. Smith stated she had no comment when asked about whether she wanted to return home from the hospital. After I asked her more questions, she asked me to leave her room and not bother her again.

Examples of subjective, vague terms include:

Abusive

Adequate

Angry

Apparently

Appeared

Appropriate

As soon as possible

Clean/dirty

Cluttered

Good/poor

Happy/sad

Healthy

Hostile

Hyper

Hysterical

Immediately

Loud

Incompetent

Incapable

Messy

Neat

Neglectful

Nervous

Nurturing

Obviously

Offensive

Physical

Proper

Quality

Regular

Seems to be

Suitable

Stable

Unmotivated

Upset

Tidy

Well cared for

The New York State Society for Clinical Social Work “Clinical Documentation and Recordkeeping” includes the following elements of good documentation:

1. Provides relevant information in appropriate detail
2. Is organized with logical progression
3. Is thoughtful, reflecting the application of professional knowledge, skills, and judgment in the services provided
4. Is appropriately concise
5. Uses relevant direct quotes from the individual and other sources identified as such by utilizing quotation marks
6. Distinguishes clearly between facts, observations, hard data, and opinions
7. States the source(s) of the facts, observations, hard data, opinions, and other information being relied upon, and provides an assessment of the reliability of that material
8. Is internally consistent

200/300 Title III B Supportive Services

206 Senior Center Requirements

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	01/15/2021
	Section Title:	Senior Center Requirements	**Reviewed or Updated in:**	01/08/2024
	Section Number:	206	**Next Review:**	01/08/2026

206.1 Summary Statement

The standards contained in this section are to be used by senior center facilities to meet the operational, programmatic, and service requirements for any activities provided under the authority of the senior center.

206.2 Scope

These requirements apply to all senior center facilities, including nutrition sites, that are operated:

- Under contract or agreement and funded in whole or in part through the Older Americans Act funding,
- With state general revenue,
- With other funding granted or appropriated through the Division of Aging Services, or;
- With other funds pooled with such funds to meet the costs for services under the Older Americans Act.

206.3 Definitions

Program Models

Traditional Senior Center

a community focal point where older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community. Vouchers for meals and services are allowed.

Collaborative-Style Center

an identified natural gathering place for older adults that has the same minimum services and programs as a senior center, but without a center manager. Services and programs are organized by volunteers. Vouchers for meals and services are allowed.

Center Without Walls

a community based option for participants to access programs and services outside of a traditional senior center. All activities, including meals, occur in the community. Vouchers for meals and services are allowed.

Other Definitions

Distance Programming

programming conducted when center staff and participants are not in the same location at the same time. Modes of delivering programming can include telephone, internet, radio, public television, mail, delivery, or other modes that provide activity or social engagement for senior center participants; can be used across all senior center models.

Congregate Nutrition Program

the provision of nutritious meals and opportunities for social contact. Congregate nutrition services shall be part of a system of services that promotes independent living for older adults.

Cafeteria Style Service

participants are served at a counter and carry their meals to tables.

Buffet Style Service

food is placed in a public area where the diners may serve themselves.

Family Style Service

food is placed onto platters (or other serving containers) and placed onto tables where participants may serve themselves.

Restaurant Style Service

food is brought directly to participants at their tables.

Wellness Activities

non-evidence-based programming that supports health and wellness. Wellness activities should help participants increase their well-being through: finding their own unique skills and talents that are both personally meaningful and rewarding, regular physical activity, good eating habits,

connecting to one's environment and community, engaging in creative, stimulating mental activities, searching for meaning and purpose in life, raising awareness and acceptance of one's feelings, and/or assessing limitations and ability to cope with stress. See "The Six Dimensions of Wellness Model" in the references section. Evidence-based health and wellness programs are allowable.

Voucher

A document, receipt, stamp, or the like that authorizes credit for a meal or service.

206.4 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.

All nutrition requirements can be found in MAN 5300, 304 Nutrition Service Program Guidelines and Requirements.

206.5 Service Outcomes

At a minimum:

- To provide a community facility or gathering place where persons aged 60 or older meet to pursue mutual interests, receive services, and take part in activities that will enhance their health/wellness and quality of life;
- To reduce isolation of program participants through socialization.
- To address potential malnutrition and/or hunger through the provision of nutritionally- balanced and participant-approved meals and nutrition services.

206.6 Service Activities (All Models)

1. The provision of meals 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 and shopping assistance through transportation services (if available);
4. Health, fitness, and other educational programs; and
5. Recreational activities.

206.7 Eligibility and Priority of Services

Eligible persons are:

- Aged 60 and over, or a spouse (regardless of age) of a person aged 60 or older;
- 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 aged 60 and older, approved conditionally upon AAA policies
- Able to move about the center and perform tasks such as feeding self and attending restroom without human assistance (assistive devices like canes, walkers, wheelchairs are allowed). If assistance is needed, it must be provided by the person's caregiver.

AAAs shall give priority to those in greatest social and economic need, in conjunction with the income worksheet, as well as nutrition risk and hunger status, as indicated by the NSI-DETERMINE (NSI-D) checklist and by the Food Security Survey.

The DON-R is not required.

206.8 Senior Center Operations

Three models for providing services may be offered:

1. **Traditional Senior Center**
    - Building open to participants for a minimum of 4 hours per day.
    - Management must provide adequate coverage by paid staff to assure that a trained person is present in the center at all times that participants are present; volunteers may assist paid staff as necessary
    - Serve a minimum of 20 meals per day per center, and 30 people per day per Area Agency on Aging, based on the average number of meals served per day during any given month, considering all meals and activities served through all fund sources.
    - Serve meals at least once per day, five days a week, for a minimum of 250 serving days per year. Up to ten holidays may be scheduled per year, provided management makes provision for meals needed by participants during the holiday closing.
2. **Collaborative Center**
    - If a traditional center cannot meet the minimum requirements for meals and/or serving days, or if a natural gathering place in the community is identified, a collaborative center may be used.
    - Managed by volunteers, no center manager
    - Will have a "sponsor center", which will be a traditional senior center, to assure minimum requirements are met.
        - Between the traditional center and collaborative center, serve a minimum of 20 meals per day per center, and 30 people per day per Area Agency on Aging, based on the average number of meals served per day during any given month, considering all meals and activities served through all fund sources.
        - Between the traditional center and collaborative center, serve meals at least once per day, five days a week, for a minimum of 250 serving days per year. Up to ten holidays may be scheduled per year, provided management makes provision for meals needed by participants during the holiday closing.
    - No on-site food preparation allowed. Meals will be catered or a voucher program will be put in place to allow approved meals in approved restaurants.
3. **Center Without Walls**

- All activities, including the meal, will occur in the community
- Managed by at least one paid staff member; volunteers may assist paid staff as necessary
- Serve a minimum of 20 meals per day per center, and 30 people per day per Area Agency on Aging, based on the average number of meals served per day during any given month, considering all meals and activities served through all fund sources.
- Serve meals at least once per day, five days a week, for a minimum of 250 serving days per year. Up to ten holidays may be scheduled per year, provided management makes provision for meals needed by participants during the holiday closing.
- Voucher program for meals will apply

Meals served at collaborative sites and/or with a voucher will count toward the minimum average. If a center is not meeting the minimum attendance requirements, it will be considered a "meal site" and will only receive reimbursement for the meal cost (no activities). Meal cost includes raw food, production, packaging, and delivery.

Participants in any model of senior center may not be identified in any way by fund source and will not be physically separated, served at a different time, or offered different food items.

206.9 Facility Requirements

In addition to all federal, state, and local laws and codes, traditional senior centers must provide for the safety, sanitation, accessibility and convenience of participants, and efficiency of service, and shall include the following:

1. The building will be located in as close proximity as possible to the majority of eligible individuals' residences, within walking distance where feasible, and with transportation made available (where possible);
2. Space will be identified within the center to allow for privacy and confidentiality where services such as individual counseling may be provided. If no separate room is available full time in an existing facility, staff may provide counseling in a shared space as long as other occupants vacate the room.
3. The grounds, building and furnishings shall be free from litter, clean, safe, and in good repair.
4. Toilet rooms and fixtures shall function properly and shall be equipped with adequate supplies and maintained in a sanitary and odor-free condition at all times.
5. The facility must make every effort to guard against insects, rodents, and any other conditions that would affect a sanitary environment.
6. The center shall have a telephone that is immediately accessible to all occupants during hours of operation. Center management shall post and maintain a list of local emergency numbers at each telephone.
7. The center shall provide sufficient furniture and equipment for use by participants that assures comfort and safety and is appropriate for the adult population being served.
8. Room temperature shall be maintained at a level that assures the health, safety, and comfort of the participants.

For collaborative sites and centers without walls, every effort will be made to ensure the safety and

comfort of all participants.

206.10 Outdoor Space (Traditional Model)

Any outdoor spaces used by participants in traditional senior centers must be safe and suitable for recreation activities:

- The area must be connected to, be a part of, and be directly accessible from the center.
- If not owned by the center, suitable arrangements must be made for its use.
- Exterior activity areas shall include protected, shaded areas.
- The areas must be properly furnished with safe, clean furniture and equipment.

206.11 Staff Requirements (All Models)

All full-time staff (or volunteers at the collaborative sites) shall be trained to perform the following:

- Basic First Aid
- CPR
- Heimlich Maneuver

At least one trained staff person will be in the facility whenever participants are present.

At least one staff member certified by an organization accredited by the American National Standards Institute Conference for Food Protection, such as ServSafe, will be present while food is being prepared, handled, or served.

Center management shall ensure the following notices are posted in visible locations and in legible formats, or distributed to participants:

- The certified menu for the week and information on meal costs
- Policies and procedures for making voluntary contributions (including acceptance of SNAP benefits) and any cost share required by specific fund sources.
- Calendar of planned activities
- Notices of accessibility and non-discrimination policies and participant complaint procedures
- Emergency evacuation plan
- Visual nutrition education materials.

Staff responsible for the operation of senior centers must demonstrate appropriate knowledge of and skills in working with an elderly population, general ability to manage administrative requirements, including the ability to complete required assessment documents, and fiscal and programmatic reports in an accurate and timely manner, and to gather and report required client data in the manner specified by the Area Agency and/or Division.

Any staff member (paid or un-paid or volunteer) who has direct contact with a participant must have a background check on file in accordance with DAS policy (MAN 5600, 3040 Criminal History Investigations).

Unless designated as a collaborative site, each center must assign at least one full time, paid staff person responsible for day-to-day operations.

206.12 Senior Center Sustainability

The provider may assess a fee for activities to cover the cost of supplies, materials, or the time of a professional instructor, and/or food offered in addition to the approved meal, with all profits going back to senior center programs.

The provider will develop procedures for assessing and collecting fees for any cost shared services, in accordance with DAS requirements.

Refer to MAN 5600, Chapter 2000, Sections: 2025, 2026, 2027, and 2028 for information on Fee for Service, Cost Share, Voluntary Contributions and Private Pay Services.

206.13 Programming (All Models)

Senior centers must plan for and provide a broad range of group and individual activities that reflect the needs and interests of the participants and other older persons in its service area.

Center management, in collaboration with site councils, shall develop and implement formal mechanisms for soliciting input and feedback regarding program activities and use the information in the process of planning and evaluating the effectiveness of center activities.

All center models must offer a minimum of:

- One hour of planned wellness activities per day
- 15 minutes of nutrition education per month
    - Requirements for nutrition education can be found in MAN5300, Chapter 304.

Center management is responsible for assuring that any programs presented by proprietary organizations or individuals are informational in nature only and not for the purpose of selling goods, products, or services to participants.

206.14 Site Councils

Center management shall be responsible for developing a site council to represent participants and give input on:

- Program/activity planning
- Feedback on quality/acceptability of services provided (particularly regarding quality of meals and input on menu planning)
- Recommendations for improved center operations
- Identifying a center-specific wellness goal

Participants shall elect members and officers. The center director may be on the council if the council chooses. Participation in the site council is not limited to center members.

Appendix A contains guidance for identifying and setting a center-specific wellness goal.

206.15 Food Service | Sanitation

Individuals who prepare, handle and/or serve meals at any nutrition site shall be trained in food-service sanitation and proper food handling practices. At least one person who is certified by an organization accredited by the American National Standards Institute Conference for Food Protection, such as ServSafe, must be on the premises while food is being prepared, handled, or served.

All nutrition requirements can be found in MAN 5300, 304 Nutrition Service Program Guidelines and Requirements.

Providers of congregate nutrition services shall use an advance reservation system to determine the number of meals necessary for each day's service and inform participants of procedures for reserving meals.

Providers may serve eligible drop-in older adults and other unscheduled guests only after participants who have made reservations are served.

Meals may be served cafeteria style, buffet style, family style, or restaurant style at the discretion of the center management based on the abilities and/or willingness of the participants to serve themselves.

Expanded Options

Additional offerings of food items may be made available for participants to purchase. Examples: Specialty drinks (coffee, smoothies), salad bar, soup, etc. Senior center management or the AAA will determine the cost of these items and charge accordingly. All profits will go back into senior center programming.

Carry Out Meals

Carry out meals do not qualify for Older Americans Act funding. However, the nutrition service provider and/or site may set up policies and procedures to provide fee-for-service meals. For the nutrition program, a carry out meal is considered to be food that is additional to the meal served at the site daily. The price of the carry out meal will cover the actual cost of the meal and a profit, to be determined by the center and approved by the AAA. The profit will go back into senior center programming.

Leftovers and/or carry out meals may be taken from the center if the following conditions are met:

1. A waiver of liability is signed releasing the center from any responsibility for the food after it leaves the building, **or**;

   The food is labeled with wording to indicate that participants are removing food at their own risk and all food should be consumed or refrigerated within two hours. The label must have a date and time stamp. **and**;

2. Instructions on safe food handling/food safety are provided to all participants on a quarterly basis.

Participants may use their own containers to transport carry out meals, as long as serving sizes provided are the same for all carry out meals and all food safety guidelines are followed. Participants

using their own containers must meet the conditions (1) and (2) noted above.

It is recommended (not required) that the center develops a hazard analysis and critical control points (HACCP) plan that is approved by a registered dietitian.

206.16 Service Needs | Outreach

Each provider operating a senior center funded in whole or in part through Older Americans Act funding and/or state funding shall specify in an annual proposal or update how the service needs of participants will be assured. Providers shall also specify how outreach efforts will be conducted to identify eligible persons, with special emphasis on those in greatest social and economic need. AAAs shall develop procedures for contractors to refer persons for intake and screening, prior to services being initiated. The evaluation of the nutrition program will be included in this report (see MAN 5300, 304 Nutrition Service Program Guidelines and Requirements for guidance).

206.17 Emergency Plan

The senior center will make facilities, equipment, and services available to the fullest extent possible in emergencies and disasters, according to the AAA regional emergency/disaster plan.

The senior center 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. Specifying 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. www.mealsonwheelsamerica.org/docs/default-source/conference/2019-session-materials-handouts/tuesday/200/meals-on-wheels-america-ep-standards.pdf?sfvrsn=f82ab93b_2

Shelf-stable meals provided to participants must be replaced at the center within 24 hours (or within 24 hours of the center re-opening).

206.18 Political Activity

Senior center facilities shall not be used for political campaigning. Political materials shall not be posted nor distributed in center facilities.

Candidates for public office may visit senior centers to observe their operations and/or to receive input from participants regarding their service needs. Political forums may be held, as long as all candidates are invited to participate.

206.19 Non-Sectarian Use

Centers acquired and/or constructed with federal funds or operated with federal funds shall not be used for sectarian instruction or as places for formal religious worship.

206.20 Site Approvals, Relocations, and Closings

AAAs shall establish policies and procedures for contractors to use in providing notice to the AAA of any new sites to be occupied, relocated, or closed. The AAA is responsible for providing written notice to the Division of any proposed closing/relocation at least two weeks prior to the proposed action, unless it is due to an emergency (fire, weather, utility outages, etc.) In the event of such an emergency, the AAA shall notify the Division within 24 hours or the next business day, whichever occurs first.

AAAs shall request written approval from the Division for any new sites prior to occupancy, as well as site relocations of more than five days duration. In the request, the AAA shall document that it has completed an on-site review and assure that the site is ready for occupancy.

AAAs shall provide written notice to the Division of any site modifications or renovations, if such changes would reduce accessibility or otherwise affect continuity of services. Center management is responsible for scheduling incidental repair/renovation work to interfere as little as possible with program activities.

206.21 Reversionary Policy

The policy with regard to protecting the federal reversionary interest in senior centers is as follows:

> When OAA funds have been used for the acquisition, construction, and/or alteration/renovation of a senior center, there remains a federal reversionary interest for the current market value of the facility equal to the percentage of OAA funds contributed to the original costs of the facility for ten years after acquisition, or for 20 years after the completion of construction.

Each AAA shall maintain an accurate inventory of center facilities which were acquired, constructed and/or renovated with OAA funds and provide an accounting to the Division upon request.

- The federal government, through the Division, is entitled to recover its funds in accordance with OAA if:
  1. The owner of the facility ceases to be a public or non-profit private agency or organization; or
  2. The facility ceases to be used for the purpose for which it was acquired, within the above time periods.
- The AAA is responsible for notifying the Division in writing within ten business days after any changes occur which could affect the federal reversionary interest in a facility.
- All grantees of OAA construction or acquisition awards must file a notice of record within 30 calendar days with appropriate unit of local government upon purchase or completion of construction of the facility.

206.22 Mandatory Reporting of Suspected Abuse, Neglect, or Exploitation

All senior center staff are mandated reporters according to state law. Please refer to MAN5300, Chapter 202.21.B for all guidance.

References

Manual for the Voluntary Use of HACCP Principles for Operators of Food Service and Retail Establishments: www.fda.gov/Food/GuidanceRegulation/HACCP/ucm2006811.htm

Six Dimensions of Wellness Model
nationalwellness.org/resources/six-dimensions-of-wellness/

American National Standards Institute Conference for Food Protection
anabpd.ansi.org/accreditation/credentialing/personnel-certification/food-protection-manager/ALLdirectoryListing?prgID=8&statusID=4

ServSafe
www.servsafe.com

DAS Service Requirements, Nutrition MAN 5300, Ch. 304
odis.dhs.ga.gov/General

Appendix 206-A Designing a Wellness Goal

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	01/15/2021
	Section Title:	Designing a Wellness Goal	**Reviewed or Updated in:**	01/08/2024
	Section Number:	Appendix 206-A	**Next Review:**	01/08/2026

Center-Specific Wellness Goal

In order to develop a wellness goal that promotes wellness in the senior center, it is important to conduct a needs assessment. This can be done as part of a site council meeting, a separate meeting, a questionnaire, or any way the center finds appropriate. Please refer to the “Six Dimensions of Wellness” in the references section of this chapter.

Wellness is more than just physical and/or emotional harmony. Wellness also includes: occupational, social, spiritual, and intellectual balance.

Wellness Goal: Which dimension will the center use based on the needs assessment? The goal is designed to be met over a one-year period. The goal will be measured at the end of the current year. .

Goal:

The _____ (name of senior center)
will _____ (do)
_____ (how much) by the end of (current year).

Example:

Wellness Dimension-Social

Goal:

The Fairfield Senior Center (name of senior center)
will volunteer in the community (do)
100 hours (how much) by the end of 2022.

Steps

You may need to ask additional questions to achieve your goal.

What is needed to achieve this goal? Will you need community partners, financial contributions, special committee, etc.?

How will you measure or track your goal? Results will be included in the annual report to the AAA/DAS.

208 In-Home Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	03/01/2023
	Section Title:	In-Home Services	**Reviewed or Updated in:**	2023-01
	Section Number:	208	**Previous Update:**	2015

208.1 Purpose

The standards contained in this section are to be used by senior center facilities to meet the operational, programmatic, and service requirements for any activities provided under the authority of the senior center.

208.2 Scope

AAAs should provide in-home services to secure and maintain maximum independence and dignity in a home environment for older individuals and persons with disabilities who are capable of self-care with appropriate supportive services.

These requirements apply, except where noted, to:

- Homemaker
- Personal care
- Home modification/repair service
- Chore service
- Friendly Visiting

- Telephone Reassurance
- Assistive Technology

Specific program requirements can be found in each service's corresponding chapter.

208.3 Definitions

Supportive services

services designed to assist older individuals in avoiding institutionalization. Services include in-home services and other community services, including home health, homemakers, shopping, escort, reader, and letter writing services, to assist older individuals to live independently in a home environment. (see OAA – Section 321(a)(5)).

208.4 Target Group / Eligibility

Eligible individuals must meet the following criteria:

1. Are age 60 and older, or
2. Adults of any age who receive services through the State-funded Alzheimer's fund source, who have Alzheimer's disease or a related disorder, or
3. Adults who have a physical or mental disability that restricts his/her ability to perform basic activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs), or that threatens his/her capacity to live independently

In addition, the individual must lack sufficient access to persons who are willing and/or able to assist with or perform needed basic ADLs and/or IADLs or provide adequate support to enable the individual to continue to live independently.

The AAA should place special emphasis on individuals that the Older Americans Act identifies as priority populations (See MAN 5300, 118 Prioritizing Clients).

When determining eligibility criteria for enrollment of clients into services, the AAA must follow the criteria established for each fund source.

Because not every consumer will desire, accept, or benefit from in-home services, it is imperative that the AAA target in-home services to consumers who can most benefit from community-based in-home services and who are at highest risk of institutionalization.

AAAs may not provide In-Home Services in a nursing home, personal care home, or other setting where the provision of this service is included in the cost of care.

208.5 Conflict-Free Service Delivery

An efficient service delivery system is characterized by person-centered approaches and cost-effective outcomes for both consumers and the community. Therefore, DAS supports the implementation of a conflict-free service delivery system.

MAN 5300, 202 Program Guidelines and Requirements includes the key elements included in the design of such a system.

208.6A Service Activities

Service activities include:

- Homemaker services (Appendix A)
- Personal care services (Appendix A)
- Chore services (Appendix A)
- Home modification/repair services (CH 314)

Service activities do not include:

- Physical, speech, or occupational therapies
- Medical nutrition therapy
- Medical social services
- Home health aide services provided by a home health agency
- Skilled nursing services

Refer to Appendix A for details about allowable activities and prohibited activities.

208.6B Prohibited Activities

Refer to MAN 5300, 202 Program Guidelines and Requirements

See Appendix A for prohibited activities.

208.7 Access to Services

For information regarding screening through Aging & Disability Resource Connection, see MAN 5200, Section 5025. The AAAs will maintain and manage waiting lists for the services, as necessary. See Manual 5200, Section 5038 “Waiting List Management”.

Not every applicant will request, require, or benefit from in-home services. Each AAA will clearly identify in its Area Plan how services will be coordinated and how resources will be allocated and managed to optimize the effectiveness and efficiency of in-home services.

208.8 Assessments

DAS requires that staff use the DON-R to determine an individual’s need and potential benefit for in-home services. The preferred method of assessment for in-home services is via home visit.

MAN 5300, 114 Guidelines for Client Assessment contains training information and guides for the DON-R and other instruments for assessment.

208.9 Service Initiation and Standards of Promptness

The provider agency has the discretion to begin providing minimal levels of service prior to the completion of the initial service plan (refer to MAN 5300, 114 Guidelines for Client Assessment).

The agency must initiate services within ten (10) working days from the date of receiving the refer-

ral, and thereafter deliver them on a regular basis in accordance with the established service plan. The AAA or its designee must contact the client within the first sixty (60) days of service initiation and annually thereafter to ensure client satisfaction and that services are meeting the needs of the individual/family.

208.10 Service Plan

Designated staff will begin developing the in-home service plan, using a format provided or approved by the Division of Aging Services (DAS), with the client and/or family during the in-home assessment visit.

The in-home service plan must include, at a minimum:

- Types of services requested
- Discrete tasks requested
- Frequency of services requested
- The preferred days, times, frequency, and duration of visits in the client's residence
- Estimated duration of the need for services

208.11 Service Outcomes

The primary goal of in-home services is to aid older adults, persons with disabilities, and their caregivers to achieve maximum self-sufficiency and enhance their quality of life.

Outcome #1: Ensure maximum safety and health in the individual's residence of choice Indicators:

1. Reduction in number of barriers to living safely in the home provided by provision of home repair/home modification as measured by a home safety assessment
2. Reduction in safety hazard by provision of chore services as measured by Unmet Need for Care in the outside home domain of DON-R
3. Maintaining or reducing safety and health hazards by provision of homemaker services as measured by Unmet Need for Care in following domains of DON-R: housekeeping, laundry, preparing meals
4. Reduce personal health barriers by provision of personal care services as measured by Unmet Need for Care in the following domains of DON-R: eating, bathing, grooming, dressing, transferring, continence

Outcome #2: Enhance maximum independence for the individual to live in their residence of choice

Indicators:

1. Reduction in number of barriers to accessibility within the home provided by home modification services as measured by a home and safety assessment such as Safe at Home Checklist (Appendix B) or other appropriate home safety evaluation.

For specific outcomes for assistive technology services, see MAN 5300, CH 208.

208.12 Reassessments

Designated staff must conduct reassessments according to DAS requirements. The reassessment will address changes in the cognitive, emotional, physical, functional, economic, or physical/social environment in which the client lives and must provide the basis for any changes indicated for the service plan. MAN 5300, 114 Guidelines for Client Assessment contains information and guidelines about reassessments.

208.13 Emergency Contact

The AAA should ensure that each client record contains emergency contact information (name and telephone number(s) at a minimum) and verify/update emergency contact during each reassessment.

208.14 Service Termination and Discharge

Refer to MAN 5300, 202 Program Guidelines and Requirements

208.15 Client's Rights and Responsibilities

AAAs and provider agencies will assure that all consumers, or their caregivers, receive a written copy of their rights and responsibilities as program/service participants upon their admission to services. See MAN 5300 Appendix E for the suggested "Client's Rights and Responsibilities".

208.16 Client Complaint Procedures

AAAs will establish written client complaint procedures for use by each provider. Procedures should include the minimum requirements outlined in MAN 5300, 202 Program Guidelines and Requirements. In addition, the complaint procedures must include:

- A telephone number for the provider which the client can call for information, questions, or complaints about the services supplied by the provider and information regarding supervision by the agency of the services to be provided
- The telephone number of the state licensing authority for information and filing of complaints which have not been resolved satisfactorily at the local level, for those agencies providing services subject to state licensure, or the number of the AAA and DAS, if not subject to licensure

208.17 Appeals and Grievances

AAAs will establish written appeals procedures for use by each provider and are consistent with MAN 5300, 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs.

208.18 Service Agreements

Providers must adhere to guidelines issued by the Georgia Department of Community Health related to service agreements with recipients of in-home services from licensed private home care providers agencies, found in Department of Community Health Rules and Regulations of the State of Georgia as found at 111-8-65.09. DAS may ask for proof of compliance or of licensing or certification as issued by the Department of Community Health.

AAA must notify DCH immediately if they believe the service provider(s) is not in compliance with DCH Rules and Regulations.

208.19 State Licensure

Providers of in-home services must provide a current, valid license to operate a private home care agency issued by the Georgia Department of Community Health to prove that they are in compliance and good standing with all applicable licensure requirements for private home care providers under the Rules and Regulations of the State of Georgia as found at section 111-8-65.

AAA must notify DCH immediately if they believe the service provider(s) is not in compliance with DCH Rules and Regulations.

208.20 Insurance Coverage

AAAs are responsible for ensuring that each provider agency maintains appropriate types and levels of insurance coverage that protects the health and safety of clients and employees, and that comply with all applicable contractual obligations and state and federal statutes to include:

- Worker's compensation
- Professional liability
- Errors and omissions
- General liability
- Any agency-owned vehicles

208.21 Staffing

Providers of in-home services must have enough qualified staff to provide services specified in the service agreements with clients.

Providers must meet all staffing rules and regulations cited by licensing agencies. Information and guidelines are located: State of Georgia Rules and Regulations for Private Home Care Providers: 111-8-65-.09(5) rules.sos.state.ga.us/gac/111-8-65

208.22 Employee Identification

The provider agency will furnish adequate identification (ID) to employees who provide in-home services or who have direct contact with clients/caregivers.

1. Each employee must carry the ID and either wear it on his/her person or present it to the client/caregiver upon request
2. An adequate ID is one that is made of permanent materials and which shows the provider agency name, the employee's name, title, and photograph.
3. The provider must issue the ID at time of employment and must require the return of the ID upon termination of employment.

208.23 Orientation and Training Requirements

In addition to state regulatory guidelines for staff training, the provider agency will employ personnel who possess the qualifications and competencies to perform the requested and agreed upon services of the client or family.

The provider agency must ensure each employee receives the following information during orientation and training:

1. Agency policies and procedures
2. Philosophy and values of community integration
3. Consumer-directed care
4. Person-centered planning
5. Recognizing and reporting suspected abuse, neglect, exploitation
6. Recognizing changes in the client's health condition indicating the need for emergency procedures or health services
7. Agency code of ethics and employee conduct
8. Client rights and responsibilities
9. Agency complaint process
10. Recognizing and reporting client progress, services provided, and problems to supervisory staff
11. Employee's obligations to inform the employer of known exposure to tuberculosis, hepatitis, or any other communicable disease

The provider agency must ensure that the staff responsible for directing/providing training meets minimum qualifications.

Annual Training

Each employee must participate in a minimum of eight (8) clock hours annually of in-service or additional training related to performance of job duties. The provider agency may provide the training or assist employees in locating and attending the appropriate training. The objective of ongoing training is to improve each employee's ability to meet the needs of the client/caregiver and support the accomplishment of service outcomes.

208.24 Criminal Records Investigations

AAAs must assure that providers employing persons having direct care or treatment responsibilities, as primary, secondary or alternative job duties conduct a criminal records investigation, according to state law and current policy of the Department of Human Services in MAN 5600, 3040 Criminal History Investigations.

208.25 Supervisory Visits

Appropriate supervisory staff will make visits to each client's residence, in accordance with time frames by state licensure requirements (see State of Georgia Rules and Regulations for Private Home Care Providers: 111-8-65-.10, rules.sos.state.ga.us/gac/111-8-65).

208.26 Administrative Requirements

The providers must establish and implement written policies and procedures that define the scope of in-home services it offers and the type of clients it serves.

Provider agencies must maintain accurate administrative, fiscal, personnel, and client case records that will be accessible and available to authorized representatives of the AAA, DAS, the Department of Human Services, and others, as required by law and in compliance with MAN 5300 and MAN 5600.

208.27 Data Collection and Reporting

Providers must maintain separate files containing all written or electronic records pertaining to the services provided for each client served, including, at a minimum, the following:

1. Identifying information including the name, address, telephone number, and responsible party, if applicable
2. Assessment and reassessment documentation, gathered through the use of instruments or inventories specified or approved by DAS
3. Current service agreement
4. Current service plan
5. Documentation of tasks performed
6. Documentation of findings of home supervisory visits
7. Any material reports from or about the client that relate to the care being provided, including items such as progress notes and problems reported by employees of the provider agency; communications with personal physicians or other health care providers; communications with family members or responsible parties
8. The names, addresses and telephone numbers of the client's personal physicians, if any, if applicable to the service being provided
9. The date of the referral
10. Any additional information requested or required by DAS

208.28 Retention and Confidentiality of Records

Providers must establish and implement written policies and procedures for the maintenance and security of client records, specifying who will supervise the maintenance of records, which will have custody of records, to whom records may be released, and for what purposes in compliance with MAN 5600, 3012 Provision of Services by Area Agencies on Aging.

208.29 Personnel Records

Refer to MAN 5300, 202 Program Guidelines and Requirements

If the agency requires employees to be bonded, the personnel records must include documentation of bonding, if employee performs homemaker functions which permits limited or unlimited access to the client's personal funds. If coverage is provided through a general liability policy, the provider

need not maintain documentation separately in each personnel file.

208.30 Fee for Service Guidelines

Each AAA/provider is encouraged to offer in-home services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Sections 2025-2028, “Fee for Service System”, “Cost Share”, “Voluntary Contribution”, and “Private Pay Services”.

In-home services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

208.31 Reports of Grievances, Complaints, and Incidents

Refer to MAN 5300, 202 Program Guidelines and Requirements

208.32 Mandatory Reporting of Abuse / Neglect / Exploitation

Refer to MAN 5300, 202 Program Guidelines and Requirements

208.33 Program Evaluation and Monitoring

Refer to MAN 5300, 202 Program Guidelines and Requirements

208.34 References

Older Americans Act Of 1965: 2020 Reauthorization

State of Georgia Rules and Regulations for Private Home Care Providers

DAS Manual 5200, Section 5025 - Service Availability and Access

DAS Manual 5200, Section 5038 - Waiting List Management

DAS Manual 5300, 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs

DAS Manual 5300, 114 Guidelines for Client Assessment

DAS Manual 5300, 118 Prioritizing Clients

DAS Manual 5300, 202 Program Guidelines and Requirements

DAS Manual 5300, Section 314 - Home Modification and Repair Services

DAS Manual 5300, Appendix E - Client Rights and Responsibilities

DAS Manual 5600, Section 2025 - Fee for Service System

DAS Manual 5600, Section 2026 - Cost Share

DAS Manual 5600, Section 2027 - Voluntary Contribution

DAS Manual 5600, Section 2028 - Private Pay Services

DAS Manual 5600, Section 3012 - Area Agency on Aging Records

DAS Manual 5600, Section 3015 - Area Agency on Aging Monitoring and Evaluation of Service Providers

DAS Manual 5600, Section 3036 - Criminal History Investigations

Rebuilding Together: Safe at Home Checklist

Appendix 208-A Authorized and Prohibited Activities

Appendix 208-B Rebuilding Together: Safe at Home Checklist

Appendix 208-A Authorized and Prohibited Activities

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	03/01/2023
	Section Title:	Authorized and Prohibited Activities	**Reviewed or Updated in:**	2023-01
	Section Number:	Appendix 208-A	**Previous Update:**	2015

Personal Care Services

Personal care service activities are planned and provided with input from the client, based on the assessment of the client's needs, degree of functional impairment, current support system, and remaining capacity for self-care and self-sufficiency. Service activities must align with the domains of impairment and essential components indicated by the DON-R. Service activities include assistance related to the care of the client's physical health.

Allowable activities include:

- Dressing and undressing
- Bathing
- Shaving
- Dental care and oral hygiene
- Grooming
- Toileting
- Self-administration of medication
- Transferring
- Mobility in and around the home
- Eating

Prohibited activities include:

- Pet grooming/care

- Home repair
- Moving heavy objects of furnishings
- Physical, speech, or occupational therapies
- Medical nutrition therapies
- Medical social services
- Home health aide services provided by a home health agency
- Skilled nursing services
- Meal preparation
- Housekeeping tasks
- Household maintenance activities
- Personal finances and mail
- Shopping
- Performing personal care or other tasks for other members of the household
- Providing friendly visiting only
- Performing tasks not assigned by the supervisor/case manager and reflected in the care plan

Homemaker Services

Service activities are planned and provided with input from the client, based on the assessment of the client's needs, degree of functional impairment, current support system, and remaining capacity for self-care and self-sufficiency. Service activities must align with the domains of impairment and essential components indicated by the DON-R.

Allowable activities include:

1. Housekeeping and home management activities:
    a. Cleaning, vacuuming, sweeping, mopping, dusting
    b. Laundry
    c. Ironing and mending clothes and linens
    d. Washing, drying, and storing dishes
    e. Bagging and placing garbage in collection containers
    f. Making beds and changing linens (only while client is out of bed)
    g. Shopping for household essentials
    h. Assisting in organizing household routines
    i. Performing necessary reading and writing tasks, if requested and indicated by client's inability to read
    j. Performing essential errands
2. Meal preparation: a.older person's needs and are consistent with the Dietary Guidelines for Americans (see references)

a. Preparing and serving meals
b. Using sanitary practices for handling, preparing, and storing food

3. Escort assistance:
    a. Accompanying a client on trips to obtain healthcare services and other necessary items and services
4. Client education:
    a. Instructing clients in ways to become self-sufficient in performing household tasks, when appropriate and beneficial

Prohibited activities include:

- Administering medications, either over-the-counter or prescribed or reminding clients to take medications
- Providing household services not essential to the client's needs
- Providing only friendly visiting
- Providing therapeutic/health related activities that are appropriately performed by a licensed healthcare professional
- Home repair
- Yard maintenance
- Moving heavy objects such as furniture
- Performing services for other members of the household
- Transporting the client in the worker's or client's personal vehicle, unless the provider agency has proof through written verification that the employee has adequate and current liability insurance coverage
- Performing tasks not in the care plan or assigned by a supervisor

Chore Services

Chore service activities are planned with input from the client whenever possible, or a representative, based upon an assessment of his/her needs and the degree of physical and/or cognitive impairment of the care receiver. Service activities are one-time, seasonal, or occasional in nature and include, but are not limited to:

- cleaning appliances, including cleaning ovens and defrosting and cleaning refrigerators
- replacing fuses, light bulbs; repairing electric plugs, frayed cords
- cleaning and securing carpets and rugs; cleaning and waxing wood or tile floors
- washing walls and windows
- installing window shades, blinds, and curtain rods, hanging draperies
- installing screens and installing and removing storm doors and windows
- moving or rearranging furniture to provide safe entry, mobility, and egress
- turning mattresses

- cleaning closets and drawers
- cleaning attics, basements, porches and outbuildings to remove fire and health hazards
- cleaning of exterior surfaces, such as removing mildew from siding or decking
- pest control, interior and exterior
- grass cutting and leaf raking
- clearing walkways of ice, snow and leaves
- clearing interior and exterior debris following natural disasters
- trimming overhanging tree branches
- changing interior and exterior light bulbs
- changing batteries in smoke, carbon monoxide detectors.

Service activities performed by chore service workers do not include any of the routine housekeeping and home management tasks performed by homemaker service agencies or hands-on personal care tasks performed by licensed providers of in-home services. Chore services also do not include activities that are more appropriately provided through a residential repair or home modification program.

Appendix 208-B Rebuilding Together: Safe at Home Checklist

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	03/01/2023
	Section Title:	Rebuilding Together: Safe at Home Checklist	**Reviewed or Updated in:**	2023-01
	Section Number:	Appendix 208-B	**Previous Update:**	2015

Safe AT HOME Checklist

Created in partnership with the Administration on Aging and the American Occupational Therapy Association

Rebuilding Together
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Rebuilding Together has long recognized that greater attention must be given our elderly population, so they may age-in-place and safely in their homes. We have also built lasting national partnerships with Area Agencies on Aging, AARP, American Occupational Therapy Association, National Association of Home Builders, National Council on Aging, and others.

Use this list to identify home safety, fall hazards and accessibility issues for the homeowner and family members. Home safety, fall prevention and accessibility modification interventions on the reverse side of this page can help prioritize your work. Underline or use a highlighter to note problems and add comments.

1. EXTERIOR ENTRANCES AND EXITS
- ☐ Note condition of walk and drive surface; existence of curb cuts
- ☐ Note handrail condition, right and left sides
- ☐ Note light level for driveway, walk, porch
- ☐ Check door threshold height
- ☐ Note ability to use knob, lock, key, mailbox, peephole, and package shelf
- ☐ Do door and window locks work easily?
- ☐ Are the house numbers visible from the street?
- ☐ Are bushes and shrubs trimmed to allow safe access?
- ☐ Is there a working door bell?

2. INTERIOR DOORS, STAIRS, HALLS
- ☐ Note height of door threshold, knob and hinge types; clear width door opening; determine direction that door swings
- ☐ Note presence of floor level changes
- ☐ Note hall width, adequate for walker/wheelchair
- ☐ Determine stair flight run: straight or curved
- ☐ Note stair rails: condition, right and left side
- ☐ Examine stairway light level
- ☐ Note floor surface texture and contrast
- ☐ Note if clutter on stairway

3. BATHROOM
- ☐ Are sink basin and tub faucets, shower control and drain plugs manageable?
- ☐ Are hot water pipes covered?
- ☐ Is mirror height appropriate, sit and stand?
- ☐ Note ability reach shelf above, below sink basin
- ☐ Note ability to step in and out of the bath and shower
- ☐ Can resident use bath bench in tub or shower?
- ☐ Note toilet height; ability to reach paper; flush; come from sit to stand posture
- ☐ Is space available for caregiver to assist?

4. KITCHEN
- ☐ Note overall light level, task lighting
- ☐ Note sink and counter heights
- ☐ Note wall and floor storage shelf heights
- ☐ Are under sink hot water pipes covered?
- ☐ Is there under counter knee space?
- ☐ Is there a nearby surface to rest hot foods on when removed from oven?
- ☐ Note stove condition and control location (rear or front)
- ☐ Is there adequate counter space to safely prepare meals?

5. LIVING, DINING, BEDROOM
- ☐ Chair, sofa, bed heights allow sitting or standing?
- ☐ Do rugs have non-slip pad or rug tape?
- ☐ Chair available with arm rests?
- ☐ Able to turn on light, radio, TV, place a phone call from bed, chair, and sofa?

6. LAUNDRY
- ☐ Able to hand-wash and hang clothes to dry?
- ☐ Able to safely access washer/dryer?

7. BASEMENT
- ☐ Are the basement stairs stable and well lit?
- ☐ Is there any storage of combustible materials?

8. TELEPHONE AND DOOR
- ☐ Phone jack location near bed, sofa, chair?
- ☐ Able to get phone, dial, hear caller?
- ☐ Able to identify visitors, hear doorbell?
- ☐ Able to reach and empty mailbox?
- ☐ Wears neck/wrist device to obtain emergency help?
- ☐ Is there an answering machine?
- ☐ Is there a wireless phone system?

9. STORAGE SPACE
- ☐ Able to reach closet rods and hooks, open bureau drawers?
- ☐ Is there a light inside the closet?

10. WINDOWS
- ☐ Opening mechanism at 42 inches from floor?
- ☐ Lock accessible, easy to operate?
- ☐ Sill height above floor level?
- ☐ Are storm windows functional?

11. ELECTRIC OUTLETS AND CONTROLS
- ☐ Sufficient outlets?
- ☐ Are there ground fault outlets in kitchen and bathroom?
- ☐ Light switch at the entrance to each room
- ☐ Outlet height, wall locations
- ☐ Low vision/sound warnings available?
- ☐ Extension cord hazard?
- ☐ Are there any uncovered outlets or switches?

12. HEAT, LIGHT, VENTILATION, SMOKE, CARBON MONOXIDE, WATER TEMP CONTROL
- ☐ Are there smoke/CO alarms and a fire extinguisher?
- ☐ Are Thermostat displays easily accessible and readable?
- ☐ Note rooms where poor light level exists
- ☐ Able to open windows; slide patio doors?
- ☐ Able to open drapes or curtains?
- ☐ Note last service date for heating/cooling system
- ☐ Observe temperature setting of the water heater

COMMENTS:

1. EXTERIOR ENTRANCES AND EXITS
- ☐ Increase lighting at entry area
- ☐ Install stair rails on both sides
- ☐ Install door lever handles; double-bolt lock
- ☐ Install beveled, no step, no trip threshold
- ☐ Remove screen or storm door if needed
- ☐ Create surface to place packages when opening door
- ☐ Install peephole on exterior door
- ☐ Repair holes, uneven joints on walkway
- ☐ Provide non-slip finish to walkway surface
- ☐ Add ramp as needed
- ☐ Trim bushes and shrubs to provide clear view from doors and windows
- ☐ Trim low hanging branches

2. INTERIOR DOORS, HALLS, STAIRS
- ☐ Create clear pathways between rooms
- ☐ Apply color contrast or texture change at top and bottom stair edges
- ☐ Install door lever handle
- ☐ Install swing-clear hinges to widen doorway. Minimum width: 32 inches
- ☐ Install beveled thresholds (max 1/2 inch)
- ☐ Replace or add non-slip surface on steps
- ☐ Repair or install stair handrails on both sides

3. BATHROOM
- ☐ Install swing-clear hinges to widen doorway. Minimum width: 32 inches
- ☐ Install secure grab bars at toilet, bath and shower
- ☐ Install adjustable-height, hand held shower head
- ☐ Install non-slip strips in bath/shower
- ☐ Secure floor bathmat with non-slip, double-sided rug tape
- ☐ Adapt flush handle or install flush sensor
- ☐ Adapt or relocate toilet paper dispenser
- ☐ Round counter corners to provide safety
- ☐ Insulate hot water pipes if exposed
- ☐ Create sitting knee clearance at basin by removing vanity door and shelves underneath
- ☐ Install mirror for sitting or standing view
- ☐ Install good-quality non-glare lighting
- ☐ Install shower with no threshold if bathing abilities are severely limited
- ☐ Elevate toilet height by adding under seat riser, portable seat, or raising toilet at the base

4. KITCHEN
- ☐ Increase task lighting at sink, stove, etc.
- ☐ Install D-type cupboard door handles
- ☐ Install adjustable shelving to increase access to upper cabinets
- ☐ Increase access to under counter storage space by installing pull-out units
- ☐ Insulate hot water pipes if exposed
- ☐ Install hot-proof surface near oven
- ☐ Install switches and outlets at front of counter
- ☐ Install pressure-balanced, temperature-regulated, lever faucets
- ☐ Expand counter surface
- ☐ Create sitting knee clearance under work sites by removing doors or shelves
- ☐ Improve color contrast of cabinet and counters surface edges for those with low vision
- ☐ Add tactile and color-contrasted controls for those with low vision
- ☐ Provide sturdy step stool with hand rail
- ☐ Clean or install new range hood

5. LIVING, DINING, BEDROOM
- ☐ Widen or clear pathways within each room by rear- ranging furniture
- ☐ Secure throw and area rug edges with double-sided tape
- ☐ Improve access to and from chairs and beds by inserting risers under furniture legs
- ☐ Use side bed rail or chairs with armrests
- ☐ Enlarge lamp switch or install touch-control lamp at bedside
- ☐ Install adjustable closet rods, shelving, and light source for better storage access
- ☐ Install vertical pole adjacent to chair and sofa
- ☐ Raise furniture to appropriate height using leg extender products
- ☐ Install uniform level floor surfaces using wood, tile, or low-pile rugs
- ☐ Install telephone jack near bed and favorite chair

6. LAUNDRY
- ☐ Build a counter for sorting and folding clothes
- ☐ Adjust clothesline to convenient height
- ☐ Relocate laundry appliances
- ☐ Clean dryer vent or replace with metallic hose

7. BASEMENT
- ☐ Identify and eliminate sources of water in basement (usually gutters our plumbing)
- ☐ Add additional lighting as needed
- ☐ Remove combustible materials and hazardous waste
- ☐ Clear pathway to utilities

8. TELEPHONE AND DOOR
- ☐ Install wireless phone system near bed, sofa, and chair
- ☐ Install peephole at convenient height
- ☐ Install flashing light or sound amplifier to indicate ringing doorbell for those with visual or hearing problems
- ☐ Install mailbox at accessible height

9. STORAGE SPACE
- ☐ Install lights inside closet
- ☐ Install adjustable closet rods and shelves
- ☐ Install bi-fold or pocket doors

10. WINDOWS
- ☐ Install handles and locks that are easy to grip, placed at appropriate heights
- ☐ Replace windows or storms that are not functional

11. ELECTRICAL OUTLETS AND CONTROLS
- ☐ Install light fixtures or outlet for lamps
- ☐ Install switches at top and bottom of stairs
- ☐ Install Ground Fault outlets in kitchen and bathroom
- ☐ Install wireless light switches where needed

12. HEAT, AIR, LIGHT, SMOKE, CARBON MONOXIDE, WATER TEMP CONTROLS
- ☐ Install smoke/CO alarms, fire extinguishers
- ☐ Replace thermostat with easy to read programmable type
- ☐ Order service for heating/AC system
- ☐ Install Compact Florescent lights where appropriate
- ☐ Reduce hot water temperature to 120 degrees

COMMENTS:

210 Case Management Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/26/2021
	Section Title:	Case Management Services	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	210	**Previous Update:**	MT 2021-01

210.1 Purpose

This chapter establishes the guidelines and requirements for Area Agencies on Aging (AAAs) that provide or contract for the provision of case management services to older adults, persons with disabilities, and their caregivers. These requirements apply to case management services funded fully or partially by funds received through the Division of Aging Services, and DAS suggests their use by agencies providing case management as a fee-for-service enterprise.

Case management provides access for individuals to community resources or assists individuals in identifying and securing resources or services to enhance wellness and remain in the community for as long and as safely as possible.

Case management is a person-centric, collaborative process designed to meet an individual's complex social and health needs. Through ongoing monitoring and evaluation, case management promotes quality, cost-effective outcomes for the individual and the community.

Case management services must maintain the flexibility to respond to changing needs and preferences of individuals. Therefore, these guidelines seek to enhance the ability of case management to vary service delivery in response to changing individual needs and preferences.

Not every individual who requires long term care services needs or desires case management, and not every individual who can benefit from case management needs long-term care services. Moreover, not every individual who can benefit from case management needs it indefinitely or always requires intensive levels of case management services, (Connecticut Community Care, Inc. (CCCI), p. 11)).

210.2 Definitions

Section moved to MAN 5600, Appendix E, January 1, 2021

210.3 Core Principles

AAAs will ensure that case management services are implemented according to the following Core Principles:

1. **Capacity based**: Older persons and persons with disabilities have the capacity for continued growth and autonomy and are the authority on their own needs, know what they need most to achieve well-being, and have abilities, competencies, and resources to help achieve their goals.
2. **Conflict-free**: Program staff remains neutral with no interest in the choices made by individuals nor in the types of services or providers selected by the individuals; and to the extent possible, avoids the appearance of conflicts regarding referrals on behalf of individuals.
3. **Culturally Competent**: Program staff understands and respects the culture of individuals and interacts with them in ways that are culturally and linguistically competent; and appreciates the ways cultural beliefs and values inform the individual's acceptance of Service Plan options.
4. **Individualized**: Services should focus on meeting the specific needs and preferences of each individual and/or family through joint development, implementation, and review of the Service Plan.
5. **Person-Centered**: Program staff approaches individuals and families with empathy and an

understanding of their life experiences and challenges by searching for and acting upon what is important to that individual, including their wants, needs, and values.

6. **Professionally Responsible**: Program staff maintains the privacy, confidentiality, health, and safety of individuals by adhering to ethical and legal standards and to program guidelines.

210.4A Service Goals

The goals of case management services include:

1. Maintaining the greatest possible amount of independence and dignity for each person by:
    a. Identifying and enhancing the knowledge, skills, and assets of each individual and his/her family and community
    b. Enabling individuals to remain in the most appropriate and safest environment they prefer
2. Ensuring that the right services are provided at the appropriate levels, for the right duration, to the satisfaction of the individual, and at the preferred times to the extent possible, including:
    a. Increasing access for individuals to community-based services (regardless of fund source or type of need) by helping individuals navigate the service system, and by providing information and support necessary for individuals to access services
    b. Providing an appropriate, comprehensive, and coordinated response to the individual's needs and abilities, including prevention, maintenance, and restoration of abilities, whenever possible
    c. Maximizing community resources by assuring the use of appropriate services through the development of Service Plans that avoid duplication of services
3. Building and strengthening family and community support by:
    a. Improving availability and quality of services
    b. Teaching individuals to advocate for themselves through information, education, and support

210.4B Service Outcomes

The desired outcomes of individuals receiving case management services include:

Outcome #1: Older persons and persons with disabilities will experience reduction in risk factors that contribute to out of home placement.

- Indicator #1: increased support as measured by Unmet Need score from DON-R
- Indicator #2: reduction in intention to place as reported by caregivers, when present
- Indicator #3: reduced number of risk factors indicated by periodic reassessments

Outcome #2: Older persons and persons with disabilities will have increased awareness and/or access to services.

- Indicator #1: number of services offered/referred/or provided by case management
- Indicator #2: number of education activities provided by case management

- Indicator #3: reduction in barriers to accessing services indicated by Service Plan documents

DAS does not require that the AAA achieve every outcome and/or indicator for the delivery of case management services to be deemed effective.

210.5 Target Consumer Groups

Because not every individual will desire, accept, or benefit from case management services, it is imperative that AAAs target individuals who can most benefit from community-based case management services and who are at highest risk for institutionalization.

Eligibility criteria for non-Medicaid Home and Community Based case management services include persons who are age 60 and older or who are of any age and have Alzheimer's Disease or a related disorder, persons with disabilities, and their caregivers.

For the Older Americans Act (OAA) Family Caregiver Support Program, the caregiver is considered a candidate to receive case management support for their own needs. For case management services funded by the Title III-E Family and Caregiver Support Program, the following criteria apply:

1. An adult, age 18 or older, who provides care for an elderly person, age 60 or older, or who provides care for a person with Alzheimer's Disease or a related disorder, or
2. An adult, age 55 or older, who is the grandparent/relative caregiver of a child aged 18 or under or of a disabled person of any age. Children may be related through birth, marriage, or adoption.

ADRC staff should refer clients to case management who have an immediate risk to health and safety and who cannot be adequately served through ADRC interventions. Immediate risk includes, but is not limited to:

1. Lack of food
2. Crisis with shelter or environment, including lack of utilities, significant risks related to physical structure, or non-functional essential systems
3. Crisis with caregiver or support system
4. Crisis with health, including a prior hospitalization within the last 180 days and a high risk of readmission, and/or
5. Abuse, neglect, or exploitation

Other appropriate uses of case management services, dependent upon adequate resources, include:

1. The individual or caregivers desire education and/or assistance in planning for:
    - current or future care and support needs of family members who are elderly or who have a disability,
    - specific education, counseling, access to resources, or assistance with making plans to support physical, mental, and/or emotional well-being of the individual or the caregiver, or
    - specific information about chronic health conditions.
2. The individual is transitioning from one level of care to another, such as discharge to or from a

hospital, rehabilitation facility or nursing home or other level of care.

3. Complex cases as defined in MAN 5300 CH 202.4E.

The following conditions or situations may suggest that case management services may not be appropriate:

1. Individual need is not indicated based on individual assessment results including but not limited to: DON-R, NSI, Food Security, and caregiver screening
2. The individual does not present as being at high risk for institutionalization, or
3. The individual does not wish to receive case management services.

210.6 Case Management Model

Case management uses the bio-psycho-social-cultural model of assessment that examines the interplay of the client's functional status and environment.

Case management uses a strengths-based or capacity-based philosophy to service delivery that includes the following components in contrast to a needs-based approach:

- Engagement – an unstructured conversational approach vs. structured interview
- Strengths Inventory – assesses strengths, abilities, and accomplishments of the individual and the priorities identified by the client vs. traditional needs-based assessment
- Personal Goal Planning – the client sets goals, and the Service Plan is developed collaboratively vs. goals driven by case manager
- Resource Acquisition – the enhancement of the client's ability to identify and/or access a wide array of formal and informal services vs. service brokering
- Continuing Collaboration – the evaluation of goals and tasks is a collaborative effort vs. an approach based on monitoring or review
- Graduated disengagement – an approach that begins with the initial interaction and occurs gradually as the client learns negotiation skills and their support system expands, thus phasing out the need for formal case management vs. service termination

Case management should identify and present to the individual opportunities for intervention in situations that reduce quality of life and potentially reduce the client's ability to remain in the community, including:

- Improper use of services, including duplication of services
- Under-use of services
- Premature discharge from an appropriate level of care
- Inappropriate use of health resources (for example, using emergency room services instead of a primary care physician or health clinic)
- Lack of education about chronic conditions or disease processes
- Permanent or temporary changes in functioning that may require medical or other evaluation
- Use of ineffective services or treatments

- Unstable or deteriorating support system
- Inability to self-manage health and/or personal affairs

210.7 Access to Services

The AAA will coordinate the provision of case management services with the ADRC program and will develop and implement protocols that facilitate appropriate and timely referrals from ADRC and that initiate case management services in a timely manner.

Not every applicant for services will request, require, or benefit from case management services. Each AAA will clearly identify in its Area Plan how it will coordinate services with ADRC and how it will allocate and manage resources to optimize the effectiveness and efficiency of case management services.

210.8A Core Functions of Case Management

An optimal case management program requires case management staff who have specialized skills and competencies to provide the following core functions:

- Assessment
- Service Plan Development
- Service Plan Coordination
- Advocacy
- Reassessment
- Discharge

Each core function is described in more detail below.

An associated, but equally important, function of case management includes providing education to the client and/or caregiver about a range of topics including health and wellness, personal safety, home safety, accessing the service delivery network, and disease progression.

210.8B Allowable Activities

The AAA may report the following activities in its reimbursement for case management services:

1. Assessment
2. Periodic Reassessment
3. Service Plan Development and Coordination
4. Follow up by telephone, email, or in person with clients and caregivers, when appropriate and necessary, in accordance with program and service requirements
5. Coordination with other programs and advocacy on behalf of individuals who require assistance in accessing other systems of care
6. Documentation, data collection, data entry, and programmatic reporting

Travel to and from the homes of applicants/clients for the purpose of assessment or reassessment

may not be billed as units. However, travel is a cost of performing this service and should be included in unit cost calculations.

210.9A Assessment

Assessment occurs over time and seeks to identify the client's perception of his/her need.

The goal of assessment is to discover the individuals' interests, needs, assets, and abilities leading to a Service Plan that will capitalize on remaining strengths and compensate for deficits. In addition to information obtained during the assessment, Case Managers must use their experience, expertise, observations, and judgment to determine the individual's need for services, supports, and resources.

The CMA will ensure that case managers use instruments and tools specified by DAS to appraise clients' status and needs, and that case managers are proficient in their use. To the extent possible, DAS will provide assessment tools that are evidence-based or validated to maximize the effectiveness and efficacy of the assessment process.

Not all individuals will require the use of every tool; however, the core instruments are required for all individuals. Case Managers will use optional specialized instruments based on the identification of possible areas of concern or need.

MAN 5300 114 Guidelines for Client Assessment describes these assessment domains and specific assessment tools.

Assessment helps the case manager determine whether collateral information is needed and, if so, from whom they should obtain the information. Instances in which collateral information may be needed include, but are not limited to:

- The individual seems to be withholding information
- The observable function does not match self-reported function
- There is suspected cognitive impairment

210.9B Service Plan Development

The plan defines how the Case Manager will measure the success of the intervention(s) and provides a basis for the AAA to evaluate the effectiveness of the Case Manager and for the purchase of or referral to services.

The Case Manager facilitates the client setting goals and establishing a person-centered plan of action necessary to meet the client's goals. The Case Manager may assign action steps needed to reach these goals to the individual, the case manager, and/or various formal and informal support entities. Public-funded services are intended only as activities to support the client's personal goals.

Service Planning is intended to empower individuals toward self-efficacy and self-advocacy, therefore minimizing dependence on case management services and the publicly funded services network, whenever feasible. The Service Plan must emphasize the strengths or capacities of the individual, including his/her support system. The Level of Risk and the specific areas of risk identified during the assessment and the client's personal goals drive development of the Service Plan.

Activities of the Service Planning process include:

1. Monitoring progress on client's goals and the Service Plan
2. Identifying gaps and barriers to the client to enhance outcomes for current and future clients
3. Advocating on behalf of clients to maximize personal outcomes
4. Assisting the client to access needed services, including providing referrals and brokering services
5. Reassessing client needs and the Service Plan periodically
6. Modifying the Service Plan and the use of service providers as necessary

The Service Plan is the key to the provision of home and community-based services through the public-funded Aging services network. The Service Plan should clearly articulate the duration and level of formal services and the Case Manager should ensure that individuals understand that future service levels are contingent upon periodic reassessments and Service Plan revisions.

Service Plan Development – the Case Manager will utilize the following guidelines in developing the individualized Service Plan for everyone:

1. Develop and document Service Plans according to DAS specifications and will use assessment data as the basis for planning effective interventions.
2. Use a multi-disciplinary and holistic approach to care including obtaining input from other professionals involved in the care of the individual including health care providers, registered dieticians, dentists, pharmacists, rehabilitation therapists, mental health professionals, etc., when possible and appropriate.
3. Clearly link services to be provided with the Level of Impairments and Unmet Needs for Care from the DON-R, with other instruments used in assessing the client and/or caregiver, and link clearly to identified risks.
4. Complete the initial Service Plan developed with the individual within five business days of the in-home assessment unless a reasonable exception is documented in the client's record. The Case Manager will document the agreement of the individual and/or the authorized representative to the Service Plan and mail or otherwise provide a copy of the plan to the individual within five business days of completing it.
5. The Service Plan will include at a minimum:
    - The problem or need for assistance as identified by the individual
    - The needs identified by the assessment
    - The types of services/activities to be provided and the resources to be used, including assistance provided by family, friends, payer sources, or volunteers
    - The expected days, times, frequency, and duration of the services or activities
    - Long-term and short-term goals, from both a person-centered and safety perspective, as appropriate
    - Time frame for follow up and evaluation
    - Collaborative approaches to be used

- Anticipated outcomes

6. The Case Manager will ensure that appropriate formal service providers engaged in the client's care receive a copy of the Service Plan. The individual may authorize other persons or entities to receive a copy of the Service Plan.

The assignment of Service Plan activities is a key component of the process. DAS recommends the following tiered level of assignment:

1. The Case Manager assigns as many tasks to the individual as possible, considering the individual's resources and capacities. This approach is the most effective because it builds on the client's capacities and builds future problem-solving skills.
2. The Case Manager assigns as many shared tasks as possible. Tasks may be shared between or among the client and his/her support system or may be shared with the Case Manager. In this situation, coaching by the Case Manager may have long-term benefits for the client.
3. The Case Manager performs tasks that the client or family is unable to perform. This level should trigger assessment of the capacity and willingness of the client for active involvement.

The Case Manager may use the optional Case Management Action Plan to provide specific individuals involved in Service Plan activities a more user-friendly option than the Service Plan document.

See Appendix 210-D for instructions on how to use the Service Plan documents.

210.9C Care Plan Coordination

Case Managers should ensure that the Service Plan is successfully implemented and that services are effectively coordinated to achieve the greatest impact on behalf of the individual and to maximize the use of community resources. (Note: Service Plan and Care Plan are often used interchangeably)

The case manager should coordinate the Service Plan in a manner that maximizes the independence and choice of the individual while ensuring interventions are the least intensive, least intrusive, most cost-effective, and of the highest possible quality. Coordination may refer to the specific Service Plan and/or to the need for further assessment. Service Plan coordination should include the following activities (CCCI, p. 38):

1. Referral to and negotiating with both formal and informal providers of care
2. Communicating, with the individual's written consent, with the formal and informal service providers, health providers, and family about the coordination of the Service Plan
3. Empowering the individual and his/her informal caregivers by teaching them how to maximize their access to and utilization of needed health and social services

Teaching and coaching of individuals and their support network are critical components of Service Plan coordination. Ensuring they have essential information to allow informed choices about a variety of care issues contributes to the successful coordination of the Service Plan.

The Case Manager will maintain regular contact with the individual, family and other informal caregivers, and other service providers to evaluate whether the Service Plan is meeting the needs and goals of the individual, whether formal services are being provided in a manner satisfactory to

the individual and are meeting the individual's needs adequately, and whether problems are resolved promptly and appropriately.

1. The Case Manager will follow up by telephone with individuals or caregivers at the end of the first sixty (60) days of Service Plan implementation to determine progress toward goals and satisfaction with services.
2. The Case Manager must always review the Service Plan any time the individual is reassessed but may review the Service Plan at other times based on client need and progress toward meeting goals.
3. The Case Manager will document all contacts and their substance in the client record.
4. Monitoring of the Service Plan will include:
    a. Evaluating the extent to which action steps and strategies have been achieved and have been successful in meeting the individual's goal
    b. Negotiating with the individual to identify gaps and barriers to action steps and goals not being achieved and to identify strategies to overcome those gaps and barriers
    c. Reviewing the quantity and quality of formal services and taking appropriate steps to ensure that substandard care is improved or arranging for alternate service provision.

210.9D Advocacy

The case manager should advocate for clients at the service-delivery, benefits-administration, and policy-making levels. The following activities and principles demonstrate effective advocacy:

1. Promoting the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy
2. Educating other health care and service providers in recognizing and respecting the needs, strengths, and goals of the client
3. Facilitating client access to necessary and appropriate services while educating the client and family or caregiver about resources availability within the community
4. Recognizing, preventing, and eliminating disparities in accessing high quality care.

    (See Case Management Society of America, "Standards of Practice for Case Management")

210.9E Reassessment

The Case Manager must conduct formal assessments according to intervals established by the individual's Service Plan or when a significant change occurs in one or more of the following areas:

- Health status
- Emergency room visit, hospital admission, or nursing home/rehabilitation admission
- Behavioral status
- Cognitive status
- Emotional status
- Functional status

- Formal or informal support system
- Risk category
- Service utilization
- Housing/environment status

Whenever completing a reassessment of an individual, the Case Manager must also review the individual's Service Plan to ensure its continued appropriateness and effectiveness.

210.9F Discharge

Planning for termination of services begins during initial contact with the individual or family. Disengagement occurs gradually as the client learns negotiation and self-help skills and as the formal and informal support systems expand, thus often phasing out the need for formal case management. Throughout the period of service delivery, case management fosters maximum independence and empowerment and minimizes dependence on the case manager.

The AAA may discontinue Case Management at any time by mutual agreement between the individual/caregiver and case manager without affecting the individual's receipt of support services if such services are still justified. Case management may be discontinued at any time at the request of the individual or the caregiver when acting as authorized representative for the individual. The case manager will coordinate discontinuation of case management services with individuals and agencies providing supportive services. The CMA will develop procedures for supervisory review of pending closures.

The CMA shall discontinue case management services when any of the following conditions exist:

1. The goals and objectives of the Service Plan have substantially been met and no additional goals or objectives are identified
2. The individual has moved to a long-term care facility or other community placement for an extended or permanent duration
3. Another service is more appropriate and case management will be provided (such as EDWP, Veterans' Assistance Programs, other waiver programs, etc.)
4. The case manager cannot document reasonable progress toward achievement of Service Plan goals and objectives, or the individual is non-compliant with the Service Plan, or the persistent actions of the individual or the family negate the services provided by the various agencies/individuals involved, AND the case manager has documented attempts to counsel with the individual/family to encourage compliance prior to discontinuing services
5. The family has developed or strengthened a support system that can provide adequate and acceptable care, and the family and other service providers are informed of how to contact the area ADRC if a future need for case management services arise
6. The individual, caregiver, or individual's family threatens service provider staff (including the case manager) or engages in illegal or hostile/threatening activity such that the welfare and safety of service provider staff are in jeopardy AND good faith attempts at corrective action have failed
7. The individual has relocated outside the service area and any transition assistance has been

provided, including coordination with case management staff in the area of relocation

8. The individual request that case management be discontinued
9. The individual has deceased

Situations may arise in which the current level of service provision is inadequate to ensure the safety and health of the individual. In such situations, the case manager must be diligent about documenting efforts to educate the individual or family about other community resources including more appropriate levels of care, limitations of current services, and the right of the individual to make informed choices. The case manager should assist wherever possible to ensure a smooth transition from case management services.

Case Managers must comply with MAN 5300, CH 202.18 when discharging clients or reducing levels of service.

210.10 Documentation

See MAN 5300, CH 202.5A and MAN 5300, Appendix B.

210.11 Efficient Use of Resources

Case Management services must balance needs and preferences of individuals with the efficient use of public and private resources. Case managers must continually monitor this aspect of service delivery. At times, individual needs or preferences may conflict with payer requirements. Case managers should attempt to educate all parties to maximize impact and the efficient use of services.

The following activities will assist Case Managers in fulfilling this requirement:

1. Identify comparative costs of alternative Service Plan options
2. Calculate private and public costs of services recommended in the Service Plan
3. Communicate cost information to individuals to facilitate an evaluation of their options
4. Monitor service expenditures over time

Evaluating the efficient use of resources should also include comparing the relative costs of specific services to the value or impact that the specific service provides to the individual.

210.12 Fee-For-Service Guidelines

Each AAA/CMA is encouraged to offer case management services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In so doing, the AAA must follow requirements of the Older Americans Act and MAN 5600 3090 Fee for Service System Overview and MAN 5600 3093 Private Pay Services.

Case management provided to individuals as a fee-for-service should not differ in quality from service provided to individuals funded through public funds. In establishing its fee for service structure, the AAA/CMA should account for the actual cost of the services, including administrative costs, and consider comparable rates within the service market area.

210.13 Administrative Requirements

Providers of case management services, whether AAA or CMA, must adhere to specific administrative requirements to ensure an effective and efficient service delivery system as described below.

Specifically, the AAA will ensure that the following administrative requirements are addressed in policy and procedures:

1. Retention and Record Keeping (See MAN 5300 CH 202.5 and MAN 5600 1060 Division Reports, Overview)
2. Confidentiality (See MAN 5300 CH 02.5A, MAN 5600 2053 Grant Submittal Instructions and MAN 5600 2053 Grant Management).
3. Mandatory Reporting of Elder Abuse (See CH 202.19A)
4. Ethical and Legal Practice (See CH 202.13)
5. Appeals and Grievances (See MAN 5300 CH 110 and MAN 5300 CH 202.5D)
6. Fiscal Management (See MAN 5300 CH 102.14 and MAN 5600 3022 Financial Management)

210.13A Eligible Organizations

AAAs may provide non-Medicaid case management services directly (following OAA guidelines) or may contract services to a qualified CMA. The AAA must ensure objectivity and maximize conflict-free service delivery by separating the assessment of individuals from the delivery of other home and community-based services (see MAN 5300 CH 202.4F “Conflict Free Service Delivery”).

Entities qualifying as contractors of AAAs must demonstrate experience in providing case management services to older adults and provide adequate documentation of fiscal viability prior to contract execution (see MAN 5600 3010 Emergency Planning and Management and MAN 5600 3024 Risk Management). CMAs must meet all requirements for contracting as defined in MAN 5600 7001 Compliance with Contractor Responsibilities and Sanctions.

210.13B Agency Structure

The AAA will ensure that the agency providing case management services implements written policies and procedures that govern all aspects of case management operations, including, but not limited to:

- The organizational framework for case management services, including how case management assistance is coordinated with AAA ADRC/Gateway operations and with providers of supportive services, including other care coordination/case management entities
- Oversight and internal reporting requirements of the case management program, outside of those established by DAS
- Personnel management of case managers and other staff of the case management program
- The delivery of case management services, including:
    - the role of professional, clinical advisors or consultants in the case management program
    - timeframes for providing timely responses to individuals’ or caregivers’ inquiries about case management activities

- protocols for communicating with individuals and/or their caregivers regarding case management recommendations and actions
- any aspects of service delivery required by the AAA that exceed DAS requirements

210.13C Staff Administration and Supervision

The CMA will employ a program director/administrator who is accountable for administering the program according to DAS requirements, overseeing quality improvement activities, and supervising case management personnel.

Depending on the size and structure of the organization, the program administrator may provide direct supervision to case managers or there may be additional levels of staffing for supervisory staff who are not involved in overall organizational administration. The CMA will ensure the availability of clinical supervision either via staffing or via contract.

Supervisory Qualifications - The staff person directly responsible for supervision of case managers must have the following qualifications:

- Hold a bachelor's or higher degree in social work, human services, social services, gerontology, health, nursing, or other closely related field, with a background and experience in gerontology, long-term care, or the delivery of community-based services; *or*
- Be a Registered Nurse, properly licensed in the state of Georgia, with a background and experience in gerontology, long-term care, or the delivery of community-based services; *and*
- Demonstrate relevant experience in the provision of community-based case management services; *and*
- Have a minimum of two years' experience in the supervision of professional case management and support staff; *and*
- Have no conviction in any jurisdiction of any charge of abuse, neglect or exploitation or convicted of any crime (excluding misdemeanors or traffic violations) that would pose a safety or health risk to clients and their families; *and*
- Demonstrate proficiency in the core competencies referenced in 210.11G.

Supervisory Role and Responsibilities – the role and responsibilities of the administrator/director/supervisor include:

- To support and clarify the role of the case manager
- To be accessible to case managers on a scheduled and as-needed basis
- To provide guidance on decisions requiring judgment, assistance with problem situations, and monitoring/approval of Service Plans (including plans for discharge)
- To explain goals, policy, and procedures, and to assist staff in adjusting to changes that occur
- To encourage professional development and upgrading of skills through access to training and professional resources
- To evaluate performance of case managers based on established criteria that include at a minimum: review of individuals' records, observations of home visits, supervisory conferences, and measurements of productivity and outcomes

Staff ratio – The maximum staffing ratio is one supervisor for every eight case managers.

Agencies are encouraged to identify qualified case management staff who demonstrate the potential for advancement to the supervisory level, and to include training and other educational opportunities in the employee's professional development.

210.13D Caseload Management

The CMA will consider the following factors when establishing and managing staff caseloads:

- The geographic size of the area covered, taking transportation resources into account
- The amount of assistant, clerical, and supervisory support available
- The availability of community-based services and resources
- The Risk Levels of individuals being served
- Target populations served
- The extent, if any, of responsibility for and control over funding for service interventions exercised by the case manager in voucher or direct purchase service delivery systems

The following factors often predict high use of case management time and should be considered in managing staff caseloads:

- Problematic client behaviors, including mental health issues and/or dementia
- Low functional capacity and/or high acuity
- Problematic informal support, including mental health issues or unrealistic expectations
- Problematic formal services, including unreliable or poorly trained staff

210.13E Staff Qualifications

Professional Staff - Based on the estimated staffing needs for caseload coverage (see §210.11D), the CMA will employ and/or contract with an adequate number of competent and qualified personnel to provide case management services.

Minimum qualifications include:

- A bachelor's or higher degree in social work, social services, gerontology, health, nursing, or closely related field; *or*
- A Registered Nurse or Licensed Practical Nurse, properly licensed in the state of Georgia; *and*
- A background in gerontology, long term care, delivery of community-based services or other related practice; *and*
- At least two years of relevant experience in the provision of community-based case management services; *or*
- An equivalent combination of education and experience in applicable fields; *and*
- Not have been convicted in any jurisdiction of any charge of abuse, neglect or exploitation or convicted of any crime (excluding misdemeanors or traffic violations) that would pose a safety or health risk to clients and their families; *and*

- Be able to demonstrate proficiency in the core competencies referenced in 210.11G.

Any staff who holds professional licensure, whose employing organization recruited for the position based on a candidate having that licensure status will meet licensure requirements based on applicable state statutes; maintain a current license; and practice within the scope of that profession.

The CMA will verify licensing and credentials of licensed or certified personnel upon hire and thereafter no less than every two years and have policies/procedures to prevent or address lapses in licensure or certification.

Paraprofessional Staff – The CMA may employ case management assistants to support the delivery of services to individuals and must identify specific tasks appropriate for a paraprofessional. Qualifications for such staff include:

1. Associate degree in a field of study related to health and human services; *or*
2. High school diploma or G.E.D. combined with experience in aging services or a relevant field of health or human services; *and*
3. Not have been convicted in any jurisdiction of any charge of abuse, neglect or exploitation or convicted of any crime (excluding misdemeanors or traffic violations), that would pose a safety or health risk to clients and their families.

210.13F Staff Management and Development

Effective case management is contingent upon proper training in assessment, intervention, and evaluation; knowledge of community resources; continuing training and education; and manageable caseloads that provide time for adequate contact.

Written Job Descriptions – The CMA will develop written job descriptions including statements of qualifications and expected professional competencies for all personnel engaged in case management and will implement a process for performance evaluation that occurs at least annually. See Appendix 210-A Core Competencies for Case Managers.

Orientation – The CMA will ensure that case managers receive orientation in current principles, procedures, and areas of case management, with orientation and in-service training to include at a minimum:

- The mission, vision, and values of the agency and the aging network
- DAS standards and requirements
- Policies and procedures, including the agency's code of ethics
- Client's Rights and Responsibilities
- Characteristics and resources of the communities served
- Cultural competency appropriate to the population(s) being served
- Overview of the regional and state aging networks, the Older Americans Act, and other statutory authorities
- Information about all laws, policies, procedures, and reporting requirements regarding client

abuse, neglect, and exploitation that is provided prior to the employee providing direct services

- The use of instruments and tools designated by DAS in the assessment of clients and their caregivers
- Practice related to safety of case managers in the field
- Ethical and legal issues related to case management
- The use of required electronic and other systems used for data collection, reporting, and maintenance of individual records

Staff Development - The CMA will encourage and document the ongoing professional development of case management staff. When possible, the CMA will provide support for professional participation through membership in or attendance at meetings of professional case management associations.

Time management – Supervisors will assure that case management staff have built into their work plans time for attending routine meetings and trainings and have protected time for administrative duties including documentation.

210.13G Core Competencies

In addition to the minimum qualifications specified in CH 210.11E, AAAs/CMAs will develop recruitment and candidate selection materials and processes, and job descriptions that incorporate and reflect specific attributes that have been identified in successful case management practitioners. AAAs/CMAs should also use these core competencies as the basis for staff development programs. (See Appendix 210-A Core Competencies for Case Managers)

210.13H Information Systems and Information Management

See MAN 5300, CH 202.8

210.13I Client Records

CMAs will maintain separate files, in a manner specified or approved by the Division, containing all written or electronic documentation pertaining to the services provided for each client served, including the following, at a minimum:

1. Assessment and reassessment documentation
2. Identifying information, including the name, address, telephone number of the client/responsible party and the emergency contact
3. Service Plans
4. Any material reports from or about the client that relate to the services being provided, including progress notes, medical records obtained on behalf of the client, and problems reported by employees of the provider agency
5. Communications with family members or responsible parties and any other pertinent communication
6. All case notes related to activities with or on behalf of the client
7. The date of the referral and dates of any significant contacts, developments, decisions, or

changes in plans

8. All additional information requested or required by the Division.

210.13J Accessibility and Identification

The CMA will ensure community access to case management services by a telephone system that at a minimum:

- Operates via a toll-free or collect telephone line that is available during normal working hours
- Provides a mechanism to receive timely callbacks from providers and establishes written procedures for receiving or directing after-hours calls, either in person or by recording
- Allows access during reasonable and normal business hours, unless mutually agreed upon
- Requires all CMA staff to identify themselves when making or receiving calls by full name, title, and agency name

The CMA will provide appropriate office space to allow case managers to conduct appointments with clients, caregivers, or health professionals in a private, confidential setting. The AAA is responsible for establishing regular business hours for case management services and for assessing the extent to which individuals, including family caregivers, need case management services outside of regular business hours (including weekends and holidays) and shall incorporate into its Area Plan documents specific strategies to expand capacity to meet those needs. The AAA may involve the CMA in the assessment of need and/or development of strategies.

The AAA may negotiate differential unit costs for services provided outside of core agency hours only if the provision of such service results in an increased cost to the agency.

The CMA will furnish adequate identification (ID) to Case Management staff who have direct contact with individuals and caregivers. Each employee must carry the identification and either wear it on his/her person or present it to the individual upon request.

An adequate ID is one that is made of permanent materials and that shows the provider agency name, and the name, title, and photograph of the employee. The provider will issue the ID at the time of employment and require its return from each employee upon termination of employment.

210.13K Standards of Promptness

Case managers will initiate contact with the individual or with the caregiver or other representative when contact with the individual is not possible or appropriate, *within two business days* of receiving a referral from the ADRC for the purposes of introduction and scheduling the initial home visit.

Case managers will conduct face-to-face assessments of individuals in their places of residence (except as noted below) *within ten business days* of receiving a referral from the ADRC.

Should service requests involve assessment and service planning for persons due to be discharged from a hospital or nursing facility to his/her home or to the home of a caregiver, the assigned case manager will make every effort to conduct the assessment prior to the discharge. The case manager will conduct a follow-up contact (either by telephone or in person) within 2 business days of the discharge to determine whether services needs are being met. If the individual has been discharged,

the case manager will conduct the in-home assessment *within two business days* of the discharge.

If any standard of promptness cannot be met due to circumstances beyond the case manager's control, the case manager will document the efforts to achieve compliance in the client's record/file.

210.13L Authorization for Information Sharing

Case managers will initiate contact with the individual or with the caregiver or other representative when contact with the individual is not possible or appropriate, *within two business days* of receiving a referral from the ADRC for the purposes of introduction and scheduling the initial home visit.

Case managers will conduct face-to-face assessments of individuals in their places of residence (except as noted below) *within ten business days* of receiving a referral from the ADRC.

Should service requests involve assessment and service planning for persons due to be discharged from a hospital or nursing facility to his/her home or to the home of a caregiver, the assigned case manager will make every effort to conduct the assessment prior to the discharge. The case manager will conduct a follow-up contact (either by telephone or in person) within 2 business days of the discharge to determine whether services needs are being met. If the individual has been discharged, the case manager will conduct the in-home assessment *within two business days* of the discharge.

If any standard of promptness cannot be met due to circumstances beyond the case manager's control, the case manager will document the efforts to achieve compliance in the client's record/file.

210.13M Ethical and Legal Issues

In fulfilling their ethical responsibilities to individuals, case managers will:

1. Provide services with respect for the autonomy, dignity, privacy, and rights of the individual
2. Provide information to the individual that supports making informed decisions about their situation and need for assistance
3. Respect the individual's right to privacy by sharing only information relevant to his/her care within the requirements of law
4. Seek appropriate resources and consultation to help formulate ethical decisions

In addition to following guidelines for ethical and legal practice required by MAN 5300 CH 202.13, and the responsibilities described above, case managers must be especially diligent about issues that arise during the practice of case management services, including:

- When the case manager's professional judgment or values conflict with the beliefs, values, or preferences of the individual or the individual's family
- When the individual's beliefs, values, or opinions about services conflict with those of the caregiver or responsible party
- When there is tension among the individual's preferences, case manager's judgment, and payer constraints
- When the individual's preferences are at odds with the case manager's role of managing public or community resources effectively

- When conflict is created by the individual's right to dignity of risk

The CMA should include such information in initial orientation and training and/or in the agency's ongoing staff development program. The following techniques may be useful in handling ethical concerns:

- Involving the individual in goal setting and Service Planning
- Providing as much information as possible to the individual to allow for informed consent
- Using peer review, Service Planning committees, or clinical supervision to discuss and resolve issues of dignity of risk or allocation of resources
- Following HIPAA and other confidentiality guidelines
- Using outcome measures to track the type and quantity of services that are appropriate

210.13N Grievances and Appeals

Individuals may appeal recommendations to change, reduce or terminate the delivery of case management services. The case management agency must follow requirements set forth in MAN 5300 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs.

210.13O Program Evaluation and Monitoring

Using tools specified by the Division at a minimum, the AAA and DAS will periodically monitor the performance of the CMA to determine the degree to which the CMA accomplished defined program outcomes and objectives and individual client outcomes. The AAA will monitor for compliance with these requirements and evaluate performance on at least an annual basis and shall provide written feedback to the CMA about its findings and will provide technical assistance for continuous quality improvement. If the AAA is the CMA, it will develop and implement a protocol for self-evaluation and objective internal review of case management services.

The AAA must monitor and evaluate the following processes, at a minimum:

- Identification and tracking of key quality indicators (see Appendix 210-B, "Quality Improvement Data")
- Review of client records, including assessments, Service Plans, and documentation to measure quality, accuracy, and consistency of records
- Review of the degree to which case management serves target populations
- Review of compliance with these guidelines
- Review of existing program's operations, including cost-effectiveness of service
- Mechanism for internal reporting of quality-related problems
- Implementation of corrective action plans for identified problems

References

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National Association of Social Workers, Standards for Social Work Case Management

Division of Aging Services, MAN 5300 CH 114, Guidelines for Client Assessment

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Canadian Core Competency Profile for Case Management Providers

Documentation and Record Keeping: A Guide for Service Providers, National Council of Social Service.

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Center for Aging & Disability Education and Research at Boston University, School of Social Work.

“Clinical Documentation and Recordkeeping” by Hillel Bodek, Chairperson of the Committee on Ethics and Professional Standards and the Committee on Forensic Clinical Social Work New York State Society for Clinical Social Work, Inc.

DAS MAN 5600, Appendix E “Glossary of Terms, Abbreviations and Acronyms”

Appendix 210-A Core Competencies for Case Managers

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/26/2021
	Section Title:	Core Competencies for Case Managers	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	Appendix 210-A	**Previous Update:**	MT 2021-01

Case Managers should master the following specific competencies to ensure optimal efficiency and effectiveness of the case management program:

General Competencies

- **Cultural and Linguistic Competence** – the ability to interact and communicate with individuals from a variety of cultural contexts, including but not limited to gender, sexual orientation, ethnicity, geographic origin, spiritual traditions
- **Safety** – the ability to understand and practice general safety procedures in the community and office environments
- **Knowledge of Current Laws and Regulations** – including privacy and confidentiality, ethics, and the ability to understand and apply appropriate boundaries in working with individuals
- **Use of Technology** – the ability to use agency computer systems efficiently and effectively and to successfully engage individuals while using technology, and the ability to recommend appropriate use of technology as an adjunct to service delivery
- **Knowledge of Aging and Disabilities** - including issues related to psycho-social functioning, dementia, caregiving for older persons and persons with disabilities, and person-first language

- **Foundations of Case Management** – including models of case management and individuals served, documentation, policies, rules and regulations on case management, and funding requirements (Medicaid, etc.)
- **Interpersonal Team Skills** – including advanced abilities in verbal and written communication, listening, problem-solving, establishing rapport, effectively working with internal and external teams of services and supports, and eliciting and synthesizing relevant information and perspectives from clients, social networks, and stakeholders
- **Judgment and Analytical Ability** – the ability to identify critical issues, act appropriately in high-risk situations, assess and reassess appropriate crisis responses, and assist individuals and service providers in utilizing creative approaches to problem solving
- **Adaptability** – the ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's needs as they change
- **Organizational Skills** – the ability to independently manage caseloads and prioritize direct services and administrative accountability

Technical Knowledge

- **Assessment Skills** – the ability to identify needs, strengths, capacities, and competencies; to use a variety of specialized assessment/evaluation tools; to gather and summarize information; and to assist in identifying personal values, goals, and priorities, and the ability to interpret psychosocial and clinical information
- **Service Planning and Service Access** – the ability to develop and implement individualized and collaborative Service Plans and supports based on the results of the assessment and that meets the individual's needs and preferences, to facilitate service acquisition, Service Plan meetings, and intake and discharge planning
- **Advocacy** – the ability to act in the individual's best interest, provide family support and education, enhance knowledge and use of community resources, promote the development of other needed services and supports, clearly present service/health care options, and support dignity of risk, and the ability to use expertise and influence to speak on behalf of clients, the community, or population to advance their well-being
- **Evaluation** - the ability to evaluate the effectiveness of individualized Service Plans in meeting the individual's goals and addressing critical issues, including monitoring progress toward goals, identifying gaps and barriers, ensuring that services are appropriate to the individual, are of high quality and are efficient in use of private and public resources, and the ability to evaluate the outcomes of the case management service in terms of impact to the community
- **Specialized Techniques** - the ability to understand and effectively practice capacity-based approaches, motivational interviewing, person-centered models, and other techniques to maximize delivery of case management services

Technical Skills

- Excellent interviewing skills
- Ability to establish and maintain empathic relationships
- Experience in conducting social and health assessments, including psychosocial aspects

- Knowledge of human behavior
- Knowledge of family/caregiver dynamics
- Human development and disability
- Awareness of community services and resources
- Knowledge of self-care management (self-directed care, self-advocacy, informed consent)
- Knowledge of crisis intervention strategies
- Knowledge of change theory and stages of change
- Knowledge of health care management and delivery
- Understanding dementia in assessment and practice
- Recognizing signs of abuse/neglect/exploitation

Adapted from:

- Southern Illinois University College of Education and Human Services
- "Creating Opportunities", Case Management Workgroup Report, March 2011, Virginia Department of Behavioral Health and Development Services
- Commission for Case Management Certification, "Certification Guide to the CCM Examination"
- National Case Management Network, "Canadian Core Competency Profile for Case Management Providers, October 2012
- Guidelines for Case Management Practice across the Long-Term Care Continuum. Report supported by grant from The Robert Wood Johnson Foundation, November 1994.
- "Certification Guide to the CCM® Examination."

Appendix 210-B Quality Improvement Data

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/26/2021
	Section Title:	Quality Improvement Data	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	Appendix 210-B	**Previous Update:**	MT 2021-01

Quality Improvement Data

In establishing quality improvement programs, case management organizations will collect and analyze information through case reviews by supervisory or other management staff to ensure achievement of service goals as established in individual client Service Plans.

Supervisors should use the following data at a minimum in its analysis:

- Client-specific data, such as DON-R or other assessment score
- Comparison of client-specific desired outcomes per the Service Plans with actual results, including improvements in client knowledge or compliance with treatment, involvement in self-care,

meeting goals identified in the Service Plan, or degree of empowerment

- Quality, accuracy, and timeliness of documentation
- Information leading to the identification of best practices in case management

Program Implementation

Aspects of client care that will contribute to the quality improvement plan may include but not be limited to:

- Individual satisfaction with case management services
- Number, frequency, and nature of case management related complaints, appeals, and grievances
- Rate of achievement of case management goals as established in individual Service Plans
- Availability and accessibility of care
- Coordination and continuity of care
- Record keeping
- Standards of promptness
- Cost and/or cost effectiveness of providing case management services
- Evaluation of Program Outcomes described in Section 210.4B

The CMA will select the area(s) targeted for improvement, collect the data necessary to baseline performance, and obtain comparative data over time. DAS may collect comparative data among AAAs/CMAs to suggest areas for improvement. Agency leadership will provide feedback to case management staff regarding the status of improvement plans and solicit their input in all steps of the process.

Appendix 210-C Service Plan Documents

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/26/2021
	Section Title:	Service Plan Documents	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	Appendix 210-C	**Previous Update:**	MT 2021-01

Case Managers will develop Service Plans using information gathered through the assessment of clients and their caregivers, when present and involved. Based on information gathered from the DON-R and other assessment instruments, staff develops a plan that identifies and documents immediate, short term, and ongoing needs, as well as where and how the care needs are to be met. The plan sets goals and time frames for clients and caregivers to accomplish goals that are appropriate to each individual and to which each party agrees. Ideally funding and/or community resources are available to implement the plan.

Measurements of effective Service Planning are:

1. Staff demonstrates ability to interview, do research, and otherwise gather information that provides a factual base for developing the plan
2. Staff demonstrates knowledge and understanding of the client's condition, including any diagnoses of illness or chronic disease; the probable course and outcome or likelihood of recovery; care needs; remaining capacities of the client and/or the support system; the client's values; and desired outcomes and goals of the Service Plan
3. Staff demonstrates the ability to critically analyze and evaluate situations to identify barriers to goal accomplishment

The Individual Service Plan captures information about problems and care needs; identifies responsibilities for activities generated by the plan; documents the establishment and degree of accomplishment of goals and outcomes; and reflects time frames for services and activities. Staff also will be able to track progress in attaining and maintaining goals to measure accomplishment.

Heading	Description
Client Name	Insert Client Name
Date Prepared	Insert date the Service Plan is Prepared
Service Plan End Date	Insert the latest completion date for any Action Step chosen for the Service Plan.
Service Plan Type:	Initial or Review
Next Service Plan Review:	This is the same as the Service Plan End Date
Risk Level:	This is derived from the Risk Assessment Tool. Choose Level I, Level II, Level III
Date Service Plan Provided to Client:	Insert the date that the Service Plan was provided to client, either in person, by mail, or by electronic transmission.
Desired Outcome(s) for Service Plan as Stated by Client	List up to three desired outcomes as stated by the client. For example: "I want more time for myself so I can care for my husband" or "I want to get healthier so I can play with my grandchild."
Case Management Outcomes	Check any or all the program outcomes that relate to the outcome(s) stated by the client.
Problem or Need for Assistance	Staff will document problems, their origins/causes, indicators of the problems, and risk factors that contribute to the problems. The problem or need for assistance should document an issue that prevents or impairs the client achieving the desired outcome(s).
Goal	Staff will help the client to develop goals (short-term or long-term) that address the problem of need for assistance, and which will enable the client to achieve the desired outcome(s). A goal should be: S – specific M – measurable A – attainable R – realistic T – timely or time-specific (by when)
Action Step(s)	Staff will help the client to develop a series of incremental steps that will lead toward the goal. Action Steps should emphasize what the individual is **going to do** rather than what s/he is **going to stop doing**.
Who is Responsible?	Staff will record the name(s) of the participants in the plan who will take responsibility for each activity. Staff should develop plans based on the client's remaining strengths and abilities, allowing clients to assume a greater portion of responsibility than a provider or the case manager,

Heading	Description
Schedule	Staff will enter the date that each service or activity begins, how often it will occur, the duration of the service if known, how long it is expected to last, and, if appropriate, the payor source.
Status of Goal	During each Service Plan review, staff will evaluate and document progress to date using any established programmatic time frames for case review and reassessment. Using the criteria on the Service Plan, staff will note the client's actual behavior relative to each goal or outcome. Monitoring staff may evaluate the percentages in each category as indicators of Service Planning capacity of individual staff and overall effectiveness of the case management organization's interventions. This is not the sole criterion, however.
Notes	Staff will provide any notes relevant to the progress or lack of progress of that specific goal and/or action step(s).
Factors Facilitating or Hampering Progress to Meeting Action Steps/Outcomes	Staff will document any factors that facilitate or hamper progress toward the client meeting the action steps or goals. These may relate to the client's support network, availability of resources, client's skills and abilities, client's motivation or resistance, or other factors. Staff should address these factors to determine the extent to which the overall goals and outcomes can be obtained and what, if any, additional resources may be needed.
Narrative Notes and Recommendations	Staff and supervisors will use this section to enter observations and recommendations for plan adjustments.

Sample Care Plan

Case Management Outcomes	
Desired Outcome as Stated by Client 1:	I don't want to get evicted
Desired Outcome as Stated by Client 2:	
Desired Outcome as Stated by Client 3:	
Desired Outcome as Defined by Case Manager:	Reduction in risk factors that contribute to out-c Increased awareness of and/or access to servi Increased management of chronic conditions

Problems, Goals, and Action Steps	
Problem (or Need for Assistance) 1:	Mr. Howard is behind in his rent and needs to get caught up
Goal 1-A:	Determine past due balance and options to get caught up
Action Step 1-A-a:	Mr. Howard will contact landlord (770-678-7878) by 10/05/2020 to obtain past due balance.
Action Step 1-A-b:	CM will call Mr. Howard on 10/06/20 to discuss past due balance.
Action Step 1-A-c:	Mr. Howard will gather list of bills by 10/06/2020

212 Consumer Directed Services

Georgia Division of Aging Services Home and Community-Based Services Manual			
Chapter:	200	**Effective Date:**	January 2010
Section Title:	Consumer Directed Services	**Reviewed or Updated in:**	
Section Number:	212	**Previous Update:**	

212.1 Purpose and Background

This chapter establishes policies, guidelines and standards for Area Agencies on Aging that contract for or provide directly a consumer-directed option for services and supports to the elderly, their caregivers, and certain disabled adults. The purposes of the service option are:

- to promote the investment of Older Americans Act and state funds in strategies for services that target community-dwelling individuals who are potential consumers of institutional long-term care services, and their caregivers when present, and promote their ability to remain in their homes and communities,
- to promote consumer independence, choice, and control over his/her circumstances,
- to assure that appropriate and effective relationships are established,
- to assure that consumers, and/or their representatives, receive adequate information and support in planning and decision-making, and
- to assure consumers' health and safety, while at the same time assuring accountability for any public (State and/or Federal) funds used to secure goods, services and supports.

The Consumer Directed Care service option has been developed through the federal Administration on Aging's Nursing Home Diversion and Modernization demonstration grant funding to the Division of Aging Services and the Atlanta Regional Commission Area Agency on Aging (ARC), as partnering organization during Fiscal Years 2008 and 2009. The demonstration grant initiative was renamed the "Community Living Program" by AoA during 2009. During the grant phase, ARC (has) used the term "Support Options" and "Support Options Counselors" to identify the program and staff involved, and those terms will be used in these policies. These guidelines are based on the experience and results from the demonstration and are intended to guide Georgia's Area Agencies in replicating and implementing consumer-directed models and options in their planning and service areas.

212.2 Scope

These guidelines apply to consumer-directed service options provided in whole or in part with non-Medicaid federal and state funds managed by Area Agencies, any associated matching funds, and any cost share payments made by participants. Fund sources that may be used include Older Americans Act Title III-B, Supportive Services and Title III-E, National Family Caregiver Support Program, the Social Services Block Grant (SSBG), State-funded Alzheimer's Services, and State Community Based Services (CBS) appropriations.

212.3 Definitions

Following are definitions of terms commonly used in consumer directed programs:

Authorized Representative (or Representative)

An uncompensated individual who is designated by the consumer to assist in managing the consumer's budget allowance and needed services.

Budget allowance

The amount of public funding available each month to a consumer to purchase needed long-term care services.

Consumer

An individual who chooses to participate in the consumer-directed care program, meets the targeting/eligibility requirements, and on whose behalf a monthly budget allowance is paid to a fiscal/employer agent for payment of wages to employees or reimbursement of expenses for goods and services. For the purpose of this program, the consumer may be an eligible caregiver of a functionally and/or cognitively impaired adult who is completely dependent for care and who is not capable of participating in directing his/her own care. Within this document, where "consumer" is used, for the sake of brevity, this also can be read to mean "authorized representative," if one has been designated and is actively providing support.

Consumer- or Self-Directed Care

The embodiment of both a philosophy and a practice model for home care. As a philosophy, it emphasizes consumer choice and control, recognizing that service recipients themselves are the ones who best know their needs and preferences and, as such, should have primary authority and responsibility for making decisions about those services. In practice, consumer direction means that consumers make concrete choices about their care and ultimately manage the delivery of their services to the extent that they are willing and able to do so.[1]

Consultant Services

One of two broad categories of support in a consumer-directed care program. Consultants train, coach, and provide technical assistance to consumers. The training and technical assistance are to assist consumers in using their budgets correctly and avoiding overspending. See also "Support Options Counselor."

Direct support worker

A provider of supports and services who is privately hired, works under the direction of the consumer/participant, working when and where the consumer chooses, and using materials, equipment and methods selected or designated by the consumer.

Employee

Anyone who performs services for any entity, including an individual, if that entity can control what will be done and how it will be done, even if the entity gives the employee freedom of action.[2] Except for spouses, family members of enrollees in the consumer-directed option may be hired to provide assistance, and thus, may be considered an employee, for the purpose of this program. Employees of participants in self-directed programs are classified by the IRS as "household or domestic" workers.

Employer of Record

An entity or individual who handles legally defined responsibilities of an employer.

Fiscal Management Services (FMS)[3]

An entity/organization (which may be an Area Agency on Aging) that assists consumers by handling such activities as payroll processing, withholding of required taxes, and reconciling expenditures with authorized spending plans.

The FMS receives, disburses and tracks public funds on behalf of individuals. FMS is a broad category of a type of self-directed support, the purpose of which is to provide protections and safeguards for participants, their representatives, and agencies administering consumer-directed

programs.

Independent Contractor

In a consumer-directed service model, an entity/individual who is self-employed. According to the IRS, the general rule is that an individual is an independent contractor if the person for whom the services are performed has the right to control or direct only the result of the work and not the means and methods of accomplishing the result. An example of an independent contractor is a physical therapist hired to assist a consumer in regaining range of motion in the shoulder after rotator cuff repair surgery.

Information and Assistance in Support of Self-Direction

For the purpose of this program, a broad range of assistance to individuals in managing their self-directed support services (help with developing and implementing service plans and budgets, assistance to access services and workers).[4]

Repurposed Funds

A budgeting strategy that redirects funding from the service(s) or function(s) for which it originally was allocated, in order to implement other service(s), function(s) or initiatives, subject to the prior authorization by or approval of the Division.

Service Provider

An individual, such as a family member or friend who provides assistance to a consumer, or an agency, whose employees provide services and supports

Support Options Counselor

An individual who provides skills training and support to consumers in meeting their responsibilities as participants in the consumer-directed model of services.

Vendor

In reference to a provider of Fiscal Management Services, a private or public entity (non-governmental), approved by the Internal Revenue Service to act as an employer agency on behalf of individuals/their representatives. May also be referred to as a Fiscal/Employer Agent (F/EA). A vendor also may be an agency or independent contractor that provides services. The consumer does not pay employment taxes for agency or independent contractors.

212.4 Role of the State Unit on Aging in Consumer Directed Care

a. **Program Administration**: The Georgia Department of Human Services Division of Aging Services is designated by the Governor as the State Agency on Aging, commonly referred to as the State Unit on Aging. The Division's role in creating consumer directed options is to provide direction and guidance to Area Agencies on Aging as they develop and implement consumer-directed options, through policy development and implementation and the provision of technical assistance to Area Agencies on Aging and providers. Further the Division provides allocations of federal and state funding to Area Agencies on Aging wishing to implement the consumer-directed model of community based services. To implement consumer-directed care initiatives, Area Agencies are expected to repurpose a portion of funding originally allocated to them for the provision of traditional services. The Division is not the employer of workers, vendors or providers of services, goods, or benefits funded through consumer-directed options, nor

does the Division assume responsibility for emergency, backup care for program participants.

b. **Problem Resolution/Grievances**: The Division will participate in resolving problems with consumers' concerns regarding service delivery that cannot be addressed informally, to the consumers' satisfaction, within the provisions of DAS HCBS policies, Chapter 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs. If allegations of abuse, neglect or exploitation are made to the Division, a report will be made to the DAS Adult Protective Services program.

c. **Program Oversight**: The Division will provide a reasonable degree of oversight of the consumer-directed options program by conducting periodic monitoring and reviews of agency and consumer records and activities, expenditure and reimbursement data and other relevant programmatic data. DAS will provide feedback necessary for corrective action at the programmatic level and to assure program integrity to Area Agencies, counselors, providers, and consumers/caregivers, as appropriate and indicated.

212.5 Eligibility and Target Consumer Groups

a. **Consumer eligibility criteria**:

1. Adults, age 60 and older
2. People at risk of nursing home admission, based on a functional impairment level of at least 15 points, plus at least 1 point for unmet need for care, on the Determination of Need-Revised (DON-R) assessment tool, for a total minimum score of 16 points.
3. Adult caregivers of the elderly (age 60+) and adult caregivers of people of any age with Alzheimer's Disease or Related Disorders.
4. Military veterans with disabilities, and their caregivers, who are deemed eligible and qualify through Veterans Administration programs and initiatives.
5. People who have the capacity and interest to direct their own care, or who have an appropriate representative, able and willing to do so.
6. People whose needs for care can be safely and adequately met through the services and supports available through a given self-direction program.

b. **Financial targeting criteria**.[5] Applicants for the Consumer Directed Care program must meet all of the following criteria to enroll in the program:

1. Can not be currently Medicaid eligible, but must be at risk of "spending down" to Medicaid eligibility.
2. Have a monthly income at or below 300% of Supplemental Security Income (SSI) level.[6]
3. For individuals, may have resources between $12,000 and $39,000; for couples between $116,400 and $143,000.[7]
4. Must be willing to participate in cost sharing for specified services, based on individual income status.

212.6 Consumer Enrollment Process

a. **Program Access**:

1. Through the intake and telephone screening process Area Agency Gateway staff will identify

applicants for service who meet eligibility criteria and fall into the target financial status for individuals and couples.

2. Gateway staff will refer people who are eligible, within the target group, and interested in participating in self-directing their services to a Support Options Counselor or Consultant, either on the AAA staff, or to individual or agency contractors.

b. **Initial Contact**: The Support Options Counselor (SOC) will visit the consumer at home, to validate the initial DON-R score, verify income and resources, and conduct any other assessment activities indicated to permit the counselor to effectively assist the consumer in developing his/her support plan.

1. In addition to interpreting DON-R scoring results, the SOC may assist the consumer in using a self-assessment to identify care needs. See Appendix 212-B-1 for suggested content.
2. The SOC will determine and document the consumer's ability to understand the risks, rights and responsibilities of managing his/her own care with a monthly budget allowance.
3. The SOC will obtain the consumer's clear, express and voluntary agreement to enroll and participate in the program, as documented by appropriate language in and the consumer's signature on an enrollment agreement.

c. **Evaluation of Need for Authorized Representative**:

1. If the consumer cannot or elects not to direct his/her own care, s/he will be asked to select a willing and appropriate representative, with the SOC's assistance, as needed.
2. If the consumer clearly has the capacity to direct his/her care, the SOC nevertheless should encourage the consumer to designate in advance a representative willing and able to serve if/when the consumer no longer can or no longer wishes to direct care, but could remain in the program with the assistance of a representative.
3. If the consumer's capacity to self-direct is questionable at the outset of enrollment, and the consumer has no known available and appropriate representative, the SOC should:
   A. review DON-R assessment results to determine whether there are physical/functional indicators of ability or inability to self-direct. Examples: Does s/he demonstrate insight to and understanding of his/her care needs? Can the consumer follow/give directions? Can s/he give directions to the home? Can s/he review and sign a timesheet?
   B. assess potential representatives, using the A/R Screening Questionnaire (See Appendix 212-B-4). The SOC will provide information to the consumer about potential, suitable representatives the consumer may choose to designate.
4. If the SOC has concerns about a proposed authorized representative's willingness and ability to serve in the consumer's best interests, the SOC will advise the consumer (and family if present) of those concerns, document the information shared in the consumer's file, and proceed with enrollment. The consumer may elect to designate a different authorized representative.

d. **Suspension or Discontinuation of Enrollment**:

1. *The SOC shall suspend or discontinue the enrollment process, if designation of an authorized representative is indicated, but not completed by a consumer, who clearly cannot direct his/her own care by reason of incapacity, or who elects not to direct his/her own care.*
2. If enrollment is suspended, the process may be reinstated, within 30 calendar days, upon the

consumer's request and designation of a suitable representative.

3. After 30 calendar days, the SOC shall terminate enrollment and provide written notice of same to the consumer, by registered mail (USPS), with return receipt notification.
4. The SOC shall assist the consumer with identifying and referring to other community resources and/or refer him/her to a traditional care management provider for assistance.

e. **Consumer/Representative Agreement**: If an authorized representative will be assisting the consumer, the SOC will assure the completion and signing of the agreement form by both the consumer and the representative, except where a guardian for the consumer has been appointed. In this instance, the legal guardian has the right to consent to participation. (See Appendix 212-B-5)

f. **Consumer/SOC Agreement**: The SOC will provide the program participation agreement to be signed by both the consumer and SOC. (See Appendix 212-B-2)

g. **Income/Resource Documentation**: The SOC will document the consumer's income and resources, using the Consumer Direction Financial Worksheet. (See Appendix 212-B-6)

h. **Support Plan and Backup Plan**: The SOC will assist the consumer, as needed, in developing his/her support plan, including the identification of emergency or backup plans, should a worker fail to work as scheduled for any reason. Having a reliable backup plan is a mandatory condition for participating in the self-directed program. Also see §212.6.1(d) regarding consumers' responsibility for backup planning.

i. **Explanation of Consumer's Role and Responsibilities as Employer**: The SOC will explain the role and responsibilities of the consumer as the employer and assist, as needed, with the completion of any paperwork required of the consumer for working with a fiscal/employer agent or bookkeeping firm.

212.7 Support Options Counselors

The role of the Support Options Counselor, and his/her relationship to the consumer/caregiver, differs significantly from that of a traditional care coordinator, caseworker or case manager. The SOC's primary role is that of acting in a consultative capacity to provide skills training to consumers to help them become employers of their support workers, to inform consumers of their options and provide them support in decision-making. However, the SOC does not substitute his/her judgment in decision-making for that of the consumer. Central to the relationship between the SOC and the consumer is the counselor's role in providing access to information about service options. The SOC may not serve as a consumer's representative, nor provide any other supports or services outside of the consulting role. A key component of the SOC's job is to help maximize the consumer's capacity to manage risk without clearly becoming a danger to herself or the victim of someone else's fraudulent or abusive behavior.

a. **Staff qualifications**: Support Options Counselors must meet the minimum educational and experiential qualifications for case managers/care coordinators, as provided in DAS HCBS Manual Chapter 210, and complete any required training on program content, policies and procedures.

b. **Operational Responsibilities**: The Support Options Counselor is responsible for:

1. Receiving referrals from AAA Gateway staff and verifying potential enrollees' eligibility for program participation based on targeting criteria;

2. Conducting initial assessment of consumers' functional status and needs for care, and/or assisting consumers with completing a self-assessment of support needs and options, using tools or instruments authorized or approved by the Division;
3. Documenting all interactions with consumers, their authorized representatives, the F/EA and any other parties to the program, in the manner authorized or approved by the Division;
4. Periodically (at least annually, or when changes in the consumer's condition/situation indicate) review and verify consumers' eligibility status and continued appropriateness for self-direction, efficacy of support plans and adequacy of monthly allowance. The SOC will assist the consumer as necessary in making any changes in plans and budgets that are indicated, based on the consumers' current status, needs and preferences.
5. Collecting, maintaining and reporting any consumer-related and programmatic data required by the Division or other entities, in the format and medium authorized or approved.

212.7.1 Support Options Counseling Services and Activities

Support Options Counselors provide skills training and consultation to consumers and representatives as follows:

a. **Orientation and Training**: Concurrent with the Enrollment Process, SOCs will provide orientation and training on self-direction to consumers/representatives, either individually or in small groups when appropriate. Orientation will determine the knowledge the consumer/representative possesses on employer issues and determine the type and amount of training needed on the topics of their role and responsibilities as an employer and recruitment, interviewing, hiring, supervising, evaluating and terminating service providers. During this phase, the SOC will assess the consumer's/representative's ability to self-direct and will provide individualized training to assure that all needs are identified and appropriately addressed. During orientation and training, the SOC should encourage the consumer to request background checks for any prospective employees with whom the consumer has had no prior relationship.

   It is of utmost importance that the SOC clearly communicate to and with the consumer that the consumer bears primary and ultimate responsibility for decisions regarding the development of the spending plan, the backup plan, and the selection and supervision of workers, including hiring/firing, training and scheduling of workers. The consumer also bears full responsibility for the purchase of goods and services required for his/her care. See Appendix 212-B-2 for a template for a Consumer/SOC Agreement Form.

b. **Assistance with Development of the Support and Spending Plans**. The SOC will use the DON-R to assess the consumer's status for activities of daily living/instrumental activities of daily living, and other aspects of the consumer's ability to live at home/in the community, and, as needed, provide information about resources that may be available to meet those needs. Based on the consumer's individual needs and preferences:
   1. During the enrollment process, the SOC will assist each consumer/representative with development of an individual plan that projects how the monthly allowance will be spent. The SOC will approve the plan, provided it addresses needs identified in the assessment process, including those identified by the consumer, within the bounds of goods, services and sup-

ports that are allowable through the program.

2. In instances in which plan fulfillment requires resources in excess of the monthly budget allowance, or calls for otherwise ineligible expenditures, the SOC may override the plan and assist the consumer with developing a corrective action to modify the plan.
3. The SOC may assist with reviewing and adjusting the plans whenever circumstances change, subject to the continued availability of public funding, but not less than annually. The consumer must obtain the SOC's concurrence with any adjustments the consumer initiates, to assure that needs continue to be safely met and that the changes can be supported by the monthly budget allowance.
4. The SOC may approve a plan through which the consumer, through the assistance of the FMS, saves a portion of the monthly allowance to accumulate enough funding to budget for some higher cost needs.
    A. Public funds must be liquidated within the state fiscal year that they are allocated.
    B. If the savings are accrued from the consumer's cost share payments, the funds may be carried over from one fiscal year the next, but the consumer must have a specific plan for using the accrued funds and a goal completion date for making the desired transactions.
5. Consistent inability or failure of the consumer to adhere to the allocated budget and approved spending plan may result in the SOC's decision to terminate and discharge the consumer from the consumer directed program. Should this occur, the SOC will evaluate other community resources that may be available to provide assistance and follow the process established for providing notice of discharge.

c. **Assistance with Work Agreements**

1. The SOC will verify that the consumer, or representative, has executed a separate, written work agreement with each employee. Both the consumer/representative and worker will indicate acceptance of the terms of the agreement by their signatures.
2. The SOC will verify that the agreement(s) detail the tasks to be performed, scheduled days and number of hours of service that the consumer/representative and each employee have agreed upon.
3. The consumer/representative and each employee will retain copies of each agreement executed.
4. Work agreements shall reflect at-will employment status as provided in Georgia law. (Also see Appendix 212-C, regarding dismissal of employees/termination of employment.)

d. **Assistance with Backup and Emergency Plans**

1. The SOC will assist the consumer/representative in developing contingency plans for how the consumer's needs will be met should a worker/service provider fail to keep a scheduled appointment, terminate a work agreement without notice, or fail to provide scheduled assistance for any reason.
2. The consumer's contingency plan may identify informal caregivers who will agree to provide assistance on a timely, short term basis, or may identify a home care or other provider agency which has the capacity, including adequate staff, to provide timely, short term or long term assistance for a fee to be paid by the consumer from the monthly allowance.

3. Contingency planning also is to address how the consumer will have needs met should a shortage or rescission of public funding occur.
4. During periodic direct contacts, the SOC will determine whether the consumer has had a need to use the backup plan, how often, and whether the backup resources were actually available and adequate.
5. The SOC will assure that the consumer/representative amends the backup plan as often as is necessary to assure that an adequate plan is in place at all times.
6. In anticipation of a community-wide emergency (natural disaster or other catastrophic event) or in the recovery phase of such an emergency, the SOC will identify consumers who may be or have been impacted and provide assistance as directed by the emergency management plans of the state, region, or county of residence (either permanent or temporary) of the consumer.
7. The consumer or representative is ultimately responsible for developing and maintaining a viable backup plan that addresses all interruptions of support and care, including those caused by emergencies and disasters.

e. **Monitoring and Evaluation**:

1. Through home visits, telephone contacts, and reviews of financial/expenditure reports, and other pertinent information, the SOC will monitor the support plan and related expenditures frequently enough to determine that the consumer's self-direction, or that of his/her representative, is adequate to maintain the consumer's health, safety, well-being and satisfaction.
2. The SOC will maintain periodic contact with consumers/representatives through telephone calls, at which time the SOC will review expenditures, use of backup plans, the consumer's satisfaction with care and support, and any other issues pertinent to a consumer's individual situation.
3. Once the consumer has begun receiving planned assistance and supports, the SOC will make a home visit during the second month of service activity and plan implementation, and at a minimum, annually thereafter, for the dual purposes of assessing the status of the consumer's plans and service use, as well as nurturing and sustaining the relationship with the consumer and family. If the SOC has concerns about the quality of care the consumer is receiving, including concerns about abuse or neglect, the consultant may make unannounced home visits. The SOC is a mandated reporter under Georgia law, with regard to making reports to the DHS DAS Adult Protective Services Section about suspected incidents of abuse, neglect or exploitation of adults enrolled in the program.
4. The SOC will, as a part of monitoring, use the DON-R at least annually, or more often as indicated, to identify and document any changes in the consumer's functional capacity and unmet need for care, and recommend any adjustments to the consumer's plans that may be indicated to preserve the health and safety of the consumer. The SOC may initiate discharge planning to conventional forms of case management and supportive service assistance for consumers whose conditions decline to the point that available assistance no longer supports safe and adequate care.
5. At least annually the SOC will evaluate the quality of the self-directed care, taking into account the stability of the support plan, the efficacy of costs incurred, the adequacy of the backup plan, and the consumer's satisfaction with care received.

6. The SOC will determine whether the needs identified by the consumer in the support plan are being addressed in such a way that provides for the consumer's safety, independence and overall well-being.

f. **Documentation**:

1. The SOC will establish a record in the manner and medium authorized or approved by DAS for each person enrolled in the consumer-directed program.
2. The SOC will maintain records in accordance with any standards established in DAS HCBS Manual Chapter 210, Case Management.
3. The SOC will retain copies of all consumer assessments, support plans, monthly budgets/spending plans, work agreements, backup plans, authorized representative designations, and any other documentation pertaining to program participation.
4. The SOC will document all contacts, activities and assistance provided by the counselor in each consumer's record. Each contact will be recorded as a summary or narrative note. Upon development and implementation of the Support Options Counselor Activity Log, the SOC will enter required data into AIMS. Any standards of promptness for documentation established by DAS HCBS Manual Chapter 210, Case Management, shall apply.
5. The SOC will observe the consumer for any changes in condition that would indicate that a complete re-assessment is indicated; assess the continued appropriateness of activities by any authorized representative; assess the quality of the self-directed care in terms of positive consumer outcomes; and assess whether the consumer's needs identified in the current plan are being met.
6. The SOC will document in each consumer record that s/he has provided the consumer/representative with written information about potential risks of enrolling in the consumer direction program and the consumer's/representative's agreement to assuming these risks. The voluntary participation agreement may serve as the required documentation if signed by the consumer/representative and if the SOC has provided written information about risk management to the consumer. (See Appendix 212-B-3)

g. **Reporting**: The Division will establish reporting requirements, timeframes and mechanisms. The SOC is responsible for reporting any consumer-related and programmatic data required by the Division in the format and medium authorized or approved.

212.8 Authorized Representatives

Some consumers may desire, need or require an authorized representative to assure their successful participation in the consumer-directed model of care. If these consumers have competent caregivers, they should, to the greatest extent possible, be assisted to continue to express their values in receiving care and to participate in the planning process, with respect to having their preferences for care addressed and met.

a. Consumers who have a legal guardian or an established payee of income for reason of mental or cognitive incapacity will be required to have an authorized representative.
b. SOCs will evaluate consumers who have had representative payees for income management appointed due solely to consumers' physical incapacity or who have given general power of attorney to another who serves as attorney-in-fact to determine whether an authorized representative for the purpose of self-direction is indicated.

c. A potential enrollee will be required to designate an authorized representative if s/he is known to be or appears to be affected in one or more of the following areas of functioning:
    1. unable to understand his/her own personal care needs;
    2. unable to make decisions about his/her own care;
    3. unable to organize his/her lifestyle and environment by making these choices;
    4. unable to understand how to recruit, hire, train and supervise personal care assistants and other support providers;
    5. unable to understand the impact of his/her decisions and assume responsibility for the results; and/or
    6. at any time, has been determined to have experienced a change in competency/capacity or ability to continue to direct his/her own care.

d. **Who may request a representative**:
    1. The potential enrollee
    2. The Support Options Counselor
    3. A representative who is no longer willing/able to continue to assist;
    4. A representative of the fiscal intermediary organization.

e. **Who may serve as a representative**[8]:
    1. A family member of the consumer, who is not or will not be receiving payment for providing care
    2. A friend of the consumer
    3. A legal guardian, appointed by the Probate Court
    4. Any other legally appointed representative
    5. A representative payee for income from Social Security benefits, Supplemental Security Income, Railroad Retirement benefits, and any other source of income which provides for payeeship.

f. **Responsibilities of the Authorized Representative**. The authorized representative shall:
    1. demonstrate a strong personal commitment to the consumer;
    2. demonstrate knowledge of the consumer's preferences;
    3. agree to a predetermined frequency of contact with the consumer;
    4. be at least 18 years old;
    5. be able and willing to serve;
    6. obtain approval from the consumer, if nominated by someone else, and obtain agreement to the nomination from a family member, if one is available.
    7. agree to serve without compensation;
    8. be willing to become payee of the consumer's income, such as Social Security or Supplemental Security Income benefits, if necessary;
    9. be willing to serve as joint employer and participate, with or on behalf of the consumer, in

part or in full, in the hiring, training, supervision, and dismissal of workers;

10. not be known to abuse alcohol or drugs;
11. not be known to have a history of physical, mental abuse or financial exploitation.
12. be willing to complete and sign the Representative Screening Questionnaire and Authorized Representative Designation Form. (See Appendix 212-B-4 and 212-B-5)

g. **Misfeasance/Negligence or Malfeasance[9] of the Authorized Representative**. If a representative is negligent in performing his duties or otherwise fails to act in the consumer's best interests, the SOC shall document all observations, facts and conclusions in support of the finding of negligence or malfeasance and in consultation with his/her supervisor/the administrative agency, communicate these findings to the consumer and the representative.

1. If the consumer is able to do so, s/he may terminate the designation of the negligent representative and designate another person to serve.
2. If the negligent/malfeasant representative is a court-appointed guardian, the SOC/administrative agency shall report the suspect activity to the Probate Court of jurisdiction and to the Division.
3. If the negligent/malfeasant representative is a benefits payee appointed by the Social Security Administration, or other payor of benefits, the SOC/administrative agency will report the suspect activity to that agency and to the Division.
4. If the negligence or malfeasance of the representative is found to have resulted in abuse, neglect and/or exploitation of the consumer, the SOC, immediately upon making that determination, shall make a report to the DAS Adult Protective Services Central Intake Office. If the situation is one of medical emergency or other urgency, the SOC also shall contact the law enforcement agency with jurisdiction and/or obtain emergency medical assistance for the consumer. The SOC will inform the Area Agency within one business day of any reports made to DAS Adult Protective Services. The Area Agency likewise will inform the DAS Director within one business day of any reports made.
5. If negligence/malfeasance on the part of the representative is confirmed and involves the fiscal affairs of the consumer, the SOC also shall communicate such findings within one business day to the FMS.
6. If in these circumstances the consumer, family members or friends cannot identify a suitable alternative representative, and self-direction is no longer feasible, the SOC shall initiate discharge planning to traditional case management and supportive services programs, or to other home and community based or institutional long-term care programs.

212.9 Fiscal Management Services

Area Agencies desiring to implement consumer-directed options shall solicit through a competitive procurement process the services of a qualified fiscal/employer agent or agents (F/EA), negotiate to use an F/EA currently under contract to the state, or provide fiscal management services directly through its own organization, employing adequate numbers of qualified staff to do so. At a minimum the F/EA must demonstrate capacity to provide hardware and standardized financial management software to establish individual accounts, to segregate public funds for each enrolled participant, to track the receipt and use of funds held in the accounts, to transfer cash to interest-bearing accounts identified solely for participant savings. Services provided by the F/EA include, but may

not be limited to:

a. **Orientation, Training and Ongoing Support**. The F/EA will provide any necessary training and assistance to new consumers/representatives that may be needed for them to successfully complete and submit all applicable state and federal tax withholding forms, insurance forms and any other forms required in conjunction with employing and paying workers. The F/EA will prepare and distribute a start-up kit for consumers that includes information on how and when to contact the fiscal agent. The F/EA will be available to provide assistance and consultation for the duration of the consumer's enrollment in the program. On a continuous basis, the F/EA shall accept and answer any questions related to financial management from consumers, representatives and employees.

b. **Employee Management**: The F/EA assists the consumer in managing employees by:

    1. Preparing and distributing employment forms packets, including multiple copies of the time sheet for employee use and required federal and state forms, such as W-4 forms for tax withholding;
    2. Conducting employee background screening/criminal records checks upon request of the consumer or representative;
    3. Verifying citizenship/legal alien status of all workers;
    4. Providing Worker's Compensation insurance coverage for each employee[10]

c. **Banking and Payroll Functions**: The F/EA provides banking and payroll assistance by:

    1. Receiving public funds and establishing individual accounts on behalf of the consumer, including assigning employer and employee Federal Identification Numbers;
    2. Receiving timesheets signed and submitted by the consumer/representative and each worker and entering data into the payroll system;
    3. Processing and issuance of payroll checks;
    4. Invoicing consumers for and receiving and applying cost share payments to account balances;
    5. Providing monthly reports (or for other specified time periods) to consumers, counselors/program administrators with information regarding expenditures, payments and account balances;
    6. Managing federal and state employment taxes, preparing filings, and distributing funds, net of employment taxes;
    7. Reconciling consumer accounts monthly and mailing statements to each consumer, with a copy to the consumer's SOC;
    8. Assisting the consumer to accrue funds from monthly budgets over time in order to make approved special purchases;
    9. Receiving private funds and establishing individual accounts on behalf of the consumer.

d. **Other**: Providing any equipment/communications devices to consumers as agreed contractually.

212.10 Services and Supports Eligible for Reimbursement

Area Agencies will determine the services and supports that will be available for consumers who self-direct their care, subject to the approval of the State Unit. Area Agencies will document plans for implementing consumer-directed models of care in the Area Plan or Area Plan Update that precedes the fiscal year of anticipated implementation. The AAA shall describe the goods, services and supports that will be authorized, giving special attention to those not currently included in and defined by the DAS Taxonomy of Services. The State Unit reserves the right to disallow certain goods, services and supports, if in the SUA's opinion, the use of federal and/or state funds to purchase or reimburse for these options would be inappropriate, inconsistent with the purpose of the program, or not beneficial to consumers. See Appendix 212-D for currently-approved services and supports.

212.11 Ineligible Expenditures

a. Division of Aging Services policy does not allow for the purchase of, nor reimbursement for, such items that include, but are not limited to:
    - Gifts for workers, family or friends
    - Loans to workers
    - Rent or mortgage payments
    - Payments to someone to be a consumer's representative
    - Clothing (exception: special clothing items, such as compression hose, or clothing/footwear modified for accessible and independent use)
    - Groceries (exception: special food/nutritional products required to improve/maintain nutritional status)
    - Lottery tickets
    - Alcoholic beverages
    - Entertainment activities and equipment
    - Tobacco products
    - Services and supplies that can be obtained at no cost from community organizations
    - Items, such as durable medical equipment and medical supplies, which may be obtained through Medicare or other insurance coverage, if the consumer is a beneficiary of that coverage.
b. The Division retains final approval authority for any purchases or expenditures that are unusual or not within the stated guidelines. Area Agencies/SOCs may submit to the Division written requests for consideration of exceptions or waivers for good cause.

212.12 Development and Management of Monthly Budgets / Spending Plans

During the demonstration phase of the AoA Community Living Program (CLP) (formerly the Nursing Home Diversion and Modernization Grant), the amount available for consumers' monthly spending plans/budgets is determined by the amount of federal funds allocated and the availability of state funds used to match them. Consumers may arrange to purchase goods, services and other supports, as allowed by policy, up to the amount available in the approved budget.

a. The consumer will develop a monthly spending plan that will demonstrate a correlation to his/her assessment of need and preference for receiving care; the DON-R standardized assessment of unmet need for assistance with activities of daily living, instrumental activities of daily living, home/environmental improvements or services, health related services and supplies and any other allowable services or purchases that will enable the consumer to live as independently as possible and avoid the need for admission to a nursing home or other long-term care facility. When a caregiver is involved and identified as the consumer, the spending plan may reflect supports and services for the caregiver, in order to maintain/sustain his/her ability to provide care to the care receiver.

b. The SOC will review each consumer's reports of expenditures provided by the F/EA frequently enough to verify that the consumer is complying with his/her spending plan and budget. The SOC will review reports with consumers during periodic telephone or other contacts. The SOC will use his/her professional judgment and knowledge of individual consumers to determine the appropriate frequency of contacts, but shall have direct contact not less than twice a year.

c. Consumers/representatives shall not submit for reimbursement nor shall the F/EA reimburse for expenses for goods, services and supports in amounts that will exceed the approved monthly spending plan.

d. Workers will complete, sign and submit to the employer of record and the employer of record will sign and submit workers' timesheets to the FE/A in the form and manner specified. The employer's signature attests to the provision of authorized services within timeframes for pay periods established by the F/EA. Failure of workers to complete and submit timesheets to their employers in a timely manner will result in a delay in the employers' signing and submission to from the F/EA, delaying payments from the F/EA.

e. The F/EA will confirm with the SOC that any changes to a spending plan/budget requested/submitted by a consumer has been reviewed and approved by the SOC.

212.13 Risk Management and Accountability

a. **Consumer's clear decision to participate**: The decision to participate in a consumer directed model of services means that the consumer/representative agrees to take on a particular set of risks and responsibilities. Agreement to participate must involve three components:

    1. The consumer's choice to participate is completely voluntary. In order to assure that the decision to participate is, in fact, voluntary, it is important that the consumer retain the option of obtaining care from the traditional model of agency-provided home and community based services. The consumer's choices must include the option not to direct his/her own care.

    2. The consumer must be provided all information about participation that s/he needs to make a voluntary and intelligent decision. This information may be provided both orally and in writing and may be conveyed through a consumer's agreement or guide to participation.

    3. The consumer has the capacity to understand the information provided and to make a choice.

b. **Liability**: In the consumer-directed model of community supports and services, the consumer assumes risk in exchange for the ability to make decisions and choices about and control of the care and support s/he needs and receives. It is essential that SOCs advise consumers during enrollment and orientation, their family members, and representatives of areas of potential risk

and ways that they can minimize risk and avoid potential liability. See Appendix 212-C regarding suggested advisory information content.

c. **Programmatic and Financial Accountability**: Four strategies are employed to prevent misuse or abuse of the monthly allowance.

   1. Upon enrollment, each consumer will be provided a statement of his/her role and responsibilities, in which accountability is emphasized. See Appendix 212-B-2 for the Consumer/Support Options Counselor Agreement and listing of the consumer's and counselor's roles and responsibilities.
   2. SOCs periodically will review the consumer's recent financial statements, prepared and distributed by the F/EA, with the consumer or representative during a direct contact (call or visit).
   3. Consumers will maintain a record of any incidental purchases they have made and keep receipts for those purchases, in order to be reimbursed.
   4. The F/EA will pay only for services provided and purchases specifically identified in the approved purchasing plan, except for incidental purchases as described in item (3) preceding.
   5. The SOC will call for a corrective action plan to be developed and implemented by any consumer whose spending and service use does not comport to the approved budget and spending plan, for either over-expending or underutilizing resources.

212.14 Continuation in and Termination / Discharge from Consumer Directed Care

a. **Continuation**: Admission to the Consumer Directed Care program is predicated upon the consumer's informed consent and clear and express agreement to voluntarily participate in the program. As a part of annual reassessment (at a minimum), SOCs will review the consumer's willingness, ability and desire to continue to participate.

   1. **Consumer's Status Unchanged**: If there have been no significant changes in the consumer's status, condition and situation, continuation in the program is contingent upon the consumer's interest and willingness to continue to direct his/her own care and the continued availability and willingness to serve of a representative, if one has been designated and serving on the consumer's behalf.
   2. **Temporary Absence from the Home**: At the discretion of the SOC, the consumer may continue to receive scheduled supports and services outside of his/her residence, if the SOC authorizes in advance the provision of needed services during a trip or vacation.
   3. **Hospitalization**: At the discretion of the SOC, a consumer who is hospitalized for a brief duration may remain in the program to continue to receive scheduled services upon his/her discharge and return home. The consumer or representative shall be responsible for communicating with the SOC, and with care providers, regarding all hospital admissions and expected durations. The SOC may discharge a consumer whose stay is anticipated to be of such length that significant lapse of state/federal funds could occur, with the understanding that the consumer could apply for readmission at a later time.
   4. Continued enrollment also is contingent upon the continued availability of public funds allocated to the program.

b. **Voluntary Withdrawal**: The consumer may request withdrawal from the program at any time.

See Appendix 212-B-7 for voluntary withdrawal form template.

1. If a consumer indicates a desire to withdraw from the program, the SOC will try to identify and resolve any problems that may be barriers to continued participation.
2. The SOC will use the Voluntary Disenrollment Form to document the consumer's reasons for withdrawing from the program and the SOC's efforts to resolve problems prior to termination.
3. Area Agencies and the Division will consider data collected regarding voluntary withdrawals from the program in evaluating program results and designing program improvements.

c. **Involuntary Disenrollment/Discharge**: SOCs may discharge consumers for two primary reasons:

1. The consumer directed services program can no longer meet the consumer's health, welfare and safety needs, for whatever reason. This can include a significant change in the consumer's condition and/or his/her refusal of assistance of a representative, when one is indicated for successful continued participation.
2. The consumer/representative has failed to carry out budget management and/or employer responsibilities in accordance with program policy, despite the provision of reasonable technical assistance and support consultation by the SOC. This can include misuse of a budget allowance, consistent over-expenditures, consistent failure to complete and submit workers' timesheets, consistent failure to provide required documentation and failure to pay agreed-upon cost share. If no representative has been involved up to this point, the SOC may explore the possibility of the designation of a responsible representative, prior to initiating involuntary discharge plans.

d. **Other Administrative Reasons for Discharge**:

1. **Loss of Eligibility Status**: The SOC will initiate discharge plans if the consumer no longer meets program eligibility criteria for the nursing home level of care or financial eligibility.
2. **Loss of Public Funding**: If for any reason there is a shortfall or rescission of public funds allocated to the Consumer Directed Care program, the SOC in coordination with the Area Agency will initiate discharge planning for affected consumers. If provision of notice of discharge within current standards is not possible, the SOC and AAA will provide as much prior notice as possible, and assist consumers with obtaining services from other sources that may be available.

   Discharge due to a program's or agency's loss of funding, through no fault of its own, is not subject to the consumer appeal process.

3. Death of the consumer;
4. Relocation of the consumer from the service area.
5. The consumer is more appropriately served by another home and community based program, based on assessment data and/or consumer's choice.
6. The consumer enters the institutional long-term care system.

e. **Governing Standards for Discharge**: SOCs will use the guidelines and standards for due process and timeliness established in the DAS HCBS Manual, Chapter 210, Case Management

Services, §210.2(i), “Transitions due to Discharge/Termination.”

f. **Referral Assistance**: Except in the case of the death of a consumer, SOCs will offer assistance to consumers, as appropriate, in identifying other sources of services and supports, including working with AAA Gateway staff to help the consumers access traditional agency-provided services through the Area Agency’s network of providers.

Effective Date

Upon Issuance. AAAs shall assure that staff and providers subject to these policies and guidelines receive copies of this chapter in a timely manner and shall allow providers a reasonable period of time in which to make adjustments to comply. The official copy of this policy document will be posted to the DHS Online Directives Information System (ODIS) not later than the first day of the next month following issuance.

Appendix 212-A Principles of Consumer Direction

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	January 2010
	Section Title:	Principles of Consumer Direction	**Reviewed or Updated in:**	
	Section Number:	Appendix 212-A	**Previous Update:**	

Principles of Consumer Direction

- Systems should be based on the presumption that consumers are the experts [about] their service needs.
- Different types of services warrant different levels of professional involvement.
- Choice and control can be introduced into all service delivery environments.
- Consumer-directed service systems support the dignity of people requiring assistance as well as cost less when properly designed.
- Consumer direction should be available regardless of payer.[11]

Additional Thoughts on Consumer Directed Care (CDC)

“CDC serves to counteract the protective instincts of providers who resist consumer direction because of concern about legal and regulatory exposure. Choices are not offered because providers feel there is an unacceptable level of risk even if those choices would improve the consumer’s quality of life. With shared risk established within a set or rights and responsibilities, these concerns may be allayed.”[12]

“Policymakers should avoid imposing a heavy-handed regulatory scheme on CDC. The regulatory objectives for CDC should be the prevention of fraud, abuse and neglect and maintaining an acceptable quality of life from the perspectives of the consumer and the caregiver(s). The care counselor should be trained to identify and respond appropriately to fraud, abuse and neglect.”[13]

“The structure and process focus of conventional long-term care regulation is only partially applica-

ble in the context of consumer direction. The counselor certainly needs to ensure that caregivers know their job and that necessary services (i.e., home health care) are being appropriately provided. But the regulatory priority in CDC must be on quality of life and the extent to which criteria based on the concepts of autonomy, dignity, emotional well-being and general life satisfaction are being met. Information on these criteria should be gathered through face-to-face interviews with consumers and caregivers conducted at regular intervals and on an as-needed basis.

The principle focus of this approach to care monitoring is the quality of the consumer's relationship with the caregiver, service providers and others, rather than the more material conditions of the consumer, except as they bear on her satisfaction with her quality of life."[14]

Appendix 212-B Forms and Templates

Appendix 212-C Risk Management Consumer Advisory Information

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	January 2010
	Section Title:	Risk Management Consumer Advisory Information	**Reviewed or Updated in:**	
	Section Number:	Appendix 212-C	**Previous Update:**	

Advisory Information for Participants in Consumer-Directed Models of Service

Area Agencies are encouraged to consult with their legal counsel and develop written advisory materials that Support Options Counselors can use to inform potential enrollees in consumer directed services, as well as their representatives, of practices as employers that will protect them from potential liability.[15] Suggested content includes, but is not limited to information that covers –

Negligence in maintaining the workplace. As the consumer's home is the workplace, s/he faces potential risk of personal liability for injuries sustained by individual workers s/he employs to provide care. Some workers, those defined as "domestic employees," such as homemakers, are exempt from coverage for workers' compensation. However, even exempt workers may seek compensation from the employer for injuries sustained as a result of a employer/homeowner's creating or failing to correct hazardous conditions in the home. If the consumer/employer lives with a family member or friend who is the owner or renter of the consumer's home, the family member/friend also may be liable for injury caused to any person, including an employee, invited into his/her home.

The legal principle of "duty of care" may be invoked: the consumer, as employer, has a duty to provide a reasonably safe work place. The owner of the premises where the provider works, who may or may not be the consumer, will also have a duty under premises liability law. Consumers and family members who own their own homes will want to verify the coverage against liability provided to them under their homeowners' insurance policies.

Discriminatory employment practices. While federal and state laws prohibiting discriminatory employment practices generally apply to employers of 15 or more employees, nonetheless, participants in the state Consumer Direction Program are encouraged to avoid employment practices that may appear, or in fact, be discriminatory in nature. Georgia law prohibits discrimination in hiring based on someone's age, having filed bankruptcy, having a disability, race, color, religion, national

origin, and gender (with respect to both hiring and compensation). One exception regarding questions that an employer may ask a prospective worker involves the worker's country of origin. Employers are required to hire only those employees who may legally work in the United States. For that reason, employers may ask if the prospective employee is eligible to work in the United States

While it is unlikely that a consumer would consider the age of an applicant an issue in hiring his/her workers, workers over the age of 40 are protected from discriminatory hiring practices. The law, however, does not prohibit interviewers from posing questions about age, but does prohibit discrimination on the basis of age, unless age directly affects the job. For example, an employer may rightfully inquire whether or not a job candidate meets the minimum federal age requirement for employment under child-labor law.

It is illegal to discriminate against an applicant on the basis of his/her religion. An exception to asking interview questions about the applicant's religion may be when an employer has a specific religious orientation and might ask questions relevant to religious practices and beliefs. Employers may also contact people and organizations affiliated with an applicant's religious beliefs, if those people and organizations were provided as references.

In general, employers may not ask questions related to an applicant's family situation. However an employer legally may inquire whether the applicant has ever worked under a different name or whether s/he has personal responsibilities that could interfere with requirements of the job.

Under the Americans with Disabilities Act and Rehabilitation Act, employers may not discriminate on the basis of disability. However, an employer legally may ask whether an applicant has any conditions that would keep him/her from performing the specific tasks of the job for which s/he is applying. Agencies as employers often require that all job candidates for certain positions pass medical examinations that are relevant to the responsibilities of those jobs and may subject job candidates to drug tests or ask if they take illegal drugs.

A separate issue involving the workplace itself is that of avoiding the creation of a hostile work environment. This is a form of discrimination that includes harassment that creates an intimidating, offensive, abusive or hostile work environment for employees.

Support Options Counselors should advise the consumer/representative to avoid even the appearance of discrimination in employment decisions, including the need to be careful about making candid comments that might be misinterpreted or taken out of context.

Wrongful discharge and other employment issues. The philosophy that drives consumer direction holds that consumers have the authority to select and hire the workers of their choice, but at the same time, that they are able to discharge workers whenever the consumers become dissatisfied with the care they are receiving. Georgia is an "at will" state for employment, meaning that the consumer can generally lawfully discharge a worker at any time, or "at will." Exceptions to this rule are when the employee has been provided a contract or some other evidence of a promise or guarantee of continued employment, or the employer's reason for discharge is unlawful.

To be confident in their ability to hire and fire employees without facing potential legal problems, consumers should be advised to:

- Avoid making any statements, either verbal or written, that imply that a worker is guaranteed

employment for a definite period of time or that the worker will only be terminated for cause;

- If the consumer and worker enter into a written agreement, include in the agreement language that clearly states that the worker's employment is terminable at will by the employer. The worker should sign off on the agreement, acknowledging her at-will employment status; and
- Exercise great care in making any statements about reasons for employment decisions, to protect against claims of unlawful termination or having made defamatory statements about the worker.

Since the doctrine of "at will" employment is based on the concept that employment is voluntary and indefinite on the part of both employer and employee, it is important that employment agreements also contain language that requires the employee to provide specific written, advance notice, of his/her intent to terminate the employment agreement.

Issues involving third parties. While most employees in the Consumer Directed Program will be classified as "domestic servants," and thus excluded from coverage by Workers Compensation laws, there is still some potential for liability issues to arise when workers have contact with third parties who are not either the employer or his/her representative.

Worker is injured by a third party. This may be the most common situation, one in which a worker is injured by a third party while the work is acting within the scope of his/her job. For example, a worker is injured in an automobile accident while running an errand for her employer. While the "domestic servant" definition holds in this case and the worker is not entitled to workers compensation, she may bring a personal injury claim against the driver of the other car. However, if the other driver was not at fault, or was uninsured, and therefore "judgment proof," the worker still may not receive any compensation for injuries sustained.

Worker causes injury to a third party. Also a common situation is an injury to a third party cause by the worker while acting within the scope of his/her job. In this instance the third party could seek compensation from both the worker and the consumer, under the argument that the employer is "vicariously liable" for any act of negligence or wrongdoing committed by the worker within the scope of employment. For example, a worker is operating the consumer's vehicle to transport the consumer to a medical appointment. She parks the car, but leaves it running, while getting out to assist the employer from the vehicle. The car starts rolling and the consumer, still in the car, accidentally pushes the accelerator instead of the brake while trying to stop the car. The worker and a bystander are injured by the moving vehicle. The bystander sues the consumer as employer and the worker for damages. *In this instance, if a provider, worker or consumer has significant assets that could be at risk, the provider or consumer should consider obtaining a personal liability umbrella policy or similar coverage against this type of claim.*

Consumer injures a third-party and the worker is sued. This is a less common situation and one in which the worker is sued for the actions of the employer. A worker is hired to provide care for a consumer who uses a motorized wheelchair. The consumer strikes a third party while operating the wheelchair and the individual sues the worker for having failed to control the actions of the consumer. In this case it is unlikely that the third party could recover damages from the worker, since the consumer controls the relationship between herself and the worker, and, although the worker does have a duty to provide care to the employer, she does not have "custody" of the employer, and therefore cannot be held liable in this situation.

Additional Areas of Concern for Authorized Representatives

Breach of fiduciary duty. In addition to the areas of potential risk and liability that may apply to both consumers and authorized representatives, representatives also may be found to have a heightened "fiduciary duty," to the consumer, particularly if the representative also has been appointed by the court as the consumer's guardian. In those circumstances the representative owes a very high duty of care to the consumer, both to oversee the spending plan and to supervise support workers. The most blatant example of a breach of such duty would be the representative's use of the consumer's benefits or supports for the representative's personal benefit. Because most representatives are friends or relatives of the consumer with a high level of commitment to the person, this type of situation is unlikely to occur.

Negligent hiring of a worker. If a representative is responsible for hiring workers to assist a consumer who exhibits any behaviors that could result in harm or injury to the worker, the representative should fully disclose to prospective employees the consumer's behaviors that may cause harm. The representative faced with hiring support workers for behaviorally-difficult consumers also should obtain necessary assurances, primarily by checking references, that the worker(s) would be competent to supervise the consumer and ensure that such dangers and risks do not occur. Finally the representative should be careful to supervise and instruct the worker(s) on how to prevent the dangers and risks.

Liability as the employer of the worker. The representative will generally be considered to be the joint employer, or the sole employer of the worker, if the consumer is not able to self-direct his/her care. In that role the representative faces the same liability as the consumer as employer.

Liability for abuse, neglect, or exploitation of the consumer. The representative could be prosecuted if found to have abused, neglected or exploited the consumer. Also DAS policy treats the representative as a mandatory reporter to Adult Protective Services, when abuse, neglect or exploitation of the consumer by others is suspected by or evident to the representative.

Appendix 212-D Services and Supports

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	January 2010
	Section Title:	Services and Supports	**Reviewed or Updated in:**	
	Section Number:	Appendix 212-D	**Previous Update:**	

In-Home and Supportive Services: Support or assistance provided by someone hired to help with activities of daily living and instrumental activities of daily living through hands-on assistance, cueing, prompting and instruction in completing tasks. Also may include installation of and in-home monitoring through an emergency response unit.

Service	Unit
Personal Care	1 Hour
Homemaker	1 Hour
Chore Services	1 Hour

Service	Unit
Assisted Transportation	1 One-Way Trip
Emergency Response Installation	1 Installation
Emergency Response Monitoring	1 Month of Monitoring

Respite Care: Services that offer temporary, substitute supports or living arrangements for consumers in order to provide a brief, or intermittent, period of relief or rest for caregivers.

Service	Unit
In-Home Respite	1 Hour
Out-of-Home Respite	1 Hour

Treatment and Training: Includes those services that promote the consumer's health and ability to participate in the community. These services are typically performed by providers with specialized knowledge, skill, certification or licenses.

Service	Unit
Adult Day Care/Day Health	1 Hour
Community/Public Education	1 Session
Counseling	1 Session
Health Related Services[16]	1 Session, 1 Purchase, 1 Hour

Environmental Modifications and Adaptations: Supports, services and goods provided to the consumer/caregiver to maintain a physical environment that assists the person to live and participate in the community, or that are required to maintain health, safety and well-being.

Service	Unit
Material Aid- Supplies, Equipment, Mileage Reimbursement	1 Purchase
Transportation	1 One-Way Trip
Home Modifications and Adaptations	1 Completed Job
Home Delivered Meals	1 Meal

Consumer Support/Financial Management Services: Activities conducted by a third-party to assist the consumer with billing and payroll management for employees of the consumer.

Service	Unit
Fiscal Management Services	1 Month of Service

218 Transportation Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/26/2021
	Section Title:	Transportation Services	**Reviewed or Updated in:**	MT 2019-05
	Section Number:	218	**Previous Update:**	MT 2019-05

218.1 Summary Statement

This chapter establishes the guidelines and requirements for Area Agencies on Aging that provide transportation services to older adults, people with disabilities, and accompanying caregivers through direct service, contract, or partnerships with other community entities.

218.2 Scope

These guidelines and requirements apply to transportation that:

- Is funded partially or in full through the Older Americans Act and/or
- Is administered through the Department of Human Services (DHS) Coordinated Transportation system.

Applicable services include those that are provided by government and for-profit providers, partnering community organizations, volunteer drivers, voucher-paid drivers, independent contractors, and sources of supplemental transportation not defined above.

These guidelines are suggested, but not required, for transportation services provided via other funds sources or outside the DHS Coordinated Transportation System.

218.3 Definitions

Consumer-Directed Transportation

program in which individuals serve as the managers of records for their drivers.

Curb-to-curb service

service in which the passengers are picked up and let off at the curb or driveway in front of their homes or destination. The driver does not assist or escort passengers to the door.

Door-to-door service

service in which the driver assists the passenger between the vehicle and the door of his/her home or other destination.

Door-through-door service

a service for persons with significant mobility limitations in which a driver escorts the passenger into the home or destination and may help with belongings (ex: groceries).

Demand-response service

a non-fixed route service, usually using vans or small buses, with passengers contacting the provider in advance to arrange a ride to a location within the provider's service area.

Fixed-route transportation

service provided on a repetitive, fixed-schedule basis along a specific route with vehicles stopping to pick up and drop off passengers.

Mobility management

a customer-centered approach to finding transportation solutions for all populations with a particular focus on people with disabilities, aging populations, English-language learners, low-

income communities, and other groups with unique needs.

Mobility transition counseling

an intervention that facilitates a planned transition among mobility options that is based on the consumer's changing circumstances, level of awareness about these circumstances, and the consumer's personal preferences and abilities.

No Show

A consumer who is not at the appointed pick-up location at the estimated time, and the trip has not been cancelled according to local policy, is considered a no-show. The driver must wait 5 minutes after the appointed pick-up time before a consumer is considered a no-show.

Non-coordinated transportation

transportation services provided under contract (not using coordinated transportation).

Ride-sharing Program

an arrangement in which a passenger travels in a private vehicle driven by its owner, for free or for a fee, especially as arranged by means of a website or app.

Volunteer Driver Program

programs in which AAAs or managing partner organizations broker services by recruiting volunteer drivers and matching them to consumers based on schedules and destinations.

218.4 DHS Coordinated Transportation System

The Department of Human Services (DHS) provides quality and cost-effective transportation to eligible consumers for vital services that enhance health, independence, and self-sufficiency. This program is managed by the Office of Facilities and Support Services (OFSS). The Coordinated Transportation System serves the following agencies:

- DHS Division of Aging Services
- DHS Division of Family and Children Services
- DHS Office of Child Support Services
- Department of Behavioral Health and Developmental Disabilities
- Georgia Vocational Rehabilitation Agency (GVRA)

Prior to the Coordinated Transportation system, the divisions and programs operated independently of each other, resulting in segregated services and duplication of transportation efforts. The Coordinated Transportation system began in fiscal year 1999 with the start-up in four DHS regions (Regions 1, 4, 5, and 10) and has since expanded to all 159 counties.

The structure and operating policies for the DHS Coordinated Transportation System can be found in MAN 1425 in the Office of Facilities and Support Services.

218.4A Funding Structure of DHS Coordinated Transportation System

Each agency contributes funding to support the DHS Coordinated Transportation System. These funds are added to federal transportation funds administered by the Federal Transit Administration

(FTA), such as 49. U.S.C. Section 5310, Section 5311, and others.

DHS allocates Social Services Block Grant (SSBG) funds to support transportation services on behalf of the Division of Aging. OFSS allocates these funds to the twelve Area Agencies on Aging (AAAs) based on the current interstate funding formula (IFF) guidelines.

In addition, each AAA may choose to designate a portion of its allocation of funding for Aging services to support transportation in its area, over and above the amount allocated by OFSS.

218.5 Priority Types of Trips

Essential trips for transportation services include the following:

- Trips to and from senior centers
- Trips to and from medical appointments (including dialysis, chemotherapy, etc.)
- Trips to and from preventative health screenings and appointments (including dental, vision, hearing, etc.)
- Trips for shopping (groceries, medications, etc.)
- Trips to and from work/employment
- Field trips
- Trips that support application and management of public benefits
- Trips to pay bills, conduct banking, etc.
- Trips that support civic engagement and continued involvement in the community (including cultural activities and volunteer activities)
- Trips that support evidence-based programs offered through DAS and health/wellness activities offered in the community
- Trips that facilitate attendance at support group meetings for both caregiver services and kinship care services

It is the responsibility of each AAA to identify and, if necessary, prioritize in its Area Plan documents the types of trips to be funded during each program year.

218.6 Eligibility

Each AAA may determine eligibility requirements for transportation services that are funded fully or partially with Older Americans Act funds. Individuals who are served using Title III funds must meet the following eligibility requirements:

1. Be age 60 or older, have a disability, or have Alzheimer's disease or related dementia; or
2. Be a caregiver who must accompany an older adult, a person with a disability, or a person with Alzheimer's disease or related dementia.

AAAs must also follow Division guidelines regarding client prioritization (MAN 5300, 118 Prioritizing Clients) when demand exceeds available resources.

Children who are in older adults' care may also receive trips when accompanying eligible individu-

als as programmatic and local policies exist to support this service. The AAA or partnering organization is responsible for determining fare guidelines that apply to accompanying adults or children.

Active participants in nursing home transition programs administered through Area Agencies on Aging (or their sub-contractors) are eligible for transportation services to attend program-approved evidence-based sessions.

218.7 Fiscal Management

AAAs, contractors and partnering community organizations providing transportation services will practice sound and effective fiscal planning and management, financial and administrative record keeping and reporting. Refer to Manual 5600, 3099 Allowable Services by Fund Source and Appendix F, "Taxonomy of Services".

Allowable Fund Sources - Fund sources that may be used for transportation services include:

- Older Americans Act Title III-B Supportive Services
- Social Services Block Grant (SSBG)
- State Community Based Services (CBS) appropriations
- Title III-E funds (National Family Caregiver Support Program), may be used for transportation services that support family caregivers
- Title V funds can support Senior Community Service Employment Program (SCSEP) participants in getting to and from on-the-job training sites using the Other Program Costs line item for supportive services.

Funds from Older Americans Act Title IV grants and contracts may also be used to develop transportation components of innovative programs.

Cost sharing – DAS encourages the use of cost sharing to support expansion of transportation services in accordance with MAN 5600, 3091 Cost Share.

Voluntary Contributions - The Older Americans Act allows for non-coercive solicitation of voluntary contributions for all services funded through the Act. Refer to MAN 5600, 3092 Voluntary Contributions.

218.8 No Shows

Each AAA must implement a "No Show" policy that includes the maximum percentage of trips that will be allowed as "no shows" per human services provider and must monitor available data on a regular basis to ensure that all providers comply. The AAA, in collaboration with TSS staff, may establish or adjust the target percentage, determine corrective actions, and provide any technical assistance needed.

The No Show policy must include clear language about the definition of a no show, the frequency of no shows that constitutes a policy violation (example: 2 no shows per month), and the process for counseling consumers to mitigate further violations. The goal of the no show policy is to maximize resources, not to punish consumers.

218.9 Partnership, Contracts, and Other Forms of Collaboration

Organizational relationship may take many forms, including but not limited to contracts with providers, partnerships with community organizations, and agreements with voucher program participants. DAS recommends that each AAA develop appropriate written agreements with partners, subcontractors, and other entities that may assist the AAA with the delivery of formal and informal transportation services.

Each AAA is expected to actively participate in the DHS Regional Transportation Coordinating Council (RTCC) for its area. Active participation includes:

- regularly attending scheduled meetings,
- reviewing trip records and consumer feedback,
- taking appropriate action to ensure customer satisfaction, and
- informing the assigned Regional Transportation Office of new formal or supplemental transportation initiatives.

218.10 Laws and Codes

AAAs, providers, and partners are required to adhere to all applicable state, federal, and local laws and codes regarding vehicle operations and maintenance. Refer to MAN 1425 in the Office of Facilities and Support Services.

218.11 Program Records

The AAA and contract provider must maintain systems that are sufficient to manage and support the record keeping demands of each program. A computerized system is recommended. Programs that are supported fully or in-part with Older Americans Act, SSBG, or CBS funds may require documentation in the DAS data system as group services. AAAs should consult their assigned DAS Regional Coordinator for technical assistance.

Documentation of such funded trips should include:

- Numbers of consumers
- Numbers of trips
- Partners providing services (manual reporting)
- Complaint resolution tracking (manual reporting)

For transportation programs funded fully or in-part with Older Americans Act funds, AAAs must maintain appropriate records pertaining to said transportation, and make such materials available for inspection upon request to DHS and participating organizations or their representatives. These records must also include evidence of required annual inspection records. Refer to the Vehicle Maintenance section of MAN 1425 in the Office of Facilities and Support Services.

218.12 Complaint Process

AAAs and providers are encouraged to develop a written grievance policy that is specific to the transportation program's structure and needs. Policies must be in alignment with requirement

stated in HCBS Manual 5300, §110 “Grievance Procedures for Participants in Non-Medicaid Home and Community-Based Services Programs.” The DHS Coordinated Transportation system’s complaint process is required for all providers in that system. Refer to the Complaint Process section of MAN 1425 in the Office of Facilities and Support Services.

218.13 Quality Assurance and Compliance Monitoring

Programs that are funded fully or partially with Older Americans Act funds must include a monitoring and evaluation component to ensure program safety, efficiency, and responsiveness to consumer needs. DHS Coordinated Transportation staff conducts monitoring of service providers. AAAs are encouraged to coordinate monitoring of its transportation services to avoid duplication of effort.

218.14 Consumer Satisfaction

The AAA and its provider are encouraged to conduct consumer satisfaction evaluations on at least an annual basis. DHS Coordinated Transportation staff conducts periodic customer satisfaction surveys, and the AAA may utilize these surveys to determine the appropriateness and effectiveness of services in its area. Collection methods may include surveys, interviews, and/or focus groups. The DAS Program Integrity section is available to provide technical assistance with survey design.

218.15 Management Review

This requirement pertains only to AAA transportation activities not funded through the DHS Coordinated Transportation System. DAS recommends that the AAA conduct regular desk reviews of each provider’s records to ensure that programs are managed efficiently and sustainably. Such reviews may include, but are not limited to, an examination of financial data, consumer information records, vehicle maintenance documentation, and complaint resolution summaries. At any time, DAS representatives may request to read AAA’s desk review files on funded transportation programs.

218.16 Access to Consumer Records

Area Agencies will ensure through contractual requirements that subcontractors protect consumer information records, in accordance with the requirements set forth in HCBS Manual 5300, 202 Program Guidelines and Requirements.

218.17 Privacy Policy Development and Enforcement

DAS requires that AAAs develop and enforce a confidentiality policy that is in alignment with federal, state and Division standards. All individuals who participate in programs that provide transportation to DHS consumers must receive information about confidentiality expectations and consequences for violating privacy policies. Providers are required to document consumer’s receipt of privacy policy information.

218.18 Non-Coordinated Transportation Provided Under Contract

The AAA will monitor transportation, using standards in MAN 1425 in the Office of Facilities and Support Services. AAAs may adapt DHS vehicle inspection forms as needed. DAS recommends that AAAs consult their legal counsel to develop local program policies.

218.19 Volunteer Driver Program

DAS encourages the use of volunteer driver programs where feasible. The following guidelines are intended to provide support to agencies offering a volunteer driver program.

Concerns over liability issues often arise in discussions about volunteer driver programs. While liability may always be an issue, best practices suggest that the most effective way to mitigate liability is to ensure that the volunteer drive program follows appropriate policies and practice in recruiting, training, and monitoring volunteer drivers; and that sufficient protocols are in place to verify volunteer drivers' compliance with relevant laws (current automobile registrations, valid drivers' licenses, automobiles in proper working order, etc.).

See O.C.G.A. 5-1-42 for information about potential liability issues. The law presumes heightened duty of care for motor vehicle passengers. To be driving in "good faith" and without "willful and wanton misconduct" the driver should follow all laws and safe driving practices, including driving below the posted speed limit, not running red lights or stop signs, car in appropriate working order and all lights functioning – in addition to a driver's license in good standing.

218.19A Volunteer Driver Program Policies

Program Policies

DAS recommends that AAAs consult their legal counsel to develop local program policies. Policies must align with MAN 5600, 4020 Civil Rights.

At a minimum, AAAs must:

- Include a photocopy of the volunteer's driver's license and the valid vehicle insurance card in the volunteer's files, which are to be maintained by the AAA or the partnering organization that manages the volunteer.
- Require that all drivers who transport DHS consumers maintain valid liability coverage as required by law.
- Verify that nonprofit organizations are responsible for securing their own vehicle insurance coverage on privately-owned vehicles used to provide transportation to consumers. This coverage is intended to augment a volunteer driver's personal automobile insurance coverage. DAS recommends that the managing nonprofit carry a minimum:
    1. Liability insurance coverage of $100,000 per person and $300,000 per occurrence, and
    2. Bodily injury and property damage coverage in the amount of $100,000 per person, and $300,000 per occurrence.
- Ensure that volunteers are not permitted to drive DHS vehicles.

Accident Reporting for Non State-Owned Vehicles

Procedures for reporting accidents have been adapted for AAA-managed programs and are in alignment with the Risk Management/Insurance section of MAN 1425 in the Office of Facilities and Support Services.

1. The volunteer driver will report the accident to the AAA, and the partnering organization if

applicable, within one (1) hour of the occurrence, or if the office is closed, by 9:00 a.m. the next business day.

2. The provider or partnering organization will complete an accident reporting form to be issued by the AAA. The form must be submitted to the AAA within two business days. The AAA will log the time of receipt.
3. A copy of the investigating officer's accident report must be forwarded to the AAA within five (5) business days from the time the report becomes available. The AAA will log the time of receipt.
4. Each consumer's emergency contact will be notified immediately by the provider in the event of an accident. The AAA will log the time of contact.
5. The AAA, provider, and/or partnering organization will maintain copies of each accident report in the driver's files.

Religious Activities

Volunteer drivers representing faith communities may use vehicles that bear faith-based language and imagery (such as van signage) if passengers are aware of the signage in advance and have the option of riding in a vehicle that does not feature sectarian language or imagery.

Partnering organizations should contact the AAA, and the AAA will seek comparable alternative transportation for consumer with objections. While the AAA will seek an alternative service with an equal or lower fee, it cannot guarantee the availability of such service.

Drivers are not permitted to promote, encourage, or proselytize any religious beliefs to consumers at any time.

Political Activities

Drivers are not permitted to politically solicit DHS consumers at any time. They are permitted, however, to drive consumers to political functions at the passenger's request.

Volunteer Recognition and Retentions

The AAA is encouraged to maintain a robust program of volunteer recognition and retention. Such a program may include the use of incentives to demonstrate appreciation to volunteer drivers. Examples of incentives may include:

- Reimbursement for meeting requirements of the AARP Driver Safety program or similar program
- Periodic gift cards for fuel

Incentives may be used as program match if funded at the local level. AAAs are encouraged to maintain proper fiscal documentation of an incentive program.

218.19B Volunteer Driver Requirements

Driver Qualification Files

The AAA, provider, or partnering organization is responsible for establishing and maintaining a

Driver Qualification File on each driver.

At a minimum, the Driver Qualification file will include the following items:

- Copy of current Georgia Driver's License
- Motor Vehicle Report (MVR) and documentation of annual reviews
- Criminal Records Clerk
- Documentation of any complaints received about the driver and any accidents or moving violations involved the driver
- Documentation of any training received
- Proof of pre-assignment/annual drug testing

A representative of the AAA or partnering organization must review the MVR with the driver annually and identify any serious traffic offenses. Any vehicle accident (regardless of severity) should be documented in writing with the copies of the police report and placed in the driver's Driver Qualification File. The review should be documented with the name of the reviewer and the date of the review.

Driver Training

Unless otherwise specified, DAS requires that volunteer drivers under programs funded fully or partially with state or federal funds successfully complete an Introductory Training Class that includes the following elements:

- General Volunteer Orientation
- Consumer Service, Courtesy, and Sensitivity Awareness
- Driver Conduct
- Pre-Trip Vehicle Inspections and (if applicable) Vehicle Orientation
- Proper Handling and Security of Mobility Aids
- Record Keeping Requirements
- Emergency Procedures

Volunteer drivers who transport DHS consumers are required to take a certified CPR and basic first aid training course. Drivers must maintain a current certification for first aid and CPR, and evidence of such must be kept in their driver qualification file. DAS encourages all drivers who transport DHS consumers to attend a certified defensive driving course every three years.

The AAA is responsible for approving a curriculum to meet the Introductory Training Class requirements listed above. Additional courses and refresher modules should be provided as necessary to ensure quality service delivery. All training materials should be updated periodically to reflect changes in policy and revised or new procedures.

Fees for required Basic First Aid and CPR training may be paid directly by volunteers or through other sources that the AAA deems appropriate, including but not limited to Older Americans Act funds.

Any driver, who has not previously completed required training, must satisfactorily complete the required training within ninety (90) days of assignment.

Criminal History and Background Checks

Volunteer drivers are required to have criminal history records checks through the Georgia Crime Information Center (GCIC) and the Federal Bureau of Investigation (FBI). Refer to the Driver Requirements section of MAN 1425 in the Office of Facilities and Support Services.

Driver Responsibilities Related to Law

All volunteer drivers must comply with applicable laws. All drivers have a responsibility of keeping the AAA and/or partnering organization informed of legal violations.

Volunteer drivers have a responsibility to keep the AAA and/or partnering organization informed of any arrests or convictions. Drivers are required to provide notification of any arrests and or convictions within five (5) calendar days of the date of arrest or conviction. The AAA will determine appropriate action on a case-by-case basis.

A volunteer driver who is convicted of violating, in any type of vehicle, a state or local law relating to motor vehicle traffic control must notify the AAA or partnering organization of such conviction. The notification must be made within five (5) calendar days of such conviction.

A volunteer driver who loses driving privileges in any state through cancellation, revocation, or suspension is not permitted to transport DHS clients. The volunteer driver shall notify the AAA or partnering organization no later than the end of the business day following the notice of suspension or loss of privilege.

No volunteer driver may have any prior convictions for a sexual crime or crime of violence. Any person convicted of a felony during the past five (5) years will drive only after satisfactory review by the AAA.

The AAA and partnering organization will not utilize volunteer drivers who are known abusers of alcohol or known current consumers of narcotics or drugs/medications that would endanger the safety of transportation consumers. If the AAA or partnering organization suspects a driver to be driving under the influence of alcohol, narcotics or drugs medications that would endanger the safety of consumers, then the provider will immediately remove the driver from providing services.

Any volunteer driver who currently has a suspended or revoked driver's license, commercial or other, or for whom the suspension/revocation occurred within the past three (3) years, is prohibited from driving for any purposes.

218.20 Consumer-Directed Transportation

DAS recommends all individuals utilizing consumer-directed transportation (including services such as Uber and Lyft) be responsible for:

- Ensuring that their personally selected drivers are legally licensed and have at least the minimum level of insurance coverage required by the State of Georgia; and

- Ensuring that the vehicle in which they are to be transported has an annual inspection or proof of maintenance by a certified mechanic; and
- Ensuring that their personally selected drivers have a recently completed background/criminal history check.

Refer to MAN 5300 212 Consumer Directed Services for complete instructions on consumer direction.

218.21 Voucher Programs

DAS recommends that AAAs consult their legal counsel to develop local program policies. At a minimum:

- AAAs must provide consumers with an appropriate level of screening to ensure that consumers can manage a voucher program and with technical assistance to enable consumers to track numbers of trips, destination types, drivers, complaint resolution, and reimbursement amounts as deemed necessary by the AAA.
- AAAs are encouraged to develop a written grievance policy for consumers participating in voucher programs. Policies must be in alignment with requirements stated in HCBS Manual 5300 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs. Additional guidance is available in the Complaint Process section of MAN 1425 in the Office of Facilities and Support Services.
- AAAs will provide consumers with safety tips and information available through the Georgia Traffic Injury Prevention Institute and other publicly funded state or national organizations.

218.22 Mobility Transition Counseling

Mobility Transition Counseling (MTC) is an intervention that strives to facilitate and implement a planned transition for optimal mobility (courtesy of MTC website). MTC works best when integrated into a comprehensive assessment and intervention process to assist older adults and their families to remain mobile, engaged, and productive. Individual screening is important when counseling older adults concerning the transition from driving to non-driving mobility. Mobility transition counseling will depend on the consumer's level of awareness and concern about his/her mobility change. Any AAA or provider interested in providing MTC is encouraged to contact the Division for technical assistance.

References

General References

Federal Transit Administration
www.transit.dot.gov

Mobility Transition Counseling Training & Research Initiative.
www.umsl.edu/mtci/About/index.html

MAN 5300, 212 Consumer Directed Services

National Aging and Disability Transportation Center (NADTC)

www.nadtc.org

www.spedsta.com

NADTC Volunteer Transportation Information Brief
www.nadtc.org/wp-content/uploads/Volunteer-Transportation-Info-Brief-Cover.pdf

National Volunteer Transportation Center (NVTC)
ctaa.org/national-volunteer-transportation-center/

Road to Recovery, American Cancer Society Volunteer Transportation Program
www.cancer.org/support-programs-and-services/road-to-recovery.html

Community Transportation Association of America (CTAA)
ctaa.org/

Freedom Express, Wickenburg AZ
www.wickenburgaz.gov/1128/Dial-A-Ride-Transportation

GoGoGrandparent
www.gogograndparent.com/

O.C.G.A. 51-1-4
law.justia.com/codes/georgia/2010/title-51/chapter-1/51-1-42/

DHS Coordinated Transportation System Manual

Volunteer Driver Programs

NADTC Volunteer Transportation Information Brief

National Volunteer Transportation Center (NVTC)

Road to Recovery, American Cancer Society Volunteer Transportation Program

Community Transportation Association of America (CTAA)

Freedom Express, Wickenburg AZ

Ride Share Programs

GoGoGrandparent

Resources

O.C.G.A. 51-1-42

220 The Village Concept

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	
	Section Title:	The Village Concept	**Reviewed or Updated in:**	
	Section Number:	220	**Previous Update:**	

220.1 Purpose

This section discusses the definition of the Village concept and offers guidance in consistent and successful implementation.

220.2 Village Definition

The Village is a membership-driven, grass-roots organization developed by and for older adults. A Village coordinates access to affordable services and vetted/discounted providers for goods and services, all of which are based on the needs of the community served. The organization's main goal is to help members remain independent in their homes and community.

220.3 Background

The first Village was created in 2001 by a group of seniors living in the Beacon Hill neighborhood of Boston, Massachusetts who were seeking a way to help one another age in place. That entity is now an independent non-profit that is governed by the members themselves and supported by member dues and external donations. In the following decade, nearly 100 more Villages opened around the country based on the original ideals of Beacon Hill Village.

DAS recognizes the success of these Villages and endorses the concept as a community-based program to help individuals age in place. While funding may not always be available to assist in the initiation of a Village, DAS can provide technical assistance during the beginning of the project.

220.4 Basic Considerations

The Village is meant to be a dynamic organization uniquely crafted by the population it serves, but the following are definitions of the specific requirements that must be met in order to sustain a successful endeavor.

- **Self-governing** - A minimum of 50% of board members must be village members. This ensures voices from the community are heard and the organization is responsive to its member's needs.
- **Grassroots** - The organization has to develop from the ground-up, emanating from the groundswell of the community. This ensures that the community is demand-driven and not supply-driven.
- **Community-based** - The organization must serve its local population with well-established geographical boundaries.
- **Affordability** - The Village is a self-sustaining entity funded primarily by paid dues and fundraising. Dues should be affordable to each and every member though; this means discounts being offered to those with low-income or offering couples/families discounts if they join as a group.

- **Offer vetted/discounted providers** - The organization must serve as a service broker/consolidator by maintaining information on community services and helping connect members to the information and services they request. The organization should also be able to use its clout to leverage group discounts on services. This provides an economic incentive for the aging population to join and support the organization.
- **Transportation** - This service is a high demand need within most villages and can be made available through either paid staff or volunteers. Some examples of transportation services are to and from grocery stores, medical appointments, etc.
- **Be highly responsive to requests of members** - The Village will have to adapt to the unique requests of its members.
- **Membership** - Qualifications for membership can be uniquely determined by Villages but it is recommended that they allow individuals with disabilities to join, regardless of age. Also, a Village that discriminates based upon protected categories is explicitly excluded from what is defined as a Village within this policy.

220.5 Helpful Information

The suggested first step for creating a Village is to understand the targeted population which will ensure that the demand for the Village exists. This is crucial as the organization is demand-driven, not supply-driven. Ideally, this should be data-oriented with polling to gauge interest.

The School of Social Work at Rutgers University conducted a national survey in 2012 entitled *A National Overview of Villages: Results from a 2012 Organizational Survey* to provide a "snapshot" of 69 Villages in regards to finances, community setting/membership characteristics, services, and organizational governance and collaborations. The study can help guide the creation of a new Village by showing how others have set up their organization.

While it is helpful to look towards successful Villages for guidance, each Village is meant to naturally develop from the groundswell of the community and become uniquely tailored to its members.

220.6 References

1. Greenfield, Emily, et al. "A National Overview of Villages: Results from a 2012 Organizational Survey." Rutgers University. December 2012.
2. www.beaconhillvillage.org
3. www.vtvnetwork.org

222 Behavioral Health Coaching

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	09/20/2021
	Section Title:	Behavioral Health Coaching	**Reviewed or Updated in:**	MT 2022-01
	Section Number:	222	**Previous Update:**	MT 2022-01

222.1 Summary Statement

This chapter establishes guidelines and requirements to be followed when Area Agencies on Aging (AAAs) provide or contract for the provision of behavioral health coaching services. The primary goal of this policy is to provide maximum flexibility for AAAs to expand services, while continuing to protect the health, safety, and well-being of persons living with a behavioral health diagnosis.

222.2 Scope

These requirements apply to services provided in whole or in part with non-Medicaid federal and specially appropriated state funds managed by AAAs, and any associated matching and local discretionary funds. These requirements may also provide guidance to agencies implementing behavioral health coaching services funded by other sources.

222.3 Target Group and Eligibility

The target group for these services comprises persons who have mental health, substance use or misuse, and/or memory challenges and who may benefit from a person-centered coaching model to maintain or enhance their ability to live in the community successfully.

The AAA may use other allowable, non-federal fund sources for services targeting individuals who do not meet Older Americans Act eligibility criteria.

The AAA may provide behavioral health coaching services to individuals living in public housing authorities or scatter-site housing programs, or who are living independently in the community.

222.4 Access to Services

Behavioral health coaching is intended to serve as an extension of the AAA's Access to Care model.

The AAA shall receive requests for behavioral health coaching services provided either directly or through their subcontract agencies and maintain and manage waiting lists, as needed. Referrals may come directly to the ADRC or indirectly from behavioral health coaches.

222.5 Core Principles

AAAs will implement behavioral health coaching services according to the following core principles:

1. **Capacity based**: Persons living with behavioral health diagnoses have the capacity for continued growth and autonomy and are the authority on their own needs, have the capacity to know what they need most to achieve well-being, and have abilities, competencies, and resources to help achieve their goals.
2. **Conflict-free**: Program staff remains neutral with no interest in the choices made by consumers nor in the types of services or providers selected by the consumers; and to the extent possible, avoids the appearance of conflicts regarding referrals on behalf of consumers.
3. **Culturally Competent**: Program staff understands and respects the culture of consumers and interacts with them in ways that are culturally and linguistically competent; and appreciates the ways cultural beliefs and values inform the consumer's acceptance of Service Plan options.

4. **Individualized**: Services should focus on meeting the specific needs and preferences of each individual consumer and/or family through joint development, implementation, and review of the Service Plan.
5. **Person-Centered**: Program staff approaches consumers and families with empathy and an understanding of their life experiences and challenges by searching for and acting upon what is important to that consumer, including their wants, needs, and values.
6. **Professionally Responsible**: Program staff maintains the privacy, confidentiality, health, and safety of consumers by adhering to ethical and legal standards and to program guidelines.

222.6 Service Goals

The goals of providing behavioral health coaching services include:

- Helping clients reconnect with medical providers (including behavioral health, oral health, therapy services, etc.)
- Maximizing public benefits and support services
- Maintaining stable housing
- Helping the individual learn to effectively use a formal and informal support system, and
- Aging in place

222.7 Service Activities

The AAA may provide any of the following activities as components of a robust behavioral health coaching service:

- Assessment – behavioral health coaches will assess individuals in a person-centered manner that may include use of the DON-R, PHQ-9, GAD-7, or any other assessment tool approved by the Division. Coaches must be sensitive to the need to establish trust with individuals to be served through behavioral health coaching; therefore, it may not be possible or desirable to complete an assessment during the initial contact with the individual.
- Service coordination – behavioral health coaches will support individuals in accessing programs that maximize benefits, transportation, housing, caregiver support, social engagement, material aid, and wellness (including chronic disease self-management programs).
- Crisis stabilization - behavioral health coaches may provide an intensive level of hands-on, in-person intervention if the client is in a crisis, such as being in danger of homelessness. This work usually centers around engaging with the client, developing person-centered goals, and helping them navigate access to medical care and personal support services.
- Education – behavioral health coaches may assist individuals in accessing services that help them learn about how to use assistive technology or medical equipment, learn home management skills, or other activities that promote maximum self-sufficiency.

Behavioral Health Coaching includes the following activities that may be included in reimbursement for services:

1. Assessment

2. Periodic Reassessment
3. Service Plan Development and Coordination
4. Follow up by telephone, email, or in person with clients and caregivers, when appropriate and necessary, in accordance with program and service requirements
5. Coordination with other programs and advocacy on behalf of individuals
6. Education with individuals and/or community partners who require assistance in accessing other systems of care
7. Education to staff at housing facilities, or education to resident groups or community groups
8. Assisting individuals with applying for or accessing public or private benefits programs
9. Documentation, data collection, data entry, and programmatic reporting

Travel to and from the homes of applicants/clients for the purpose of assessment or reassessment may not be billed as units. However, travel is a cost of performing this service and should be included in unit cost calculations.

Each AAA must develop protocols for frequency of intervention and levels of support and must monitor compliance with those protocols.

222.8 Staffing

The AAA will provide adequate numbers of staff, qualified by training and experience to implement behavioral health coaching services. The AAA may directly employ staff or contract for the implementation and administration of the program. Qualifications for behavioral health coaches will mirror those for case management (See MAN 5300, CH 210.13#) plus knowledge and experience in behavioral health services.

Each AAA will determine ideal staffing patterns and staff-to-client ratios that reflect the complex nature of the population served.

222.9 Data Collection and Reporting

The AAA and subcontractors will collect, record, and maintain client information in the form and formats specified by the Division. The Division may establish additional reporting requirements and formats, including a required minimum set of data to account for program activities and outcomes.

222.10 Monitoring and Evaluation

The AAA will monitor providers at least annually to assure accountability for the use of program resources and evaluate the effectiveness of the program activities, using criteria and tools specified or approved by the Division, and other discretionary measures. Standards and guidelines established by the Division apply to eligible service components.

The AAA will provide written feedback to providers within thirty (30) days of completing program monitoring and provide technical assistance for continuous improvement in the program.

The Division will evaluate program data periodically and may conduct on-site monitoring evalua-

tions of activities and records.

References

Peer Wellness Coach Supervisors Manual 2010, SAMHSA

Life Coaches and Mental Illness, Psychology Today

314 Home Modification and Repair Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	03/01/2023
	Section Title:	Home Modification and Repair Services	**Reviewed or Updated in:**	MT 2023-02
	Section Number:	314	**Previous Update:**	June 2002

314.1 Purpose

This chapter establishes the requirements for home modification and repair services funded in whole or in part with non-Medicaid federal and state funds managed by the Area Agency on Aging (AAA), and any associated matching funds. These requirements may act as guidelines for a fee-for-service model.

According to the Older Americans Act (OAA), the purpose of this program is:

A. To assist older individuals to obtain residential repair and renovations projects designed to enable older individuals to maintain their homes in conformity with minimum housing standards.

   Minor modifications of homes that are necessary to facilitate the ability of older individuals to remain at home

B. To adapt homes to meet the needs of older individuals who have physical disabilities

C. To prevent unlawful entry into residences of older individuals, through the installation of security devices and through structural modifications or alteration of such residences

D. Other initiatives include support of evidence-based falls prevention home assessments, and home modifications for older adults and individuals with disabilities.

314.2 Scope

The requirements apply to home modification and repair services funded in whole or in part with non-Medicaid federal and state funds, managed by the AAA, and any associated matching funds. Modifications may include installation of adaptive and assistive devices and structural alterations to improve accessibility and mobility both within and outside the residence.

Repair services are designed to reduce or remove structural or environmental hazards by returning the dwelling to as safe a condition as possible, allowing the resident to continue living in the community. Repairs and modifications shall be of quality workmanship and provided at a reason-

able cost in accordance with state and local building codes.

Repairs and modifications are provided with the program resources only when there are no other public or private resources available to pay for the repair/modification home assessment, materials, equipment, supplies, labor, and any necessary inspections.

Whenever possible, adaptive equipment and modifications are planned and installed in such a manner that they may be recycled and made available to other clients, when no longer needed in the residence of original installation.

For individuals requiring repairs on rental properties refer to Section 314.

314.3 Definitions

Home Modifications

the installation of adaptive and assistive devices and/or structural alterations to improve the accessibility and mobility both within and outside the residence.

Home Repairs

services that are designed to reduce or remove structural and/or environmental hazards by returning the dwelling to as safe a condition as possible, allowing the resident to continue living in their community.

314.4 Target Group / Eligibility

Home modification and repair services are offered to:

- persons who have a physical or mental disability or disorder that restricts his/her ability to perform basic activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs),
- mitigate threats to individuals and their caregiver's capacity to live independently. (See MAN 5300, CH 316 for additional priorities for caregiver services)

AAAs should follow additional criteria specific to fund sources. If funding is not sufficient to serve all eligible consumers requesting services, the Older Americans Act and Client Prioritization guidelines, found in MAN 5300, CH 118 provides for giving preference to specific persons:

- Persons 60 years of age or older
- Persons in greatest economic need
- Persons in greatest social need,
- Persons who are frail, and
- Persons who are at risk of institutionalization
- Underrepresented population:
  - persons who are minorities
  - persons with limited English proficiency
  - persons from rural areas

Individuals must have an impairment(s) and/or unmet need(s), as indicated by his/her DON-R score. AAAs should prioritize individuals who have impairment and/or unmet need in any of the domains with scores of 2 or greater.

AAAs will **not** provide home modification and repair services in a nursing home, personal care home, or other setting where the provision of this service is included in the cost of care.

314.5 Conflict-Free Service Delivery

An efficient service delivery system is characterized by person-centered approaches and cost-effective outcomes for both consumers and the community. Therefore, DAS supports the implementation of a conflict-free service delivery system.

MAN 5300, 202 Program Guidelines and Requirements includes the key elements included in the design of such a system.

314.6A Service Activities

Home modification and repair(s) activities must be planned with input from the client, whenever possible, caregiver or a representative, based on an assessment of their needs and the degree of physical and/or cognitive impairment of the care receiver.

Assessment/evaluation fees is an allowable service activity in the provision of home modification and repair services.

The types of repairs or modifications may include:

- repairs to the structure itself
- electrical
- plumbing repairs
- weatherization
- accessibility modifications
- security modifications
- home maintenance essential to maintaining the health and safety of the older individual

Refer to Appendix A for additional examples of repair work/modifications.

314.6B Prohibited Activities

Non-reimbursable activities include the following:

- Major repair of houses and/or furnishings such as replacement of roof, floor, and foundation
- Construction repair of maintenance of outbuildings such as garages, carports, animal shelters or greenhouses
- Installation, repair or maintenance on nonessential appliance
- Beautification of property or activities which are strictly for cosmetic purposes such as landscaping, planting a garden, purchase of gardening equipment, complete paint job, ornamental

shutters or trim, fancy porch supports, carpeting, patio and/or mending fences unless essential to the client's safety.

- Project management costs

314.7 Access to Services

AAA staff shall screen individuals including identifying problems that he/she experiences in daily life and that he/she hopes are eliminated or diminished as a result by home modification and repair services.

AAA staff shall discuss with potential clients how home modification and repair services can:

1. improve access to their home (home accessibility)
2. maintain their safety and independence (living in home longer).

The AAA staff will initiate service delivery, refer clients to provider organizations or other resources (e.g., occupational therapist, Center for Independent Living, certified aging in place specialist, etc.), or place them on a waiting list for services.

For information regarding screening through Aging & Disability Resource Connection, see MAN 5200, Section 5025. The AAAs will maintain and manage waiting lists for the services, as necessary. See Manual 5200, Section 5038 "Waiting List Management".

Not every applicant will request, require, or benefit from home modification and repair services. Each AAA will clearly identify in its Area Plan how services will be coordinated and how resources will be allocated and managed to optimize the effectiveness and efficiency of home modification and repair services.

314.8 Standards of Promptness

Refer to MAN 5300, 114 Guidelines for Client Assessment

314.9 Service Provider Eligibility

AAAs may provide directly or contract for the provision of home modification and/or repair services with private non-profit organizations or commercial businesses that have the capacity to perform the tasks necessary to improve residential environments and increase the safety and independence of community-dwelling older adults and adults with disabilities.

Businesses that contract with the AAA to provide modification and/or repair services shall meet all professional standards, including licensure and certification (if applicable according to state/county/municipal codes) or any state training requirements. AAAs also may establish contracts/working agreements with individuals or other organizations such as community and social service agencies and area technical schools, which demonstrate expertise in providing modification and repair services, using either paid or volunteer staff, or both, or who agree to act as an intermediary for developing working agreements with commercial concerns. Qualified providers may include:

- Licensed/ certified housing contractors (if applicable)

- Licensed handyman
- Licensed plumbers
- Licensed electricians
- Licensed architects
- Rehabilitation engineers
- Licensed occupational or physical therapists
- Home health care and medical equipment suppliers/retailers
- Volunteers with experience in and credentials for performing licensed work
- Students working under the supervision of qualified instructors or supervisors

License Requirements:

- Contractor: State of Georgia Contractor's License
- Handyman: Local Business License

Insurance Requirements:

- General Liability
- Automobile Liability
- Workman's Compensation
- Bond

Additional Requirements:

- AAAs must assure that the provider for services that cost more than $1,000 (total materials and labor) is a licensed contractor, is bonded, and insured.
- If services are less than a $1,000, a handyman may be used. Hourly handymen must be bonded, insured, and have a valid local business license. Workman's compensation is required for a company that regularly employs three or more persons in their Georgia business. sbwc.georgia.gov/workers-compensation-insurance-faqs
- The need for building inspection is governed by local ordinance: if an inspection is required, a copy of the inspection clearance shall be attached to the invoice for services.
- Qualified providers should have an awareness of biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; the housing needs of older individuals.
- Workmanship will be warranted for at least 90 days from the date of completion of structural repairs, modifications, or installations when funded in whole or in part with non-Medicaid federal and state funds.

314.10 Service Process Guidelines

Appropriate assessment tool(s) (such as STEADI, DON-R, home safety assessment, etc.) administered by trained personnel (OT, contractor, certified aging in place specialist, etc.) may be used to identify and/or recommend home modification and repair services.

During the screening process, the Stopping Elderly Accidents, Deaths & Injuries (STEADI) (Appendix C) may identify a client at risk for falls. Clients at risk for falls should be referred to qualified professionals for home assessment to identify/make recommendations for any home modification/repair to reduce any falls risks. Such clients should also be referred to evidence-based falls prevention workshops such as Matter of Balance, Tai Chi for Health, etc.

Home repair/modifications must be justified in the service/care plan on a qualified residence and can only be performed after an on-site evaluation/assessment of the home by a case manager, occupational therapist, CAPS, or other provider staff has been made prior to work being performed. There is a bidding process, and the client will obtain two bids to determine the lowest bid. See Appendix B for suggested client contract guidance.

Two scope/bid quotes are required for home modifications. Scope/bid quotes must come from qualified service providers and scope/bids must separate charges for labor and materials. Quotes from contractors must be based on using standard materials. Any materials used beyond basic/standard materials will be subsidized by the property owner.

OR –

AAA can request RFP's to qualifying contractors to assess, make any appropriate repairs/modifications, obtain any necessary permits. Two scope/bids are not required if a AAA has an established contract with a home modification/repairs services provider.

Contractor scope/bids must be itemized by area modified (i.e. bathroom), itemized by task (i.e. remove toilet and install new Americans with Disabilities Act (ADA) toilet) and provide a breakdown of materials and labor. Grand total of labor + materials must be included in the scope/bid. The winning scope/bid is typically the lowest bid, but not required if justification is presented and accepted for a more costly bid.

Modifications cannot exceed the budget of $2,000.00 when using Title IIIB funds. Georgia's State Unit on Aging (SUA) Director can authorize up to an additional $1,500, as individual situations warrant. Other funding sources maybe used, if available. Home modification and Repair service workers may not perform all tasks identified as necessary through an assessment due to budgetary constraints. Information regarding those needs should be referred to appropriate AAA staff for a referral to other community resources.

Both quotes obtained by client must be submitted to appropriate AAA staff and the winning bid indicated. Supporting documentation includes the scope/bid quotes from qualified provider and notarized permission letters from owners/landlords. AAA staff will collect and review all supporting documents.

All home modifications and repair services must comply with local building codes and permitting processes. All structural modifications, such as the installation of ramps, zero-step entries, widening of doorways, etc. shall conform to minimum Americans with Disabilities Act (ADA) standards.

AAA staff will approve home modification/repairs and will coordinate with the client and contractor the start of any repairs/modifications.

Upon completion of modifications/repairs, verification is required to ensure work was done in a satisfactory manner, and if/how repairs/modification are impacting the individual's quality of life.

314.11 Repair of Rental Property

Residential repair/modification services on rental property/units are not allowed without prior approval by the Area Agency on Aging or its designee. The AAA or service provider must verify that needed repairs or modifications to rental property are not the responsibility of the owner, landlord, management company or housing authority prior to authorizing the work to be done by referring to a provider.

If work is performed on rental units, the residential repair services provider shall obtain a signed and notarized agreement from the landlord, or other entity controlling the property, authorizing the repairs and/or modifications and stating that the tenant:

- will not be evicted within one year of the completion of the repairs and/or modifications without substantial cause
- the rent will not be raised due to the increased value of the unit as a result of the repairs and/or modifications.

314.12 Service Outcomes

The primary goal of home modification and repair services is to aid older adults, persons with disabilities to maintain their homes in conformity with minimum housing requirements to ensure their ability to remain in their home and/or to adapt homes to meet the needs of older individuals who have physical disabilities.

314.13 Emergency Contact

The AAA should ensure that each client record contains emergency contact information (name and telephone number(s) at a minimum).

314.14 Service Termination and Discharge

It is the explicit intent of DAS to serve clients in greatest need and to maximize the efficiency and effectiveness of the Aging Network.

DAS anticipates that during the span of service delivery to a consumer, the consumer's needs, supports, and resources will change. Based upon the ongoing process of assessment and reassessment, the AAA may determine that the individual is receiving maximum benefit from home modification/repair services and initiate discharge according to DAS policy (see MAN 5300, CH 202).

Staff must include proper documentation in the DDS system that includes the reason for discharge and whether any reusable modification was collected, and/or re-utilized.

314.15 Client's Rights and Responsibilities

AAAs and provider agencies will assure that all consumers, or their caregivers, receive a written copy of their rights and responsibilities as program/service participants upon their admission to services. See MAN 5300 Appendix E for the suggested "Client's Rights and Responsibilities".

314.16 Client Complaint Procedures

AAAs will establish written client complaint procedures for use by each provider. Procedures should include the minimum requirements outlined in MAN 5300, CH 202. In addition, the complaint procedures must include:

- A telephone number for the provider which the client can call for information, questions, or complaints about the services supplied by the provider and information regarding supervision by the agency of the services to be provided
- The telephone number of the state licensing authority for information and filing of complaints which have not been resolved satisfactorily at the local level, for those agencies providing services subject to state licensure, or the number of the AAA and DAS, if not subject to licensure.

314.17 Appeals and Grievances

AAAs will establish written appeals procedures for use by each provider and are consistent with MAN 5300, 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs.

314.18 Criminal Records Investigations

AAAs must assure that providers employing persons having direct contact as primary, secondary or alternative job duties conduct a criminal records investigation, according to state law and current policy of the Department of Human Services in MAN 5600, 3040 Criminal History Investigations.

314.19 Volunteer Management

AAAs or providers, at a minimum, must comply with all volunteer management procedures found in MAN 5600, 4020 Civil Rights.

314.20 Administrative Requirements

The provider agency or individual contractors shall have the necessary legal authority to operate in conformity with federal, state, and local law and shall maintain the following:

- Service agreements between the service provider and the recipient of services and the landlord, if applicable, shall be executed. Copies of the service agreement and the area agency's approval, if applicable, shall be maintained and updated for each program year.
- Documentation of necessary and appropriate liability insurance coverage and bonding for employees who perform work in and around client's home.

The following documentation of activities must be accomplished each program year to certify the delivery of services:

1. The AAA must assure through the intake process that an individual is eligible for the service prior to repairs and modification work beginning
2. Assessment, case management or provider staff will conduct an on-site evaluation/assessment of the home and develop a written service agreement with the client (or his/her representative), advising of the work to be performed prior to service delivery. All repairs and modifications shall directly relate to reducing environmental hazards and/or increasing the client's ability to

continue to live independently and are made only with the consent of the client or his/her representative.

3. Documentation of quotes (if applicable) and invoices
4. Signed affidavit by the client (or representative) that the work was completed and performed in a satisfactory manner
5. Signed certification of compliance with all appropriate codes for building, plumbing and electrical repair and issue a written warranty of the work performed. If applicable, any approved inspection reports.
6. Specific information on the number of residences and the cost per residence repaired and/or modified with aging contract fund sources
7. Specific information on coordination activities with other funding sources which resulted in the leveraging of additional funds for residential repair and/or modifications.

314.21 Fiscal Management

Businesses, agencies and individuals providing assistive technology services shall practice sound and effective fiscal planning and management, financial and administrative record keeping and reporting.

314.22 Data Collection and Reporting

General information about data collection and reporting are described in CH 202. The AAA may require additional information systems at its discretion but may not fail to meet the minimal standards required by DAS. The AAA must retain relevant information not captured in the DAS data system in paper files according to DAS program policies.

Specific programmatic/service requirements for collection and/or reporting of data include:

- Information gathered from persons served.
- Appropriate consent forms, issued or approved by DAS
- Provider information
- Pertinent financial information regarding applicable cost shares
- Coordination with the ADRC regarding waiting lists and referrals to home modification/repair services
- Tools and plans for measuring quality of life and customer satisfaction approved or required by DAS
- Notation in the DAS data system that includes a listing of all home modifications and/or repairs

The AAA staff will use data from the DAS data system, at a minimum, to facilitate quality improvement and data analysis.

314.23 Retention and Confidentiality of Records

Providers must establish and implement written policies and procedures for the maintenance and security of client records, specifying who will supervise the maintenance of records, which will

have custody of records, to whom records may be released, and for what purposes in compliance with MAN 5600, 3012 Provision of Services by Area Agencies on Aging.

Each client record must include the following information about home modification/repair services in the manner that DAS requires:

- Type(s) of modification/repair
- Cost for each modification/repair(s)

314.24 Fee for Service Guidelines

Each AAA/provider is encouraged to offer in-home services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Sections 2025-2028, “Fee for Service System”, “Cost Share”, “Voluntary Contribution”, and “Private Pay Services”.

Home modification and repair services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

314.25 Reports of Grievances, Complaints, and Incidents

Refer to MAN 5300, 202 Program Guidelines and Requirements

314.26 Mandatory Reporting of Abuse / Neglect / Exploitation

Refer to MAN 5300, 202 Program Guidelines and Requirements

314.27 Program Evaluation and Monitoring

The Area Agency will make follow-up contacts to recipients of modification and repair services to determine their satisfaction with the work performed and the degree to which their safety and independence is enhanced or improved.

The Area Agency also will monitor provider records regarding work performed at least once annually to assure compliance with all applicable codes and regulations. The AAA shall provide written feedback to contractors on the findings and provide any necessary technical assistance for continuous quality improvement where appropriate.

314.28 References

Older Americans Act Of 1965: 2020 Reauthorization

DAS Manual 5200, Section 5025 - Service Availability and Access

DAS Manual 5200, Section 5038 - Waiting List Management

DAS Manual 5300, Section 114 - Guidelines for Client Assessment

DAS Manual 5300, Section 118 - Prioritizing Clients

DAS Manual 5300, Section 202 - Program Guidelines and Requirements

DAS Manual 5300, Section 316 - Caregiver Services

DAS Manual 5600, Section 1060 - Technology and Data Management

DAS Manual 5600, Section 2025 - Fee for Service System

DAS Manual 5600, Section 2026 - Cost Share

DAS Manual 5600, Section 2027 - Voluntary Contribution

DAS Manual 5600, Section 2028 - Private Pay Services

STEADI Falls Risk Assessment

Appendix A: Examples of Home Modifications/Repairs Appendix B: Client Contractor Guidance

Appendix C: Stopping Elderly Accidents, Deaths, and Injuries (STEADI) - Falls Risk Assessment

Appendix 314-A Examples of Home Modifications / Repairs

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	03/01/2023
	Section Title:	Examples of Home Modifications / Repairs	**Reviewed or Updated in:**	MT 2023-02
	Section Number:	Appendix 314-A	**Previous Update:**	June 2002

Home Modifications / Repairs

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Site	• adding or replacing address numbers so it its visible from the street for emergency responders	• repair of walkways, driveways or parking areas
Building Exterior	• adding exterior lighting at entrances (to include automatic sensors) • installing new or adjusting mailbox to make it easier to reach • fixing gutters and downspouts if causing safety hazard • manufactured / mobile home skirting • minor roof repairs	• gutter and/or downspout installation

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Exterior walkways and steps	• graded ground ramps • installing temporary/modular ramps (placed on top of the ground) for accessibility for individuals with a disability • placing temporary anti-slip tape or colored tape or paint on surfaces • applying directional signage or marking for wayfinding • installing handrails on both sides of steps and/or pathways • repairing cracked, broken, or uneven pathways (pavement, brick, etc.) • installing pathway lighting	• installing/repairing ramps (with footings set into the ground) for accessibility • installing/repairing exterior stairlift • installing/repairing wheelchair platform and lift
Exterior Windows and Doors	• installing automatic doors or automatic door openers • installing magnetic screen door • replacing door lock with one that is easier to operate • replacing doorknobs with lever style handles • adding or adjusting peephole or viewing panel to correct height for client • eliminating trip hazards at entry threshold • installing “tap-n-go” or other hands-free door hold open capability • adjusting windows to make them easier to open and close • fixing broken window pane(s), storm window(s) or damaged entry door • adding storm windows or storm doors	• widening exterior doorway to accommodate a walker or wheelchair • replacement of exterior door • replacement of windows
Interior Walls, Windows, and Ceilings	• adjusting or replacing hardware for drapes, shades, and/or curtains to make them easier to use • building shelf to improve hands-free activity or to improve accessibility • patching or mending cracked plaster • patching or fixing holes or cracks in drywall	• installing new drywall or paneling • installing new acoustical ceiling

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Interior Doors and Hallways	• adjusting door swings to reverse or remove awkwardness • installing/repairing automatic doors or door openers • installing door hinge offset or swing clear door hinges • repairing flooring transitions so there is zero height difference between them • repairing floor tile to remove uneven surfaces • repairing floors to remove uneven surfaces • stripping floors and resealing when incidental to other work • installing linoleum/vinyl flooring to remove uneven surfaces that pose extensive slipping or tripping hazards • carpet removal • cleaning floor when incidental to other work	• installing different door type • widening interior doorways to accommodate a walker or wheelchair • widening hallways to accommodate a walker or wheelchair
Interior Stairways (Circulation)	• installing/repairing railings maintaining chair lift/stair climber • replacing broken stair treads or balusters • applying adhesive strips with non-slip surface • applying adhesive tape or paint to distinguish thresholds and edges • carpet removal	• installing/repairing chair lift/stair climbers

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Bathroom/ Laundry	• installing grab bars • adding nonskid strips to bathtub or shower floor • installing a hand-held or adjustable showerhead • installing clamp for handheld shower on wall or grab bar • tub cuts to enable easy entry/conversion to shower • installing curved shower rod • installing easy-to-use lever handles rather than knobs or turn handles for the sink, bathtub and shower faucets feature • replacing toilet with comfort height model • installing pedestal or wall hung sink for wheelchair accessibility • insulating exposed pipes beneath the sink to protect against touching a hot pipe • cushioning exposed pipes beneath the sink to protect against bumping • replacing or adjusting position of bathroom mirror, toilet paper holder, and other accessories to meet client's needs • replacing cabinet hardware, such as replacing round knobs with D-shaped handles • installing new toilet handles • installing toilet riser with handles • installing toilet safety frame or rails • repairing toilet seats • installing wall soap holder • repairing wall tile • securing rugs with rubber carpet mesh or double-sided rug tape • unclogging sink or toilet when incidental to other work • replacing broken medicine cabinet	• installing new wall tile • installing a walk-in shower or bathtub

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Kitchens	• replacing cabinet hardware, such as replacing round knobs with D-shaped handles • removing or replacing interior of existing cabinetry for easier access (e.g., pull-out drawers and shelves) • replace faucets with lever-, touch-, or sensor-style faucet • install easy-to-use ABC-rated fire extinguisher in an easy- to reach place • install automatic stove turnoff devices	• install lower work surface that can be used while seated • lowering of cabinets
Electrical/ Lighting	• adding stick-on motion sensor lighting • adding task lighting under cabinets and over counters and tables • changing light bulbs • adding light switches at top and bottom of stairs for safety • replacing light switches with safety and accessibility features such as glow in the dark, rocker-style switches, or other easy-to-function switches • moving light switches and electrical outlets where they are more accessible to the individual • adding ball chain extension to ceiling fan/light	• replacing or moving electrical panels
HVAC / Plumbing systems	• replacing thermostat with one that has accessibility features • setting home's water heater or replacing its thermostat, to ensure hot water is at or below 120°F to avoid scalding • installing pressure-balanced, temperature-regulated sink faucets in kitchen and bath	
Security	• adding security technology to entrance door • installing secure slide latch or chain inside entrance door	• installing new security alarm system

Feature or System	Examples of Repair Activities	Examples of Rehabilitation Repair
Life Safety	• installing GFCI outlet • repairing electrical outlets • installing or servicing smoke, fire and CO detectors • installing or replacing doorbell that can be seen or heard by client throughout the house • cleaning surface mold	• chimney repairs • mold remediation

Appendix 314-B Client Contractor Guidance

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	03/01/2023
	Section Title:	Client Contractor Guidance	**Reviewed or Updated in:**	MT 2023-02
	Section Number:	Appendix 314-B	**Previous Update:**	June 2002

Homeowner Beware: Things to Consider Before Entering into a Construction Contract

Under the Home modification and repairs, you,_____, the Owner(s), are responsible to select your own contractor and enter into a contract for the necessary repairs/modifications. Because neither the Georgia Division of Aging Services nor the _____ Area Agency on Aging guarantee the contractor's performance, you must be diligent and thorough in your selection of a contractor. This document provides you with tips on selecting and working with contractors.

If it sounds too good to be true, it probably is. Be cautious of contractors with estimates much less than others. For example, if two bids come in at $5,000 and a third bid comes in at $1,000, it is likely that the third contractor will have to cut corners during performance of the work.	**Confirm insurance, licensing and permitting.** Only licensed contractors should perform work on your property. It must be a contracting license, not just a business license. Also, even if the contractor produces a copy of his insurance, you should call the insurance company to confirm coverage is still effective. Finally, talk to local code enforcement office to make sure the appropriate permits are taken out.
Compare bids. Contractors should be able to defend every line item. If something is priced on one bid and not another, ask why it is missing.	**Contact references.** Ask the contractor for four references, preferably two clients of current projects and two clients from the last two projects. Verify the contractor's work is good.
Carefully consider upfront costs. DAS/AAA discourages payment of upfront costs. If you must pay such costs, they should only equal materials costs. Understand that AAA cannot reimburse a project until it is complete. AAA will not pay for upfront costs.	**Reputable contractors will likely have a waiting list.** Beware of scammers who knock on your door and tell you a job just fell through and they can give you a good deal.

Plan for surprises.

Modifications may reveal pre-existing issues or structural integrity problems with your home. For example, demolition of walls may reveal hidden defects. The Home Repair and Modification Program cannot fund repairs of these issues. Ask the contractor what they see as potential problem areas. You are responsible for costs associated with pre-existing issues or structural integrity problems that fall outside the scope of work approved by the AAA. Before contracting with the contractor, know that you may have to fund repairs of these issues so that the contractor can complete the work.

Remember that the Home Modification and Repair Program is unable issue payment to a contractor until the work is completely finished. If a contractor completes half the work before discovering the issue(s), you will be responsible for remedying the issue(s) so the contractor can continue.

Be cautious of bringing friends in to help or repair issues. Friends not under contract with you may not be liable to you for substandard or delayed timeliness of work. Conversely, the law requires a Georgia licensed contractor to provide you a written warranty.	**Develop a very specific work scope.** You should work with the contractor to make sure each material and item of performance is as detailed as possible so each party understand what is expected. Being specific up front can prevent disputes later on.

Warranties.

Make sure you obtain and read a copy of the contractor's written warranty before construction begins. The materials used will also have manufacturer's warranties, which you should ask for as well.

Note:

Home modification and Repair service workers may not perform all tasks identified as necessary through the proper assessment tool(s) due to budgetary constraints. Information regarding those needs should be referred to appropriate AAA staff for a referral to other community resources.

_____ Owner Initials
_____ Owner Initials

If you believe the contractor is performing substandard work or has negligently or intentionally caused property damage or personal injury, **you will be responsible for obtaining any remedy against the contractor**. Neither the Division of Aging Services nor the Area Agency on Aging will make legal claims or demands against the contractor on your behalf. You may need to speak with the contractor, his or her insurance company, and/or consult with an attorney. Understand that Georgia law and your contract grants the contractor a right to remedy his or her performance before you can pursue legal remedies. The Home Modification and Repair Program cannot fund activities such as:

- Remediation of substandard work performed by the contractor.
- Repairs of property damage caused by the contractor.
- Legal fees for pursuing remedies against the contractor.

Liens. In Georgia, contractors and subcontractors can record a lien, mortgage or other security interest on your home for unpaid amounts owed for services performed or materials supplied. For example, subcontractors not paid by the contractor may file a lien. Your failure to permit the contractor to finish his work and receive payment from the Home Modification and Repair Program may also result in a lien on your home.

By evidence of Owner(s)' signature below, Owner(s) certifies that he or she is (are) the sole person(s) with ownership interest in the property and has read, understands and agrees with this document.

_____

Owner

_____

Date

_____

Owner

_____

Date

Appendix 314-C Stopping Elderly Accidents, Deaths, and Injuries (STEADI) Falls Risk Assessment

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	03/01/2023
	Section Title:	Stopping Elderly Accidents, Deaths, and Injuries (STEADI) Falls Risk Assessment	**Reviewed or Updated in:**	MT 2023-02
	Section Number:	Appendix 314-C	**Previous Update:**	June 2002

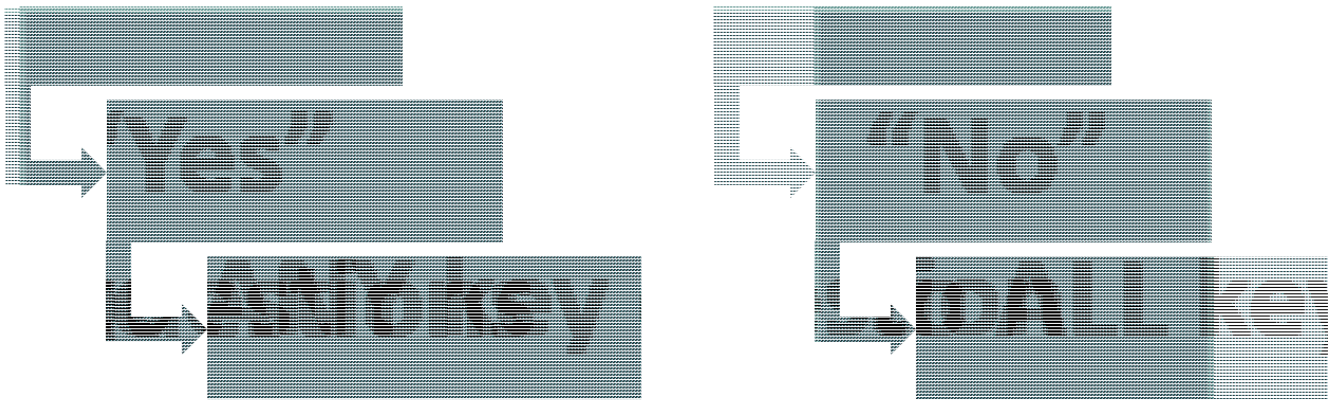
Stopping Elderly Accidents, Deaths, and Injuries (STEADI)

Screening Tool: The Three Key Questions

Ask the client these questions:

- Have you fallen in the past year?
- Do you feel unsteady when standing or walking?
- Do you worry about falling?

Results



320 Telephone Reassurance

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	
	Section Title:	Telephone Reassurance	**Reviewed or Updated in:**	MT 2015-06
	Section Number:	320	**Previous Update:**	

320.1 Summary Statement

This chapter establishes policies, guidelines, and standards for Area Agencies on Aging (AAA) who contract or provide telephone reassurance to older adults, their caregivers if present, and adults with disabilities.

320.2 Scope

These guidelines apply to telephone reassurance provided under contract, funded in part or in whole with funds provided by the Division of Aging Services (DAS). These rules provide suggested guidelines for services paid for entirely by local funds and for volunteer based telephone reassurance programs.

320.3 Definitions

Frail

(As defined by the Older American's Act) unable to perform at least three activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

Telephone Reassurance

Interactions with an individual by telephone to reduce social isolation, provide support, and ensure health and safety.

320.4 Delivery Types

The AAA operates the Telephone Reassurance program directly or subcontracts with a service provider for program service delivery.

Telephone reassurance can be provided through a variety of different models these include, but are not limited to:

- Non-Volunteer Model
- Volunteer Model
- Fee-for-Service

The AAA must identify and describe implementation of its model in its Area Plan.

320.5 Eligibility and Recruitment

Eligibility for Telephone Reassurance is based on the fund source that each AAA or provider agency is using. For those programs funded through a caregiver fund source, requirements outlined for caregiver services must be met.

If funded by the Older American's Act, eligibility for services is limited to the following:

1. any person, age 60 or over and
2. any person, regardless of age, who is identified as having Alzheimer's disease or a related disorder, and the families and caregivers of those persons.

If funding is not sufficient to serve all consumers requesting services, refer to MAN 5300, Section 118 for Client Prioritization.

AAAs can further determine eligibility for individuals, such as, but not limited to, giving greater preference to those individuals who are isolated, do not receive any services in the home, individuals who are homebound and/or have very little to no caregiver support.

AAAs may develop fee-for-service programs for persons who may not otherwise meet these eligibility requirements.

320.6 Service Outcomes

The outcome of this program is to:

- decrease isolation
- provide emotional support
- provide sense of assurance
- provide coping strategies for caregivers, when applicable
- ensure health and safety of the individual
- share resource information

These outcomes will be measured through evaluation and satisfaction surveys distributed by the program and completed by program participants on an annual basis. Surveys will also be completed by volunteers, in programs where a volunteer model is utilized.

320.7 Non-Volunteer Model

In the Non-Volunteer Model, paid staff members of the service provider or AAA provide telephone reassurance to clients.

320.8 Volunteer Model

Volunteers complete calls to clients. A staff member from the AAA or provider will be designated as the Program Coordinator. The Program Coordinator will create administrative forms, complete record keeping, and will be responsible for recruiting volunteers and program participants and provide oversight of the program. The AAA is encouraged to draft guidelines for a volunteer model.

Examples of specific program guides are included in Appendix 320-A and 320-B:

- Heart to Heart (River Valley AAA)
- A Time to Talk (Alzheimer's Association)

320.9 Volunteer Management

AAAs, at a minimum, must comply with all volunteer management procedures found in MAN 5600, 4020 Civil Rights.

Program volunteers can be recruited from the community as well as from HCBS waiting lists. For volunteers recruited from wait lists, the volunteer must have a low DON-R score, usually ten (10) or below. If the volunteer is operating from any location other than the provider's location, he/she must have a phone that is in service.

320.10 Volunteer Training

Volunteers shall receive an orientation and training and any additional training at intervals to be determined by AAA policy and in compliance with MAN 5600, 4020 Civil Rights. Orientation should include an introduction to HIPAA privacy standards, safety precautions, and standards of conduct required of employees, interns, and volunteers.

The training shall include but is not limited to:

- Goals of the program
- Volunteer Expectations
- Confidentiality
- Conducting phone calls
- Resource information
- Documentation
- Reporting methods
- Telephone etiquette
- Emergency procedures

320.11 Fee-For-Service Model

Each AAA/provider is encouraged to offer telephone reassurance as a fee-for-service enterprise to enhance the sustainability of the Aging network. In doing so, the AAA must follow all requirements of the Older Americans Act and MAN 5600 3090 Fee for Service System Overview.

Services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

320.12 Continuation and Discharge

The provider agency will discontinue services:

1. Upon the death of the client, entry of the client into a personal care or nursing home, or when there is no longer a need for the service.
2. When the client or caregiver is non-compliant through persistent actions of the client or family which negates the services provided by the agency, but only after all attempts to counsel with the client/family have failed to produce a change in behavior leading to compliance.
3. When the provider agency resources are no longer adequate to provide telephone reassurance, including providing oversight and management.
4. Upon the request of the client or caregiver, if acting as the authorized representative of the client.

Discharge must be conducted in compliance with MAN 5300, Section 202.20.

320.13 Administrative Requirements

The providers must establish and implement written policies and procedures that define the scope of telephone reassurance services it offers and the type of clients it serves.

Provider agencies must maintain accurate administrative, fiscal, personnel, and client case records that will be accessible and available to authorized representatives of the AAA, DAS, the Department of Human Services, and others, as required by law and in compliance with MAN 5600.

Providers will also practice effective fiscal planning and management, financial and administrative reporting, and complying with generally accepted accounting principles as described in MAN 5600, Section 3025 and 3050.

320.14 Record Keeping

Providers must maintain separate files containing all written or electronic records pertaining to the services provided for each client served including report logs of when telephone reassurance was provided in the data system approved by DAS.

320.15 Mandatory Reporting

All staff will be familiar with and be able to recognize situations of possible abuse, neglect, or exploitation or likelihood of serious physical harm to persons receiving services. Providers must develop procedures for reporting suspected abuse, neglect, or exploitation.

Suspected cases of abuse, neglect and/or exploitation of community-dwelling older adults or adults over the age 18 with a disability, are to be referred to the Division's Adult Protective Services Centralized Intake during the business hours of 7am to 7pm and a voicemail may be left after hours (1-866-552-4464). Alternatively, a fax referral form and instructions as well as a web reporting form are available on DAS's web page.

Any situations in which abuse of minor child/children is suspected are to be reported to the Division of Family and Children Services (DFCS) at 1-855-GACHILD.

320.16 Quality Assurance

Providers of telephone reassurance must develop and implement an annual plan to evaluate and

improve the effectiveness of the program to ensure continuous improvement in service delivery. The provider will include any direct workers, volunteers, and/or supervisory staff in the evaluation process and development of improvement goals.

The process must include, but not be limited to:

1. A review of the existing program's operations
2. Satisfaction survey results from participants and job satisfaction survey results from staff and/or volunteers
3. Program modifications made that responded to changing needs of participants and staff and/or volunteers
4. Proposed program improvements

320.17 Compliance Monitoring

The AAA must conduct at least one annual on-site fiscal and program monitoring of provider agencies, if one is used. The AAA must conduct desk reviews of fiscal and programmatic performance and monitor for compliance with any requirements. The AAA must provide formal, written feedback of program status and any required corrective action as well as any technical assistance necessary for continuous quality improvement, at least quarterly, or more often as indicated, and at year-end in compliance with MAN 5300, Section 202.18.

Information and guidelines for monitoring and evaluation of service providers can be found in MAN 5600, 3009 Area Agency on Aging Monitoring and Evaluation of Service Providers.

320.18 References

A Time To Talk Program Guide (Alzheimer's Association)

Heart to Heart, A Telephone Reassurance Program Guide (River Valley AAA)

DAS Manual 5300, Section 118

DAS Manual 5300, Section 202

DAS Manual 5600, Section 2025

DAS Manual 5600, Section 3015

DAS Manual 5600, Section 3035

DAS Manual 5600, Section 3050

DAS Manual 5600, Section 4020

Appendix 320-A Heart to Heart Program Guide

River Valley Regional Commission Area Agency on Aging
Heart to Heart (H2H)
(A Telephone Reassurance Formula)

Implementing a Telephone Reassurance Program in Your Area Agency on Aging

Submitted By

Linda Harris
Telephone Reassurance Program Coordinator
River Valley AAA

Purpose of Manual

The purpose of this manual is to establish guidelines and requirements for the River Valley Area Agency's Telephone Reassurance Program, hereinafter to be referred to as Heart to Heart. This manual may also serve as a guide to the twelve Georgia Area Agencies on Aging in implementing a telephone support program.

Program Inception

Heart to Heart is a telephone reassurance program developed by the River Valley Area Agency on Aging in 2010. It was launched as an outreach program to support at-risk seniors over 60, persons with disabilities, who typically live alone, are homebound, and/or have little or no caregiver support. Caregivers and clients who have been diagnosed with Dementia are also targeted. Clients benefit from this program through one on one communication with another caring individual. Brief phone calls are made Monday – Friday, not only addressing physical needs, but emotional needs as well. This is vital because social isolation is huge among our senior population. Other benefits include sharing of information, promoting safety, and providing a sense of assurance to our clients.

In order to give our more functional and independent seniors a sense of being needed, we have included them as part of our volunteer program. In order to retain and reduce the commitment time of volunteers, volunteer / recipient ratio is usually 1:3. This varies depending on the availability and commitment of volunteers. The program was piloted in Muscogee County, and is now active in 8 counties. Currently there are 65 participants with plans to add 15 participants during FY 2015. Both volunteers and recipients report being satisfied with the program. It is our goal to be able to increase the number of volunteer support in the communities, thereby enabling us to reach more seniors. During FY2015, River Valley Area Agency has plans to expand the program into 2 additional rural counties.

Goals of the Program

- Promote safety for HCBS clients by identifying emergency situations and providing a telephone security check for frail and vulnerable clients.
- Decrease social isolation and loneliness by providing telephone contact with trained peer support volunteers.
- Share resource information with HCBS clients by providing peer support volunteers with resource manuals.
- Provide sense of well-being by monitoring clients through peer support telephone calls.

Implementation

A staff member will be designated as the Program Coordinator. The Program Coordinator, along with any other designated staff available, will create administrative forms, record keeping procedures, and will be responsible for recruiting volunteers and participants. This staff member must be familiar with client waiting lists and interpretation of DON-R scores. The Program Coordinator is responsible for monitoring all aspects of the program

Volunteer Recruitment

The Program Coordinator is responsible for recruiting volunteers. Because volunteers are recruited primarily from the HCBS waiting lists, it is important that the Program Coordinator be familiar with client records. Volunteers are primarily clients who are more functional and have low DON-R scores, usually 10 and below. In some instances, clients with higher DON can be utilized. Volunteers must have a phone that is in service. Logistics are important (area codes/long distance). When recruiting volunteers, pay close attention to how they converse on the telephone. Since volunteers are the heartbeat of the program, establishing a rapport with volunteers is of the utmost importance. When recruiting volunteers, be sure to consider persons with disabilities.

Volunteer Training

All volunteers receive a volunteer packet which includes a letter thanking them for their willingness to call participants, calling instructions, and a profile of the participants. All volunteers must be willing to sign a statement of confidentiality as well as a participation agreement. A copy of the AAA privacy notice and a copy of the Telephone Reassurance Privacy Rules must be given. It is important that volunteers understand that they are functioning as such and that their participation does not, nor will it ever interfere with their status as an AAA client. Volunteers must understand, and it must be stated in the participation agreement, that there is no compensation— monetary or otherwise, for program participation. Volunteers do not have physical contact with participants.

Volunteers are trained in the following areas:

- Goals of Program
- Volunteer Role/Expectations
- Confidentiality
- Conducting Phone Calls
- Peer Support Questions

- Resource Information
- Boundaries
- Documentation - Client records and reporting forms
- Reporting Methods
- Telephone Etiquette
- Emergency Procedures
- Client Profiles

Volunteer Retainment

Dedicated volunteers are an integral component of a telephone reassurance program. Compassion and consistency are vital in order to establish trust and provide peer support. In order to retain volunteers, it is important that the Program Coordinator frequently contact volunteers to express appreciation. Let them know that they are the heartbeat of the program. The Program Coordinator should make every effort to let volunteers know that their well-being is important, not just because they are volunteers, but because they are AAA clients. Volunteers decide the number of participants on their list. Keep your volunteer stocked with supplies at all times.

Conducting the Call

Prior to volunteers placing calls, the Program Coordinator will call the participant and give the name of the volunteer that will be calling them. At least 2 calls per month will be made. Volunteer will follow instructions given in training. Peer support questions are asked. At end of call, the volunteer documents on the contact sheet. Volunteers will only call the participants that are assigned to them. Volunteers must abide by privacy rules and procedures during all calls.

Resource Information

The Program Coordinator will provide volunteers with Resource Information from database and other relevant sources.

Participant Recruitment

Participants are recruited from the HCBS waiting list. Participants are clients who have high DONRs, who have little or no caregiver support, who are caregivers, and who are diagnosed with Dementia.

Emergency Procedures

In the case of an actual emergency that requires immediate assistance, the volunteer will call 911. Program coordinator and/or Gateway will be notified. Caregiver and/or emergency contact person will be notified also.

Reporting / Record Keeping

Volunteers mail report logs to Program Coordinator by the 6th day of the following month. Report logs are mailed using the SASE provided to the volunteers. All Heart to Heart files are kept under lock in Program Coordinator’s office. Monthly calls are filed electronically.

Program Evaluation

The Program Coordinator will conduct surveys every six months by telephone.

Disenrollment

- Death of participant - at which time we will determine if caregiver would like to be called for a limited time
- Termination by request - client requests to be removed from program.
- Inactive List - participants may be temporarily unavailable.
- Inappropriate Contact - behavior outside the scope of the AAA privacy rules and/or the Heart to Heart guidelines.

Discharge Evaluation

The Program Coordinator documents reasons for discharge. Program Coordinator will notify participant when there is a request for discharge. The information obtained may be used to improve program.

Heart to Heart Telephone Reassurance Program Phone Survey

1. Why did you agree to become a participant in the Heart to Heart Program?
2. Do you know the name of the person who calls you?
3. Do you think that your volunteer is a good match for you?
4. Do you feel safer knowing that you will receive a phone call?
5. Does your volunteer call you at least 2 times per each month?
6. Do you live alone?
7. What do you like least about the program?
8. What do you like best about the program?
9. Would you recommend the program to others?
10. Do you have any comments or suggestions?

For any questions or additional information regarding this manual contact:

Linda Harris, River Valley Area Agency on Aging
1-800 (615)-4379
706-256-2939
lharris@rivervalleyrcaaa.org

Appendix 320-B How to Implement a Telephone Support Program for Persons with Early Stage Dementia and Caregivers

Alzheimer's Association, Georgia Chapter
Telephone Reassurance Program

This manual developed with funding provided by the Department of Human Services through the Division of Aging Services

DHS Contract #42700-373-0000011168

Prepared by:
Camille Noell
Helpline Support Manager
Alzheimer's Association, Georgia Chapter

Program Background

How the Program Originated

In June of 2011, a work team meeting was held at Callaway Gardens. Representatives from the twelve Area Agencies on Aging, Adult Protective Services, Medicaid waiver programs, the Alzheimer's Association, and the Georgia Division of Aging Services were present. Discussions were held on how to better serve persons with early stage dementia and their caregivers. Many representatives expressed that long waiting lists hindered the ability for individuals to obtain services. The Director of the River Valley AAA reported implementing telephone support for individuals on their waiting list. They used people with low DON-R scores on the waiting list to serve as volunteers in making support calls to others. From this came the idea of implementing a peer telephone support program for caregivers and persons with early stage dementia, which would utilize volunteers to place calls to participants.

Purpose of this Manual

The purpose of this manual is to meet one of the requirements of the grant in composing a how to manual for others to have the ability to duplicate the program. It will serve as a guide to the twelve Area Agencies on Agency in implementing a telephone support program.

Contact information about the Manual

For additional information on this manual, please contact Camille Noell, Helpline Support Manager, at the Alzheimer's Association via e-mail cnoell@alz.org or by phone at (404)728-1181.

Telephone Reassurance Program

About Telephone Reassurance

Telephone Reassurance is a one on one peer telephone support program. Persons with early memory loss provide telephone calls to persons with early stage dementia. Present or past caregivers provide telephone calls to current caregivers. Callers and participants connect through similar situations and experiences. Callers provide emotional support, share coping strategies, and offer a listening ear to participants.

Goals of the Program

There are three objectives for the program, which are as follows:

1. Increase support for persons with early stage dementia and caregivers of persons with dementia by developing and implementing a statewide financially viable and sustainable volunteer based telephone support system.
2. Increase access for persons with early stage dementia and caregivers to the telephone support system by developing and implementing a physician referral program.
3. Increase the availability of telephone support programs by offering training to the twelve Area Agencies on Aging in Georgia.

Implementation

Getting Started

In preparing for the program to begin, a Program Coordinator will need to be designated. It is important for the Program Coordinator to be qualified to recruit and manage volunteers, provide direction in difficult situations, maintain files, market program, and recruit participants. In managing early stage volunteers, the Program Coordinator will have to oversee phone calls more closely to ensure there are no inappropriate conversations or that no documentation is forgotten. The Program Coordinator should also watch for and assess the ability of the volunteer to continue making phone calls when there is a progression of the decline in the person's memory.

An appropriate area will need to be designated for volunteers to conduct phone calls. The area should be easily accessible to the Program Coordinator yet private enough for volunteers to talk freely without worrying about disrupting others or breeching confidentiality. The area should be equipped with a phone, pen and paper for taking notes, a desk for writing, and a chair. The area should also have any important reminders posted to assist the volunteer in remembering what he/she needs to do. You may also want to consider other optional things such as providing candies and/or water which will make the area more welcoming and comfortable for the volunteer.

Recruiting Volunteers

The Program Coordinator for the program should explore several different avenues for recruiting appropriate volunteers. Potential volunteers could be recruited from agency callers, support groups, programs for persons with early stage dementia, volunteer websites, physician's offices, case management programs, and in-home providers. The Alzheimer's Association has been most successful in recruiting volunteers from its early stage programs and posting the opportunity on volunteermatch.org. The Program Coordinator will need to contact potential volunteers who are

interested in assisting to discuss the program, answer any question, and assess the ability of the volunteer. To be eligible to volunteer, early stage dementia volunteers must be diagnosed with Early Stage Dementia or have self-reported memory loss. Caregivers must have past or present experience caring for a person with dementia. The potential volunteer must also be willing to submit to a background check, attend a training session prior to starting, and agree to the terms of the confidentiality policy. It would also be beneficial if the volunteer resides close to the office as the volunteer will need to be able to travel to the office to conduct phone calls.

Volunteer Training

Prior to placing phone calls, all volunteers should sign a confidentiality agreement, submit to a background check, and attend a training session. Volunteers are not expected to have direct contact with participants. If direct care becomes necessary at some point, then a volunteer should also submit to a fingerprint record check prior to providing direct care.

During the training session, volunteers should be provided with a training manual for reference and trained in the following areas:

Overview of resources available
Goal of the program
Expectations and roll of the volunteer
Conducting Phone Calls
Boundaries – when to advise a participant and when to make a referral
Documentation – how to fill out contact and critical incident forms
Keeping information confidential
Telephone Etiquette
Emergency Procedures

Retaining Volunteers

Regular volunteers are important to participants in establishing relationships and trust in the volunteer. It also important to the Program Coordinator whereas recruiting and training new volunteers is costly and time consuming. There are several ways to ensure the commitment of volunteers. Ultimately, volunteers want to feel welcome and valued. So, the volunteer area should be inviting and close to the Program Coordinator for easy access to support if needed. The Alzheimer's Association has set up two cubicles adjacent to the Program Coordinator. In addition to easy access to the Program Coordinator, volunteers have access to drinks and candy to make them feel more at home. Regular communication and recognition from the Program Coordinator will make the volunteers feel valued. The Alzheimer's Association provides regular volunteer appreciation quarterly with a personalized thank you note and a small gift.

Recruiting Participants

The Program Coordinator should explore many different options for recruiting participants. Potential participants could be recruited from agency callers, support groups, programs for persons with early stage dementia, physician's offices, case management programs, and in-home providers. The participants must either be a current caregiver for a person with dementia or diagnosed with early stage dementia. Most referrals to the Alzheimer's Association program come from Helpline calls. The Program Coordinator is responsible for contacting potential participants to discuss the pro-

gram and answer any questions. Once a participant has decided to enroll, the Program Coordinator will assign a volunteer to the participant for twice a month telephone calls

Enrolling / Disenrolling Participants

New participants will be referred to the Program Coordinator for enrollment. The Program Coordinator will complete a participant information sheet and set up a new file. The information sheet will include a participant's name, DOB, address, phone numbers, e-mail address, emergency contact, referral source, and best times to call. New participants will be assigned to a volunteer and placed on a volunteer's master call list. The Program Coordinator will also send the new participant a welcome letter containing contact information for the program and information on the evaluation process.

Participants who request to be disenrolled from the program will also be referred to the Program Coordinator who will remove the participant from a volunteer's master call list. The Program Coordinator will document the date of disenrollment and reason on the participant information sheet. The Program Coordinator may make changes to improve the quality of the program based on the response of the former participant.

Participants who are unable to be reached and do not respond to messages can also be discharged. If a participant is unable to be reached for two consecutive months, then a letter should be sent to the participant by the Program Coordinator. The letter should request the participant contact the Program Coordinator to continue in the program. Upon sending the letter, the Program Coordinator should give ample time for the participant to respond. If there is no response after two weeks, then the Program Coordinator should disenroll the participant.

Conducting Phone Calls

The Program Coordinator should maintain a consistent call schedule for each volunteer to ensure adequate volunteer space and expected call times for the participants. Volunteers with early memory loss and caregivers will report to the office to conduct phone calls. Upon arriving to the office, volunteers will check in with the Program Coordinator and obtain their master list of participants to be called. Each volunteer will have their own list in order to limit access to other participant information. The volunteer will pull the files of each participant to be called. The file will contain the participant information sheet. The file will also contain past contact reporting forms and incident reports for the volunteer's review.

Volunteers will contact a participant two times per month to provide support and coping strategies. A volunteer with early memory loss will call up to three participants with early stage dementia. A caregiver volunteer will call up to five participants. Whenever possible, the same volunteer will contact the same participant. If the participant needs further assistance, then a volunteer will refer the participant to the appropriate program. If the volunteer is unsure where to refer the participant to, then the volunteer will consult with the Program Coordinator.

At the completion of each phone call, the volunteer will complete a contact reporting form. When a volunteer is made aware of a critical incident, then he/she will also complete a critical incident report with the assistance of the Program Coordinator. The volunteer and program coordinator will come up with a plan for preventing or responding to the incident. Forms will be filed in the participant's record by the volunteer.

Upon completing all phone calls, volunteers will replace the participant files in the filing cabinet. The files will be maintained in alphabetical order and reviewed monthly by the Program Coordinator.

Emergency Procedure

In case of a reported emergency, a volunteer will call 911 to ensure a participant receives the required assistance. An emergency is any situation that requires immediate assistance from medical, police, or fire services. The volunteer will notify the Program Coordinator and complete a critical incident report. The volunteer will also follow up with the participant on the next scheduled telephone call to see if further assistance is needed.

Record Keeping

Each participant will have an individual file to limit access of other participant information. Files will be kept in a locked cabinet next to the Program Coordinator's office area. Filing drawers will be labeled either "active" or "inactive". Active drawers will contain all of the current participant files. Inactive drawers will contain all of the former participant files. All files will be kept in alphabetical order. Files will be kept for 6 years following disenrollment. All information to be discarded will be shredded.

Program Evaluation

Follow Up Interviews

Program participants will be called for an interview after they have been enrolled in the program for six months. Interview questions have been constructed through 1) a review of the St. Louis program that served as a model for the Georgia program, 2) a review of the Georgia program operational protocol, program description, flyer, and 3) an interview with the Telephone Reassurance program manager that focused on the goals, objectives, and evaluation questions. The interview guides have been reviewed by Alzheimer's Association (AA) program staff and Division of Aging staff. The interview is optional to the participant.

Discharge Evaluation

The Program Coordinator will discuss with the participant why he/she wants to disenroll. The Program Coordinator will document the date of disenrollment and reason on the participant information sheet. The Program Coordinator may make changes to improve the quality of the program based on the response of the former participant.

A Time to Talk Follow-Up Interview

ID:_____
Date:_____
Interviewer:_____

We are going to ask you some questions regarding your experience with A Time to Talk over the last six months. (*Some or all of the following questions may be asked*)

1. Please tell me what interested you in the Time to Talk program.

2. Was the program what you expected? If so, how? If not, could you help me understand why it was different than what you expected it to be?
3. Can you tell me a bit about the person who called you?
4. Do you think the volunteer was a good match for you? Why or why not?
5. Was he/she reliable?
6. Did your call partner give you ideas for how to cope with any issue(s) or challenges you were having?
7. Did you have questions that he/she couldn't answer?
8. Did you talk about things that you haven't talked about with other family or friends? If yes, would you feel comfortable telling me what kinds of things?
9. Are there things that you would like to talk about, but felt that you couldn't as part of this program? If yes, would you feel comfortable telling me what kinds of things?
10. What did you like best about the program?
11. Are there things about the program that you think could be better?
12. Would you recommend this program to others?
13. Can you describe your living situation?
14. Has this program changed how you feel about your current living situation? How about for your plans for living arrangements in the future?
15. How did you find out about this program? Are you participating in other programs or receiving services from another program? (probe for importance of telephone/stay at home program)

322 Friendly Visiting

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	10/27/2021
	Section Title:	Friendly Visiting	**Reviewed or Updated in:**	MT 2016-05
	Section Number:	322	**Previous Update:**	MT 2016-05

322.1 Summary Statement

This chapter establishes the policies, guidelines, and standards for Area Agencies on Aging (AAA) that directly provide or contract for the delivery of Friendly Visiting to older adults and adults with disabilities.

322.2 Scope

These requirements apply to Friendly Visiting services funded in whole or in part with non-Medicaid federal and state funds, managed by the AAA, and any associated matching funds. These requirements may act as guidelines for a volunteer-based or fee-for-service model.

322.3 Definitions

Friendly Visiting

visiting an individual in their place of residence on a regular or specified basis to reduce social isolation and feelings of loneliness. The visits must be social in nature. Best practices suggest that visits occur once a week for an hour or two to establish meaningful relationships between the Friendly Visitor and the client.

Friendly Visitor

a screened and trained person who engages in meaningful activities with an individual who is socially isolated.

322.4 Eligibility

When determining eligibility criteria for enrollment of clients into services, the criteria established by each fund source must be followed. Program participants, at a minimum, must meet eligibility criteria found in MAN 5300 CH 208.4.

If funding is not sufficient or not enough staff or volunteers are available to serve all consumers requesting services, refer to MAN 5300 CH 118 for Client Prioritization.

AAAs may develop fee-for-service programs for persons who may not otherwise meet eligibility requirements.

AAAs can further determine eligibility for individuals, such as, but not limited to, giving greater preference to those individuals who are isolated, do not receive any services in the home, individuals who are homebound and/or have very little to no caregiver support.

322.5 Access to Services

AAAs may receive requests for services from a variety of sources. The AAA will screen all applicants for service. Subject to the availability of services, the AAA will initiate service delivery or refer appropriate applicants to provider organizations or other resources; or place them on a waiting list for services. For information regarding screening through ADRC Gateway, refer to MAN 5200 CH 5024.

Not every applicant will request, require, or benefit from Friendly Visiting services. Each AAA will clearly identify in their Area Plan the coordination of services and the allocation and management of resources to optimize the effectiveness and efficiency of Friendly Visiting services.

322.6 Service Activities

Friendly Visitors are encouraged to be creative with activities during visits that share mutual interest among themselves and clients. Service activities include, but not limited to:

- Companionship
- Letter writing
- Reading
- Playing cards or board games

- Creating art
- Discussing current events or shared interests

322.7 Prohibited Service Activities

Friendly Visitors will not provide personal care or homemaker services unless:

- They are trained to provide such services;
- The employing agency is licensed to provide such services if required; and

The AAA is contracting with the employing agency for the provision of both friendly visiting and homemaker/personal care services, and the individual is enrolled to receive personal care/homemaker services.

322.8 Outcomes and Indicators

Friendly visits must be scheduled on a regular or specified basis to reduce social isolation and feelings of loneliness.

The outcomes of this program are to:

- Decrease social isolation
- Decrease feelings of loneliness

These outcomes will be measured through program evaluation and satisfaction surveys (see Appendix A) distributed by the program and completed by program participants on a semi-annual basis.

322.9 Delivery Types

The AAA operates the Friendly Visiting program directly or subcontracts with a service provider for program service delivery.

Friendly Visiting can be provided through a variety of different models including, but not limited to:

- Non-Volunteer Model
- Volunteer Model
- Fee-for-Service Model

The AAA must identify and describe the implementation of its model in its Area Plan.

322.10 Non-Volunteer Model

In the Non-Volunteer Model, paid staff members of the service provider or AAA provide friendly visits to clients.

322.11 Volunteer Model

Volunteers visit with clients. A staff member from the AAA or provider will be designated as the

Program Coordinator. The Program Coordinator will create administrative forms, complete record keeping, be responsible for recruiting volunteers and program participants, and provide oversight of the program.

322.12 Volunteer Management

AAAs or providers, at a minimum, must comply with all volunteer management procedures found in MAN 5600 4020 Civil Rights.

322.13 Volunteer Training

Volunteers must receive orientation and training and any additional training at intervals to be determined by AAA policy and in compliance with MAN 5600 4020 Civil Rights.

The training must include but is not limited to:

- Goals of the program
- Volunteer Expectations
- Confidentiality
- Resource information about community-based services
- Documentation
- Reporting methods
- Emergency procedures

322.14 Fee-For-Service Model

Each AAA/provider is encouraged to offer friendly visiting as a fee-for-service enterprise to enhance the sustainability of the Aging network. In doing so, the AAA/provider must follow all requirements of the Older Americans Act and MAN 5600 3090 Fee for Service System Overview.

Services provided to consumers as a fee-for-service must not differ in quality from services provided to consumers funded through public funds.

322.15 Discharge

The provider agency will discontinue services:

- Upon the death of the client, entry of the client into a personal care or nursing home, or when there is no longer a need for the service
- When the client is non-compliant through persistent actions of the client which negate the services provided by the agency, but only after all attempts to counsel with the client have failed to produce a change in behavior leading to compliance
- When the provider agency resources are no longer adequate to provide Friendly Visiting, including providing oversight and management
- Upon the request of the client

Discharge must be conducted in compliance with MAN 5300 CH 202.20.

322.16 Administrative Requirements

The providers must establish and implement written policies and procedures that define the scope of Friendly Visiting services it offers and the type of clients it serves.

Provider agencies must maintain accurate administrative, fiscal, personnel, and client case records that will be accessible and available to authorized representatives of the AAA, DAS, the Department of Human Services, and others, as required by law and in compliance with MAN 5600.

Providers will also practice effective fiscal planning and management, financial and administrative reporting, and comply with generally accepted accounting principles as described in MAN 5600 3022 Financial Management and MAN 5600 7001 Compliance with Contractor Responsibilities and Sanctions.

322.17 Record Keeping

Providers must maintain separate files containing all written or electronic records pertaining to the services provided for each client served including report logs of when Friendly Visiting was provided in the data system approved by DAS.

322.18 Mandatory Reporting

All staff will be familiar with and be able to recognize situations of possible abuse, neglect, or exploitation or likelihood of serious physical harm to persons receiving services. Providers must develop procedures for reporting suspected abuse, neglect, or exploitation.

Suspected cases of abuse, neglect and/or exploitation of community-dwelling older adults or adults over the age 18 with a disability, are to be referred to the Division's Adult Protective Services Centralized Intake during the business hours of 7am to 7pm and a voicemail may be left after hours (1-866-552-4464). Alternatively, a fax referral form and instructions, as well as a web reporting form, are available on DAS's web page.

Any situations in which abuse of minor child/children is suspected are to be reported to the Division of Family and Children Services (DFCS) at 1-855-GACHILD.

322.19 Quality Assurance

Providers of Friendly Visiting must develop and implement an annual plan to evaluate and improve the effectiveness of the program to ensure continuous improvement in service delivery. The provider will include any direct workers, volunteers, and/or supervisory staff in the evaluation process and development of improvement goals.

The process must include, but not be limited to:

- A review of the existing program's operations
- Satisfaction survey results from participants and job satisfaction survey results from staff and/or volunteers
- Program modifications made that responded to changing needs of participants and staff and/or volunteers

- Proposed program improvements

322.20 Compliance Monitoring

The AAA must conduct at least one annual on-site fiscal and program monitoring of provider agencies if one is used. The AAA must conduct desk reviews of fiscal and programmatic performance and monitor for compliance with any requirements. The AAA must provide formal, written feedback on program status and any required corrective action as well as any technical assistance necessary for continuous quality improvement, at least quarterly, or more often as indicated, and at year-end in compliance with MAN 5300 CH 202.18.

Information and guidelines for monitoring and evaluation of service providers can be found in MAN 5600 3009 Area Agency on Aging Monitoring and Evaluation of Service Providers.

References

DAS Manual 5200 CH 5024

DAS Manual 5300 CH 118

DAS Manual 5300 CH 202

DAS Manual 5300 CH 208

DAS Manual 5600 CH 2025

DAS Manual 5600 CH 3015

DAS Manual 5600 CH 3025

DAS Manual 5600 CH 4020

Appendix 322-A A Friendly Visiting Program Survey

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	10/27/2021
	Section Title:	A Friendly Visiting Program Survey	**Reviewed or Updated in:**	MT 2016-05
	Section Number:	Appendix 322-A	**Previous Update:**	MT 2016-05

Friendly Visiting Program Satisfaction Survey

Thank you for taking the time to complete this survey. We would like to know how the Friendly Visitor who has been visiting you has affected your life. All information will be kept confidential; please do not disclose your name. You may choose not to answer questions.

Please rate how strongly you agree or disagree with each of the following statements by placing an X in the appropriate box.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Because I have a Friendly Visitor visiting me, I feel like someone cares how I'm doing.	▢	▢	▢	▢	▢
2. Because I have a Friendly Visitor visiting me, I feel less lonely.	▢	▢	▢	▢	▢
3. Because I have a Friendly Visitor visiting me, I feel I have close ties to more people.	▢	▢	▢	▢	▢
4. I feel safer knowing someone will check on me.	▢	▢	▢	▢	▢
5. I look forward to the visits.	▢	▢	▢	▢	▢
6. Overall, I am satisfied with my Friendly Visitor.	▢	▢	▢	▢	▢
7. Overall, this Friendly Visiting program has met my expectations	▢	▢	▢	▢	▢

Think about the Friendly Visiting service that you receive. Please tell us how satisfied you are with the following statements by placing an X in the appropriate box.

	Not Satisfied	Satisfied	Very Satisfied
8. With the time visits are made.	▢	▢	▢
9. That visits are made as scheduled.	▢	▢	▢
10. That the service is meeting your needs?	▢	▢	▢

Please offer any suggestions and/or comments:

324 Assistive Technology Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	03/01/2023
	Section Title:	Assistive Technology Services	**Reviewed or Updated in:**	MT 2023-03
	Section Number:	324	**Previous Update:**	N/A

324.1 Purpose

This chapter establishes the requirements for assistive technology services to individuals in their place of residence funded in whole or in part with non-Medicaid federal and state funds managed by the Area Agency on Aging (AAA), and any associated matching funds. These requirements may act as guidelines for a fee-for-service model.

Under the Assistive Technology Act of 1998 (ATA), the Governor of a state shall designate a public agency as a lead agency for implementing assistive technology services. Georgia's public agency is Tools for Life (TFL), a program of the Georgia Institute of Technology, College of Design, Center for Inclusive Design, and Innovation (formerly AMAC Accessibility).

According to the Assistive Technology Act (ATA), the purpose of an assistive technology (AT) program is:

1. Support State efforts to improve the provision of assistive technology to individuals with disabilities through comprehensive statewide programs of technology-related assistance, for individuals with disabilities of all ages, that are designed to—
    A. increase the availability of, funding for, access to, provision of, and training about assistive technology devices and assistive technology services
    B. increase the ability of individuals with disabilities of all ages to secure and maintain possession of assistive technology devices as such individuals make the transition between services offered by educational or human service agencies or between settings of daily living (for example, between home and work)
    C. increase the capacity of public agencies and private entities to provide and pay for assistive technology devices and assistive technology services on a statewide basis for individuals with disabilities of all ages
    D. increase the involvement of individuals with disabilities and, if appropriate, their family members, guardians, advocates, and authorized representatives, in decisions related to the provision of assistive technology devices and assistive technology services
    E. increase and promote coordination among State agencies, between State and local agencies, among local agencies, and between State and local agencies and private entities (such as managed care providers), that are involved or are eligible to be involved in carrying out activities under this Act
    F. increase the awareness and facilitate the change of laws, regulations, policies, practices, procedures, and organizational structures, that facilitate the availability or provision of assistive technology devices and assistive technology services
    G. increase awareness and knowledge of the benefits of assistive technology devices and assistive technology services among targeted individuals and entities and the general population
2. Provide States with financial assistance that supports programs designed to maximize the ability of individuals with disabilities and their family members, guardians, advocates, and authorized representatives to obtain assistive technology devices and assistive technology services.

324.2A Scope

AAAs should provide assistive technology services to secure and maintain maximum independence and dignity in a home environment for older individuals and persons with disabilities who are capable of self-care with appropriate supportive services.

The Division of Aging Services (DAS) is **not** the State's lead agency; however, DAS supports the Assistive Technology Act by providing the following services:

a. **Assessment/Evaluation** - includes identifying levels of impairment and/or unmet need and the individual's capacity to effectively use assistive devices
b. **Service/Device Acquisition** - includes the purchasing, leasing, or acquisition of refurbished assistive technology devices
    - Acquisition of devices can be done through device reutilization program and/or and device

loan program

- Selecting, designing, fitting, customizing, adapting, applying, maintaining, or donating (device reutilization program) assistive technology devices. Includes trial use and short-term loans of assistive technology. “Try before you buy” (device loan program)
- Coordinating and using necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with education and rehabilitation plans and programs
- DAS discourages bulk purchases of assistive technology items.

c. **Education** - includes training to ensure the appropriate application and use of assistive devices, education about home safety or accessing the service delivery network, and education about progression of health conditions that may impact future needs for assistive devices
   - Training or technical assistance for an individual with a disability or, where appropriate, the family members, guardians, advocates, or authorized representatives of such an individual
   - Training or technical assistance for professionals (including individuals providing education and rehabilitation services and entities that manufacture or sell assistive technology devices), employers, providers of employment and training services, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life function of individuals with disabilities

d. **Advocacy** – includes expanding the availability of access to technology, including electronics and information technology, to individuals with disabilities

e. **Reassessment** – includes follow-up with individuals (or their caregivers) to determine the extent to which assistive technology is adequately meeting their needs, and to adjust services as indicated

f. **Discharge** – includes documentation that services are meeting the needs of the individual/family and that the client has information about how to access additional services at a later date

DAS encourages AAAs to follow these ATA service definitions in establishing the scope of their assistive technology program. AAA may contract, partner, and/or establish referral mechanisms with qualified individuals or agencies to fulfill specific service activities.

324.2B Core Principles

The ATA identifies core principles that AAAs should follow in administering AT services and in serving older adults and persons with disabilities.

In serving clients AAAs should demonstrate:

- Respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice
- Respect for the privacy, rights, and equal access (including the use of accessible formats)
- Inclusion, integration, and full participation of such individuals in society
- Support for the involvement in decisions of a family member, a guardian, and advocate, or an authorized representative, if an individual with a disability request, desires, or needs such

involvement

In administering AT services, AAAs should:

- Ensure that program/services are easily accessible to, and usable by, individuals with disabilities and, when appropriate, their family members, guardians, advocates, or authorized representatives
- Respond to the needs of individuals with disabilities in a timely and appropriate manner
- Facilitate the full and meaningful participation of individuals with disabilities (including individuals from underrepresented populations and rural populations) and their family members, guardians, advocates, and authorized representatives in:
  - Decisions relating to the provisions of assistive technology devices and assistive technology services
  - Decisions related to the maintenance, improvement, and evaluation of the comprehensive statewide program of technology-related assistance, including decisions that affect capacity building and advocacy activities

DAS requires that assistive technology services be delivered in a person-centered manner. Program staff should approach individuals and families with empathy and an understanding of their life experiences and challenges by searching for and acting upon what is important to that individual, including their wants, needs, and values.

DAS strongly encourages collaboration between the AAAs and the Centers for Independent Living (CIL) to facilitate access to information, resources, and education about assistive technology.

324.3 Definitions

Assistive Technology Service

any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

Assistive Technology Device

any item, piece of equipment, including durable medical equipment or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of older adults and individuals with disabilities.

- AT can be low-tech: grab bars, magnifiers, lever handles, shower seats/benches
- AT can be high-tech: automated lights, hearing amplifiers, tablets, computers

Device Demonstration

Using personnel who are familiar with assistive technology devices, services and their applications, assist individuals in making informed choices regarding AT by providing experiences with the devices and services.

Device Loan Program

allows for trial use of devices for up to 45 days to assist in selecting the appropriate device/equipment.

Device Reutilization Programs

provide for the exchange, repair, recycling, or other reutilization of assistive technology devices, which may include redistribution through device sales, loans, rentals, or donations.

324.4 Target Group / Eligibility

Assistive technology services target persons who have a physical or mental disability or disorder that restricts his/her ability to perform basic activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs), or that threatens his/her capacity to live independently, and their caregivers. (See MAN 5300, CH 316 for additional priorities for caregiver services)

AAAs should follow additional criteria specific to fund sources. If funding is not sufficient to serve all eligible consumers requesting services, the Older Americans Act and Client Prioritization guidelines, found in MAN 5300, CH 118 provides for giving preference to specific persons:

- Persons in greatest economic need,
- Persons in greatest social need,
- Persons who are frail, and
- Persons who are at risk of institutionalization.
- Underrepresented population:
  - persons who are minorities,
  - persons with limited English proficiency
  - persons from rural areas

Individuals must have an impairment(s) and/or unmet need(s), as indicated by his/her DON- R score. AAAs should prioritize individuals who have impairment and/or unmet need in any of the domains with scores of 2 or greater.

AAAs will **not** provide assistive technology services in a nursing home, personal care home, or other setting where the provision of this service is included in the cost of care.

324.5 Conflict-Free Service Delivery

An efficient service delivery system is characterized by person-centered approaches and cost-effective outcomes for both consumers and the community. Therefore, DAS supports the implementation of a conflict-free service delivery system.

MAN 5300, 202 Program Guidelines and Requirements includes the key elements included in the design of such a system.

324.6 Service Activities

Assistive technology activities must be planned with input from the client, whenever possible, caregiver or a representative, based on an assessment of their needs and the degree of physical and/or cognitive impairment of the care receiver.

Assessment/evaluation fees is an allowable service activity in the provision of assistive technology

services.

An optimal assistive technology program requires staff who have specialized skills and competencies to provide the following core functions:

- Assessment/Evaluation
- Service/Device Acquisition
- Education
- Advocacy
- Reassessment
- Discharge

324.7 Access to Services

AAA staff shall screen individuals including identifying problems that he/she experiences in daily life and that he/she hopes are eliminated or diminished as a result by AT services.

AAA staff shall discuss with potential clients how AT can address their level of impairment, unmet need, or both. The AAA staff will initiate service delivery, refer clients to provider organizations or other resources (i.e.: Tools for Life), or place them on a waiting list for services. AAA staff shall assist in the selection, acquisition, and proper usage of identified assistive technology devices.

For information regarding screening through Aging & Disability Resource Connection, see MAN 5200, 5025 Service Availability and Access. The AAAs will maintain and manage waiting lists for the services, as necessary. See Manual 5200, 5038 Waiting List Management and Criteria for Admission to Services.

Not every applicant will request, require, or benefit from Assistive Technology services. Each AAA will clearly identify in its Area Plan how services will be coordinated and how resources will be allocated and managed to optimize the effectiveness and efficiency of Assistive Technology services.

324.8 Standards of Promptness

Refer to MAN 5300, 114 Guidelines for Client Assessment

324.9A Assessments

DAS requires that staff use the DON-R to determine an individual's need and potential benefit for assistive technology. Assistive technology may reduce an individual's level of impairment and/or their unmet need for care. The preferred method of assessment for assistive technology services is via home visit.

Staff should also assess the degree to which the individual can properly use assistive technology devices based on physical disability, cognitive impairment, or behavioral health condition. This may require referrals to experts in assessing an individual's ability to benefit from assistive technology (ex: occupational therapy, Tools for Life, etc.).

The AAA may provide device demonstrations to determine the degree to which individuals can use or may benefit from AT. AAAs are to follow their device loan program procedures and guidelines to assist individuals in proper usage of devices (or durable medical equipment) before purchasing devices.

Staff should follow up with each individual 60 days after receiving AT devices to determine whether assistive technology devices are being used properly, whether the devices are reducing level of impairment and/or reducing unmet need for care, and whether the assistive devices are impacting the individual's quality of life.

For assessments of caregivers and to use assistive technology to reduce caregiver burden, refer to MAN 5300, Chapter 316 – Caregiver Services.

324.9B Education and Advocacy

The ATA states that the term "capacity building and advocacy activities" mean efforts that:

A. result in laws, regulations, policies, practices, procedures, or organizational structures that promote consumer-responsive programs or entities; and
B. facilitate and increase access to, provisions of, and funding for, assistive technology devices and assistive technology services, in order to empower individuals with disabilities to achieve greater independence, productivity, and integration and inclusion within the community and the workforce."

To support these advocacy efforts, each AAA should include information about assistive technology in its outreach and community education, for example:

- Device demonstrations
- Assistive Technology labs (tours and demonstrations)
- AT information posted on the AAA website

At a minimum, each AAA must provide AT device demonstrations twice a year through community outreach events.

324.9C Client Safety and Well-Being

AAA staff should practice diligence to promote the safety and well-being of individuals to whom the AAA provides assistive technology, including:

- Proper installation or assembly of assistive device
- Documentation that the individual has the capacity and knowledge to use the assistive device safely
- Documentation that the individual and/or their support system has received training in the proper use of the assistive device

324.10 Service Outcomes

The primary goal of assistive technology services is to aid older adults, persons with disabilities,

and their caregivers to achieve maximum self-sufficiency and enhance their quality of life.

AAAs must choose at least one outcome measure for their AT program:

Outcome #1: Reduce caregiver burden by providing assistive technology

Indicators:

- Reduction in intention to place as measured by Section H on the Risk Assessment Tool
- Reduced level of caregiver burden as measured by the Bakas Caregiving Outcomes Scale

Outcome #2: Increase independence for individuals by providing assistive technology

Indicators:

- Reduction in Level of Impairment as measured by DON-R scores
- Reduction in Unmet Need for Care as measured by DON-R scores

Outcome #3: Increase opportunities for individuals to participate in meaningful activities providing assistive technology

Indicators:

- Reduction in Level of Impairment as measured by DON-R scores
- Reduction in Lubben Social Network Scale and/or reduction in UCLA-3 Loneliness scale

DAS does not require that a AAA achieve every outcome and/or indicator for the delivery of assistive technology services to be deemed effective.

324.11 Emergency Contact

The AAA should ensure that each client record contains emergency contact information (name and telephone number(s) at a minimum).

324.12 Service Termination and Discharge

It is the explicit intent of DAS to serve clients in greatest need and to maximize the efficiency and effectiveness of the Aging Network.

DAS anticipates that during the span of service delivery to a consumer, the consumer's needs, supports, and resources will change. Based upon the ongoing process of assessment and reassessment, the AAA may determine that the individual is receiving maximum benefit from assistive technology and initiate discharge according to DAS policy (see MAN 5300, 202 Program Guidelines and Requirements).

When a device such as walkers, canes, wheelchairs, or other durable medical equipment is no longer useful/needed, the AAAs are to follow their own procedures and guidelines to provide the individuals the option to return the item for another agency or individual to re-use (device can be recycled, reused).

Staff must include proper documentation in the DDS system that includes the reason for discharge and whether the device was collected, and/or re-utilized.

324.13 Client's Rights and Responsibilities

AAAs and provider agencies will assure that all consumers, or their caregivers, receive a written copy of their rights and responsibilities as program/service participants upon their admission to services. See MAN 5300 Appendix E for the suggested "Client's Rights and Responsibilities".

324.14 Client Complaint Procedures

AAAs will establish written client complaint procedures for use by each provider. Procedures should include the minimum requirements outlined in MAN 5300, 202 Program Guidelines and Requirements. In addition, the complaint procedures must include:

- A telephone number for the provider which the client can call for information, questions, or complaints about the services supplied by the provider and information regarding supervision by the agency of the services to be provided
- The telephone number of the state licensing authority for information and filing of complaints which have not been resolved satisfactorily at the local level, for those agencies providing services subject to state licensure, or the number of the AAA and DAS, if not subject to licensure.

324.15 Appeals and Grievances

AAAs will establish written appeals procedures for use by each provider and are consistent with MAN 5300, 110 Grievance Procedures for Individuals in Non-Medicaid HCBS Programs.

324.16 Staffing and Training Requirements

General staffing information is described in MAN 5300, 202 Program Guidelines and Requirements.

Staff providing assistive technology services must view the following 3 introductory training videos (link provided below):

gatfl.gatech.edu/New Staff Training Videos

- Basic AT for Activities of Daily Living
- Treasure Chest: How to Find Treasures in Funding for AT Purchases
- Connections for Older Adults: How to Access Digital Services for Individuals

Staff must conduct a site visit with an existing assistive technology program within the first 3 months of employment.

Additionally, it is recommended but not required staff should view the Sharpening Your Skills: Exploring Assistive Technology Toolkits PowerPoint presentation found on the Tools for Life website, under the TFL WIKI tab.

324.17 Criminal Records Investigations

AAAs must assure that providers employing persons having direct contact as primary, secondary or alternative job duties conduct a criminal records investigation, according to state law and current policy of the Department of Human Services in MAN 5600, 3040 Criminal History Investigations.

324.18 Fiscal Management

Businesses, agencies and individuals providing assistive technology services shall practice sound and effective fiscal planning and management, financial and administrative record keeping and reporting.

324.19 Data Collection and Reporting

General information about data collection and reporting are described in CH 202. The AAA may require additional information systems at its discretion but may not fail to meet the minimal standards required by DAS. The AAA must retain relevant information not captured in the DAS data system in paper files according to DAS program policies.

Specific programmatic/service requirements for collection and/or reporting of data include:

- Information gathered from persons served.
- Appropriate consent forms, issued or approved by DAS
- Provider information
- Pertinent financial information regarding applicable cost shares
- Coordination with the ADRC regarding waiting lists and referrals to assistive technology services
- Tools and plans for measuring quality of life and customer satisfaction approved or required by DAS
- Notation in the DAS data system that includes the name of the device and the cost of the device
- Documentation of education and advocacy efforts (see 324.9B)

The AAA staff will use data from the DAS data system, at a minimum, to facilitate quality improvement and data analysis.

324.20 Retention and Confidentiality of Records

Providers must establish and implement written policies and procedures for the maintenance and security of client records, specifying who will supervise the maintenance of records, which will have custody of records, to whom records may be released, and for what purposes in compliance with MAN 5600, 3012 Provision of Services by Area Agencies on Aging.

Each client record must include the following information about assistive technology devices\services in the manner that DAS requires:

- Type(s) of assistive technology
- Cost for each assistive device(s)

324.21 Fee for Service Guidelines

Each AAA/provider is encouraged to offer in-home services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Sections 2025-2028, “Fee for Service System”, “Cost Share”, “Voluntary Contribution”, and “Private Pay Services”.

Assistive technology services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

324.22 Reports of Grievances, Complaints, and Incidents

Refer to MAN 5300, 202 Program Guidelines and Requirements

324.23 Mandatory Reporting of Abuse / Neglect / Exploitation

Refer to MAN 5300, 202 Program Guidelines and Requirements

324.24 Program Evaluation and Monitoring

Refer to MAN 5300, 202 Program Guidelines and Requirements

324.25 References

Assistive Technology Act of 1998

Older Americans Act Of 1965: 2020 Reauthorization

DAS Manual 5200, Section 5025 - Service Availability and Access

DAS Manual 5200, Section 5038 - Waiting List Management

DAS Manual 5300, Section 114 - Guidelines for Client Assessment

DAS Manual 5300, Section 118 - Prioritizing Clients

DAS Manual 5300, Section 202 - Program Guidelines and Requirements

DAS Manual 5600, Section 316 - Caregiver Services

Tools for Life

Tools for Life New Staff Training Videos

300 Title III C Nutrition Services

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, insur-

ance 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 Georgia Nutrition Program Nutrient Targets for Meals; 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 Georgia Nutrition Program Nutrient Targets for Meals; 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 Nutrition Assessment

Area Agencies and nutrition service providers are to work collaboratively to identify or develop resources for the provision of nutrition assessments for 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

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.

Congregate

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.

Home Delivered

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. www.mealsonwheelsamerica.org/docs/default-source/conference/2019-session-materials-handouts/tuesday/200/meals-on-wheels-america-ep-standards.pdf?sfvrsn=f82ab93b_2

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 Nutrition Outreach

Providers shall conduct outreach activities with emphasis on identifying potential program participants who are among those in greatest social and 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 Foodborne Illness Complaints

The provider shall report to local health authorities within 24 hours of receiving complaints involving two or more persons with symptoms of foodborne illness within a similar time frame after consuming food supplied through the nutrition service program. Providers shall report any complaints regarding foodborne 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.servsafe.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 Manual 5600, Sections 2025, 2026, 2027, and 2028 for full guidance.

304.43 Nutrition Services Incentive Program (NSIP)

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.

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, 3009 Area Agency on Aging Monitoring and Evaluation of Service Providers.

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 Manual 5300, 202 Program Guidelines and 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 Manual 5600, 3007 Area Agency on Aging 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 Manual 5600, 3009 Area Agency on Aging 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 Manual 5600, 3007 Area Agency on Aging 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

www.nal.usda.gov/human-nutrition-and-food-safety, 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 extension.uga.edu/food/

Georgia Department of Public Health Rules and Regulations Governing Food Service dph.georgia.gov/environmental-health/food-service

ServSafe www.servsafe.com

MOWAA Disaster Planning Sample and Guide www.mealsonwheelsamerica.org/docs/default-source/conference/2019-session-materials-handouts/tuesday/200/meals-on-wheels-america-ep-standards.pdf?sfvrsn=f82ab93b_2

Dietary Guidelines for Americans 2015-2020 odphp.health.gov/our-work/nutrition-physical-activity/dietary-guidelines/previous-dietary-guidelines/2015

Appendix 304-A Evaluation of Individuals for Appropriate Meal Type

Appendix 304-B Georgia Nutrition Program Nutrient Targets for Meals

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	
	Section Title:	Georgia Nutrition Program Nutrient Targets for Meals	**Reviewed or Updated in:**	MT 2019-03
	Section Number:	Appendix 304-B	**Previous Update:**	

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 B6	0.57 micrograms
*Vitamin B12	0.8 micrograms
*Vitamin D	5 micrograms
*Vitamin E	5 milligrams
*Folate	133 micrograms
*Fiber	≥ 8 grams
*Vitamin C	≥ 27 milligrams

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

Appendix 304-C Hold Harmless Guidance

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	
	Section Title:	Hold Harmless Guidance	**Reviewed or Updated in:**	MT 2019-03
	Section Number:	Appendix 304-C	**Previous Update:**	

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.

200 Title III D Evidence Based Disease Prevention and Health Promotion Services

214 Wellness Program Guidelines and Requirements

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	10/27/2021
	Section Title:	Wellness Program Guidelines and Requirements	**Reviewed or Updated in:**	MT 2019-09
	Section Number:	214	**Previous Update:**	MT 2019-09

214.1 Summary Statement

This chapter establishes guidelines and requirements to be followed by Area Agencies on Aging and their contractors when providing State Wellness Program services. The program encompasses the activities authorized by the Older Americans Act of 1965, as amended in 2000 and 2006, through Title III, Part D, Disease Prevention and Health Promotion Services.

214.1A Scope

These requirements apply to services provided in whole or in part by non-Medicaid federal and state funds and any associated matching funds managed by Area Agencies on Aging and their contractors. The use of funds from Title III, Part B, Supportive Services program, and Title III, Parts C1 and C2, Nutrition Services Programs, for related services is also consistent with the purpose of the state's comprehensive and integrated Wellness Program. Subject to continued availability, State Community Based Services funding is also allocated to the program. The Area Agencies on Aging are responsible for coordinating resources and, where none exist, for creating a way to fill the gaps in services. To prevent duplication of existing community resources, the Area Agencies on Aging will make every effort to fund only those services for which no other resource(s) can be identified.

214.1B Definitions

Evidence-Based Programming

Per the guidelines of the Administration for Community Living (see References – number 1), beginning October 1, 2016, programming for non-Medicaid Disease Prevention and Health Promotion Services shall meet the following criteria:

1. Undergone experimental or quasi-experimental design; and
2. Level at which full translation has occurred within a community site; and
3. Level at which dissemination products have been developed and are available to the public.

A list of evidence-based programs that can be supported by Title III-D funds can be found at www.ncoa.org/resources/ebpchart/.

NOTE This list is not exhaustive. Please see Administration for Community Living's III-D Checklist to verify if programs not included can be supported by III-D funding.

Disease Management

A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management:

1. Supports the physician or practitioner/patient relationship and plan of care,
2. Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and
3. Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health
4. Disease Management Components include:
    a. Population identification processes
    b. Evidence-based practice guidelines
    c. Collaborative practice models to include physician and support-service providers
    d. Patient self-management education (may include primary prevention, behavior modification programs, and/or compliance)
    e. Process and outcomes measurement, evaluation, and management
    f. Routine reporting/feedback loop (may include communication with patient, physician, caregiver, health plan, and ancillary providers); and
    g. Full-service disease management programs must include all six components. Programs of fewer components are Disease Management Support Services.

Physical Activity

A variety of leisure time, occupational, and self-care activities which, if performed routinely, result in biochemical and physiological adaptations that improve the body's functional capacity, efficiency, muscular endurance, and range of motion. (A listing of some evidence-based physical activity programs can be found at the link referenced above.)

Health Promotion

The process of enabling people to increase control over and improve their health.

Health Indicator

A characteristic of an individual, population or environment which is subject to being measured, either directly or indirectly, and which can be used to describe one or more aspects of the health of an individual or population in units of quality, quantity, and/or time.

Health Literacy

The cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health.

Health Outcomes

A change in the health status of an individual, group, or population that can be attributed to a planned intervention or series of interventions.

Health Promotion Evaluation

An assessment of the extent to which health promotion actions achieve a “valued” outcome.

Health Promotion Outcomes

Changes to personal characteristics and skills which can be attributed to health promotion activities.

Levels of Preventive Action

Three levels of measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established:

1. **Primary Prevention** includes interventions designed to keep a disease from ever happening or a trauma from ever occurring. Examples: immunizations; reducing household hazards; reducing risk factors for heart disease; increasing regular, moderate physical activity; and maintaining good nutritional status. Health promotion programs are usually at the primary prevention level.
2. **Secondary Prevention** is the use of early detection and early intervention against a disease before it develops fully. Examples: screening programs with referral of persons who appear to be at risk of a particular disease for follow-up and treatment by a health professional [see section 214.2b]; or risk assessments of residential environments.
3. **Tertiary Prevention** are interventions that take place after a disease or injury has occurred, intended to prevent deterioration and complication and to rehabilitate and return individuals to as full physical, mental, and social functioning as possible. Usually provided by health professionals.

Self-Care or Self-Management

The activities that individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills of both professional and lay experience. They are undertaken by consumers on their own behalf, either independently or in collaboration with professionals (see References - number 5).

214.1C Laws and Codes

Each Wellness Program Services site shall operate 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.

214.2 Disease Prevention and Health Promotion Service Objectives

The objective of Title III-D is to promote better physical, mental, and social health for older adults, persons with disabilities, and caregivers through the provision of the three tiers of evidence-based disease prevention and health promotion programs.

Through using Evidence-Based health and wellness programs, the broad objectives of Wellness Program implementation which affect health and wellness at both the individual and community level are:

1. To reduce disease and disability
2. To improve individuals' health literacy and understanding of diagnosed conditions
3. To reduce the prevalence of risks to health or to increase behaviors known to reduce such risks
4. To assist participants in developing behaviors and skills which are conducive to individual and community health
5. To increase comprehensiveness, accessibility and/or quality of health promotion and preventive services and interventions; and
6. To promote empowered users of the health care system.

214.2A Service Outcomes

Title III-D programs are implemented to maintain or improve the level of health and wellness of those persons aged 60 years and older, persons with disabilities, and their caregivers through the implementation of evidence-based, community level initiatives.

More specific long-term outcomes for individuals and groups may include, but not be limited to:

1. Increased physical strength and endurance
2. Maintaining or increasing independence
3. Ability to independently perform self-care (activities of daily living)
4. Ability to independently participate in community and leisure activities (instrumental activities of daily living)
5. Maintaining or improving nutrition and physical activity behaviors; and
6. Maintaining or improving overall quality of life/life satisfaction.

214.2B Service Activities

Evidence-based Wellness Program services, provided in both the homes of participants and in community settings, and encompassing both disease prevention and health promotion services **must** include one or more of the following evidence-based activities:

1. **Health Risk Assessments** To identify people at risk and refer them to the appropriate follow-up services. These services may be provided in senior centers, nutrition sites, with health professionals, individuals' homes, or other community settings. Assessments may include, but are not limited to the following:
    a. Falls risk using the STEADI Toolkit (See MAN 5300, 114 Guidelines for Client Assessment)

b. Medication management understanding including:
    i. Assessment
    ii. Education to prevent incorrect use of medications; and
    iii. Prevention of adverse drug events.
c. Health literacy
d. Self-efficacy for self-care
e. Nutrition
f. Home safety:
    i. Assessments of high-risk home environments
    ii. Provision of educational programs and materials on injury prevention; and
    iii. Fall prevention education.
g. Cognition
h. Depression:
    i. The Patient Health Questionnaire, 9 question version (PHQ-9) – see MAN 5300, 114 Guidelines for Client Assessment
    ii. Identifying older adults, persons with disabilities, and caregivers experiencing grief over personal losses; and
    iii. Related assistance may include coordination of community mental health services, provision of education activities, and referral to appropriate psychiatric and psychological services.

2. **Health Screenings/services** administered by trained and certified professionals including, but not limited to, one or more of the following evaluations:
    a. Blood pressure
    b. Hearing
    c. Vision, to include glaucoma
    d. Dental
    e. Podiatry
    f. Blood tests, including diabetes and cholesterol
    g. Urinalysis
    h. Bone density
    i. Mammography
    j. Prostate
    k. Flu vaccination
    l. Pneumonia vaccination; and
    m. Abdominal aortic aneurysm screening.
3. **Health Counseling** may also include specific counseling services. Some types of counseling

include, but are not limited to:

a. Gerontological
b. Caregiver
c. Social services
d. Nutrition [see also MAN 5300 304 Nutrition Service Program Guidelines and Requirements]
e. Mental health
f. Depression Screening
g. Medication compliance; and
h. Psychological services.

4. **Nutrition Screening** [refer to MAN 5300 CH 304.1b and MAN 5300 CH 304.2j] The process of using characteristics known to be associated with nutrition problems to identify individuals who are nutritionally at risk.
5. **Nutrition Counseling** [refer to MAN 5300 CH 304.1b and MAN 5300 CH 304.2m] 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.
6. **Nutrition Education** [see also MAN 5300 CH 304.1b and MAN 5300 CH 304.2l] The provision of information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve their nutritional status.
7. **Health Promotion Programming** including, but not limited to programs relating to prevention and reduction of the effects of:

a. Chronic conditions (e.g., osteoporosis, arthritis, diabetes, cardiovascular disease, etc.)
b. Alcohol and substance abuse
c. Smoking
d. Obesity
e. Stress/anxiety

8. **Physical Fitness Activities** including, but not limited to:

a. Walking programs
b. Chair exercises
c. Arthritis exercise programs
d. Group exercises
e. Aquatic classes
f. Resistance programs; and
g. Other evidence-based low impact aerobics programs

9. **Music, art, and dance movement activities or therapies**

10. **Hospital Transitions** For more information on a number of evidence-based Hospital Transition programs, visit AoA's PowerPoint presentation transcript at: acl.gov/sites/default/files/programs/2017-03/AoA_ACA_CT1_transcript_012411.pdf
11. **Benefits Education Program** [see Manual 5200 Chapter 5000]

AAAs must include one or more goals for Wellness Programs focused on evidence-based health and wellness program implementation in the Area Plans.

214.2C Target Groups, Eligibility, and Priority for Services

Persons eligible for Wellness Programs are those:

1. Aged 60 and over, or a spouse (regardless of age) of a person aged 60 or older
2. Persons with disabilities (18 and older) who are residents of housing facilities occupied primarily by older adults at which congregate nutrition services are provided
3. Caregivers to persons aged 60 and older or to persons with disabilities.

AAAs shall give priority to areas within their region:

1. which are medically underserved; and
2. in which there are many older individuals who have the greatest economic need for such services. (42 U.S.C. 3030n)

Services may be designed to assist healthy older adults, persons with disabilities, and caregivers in maintaining positive health states; to assist persons with chronic conditions to better manage their health; and to promote healthy lifestyles and behaviors among all persons at the community level.

214.2D 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.

214.3 Participant Records

The service provider shall maintain files in a form and format approved/accepted by DAS, including information that, at a minimum, identifies participant demographics; documents individuals' eligibility for the program (based on program requirements); and contains instructions for emergency contacts and care preferences. All providers shall maintain any additional participant information as specified by DAS program policies and procedures and as required by program developers. Refer to MAN 5600 1060 Division Reports, Overview and other sections for record keeping policies.

Files of participants served through the DAS contract are confidential and remain the property of the Department of Human Services. All participant files are subject to review and monitoring by the AAA, DAS, and any federal granting agencies.

214.3A 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 established AAA regional emergency/disaster plan.

The provider agency shall develop a written continuity of operations plan for their agency which will include policies and procedures for operation during any type of emergency and/or disaster. Examples of emergencies include, but are not limited to vehicle breakdowns, inclement weather, or program leader emergencies. Refer also to MAN 5600 3010 Emergency Planning and Management.

214.3B Management and Oversight of the Wellness Program

The AAAs shall identify staff responsible for the overall management of wellness services and compliance with performance standards, requirements, and procedures.

If services are provided by a sub-contracted agency the AAA is responsible for ensuring program adherence and fidelity in implementation as required

214.3C 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 for providing safe, appropriate, and efficient evidence-based wellness 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.

214.3D Record Keeping and Reporting

Providers shall comply with all record keeping and reporting and retention requirements as prescribed by DAS. Documentation requirements specific to wellness services include, but are not limited to:

1. Daily records documenting persons who receive wellness services (units and persons served)
2. Documentation of participant feedback, and the method used to obtain feedback on a routine basis.

To document and validate which evidence-based criteria level the selected Wellness Program meets AAAs must:

1. Retain documentation of the evidence behind their chosen Title IIID health promotion program(s) for AAA records and monitoring purposes.
    - Depending on the program, this could be anything from a copy of an appropriately credentialed practitioner's certification (e.g., registered dietitian, pharmacist, dentist, CNA, LPN, etc.), to a peer-reviewed journal article, to dissemination products.
2. For a Title IIID evidence-based health promotion program meeting the minimal criteria such as blood pressure screenings, documentation could include a copy of the CNA, LPN, RN, or other performing practitioner's license number along with information about the blood pressure screenings that were performed. In the event student volunteers are used, such as dental students, nutritionists or pharmacists, a letter or email from the faculty instructor could be retained as a record of the evidence-base of the health promotion program implemented with Title II-ID funds.

3. Collect and report pre and post testing as required for specific program implementation (e.g., Chronic Disease Self-Management Education and Matter of Balance requirements found in the appendices).

Refer to MAN 5600 1060 Division Reports, Overview and other sections for additional DAS record keeping policies.

214.3E Contributions

Refer to MAN 5600, 3022 Financial Management.

214.3F Provider Quality Assurance and Program Evaluation

Each wellness 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
- Proposed program and administrative improvements

If not directly administered by the AAA, each sub-contracted 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 implementation.

214.3G Monitoring by Service Provider

Each provider shall adhere to established fidelity guidelines and monitoring policies and procedures as published by DAS or program developers. Refer to MAN 5600 for additional monitoring requirements.

214.4 AAA Responsibility for the Wellness Services Program

The AAA shall develop and implement any necessary additional policies and procedures for the following:

1. Compliance with the Older Americans Act Title III-D program implementation; and
2. Verification that all providers comply with licensing and fidelity guidelines for evidence-based programming

References

acl.gov/programs/health-wellness/disease-prevention

Adapted from the World Health Organization, apps.who.int/iris/handle/10665/205887

Hospital Care Transitions Manual

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	
	Section Title:	Hospital Transitions: Manual to Engage Georgia Aging Network	**Reviewed or Updated in:**	
	Section Number:		**Previous Update:**	

The Perfect Storm: Hospital Readmissions and the Aging Network

Excessive and potentially avoidable re-admissions to acute care settings are costly to hospitals and a drain on the Medicare system. Beginning October 1, 2012, as written in the Patient Protection and Affordable Care Act (2010), hospitals will be increasingly penalized for patients re-admitted for four identified conditions (Heart Failure, Pneumonia, COPD, and Acute Myocardial Infarction) within 30 days of being discharged, and will eventually include "all cause" admissions. A number of organizations have developed evidence-based Hospital Transitions (HT) interventions to identify patients who may be at high risk for avoidable readmission and to provide enhanced pre and post-discharge support. These programs prevent a statistically significant number of at-risk patients from returning to the emergency room. Many of the interventions target hospital culture change, with an emphasis on enhanced discharge planning, but little about connection to services post-discharge. However, programs like the Bridge Model and the Care Transitions Intervention suggest the need to link at-risk patients to existing resources in their communities after discharge.

This recent shift in Medicare policy that has left many hospitals struggling to find ways to reduce re-admissions makes it a perfect time for the Georgia Aging Network to reach out to local hospitals. The Aging Network's link to referral sources and service providers can provide the needed connection to community-based supports and services for these at-risk and vulnerable patients. The intention of this manual is to provide Area Agencies on Aging (AAA), County Based Agencies (CBA), and other Home and Community Based Service (HCBS) organizations:

1. a brief overview of a number of evidence-based interventions accepted and promoted by the U.S. Administration on Community Living,
2. information on how to access and implement these programs,
3. some steps to take to demonstrate to hospitals the value of partnering with the Aging Network,
4. ways to market the support services already provided to older adults throughout the community, and
5. tools to expand service provision on a fee-for-service basis with the hospitals.

Adequate and appropriate community and social support needs to be in place to have successful and healthy transitions from one setting to another. AAAs, CBAs, and HCBS providers can play that pivotal role for individuals transitioning back into their homes from the hospital. Services may include, but are not limited to:

- in-home care,
- transportation,

- home delivered meals,
- case management,
- home repair,
- social engagement (senior centers),
- chronic disease self-management programs,
- adult day care,
- respite,
- caregiver support,
- help navigating the health care system,
- Adult Protective Services,
- Aging and Disability Resource Connection - information, referral, counseling, and access to services.

This manual also serves to guide Aging Network providers in various stages of HT implementation to: 1) assess internal readiness, 2) prepare a package of services, 3) develop mutually beneficial partnerships with hospitals (selling these service packages), and 4) then implementing HT with a new fund source. This iterative manual will eventually include a proposal for Aging Network providers to add a Medications Management component to any package or evidence-based program selected.

References

Im, E. (2011). Transitions theory: A trajectory of theoretical development in nursing. Nursing Outlook, 59, 278-285. doi: 10.1016/j.outlook.2011.03.008

Meleis, A. I., Sawyer, L. M., Im, E., Hilfinger Messias, D. K., & Schumacher, K. (2000). Experiencing transitions: An emerging middle range theory.Advances in Nursing Science, 23(1), 12-28.

One Hundred Eleventh Congress of the United States of America, (2010). Patient protection and affordable care act (H. R. 3590). Retrieved from website: http://www.g;po.gov/fdsys/pkg/B[LLS-l I lhr3590enr/pdtJBILLS-l l l hr3590enr.pdf

Reducing Readmissions: A Literature Review of Evidence-Based Programs

Introduction

Excessive and potentially avoidable readmissions to acute care settings are a drain on the Medicare system and are indicative that many older patients are in need of increased supports and services to be able to manage their health conditions after discharge. As of October 1, 2012, as written in the Patient Protection and Affordable Care Act, hospitals are increasingly penalized for patients readmitted for certain conditions within 30 days of being discharged ("Patient protection and," 2010). Due to high readmission rates, Georgia hospitals have been charged to reduce all-cause readmissions by 20% by the end of2013 (Reid, 2013).

Predicting this policy change, a number of organizations developed what are now evidence-based, hospital transition (EBHT) interventions and programs to identify patients who may be at high risk

for early readmission, provide enhanced pre and post-discharge support, promote patient, family, and caregiver engagement, and prevent some patients from unnecessarily returning to the emergency room (Allendorf, 2012; Boult et al., 2011; Coleman, Mahoney, & Parry, 2005; Illinois Transitional Care Consortium (ITCC], 2013; Jack & Bickmore, 2010; Naylor, Kurtzman, & Pauly, 2009). Seven of these interventions, promoted by the Administration for Community Living, are included in this literature review.

Interventions

Common program components

The seven evidence-based, hospital transition (EBHT) programs articles include many common implementation elements. Four programs rely on trained individuals to coordinate and implement the EBHT components (Boult et al., 2011; Coleman, Mahoney, & Parry, 2005; ITCC, 2013; Naylor, Kurtzman, & Pauly, 2009), and the other three have a team approach to providing structured support to patients identified as being at risk for readmission (Allendorf, 2012; Counsell et al., 2006; Jack & Bickmore, 2010). All seven programs identified medications management and encouraging self-management, caregiver engagement, enhanced healthcare team communication, and a post-discharge follow-up of some sort.

Each of the programs have unique components, are offered for varying durations, occur within different settings, and have differing training requirements for staff conducting the program. The two most well-known EBHT programs are the Care Transition Intervention (CTI) and the Transitional Care Model (TCM) (Meier & Beresford, 2008; Lim, Foust, & Van Cleave, 2012). Four additional programs promoted by the U.S. Administration on Community Living (Padilla, Ryan, & Markwood, 2011) are Project BOOST (Better Outcomes by Optimizing Safe Transitions), The GRACE (Geriatric Resources for Assessment and Care of Elders) Model, The Bridge Program, and Guided Care. The Georgia Hospital Engagement Network selected Project Re-Engineer Discharge (RED) to promote, which is also included in this literature review (Cameron, 2013).

Care Transitions Intervention (Coleman Model)

The Care Transitions Intervention (CTI) relies on training a registered nurse as a Transitions Coach (TC) to implement the four week intervention. The TC coordinates the care of the identified patient and ensures, through encouraging and modeling self-management (Lim, Foust, & Van Cleave, 2012) that the individual is able to adhere to a discharge plan revolving around the following four pillars: proper medications management, use of a Patient Health Record, ability to schedule and get to recommended follow-up appointments, and that the patient and caregivers are aware of possible "red flags" that a condition is worsening and then know what to do in such a case.

The TC meets with the patient pre-discharge, schedules and conducts a home visit within 72 hours, and then makes three or four follow-up phone calls over the remaining duration of the 28-day program to ensure the patient and any caregivers have full mastery of the four pillar concepts.

Dr. Eric Coleman and colleagues at the University of Colorado developed the CTI well over a decade ago and have conducted extensive research on its effectiveness in reducing acute care readmissions (Meier & Beresford, 2008). In their 2006 study, Coleman, Parry, Chalmers, & Min found CTI to reduce readmissions with statistical significance at 90 and 180 days post-discharge. In the articles reviewed, however, there was not a great deal of information regarding study subjects in terms of

socioeconomic status or diversity in terms of race and ethnicity. Based on a 2009 study with Medicare fee-for-service clients (many lower-income individuals), CTI was found to be an effective intervention though demographics of participants were not discussed (Parry et al., 2009).

As for cost savings, Coleman, Parry, Chalmers, & Min (2006) found the return on investment for using the CTI on their study sample was a conservatively estimated annual savings of approximately $295,500 per Transition Coach's caseload (24-28 participants at any given time).

Transitional Care Model (Naylor Model)

Dr. Mary Naylor and colleagues at the University of Pennsylvania developed the Transitional Care Model (TCM). Similar to the CTI, one person is responsible for the TCM's implementation. However, for this model it is a trained Advanced Practice Nurse, or Transitional Care Nurse (TCN), who provides continuity of care for the individual patient, beginning no more than 24 hours after being admitted to the hospital. The duration of the TCM intervention is as short as one month and up to three months, depending on the client's needs.

Over this time, the TCN implements the TCM's "nine core elements": pre-discharge assessment and established care plan; continuity of care facilitated by TCN; scheduled and regular home-visits and 24 hour access to support via telephone; patient-centered care; engagement of patient and informal and formal caregivers in care plan ownership; setting long-term goals with patient and caregivers and providing education and support for ways to meet those goals to ensure successful outcomes; using a multi-disciplinary, team building approach; communicating directly to physicians and Primary Care Providers (PCP) on the patient's behalf with knowledge of healthcare goals; and acting as the liaison and providing effective and clear communication between patient, family, caregivers, and healthcare providers (Meier & Beresford, 2008).

The TCN accomplishes this by meeting daily with the patient while admitted to establish a rapport with the patient and to ascertain the patient's long-term health goals. Post-discharge, the TCN schedules and visits the home within 24 hours, and once a week for the rest of a month's time. The TCN, during one of the first month's visits, accompanies the patient to their first PCP appointment to provide healthcare-speak "translation."

Through their 1999 randomized clinical trial, Naylor et al. had an excellent representation of African Americans, persons of low-income, those with limited education, and persons self-reporting only fair or poor health. The researchers found, with statistical significance, that the intervention group experienced fewer acute events resulting in fewer hospitalizations after 24 weeks. The reimbursement requests for the control group were more than double that of the intervention participants.

Though the TCM is more costly to implement (use of a master's level nurse and up to a three month intervention), Lim, Foust, & Van Cleave (2012), gleaned from former publications of the TCM developers that intervention participants had a reduction in hospitalizations as compared to the control group resulting in an average $5,000 annual healthcare saving per individual. The authors also stated that patients reported an increased quality of life, enhanced physical functioning, and higher satisfaction with care received.

Project BOOST (Better Outcomes by Optimizing Safe Transitions)

Developed by the Society of Hospitalists, Project BOOST uses a healthcare team approach to ensure

five key program elements: I) to assist hospitals develop a comprehensive intervention; 2) to construct a comprehensive implementation guide; 3) to provide hospitals with longitudinal technical assistance with face-to-face visits for the year-long patient intervention; 4) to establish a BOOST collaboration for those implementing the model to share tools and resources; and 4) the BOOST data center provides online communication, tools and resources for members (Enderlin et al., 2013).

According to Allendorf (2012) and the "Society of Hospital Medicine…" (2012), studies have found that early adopters of Project BOOST reduced 30 day readmission rates by more than 3%, and produced "a 21% reduction in 30 day all-cause readmission rates." From the literature, BOOST is geared towards helping hospitals change their culture and processes to improve communication and teamwork across the many healthcare staff and functions, ultimately resulting in more efficient and quality service provision to patients.

The Bridge Model

As with CTI and TCM, the Bridge Model relies on trained individuals to coordinate the three phases of intervention. However, instead of RNs or APNs, trained social workers (MSW), called Bridge Care Coordinators (BCC), implement the pieces of the Bridge Model. Members of the Illinois Transitional Care Consortium identified the following three phases for transition: pre-discharge, post-discharge, and follow-up (ITCC, 2013).

During the pre-discharge phase, the BCC is made aware of an at-risk patient and meets with the individual and caregiver(s) in the patient's room or in the on-site Aging Resource Center (ARC) to conduct a needs-based assessment and to make referrals to or set up services for the older adult to access prior to phase two (Altfeld, Pavle, Rosenberg & Shure, 2013). At this time the BCC also connects to additional interdisciplinary healthcare staff (physicians, nurses, pharmacists, etc.) to enhance the coordination of discharge planning.

Post-discharge the BCC follows-up with a phone call to see if additional necessary supports and services were identified after the first two days at home, and will coordinate acquisition of those resources. Finally, at 30 days, the BCC places one last follow-up phone call to check on the patient and address any additional concerns or service needs.

The unique aspect of the Bridge Model is that its social work-based design can be implemented by a hospital or by a community-based organization. The BCC work to provide care coordination between healthcare professionals and community-based service providers (e.g. Area Agencies on Aging and Aging and Disability Resource Centers), while at the same time providing psychosocial support to the patient and caregivers.

From early evaluation of 315 intervention participants, Altfeld et al. (2013) reported a 14% readmission rate compared to the 19.6% national average. The authors also stated the participant satisfaction rates were in the upper 90%. No details were given about participant demographics, nor was any financial return on investment mentioned for the Bridge Model.

GRACE (Geriatric Resources for Assessment and Care of Elders) Model

GRACE is a model designed to be implemented within the primary care setting for low-income patients at high risk for hospital utilization. The main goal of GRACE is to improve the quality of primary geriatric care services in order to promote aging in place or to prolong long-term care facility placement. Unlike CTI, TCM, and the Bridge Model, GRACE implementation centers around the

GRACE support team. A trained nurse and social worker are the main components of the support team, and they coordinate the larger interdisciplinary team that may be comprised of the PCP, pharmacist, physical therapist, occupational therapist, and a community liaison.

This model requires the use of electronic medical records and a long-term ongoing tracking mechanism to gauge the participant's progress as long as he/she is a patient. The small GRACE support team conducts a home visit with the patient and available caregiver(s) and administers a formal geriatric assessment and a home safety assessment. The nurse and social worker then convene a meeting with the full team to create a care plan, obtain the PCP's input and approval, and then work with the patient to implement their plan. The support team provides ongoing support throughout the year and reassesses the client annually.

Counsell, Callahan, Buttar, Clark, & Frank (2006) conducted a longitudinal study utilizing the GRACE Model within a primary care setting. They offered the intervention to 254 patients and found that the diverse, low-income, mostly frail participants responded quite well to the supports offered by their GRACE support team. Though time consuming and labor intensive for PC staff, when surveyed they reported being very satisfied with the GRACE process and was found to be somewhat to very helpful in providing healthcare to elderly patients.

According to their 2009 article, Counsell et al. found the GRACE Model to be cost neutral, but that more cost-effective evaluation would need to be conducted.

Guided Care

Similar to the GRACE Model, Guided Care is also designed for implementation within a primary care setting. A trained Guided Care Nurse (GCN) engages the PCP throughout the intervention and coordinates the eight services provided under this model: 1) a comprehensive patient assessment, 2) development of a patient-centered care plan, 3) monthly monitoring, 4) encouragement of self-management behaviors, 5) provision of coordinated care transitions, 6) liaison between members of the healthcare team, 7) caregiver and family support, and 8) referrals to community-based services.

Boult et al. (2011) conducted a yearlong study to see if the Guided Care intervention would have any effect on healthcare utilization and found that Guided Care may improve the quality of care administered to older patients with multiple chronic conditions. Kaiser insured participants in the intervention group reported a decreased use of some health care services but not with statistical significance. However, the researchers did find statistically significant differences between the control and intervention group in terms of being admitted to and spending time in a skilled-nursing facility, with the intervention group admissions considerably fewer. The Guided Care participants also reported a 29.7% decrease in negative at-home healthcare events.

Though the overall healthcare utilization numbers did not all reflect significant change as a result of the intervention, Guided Care patients reported increased quality of life and satisfaction with the healthcare services provided. Boult et al. (2011) were not able to determine if there were any significant cost savings of Guided Care patients involved in this particular study and more research needs to be conducted.

Project RED (Re-Engineered Discharge)

Project **RED**, designed by the Boston University Medical Center, is a team-based, interdisciplinary

approach to implement all eleven components of the intervention to enhance the quality of the patient's discharge experience. The eleven components of the intervention include: 1) patient education of condition, 2) scheduling follow-up PCP appointments for the patient before discharge, 3) explaining the purpose of any additional medical tests if they are required post-discharge, 4) coordinating post-discharge supports, 5)reviewing and confirming appropriateness of the medication regime, 6) comparing the After Hospital Care Plan (AHCP) with the national guidelines, 7) ensuring the patient understands what to do if symptoms worsen, 8) communicating with and transferring the patients AHCP to the patient's primary healthcare provider, 9) assessing the patient's comprehension of the AHCP, 10) making sure the patient and caregiver(s) have a written copy of the AHCP, and 11) follow-up via telephone within two to three days post-discharge to make certain the patient is able to adhere to the plan.

The intervention is unique in its use of a "virtual patient advocate" (Enderlin et al., 2013). To support the various components of this model, participants have access to computer-generated information about the individual's AHCP. The computer-based modules are tailored to the patient's personal diagnosis and provide the patient with education on the condition(s), medications, and AHCP instructions. The "virtual patient advocate" enhances the interactions with the participant's healthcare team by allowing the patient time, before discharge, to learn about the condition(s) and to then ask questions of healthcare professionals if needed (Enderlin et al., 2013).

Jack & Bickmore's (2011) article discusses, briefly, the results of a randomized control trial (RCT) to gauge the effectiveness of Project RED on reducing readmissions. Half of the 749 participants received the Project RED intervention with the use of the AHCP and the other half received usual care. Intervention participants reported 30% fewer re-hospitalizations within 30-days after discharge as compared to the control group. Jack & Brickmore (2011) further reported an average healthcare utilization cost savings of $412 per intervention participant, which was a 33.9% cost difference between the two groups.

This article did not describe the participant selection process or any demographic composition of the participants.

Conclusion

Strengths

Some of these EBHT programs, interventions, and models were established more than twenty years ago (Naylor et al., 1999) allowing for the accumulation of RCT studies and collected data to create, further study, and implement a variety EBHTs for use by a number of organizations interested in improving transitions of care. The common elements of assuring proper medications management, having a person responsible for ensuring continuity of care, encouraging patient self-management, and providing patient-centered care over the course of a transition from hospital to home have proved effective in reducing acute care occurrences, but more importantly improving the overall experience during a difficult event and increasing the patient's quality of life.

Weaknesses

The literature reviewed rarely offered information as to the demographics of the participants engaged in the various interventions. This is a weakness as many of the articles claimed great generalizability and that the interventions would be successful with the population at large. As these

programs tend to be geared towards supporting the frailer, lower income, lesser insured populations, perhaps those are the participants we are to assume are being studied.

The issue of health literacy and enhanced medication management support was not clearly addressed by any of the models. Non-adherence to medications after an acute episode accounts for many readmissions. Beyond the cost of access to prescriptions, which is a common barrier, understanding the importance of and then actually taking medications when and how they are prescribed may be something that needs to be addressed further through these interventions.

Gaps

The most obvious gap in the hospital transition literature is that the majority of the interventions target hospital culture change, with an emphasis on improved discharge planning and suggested staffing changes and training - all internal hospital processes. However, there are very few interventions, with the Bridge Model the only example, that mention linking at-risk patients to existing resources in their communities. In fact, the Bridge Model literature was the only EBHT program to acknowledge the Aging Services Network as a viable partner to enhance quality transitions of care.

Recommendations

Future Research Recommendations

The Transitions Theory looks at transitions of any kind as a continuous process. Im (2011) identified that the Transitions Theory of Meleis et al. (2000), is comprised of four main concepts: the nature of transitions; transition conditions; patterns of response; and nursing therapeutics. The "transition condition" involves the individual, the community, and society (Im, 2011). Established hospital transition interventions focus mainly on the nursing therapeutics component of Transitions Theory: on changes to the hospital setting and operations and not on referring participants to resources available within the community to which the patients are returning. Not only are unsuccessful transitions resulting in costly avoidable readmissions, but older adults are not successfully managing health conditions, resulting in lost quality of life, isolation, premature entry into long-term care facilities, and early death.

Ever since its passage in 1965, programs offered under the Older American's Act have been available to provide social, nutrition, and community services to older adults and their caregivers (Administration on Aging [AoA], 2010). This would suggest additional research should focus on hospital transition programs involving community-based organizations that can provide services to older adults after discharge and even after an intervention's end.

Practice Recommendations

As Transitions Theory implies, to have successful and healthy transitions from one setting to another, adequate and appropriate community and social support should be in place. Area Agencies on Aging (AAA), Community Based Organizations (CBO), and Home and Community Based Service (HCBS) providers can play that pivotal role for individuals transitioning back into their homes from the hospital. Existing services include: in-home care, transportation, home delivered meals, case management, home repair, social engagement (senior centers), chronic disease self-management programs, adult day care, respite, caregiver support, help navigating the health care system, Adult Protective Services, Aging and Disability Resource Center - information and referral, and much more.

To strengthen this argument, Altfeld, Pavle, Rosenberg, & Shure (2013) stated "40 - 50% of hospital re-admissions are linked to psychosocial problems and lack of community resources." As such, more hospital transition programs need to engage providers that are serving the social, nutritional, and community-based needs of older adults.

Policy Recommendations

Federal funding continues to dwindle for community-based, social and nutrition services for older adults, the aging population continues to grow, and Medicare spending maintains its cost escalation. As such, Federal level funders (e.g. U.S. Centers for Medicare and Medicaid Services [CMS] and the U.S. Administration on Community Living) should require and facilitate the partnering of State and Local level recipients of such funding (e.g. Medicare and Older Americans Act) to ensure partnership, communication, referral systems when serving similar populations.

Grant opportunities like the CMS sponsored Community-based Care Transitions Program engaged the Aging Network and forced community level partnership with hospitals (Centers for Medicare& Medicaid Services, 2012). This provides an opportunity for at-risk older patients to be introduced to services provided by Aging Network organizations.

Cumbler, Carter, and Kutner (2008), stated that "ultimately, it is the duty of the hospitalist to take responsibility for the safety and well-being of the patient… " While that may be true within the hospital there is a safety net of Aging Services partners ready to support, embrace, and welcome patients back into the community setting.

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Evidence-Based Hospital Transition Program Overviews

Name of Intervention	Components	Target Population	Effectiveness	Return on Investment
Care Transitions Intervention (Coleman Model)	Four Pillars: • Medications Management • Patient-centered Patient Health Record • Scheduling and going to timely follow-up appointments • Knowledge of potential "Red Flags" and ways to manage them Duration - 28 days Coordinated by a trained nurse: Transitions Coach	65 year old and older patients with one or more diagnosis: stroke, congestive heart failure, coronary artery disease, cardiac arrhythmia, COPD, diabetes mellitus, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and/or pulmonary embolism. Hospital Setting	CTI found to reduce readmissions with statistical significance at 90 and 180 days post-discharge	Coleman, Parry, Chalmers, & Min (2006)[17] found the return on investment for using the CTI on their study sample was an estimated semi-annual savings of approximately $148,000 per Transition Coach's caseload (24-28 clients at any time).

Name of Intervention	Components	Target Population	Effectiveness	Return on Investment
Transitional Care Model (Naylor Model)	Nine Core Elements: • Pre-discharge assessment and established care plan; • Continuity of care facilitated by TCN; • Scheduled and regular home-visits and 24 hour access to support via telephone; • Patient-centered care; • Engagement of patient and informal and formal caregivers in care plan ownership; • Setting long-term goals with patient and caregivers and providing education and support for ways to meet those goals to ensure successful outcomes; • Using a multi-disciplinary, team building approach; • Communicating directly to physicians and Primary Care Providers (PCP) on the patient's behalf with knowledge of healthcare goals; and • Acting as the liaison and providing effective and clear communication between patient, family, caregivers,and healthcare providers Duration – one to three months Coordinated by a trained Advance Practice Nurse: Transitional Care Nurse	Hospital Setting 65+, high-risk, cognitively intact older adults with a variety of medical and surgical conditions.	Researchers found with statistical significance the intervention group experienced fewer acute events resulting in fewer hospitalizations after 24 weeks.	Intervention participants had a reduction in hospitalizations as compared to the control group resulting in an average $5,000 annual healthcare saving per individual, Patients reported an increased quality of life, enhanced physical functioning, and higher satisfaction with care received.

Name of Intervention	Components	Target Population	Effectiveness	Return on Investment
Project BOOST (Better Outcomes by Optimizing Safe Transitions)	Five Key Program Elements: • Assist hospitals develop a comprehensive intervention; • A comprehensive implementation guide; • Provide hospitals with longitudinal technical assistance with face-to-face visits for the year-long patient intervention; • An established BOOST collaboration for those implementing the model to share tools and resources; and • The BOOST data center which provides online communication, tools and resources for members Duration - year long mentoring program for Hospital staff. Patient intervention based on developed comprehensive intervention. Coordinated by dedicated Project Boost healthcare team	Project BOOST was developed to help hospitals change the culture and processes to improve communication and teamwork across the many healthcare staff and functions, ultimately resulting in more efficient and quality service provision to all patients.	Early adopters of Project BOOST reduced 30 day readmission rates by more than 3%, and produced "a 21% reduction in 30 day all-cause readmission rates."	NA
The Bridge Model	Three Phases of Intervention: • Pre-discharge • Post-discharge • Follow-up Duration - one to three months Coordinated by a trained MSW: Bridge Care Coordinator	Hospital or Community Based Setting (AAA, ADRC, CBO, HCBS provider, etc.) 65+, high-risk for post-discharge complications.	From early evaluation of 315 intervention participants, Altfeld et al. (2013) reported a 14% readmission rate compared to the 19.6% national average. The authors also stated the participant satisfaction rates were in the upper 90%.	NA

Name of Intervention	Components	Target Population	Effectiveness	Return on Investment
GRACE (Geriatric Resources for Assessment and Care of Elders) Model	The main goal of GRACE is to improve the quality of primary geriatric care services in order to promote aging in place or to prolong long-term care facility placement. Duration - long-term, ongoing Coordinated by a trained nurse and trained social worker: GRACE Support Team	Primary Care/physician setting 65+, at-risk patients for high healthcare utilization	Researchers found that the diverse, low-income, mostly frail participants responded quite well to the supports offered by their GRACE support team.	According to their 2009 article, Counsell et al. found the GRACE Model to be cost neutral, but that more cost-effective evaluation would need to be conducted.
Guided Care	Eight Services: • Conduct a comprehensive patient assessment • Develop a patient-centered care plan • Conduct monthly monitoring • Encourage self-management behaviors • Provide coordination of any necessary transitions of care • Act as the liaison between members of the healthcare team • Provide caregiver and family support • Provide referrals to community-based services Duration - long-term, ongoing Coordinated by a trained nurse: Guided Care Nurse	Primary Care/physician setting 65+ patients with multiple chronic conditions.	Guided Care may improve the quality of care administered to older patients with multiple chronic conditions. Kaiser insured participants in one intervention group reported a decreased use of some health care services but not with statistical significance. However, the researchers did find statistically significant differences between the control and intervention group in terms of being admitted to and spending time in a skilled-nursing facility, with the intervention group admissions considerably fewer. The Guided Care participants also reported a 29.7% decrease in negative at-home healthcare events.	Not able to determine if there were any significant cost savings of Guided Care patients involved in this particular study and more research needs to be conducted.

Name of Intervention	Components	Target Population	Effectiveness	Return on Investment
Project RED (Re-Engineered Discharge)	Eleven Components: • Patient education of condition, • Scheduling follow-up PCP appointments for the patient before discharge, • Explaining the purpose of any additional medical tests if they are required post-discharge, • Coordinating post-discharge supports, • Reviewing and confirming appropriateness of the medication regime, • Comparing the After Hospital Care Plan (AHCP) with the national guidelines, • Ensuring the patient understands what to do if symptoms worsen, • Communicating with and transferring the patients AHCP to the patient's primary healthcare provider, • Assessing the patient's comprehension of the AHCP, • Making sure the patient and caregiver(s) have a written copy of the AHCP, and • Following-up via telephone within two to three days post-discharge to make certain the patient is able to adhere to the plan. Duration - one week post-discharge Coordinated by an interdisciplinary team with the use of technology: "The Virtual Patient Advocate"	Hospital Setting	Intervention participants reported 30% fewer re-hospitalizations within 30-days after discharge as compared to the control group.	An average healthcare utilization cost savings of $412 per intervention participant, which was a 33.9% cost difference between the two groups from one study.

Links for Evidence-Based Hospital Transition Programs and Interventions

Project BOOST (Better Outcomes by Optimizing Safe Transitions)
www.hospitalmedicine.org/ResourceRoomRcdesign/RR_CareTransitions/CT_Home.cfm

The Bridge Program www.transitionalcare.org/ particularly focused for Aging Services Network.

Care Transitions Intervention (CTI) www.caretransitions.org/

Geriatric Resources for Assessment and Care of Elders (GRACE)
medicine.iupui.edu/IUCAR/research/grace.aspx

Guided Care www.guidedcare.org

Project RED (Re-Engineered Discharge) www.bu.edu/fammed/projectred/index.html

Transitional Care Model (TCM) www.transitionalcare.info/index.html

U.S. Administration of Community Living Care Transitions Toolkit for Aging Services Providers
aoa.gov/AoARoot/AoA_Prograrns/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

Georgia Medical Care Foundation (GA's Quality Improvement Organization) Transition Tools
www.gmcf.org/AlliantWeb/QIOPages/ReducingReAdmissions.CCTP.aspx

Georgia Hospital Association's page with Transitions Tools and statewide readmissions reports
quality.gha.org/Home/CommunityHealth/CommunityConnections/CareTransitions.aspx

Explanation of the SWOT Assessment

The intention of conducting an internal review of an organization's Strengths, Weaknesses, Opportunities, and Threats (SWOT) is to identify any areas to enhance talking points and marketing strategies and to address any possible barriers the agency may face in establishing a relationship with a hospital.

A SWOT may be conducted face-to-face or staff may be asked to participate in electronic, de-identified, and open-ended surveys.

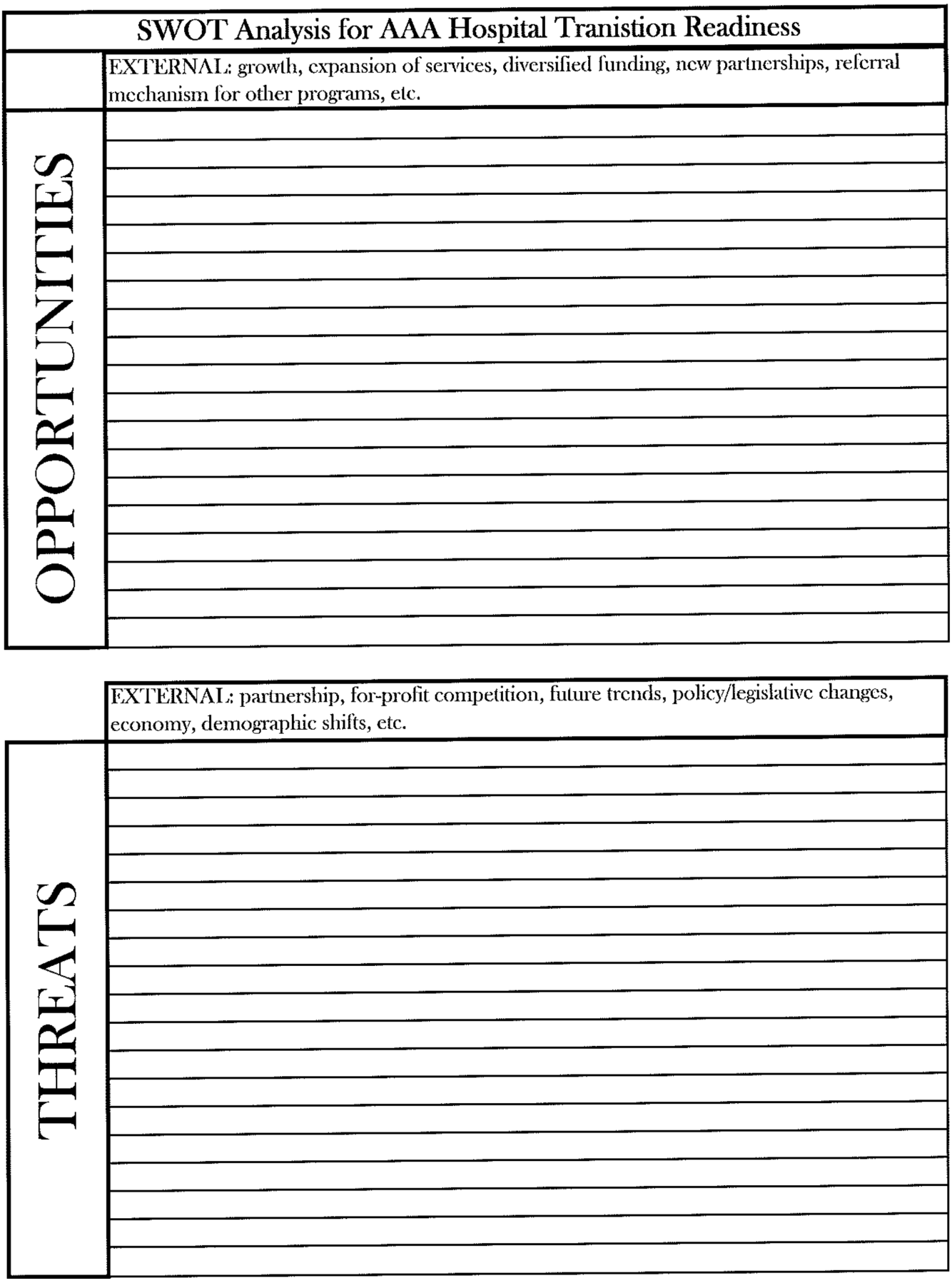
It is important to have a wide range of staff participate in these rapid brainstorming sessions. A SWOT may need to be conducted multiple times prior to contacting or approaching potential hospitals/partners.

SWOT Analysis for AAA Hospital Transition Readiness

SWOT Analysis for AAA Hospital Tranistion Readiness

	INTERNAL: resources, existing programs, qualified staff, existing partner agencies, service providers, cost of services, established service delivery systems, cultural competency, etc.
STRENGTHS	

	INTERNAL: resources, funding, staffing, knowledge, partnerships, start up costs, program availability, marketing, capacity, cultural competency, beliefs, etc.
WEAKNESSES	



Explanation of the Cost Calculator

This worksheet can be manipulated to suit the proposed services to accompany an AAA's Hospital Transition program. The expectation is for an AAA to prepare something like this to negotiate fee

for service payment directly with a hospital or from a private pay individual.

The first section will depend on the staff used. For example, if an AAA chooses to replicate an evidence-based program requiring the time and skills of an Advanced Practice nurse that can be listed and the other professionals can be taken off of this form.

The second section will itemize the package of services the AAA can offer to a hospital (per client served) or to a private pay client. An AAA can add or delete programs/services as desired.

When calculating the unit cost, an AAA should build in the intended revenue - above the fixed cost/service.

AAA Cost Calculator for Hospital Transitions Packages

Hospital Care Transitions Cost Calculator

Hospital Transitions Readiness Checklist

Hospital Transitions Readiness Checklist

Talking Points: Why the Aging Network?

(From the Administration on Aging Affordable Care Act Webinar)

- Unique/trusted community organizations for 40+ years
- Knowledge and understanding of older and aging Georgians
- Comprehension of caregiver needs and supports
- Contracting Power Broker - you already know and work with the local, community-based service providers
- Quality and assurance outcomes - your products help meet the needs of the hospitals to keep people in their homes
- Mission of your organization - Does this meet the mission of the hospitals to keep patients at home and out of the ER?
- Do you have staff trained in and able to implement an Evidence-Based HT intervention? Which one? How has this program proven to be successful in reducing readmissions? Why should the hospital contract with your agency? (Because of the above mentioned points!)
- Unique opportunity to provide tailored care to individual clients and keep them connected to community based services even after their 30-day post-discharge time frame.
- If there is competition in the area, how is your AAA staff better qualified? (i.e. access to the wide range of services, specialize across the spectrum of care, etc.)

Explanation of the Hospital Transitions Partner Readiness Assessment

Once an AAA has approached a hospital and the potential for mutually beneficial partnership has been established, both agencies should complete this simple four question readiness assessment.

The intention of the readiness assessment is to ensure very clear and open communication between

both organizations. It is important for both agencies to have an understanding of and acknowledge key partners, a commitment to a common goal, resources both entities bring to this partnership, and possible oppositions to the partnership and HT process. This will allow any possible barriers or issues to be addressed in the very beginning.

It is important to meet often, even once a process is implemented, to ensure that issues can be addressed immediately and both parties are satisfied.

Hospital Transitions Partner Readiness Assessment

	Organizational readiness for partnership: AAAs and Hospitals, Agent for change, and Actions	**Answers**
General Openness to **collaborate**	Who are the organizations' point people for Hospital Transitions?	
Anticipated or actual **response to proposed partnership**	How committed are proposed organizations to improving Hospital Transitions? Is there a common goal(s) for partnership? If yes, what? If no, why not? Are there limitations to partnership?	
Availability of **resources**	Do partnering organizations have necessary pieces in place (staff, HT tools, written commitment, financial resources, established reporting and communication requirements, etc.) to see successful HT implementation?	
Opposition to partnership	What forces outside the organizations are opposing partnership? How strong is that opposition?	

Based on Netting, Ketter, McMurtry's "Assessing System Readiness for Change".

Hospital Care Transitions Cost Calculator

Title III-D Checklist

200/300 Title III E Caregiver Support Programs

216 Kinship Care Services

216.1 Purpose

This chapter establishes guidelines and requirements to be followed when Area Agencies on Aging provide or contract for the provision of services to grandparents or other relatives raising grandchildren or other minor children. Program activities are supported by funding from Title III-E of The Older Americans Act, other state funds, and local funds, subject to their availability. The primary goal is to provide maximum flexibility for AAAs to expand needed services, while continuing to protect the health, safety, and well-being of grandparents and other relative caregivers raising children.

216.2 Scope

These requirements apply to services provided in whole or in part with non-Medicaid federal and specially appropriated state funds managed by Area Agencies on Aging, and any associated matching and local discretionary funds. The Older Americans Act, as amended in 2006 authorizes Title III, Part E, as the National Family Caregiver Support Program, which establishes services to grandparents and other relatives aged 55 and over who have custodial responsibility for grandchildren or other minor children.

216.3 Target Group and Eligibility

The target group for these services comprises grandparents, step-grandparents, or other caregivers related by blood, marriage, or adoption, who:

1. have children for whom they are responsible living with them (as opposed to providing daycare or after school care to children who reside elsewhere).
2. are the primary custodial caregivers because of the inability or unwillingness of the biological or adoptive parents to provide parental care; and
3. have a legal relationship to the children (legal custody or guardianship) or are raising the children informally.

Grandparents/relative caregivers served through the Older Americans Act portion of the program must be at least 55 years old.

The declaration of the caregiver relative regarding residence and full-time custodial responsibility for the children in their care is sufficient for determining eligibility for and admission to the Kinship Care program. Area Agencies on Aging that provide or contract for the provision of services to grandparents / relative caregivers shall give priority to caregivers who provide care for children with severe disabilities.

216.4 Access to Services

Area Agencies shall receive requests for Kinship Care services provided either directly or through their subcontract agencies and maintain and manage waiting lists, as needed. Sources of referrals include but are not limited to: County Divisions of Family and Children Services, libraries, schools, health and social services providers, case managers, Extension Service programs, churches, child-care organizations, housing authorities, and family members.

216.5 Definitions

Child

An individual under age 18.

Support Group

A group of persons who meet on a regular, defined basis to discuss common problems or life issues. The group can have a professional as a moderator or be run by members alone. Support groups function to provide an expansion of social resources and knowledge relevant to members' situations, relief and reassurance, and enhanced coping skills. Also see Appendix 216-A. (Note: definition adapted from Lean on Me - Support and Minority Outreach for Grandparents Raising Grandchildren, September 2003 and About.com web content.

Case Management

Assistance either in the form of access or care coordination in circumstances in which the older person and/or a caregiver are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Also see 210 Case Management Services.

Child(ren) with Severe Disability

An individual under 18 years of age who has a mental or physical impairment, or a combination of mental and physical impairments that has lasted or is expected to last at least 1 year, and which severely limits daily activities. Conditions may include, but are not limited to developmental disability, sensory impairments (hearing, visual, speech), emotional disturbance, autism, learning disability, or health impairments.

Counseling

Providing guidance and assistance with problem resolution by professionally qualified paid or volunteer staff to older persons or caregivers, including grandparents raising grandchildren. Counseling may be provided individually or in group settings, such as support groups or open forums to encourage sharing and questions.

216.6 Program Outcomes

The primary outcomes expected to be achieved through Kinship Care services are:

1. Increased access to and use of formal resources by kinship families (caregivers and/or children), including, but not limited to legal assistance, financial assistance, housing resources, mental/behavioral health services, food and nutrition services, childcare services, physical health care services, school/educational resources, leisure/recreational resources and DAS Wellness Programs, including Chronic Disease Self-Management Education programs;

2. Development of enhanced coping skills by relative caregivers;
3. Prevention of disruption of family care systems, including avoidance of placement of children into the formal foster care system or the assumption of caregiving responsibility for children currently in the formal foster care system;
4. Decreased stress levels among caregiver relatives; and
5. High degree of satisfaction among caregiver relatives with Kinship Care services.

The Kinship Care Survey (See MAN 5300 FORMS section) is designed to measure the expected program outcomes. See also 216.10 Program Monitoring and Evaluation.

216.7 Program Activities

Area Agencies on Aging may elect to provide two or more of the following services and/or kinship care group activities, based upon the needs identified in the respective regions. The services shall have the meaning and unit classifications established by the DAS Taxonomy of Service Definitions (MAN 5600, Appendix F).

- **Information and Assistance Services (Group)**
- **Case Management Service (Individual)**: See HCBS Manual 5300, 210 Case Management Services
- **Respite Care – Out-of-Home (Individual)**: Includes summer camps, child care, and after school care
- **Home Modifications / Repair (Individual)**
- **Material Aid (Individual or Group)**
- **Counseling (Individual or Group)**
- **Kinship Care Group Activities**: Provided on behalf of kinship caregivers and kinship care receivers to support their continued independence and wellbeing. Activities may include any of the following:
  - Care Receiver Supervision
  - Community and Public Education Events
  - Recreational Events
  - Holiday Events
  - Training
  - Tutoring
  - Support Groups
- **Caregiver Conferences and Workshops (Group)**: Targeted information and/or interactive sessions for grandparents raising grandchildren that have a formal theme and agenda, at least one primary speaker or session, and are of at least four hours' duration, inclusive of all activities

Area Agencies on Aging are to develop formal and informal networks that support the provision of Kinship Care Services and are to collaborate closely with organizations and programs as indicated by the needs of the communities being served. Potential partners may include: The DHS Division of

Family and Children Services “Promoting Safe and Stable Families” Program (PSSF); Project Healthy Grandparent Programs; Parent Teacher Organizations (PTOs); faith communities; Boys and Girls Clubs; Big Brother/Big Sister programs; YMCAs and YWCAs; and Head Start programs.

The Area Agencies on Aging may retain a reasonable portion of funding to directly provide community/public education services and/or conferences and workshops, and for collaboration activities with other public or private organizations. Area Agencies may establish line-item budgets using Kinship Care funds for both community/public education and collaboration activities noted above. The Division of Aging Services encourages the use of Evidence-Based Programs whenever possible.

216.8 Staffing

Area Agencies will provide adequate numbers of staff, qualified by training and experience, to implement the Kinship Care program. Area Agencies may directly employ staff or contract for the implementation and administration of the program.

216.9 Data Collection and Reporting

The Area Agencies and subcontractors will collect, record, and maintain client information in the form and formats specified by the Division. The Division may establish additional reporting requirements and formats when necessary to account for program activities and outcomes.

For the purposes of establishing individual client records in the DAS Data System, the *grandparent/caregiver* is recorded as the caregiver for the Older Americans Act. The HCBS Kinship Care Intake Form assessment will be completed for all grandparent/relative caregivers.

Area Agencies will submit to DAS a quarterly program report of collaboration activities conducted with other organizations not later than the 15th working day of the month following the end of each quarter (October, January, April, and July). See Appendix 216-B.

216.10 Program Monitoring and Evaluation

Area Agencies on Aging will monitor providers at least annually to assure accountability for the use of program resources and evaluate the effectiveness of the program activities, using criteria and tools specified or approved by the Division, and other discretionary measures. Standards and guidelines established by the Division apply to eligible service components.

Area Agencies will provide written feedback to providers within thirty (30) days of completing program monitoring and provide technical assistance for continuous improvement in program performance.

If providing program components directly, the Area Agencies will develop objective means of self-evaluation of program compliance and performance.

The Division will evaluate program data periodically and may conduct on-site monitoring evaluations of activities and records.

Using the format and timeframes specified by the Division, Area Agencies/subcontractors will evaluate program results by surveying participants regarding their satisfaction with services provided. Evaluation results, including agency self-evaluations, should inform program improvement and

long-range planning to meet the needs of individual consumers and the larger communities. Results indicators may include:

- the number and percent of program participants who would recommend the program to others;
- the number and percent of participants who continue to participate in support groups or other activities over time;
- the number and percent of participants who continue to provide care over time;
- the number and percent of grandparents who report lowered levels of stress because of Kinship Care program participation;
- the number and percent of grandparents who report that their coping skills have improved;
- the number and percent of grandparents who report that their overall sense of health and well-being has improved.

Staff should administer surveys at least semi-annually in a manner that will gain maximum input from as many program participants as possible. If a participant leaves the program prior to that point, staff should attempt to administer the survey at that time.

If Kinship Care services are subcontracted, the AAA may decide whether the surveys should be administered by the AAA or directly by the organization providing services.

Area Agency staff will submit a compilation and analysis of survey results, to be included with the subsequent Quarterly Program Report. See Appendix 216-B for the Quarterly Program Report template. See HCBS Manual 5300, Appendix D, Kinship Care Program Survey for the survey template.

References

The Brookdale Foundation, Relatives as Parents Program (RAPP): www.brookdalefoundation.org

University of Georgia Cooperative Extension Service: www.fcs.uga.edu/extension/family-supporting-seniors

Grand Facts - AARP Kinship Care Georgia Fact Sheet: www.aarp.org/content/dam/aarp/relationships/friends-family/grandfacts/grandfacts-georgia.pdf

Zero to Three – National Center for Infants, Toddlers, and Families: www.zerotothree.org/parenting/grandparents-extended-family

National Research Center on Grandparents Raising Grandchildren: www.wmich.edu/grandparenting/

AARP (information on caregiving for an older adult and grandchildren): www.aarp.org/caregiving/

Support Group Training Manual for Kinship Care and Grandparents Raising Grandchildren, State of Arizona, Governor's Task Force on Aging www.nysnavigator.org/documents/grandparentsmanual1.pdf

Lean on Me – Support and Minority Outreach for Grandparents Raising Grandchildren, AARP www.aarp.org/relationships/grandparenting/info-2003/aresearch-import-483.html

Appendix 216-A Support Groups

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	200	**Effective Date:**	
	Section Title:	Support Groups	**Reviewed or Updated in:**	MT 2021-06
	Section Number:	Appendix 216-A	**Previous Update:**	

Characteristics of Support Groups

Support groups:

- create a safe and supportive environment in which participants can discuss their experiences
- provide respite from the cares and worries of day-to-day problems
- educate and inform members
- assist members in developing methods and skills for solving problems
- encourage personal growth and development of members

While a support group can offer emotional support and aid in finding resources, a support group is not a replacement for:

- formal, private (one-on-one) counseling with a professional
- legal advice from a practicing attorney or paralegal
- direction from a licensed school psychologist or guidance counselor
- any other services that depend upon professional training and certification[18]

Starting a Support Group

Selecting a meeting site[19]:

Consider using churches, schools, banks, social service agencies, hospitals, libraries, YMCAs, YWCAs.

> **NOTE** Keep in mind that some grandparents are reluctant to attend meetings at "social service agencies" so you may wish to hold meetings at a "neutral" facility.

Consider the following when selecting a meeting site:

- Is there a separate and safe area for the children to meet/play?
- Is public transportation available?
- Are there kitchen facilities for meal/snack preparation or to accommodate food deliveries?
- Is the area private?
- Is the area accessible to persons with disabilities?

Identifying grandparents who are raising grandchildren:

Outreach efforts should attempt to identify grandparents through several sources, for example:

- Public/private schools/school boards/PTAs
- Pre-schools and day-care programs
- Boys' and Girls' Clubs
- 4-H Clubs
- Pediatrician and dentist offices
- Local public health departments and clinics
- After school programs
- Community centers
- Church bulletins
- Grocery stores
- Banks
- Social service agencies
- Hospitals
- Libraries
- Senior centers
- United Way
- Police and Sheriffs' departments
- Lawyers
- Court systems

Ways to market and promote support groups to the community:

- Develop a one-paragraph, easy to read summary describing your group and how it will benefit grandparents and grandchildren.
- Develop a flyer announcing the group, meeting date, time, location, childcare, contact person, phone number. Post this in:
    - grocery stores
    - drug stores
    - banks
    - childcare facilities
    - libraries
    - hospitals
    - church bulletins
    - senior or community centers

    - doctors’ offices
    - health clinics
    - Head Start programs
    - social service agencies
    - local Departments of Family and Children Services
    - social service or counseling agencies or
    - request it be sent home with school children or in school newsletters
- Have a "kick off" event in collaboration with an agency, hospital, library, or school on an issue relevant to grandparents raising grandchildren.

  For example: An evening or lunch hour presentation by an attorney discussing guardianship or custody issues. Supply the support group with “take away” information and have grandparents "sign in" at the session.

- Contact local newspaper reporters and ask them to write an article on grandparents raising grandchildren; mention the support group.
- Contact local TV and radio stations regarding opportunities for public service announcements and talk shows.

What Makes a Good Support Group

Although what is "good" differs for each person, there are some universal signs that indicate a well-functioning group[20]:

- Up-to-date, reliable information
- Prompt response to contacts
- Regular meetings or newsletters
- Access to appropriate professional advisors (for example, doctors, therapists for grief support, or employment attorneys for workplace discrimination)
- Strong leadership
- A clearly stated "confidentiality" policy
- Ensuring accessibility of the support group by planning for the time, location, and availability of transportation

Appendix 216-B Kinship Care Quarterly Program Report

302 Adult Day Care | Day Health Services

302.1 Purpose

This chapter establishes the guidelines and requirements for Area Agencies on Aging (AAAs) that provide or contract for the provision of adult day and adult day health services to older adults, persons with disabilities, and their caregivers. These requirements apply to services funded fully or partially by funds received through the Department of Human Services Division of Aging Services (DHS DAS) and are suggested for use in agencies providing these services as a fee-for-service enterprise.

Adult day services provide supports for elderly individuals, and their families, if present, who do not function fully independently, but who do not need 24-hour nursing care. Participants may have:

- Some degree of physical disability
- A social impairment
- Mental confusion
- Need for some assistance with activities of daily living that fall short of the need for placement in an institution
- Returned from a recent hospital or institutional stay

Adult day services are comprehensive and are based on participants' individual needs. They are family-focused when families are involved. They are outcome-oriented with a goal of enhanced independence. The programs provide safe group environments with coordinated health and social services aimed at stabilizing or improving self-care. Qualified staff implements best practices in service delivery. Adult day services may prevent, postpone, or reduce the need for institutional placement.

Programs providing adult day services fit into two distinct types (i.e., *adult day* and *adult day health*). *Adult day* programs follow a social model and primarily provide recreational and social activities and opportunity for community involvement. These programs target elderly adults whose physical condition is relatively stable and who perform the activities of daily living with a high degree of independence. Generally, participants in adult day programs need minimal supervision and assistance with activities of daily living.

In addition to recreational and social services, *adult day health* programs follow a medical model and provide health and rehabilitative services. The goal of services provided through these programs is rehabilitation or maintenance of each person's highest level of functioning and independence. The clients served through these programs need physical assistance and a more structured environment. Staff routinely monitors a variety of medical conditions. In many instances, programs offer therapy services when needed and based on an individual plan of care.

302.2 Scope

These requirements provide guidance on operating adult day and adult day health programs. The two program models can be provided within the same center facility conditional upon the agency or agencies being qualified to operate the discrete models. Individualized care is provided to meet the specific needs of each participant, but program activities may be blended, if appropriate, to include individuals with various limitations. Staff patterns will vary accordingly.

These requirements apply to all Adult Day/Adult Day Health activities and services provided through contracts executed by an Area Agency on Aging or its subcontractors and supported by non-Medicaid Home and Community Based Services funding, including Older Americans Act funds, State general revenues, other funding granted or appropriated through DHS DAS for use in providing services, or other funds pooled with such funds to meet the costs for services under the Older Americans Act.

302.3 Definitions

Activities of Daily Living (ADLs)

The basic tasks of everyday living that are required for self-care and independent living, and include eating, dressing, bathing, grooming, transferring, and continence.

Adult Day Care

Community based programs that provide non-medical care, primarily social and recreational activities, to persons aged 60 and over, in need of limited personal care assistance, supervision or assistance essential for sustaining the activities of daily living; or for the protection of an individual on less than a 24-hour basis. Services are provided based on individual plans of care. Participants in this model of care will have minimal to moderate levels of impairment in physical and/or mental functioning on ADLs, based on assessments using the Determination of Need-Revised (DON-R) and the Montreal Cognitive Assessment (MoCA). Unless otherwise identified, Adult Day Care implies a social model program.

Adult Day Health Care

Community based programs that provide social, rehabilitative, health and personal care services to persons aged 60 and over with physical and/or mental impairments, for restoring or maintaining optimal capacity for self-care. These programs provide services through individual plans of care and target elderly persons who could be at risk of institutional placement if intervention is not provided. These may be persons whose need for assistance is greater than that of participants in the basic adult day care program. Participants in this model of care will have moderate to high levels of impairment in physical and/or mental functioning on ADLs, based on assessments using the DON-R and the MoCA. Unless otherwise identified, Adult Day Health Care implies a medical model program.

Alzheimer's Day Care

Community based programs may provide either Adult Day Care or Adult Day Health Care described above for persons in the various (mild, moderate to severe) stages of Alzheimer's disease or related dementias, regardless of age. Participants in this model of care will have moderate to high levels of impairment in functioning on ADLs, (whether physical, mental, or cognitive) based on assessments using the DON-R and the MoCA.

Counseling

A service provided to day care participants and caregivers to assist them in making decisions and solving problems. Counseling provides guidance and assistance with problem resolution from professionally qualified paid or volunteer staff to older persons. Primary reasons for counseling include, but are not limited to, depression, grief, family problems, and lifestyle changes.

Direct service staff

Employees of a day care program, including the administrator, licensed nurses, activities director and assistants who are involved in the provision of services to individual participants. Programs may employ staff to provide business support services only, such as bookkeeping and billing, office management, etc. These positions are not used to provide care and services to participants.

Health related services

Services provided by trained and qualified nursing staff that include obtaining vital signs including weight, monitoring glucose or blood sugar levels, and administration or supervision of medications.

Mobile Adult Day Center

A program of services offered by an adult day center that utilizes a designated staff that travels from one central location to off-site location(s) to provide adult day services as described in this policy. The mobile adult day center transports the necessary staff and/or volunteers, participant records, supplies, and program materials to each off-site location for the provision of services. Mobile adult day centers may offer social or health model programs, or both, and are offered less than four days per week at any one location.

Severely Impaired

Any physical or cognitive impairment leading to a participant's inability to perform any three or more activities of daily living (ADLs) while at the program. The severely impaired participant is unable to perform these ADLs at the day care site unless staff prompts the behavior, and/or aids and supervision. This is documented by a score of 2 or higher in any three of the six ADL domains of the DON-R.

302.4 Target Group

The target group for this service is persons 60 years of age or older, and collaterally their spouses/caregivers who:

- Are experiencing some degree of impairment in their physical and/or cognitive functioning regarding the performance of activities of daily living; and/or
- Need supervision or oversight for all or part of the day; and/or
- Need a break from caregiving responsibilities for all or part of the day.

In addition, Adult Day/Adult Day Health programs may serve adults of any age (and collaterally their spouses or caregivers) who are known to have, or who exhibit symptoms of, Alzheimer's disease or related disorders using state or local funds.

Each program must develop and maintain written policy defining appropriate and inappropriate

participants.

Social model programs must not provide services to persons who:

- Are bed bound or do not have the stamina or strength to attend the center, due to extreme frailty or fatigue
- Have emotional or behavioral disorders that are severe in nature and cause them to be destructive to themselves or others, or who are disruptive in a group setting, unless the center has the capacity through adequate and qualified staffing to appropriately manage such behaviors; or
- Would not benefit from the activities and services offered at the program, due to higher levels of physical and cognitive functioning being needed for participation.

302.5 Outcomes and Indicators

The desired outcomes of Adult Day Care/Adult Day Health programs include:

- Participants will maintain or increase their level of functioning.
- Participants will experience an improved quality of life, due to increased socialization, and physical and cognitive exercises.
- Participants will be able to remain in their homes or in the community longer, delaying institutional placement.
- Caregivers are better able to cope with the stress of caregiving, due to the care receiver's participation.

302.6 Core Services

The scope of services for each program must be based on the written description of the program. Adult day centers may provide an adult day care program or an adult day health care program, which are differentiated by the intensity and scope of services.

Adult day and adult day health programs are encouraged to offer a range of holistic activities based on the Six Dimensions of Wellness (see MAN 5300 CH 302.27, References).

302.6A Core Services for Adult Day Programs

The range of services provided for social model programs must include at least the following

- Social and leisure activity programming which takes into consideration individual differences in health and functioning, lifestyles, ethnicity, religious affiliation, values, experiences, needs, interests, abilities, and skills
- Meals (and snacks based upon daily program duration)
- Counseling for participants and caregivers, when appropriate
- Assistance and supervision (including the use of visual cues with persons with dementia) commensurate with the needs of participants; and
- Individual and group activities that encourage creativity, social interaction, and exercise or physical activity appropriate to each participant's functional status and abilities.

The services provided by the program as part of implementing individualized service plans must:

- Involve participants to the maximum extent possible in the planning and implementation of the activities
- Include individual and group activities that encourage creativity, social interaction, and physical exercise; and
- Provide opportunities for indoor and outdoor activities, including outings to points of interest and involvement in the community, to the extent that participants' physical and cognitive conditions permit them to participate.

Adult day care core services offered must comply with Department of Community Health Rules Chapter 111-8-1-.12 (see link in MAN 5300 CH 302.27, References).

302.6B Core Services for Adult Day Health Programs

In addition to the core services provided, adult day health model programs must include the following health-related services:

- Nursing services
- Health monitoring
- Medication administration (see §302.13)
- Physical therapy
- Occupational therapy; and
- Speech therapy.

Nothing in these standards must preclude licensed therapists from providing services to an individual participant in an adult day setting.

Adult day health model services offered must comply with Department of Community Health Rules Chapter 111-8-1-.12 (see link in MAN 5300 CH 302.27, References).

302.6C Optional Services for Adult Day Programs

Additional services may be arranged for or provided by the social model adult day care program and may include transportation, health screening, prevention activities, social services, personal care services, assistance with medications, and educational activities. Optional services, and any associated costs, must be explained in the written program description.

Assistance with medications in an adult day social model program implies that the participant can self-administer medications with minimal staff assistance, such as reminders, verbal prompting, checking dosages according to the container label, and assisting a participant with opening or pouring medications. See MAN 5300 CH302.13, Medication Management.

302.7 Access to Services

Area Agencies on Aging must receive requests for and screen all applicants for adult day services provided by their subcontract agencies with aging program funding. The AAAs will maintain and manage waiting lists for the services, as necessary. Services will be provided in a variety of settings

outside the participants' homes.

302.8 Service Provider Eligibility

Providers must specify the type or types of day care services to be provided, based on the target population(s) to be served, and must respond to the Request for Qualifications/Proposals issued by the Area Agency on Aging.

Providers must use the DHS DAS Uniform Cost Methodology to establish a unit cost for reimbursement for the non-Medicaid funded program.

302.9 Program Characteristics

Services and activities must be identified by the following characteristics:

- The provider has identified the target population to be served by the program and has determined an initial level of functioning for each client through a comprehensive assessment.
- The level of functioning will be used to determine each client's daily activity schedule, also considering each client's personal interests and past experiences.
- Each client's daily schedule is made up of diverse activities that maintain, restore, or improve their functioning.
- Daily program activities are designed for each participant and provide the basis for individual and program outcome measurement.
- The provider collects outcome data that are used to validate current assessments of clients' levels of functioning, i.e., whether the scheduled activities in each client's individual care plan are appropriate for their level of functioning.
- The provider analyzes outcome data and modifies or adjusts individual activity plans accordingly.
- The services/activities are flexible according to each participant's abilities, interests, and needs.
- Clients have choices about which, if any, of the available services they will use.
- Staff complete periodic reassessments based on requirements described in MAN 5300 114 Guidelines for Client Assessment.
- Staff assist older persons and/or their family caregivers to act on their own behalf.

302.10 Administrative Requirements

Each provider will comply with the following administrative requirements as a condition of receiving funds distributed through the Area Agency on Aging.

302.10A Days and Hours of Operation

Each facility must establish core hours and days of operation during which day care services are available and that reflect the needs of the communities and client/caregiver populations identified as target groups.

Facilities must offer programming to participants for a minimum of five continuous hours per day

(excluding transportation time) when providing day care services. Providers must document their efforts to expand core hours and days of service to meet the needs of the communities in which they provide services, based on customer surveys and market analyses.

Providers may establish separate rates for non-traditional hours or hours beyond the core hours of operation, provided these rates are posted and consumers acknowledge the rates prior to the provision of services. Such rates must be approved by the Area Agency on Aging if used as a payor source.

302.10B Program Description

Each adult day care/adult day health program must have a written description of the following that is available to consumers upon request:

- A definition of the program goals, the days and hours of operation, a description of the services provided or made available to participants, and a description of the target population to be served by the program.
- A description of any limitations of the program for providing services to individuals with special care needs.
- The program's policy for fees for service and private pay services including the daily charge; any additional fees for specific services, goods, or supplies that are not included in the daily charge (e.g., transportation, bathing assistance, personal care assistance, etc.); the method for notifying participants or their representatives of any changes or adjustments in fees; and the policy regarding non-payment of fees.
- The program's policy and procedures for accepting voluntary contributions from or on behalf of participants, including safeguards to prevent denial of service for non-contribution.
- The procedure for informing participants' families/caregivers of any major change in general functioning or medical condition
- The procedures for documenting any incident occurring at the program site that would affect the health, safety, or welfare of participants.
- A statement of how the program will handle situations when a participant arrives at the site with a communicable illness or begins to display symptoms of such an illness while at the site.
- An explanation of how emergency medical situations will be handled at the site, including how participants and caregivers are informed of the procedures. The facility must:
    - Stock and maintain first aid supplies to treat burns, cuts and poisoning in a single location. Staff must assure that supplies with shelf dates are replaced in a timely manner to avoid expiration.
    - Plan for emergency care and/or transfer to an appropriate place for treatment, including, but not limited to, physician's office, clinic, or hospital.
    - Have a procedure in place to provide immediate notification to the client's physician, next of kin/responsible party, or agency who places the client in the facility of any accidents or injuries.
    - Describe and document each accident, injury, or illness, including a statement of final disposition.

- Policy and procedures to assure that no staff member, volunteer, visitor, or any other person may be on the premises of the center during the hours of operation if the person exhibits symptoms of illness or communicable disease transmitted by normal contact, or behavior that gives reasonable concern for the safety of the participants and others.
- A procedure for following up on any unexplained absences of participants.
- A statement of smoking restrictions for the facility and precautions to be taken for non-smoking participants, if appropriate.
- A procedure for obtaining a signed authorization from the participant or caregiver, if applicable, allowing the release of any information about the participant to a third party.
- A description of the criteria for voluntary and involuntary discharge of a participant from the program, and the time frame for notifying the participant and/or caregiver prior to an involuntary discharge.
- A procedure for investigating and resolving complaints made by participants, family or other caregivers, or other interested persons about the services provided by the program, including providing information to such persons about appropriate local, county and/or state agency contacts.
    - Staff must inform new participants or their representatives in writing of the facility's complaint procedures upon admission to the program.
    - Staff must date-stamp all written complaints received and maintain accessible records of the complaint and resolution.
    - Designated administrative staff must assure that facility staff register and evaluate all complaints brought to their attention within five business days of receipt of the complaint.
- The program must maintain an organizational chart, illustrating the lines of authority and communication within the program.
- Program staff must provide written information about the program, as described in this section, to all applicants and to other interested parties upon request.
- Program participants and/or their caregivers, if any, must receive at least 30 days' written notice prior to any changes in program goals, the days and hours of operation, the services provided or made available to participants, and target population to be served that would have a direct effect on the participants.

302.10C Written Agreements

The program must initiate and maintain written agreements that describe:

- Administrative or health related care services that are provided for the program by any outside agency or organization
- Collaborative relationships with other agencies that share space or program staff within a multi-use facility
- Disclosure of the provision of specialized services for persons with Alzheimer's disease and related disorders. Any programs or facility that advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's disease or a related dementia is required to complete the Alzheimer's Disclosure

Form and provide copies of this information to anyone who requests information about placement in, or care, treatment, or therapeutic activities from, this program (O.C.G.A. §31-8-182). (See Manual 5600, Appendix D, for a copy of the Alzheimer's Disclosure Form).

302.10D Record Maintenance

Personnel records – The facility must keep personnel records in a central location in the facility for six years according to record retention requirements.

Participant attendance records – The facility will maintain a record of daily attendance and transportation to and from the facility, including the time each person began receiving services each day and the time they left the facility's care. If transportation is provided by the facility, the driver's transportation records will also document times of arrival and departure. The facility also will document arrival and departure times for participants not using facility-provided transportation.

Transportation records – The facility driver(s) must maintain accurate daily transportation and mileage records, and records of expenses for purchases of gas and oil.

Participant program records – The program must maintain and retain participant records in a secure place according to state records retention requirements for at least six years upon discharge/termination from the program.

Complaints – Staff must date-stamp all written complaints received and maintain accessible records of the complaints and resolution.

All client records will be maintained pursuant to MAN 5600 1060 Division Reports, Overview, MAN 5600 1061 Older Americans Act Performance System (OAAPS), and MAN 5600 3012 Provision of Services by Area Agencies on Aging. See also MAN 5300 CH 202.5.

302.11 Participant Enrollment Procedures

The applicant and caregiver, if applicable, must be informed of the length of any "trial period" required by the adult day care program to determine its ability to serve the individual and the individual's desire to participate in the program.

Staff must provide clients or their representatives with written notice of the program's complaint procedures upon admission to the program.

The adult day care program must obtain and document upon acceptance into the program any additional relevant participant and caregiver information as may be required by the DHS DAS non-Medicaid Home and Community Based Services program. Program staff must have access to and maintain in an approved method and medium the following information at a minimum:

- The participant's full name, address, telephone number, date of birth and living arrangement
- The name, address, and telephone number of the participant's primary caregiver(s)
- The name, address, and telephone number of at least one family member or significant other designated as the emergency contact, if different from the primary caregiver
- The name, address, and telephone number of the participant's primary care physician; and

- The name, address, and telephone number of the referring or coordinating agency and case manager, if applicable.

The program must maintain all participant information on site, either in manual or electronic formats approved by DHS DAS.

The participant or responsible party must sign a statement acknowledging receipt of a written description of services to be provided and the cost of those services. The facility will maintain the original signed copy in the client record and provide a signed copy to the client or their representative.

Health Statement – The program must obtain a statement signed by a licensed physician, physician's assistant, or registered nurse within 90 days prior to enrollment, that includes:

- An indication that the participant is free from any communicable disease that would be detrimental to other participants and staff, including tuberculosis
- A list of current diseases, chronic conditions, and drug, food, or other allergies
- A statement of any restrictions in the participant's ability to participate in program activities; and
- The names of all prescribed over the counter and alternative medications including dosages currently being used by the participant.

Program staff must assure that any participant discovered to have a communicable condition of any duration is referred immediately for treatment.

If the AAA or other case management agency staff has assessed participants prior to admission to the day care program, that agency must provide to the day care program a copy of the comprehensive assessment for use in service planning. If no assessment has been completed prior to admission, the day care program staff must conduct the comprehensive assessment, using the instruments specified by DHS DAS prior to developing an individualized plan. Staff members conducting assessments must have the expertise, experience and/or training relevant to the client population being served.

Staff must complete the service plan to meet the person's identified needs and implement the plan within 30 days of admission. Service plans must be completed in the manner specified by the DHS DAS and must include the following:

- Comprehensive information about the participant's functional abilities and disabilities, strengths and weaknesses, personal habits, preferences, and interests, likes and dislikes, medical condition, and any other information helpful to developing the service plan, such as a life review. Staff will use the MoCA to assess cognitive functioning. The core assessment instrument for functional capacity and unmet need for care is the DON-R and, along with the MoCA, is the primary source of information for service planning. The NSI-DETERMINE Checklist is used when appropriate to determine nutritional status and unmet dietary needs.
- A statement of the services and activities the program will provide to meet the needs and personal interests identified in the initial assessment.
- Documentation of the participant's usual travel arrangements to and from the site, the usual times for arriving and leaving, and any plan for using transportation services.

- Staff must review and update the individualized service plan every six months, or more often if warranted by changes in functional status, cognitive status, health condition, or preferences. Staff must document any changes in the participant's record.
- Staff must document participant progress toward attaining and maintaining service plan goals for each participant, including using any indicators and outcomes that may be established by the DHS DAS.
- Staff must conduct comprehensive reassessments of each participant at least semi-annually, or more often as changes in conditions indicate.
- The program must establish processes and mechanisms that foster regular, timely communications among staff, and with the participant and caregiver about the participant's daily capabilities, interests, general well-being, and response to the service plan.

302.12 Meal Requirements

The program must assure that an appropriate, nutritious meal is provided to each participant in attendance at the program for four or more hours, with lunch service occurring between the hours of 11:00 a.m. and 1:00 p.m. Centers that provide flexible or alternative hours must plan for the provision of morning and/or evening meals.

Meals served by the facility must follow all requirements described in MAN 5300 CH 304 and must be served according to menus developed by a qualified dietician.

Special diet meals, including texture modifications, ordered by the client's physician, and developed by a dietician, must be labeled with the client's name and type of diet.

The facility must make available nutritious, appropriate snacks for those participants who may need and want them (morning and afternoon, at a minimum, depending on hours of operation and attendance).

Programs may purchase meals meeting the dietary requirements from agencies that provide meals for the Non-Medicaid Home and Community Based Services Program, in accordance with Older Americans Act Nutrition Program requirements.

Programs must arrange for or provide dietary counseling and nutrition education for clients and their caregivers, using the services of appropriate professionals from the field of dietetics and adult nutrition.

302.13 Medication Management

The adult day care program must have a written policy for medication management and must designate specific staff to be authorized and trained to assist with the assistance or administration of medications. The policy must address the program's role in the supervision of self-administered medications and/or staff administered medications.

Administration of Medications

All medication prescribed to clients must be dispensed through a pharmacy or by the client's treating physician or dentist.

When obtaining a physician's verbal authorization, follow-up and written documentation must be secured and included in the participant's records within 30 days to confirm the authorization.

Clients who choose not to or who cannot self-administer their medications must have their medications administered by a person who holds a current license under state law that authorizes the licensee to administer medications.

Physician samples may be given to a client provided the medication has specific dosage instructions for the individual client and is in its original packaging.

Assistance with Self-Administered Medication

Program staff may assist the participant with physician-prescribed medications that are to be self-administered. Assistance is limited to the following:

- Reminding the client to take the medicine
- Reading to the client the correct dosage and frequency indicated on the container label
- Opening containers or packages and replacing lids
- Returning medications to the proper locked areas

General Medications Management Procedures

Each client record must contain physician's orders for all prescribed medications and treatments directly related to services being delivered.

Each client record must contain a medication profile with current medications, pharmacy name(s), strength, dosages, frequency, directions for use, route of administration, prescription numbers, and dates of issuance by each pharmacy.

The label of such a prescription medication constitutes the pharmacist's transcription of documentation of the order. Such medications should also be listed on the plan of care.

Each client record must contain documentation of known drug, food and contact allergies and adverse reactions.

Staff who assist with medications must report to the RN/LPN or supervisor any changes in the client's condition, including those which may be related to medications.

The Supervisor or RN/LPN must immediately communicate any concerns or unusual reactions regarding the client's medications or treatments to the client's physician and responsible party.

When the program staff supervises or administers medications, the actual administration of medications must be documented in the participant's permanent record, including the name of the medication, dosage, method of administration, date and time administered, and the name of the staff member who administered the medication. Staff must keep a written record of occasions when the client does not receive or take medications/treatments as ordered/prescribed.

Storage of Medications

The facility must provide a locked area for all medications, including over-the-counter drugs. All

medications must remain in the original labeled containers.

Each participant's medication must be stored separately from other clients' medication within the storage area.

Refrigerators used for medication storage must be in designated and locked storage areas. Medication requiring refrigeration must be stored in a refrigerator used only for medicine storage, or in a separate and locked storage box in a refrigerator.

Poisonous substances and medications labeled "For external use only" must be stored separately from other medications within the locked storage area.

Disposal

Healthcare professionals who administer injections, or perform other procedures involving the drawing of blood, must dispose of sharps in appropriate sharps disposal systems or containers, in accordance with O.C.G.A. 31-12-13, and any applicable guidelines issued by the Centers for Disease Control and Prevention, the National Institute of Occupational Safety and Health (NIOSH), the Occupational Safety and Health Act (OSHA), and any other governing rules and regulations (see Sharps Disposal Guidelines in Appendix 302-A).

Medications kept in a central storage area are to be released to discharged clients when the clients or a responsible party have signed a receipt for the medications.

302.14 Transportation

Adult day care programs providing transportation for participants must assure that providers of transportation carry liability insurance and have a valid operator's license in the appropriate class.

All transportation provided in connection with an adult day program must comply with all requirements described in MAN 5300 218 Transportation Services.

302.15 Personnel Policies

The administrator must develop and maintain written personnel policies and provide them to each employee. The contact must address the program's/organization's policies on:

- Annual and sick leave
- Educational opportunities
- Pay practices
- Employee benefits
- Grievance procedures
- Performance and evaluation procedures
- Termination procedures
- Authority for hiring and terminations
- Use of any work test or probationary period
- Staff participation in review of personnel practices

- Maternity leave
- Military leave
- Family Medical Leave
- Civic leave (jury duty and court attendance)

302.15A Personnel Files

The adult day care program must maintain on site a file on each employee that is available to the Area Agency on Aging staff, DHS DAS staff and any other appropriate state or federal staff who may monitor the program. Programs that are operated from a central office at several branch locations may, with the AAA's approval, maintain staff files at the central office. However, such files must be made available in a prompt and timely manner for purpose of monitoring or evaluation.

Each file must include at a minimum: the employee's name, address, and date of birth; educational status; previous work experience and letters of reference; the name, address, telephone number of the person to be notified in an emergency; and any documentation or training, certifications, licensure, etc. At a minimum, emergency contact information for each employee is maintained at each site if primary files are house in a central office.

Letters of Reference – The day care administrator also must obtain three letters of reference or the names of individuals with whom a reference interview can be conducted, including at least one former employer, if any, for each prospective employee. The individuals providing reference information must be knowledgeable of the applicant's background and qualifications and may not be related by blood or marriage. If the position being recruited is that of the administrator, these requirements accrue to the employing agency

Health Status Check – All employees working directly with participants must have had a health examination within six months prior to beginning work.

The report must certify that the person is in good health, including freedom from communicable disease that are detrimental to the participants, (including tuberculosis), and otherwise fit for employment. The reports must be signed by a licensed physician, physician's assistant, or registered nurse.

If staff cannot produce evidence of acceptable health status, the administrator may commence, continue, terminate, or reassign employment status, based on an assessment of whether the employee's work tasks would pose a significant risk to the health of the employee, co-workers, or the public, or whether the employee is unable to perform the normally assigned job duties.

Performance Reviews – The administrator must establish a performance review and evaluation process that will be used by all appropriate supervisory personnel at least annually and following any probationary period.

Position Descriptions – The administrator must assure that for each full time and part time position there is a current, written job description that includes:

- Qualifications of education, experience and personal traits required
- To whom the employee is responsible

- Duties and responsibilities
- Salary ranges.

It is suggested that the employee sign their position description that indicates understanding of the duties and responsibilities to be performed.

Adult Day/Adult Day Health personnel policy must comply with Department of Community Health Rules Chapter 111-8-1-.14 (see link in MAN 5300 CH 302.27, References).

302.16 Staff Position Qualifications and Duties

Each program must be operated with adequate numbers of qualified staff, according to the target population(s) and models of programming provided. The program may contract for certain staff services, including activities director, if all program requirements ordinarily fulfilled by employees are met. The characteristics of the participants will determine the number and types of staff required. If a mixed model of programming is proposed, the staffing required for the highest level of care will be assured.

At least one staff member who has current certification in first aid and CPR must be always in the center.

Suggested staff positions are described below. Each center must have a director/administrator who is responsible for the daily operations of the program and must identify the staff person who is responsible for directing activities for the center.

302.16A Staffing Patterns and Ratios

The administrator must plan for and fill staff positions according to the goals of the program and the manpower needed to develop and direct the activities that meet the program goals.

At least one staff member must be always on the premises participants are present.

In addition to administrative staff there must be a minimum of one direct service staff person for each eight non-severely impaired participants at the day care site.

In addition to administrative staff, there must be a minimum of one direct service staff person present for each four severely impaired participants at the day care site.

The day care program must provide sufficient staff time and staff expertise to implement the program and to develop participant service plans.

The program must document daily staffing patterns through timecards, time sheets, or other appropriate methods used for payroll purposes.

Volunteers who meet the same standards, requirements, and training as employees and who have signed a written job description may be counted as part of the staff-to-client ratio.

Adult Day/Adult Day Health staffing policy must comply with Department of Community Health Rules Chapter 111-8-1-.13 (see link in MAN 5300 CH 302.27, References).

302.16B Center Director | Program Administrator

The Program Administrator must have:

- Demonstrated experience as an administrator or supervisor in adult day care, or
- A Bachelor's degree from an accredited four-year college or university, with at least one year of experience in working with people in a human services program; or
- 60 semester hours, or an associate degree from an accredited college or university with three years' experience in working with people in a human services program

Center Director/Program Administrator duties include, but are not limited to:

- Managing the adult day care program and the facility, including preparation and management of the annual budget, if applicable
- Training and supervising facility staff
- Monitoring the facility building and grounds to ensure compliance with all codes and requirement
- Developing or overseeing the preparation of clients' individual plans of care
- Maintaining or overseeing all financial and client record
- Developing relationships with community groups and agencies for identification and referral of clients; and
- Maintaining communication with clients; family members or responsible parties.

302.16C Activities Director

The Activities Director must have:

- Completed appropriate college-level and clinical training in creative art therapy (providing art, music, drama, and dance/movement therapy) and are certified by the appropriate national professional organization in their field; *or*
- A Bachelor's degree from an accredited college or university, plus one year experience in working with the elderly or people with disabilities/dementia, or in a human services program; *or*
- 60 semester hours from an accredited college or university, plus two years' experience in working with the elderly or people with disabilities/dementia, or in a human services program; *or*
- Completed a formal training program for activities directors, plus two years' experience in working with the elderly or people with disabilities/dementia; *or*
- Two years' experience in a social or recreational program within the last five years, one year of which was full-time in a patient activities program in a health care setting.

Anyone hired prior to July 1, 2015, who has served continuously in the capacity of activities director, may be considered qualified as the activities director.

Activity Director duties include, but are not limited to:

- Planning and directing the daily program of activities, including physical fitness exercises or other recreational activities

- Recording the client's social history
- Assisting with the client's related support needs
- Assuring that the identified related support services are included in the client's individual plan of care; and
- Signing and dating monthly progress notes about social and related support service provided.

302.16D Nursing Staff

Adult day health programs must always have an RN or LPN present. If the center employs an LPN, the center must ensure that the LPN is supervised by an RN and is available by phone, pager, and/or email when not on site at the center.

A **Registered Nurse** (RN) must have:

- A current Georgia license to practice as a Registered Nurse
- At least one year experience in a health or social services field, preferably with work in aging and/or adults with chronic impairments
- Current certification in CPR and First Aid

Registered Nurse duties include, but are not limited to:

- Assessing the client's nursing and medical needs, if appropriate to the population being served
- Developing or contributing to the development of client's individual plan of care
- Obtaining physician's orders, when appropriate, for medication and treatments to be administered
- Determining whether clients have appropriately taken, applied, or used self-administered medications
- Entering, dating, and signing monthly progress notes on any medical care provided
- Administering or supervising the administration of medication and treatments
- Providing health education to clients and caregivers; and
- Maintaining the medical portions of the client records.

A **Licensed Practical Nurse** (LPN) must have:

- A current Georgia license to practice as a Licensed Practical Nurse
- Experience within the last five years in a health or social services field, preferably with one year's recent (within 2 years) experience in health or social services field
- Current certification in CPR and First Aid

Licensed Practical Nurse duties include, but are not limited to:

- Writing progress notes at least monthly, if not completed by the Registered Nurse
- Assistance to the client in learning self-care
- Client teaching

- Assistance with personal care/ADLs
- Range of motion exercise and ambulation assistance
- Administering and assisting with medications under the supervision of the RN
- Observing and reporting any client changes to the RN; and
- Completing documentation.

302.16E Day Care Assistants

Day Care Assistants must be at least 18 years old, and may also perform the duties of bus drivers, aides, cooks, custodians, porters, housekeepers, and laundry workers.

All assistants who serve as drivers must have a current Georgia operator's license, which is appropriate for the class of vehicle used to transport clients and must maintain current Adult Cardio-Pulmonary Resuscitation (CPR) certification.

If an assistant prepares or serves food in the facility, they must observe and meet all state and local health requirements for food service sanitation.

Day care assistant duties include, but are not limited to:

- Providing personal care services (assistance with activities of daily living [ADLs])
- Assisting with recreational activities; and
- Providing protective supervision (observation and monitoring).

302.16F Other Staff Positions

The facility may engage the services of additional professional staff provided that associated requirements and responsibilities/duties are documented. Examples include:

- **Dietician consultant** – The dietician consultant will be a Registered Dietician, licensed to practice in Georgia, who will plan and/or review menus and will:
  - Approve in advance and sign each snack and meal menu
  - Review menus monthly to assure that any substitutions made are appropriate; and
  - Develop any special diets specified by physicians for individual clients.
- **Registered Nurse consultant** – In facilities in which nursing services are provided by a LPN, a Registered Nurse consultant must provide on-site consultation not less than four hours per week and will:
  - Document the consultation provided
  - Provide the consultation at the facility during the hours the clients are present
  - Review care plans and recommend changes, as needed
  - Assess client's health conditions
  - Consult with the LPN in solving problems involving client care and services planning
  - Counsel clients and caregivers on health needs

- Train, consult and assist the LPN in maintain proper medical records; and
- Provide in-service training for direct service staff.

302.17 Staff Training

The adult day care program must implement a written plan for providing orientation and training to staff members to meet the requirements of this section.

The Program Administrator must document the initial training and continuing education completed by each staff member, including dates, times, and topics of training.

The adult day care program must provide orientation, training, and supervision to program volunteers. Adult Day/Adult Day Health staff training policy must comply with the training requirements of Department of Community Health rules §111-8-1-.14 (see link in MAN TE00 CH 302.27, References).

302.17A Orientation

All adult day care staff who interact with participants, and volunteers who are included as part of the staff-to-participant ratio, must complete an orientation within the first two weeks of employment. Content must include, but not be limited to:

- An explanation of participant rights
- An explanation of the adult day care program policies, including the client population served
- Training in recognizing and responding appropriately to medical and safety emergencies, including adult CPR certification, first aid, and universal precautions
- Orientation to health care delivery for personal support services
- An explanation of established emergency and evacuation procedures, including proper use of fire extinguishers
- An explanation of the program's procedures related to universal precautions, prior to exposure to potentially infectious materials
- Identification and reporting of suspected abuse, neglect, and/or exploitation of participants
- Location of center's first aid kit

302.17B Training

Within 60 days of employment, all employees who provide care to participants must have received a minimum of 18 hours of training in the following areas, if the areas are relevant to their job responsibilities:

- Information about the needs of abilities of the participants served
- The physical and psychological aspects of each participant's disabilities
- The techniques used in providing personal care to participants, for example, bathing, grooming, walking, and feeding, etc.
- The interpersonal communications skills needed to relate to participants including, but not limited to:

- Understanding the philosophy of independent living
- Respecting participant rights, needs and uniqueness
- Respecting age, cultural, and ethnic differences
- Confidentiality

Substitute Staff

Staff employed as substitutes on an infrequent basis are not required to complete 18 hours of initial training.

Substitute consultant staff, if any, must complete 3 hours of orientation.

Substitutes for direct service staff used on a regular basis must complete all training requirements of this section (note: regular substitute staff are those persons with whom the provider agency has an "on-call' or other ongoing agreement for covering scheduled and unscheduled staff absences or shortages).

302.17C Continuing Education

After the first year of employment, all employees who have direct care or program activity responsibilities, including the program administrator, must complete three hours of continuing education quarterly or 12 hours in total annually.

Educational topics must be pertinent to the general job responsibilities of each staff member.

Hours of continuing education may include in-service training, outside workshops, lectures, or training provided through audio/video, or Internet interactive technology.

The trainers must be persons known to have expertise in the topics presented and may include staff members.

The program administrator must assure that appropriate staff maintains current Adult CPR and Basic First Aid certifications.

302.18 Food Service

Staff and volunteers must adhere 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 must apply. Refer to Georgia Department of Public Health Rules and Regulations Governing Food Service (see link in MAN 5300 CH 302.27, References). Each program must comply with all food service and food safety requirements described in MAN 5300 304 Nutrition Service Program Guidelines and Requirements.

Effective July 1, 1993, all newly constructed/renovated centers providing nutrition services must have a dishwasher to accommodate cleaning and sanitizing of food service utensils and durable tableware, plates, cups, and glasses, where used. (For sites not subject to this provision, refer to Appendix 302-B Guidelines for Manual Dishwashing regarding guidelines for manual dishwashing).

If food is prepared at the center, the dining area and food preparation areas must be separate from

each other.

302.19 Facilities

General Conditions

The grounds, building, and furnishings must be free from litter, clean, and safe, and in good repair.

Waste, trash, and garbage must be removed from the premises at regular intervals, in accordance with state/local practices.

All outside refuse containers must have tight fitting lids which are left in closed position.

Containers must be maintained in clean and serviceable condition.

Floors must be constructed of materials appropriate for the intended use of each room or activity area, maintained in good condition and cleaned regularly. Materials used for flooring and floor coverings must be slip-proof and secured to prevent falls.

Walls and Ceilings must be structurally sound and maintained, clean, repaired, and/or painted when needed.

Toilet Rooms and Fixtures

The rooms and fixtures must be accessible, must function properly, and must be maintained in a sanitary and odor free condition.

At least of one toilet is available for every 15 participants or fraction thereof. If separate toilets for staff and volunteers are not provided, they are included in the count. If urinals are provided, they are counted as one-half toilet.

There must be a minimum of one lavatory for every two toilets, or fraction thereof.

The floor area of each toilet room must measure a minimum of 15 square feet per installed toilet. For each additional plumbing fixture, there will be an additional eight square feet.

Multiple toilet rooms must have individual stalls with doors that can be closed.

All toilets must be equipped with grab bars.

Lavatories must provide hot and cold water, soap, and either warm air dryers or a sanitary source of individual paper towels. Each toilet room must be equipped with waste receptacles which are emptied and cleaned regularly, but not less than weekly.

Exposed lavatory pipes must be covered with an appropriate form and amount of insulating material.

Doors to all toilet rooms must be equipped with locks which can be opened from the outside, in case a participant has trouble and needs staff assistance.

Bathing Units

A minimum of one bathing unit must be provided in facilities which aid with personal care and bathing.

The bathing unit must not interfere with the use of restrooms by other participants.

Each tub or shower must be in an individual room or enclosure which provides for the private use of the fixture, for bathing, drying, and dressing.

Tubs/showers for participants use must have non-slip bottoms or floor surfaces, either installed or applied to the surface.

Odor Control

All bathrooms, toilet rooms, and other odor producing rooms, or areas where soiled materials are handled, must be mechanically ventilated to the exterior. Windows may not be the sole source of ventilation.

Pest Control

The facility must make every effort to guard against insects, rodents, and any other condition that would affect a sanitary environment.

A pest control program must be provided by qualified center staff or by contract with a licensed pest control company, using the least toxic and flammable chemicals available.

The facility must maintain documentation of routine pest control work performed.

302.20 Safety and Accessibility

Physical plant safety requirements are designed to assure the safety of adults receiving services. Adult day facilities must conform to all applicable state laws and local ordinances pertaining to occupancy. When local laws, codes, and ordinances are more stringent than DHS DAS requirements, the more stringent requirements will take precedence. Programs must also comply with required licensure guidelines related to health and safety standards of the physical plant, including access, facilities, stairways, furnishings, bathrooms, dining areas, kitchen areas, rest areas, activity areas, temperature and environment, and outdoor areas. Adult Day/Adult Day Health facilities must comply with license requirements in Department of Community Health Rules Chapter 111-8-1-.06 (see link in MAN 5300 CH 302.27, References).

302.20A Emergency Response Plan

Each program must develop and maintain a current, written emergency response plan (for each site where services are provided), with procedures for responding to fires; tornadoes and other weather-related emergencies; missing participants; injuries; and other emergencies. The site must:

- Conspicuously post the evacuation plan throughout the facility
- Inform all staff of their duties during an emergency
- Practice and maintain documentation of quarterly fire and annual tornado drills, noting the amount of time required for staff and participants to complete the drills

302.20B Fire Protection and Personal Safety

Fire safety is to be always observed.

The building must have electrical and mechanical systems which are safe and in working order, as evidenced by a fire marshal, city or county building official having jurisdiction, or a report from a registered professional engineer.

The program must maintain written documentation of annual fire safety inspections, as well as any other inspection reports required by local authorities.

The building must be kept in good repair.

Electrical, heating, and cooling systems must be maintained in a safe manner.

Electrical appliances must be used in a manner that prevents overload circuits.

Extension cords more than six feet in length must be secured to prevent falls.

Natural Gas Fuel

For new construction of facilities using natural gas systems, an initial test of gas line pressure from the meter must be conducted.

For existing facilities, pressure tests must be conducted whenever there are major renovations or additions which require an interruption of gas service.

All gas heating systems will be checked for proper operations and safety prior to the heating season each year, by a qualified individual.

Fire Extinguishers and Smoke Detectors

Each facility must have at least one 2A, 10-B-C fire extinguisher per 1,500 square feet of space, or multipurpose extinguishers with acceptable alternative ratings as approved by local fire inspection officials.

If square footage indicates the needs for only one extinguisher, it must be located near the kitchen if food is prepared on site.

Each fire extinguisher must be always maintained in operable condition, inspected once a year by a qualified person, and must bear a label indicating condition and date of last inspection.

Each facility must be equipped with automatic single station Underwriters Laboratory (UL) rated products of combustion type smoke detectors, operated by house current or hardwired/installed. Staff must consult local fire safety authorities to determine the appropriate number and placement of the detectors. Where selected equipment uses battery backups, they must be an approved minimum 10-year life battery.

Each site must have working smoke detectors in all activity rooms, food preparation areas (if applicable), and hallways. Staff must test such devices monthly and maintain a record of testing.

All staff members must be instructed in the proper use and maintenance of the fire extinguisher(s)

and smoke detectors.

Stored Items

Items in storage must be neatly arranged.

Gasoline, volatile materials, paint, and similar flammable products may not be stored in a building that houses clients, unless such storage is approved by the local fire marshal.

Accumulations of extraneous materials and refuse are not permitted.

Adequate and secure space must be provided for storing participants' coats and other personal items while in attendance at the center.

Smoking

The Surgeon General of the United States has determined that the smoking of tobacco constitutes a health hazard. Smoking of tobacco inside the center facility is prohibited during the hours of operation of day care center programs and in interior areas designed for activities funded by DHS DAS. The director may designate exterior smoking areas if containers of non-combustible materials and safe design are provided for the safe disposal of tobacco products.

302.20C Building Requirements, Furnishings, and Equipment

All facilities will comply with all applicable local and state building codes, ordinances, and health department requirements, as well as all federal and state laws, licensure requirements and regulations, to provide a safe environment for clients and staff (see Manual 5300 202 Program Guidelines and Requirements).

Existing buildings – The building must meet all local requirements pertaining to the use of the building as an adult day care facility.

Each program facility must be designed and constructed in such a way that is accessible and functional in meeting the identified needs of the adult population it serves.

Space per participant – Each program must comply with licensure and/or other occupancy requirements based on the number of participants and square footage in the facility.

Furnishings – The facility must provide sufficient furniture and equipment for use by participants, which provide comfort and safety and are appropriate for an adult population with physical limitations, visual and mobility limitations, and cognitive impairments.

Furnishings and equipment are arranged in a manner that does not obstruct exits and movement within the facility.

Lighting – Facilities must be planned and constructed to provide as much natural lighting from windows are possible, using shades, blinds, or draperies to control/prevent glare.

302.21 Reporting of Abuse, Neglect, and Exploitation

All adult day care center staff are mandated reporters according to state law and must be familiar

with and must be able to recognize situations of possible abuse, neglect, exploitation, or likelihood of serious physical harm involving persons who attend the center. Center staff are responsible for reporting suspected abuse, neglect, or exploitation to the appropriate law enforcement agency, prosecuting attorney, or county department of family and children services. See MAN 5300 202 Program Guidelines and Requirements.

302.22 Quality Assurance and Monitoring

Adult day care programs must develop and implement an annual plan to evaluate and improve the effectiveness of the program's operation and services to ensure continuous improvement in service delivery.

The evaluation plan must include:

- Satisfaction survey results from staff, participants, and families
- Program modifications made that responded to changing needs of participants
- Achievement of program outcomes

Results of the evaluation will be reported to DHS DAS via Area Plan Updates.

Contractors providing services must practice sound and effective fiscal planning and management, financial and administrative record keeping and reporting. Contractors will use the DHS DAS Uniform Cost Methodology on an annual basis to analyze, evaluate, and manage the costs of the program (refer to Manual 5600, Appendix D, in ODIS, for Unit Cost Methodology Spreadsheet).

The AAA must monitor providers of services for compliance with these and any other applicable requirements and evaluate program effectiveness, including client and program outcomes, at least annually.

References

The Adult Day Care Therapeutic Activity Manual, Norman and Horton, Aspen Publications, Gaithersburg, Maryland, 1996, is a resource for activity planning and developing outcome measures for basic day care programs.

The Six Dimensions of Wellness

Georgia Department of Public Health Rules and Regulations Governing Food Service dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/EnvHealthFinalFoodRules.pdf

Georgia Department of Community Health Rules and Regulations for Adult Day Centers Rules of Department of Community Health, Chapter 111-8, Healthcare Facility Regulation, 111-8-1, "Rules and Regulations for Adult Day Centers."

Adults with Disabilities Act of 1990 www.eeoc.gov/eeoc/history/35th/thelaw/ada.html

Rehabilitation Act of 1973 en.wikipedia.org/wiki/Rehabilitation_Act_of_1973

National Adult Day Services Association

Appendix 302-A Sharps Disposal Guidelines

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	
	Section Title:	Sharps Disposal Guidelines	**Reviewed or Updated in:**	MT 2016-10
	Section Number:	Appendix 302-A	**Previous Update:**	

The purpose of these guidelines is to lower the risk for needle stick injury and infection to both staff and the public, including day care participants.

1. Immediately after use, place sharps, such as needles and lancets, in a container designed for sharps disposal, or in a thick, puncture-proof, opaque container, such as a bleach or detergent bottle, or a coffee can with a lid. Be sure that the container can be tightly sealed.
2. Label the container to remind of the need for caution in handling the contents.
3. Keep the container safe, away from children and animals.
4. Throw out needles and syringes. Do not try to remove, bend, break or recap needles.
5. When the container is three-quarters full of needles, add bleach to sterilize. Mix one teaspoon of household bleach to 2 cups of water.
6. If using a household bottle or can, when ready for disposal, make the sure the lid is tightly sealed.
7. Reinforce the sealed lid with heavy-duty tape. If using a coffee can, make sure the plastic lid is covered with tape to prevent needle punctures.
8. Wrap the container in a brown bag or newspapers and mark it *DO NOT RECYCLE*.
9. Place in the garbage bin for regular garbage collection.

Appendix 302-B Guidelines for Manual Dishwashing

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	
	Section Title:	Guidelines for Manual Dishwashing	**Reviewed or Updated in:**	MT 2016-10
	Section Number:	Appendix 302-B	**Previous Update:**	

Adult Day care centers for which the requirement for automatic dishwashers does not apply must use the following guidelines for manually washing dishes and utensils used in the preparation and service of food.

1. All utensils and dishes must be scraped and prewashed under running water.
2. Facilities providing site prepared meals must provide a three-compartment sink and use the following three step procedure for manual dishwashing:
   A. Wash in water of at least 110 degrees Fahrenheit (43 degrees Celsius.)

B. Rinse by immersing dishes and utensils in clean, hot water to remove soap/detergent; and

C. Sanitize by immersing dishes and utensils for at least two minutes in a solution of sanitizer acceptable under Georgia Department of Public Health Rules and Regulations Governing Food Service (see link in MAN 5300 CH 302.27, References).

D. Sinks must be large enough to permit the complete immersion of utensils and equipment; each compartment must be supplied with hot and cold potable water.

E. A two-compartment sink will be acceptable for washing food preparation containers and utensils only where single-service (disposable) tableware is used.

3. Single-service (i.e., disposable) tableware is not washed and reused.

316 Caregiver Services

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	300	**Effective Date:**	05/30/2024
	Section Title:	Caregiver Services	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	316	**Next Review:**	05/30/2026

316.1 Purpose

This section establishes the guidelines and requirements for Area Agencies on Aging (AAAs) that provide or contract for provision of non-Medicaid-Home and Community Based Services for family and informal caregivers of older individuals, at-risk adults, and persons with disabilities. These requirements apply to services funded wholly or partially by funds received through the Department of Human Services Division of Aging Services (DAS) and are suggested for use by agencies providing caregiver services on a fee-for-service basis.

AAAs can make information available to caregivers about community services and assist in gaining access to those services to enhance decision-making, reduce burden, and improve the health and wellness of those caring for older adults and persons with disabilities. Supportive programs and services for caregivers can strengthen care partnerships and help care receivers to remain in their communities for as long and as safely as possible.

AAAs may choose from a variety of caregiver-targeted programs and services, including but not limited to adult day care, respite services, material aid, assistive technology, community and public education, case management, and kinship care. Some of these caregiver services have their own standards and policy requirements as outlined in applicable sections of the DHS Online Directives Information System Manual 5300, “Home and Community Based Services.”

To be eligible for caregiver services, the caregiver must be providing periodic or ongoing care for a care receiver. The service or services delivered must provide support to and address the needs of the client in their role as a family or informal caregiver.

316.2 Definitions

Activities of Daily Living (ADLs)

The basic tasks of everyday living required for self-care and independent living, and include eating, dressing, bathing, grooming, transferring, and continence.

Caregiver

A family caregiver (defined below).

Care Receiver

The person provided care by a caregiver.

Care Partnership

A term that affirms the collaborative nature of the caregiver/care receiver relationship, each an active participant in the balance of giving and receiving care.

Care Plan

A structured, action-oriented, time specific plan of action developed collaboratively between service providers, care partners, and their support system.

Community and Public Education

Instruction provided to caregivers or the general public regarding available support services for caregivers or practical information on the methods and techniques of caregiving.

Consumer Direction

Affords the option for caregivers to manage funds and choose service providers for the care receiver in accord with an established care plan.

Evidence-Based Programs (EBPs)

- Have undergone experimental or quasi-experimental design
- Have been submitted to peer review with results published in a professional journal; and
- Include fidelity measures by which community level program delivery seeks to achieve the demonstrated results of the model intervention.

Evidence-Informed Programs (EIPs)

- Have not necessarily undergone experimental or quasi-experimental design, or been submitted for peer review;
- Have a training manual that specifies the components of the practice protocol and describes how to administer it; and
- Employ pre- and post-tests indicative of statistically significant improvement on caregiver outcomes using valid and reliable measurement instruments.

Family Caregiver is

- an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual;
- an adult family member, or another individual, who is an informal provider of in-home and community care to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction; or

- an older relative caregiver (defined below).

For purposes of this chapter, the term "family caregiver" does not include individuals whose primary relationship with the older adult is based on a financial or professional agreement.

Instrumental Activities of Daily Living (IADLs)

The more complex series of life functions necessary for maintaining a person's immediate environment, and include managing money, telephoning, preparing meals, laundry, housework, going outside the home, routine health, special health, and being alone. IADLs require the application of judgment and higher-level cognitive capacity.

Intention to Place

A self-reported measure by a caregiver of whether they would consider placement of the care receiver into a different type of care setting, such as a nursing home or another care facility, given the care receiver's current condition.

Older Relative Caregiver

A caregiver who is age 55 or older and lives with, is the informal provider of in-home and community care to, and is the primary caregiver for:

- a child (see CH 216 Kinship Care Services for further details), or
- an individual with a disability. In the case of a caregiver for an individual with a disability, the caregiver is the parent, grandparent, step-grandparent, or other relative by blood, marriage, or adoption of the individual with a disability.

Respite Care

A service which offers temporary, substitute supports or living arrangements for care recipients to provide a brief period of relief or rest for caregivers.

Supplemental Services

Services provided on a limited basis to complement the care provided by caregivers.

Support Group

A service led by a trained individual, moderator, or professional to facilitate caregivers to discuss their common experiences and concerns and develop a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online.

Volunteer

A person who freely offers to take part in an enterprise or undertake a task. Volunteers are unpaid; however, training and stipends may be arranged to incentivize volunteer service.

316.3 Core Principles

AAAs should incorporate the following Core Principles when implementing caregiver services:

1. **Family-centered**: Program staff approaches families in an interactive process that accounts for a person's and family's strengths, preferences, needs, and values. The family is the best authority regarding its needs, limitations, resources, and goals. A family-centered approach actively

engages families in developing and implementing their support plans.

2. **Flexible**: Caregiving is a journey for all members of the care partnership. As needs change over time, staff should be skillful in assessing these changes, working with families to address these changes, and modify support plans. The Aging Network system must be flexible to meet these changing needs, both in type, quantity, and methods of service delivery.
3. **Holistic**: Staff must recognize that caregiving involves many characteristics of the family system, including physical, mental, spiritual, financial, and emotional. The practices of assessment, support planning, and service delivery must be holistic in its approach and delivery.
4. **Creative**: Every caregiving family's journey is different, and both staff and the Aging Network system must respond creatively to these varied needs, values, and preferences.
5. **Capacity based**: Caregivers have the capacity for continued growth and autonomy and are the authority on their own needs, have the capacity to know what they need most to achieve well-being, and have abilities, competencies, and resources to help achieve their goals. It is the responsibility of the Aging Network to help develop skills necessary to help caregivers be successful.
6. **Conflict-free**: Program staff remains neutral with no interest in the choices made neither by consumers nor in the types of services or providers selected by the consumers; and to the extent possible, avoids the appearance of conflicts regarding referrals on behalf of consumers.
7. **Culturally humble**: Program staff hold an interpersonal stance that is other-oriented rather than self-focused, characterized by respect toward an individual's and family's cultural background and experience.

316.4A Service Goals

The goals of caregiver services include:

1. Maintaining the greatest possible amount of independence and dignity for each person in the care partnership
2. Identifying and enhancing the knowledge and skills of caregivers through community and public education
3. Empowering individuals in the care partnership so that the caregiver may most effectively help the care receiver to remain in the safest and most appropriate environment, according to their preference
4. Ensuring that the right services are provided at the appropriate levels, for the right duration, to the satisfaction of the care partners, and at the preferred times to the extent possible
5. Increasing access for caregivers to community-based services by helping them navigate the service system, and by providing information and support necessary for caregivers to access services; and
6. Building and strengthening community supports for family care partnerships.

316.4B Service Outcomes

The desired outcomes of consumers receiving caregiver services include:

- Reduced levels of caregiver burden

- Improved caregiver mental and physical health
- Increased caregiver ability to provide sustained care and support to a care receiver, reducing out-of-home placement
- Improved confidence in their caregiving abilities, i.e., caregiver self-efficacy
- Opportunity for caregiver respite: a break from caregiving responsibilities to rest or attend to their own needs; and
- Increased knowledge of and access to community programs, resources, and supports.

Indicators used to measure desired caregiver service outcomes include:

- Scores on items of "Section H: Caregiver Burden" of the Risk Assessment Tool (RAT)
- Scores on items of the Bakas Caregiving Outcomes Scale (BCOS) assessment
- Responses to pre- and post-measures on survey instruments completed by participants in Evidence-Based Program and Evidence-Informed Program training sessions
- Number of services and educational activities offered, referred, and/or provided to caregivers; and
- Number of hours of respite services provided caregivers.

Survey and assessment protocols for caregiver programs are discussed in Section 316.8 "Assessment" of this document.

316.5 Target Groups

Caregiver services administered through the AAAs must be targeted toward family and other informal caregivers of older adults and persons with disabilities.

The following eligibility criteria apply for program funding through the Older Americans Act, Title III Part E – National Family and Caregiver Support Program (Title III-E):

- Adult family members or other informal caregivers aged 18 and older providing care to individuals 60 years of age and older
- Adult family members or other informal caregivers aged 18 and older providing care to individuals of any age with Alzheimer's disease and related disorders
- Older relatives (not parents) aged 55 and older providing care to children under the age of 18; and
- Older relatives, including parents, aged 55 and older providing care to adults ages 18-59 with disabilities.

This section establishes policy for the first two specific populations. For policy regarding older relative non-parental caregivers of children, refer to Manual 5300, Section 216 "Kinship Care Services".

In administering caregiver services, AAAs shall give priority to caregivers who are:

- Older individuals with the greatest social need
- Older individuals with the greatest economic need (with particular attention to low-income

older individuals)

- Individuals providing care to individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction
- If serving older relative caregivers, older relative caregivers of children or adults with severe disabilities

Additionally, other allowable, non-federal fund sources may be used for services targeting caregivers who fall outside of the above eligibility criteria: for example, to serve a caregiver under 55 years-of-age caring for a disabled military veteran. DAS encourages this approach to manage gaps that may be encountered by AAAs when administering caregiver programs in the community.

316.6 Core Services for Caregivers

All Area Agencies on Aging must offer at least one service in each of the five (5) core caregiver service categories. If there are any service changes that will eliminate a core service category from that AAA, the AAA must notify DAS immediately for assistance in coming into or maintaining compliance with this requirement.

Core services for caregivers shall include:

Information for Caregivers about Available Services: Caregivers can learn about a range of supports, resources, and services available.

Assistance to Caregivers in Gaining Access to Services: Access assistance helps connect caregivers with services offered by private and voluntary agencies.

Caregiver Education/Training, Individual Counseling, and Support Groups: These services help caregivers better manage their responsibilities and cope with the stress of caregiving.

Respite Care: Trained caregivers provide care for individuals, either at home or at adult day care facilities, so that caregivers can rest or attend to their own needs.

Supplemental Services: Services provided on a limited basis to complement the care provided by caregivers. Supplemental services may include but are not limited to transportation, material aid, home modifications, assistive technology, and telephone reassurance.

316.7 Access to Services

The AAAs shall screen potential clients for caregiver services as appropriate. The AAA will refer applicants to provider organizations or other resources; place them on a waiting list for services; or initiate service delivery as determined by the screening and assessment process.

For information regarding screening through Aging & Disability Resource Connection, see MAN 5200, Section 5025. The AAAs will maintain and manage waiting lists for the services, as necessary. See Manual 5200, Section 5038 "Waiting List Management".

Not every applicant will request, require, or benefit from caregiver services. Each AAA will clearly identify in its Area Plan how services will be coordinated and how resources will be allocated and managed to optimize the effectiveness and efficiency of caregiver services.

316.8 Assessment

AAAs and providers must follow the assessment protocols as outlined in Manual 5300, Section 114 "Guidelines for Client Assessments" and particularly in Section 114.6 "Assessment for Caregiver Services".

Instruments specifically designed to evaluate caregiver burden and help determine needed caregiver services include "Section H: Caregiver Burden" of the Risk Assessment Tool (Manual 5300, Section 114.5-E and Appendix 114-E) and the Bakas Caregiving Outcomes Scale (Manual 5300, Appendix 114-L).

Questions on Section H of the Risk Assessment Tool (RAT) may be used during client screening to preliminarily assess the level of caregiver burden and intention to place. If caregiver burden is identified during screening, the Bakas Caregiving Outcomes Scale (BCOS) should be performed. All caregivers enrolled in the HCBS-Caregiver Services Program must have a completed BCOS assessment in their client record in the DAS Data System.

For EBP and EIP training sessions, facilitators must use the survey or assessment protocols designed by the developers of the respective programs.

316.9 Consumer-directed Caregiver Services

Consumer direction allows the caregiver to manage payment and choose service providers in accord with an established care plan. This approach reflects the family-centered principle that people are the best judges of what assistance they may need and of how that assistance should be delivered. DAS encourages consumer direction of funds to the maximum extent possible for qualified caregivers to meet the varied and changing needs and preferences of a care partnership.

Consumer-directed funds enable the caregiver to purchase services from providers whose service area is located outside that of caregiver residency, i.e., the region where the care receiver resides. DAS encourages the development of consumer-directed funding strategies when regional separation of caregiver and care receiver is at issue.

AAAs may establish referral and payment mechanisms between AAAs to enable reimbursement to caregivers for purchased services. AAAs may establish or use mechanisms already in place to directly reimburse caregivers for:

- Expenses incurred in obtaining respite care services, transportation to respite care service locations, or other supportive services, and consumable supplies such as incontinence pads; and
- Expenses incurred in obtaining home modifications or assistive devices, as approved by the department, such as grab bars, safety devices, and wheelchair ramps.

See O.C.G.A. §49-6-70 to §49-6-77 "Georgia Family Caregiver Support" in Appendix 316-A: "References".

AAAs may set monetary limits on reimbursement for caregiver services, up to but not to exceed that required in the above statute.

Consumer direction of caregiver funds must comply with the policies, guidelines, and standards established in Manual 5300, Section 212 "Consumer Directed Services".

Purchased services must benefit the caregiver by providing respite from their usual caregiving duties or by lessening the stress or burden of caregiving as measured by the BCOS assessment.

316.10 Fee-for-Service Guidelines

Each AAA is encouraged to offer caregiver services as a fee-for-service enterprise to enhance the sustainability of the Aging Network. In so doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Section 2025 “Fee for Service System Overview” and MAN 5600, Section 2028 “Private Pay Services.”

Caregiver services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

In establishing its fee for service structure, the AAA should account for the actual cost of the services, including administrative costs, and consider comparable rates within the service market area.

316.11 Use of Volunteers

Each AAA that accepts Title III-E funding shall make use of trained volunteers to expand the provision of the available caregiver services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants in community service settings.

See Older Americans Act of 1965, Sec. 373 in Appendix 316-A: “References”.

Refer to Manual 5600, Section 4020 “Volunteer Management Procedures”.

Volunteer applicants must comply with background check and fingerprint policy established in Manual 5600, Section 3036 “Criminal History Investigation”.

A sample volunteer application and suggested volunteer interview questions are included in MAN 5600, Appendix D: “Forms and Templates”.

316.12 Respite Care

Respite care is a service which offers temporary, substitute supports or living arrangements for care recipients to provide a brief period of relief or rest for caregivers.

Tasks or activities which may provide respite to caregivers include, but are not limited to:

- Assistance with activities of daily living (ADLs)
- Assistance with instrumental activities of daily living (IADLs)
- Adult day care and adult day health programs
- Skilled care such as medication management and medical care
- Companionship and supervision activities; and
- Short-term or extended lodging at residential facilities.

Respite services can be provided in the home or outside the home. Respite care may be available to

families through formal programs that hire and train their staff or may be available to families through informal networks such as volunteer programs or faith-based initiatives.

Consumer direction of caregiver funds in the form of vouchers allow family caregivers to purchase appropriate in-home or out-of-home respite care and choose providers according to the changing needs and preferences of the care partnership. Refer to Section 316.9 "Consumer Directed Caregiver Services".

Agencies providing respite must comply with all regulatory requirements associated with the specific tasks performed. Service providers performing respite tasks must comply with the individual service requirements outlined in Manual 5300 "Home and Community Based Services" where applicable. Licensed private home care providers who perform respite tasks must follow rules and regulations of the Georgia Department of Community Health. See Appendix 316-A "References": Rules of Department of Community Health, Chapter 111-8 Healthcare Facility Regulation, 111-8-65 Rules and Regulations for Private Home Care Providers.

316.13 Community and Public Education

Community and Public Education is instruction provided to caregivers or the general public regarding available support services for caregivers or practical information on the methods and techniques of caregiving.

AAAs can assess the need for education and training services in the constituent communities based on information obtained through the client intake and screening process; public hearings; community surveys; stakeholder recommendations; and other methods.

Caregiver training includes but is not limited to webinars, face-to-face sessions, tutorials, and conferences organized by agencies or educational institutions. Individual training may be provided by practitioners with experience in or demonstrated knowledge of the training topic.

Service Provider Eligibility: AAAs may provide directly or contract for the provision of education and training services with individuals, agencies, or educational institutions that have demonstrated expertise and efficiency in the topic of training identified in the specified curriculum. The purchase of curriculum content developed by qualified individuals/sources as defined in this section is an allowable expenditure of state and federal funds.

Qualified providers include, but are not limited to:

- AAA staff, such as Dementia Care Specialist or Caregiver Services Specialist
- Staff of education institution
- Staff of licensed home health agencies, including home health aides, attendant care, and personal care providers; programs, agencies or individuals approved by the Department of Human Services
- Qualified staff of community mental health agencies operating through the Georgia Department of Behavioral Health and Developmental Disabilities or equivalent private entities
- Qualified staff of public or private health/human services agencies
- Qualified staff of hospitals, clinics, or other agencies and organizations

- Qualified providers of other services such as day or vocational services, and residential care providers
- Qualified individual practitioners may include, but are not limited to, licensed personnel such as:
    - registered and licensed practical nurses
    - physicians
    - psychologists
    - speech therapists
    - occupational therapists
    - physical therapists
    - registered, licensed dietitian nutritionists
    - licensed social workers
    - attorneys

Individual non-licensed practitioners or contract consultants may qualify to provide services if they have the education, training, or experience directly related to the specified needs of a group of individuals with a common interest.

Staffing and Curriculum: AAAs shall assure that staff who provide community and public education are qualified by having appropriate education, training, or experience. AAAs should review the credentials of speakers prior to the training events. Specific educational programs may require the trainer to undergo a certification process.

Staffing requirements for events will be determined by the AAA, in consultation with the training facilitator(s). Staff support for the event, including publicity, host site, registration details, and other logistics, will be provided or negotiated by the AAA and coordinated with the speaker.

AAAs that develop or contract for the development of curriculum content shall assure that persons responsible for such development are qualified by education, training, or experience, or are supervised by such persons.

Data Collection and Reporting: AAAs shall report Community and Public Education activities under the appropriate group heading on the Client Groups Chapter – Activities Page in the DAS Data System.

316.14 Support Groups

Support groups are gatherings of people who share a common health concern or interest. Support groups meet on a regular, defined basis to discuss or focus on a specific situation or condition, such as Alzheimer's Disease or diabetes. They are often formed by nonprofit or advocacy organizations.

Support groups are:

- Attended by peers, persons who are directly or indirectly affected by a particular issue or illness,

- Usually have either a professional or volunteer leader as the facilitator, and
- Often small, 12 persons or less, enabling everyone a chance to talk.

The benefits of participating in support groups may include:

- Discussion of common problems and sharing of experiences
- Reduced feelings of isolation as members make connections with others facing similar challenges
- Learning about community resources and information relevant to the group
- Reducing stress, depression, or anxiety; and
- Developing a clearer understanding about what to expect regarding their care partnership.

Support groups are not the same as group therapy sessions, which are a formal type of mental health treatment that brings together people with similar conditions under the guidance of a trained mental health provider. Through regularly scheduled meetings, support groups provide emotional support and educate caregivers to take better care of their own health and provide better care for their care partner.

Staffing: AAAs shall assure that staff, including volunteers (see Section 316.11 "Use of Volunteers"), who lead support groups are qualified to do so by having appropriate education, training, or experience.

Support groups should have co-facilitators whenever possible. This allows for a back-up if one of the facilitators is absent and the back-up to be a person the support group members already know. Additionally, if one needs to leave the meeting, the other facilitator can continue the group without interruption.

An ideal combination of co-facilitators is a professional and a family caregiver.

Potential facilitators for support groups should be screened. The screening process must include:

- A face-to-face interview and
- A criminal background check.

During the interview process, the screener should ask questions to determine the applicant's knowledge and experience, as well as look for any potential problems that would inhibit the applicant's ability to be an effective facilitator.

Support group facilitator applicants must comply with background check and fingerprint policy established in Manual 5600, Section 3036 "Criminal History Investigation".

Speakers at Support Groups: Support group facilitators may invite speakers to attend and present information on community resources. Speakers presenting to support groups should remain conflict-free, agreeing not to promote their organization or themselves for financial gain.

Interaction between speakers and support group members should be limited to group discussion and, to the extent possible, avoid the appearance of conflicts of interest. Support group members may be provided with contact information to speak with the presenter individually, outside the

group format.

Data Collection and Reporting: AAAs shall report Support Group activities under the appropriate group heading on the Client Groups Chapter – Activities Page in the DAS Data System.

316.15 Evidence-based and Evidence-informed Programs

This section establishes guidelines and requirements for evidence-based programs (EBPs) and evidence-informed programs (EIPs) targeted primarily towards caregivers.

DAS requires AAAs to offer one EBP or EIP targeted towards caregivers in their planning and service area. DAS strongly encourages AAAs to offer at least two caregiver EBP/EIPs in their region. Approved caregiver targeted EBP/EIPs are listed in the DAS Taxonomy of Services (Manual 5600, Appendix F).

Caregiver EBPs and EIPs must adhere to DAS standards regarding lay leader certification, training, and credentials; number of classes offered; and number of caregivers served. Requirements may vary according to the chosen program. DAS may establish these requirements as needed to meet program goals and outcomes, and to increase regional capacity to serve caregivers.

Caregiver EBP/EIP providers must follow the established protocols and components of the program offered and must comply with licensing and fidelity guidelines as outlined by the developers of the intervention.

Data Collection and Reporting: AAAs and/or providers shall report EBP/EIP activities under the appropriate group heading in the Client Groups Chapter – Activities Page in the DAS Data System.

EBP/EIP data should be reported in the DAS Data System in accordance with DAS and specific program requirements and may include:

- Specific EBP/EIP workshop information
- Workshop pre-and post-test data
- Workshop host site details; and
- Lay leader/master trainer certification and training history.

AAA staff or service provider program coordinators may contact the DAS Caregiver Services Specialist for technical assistance and support regarding caregiver EBP/EIP programs.

316.16 Program Evaluation and Monitoring

AAAs and service providers shall adhere to policies and procedures as established by DAS or the specific program developers. DAS will periodically monitor the performance of the AAAs to determine the degree to which defined program outcomes and objectives have been or are being accomplished.

Program elements to be monitored and evaluated include, but are not limited to, the following:

- Identification and tracking of indicators (see Section 316.4-B)
- Review of client records, including assessments and documentation

- Review of client group activities records
- Review of the degree to which target populations (see Section 316.5) are being served; and
- Review of compliance with these guidelines.

See Manual 5300, Appendix B, "Review Guide: Caregiver Services (Ch 316)".

References

OLDER AMERICANS ACT OF 1965 [Public Law 89–73] [As Amended Through P.L. 116–131, Enacted March 25, 2020]
acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf

Regulations for the Older Americans Act
www.ecfr.gov/current/title-45/subtitle-B/chapter-XIII/subchapter-C/part-1321?toc=1

Administration for Community Living Older Americans Act
acl.gov/about-acl/authorizing-statutes/older-americans-act

O.C.G.A. §49-6-70 to §49-6-77 "Georgia Family Caregiver Support"
law.justia.com/codes/georgia/2022/title-49/chapter-6/article-6/section-49-6-77/

Rules of Department of Community Health, Chapter 111-8 Healthcare Facility Regulation, 111-8-65 Rules and Regulations for Private Home Care Providers
rules.sos.ga.gov/gac111-8-65

400 Title V Senior Community Service Employment Program (SCSEP)

402 SCSEP Participant Handbook

404 SCSEP Host Agency Handbook

406 SCSEP Monitoring Tool

408 SCSEP Request for Proposal

410 SCSEP Host Agency Monitoring Form

412 SCSEP Host Agency Agreement Form

414 SCSEP Introduction

414.1 Summary Statement

The Senior Community Service Employment Program (SCSEP), authorized by Title V of the Older Americans Act (OAA), is the only federally-sponsored employment and training program targeted specifically to low-income older individuals who want to enter or re-enter the workforce. The most recent SCSEP Final Rule (20 C.F.R. Part 641.100 et seq.) can be viewed at www.doleta.gov/seniors/pdf/FinalRule2010.pdf.

414.2 SCSEP Contact

SCSEP Coordinator Livable Communities
Georgia Division of Aging Services
47 Trinity Avenue SW, 1st Floor
Atlanta, GA 30334

414.3 Program Goals

The dual goals of the SCSEP program are 1) to promote useful opportunities in community service activities and 2) to move SCSEP participants into unsubsidized employment, where appropriate, so they can achieve economic self-sufficiency.

In the 2006 OAA, Congress expressed its sense of the benefits of the SCSEP stating, “placing older individuals in community service positions strengthens the ability of the individuals to become self-sufficient, provides much-needed support to organizations that benefit from increased civic engagement, and strengthens the communities that are served by such organizations”. OAA § 516(2) at 42 U.S.C. § 3056n(2).

414.4 DAS SCSEP Administrative Structure

The Georgia Division of Aging Services (DAS) receives a grant from the U. S. Department of Labor (DOL) to administer the SCSEP program for Georgia as a state grantee. DAS sub-contracts with Area Agencies on Aging (AAA’s) (referred to as sub-grantees) or other qualified providers to implement the program, some of which contract with providers (referred to as sub-projects) to administer SCSEP services. Each sub-grantee administers the SCSEP program for a group of counties in its Public Service Area (PSA), following the Department of Labor’s Equitable Distribution (ED) of authorized positions. The ED chart for Georgia can be viewed at www.scseped.org.

414.5 National Grantees

In addition to the state grantee (DAS), the DOL awards separate SCSEP grants to two national grantees in Georgia: 1) AARP Foundation and 2) National Council on Aging (NCOA). National grantees work cooperatively with state grantees, but they operate independently. DAS does not

supervise or monitor national SCSEP grantees. The ED for national grantees also can be viewed at www.scseped.org.

414.6 DOL SCSEP Reference Documents

DAS follows all DOL SCSEP regulations, policies, and procedures as outlined in the Final Rule (20 C.F.R. Part 641, Subparts A through I. www.doleta.gov/seniors/pdf/FinalRule2010.pdf).

This policies and procedures manual is DAS-specific and supplements the Final Rule and all DOL reference documents listed below: www.doleta.gov/Seniors/html_docs/TechAsstGuides.cfm

A list of Training and Employment Guidance Letters (TEGL) that provide guidance for managing the SCSEP program can be viewed at: www.doleta.gov/Seniors/html_docs/TEGL.cfm

The policies set forth in the Older Americans Act can be viewed at:

Older Americans Act 42 U.S.C. § 3001 et seq.
SCSEP Program at 42 U.S.C. § 3056 et seq.

414.7 Data Management

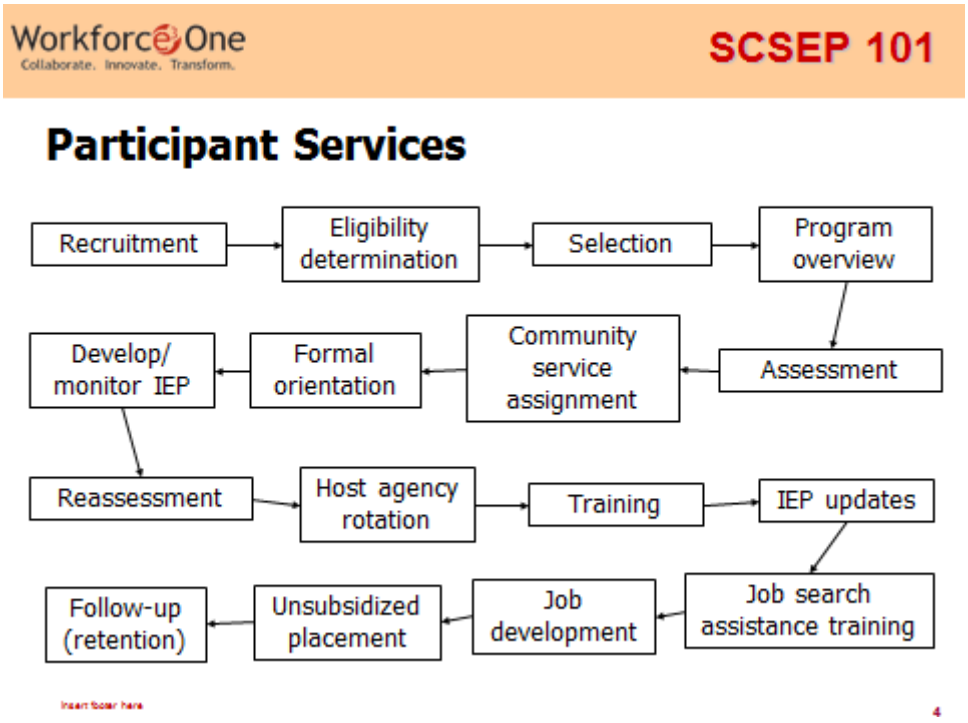
SPARQ (SCSEP Performance and Results Quarter Progress Report System) is the vehicle by which all grantees must report information on participants, host agencies, and employers, including demographic and performance information. Only DOL-authorized users may access the SPARQ system (see www.sparq.doleta.gov/).

416 SCSEP Policies and Procedures for Program Operations

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	400	**Effective Date:**	
	Section Title:	SCSEP Policies and Procedures for Program Operations	**Reviewed or Updated in:**	MT 2014-13
	Section Number:	416	**Previous Update:**	

416.1 Participant Flow Chart

An overview of the services provided to SCSEP participants from recruitment to unsubsidized employment and follow-up appear on the flow chart below:



The following sections describe the procedures for implementing each segment shown in the flow chart.

416.2 Recruitment

The sub-grantee must ensure that participant recruitment and selection follows DOL policies as outlined in 20 C.F.R. § 641.515(b) and § 641.520:

- Sub-grantees will make efforts to assure that the maximum number of eligible individuals have an opportunity to participate in SCSEP.
- These efforts must include outreach to ethnic minorities, individuals with limited English proficiency, and those with the greatest economic need, at least in proportion to their numbers in the area, taking into consideration the area's rate of poverty and unemployment.
- Priority will be given to individuals with the characteristics described in *Selection Enrollment Priorities*, ODIS page 416-7.

To ensure that these Requirements are achieved, the sub-grantees will:

1. Use the local Department of Labor Career Centers as one method in recruitment and selection of eligible individuals by notifying staff when SCSEP vacancies exist;
2. Establish collaborative relationships with agencies providing services to older persons, persons with low incomes, veterans, homeless individuals, persons with disabilities, and persons of various race/ethnic backgrounds;
3. Place flyers, brochures, posters, and other advertisements in public places where older individuals tend to congregate;
4. Use low- or no-cost media advertising, such as public service announcements on radio and TV, community service announcements, and human interest articles in local newspapers;
5. Make presentations to groups of older people or the general public to spread the word about opportunities available through the program; and

6. Develop a close working relationship with other employment and training programs such as state and local programs under the Workforce Investment Act (WIA), vocational education programs, dislocated worker programs, and adult education programs.

The State SCSEP Director will monitor the achievement of recruitment goals during annual visits with the sub-grantee and during monthly teleconferences. At no time should vacancies exist in the program when funding is available to provide training opportunities for older workers.

416.3 Eligibility Determination Criteria

To be eligible for participation in the SCSEP, an individual must meet each of the following criterions for age, income, place of residence, and eligibility to work:

1. Age - Each individual must be at least 55 years of age. No upper age limit can be imposed for initial enrollment or continued enrollment.
2. Income - The family income of an applicant or participant during the preceding 12 months or six months annualized must not exceed 125% of the poverty levels established and periodically updated by the U.S. Department of Health and Human Services. A person with a disability may be treated as a 'family of one' for income eligibility determination purposes at the option of the applicant. See additional detail in **FAMILY INCOME** section below.
3. Residence - Each individual, upon initial enrollment, will reside in the State in which the project is authorized. (Residence means an individual's declared dwelling place or address. Subgrantees may not impose a length of residency prior to enrollment in SCSEP).
4. Unemployed – Individuals applying for SCSEP must be unemployed.

The eligibility criteria described above apply to:

- Each individual who seeks initial enrollment in the SCSEP;
- Each individual who seeks re-enrollment after termination from the SCSEP because of loss of unsubsidized employment through no fault of their own, including illness; and
- Each participant who is seeking annual recertification for continued program participation.

416.4 Family Income

Definition of Family Income

"Family income" is defined as the sum of the amounts received from the income inclusions delineated in TEGL 12-06.

1. Computing Family Income
    - Computation: Refer to TEGL 12-06 wdr.doleta.gov/directives/corr_doc.cfm?DOCN=2291

    Annual family income is defined as income received during the 12-month period that ends on the date of application or the annualized income for the last 6 months period that ends on the date of application or certification for continued enrollment.

    Annual Family income for current family members refers to the sum of the amounts received from the income inclusions delineated in TEGL 12-06. The standard family definition is:

- A husband, wife and dependent children; or
- A parent or guardian and dependent children; or
- A husband and wife; or
- A person with a disability may be treated as a “family of one” for income eligibility determination purposes as currently provided at 20 C.F.R. § 641.500 of the SCSEP regulations

When the applicant is claimed as a dependent on the Federal Income Tax Return of another family member with whom they reside, the Current Population Survey (CPS) definition of family must apply.

CPS Definition of Family:

- A family is a group of two people or more related by birth, marriage, or adoption and residing together; all such people (including related subfamily members [*see definition of related subfamily below*]) are considered as members of one family for the purposes of income eligibility.
- As in the standard definition above, a person with a disability may be treated as a “family of one” for income eligibility determination purposes.

CPS Definition of Subfamily:

- **Subfamily**: A subfamily is a married couple with or without children, or a single parent with one or more of their own never-married children under 18 years old. A subfamily does not maintain his or her own household, but lives in the home of someone else.
- **Related subfamily**: A related subfamily is included in the definition of family. An unrelated subfamily is not (*see definition of unrelated subfamily below*). A related subfamily is a married couple with or without children, or one parent with one or more of their never-married children under 18 years old, living in a household and related to, but not including, the person or couple who maintains the household. One example of a related subfamily is a young married couple sharing the home of the husband or wife’s parents.
- **Unrelated subfamily**: An unrelated subfamily (formerly called a secondary family) is a married couple with or without children, or a single parent with one or more of their own never-married children or a single parent with one or more of their own never-married children under 18 years old living in a household. Unrelated subfamily members are not related to the householder. An unrelated subfamily may include people such as guests, partners, roommates, or resident employees and their spouse and/or children. An unrelated subfamily is NOT included in the determination of income eligibility for SCSEP.

2. Income Inclusions and Exclusions

   The CPS official definition of ‘income’ will govern the determination of SCSEP applicant eligibility.

   The following are income **inclusions**:

   - Earnings: Money from wage or salary income is the total income people receive for work performed as an employee during the income year.

- Net income from non-farm self-employment is the net money income (gross receipts minus expense) from one's own business, professional enterprise, or partnership.
- Net income from farm self-employment is the net money income (gross receipts minus operating expenses) from the operation of a farm by a person on his or her own account, as an owner, renter or sharecropper.
- Benefits received under Title II of the Social Security Act (of which 75% will be counted as includable income
- Survivor benefits
- Pension or retirement income
- Interest income
- Dividends
- Rents, royalties, and estates and trusts
- Educational assistance
- Alimony
- Financial assistance from outside of the household
- Other income, foreign government pensions

The following are income exclusions:

- Unemployment Compensation
- Social Security Disability Insurance
- Workers' compensation
- Child support
- Public assistance, including Aid to Families with Dependent Children (AFDC), Emergency Assistance money payments, and non-federally funded General Assistance or General Relief money payments
- Twenty-five percent of a benefit received under Title II of the Social Security Act
- Any other income exception required by applicable Federal law – e.g., stipends from programs funded by the Senior Corps of the Corporation for National and Community Service
- Payment made to or on behalf of the veterans or former members of the Armed Forces under laws administered by the Secretary of Veterans Affairs
- Disability benefits
- Supplemental Security Income (SSI)
- First $2,000 of certain per capita fund distributions made to Indians pursuant to the Indian Claims Act, P.L. 93-134 and P.L. 97-458.

Also excluded are:

- Capital gains people receive (or losses they incur) from the sale of property, including stocks, bonds, a house, or a car (unless the person engaged in the business of selling such property, in which case the net proceeds count as income from self-employment)

- Withdrawals of bank deposits
- Money borrowed
- Tax refunds
- Gifts
- Lump-sum inheritances or insurance payments

Special Note: TEGL 11-06

Congress has exempted SCSEP wages from income eligibility determinations for Federal Housing programs and SNAP (Supplemental Nutrition Assistance Program).

416.5 Federal Poverty Level Guidelines

After calculating the annual family income, refer to the U. S. Department of Health and Human Services poverty income guidelines (aspe.hhs.gov/poverty/14poverty.cfm for the size of the family to determine if the income eligibility criteria are met. For example, if the family consists of a mother, father, and one dependent child, the income guidelines for a family of three should be used to determine income eligibility. To be eligible for SCSEP, the family income must not exceed 125 percent of the poverty level established by the U.S. Department of Health and Human Services for the size of the family.

DOL issues SCSEP Income Eligibility Federal Poverty Guidelines annually. These figures are to be used to determine the income eligibility of SCSEP applicants and participants. The 2014 Federal Poverty Guidelines for SCSEP can be found at wdr.doleta.gov/directives/corr_doc.cfm?DOCN=6525.

416.6 Selection Enrollment Priorities

To assist the individuals with the greatest need, sub-grantees will follow enrollment guidelines when filling all SCSEP positions. Sub-grantees will give priority to “most-in-need” applicants, defined in 20 C.F.R. § 641.710, also at 42 U.S.C. § 3056p(a)(3)(B)(ii) and § 3056p(b).

Most-in-need participants are those who:

- Have a severe disability
- Are frail
- Are age 75 or older
- Meet the eligibility requirements related to age for, but do not receive, benefits under title II of the Social Security Act (42 U.S.C. 401 et seq.)
- Live in an area with persistent unemployment and are individuals with severely limited employment prospects
- Have limited English proficiency
- Have low literacy skills
- Have a disability
- Reside in a rural area
- Are veterans

- Have low employment prospects
- Have failed to find employment after utilizing services provided under title I of the Workforce Investment Act of 1998 (29 U.S.C. § 2801 et seq.); or
- Are homeless or at risk for homelessness.

Within all of the priorities listed above, sub-grantees will give preference to persons with poor employment prospects.

A person with poor employment prospects, as defined in 20 C.F.R. § 641.140, is as an eligible individual who is not likely to obtain employment without the assistance of the SCSEP or some other employment and training program. Persons with poor employment prospects include, but are not limited to, individuals:

- Without a substantial employment history
- Who lack basic skills
- With low English-language proficiency
- Who are displaced homemakers
- Who dropped out of school
- Who are disabled veterans
- Who are homeless
- Who live in socially and economically isolated rural or urban areas where employment opportunities are limited

416.7 Selection Enrollment Procedures

Sub-grantees will obtain and record the personal information necessary to determine eligibility for each individual. The information will be recorded on the Participant Form at the time of enrollment and each year at the time of recertification.

The sub-grantee is responsible for assuring that the information provided by the applicant is reasonable, reliable, and consistent with other statements made by the applicant. Refer to the SCSEP *Data Validation Handbook* to identify required documentation (www.scsep-help.com/Documentation/DataValidation.aspx) .

All applicants will be required to review and sign the SCSEP Participant Form at the time of enrollment. Once an applicant is deemed eligible, his or her enrollment must be properly documented. A list of intake forms follows. The latest versions of the forms are available at www.charteroakgroup.com/resources/scsep.shtml):

- SCSEP Participant Form
- SCSEP Community Service Assignment Form
- SCSEP Exit Form (when terminated)
- SCSEP Unsubsidized Employment Form (job placement)

A chart of the Enrollment Procedures process and additional forms required for participant docu-

mentation at intake are included in the Appendix.

416.8 Program Overview

The program overview provided to SCSEP applicants is included in the *DAS SCSEP Participant Handbook*, which can be viewed at: www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402.

416.9 Participant Assessment

Sub-grantees must ensure that participant assessment complies with DOL policy outlined in 20 C.F.R. § 641.535(a)(2), (3) and § 641.550. The initial assessment provides the basic framework for the Individual Employment Plan (IEP). The comprehensive assessment process identifies a participant's existing work skills and deficits, job preferences, and any barriers to employment. From the assessment, the sub-grantee can determine the appropriate employment, training, or service activities for each participant and describe each activity on the Individual Employment Plan (IEP).

All SCSEP applicants must be assessed within 30 days of application. The sub-grantee is responsible for designing and implementing an effective and comprehensive procedure to assess participants.

Guidelines for the participant assessment follow:

- The assessment will be made in partnership with the participant.
- The participant's skills, talents, training, work history, and capabilities must be considered.
- Appropriate training and employment objectives must be identified.
- Needed supportive services must be identified.
- The assessment must be the basis for the Individual Employment Plan (IEP).
- The assessment must be the basis for the community service assignment.
- The assessment must be conducted by the sub-grantee (or sub-project).

In addition, DAS requires sub-grantees to include in the assessment, at a minimum, the following:

- the individual's occupational/job preference
- education and vocational training
- occupational skills, interests, talents, and aptitudes
- physical capabilities (consistent with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990)
- positive attributes
- barriers to employment
- scores on assessment instruments
- potential for performing the proposed community service assignment duties
- potential for transition to unsubsidized employment.

Particular attention must be paid to the knowledge and skills the participant now possesses, the

types of work the participant would like to do, and the knowledge and skills the participant needs to obtain a job in the occupational field of interest. This information provides the basis for the Individual Employment Plan (IEP), and should guide training and employment decisions.

Methods of assessment which sub-grantees may use include:

- vocational testing and interest surveys
- informal (personal questionnaires) and formal structured interviews
- observations of an individual's attitudes, behavior, and body language
- basic skills testing
- workbooks/exercises to help individuals identify their work preferences, values, and options
- needs identification through self-assessment activities.

Assessment of participants is a continual responsibility of the sub-grantee. A formal re-assessment of each participant's progress toward the goals set in the IEP is required at least once every twelve (12) months.

416.10 Community Service Assignment

Based on the Participant Assessment, the sub-grantee will assign each participant to a community service assignment at an organization, referred to as a "Host Agency". Participants must be assigned to a Host Agency as soon as possible but at least within 30 days of enrollment.

Procedures for selecting, assigning, and monitoring Host Agencies can be found in the *DAS SCSEP Host Agency Handbook* and *Host Agency Agreement* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 404 and Chapter 412.

416.11 Formal Orientation

Sub-grantees must ensure that participants receive formal orientation to the SCSEP program as outlined in 20 C.F.R § 641.535 through § 641.565). Orientation topics must include but not be limited to information on:

- project goals and objectives
- community service assignments
- training opportunities
- available supportive services
- the availability of a free physical examination
- participant rights and responsibilities
- permitted and prohibited political activities

Additional detail about participant orientation is available in the *DAS SCSEP Participant Handbook* (www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402.)

416.12 Individual Employment Plan Development (IEP)

Sub-grantees must ensure that preparation of Individual Employment Plans (IEP) complies with DOL policy outlined in 20 C.F.R. § 641.535(a)(2), (3), & § 641.550.

Sub-grantees will use the information gathered during the initial assessment to develop an IEP that includes an appropriate employment goal for each participant. IEPs must be completed jointly with the SCSEP staff person and the participant.

Additional detail about developing IEPs is available in the *DAS SCSEP Participant Handbook* (www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402.)

416.13 Reassessment

Sub-grantees must comply with participant reassessment as outlined in 20 C.F.R. § 641.535(a)(2)(ii).

Subsequent eligibility assessments may be made as necessary, but must be made no less frequently than two times during a twelve month period (including the initial assessment).

416.14 Host Agency Rotation

Sub-grantees must comply with 20 C.F.R. § 641.575 before rotating participants among Host Agencies. Host Agency Rotation policies must be approved by DOL. Currently, Georgia has no DOL-approved Host Agency Rotation Policy.

Additional information about Host Agency rotation is available in the section *Reassignments* in *DAS SCSEP Host Agency Handbook* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 404).

416.15 Training

In addition to the training provided in a community service assignment, grantees and sub-recipients may arrange skill training, provided that the training complies with the policies outlined in 20 C.F.R. § 641.540. Training may be in the form of lectures, seminars, classroom instruction, individual instruction, online instruction, or on-the-job experiences (OJE). OJE training activities must be DOL-approved. Currently, Georgia does not have a DOL-approved OJE training policy.

Additional information about training is available in the section *Employability Training* in *DAS SCSEP Participant Handbook* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402).

416.16 IEP Updates

Sub-grantees must ensure that updates of Individual Employment Plans (IEP) comply with DOL policy outlined in 20 C.F.R. § 641.535(a)(2), (3), & 641.550.

Additional information about IEP Updates is available in the section *Evaluations* in *DAS SCSEP Participant Handbook* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402).

416.17 Job Search Assistance Training and Job Development

Because SCSEP is not a permanent job, but a training program, it is essential that participants actively seek a permanent job during their training assignments. Sub-grantees are required to provide job search assistance for participants. Job search assistance can be coordinated through the collaboration between the SCSEP program and the Workforce Investment Act (WIA), as outlined in 20 C.F.R. § 641.210.

Additional information about IEP Updates is available in the section *Participant Responsibilities* in *DAS SCSEP Participant Handbook* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402).

416.18 Unsubsidized Placement

The goal for SCSEP is for the participants to find permanent, unsubsidized employment. The responsibilities of sub-grantees in assisting participants to obtain unsubsidized employment are outlined in 20 C.F.R. § 641.550. See also **JOB SEARCH ASSISTANCE TRAINING** and **JOB DEVELOPMENT** above.

> **NOTE** No participant may begin a job while enrolled in SCSEP. A participant who does so must be exited for unsubsidized employment.

416.19 Follow-Up Retention

Policies that provide guidance for participant follow-up and retention after obtaining unsubsidized employment are available in OAA OAA 502(c)(6)(A)(iv), 42 U.S.C. 3056 and OAA 518(a)(7), 42 U.S.C. 3056p(a)(7) (see www.aoa.gov/AoARoot/AoA_Programs/OAA/oaa_full.asp and www.aoa.gov/AoARoot/AoA_Programs/OAA/oaa.aspx).

Sub-grantees are required to provide follow-up documentation for participants who exit for unsubsidized employment for four quarters after the date of exit. All follow-up information must be entered in the SPARQ system by an authorized SPARQ user.

416.20 Grievances and Terminations

Procedures exist to provide mediation of problems encountered at host agencies or with the SCSEP project staff and to terminate participants from the SCSEP program. A copy of grievance and termination procedures must be provided to each participant during Orientation to the SCSEP program. The DOL-approved DAS SCSEP grievance and termination procedures are available in the *DAS SCSEP Participant Handbook* which can be viewed at www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 402.

418 Program Management Requirements

418.1 Program Accountability and Performance Measures

For each Grantee, the Secretary of Labor is authorized to establish performance measures designed to promote continuous improvement in performance. Performance measures are indicators of performance and levels of performance applicable to each indicator. The U.S. Department of Labor has established a Performance Accountability System which holds each Grantee (National Sponsors and States) accountable for attaining quality levels of performance with respect to core performance measures.

Performance Measures Defined (20 C.F.R. § 641.700)

a. **Indicators of performance**. There are currently eight performance measures, of which six are core indicators and two are additional indicators. Core indicators (defined in § 641.710) are subject to goal-setting and corrective action (described in § 641.720); that is, performance level goals for each core indicator must be agreed upon between the Department and each grantee before the start of each program year, and if a grantee fails to meet the performance level goals for the core indicators, that grantee is subject to corrective action. Additional indicators (defined in § 641.710) are not subject to goal-setting and are, therefore, also not subject to corrective action.

b. **Core Indicators**. Section 42 U.S.C. § 3056k(b)(1) establishes the following core indicators of performance:

   1. Hours (in the aggregate) of community service employment
   2. Entry into unsubsidized employment
   3. Retention in unsubsidized employment for six months
   4. Earnings
   5. The number of eligible individuals served
   6. The number of most-in-need individuals served (the number of participating individuals described in § 518(a)(3)(B)(ii) or (b)(2) of the OAA).

c. **Additional indicators**. Section 42 U.S.C. § 3056k(b)(2) establishes the following additional indicators of performance:

   1. Retention in unsubsidized employment for one year
   2. Satisfaction of the participants, employers, and their host agencies with their experiences and the services provided
   3. Any other indicators of performance that the Secretary determines to be appropriate to evaluate services and performance

d. **Affected entities**. The core indicators of performance and additional indicators of performance

are applicable to each grantee without regard to whether the grantee operates the program directly or through subcontracts, sub-grants, or agreements with other entities. Grantees must assure that their sub-grantees and lower tier sub-grantees are collecting and reporting program data.

e. **Required evaluation and reporting**. An agreement to be evaluated on the core indicators of performance and to report information on the additional indicators of performance is a requirement for application for, and is a condition of, all SCSEP grants.

Core Indicators Defined (20 C.F.R. § 641.710)

a. The **core indicators** are defined as follows:

1. "Hours of community service employment" is defined as the total number of hours of community service provided by SCSEP participants divided by the number of hours of community service funded by the grant minus the number of paid training hours in the period. Paid training hours are excluded from this measure.
2. "Entry into unsubsidized employment" is defined as follows: Of those who are not employed at the date of participation, the number of participants employed in the first quarter after the exit quarter divided by the number of participants who exit during the quarter.
3. "Retention in unsubsidized employment for six months" is defined as follows: Of those who are employed in the first quarter after the exit quarter, the number employed in both the second and third quarters after the exit quarter divided by the number of participants who exit during the quarter.
4. "Earnings" is defined as follows: Of those participants who are employed in the first, second and third quarters after the exit quarter, total earnings in the second and third quarters after the exit quarter, divided by the total number of exiters during the quarter.
5. "The number of eligible individuals served" is defined as the total number of participants served divided by a grantee's authorized number of positions, after adjusting for differences in minimum wage among the States and areas.
6. "Most-in-need", or the number of participating individuals described in § 518(a)(3)(B)(ii) or (b)(2), is defined by counting the total number of the following characteristics for all participants and dividing by the number of participants served. Participants are characterized as most-in-need if they:

   - Have a severe disability
   - Are frail
   - Are age 75 or older
   - Meet the eligibility requirements related to age for, but do not receive, benefits under title II of the Social Security Act (42 U.S.C. § 401 et seq.)
   - Live in an area with persistent unemployment and are individuals with severely limited employment prospects
   - Have limited English proficiency
   - Have low literacy skills
   - Have a disability

- Reside in a rural area
- Are veterans
- Have low employment prospects
- Have failed to find employment after utilizing services provided under title I of the Workforce Investment Act of 1998 (29 U.S.C. § 2801 et seq.); or
- Are homeless or at risk for homelessness.

b. The **additional indicators** are defined as follows:

1. "**Retention in unsubsidized employment for 1 year**" is defined by the formula: Of those who are employed in the first quarter after the exit quarter: The number of participants who are employed in the fourth quarter after the exit quarter divided by the number of participants who exit during the quarter.
2. "**Satisfaction of the participants, employers, and their host agencies with their experiences and the services provided**" is defined as the results of customer satisfaction surveys administered to each of these three customer groups. The Department will prescribe the content of the surveys.

Levels of Performance Defined (20 C.F.R. § 641.720)

a. **Initial agreement**. Before the beginning of each Program Year, the Department and each grantee will undertake to agree upon expected levels of performance for each core indicator, except as provided in paragraph (b) of 20 C.F.R. § 641.730.

1. As a first step in this process, the Department proposes a performance level for each core indicator, taking into account any statutory performance requirements, the need to promote continuous improvement in the program overall and in each grantee, the grantee's past performance, and the statutory adjustment factors articulated in paragraph (b) of this section.
2. A grantee may request a revision to the Department's initial performance level goal determination. The request must be based on data that supports the revision request. The data supplied by the grantee at this stage may concern the statutory adjustment factors articulated in paragraph (b) of this section, but is not limited to those factors; it is permissible for a grantee to supply data.

Adjustments to Levels of Performance

Levels of performance may be adjusted only due to:

- High rates of unemployment, poverty, or receipt of TANF benefits in the areas served;
- Significant downturns in the local or national economy;
- A significant number of Grantee's enrollees having one or more barriers to employment relative to the enrollees of other Grantees;
- Changes in Federal, State, or local minimum wage requirements;
- Limited economies of scale for the provision of community service employment and other authorized activities in the areas served by the grantee.

Each program year, the Department of Labor will determine if Grantees have met the established

level of performance. It also will evaluate national Grantees on their performance both nationally and in every State in which they operate.

418.2 DAS Performance Requirements for Sub-Grantees

In additional to compliance with all SCSEP DOL accountability requirements, DAS SCSEP sub-grantees also will be responsible for:

- Supervision of program execution
- Selection of a sub-grantee SCSEP Project Director
- Selection of a Sub-project (Note: The sub-grantee also may serve as a Host Agency (see below)), providing participant training directly and foregoing the appointment of a sub- project.
- Achieving DOL-mandated Core Performance Measure annual goals
- Monitoring Core Performance Measures on a regular basis through the SPARQ database (*SCSEP Performance and Results Quarterly Report Database*)
- Ensuring the following record-keeping guidelines are followed:
  - Keeping a permanent record for each participant in the SCSEP program.
  - Each participant record is kept current and remains confidential at all times.
  - Participant files and confidential records are maintained in a secure location at the sub-grantee or sub-project's office.
  - All records are kept in participant files with the exception of the I-9 and any medical information. This information is maintained in a separate file, accessible only by authorized personnel.
  - Each participant has the right to review any and all documents constituting his or her personnel record.
  - All records must be retained for a minimum of six years after termination of the contract and until resolution of any pending litigation, claim, or audit involving those records.
- Selection of appropriate Host Agencies. A Host Agency must be a nonprofit, nonpartisan organization. Those eligible to serve as Host Agencies are public agencies and private organizations exempt from taxation under the provisions of Section 501(c)(3) of the Internal Revenue Code of 1954. Political parties cannot act as Host Agencies.
- Obtain a signed *Host Agency Agreement* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 412).
- Ensure that Host Agencies comply with all guidelines provided in the *DAS SCSEP Host Agency Handbook* (see www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN5300, Section 400, Chapter 404).
- Compliance with DOL "Maintenance of Effort" requirements, as outlined in 20 C.F.R. § 641.844—Note: Maintenance of Effort refers to the assurance that community service assignments for participants will:
  1. result in an increase in employment opportunities in addition to those which otherwise would be available;
  2. not result in the displacement of currently employed workers, including partial displace-

ment of currently employed workers, including such partial displacement as reduction in hours of non-overtime work, wages or employment benefits;

3. not impair any existing contract for service, or result in the substitution of federal funds provided for the operation of the host agency for other funds in connection with work that otherwise would be performed;
4. not substitute any community service assignment funded by the project sponsor for any existing federally assisted job; and not be in a position that is the same as or substantially the same as one that is occupied by any other person who is on layoff.

- Regular monitoring of the activities of the sub-projects using the DAS SCSEP Monitoring Tool (www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300 Section 400, Chapter 406).
- Regular monitoring of Host Agencies using the DAS Host Agency Monitoring Tool (www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300 Section 400, Chapter 410).

418.3 Monitoring

The U.S. Department of Labor (DOL) requires that the State periodically monitor the performance of grant-supported activities to assure that project goals related to the recruitment of priority populations are being achieved and that all requirements of the Older Americans Act and its rules and regulations are being met. The DOL-approved DAS SCSEP monitoring tool can be found at: www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400, Chapter 406.

Performance by all sub-grantee will be measured monthly by DAS, on a cumulative basis, against the goals and standards specified in the SCSEP regulations:

- The performance standards for program activities under the sub-grant contract with DAS will be monitored closely by the DAS SCSEP Coordinator through desk reviews of reports, quarterly narrative reports, and annual on-site monitoring visits.
- DAS will review and analyze monthly financial reports in the Aging Information Management System (AIMS) to determine the sub-grantees' compliance with Department of Labor and DAS spending goals. The sub-grantees will be expected to perform according to monthly financial plans, as stipulated in the DAS contract. Appropriate procedures must be initiated to assure that the total sub-grant is not over- or under-expended.
- All sub-grantee expenditures must comply with DOL limitations of expenditure of SCSEP funds and matching requirements as outlined in 20 C.F.R. § 641.867, § 641.873, and § 641.809. DAS SCSEP Allowable Costs and the related statutory regulations are outlined in the chart below.
- The match requirement for SCSEP funds must follow the guidelines outlined in the SCSEP Final Rule, sections 20 C.F.R. § 641.809 (d) and 20 C.F.R. § 641.873 (b). Match will be tracked in three separate categories, in compliance with the DAS Allowable Costs document of 11.14.2012 (copy attached in Appendix): Administrative, Enrollee Wages/Benefits, and Other Costs.

All three categories can be matched with in-kind.

418.4 SCSEP Sub-Grantee Proposal Process

Agencies who wish to apply to DAS to administer the SCSEP program must respond to a Request for Proposal (RFP). DAS will disseminate application deadlines and other details when a RFP opportunity becomes available:

The Request for Proposal is available at: www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm MAN 5300, Section 400 Chapter 408.

All of the following sections of the RFP must be completed by the applicant and submitted according to the submission guidelines:

- *General Contract Terms*
- *Scope of Services*
- *Application Face Sheet*
- *Completed Narrative Responses*
- *Program Budget*
- *Letters of Support*
- *Conflict of Interest Statement*
- *Minority Business Policy*
- *Reciprocal Preference Law*

The successful sub-grantee will contract with DAS to administer the SCSEP program in designated areas. Each sub-grantee contract will contain the same DOL Assurances agreed to by DAS (listed below). Sub-grantees will be held accountable to abide by all DOL Assurances. In addition, sub-grantees are responsible for assuring any sub-projects they contract with also abide by the Assurances.

418.5 DOL SCSEP Assurances

DOL SCSEP Programmatic Assurances

The DOL Employment Training Administration (ETA) has determined that the programmatic assurances below reflect standard grant requirements and are consistent with sound program practices.

Grantees must certify that they will conform to these assurances throughout the period of the grant by checking each of the assurances below. These assurances apply at all levels regardless of the grantee administrative structure. These assurances apply fully to any sub-recipient, local project or grantee staff involved in the delivery of services. See Attachment A, Programmatic Assurances.

418.6 Four-Year State Plan Process

DOL requires state grantees to submit a 4-year state plan, which includes proposed activities for both state sub-grantees and national grantees. DOL provides detailed instructions for the state plan preparation and 2-year update process in TEGLs. The TEGL for the most recent state plan process can be viewed at:

wdr.doleta.gov/directives/corr_doc.cfm?DOCN=5563

Attachment 418-A Programmatic Assurances

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	400	**Effective Date:**	
	Section Title:	Programmatic Assurances	**Reviewed or Updated in:**	MT 2014-13
	Section Number:	Attachment 418-A	**Previous Update:**	

Programmatic Assurances

You must certify that you will conform to these assurances throughout the period of the grant by checking each of the assurances below. These assurances apply fully to any sub-recipient, local project, or grantee staff involved in the delivery of services.

You agree to:

Recruitment and Selection of Participants

- Develop and implement methods to recruit and select eligible participants to assure maximum participation in the program.
- Use income definitions and income inclusions and exclusions for SCSEP eligibility, as described in TEGL No. 12-06, to determine and document participant eligibility.
- Develop and implement methods to recruit minority populations to ensure at least proportional representation in your assigned service area.
- Develop and implement strategies to recruit applicants who have priority of service as defined in OAA section 518(b) (1)-(2) and by the Jobs for Veterans Act (JVA). Individuals with priority include those who:
  - Are covered persons in accordance with the JVA (covered persons who are SCSEP-eligible must receive services instead of or before non-covered persons);
  - Are 65 years or older;
  - Have a disability;
  - Have limited English proficiency;
  - Have low literacy skills;
  - Reside in a rural area;
  - Have low employment prospects;
  - Have failed to find employment after utilizing services provided through the One-Stop Delivery System;
  - Are homeless or are at risk for homelessness.

Assessment

- Assess participants at least twice per 12-month period.
- Use assessment information to determine the most appropriate community service assignments (CSAs) for participants.

Individual Employment Plan (IEP)

- Establish an initial goal of unsubsidized employment for all participants.
- Update the IEP at least as frequently as assessments occur (twice per 12-month period).
- Modify the IEP as necessary to reflect other approaches to self-sufficiency, if it becomes clear that unsubsidized employment is not feasible.
- For participants who will reach the individual durational limit or would not otherwise achieve unsubsidized employment, include a provision in the IEP to transition to other services.
- Rotate participants to a new host agency (or a different assignment within the host agency) based on a rotation policy approved by DOL in the grant agreement and only when an individualized determination determines that the rotation is in the best interest of the participant. Such rotation must further the acquisition of skills listed in the IEP.

Community Service Assignment (CSA)

- Base the initial CSA on the assessment done at enrollment.
- Select only designated 501(c)(3) organizations or public agencies as host agencies.
- Put in place procedures to ensure adequate supervision of participants at host agencies.
- Ensure safe and healthy working conditions at CSA through annual monitoring.

Recertification of Participants

- Recertify the income eligibility of each participant at least once every 12 months, or more frequently if circumstances warrant.

Physical Examinations

- Offer physical examinations to participants upon program entry, and each year thereafter, as a benefit of enrollment.
- Obtain a written waiver from each participant who declines a physical examination.
- Not obtain a copy or use the results of the physical examination to establish eligibility or for any other purpose.

Host Agencies

- Develop and implement methods for recruiting new host agencies to provide a variety of training options that enable participants to increase their skill level and transition to unsubsidized employment.
- *Maintenance of Effort*: Ensure that CSAs do not reduce the number of employment opportunities or vacancies that would otherwise be available to individuals who are not SCSEP participants.

You must specifically ensure that CSAs do not:

- Displace currently-employed workers (including partial displacement, such as a reduction in non-overtime work, wages, or employment benefits).
- Impair existing contracts or result in the substitution of Federal funds for other funds in connection with work that would otherwise be performed.
- Assign or continue to assign a participant to perform the same work, or substantially the same work, as that performed by an individual who is on layoff.

Orientation

- Provide orientations for its participants and host agencies, including information on:
  - Project goals and objectives
  - Participant rights and responsibilities
  - CSAs
  - Training opportunities
  - Available supportive services
  - Availability of free physical examinations
  - Host agencies
- Local staff must address the topics listed above and provide sufficient orientation to applicants and participants on:
  - SCSEP goals and objectives
  - Grantee and local project roles, policies, and procedures
  - Documentation requirements
  - Holiday and sick leave
  - Assessment process
  - Development and implementation of IEPs
  - Evaluation of participant progress
  - Health and safety issues related to each participant's assignment
  - Role of supervisors and host agencies
  - Maximum individual duration policy, including the possibility of a waiver, if applicable
  - Termination policy
  - Grievance procedure

Wages

- Provide participants with the highest applicable required wage (highest of Federal, state, or local minimum wage) for time spent in orientation, training, and community service assignments.

Participant Benefits

- Provide workers' compensation and other benefits required by state or Federal law (such as unemployment insurance), and the costs of physical examinations.
- Establish written policies relating to compensation for scheduled work hours during which the participant's host agency is closed for Federal holidays.
- Establish written policies relating to approved breaks in participation and any necessary sick leave that is not part of an accumulated sick leave program.
- Not use grant funds to pay the cost of pension benefits, annual leave, accumulated sick leave, or bonuses.

Procedures for Payroll and Workers' Compensation

- Make all required payments for participant payroll and pay workers' compensation premiums on a timely basis.
- Ensure that host agencies do not pay workers' compensation costs for participants.

Durational Limits

Maximum Average Project Duration – 27 Months

- Maintain average project duration of 27 months or less, unless ETA approves an extension to 36 months.

Maximum Individual Participant Duration – 48 Months

- Allow participants to participate in the program no longer than 48 months (whether or not consecutively), unless your approved policy allows for an extension and the participant meets extension criteria.
- Notify participants of your policy pertaining to the maximum duration requirement, including the possibility of an extension if applicable, at the time of enrollment and each year thereafter, and whenever ETA has approved a change of policy.
- Provide 30-day written notice to participants prior to durational limit exit from the program.

Transition Services

- Develop a system to transition participants to unsubsidized employment or other assistance before each participant's maximum enrollment duration has expired.

Termination Policies

- Provide a 30-day written notice for all terminations that states the reason for termination and informs the participants of grievance procedures and right to appeal.
- Maintain written termination policies in effect and provide to participants at enrollment for:
  - Provision of false eligibility information by the participant
  - Incorrect initial eligibility determination at enrollment
  - Income ineligibility determined at recertification

- Participant has reached individual durational limit
- Participant has become employed while enrolled
- IEP-related termination
- Cause (must be approved by the ETA prior to implementation)

Equitable Distribution

- Comply with the equitable distribution (ED) plan for each state in which grantee operates and only make changes in the location of authorized positions within a state in accordance with the state ED plan and with prior ETA approval.
- Comply with the authorized position allocations / ED listed in www.scseped.org.
- Collaborate with all grantees authorized to serve in your state to achieve compliance with authorized positions while minimizing disruption to the participants.

Over-Enrollment

- Manage over-enrollment to minimize impact on participants and avoid layoffs.

Administrative Systems

- Ensure representation at all ETA-sponsored required grantee meetings.
- Communicate grant policy, data collection, and performance developments and directives to staff, sub-recipients, and local project operators on a regular basis.
- Develop a written monitoring tool that lists items you will review during monitoring visits, and provides this tool to sub-recipients and local project operators.
- Develop an annual monitoring schedule, unless the FPO approves a different standard; notify sub-recipients and local project operators of monitoring plans; and monitor sub-recipients and local project operators on a regular basis.
- Develop and provide training to increase sub-recipients' and local project operators' skills, knowledge, and abilities.
- When appropriate, prescribe corrective action and follow-up procedures for sub-recipients and local project operators to ensure that identified problems are remedied.
- Monitor the financial systems and expenditures, including sub-recipients and local project operators on a regular basis to ensure compliance with cost allocations as specified in the regulations.
- Ensure that sub-recipients and local project operators receive adequate resources to effectively operate local projects.
- Train sub-recipients and local project operators on SCSEP financial requirements to help them effectively manage their own expenditures, and provide general financial training as needed.
- Ensure that all financial reports are accurate and submit them in a timely manner, as required.
- Ensure full implementation and monitoring of requirements for customer satisfaction surveys, including participant, host agency and employer surveys.
- Develop a written plan for both disaster response and recovery so that SCSEP may continue to

operate and provide services under emergency circumstances.

Collaboration and Leveraged Resources

- Collaborate with other organizations to maximize opportunities for participants to obtain workforce development, education, and supportive services to help them move into unsubsidized employment. These organizations may include but are not limited to: workforce investment boards, American Job Centers (One-Stop Centers), vocational rehabilitation providers, disability networks, basic education and literacy providers, and community colleges.

Supportive Services

- Provide supportive services, as needed, to help participants participate in their community service assignment and to obtain and retain unsubsidized employment.
- Establish criteria to assess the need for supportive services and to determine when participants will receive supportive services, including after obtaining unsubsidized employment.

Sub-Recipient Selection (If Applicable)

- In selecting sub-recipients in areas with a substantial population of individuals with barriers to employment, national grantees should give special consideration to organizations with demonstrated expertise in serving individuals with barriers to employment (including former recipients of national grants), as defined in the statute.

Complaint Resolution

- Establish and use written grievance procedures for complaint resolution for applicants, employees, sub-recipients, and participants.
- Provide applicants, employees, sub-recipients, and participants with a copy of the grievance policy and procedures.

Maintenance of Files and Privacy Information

- Maintain participant files for three program years after the program year in which the participant received his/her final follow-up activity.
- Ensure that all participant records are securely stored by grantee or sub-recipient and access is limited to appropriate staff in order to safeguard personal identifying information.
- Ensure that all participant medical records are securely stored separately by grantee or sub-recipient from all other participant records and access is limited to authorized staff for authorized purposes.
- Establish safeguards to preclude tampering with electronic media, e.g., personal identification numbers (PINs) and SPARQ logins.
- Ensure that the ETA/SCSEP national office is immediately notified by grantee in the event of any potential security breach of personal identifying information, whether electronic files, paper files, or equipment are involved.
- Comply with and ensure that authorized users under its grant comply with all SPARQ access and security rules.

Documentation

- Maintain documentation of waivers of physical examinations by participant.
- Maintain documentation of the provision of complaint procedures to participants.
- Maintain documentation of eligibility determinations and recertifications.
- Maintain documentations of terminations and reasons for termination.
- Maintain records of grievances and outcomes.
- Maintain records required for data validation.
- Maintain documentation of monitoring reports for sub-recipients and host agencies.

Data Collection and Reporting

- Ensure the collection and reporting of all SCSEP required data according to specified time schedules.
- Ensure the use of the OMB-approved SCSEP data collection forms and the SCSEP Internet data collection and evaluation system, SPARQ.
- Ensure at the grantee or sub-recipient level that those capturing and recording data are familiar with the latest instructions for data collection, including ETA administrative issuances, e.g., TEGLs, Data Collection and Data Validation Handbooks, and the Older Worker Community of Practice.
- Ensure data are entered directly into the WDCS/SPARQ.
- Legally obligate sub-recipients to turn over complete data files in the specified electronic format, as well as hard copy case files, to the grantee when sub-recipients cease to administer SCSEP.
- Legally obligate new sub-recipients to enter complete data related to any participants whom they acquire upon becoming sub-recipients, including any participants who are still in the follow-up period.

If any box is not checked, the grantee must provide information on a separate attachment indicating what specific steps the grantee is taking to conform to those standard grant requirement(s).

By checking the boxes above, I certify that my organization will comply with each of the listed requirements and will remain in compliance for the program year for which we are submitting this application.

_____

Signature of Authorized Representative

_____

Date

420 SCSEP Budget Management

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	400	**Effective Date:**	
	Section Title:	SCSEP Budget Management	**Reviewed or Updated in:**	MT 2017-01
	Section Number:	420	**Previous Update:**	

420.1 Purpose

The Division of Aging Services (DAS) complies with all federal regulations and laws governing budget management of the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older Americans Act of 1965, as amended. The Division of Aging Services, as the grantee, is responsible to ensure statewide compliance. Sub recipients are required to comply with applicable policy and law as provided in their contracts.

420.2 Budget Categories

The SCSEP award mandates three budget categories: Enrollee Wages and Benefits (EWB), Administrative Costs, and Other Program Costs (OPC). The percentages allowed for each budget category without written permission from the United States Department of Labor are as follows:

- The **maximum** percentage allowed statewide for the Administration category is 13.5% (20 CFR Part 641 §641.867)
- The **minimum** percentage for Other Program Costs – 11.5%
- The **minimum** percentage allowed statewide for the Enrollee Wages and Benefits category is 75%.

Funding may be transferred from Administrative Costs and Other Program Costs to support additional Enrollee Wages and Benefits. Funding may also be transferred from Administrative Costs to Other Program Costs.

The grantee and sub recipients must obtain funding for administrative costs to the extent practicable from non-Federal sources (20 CFR Part 641 §861(a)).

Complete information about the expenses that are allowable in each of the three budget categories is found in Appendix 420-A SCSEP Allowable Costs with References.

Federal and Matching funds must be allocated to the three budget categories and the corresponding percentages, and reported by category.

420.3 State Budget Preparation

Step One: Calculate Total Project Budget

Divide the federal allocation by 90% to determine the total project budget. For example, if the federal portion is $1,916.572, the calculation is as follows:

$1,916,572 / .9 = $2,129,524.

Step Two: Calculate Project Match

There are two ways to calculate the project match. One method is to subtract the federal allocation from the total project budget calculated in Step One. The other method is to divide the federal portion by 90%, then multiply that amount by .1. The correct formula for the second method is: ($1,916,572 / .9) x .1. Match may be provided in cash or in-kind, and may not be provided from any federal source.

Step Three: Calculate Budget Category Amounts

Multiply the federal portion by the respective percentages for each budget category to determine the amount of federal funds to be distributed per category as follows: EWB (75%), Administrative Costs (13.5%) and Other Program Costs (11.5%). Calculate matching requirement for each category.

For example:

EWB: $1,916.572 x .75 = $1,437,429
Administration: $1,916.572 x .135 = $258,737
Other Program Costs: $1,916.572 x .115 = 220,406

Add the three budget category sub totals to ensure they total to the federal allocation.

Step Four: Determine DAS Budget

Calculate the DAS budget using the following expense categories:

1. Personnel – the salary of the State SCSEP Coordinator
2. Fringe Benefits – the cost of benefits associated with the State SCSEP Coordinator as a percentage calculation of the salary. Obtain the benefits rates from the DAS Senior Business Operations Manager or the Deputy Director.
3. Travel – estimate the costs of mileage, per diem, and lodging associated with the State SCSEP Coordinator providing data validation, monitoring, and technical assistance to sub recipients.
4. Equipment – the cost of any equipment costing $5,000 or more and with a useful life of more than one year
5. Supplies – estimate small office supplies necessary to perform State SCSEP Coordinator duties such as office supplies and printing
6. Other Costs – costs incurred in the managing of the SCSEP program that don't fit in other budget categories, including telephone, postage, training (including the annual training), etc.

DAS alignment of line items to expense categories follows guidelines outlined in Appendix 420-A SCSEP Allowable Costs with References.

Step Five: Estimate Administrative and Other Program Cost Budgets for Sub Recipients

Subtract the total of DAS Administrative Costs from the Total Administrative Costs to determine the administrative funds available to sub recipients. Likewise, subtract the total of DAS Other Program Costs from the Total Other Program Costs to determine the Other Program Costs available for sub recipients.

For example: DAS Administrative costs are $86,620. Therefore, $258,737 (from Step Three above) - $86,620 = $172,117 (the estimate of Administrative funds to be distributed to sub recipients). DAS Other Program Costs are $7,465. Therefore, $220,406 (from Step Three above) - $7,465 = $212,941 (the amount of Administrative funds to be distributed to sub recipients).

Step Six: Estimate Total Distribution to Sub Recipients

The EWB and Other Program Costs calculated in Step Three are added to the Administrative Costs calculated in Step Five to determine the total amount distributed to sub recipients. This is also the total that is listed in the state budget submitted to DOL on the SF 424 form under the category "Contractual".

For example:

EWB: $1,437,427
Administrative Costs: $172,117
Other Program Costs: $212,941
Total Distribution: $1,822,487

Add the total distribution to sub recipients to the total budgeted for DAS to ensure this total equals the total federal allocation.

Step Seven: Estimate the Costs Per Slot

To estimate the total cost per slot, divide the total amount distributed to sub recipients from Step Six by the number of approved slots.

For example: $1,822,487 / 198 = $9,204 per slot

Then, divide each budget category by the total number of slots to determine the cost per slot for each category.

For example:

EWB: $1,437,427 / 198 = $7,259.74
Administrative Costs: $172,117 / 198 = $869.28
Other Program Costs: $212,941 / 198 = $1,075.46

Add the cost per slot from each budget category to make sure it balances to the total cost per slot.

Step Eight: Estimate the Percentage for Each Budget Category

Divide the per slot cost of each budget category by the total cost per slot to determine the percentage of each budget category. The amount will be used to guide the allocation to each sub recipient in the corresponding budget categories.

For example:

EWB: $7,259.74 / $9,204 = 78.87%
Administrative Costs: $869.28 / $9,204 = 9.44%
Other Program Costs: $1,075.46 / $9,204 = 11.68%

Add the percentages for the budget categories to ensure that total 100%.

These percentages will not equal the 75/13.5/11.5 split required by the Department of Labor because DAS costs are not included in this part of the calculation. SCSEP program staff will review the estimates with the DAS Senior Business Operations Manager and staff from the DHS Office of Budget Administration to review the estimates, consider the impact of other budget issues, potential changes to benefits, travel or other rates, and any other applicable regulations to establish the final sub recipient percentages for Enrollee Wages and Benefits, Administration, and Other Costs.

Step Nine: Determine Total Allocations for Each Sub Recipient

Multiply the total cost per slot by the number of slots assigned to each sub recipient.

For example: $9,204 x 48 slots = $441,815

Add the total allocation for each sub recipient to ensure they balance to the total sub recipient allocation.

Step Ten: Determine Allocation by Budget Category for Each Sub Recipient

Multiply the total allocation for each sub recipient by the percentage for each budget category determined in Step Eight.

For example:

EWB: $441,815 x 78.87% = $348,468
Administrative Costs: $441,815 x 9.44% = $41,725
Other Program Costs: $441,815 x 11.68% = $51,622

Add the sum of each budget category to be sure it matches the total allocation for that grantee.

Step Eleven: Calculate Match for Each Budget Category

Follow Steps Six through Ten above using the match calculated for each sub recipient using the amount from Step Nine and the formula described in Step Two.

For example:

Total for sub recipient: ($441,815/.9) x .1 = $49,091 match funds
EWB: $49,091 x 78.87% = $38,718.63
Administrative Costs: $49,091 x 9.44% = $4,636.15
Other Program Costs: $49,091 x 11.68% = $5,735.78

Add the match calculated for each budget category to ensure it matches to the total match for the sub recipient calculated above.

Step Twelve: Verify Budget Compliance

Verify that the total statewide budget meets DOL guidelines for each budget category.

Divide the EWB total distributed to sub recipients by the federal allocation to be sure it meets or exceeds 75%.

Add the total Administrative Costs distributed to sub recipients to the DAS state administrative costs and divide that total by the federal allocation to be sure it does not exceed 13.5%.

Divide the Other Program Costs distributed to sub recipients by the federal allocation to be sure it does not exceed 11.5%.

Step Thirteen: Prepare Deliverables for Contracting

Prepare a summary of sub recipient funding for allocation to sub recipients, review scope of work and any other deliverables for inclusion in sub recipient contracts, and complete contract initiation forms for sub recipients other than AAAs. Forward all documents to the DAS Senior Business Operations Manager, the DAS Contracts Manager, and the DAS Contracts Specialists assigned to prepare contract documents.

420.4 Matching Funds

For the SCSEP program, the Department of Labor will pay no more than 90% of the total cost of activities carried out under a SCSEP grant. DAS must ensure that at least 10% of the total costs of the activities carried out under the SCSEP grant consist of allowable costs paid for with non-Federal funds, meaning that match (whether cash or in-kind) may not be supplied from federal funds. (20 CFR Part 641 §641.809)

The non-Federal share of costs may be provided in cash, or in-kind, or a combination of the two. (OAA §502(c) (2).

420.5 Sub Recipient Budget and Monitoring

Expenditures must be based on actual work. Functions such as recruitment, assessment, eligibility determination, host agency development, counseling, job development and placement, and costs associated with those functions are appropriately charged to Other Program Costs.

Details in Appendix A should help sub recipients prepare local budgets. DAS will provide each sub recipient with the percentages for each of the three sub categories. Sub recipients may request to transfer funds from the Administration category to Enrollee Wages and Benefits and/or Other Program Costs categories. This request must be made in writing and must be approved/declined in writing prior to implementation.

Sub recipients should prepare and monitor budgets with the core performance measures in mind. Sub recipients may choose to follow the steps outlined in §420.4 above in budget preparation, substituting the sub category percentages provided by DAS.

Sub recipients will complete the budget section of the Sub recipient Tracking Sheet each month and will submit it to the State SCSEP Coordinator on a quarterly basis, within 15 business days following the end of each quarter. This report will be reviewed by DAS and will provide a basis for quarterly technical assistance.

420.6 Indirect Costs

Sub recipients may request payment for indirect costs only within the Administration or Other Program Costs budget categories. Indirect costs can only be charged to Other Program Costs if person-

nel and non-personnel costs of staff who perform both administrative and programmatic functions are documented based on actual time worked or other equitable cost allocation methods.

Indirect costs may not exceed 10% of the total funds allocated to the Administration budget category and/or the Other Program Costs category. Further, a sub recipient may not seek reimbursement for a line item that is also included in its indirect allocation. DAS must have on file an approved indirect cost allocation plan in order for indirect costs to be evaluated for approval as part of the sub recipient budget.

420.7 Reimbursement to Sub Recipients

The Department of Labor requires that at least 75% of grant funds to be expended on enrollee wages and benefits and no more than 13.5% of grant funds to be expended on administration (20 CFR Part 641 §873). Each sub recipient will submit to DAS a report of expenses incurred for the SCSEP program on a monthly basis. This report will identify funds spent in each of the three allowable budget categories.

DAS will review these reports monthly and will reconcile them quarterly to ensure that the three allowable budget categories are expended in equal proportions. This reconciliation will provide a basis for quarterly technical assistance.

At the end of each fiscal year, DAS will not reimburse the percentages spent in the Administration category and Other Program Costs categories in a greater proportion than the percentage spent in the Enrollee Wages and Benefits category. Administration and Other Costs are earned in proportion to expenditures for Enrollee Wages and Benefits. DAS reserves the right to correct reimbursements more frequently if the parity of percentages varies too significantly.

420.8 DAS Fiscal Monitoring

The State SCSEP Coordinator will review the quarterly Sub recipient Tracking Sheet for purposes of monitoring compliance with federal guidelines, monitoring compliance with DAS contract guidelines with the sub recipient, and to provide technical assistance in both fiscal and programmatic issues.

The State SCSEP Coordinator will meet monthly with DAS Fiscal staff to review monthly expenditures and reconcile expenditures on a quarterly basis to ensure compliance with federal guidelines.

Results from this review will also be included in technical assistance provided to the sub recipients.

References

20 CFR Part § 641.864

20 CFR Part 641 §641.856

OWB 97-26

Public Law 106-501 Sec. 502

2 CFR 200, Uniform Grant Guidance

Appendix 420-A SCSEP Allowable Costs with References

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	400	**Effective Date:**	
	Section Title:	SCSEP Allowable Costs with References	**Reviewed or Updated in:**	MT 2017-01
	Section Number:	Appendix 420-A	**Previous Update:**	

CATEGORY	COSTS ASSOCIATED WITH	REFERENCES
Administrative **Definition** *"Administrative costs are that allocable portion of necessary and reasonable allowable costs of recipients and program operators that are associated with specific functions identified [in the adjacent column] that are not related to the direct provision of programmatic activities specified [below]. These costs may be both personnel and non-personnel and both direct and indirect costs."*	1. Performing general administrative and coordination functions: ◦ Accounting, budgeting, financial and cash management functions ◦ Procurement and Purchasing ◦ Property management ◦ Personnel management and supervision (except as noted in Other Program Costs) ◦ Payroll (including participant wages) ◦ Problem resolution related to audits, investigations, incidents ◦ Auditing ◦ General legal services ◦ Costs of developing IT systems required for SCSEP administration ◦ Administrative report preparation (ex. data entry into DAS data system) ◦ Other activities necessary for administration of SCSEP funds 2. Oversight and monitoring tasks 3. Costs of goods and services used to administer the program (ex. Equipment purchase/rental, office supplies, postage, office space rental and maintenance) 4. Travel incurred for the administration of the program 5. Costs of information systems required to manage the program including the purchase, systems development, maintenance, and operating costs of such systems. 6. Costs of technical assistance for program monitoring and improvement, professional organization dues 7. Staff training for staff involved in administrative functions. 8. If a sub recipient contracts the service to another entity, all costs not otherwise described in other categories are to be assigned to the Administration category **NOTE** As stated in **§ 641.859**, all levels of SCSEP operations (State, AAA, subcontractor) must adhere to the above definitions of administrative costs.	**20 CFR Part 641 §641.856;** **OWB 97-26**

CATEGORY	COSTS ASSOCIATED WITH	REFERENCES
Enrollee Wages/Benefits	Enrollee wages and benefit program activity costs include, but are not limited to: • Enrollee salaries and wages (including functions that would normally be assigned to other budget categories that are being performed by enrollees) • Fringe benefits as required by law: ◦ Workers' compensation ◦ FICA ◦ Medical examinations ◦ Compensation for scheduled work hours during which a host agency is closed for a Federal holiday, and ◦ Necessary sick leave as described in § 641.565) Subject to the restrictions in § 641.535(c), Enrollee wages may also be used for Job placement assistance, including job development and job search assistance, and the "On-the-Job- Experience" (OJE) **§ 641.540(c)**.	**Public Law 106-501 Sec. 502 (Older Americans Act)** **20 CFR Part § 641.864**

CATEGORY	COSTS ASSOCIATED WITH	REFERENCES
Other Program Costs **Definition** *"[SCSEP operators] are required to assess all participants' need for supportive services and to make every effort to assist participants in obtaining needed supportive services. [SCSEP operators] may provide directly or arrange for supportive services that are* ***necessary to enable an individual to successfully participate in a SCSEP project…"*** *(specific allowable costs in adjacent column)* Please note: "To the extent practicable, the [SCSEP operator] should arrange for the payment of these expenses from other resources." (OAA § 502(c)(6)(A)(iv) and 518(a)(7))	• Program staff's time for outreach, recruitment and selection/intake, eligibility determination, orientation, assessment, counseling, job development and placement, and preparation/updates of participants' IEPs • Program staff's time for host agency development • Enrollee training, which may be provided prior to or during the community service assignment, that may include: ◦ Payment of reasonable costs to instructors, classroom rental, training supplies, materials, equipment, and tuition, and ◦ May be provided at the Host Agency, in a classroom setting, or other appropriate arrangements • Staff training costs of staff associated with Other Program Costs functions • Verification of participant time sheets and data entry of participant hours into SPARQ • Data entry into SPARQ, quarterly program narratives, and other reporting directly related to enrollee participation • Supervision of SCSEP Coordinator as it relates to participants (case conference, grievances, etc.) • Direct contact with or on behalf of participants at any level (for example, resolving grievances or complaints) • Participant supportive services, to enable an individual to successfully participant in a SCSEP project, including but not limited to: ◦ Payment of reasonable costs of transportation ◦ Health and medical services (statutory physical examinations) ◦ Special job-related or personal counseling ◦ Incidentals such as work shoes, badges, uniforms, eyeglasses, and tools ◦ Child care and/or adult care ◦ Housing, including temporary shelter ◦ Needs-related payments ◦ Follow-up services	**20 CFR Part 641 § 641.545** **20 CFR Part 641 § 641.140** **20 CFR Part § 641.864** **(OAA §§ 502(c)(6)(A)(iv), 518(a)(7))**

422 SCSEP On-the-Job Experience (OJE)

	Georgia Division of Aging Services Home and Community-Based Services Manual			
	Chapter:	400	**Effective Date:**	
	Section Title:	SCSEP On-the-Job Experience (OJE)	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	422	**Previous Update:**	

422.1 Purpose

The purpose of this policy is to provide sub-grantees with the framework for on- the-job experience

under the regular Senior Community Service Employment Program (SCSEP).

While community service assignments offer the participants an opportunity to learn needed skills with a realistic timeline, on-the-job experience is often more practical than classroom training. However, in some instances, a participant's unsubsidized employment goal may require specific skills that are not attainable through the regular community service assignment.

422.2 Policy

Once a participant has completed two full weeks at a community service assignment, the sub-grantee may elect to provide the participant with OJE. The sub-grantee must maintain documentation to support the need for participants' training and the length of training to be provided. Such documentation must include a review of participant's past work and training history in determining an appropriate length of training.

When a person has related training or experience, more thorough rationale about the necessity and rationale for the training period must be documented.

422.3 Training Plan

A training plan will be incorporated into each contract with an employee. The training plan will outline the skills to be developed and the methods of developing those skills. Training plans will be individualized based on the trainee's needs as reflected in the Individual Employability Plan. The specific content will be tailored to individual trainee needs and employer expectations. The training plan will be kept relatively simple but will provide sufficient detail to ensure that skill attainment is tracked.

422.4 Reimbursement

The employer may be reimbursed for up to 50% of the wages earned by each trainee in OJE training that will last no more than 12 weeks.

422.5 Regular Contact

During the OJE training, regular contact must be maintained to address any issues, safety concerns, or problems with employer or participant. The contact may take place in person, by telephone or e-mail and must be noted in the participant's case notes.

422.6 After Placement Follow-Up

Successful projects tend to place emphasis on "after-placement" activities. Many successful projects systematically interview both the (former) enrollee as well as the employer to determine how placement is working out. Therefore, program staff should identify any deficiencies or problems and develop and implement a plan to remedy the problem(s). A critical component of the follow up is increasing rapport and confidence between the SCSEP project and the employer. Successful projects help the employer understand that the project is invested in successful placements – placements where both the employer and the enrollee are satisfied. If the employer is dissatisfied with the employee's performance, the problem is either resolved to the mutual satisfaction of the employer and the enrollee, or a new placement is arranged. Consequently, the employer is disposed to accept more SCSEP placements in the future – "success breeds success".

422.7 Contract Requirements

The contract for on-the-job experience may be with a public or private employer that is not also an active host agency.

- The contract must detail:
  a. The specific skills to be learned;
  b. The training timelines and benchmarks to be achieved;
  c. The hours the participant will work each week; and
  d. The number of weeks the trainee will work for this employer.
- The contract must stipulate that the employer will hire or retain the trainee in a permanent part time or full-time position at the end of the training period if the trainee has performed satisfactorily.
- The contract must stipulate that there will be significant follow-up to resolve potential unsafe conditions or issues that arise with the employer or the trainee.
- The contract must stipulate the amount the employer will be reimbursed for the OJE training.

> **NOTE** Participants should be paid the prevailing wage while in an OJE training assignment.

- The contract must state that the employer will be responsible for workers compensation claims that derive from the trainee's participation in the OJE training.
- No trainee may work for more than 40 hours per week, which includes time spent in a community service assignment if the trainee is participating in OJE and community service.
- OJE training may not exceed 12 weeks in duration per trainee.
- Sub Grantees must retain copies of all OJE contracts in the trainee's file and agree to supply such information to The Department of Labor (DOL) or the Georgia Employment Security Commission upon request.
- Each sub-grantee may exercise the OJE training option with a trainee once in any 12-month period.
- Each sub-grantee may exercise the OJE training option with the same employer, but no more than five times per year for the same job category.

422.8 Monitoring and Oversight

The Sub-Grantee must monitor each OJE site at least monthly:

- To verify that the trainee is receiving the training contracted for at the wages in the agreement, and that the trainee is not required to engage in activities prohibited by SCSEP.
- To review employer records to ensure that the trainee is receiving proper wages and that the employer is withholding taxes and paying workers compensation (or the equivalent) insurance.
- To evaluate the trainee's progress, to document that the training is being provided as outlined in

the contract, and for compliance with provisions of the contract. **Trainee's progress must be documented in case notes.**

Methods of contact can include on-site visits, phone or email and in-person visits at other locations. Methods of contact must be sufficient to assure that training is being provided as specified in the OJE contract. **Contact information will be documented in case notes.**

422.9 Occupations for which OJE Contracts Should Not Be Written

The following should not be considered for OJE:

- Jobs where the employer would typically be able to train a new employee in the first few days or weeks on the job;
- Jobs where the principal source of income is tips, commissions or payment on a piecework basis;
- Jobs for commission salespersons, occupations requiring licensing as a prerequisite and seasonal worker with SCSEP formula funds;
- Those jobs that are intermittent or seasonal; in nature; and jobs used to assist, promote, or deter union organization.

422.10 Payments

The employer shall be paid upon the submission of properly prepared invoices submitted at a time specified by the Sub-grantee and for training performed in accordance with the terms and general provision of the contract. The employer shall be paid an hourly fixed cost as specified in the contract, up to the maximum training hours allowed in the agreement. Reimbursement shall not be claimed for time in which the participant is absent from training. **This includes authorized paid absences such as holidays, sick days or vacation days.** In no event, shall payment exceed the contract amount.

422.11 Benefits

The employer agrees that OJE trainee shall be provided with the same wages, benefits, and rights afforded by the employer to its other employees.

422.12 Termination of OJE Participants

The employer agrees that the OJE trainee shall not be terminated without prior notice and that reasonable opportunity will be given for correction or improvement of performance. The employer also agrees that it will immediately notify the sub-grantee if the OJE trainee exhibits an attendance or disciplinary problem or has demonstrated an inability to perform in accordance with the training outline in the contract. The employer understands that the termination of an OJE trainee is subject to the grievance procedures of the sub-grantee.

422.13 Displacement of Currently Employed Workers (Maintenance of Effort)

The employer agrees that no currently employed worker shall be displaced by the OJE trainee including a partial displacement such as a reduction in the hours, wages, or employment benefits. The employer also agrees that no OJE trainee shall be placed into a position that is currently

vacated by an employee who is on layoff or into a position in which the employer has terminated the employment of an employee with the intention of filling the position with an OJE trainee. The employer further agrees that this contract does not infringe in any way upon the promotional opportunities of current employees.

422.14 Access to Records

The employer agrees that at any time during normal business hours, and as often as deemed necessary, the Grantee, State of Georgia or the U.S. Department of Labor may inspect and monitor any records or activities pertaining to this contract. Such inspection shall be made to determine if the contractor follows the terms and provisions of this contract and if the OJE trainee is making sufficient progress.

422.15 Record Keeping System

As with all records, sub-grantee must ensure that OJE records are maintained for the statutory period of three years from the last date of the OJE Agreement or until audits are resolved. Documentation of hours worked, wages paid, and training program must be available for the record retention period.

422.16 Documentation

The documentation listed below must be maintained in the Contract file:

- OJE payment invoices
- OJE Agreement (Original)
- Monitoring reports including problems, corrective action, and follow-up (if necessary)
- Any modification to the OJE Agreement
- Participant Performance Evaluation
- Training Time Documentation
- Justification of Failure (if necessary)

422.17 Other Specification

OJE training may be combined with other training activities, such as community services, classroom training, lectures, seminars, individual instruction, or specialized training. Sub-Grantees should consult the **SCSEP Data Collection Handbook** for further information (i.e., when to exit participants, placements, right of return, etc.)

Appendix 422-A SCSEP On-the-Job Experience Agreement

Appendix B Review Guides

206 Senior Center Review Guide

210 Case Management Review Guide

222 Behavioral Health Coaching Review Guide

302 Adult Day Care Review Guide

304 Nutrition Services Review Guide

306 Homemaker Services Review Guide

308 Personal Care Review Guide

310 In-Home Respite Review Guide

312 Chore Services Review Guide

314 Home Modification and Repair Services Review Guide

314-B Home Modification and Repair Check Sheet Review Guide

314-C Home Modification and Repair Spreadsheet Review Guide

216 Kinship Care Services Review Guide

316 Caregiver Services Review Guide

322 Friendly Visiting Review Guide

Appendix C Manual Transmittals

SFY 2024

- HCBS MT 2024-01
- HCBS MT 2024-02

SFY 2023

- HCBS MT 2023-01
- HCBS MT 2023-02
- HCBS MT 2023-03

SFY 2022

- HCBS MT 2022-01
- HCBS MT 2022-02
- HCBS MT 2022-03

SFY 2021

- HCBS MT 2021-01
- HCBS MT 2021-03
- HCBS MT 2021-04
- HCBS MT 2021-05
- HCBS MT 2021-06
- HCBS MT 2021-07
- HCBS MT 2021-09

SFY 2020

- HCBS MT 2020-01
- HCBS MT 2020-02
- HCBS MT 2020-03
- HCBS MT 2020-04
- HCBS MT 2020-05
- HCBS MT 2020-06

SFY 2019

- HCBS MT 2019-01
- HCBS MT 2019-03
- HCBS MT 2019-04
- HCBS MT 2019-05
- HCBS MT 2019-06
- HCBS MT 2019-07
- HCBS MT 2019-08
- HCBS MT 2019-09

SFY 2018

- HCBS MT 2018-01
- HCBS MT 2018-02

SFY 2017

- HCBS MT 2017-01
- HCBS MT 2017-02
- HCBS MT 2017-03

- HCBS MT 2017-04

SFY 2016

- HCBS MT 2016-01
- HCBS MT 2016-02
- HCBS MT 2016-03
- HCBS MT 2016-04
- HCBS MT 2016-05
- HCBS MT 2016-07
- HCBS MT 2016-08
- HCBS MT 2016-10
- HCBS MT 2016-11

SFY 2015

- HCBS MT 2015-01
- HCBS MT 2015-02
- HCBS MT 2015-03
- HCBS MT 2015-04
- HCBS MT 2015-05
- HCBS MT 2015-06
- HCBS MT 2015-07
- HCBS MT 2015-08
- HCBS MT 2015-09
- HCBS MT 2015-10
- HCBS MT 2015-11
- HCBS MT 2015-12
- HCBS MT 2015-13
- HCBS MT 2015-14

SFY 2014

- HCBS MT 2014-01
- HCBS MT 2014-02
- HCBS MT 2014-03
- HCBS MT 2014-04
- HCBS MT 2014-05

- HCBS MT 2014-06
- HCBS MT 2014-07
- HCBS MT 2014-08
- HCBS MT 2014-10
- HCBS MT 2014-11
- HCBS MT 2014-12
- HCBS MT 2014-13
- HCBS MT 2014-14
- HCBS MT 2014-15
- HCBS MT 2014-16
- HCBS MT 2014-17

SFY 2013

- HCBS MT 2013-01
- HCBS MT 2013-02
- HCBS MT 2013-03

SFY 2012

- HCBS MT 2012-01
- HCBS MT 2012-02
- HCBS MT 2012-03

SFY 2011

- HCBS MT 2011-01
- HCBS MT 2011-02
- HCBS MT 2011-03
- HCBS MT 2011-04

SFY 2010

- HCBS MT 2010-01
- HCBS MT 2010-02
- HCBS MT 2010-03
- HCBS MT 2010-04
- HCBS MT 2010-05

Appendix D SCSEP Forms and Templates

SCSEP Initial Assessment Form

SCSEP Initial Individual Employment Plan Form

SCSEP Case Notes Form

SCSEP Confidential Statement of Income Form

SCSEP Enrollment Procedures Chart

SCSEP Participant Acknowledgement of Terms of Enrollment Form

Appendix E HCBS Forms and Templates

Client Notification Form

Client Rights and Responsibilities Form

Kinship Care Program Survey

Program Fidelity Manual

HCBS Comprehensive Assessment

DAS General Brochure (Spanish)

HCBS Notification Form (Spanish)

[1] National Institute on Consumer Directed Long-term care Services

[2] *Financial Management Services (FMS): Facilitating the Use of Individual-Directed Support Services*, S. Flanagan, June 2008

[3] Also referred to as “fiscal intermediary,” “fiscal/employer agent,” “fiscal agency,” FMS is the term used by both CMS and in Section 3504 of the Internal Revenue Code. The concept of fiscal agency emerged in Medicaid-funded programs because of the policy that prohibits the payment of cash directly to beneficiaries, even if the beneficiary were to use the cash benefit to pay for home care.

[4] Sue Flanagan, MPH, Ph.D., AoA NHD Program Grantee technical assistance presentation, June 2008.

[5] The Division will update Income thresholds annually or as indicated by changes in relevant public policies.

[6] People with incomes above 300% of the Supplemental Security Income benefit ($2,022 per month in 2009) may be eligible for a Qualified Income, or “Miller” Trust arrangement for the purposes of participating in a consumer-directed model of services.

[7] See Appendix 212-_ for method of calculating resource thresholds and limits.

[8] There is no legal order of preference for designating authorized representatives. Acceptability is based on the A/R’s willingness and ability to assume the responsibility of assisting the consumer.

[9] “Misfeasance” is defined as doing a legal thing negligently. “Malfeasance” means doing an illegal thing.

[10] Provision of Workers’ Compensation by an F/EA is optional. AAAs engaging in competitive procurements to contract for F/EA services should be specific in detailing the scope of work if the intent is for the F/EA to provide workers’ compensation benefits.

[11] The National Institute of Consumer-Directed Long-term care Services

[12] Consumer-Directed Care: An Ethical, Empirical, and Practical Guide for State Policymakers, Florida Policy Exchange Center on Aging, Polivka and Salmon, 2001.

[13] Ibid, Polivka and Salmon.

[14] Ibid, Polivka and Salmon.

[15] Content adapted from “Addressing Liability Issues in Consumer-Directed Personal Assistance Services: The National Cash and Counseling Demonstration and Selected Other Models,” Sabatino and Hughes, January 2004, and from www.employeeissues.com

[16] Formerly displayed as : Nursing Services (LPN,RN); Habilitative Therapies (PT, OT, ST); Nutrition Screening; Nutrition Education; Nutrition Counseling.

[17] Coleman, E. A., Parry, C., Chalmers, S., & Min, S. (2006). The care transitions intervention: Results of a randomized controlled trial. Archives of internal medicine, I 66, 1822-1828.

[18] Adapted from Support Group Training Manual for Kinship Caregivers and Grandparents Raising Grandchildren, State of Arizona, Governor’s Advisory Council on Aging.

[19] Adapted from materials developed by the Illinois State Unit on Aging

[20] Adapted from Geneticheath.com web content