Olmstead Planning Committee

Georgia Olmstead Plan

DRAFT as of June 29, 2012

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Introduction

The 1999 U.S. Supreme Court ruling in the landmark case of *Olmstead v. L.C*. held that unnecessary institutionalization of individuals with disabilities violates the Americans with Disabilities Act (ADA). The ruling finds that individuals should be allowed to receive services and supports in the most integrated setting appropriate to their needs. The landmark case was initiated in 1995 by the Atlanta Legal Aid Society on behalf of Lois Curtis and Elaine Wilson, who were confined in a state psychiatric hospital long after their treatment team had recommended they could be served effectively in the community. Their unnecessary institutionalization was interpreted as discrimination by reason of disability.

To meet their obligations under the ADA, states must demonstrate they have an effective plan to transition eligible individuals with disabilities to integrated community settings and a waiting list that moves at a "reasonable pace". Georgia has prepared this Olmstead Plan to transition individuals with disabilities from institutions and to assess, build, and coordinate services in the community. Additionally, the Plan emphasizes diversion for individuals with disabilities currently in the community who are at risk of institutionalization. Workgroups consisting of Individuals with disabilities, family members, advocacy groups, state agencies, and other stakeholders have participated in developing the Georgia Olmstead Plan.

The 2003 Georgia Olmstead Plan provided strategic direction that is continued in the 2012 plan: "The State of Georgia is committed to advancing the principle that people with disabilities and the aging populations are served in the most appropriate, integrated settings. This document outlines what has been done in Georgia and the strategies for continued improvements in the service delivery system. The State's response will be guided by the principle of partnership between the state agencies and individuals, their families, advocates and their communities to bring the resources of each partner together to provide the services to individuals in community settings"

The Georgia Olmstead Plan (the Plan) focuses on providing home and community based services (HCBS) which allow people with mental illness, developmental disabilities, physical disabilities, brain injury (including those requiring neurobehavioral supports) , and substance use disorder/addiction to receive services and supports necessary to live independent, productive, healthy, and safe lives. The Plan recognizes that there are individuals with disabilities on HCBS waiting lists, individuals with disabilities living with aging caregivers, and individuals with disabilities at-risk of institutionalization who have a greater need for community based services and supports in order to maintain their life in the community. To sustain the Plan over time, it is critical that we build a comprehensive, responsive system of services and supports in the community that is the strategic center of gravity for the Plan. Importantly, the Plan must be resourced and sustained over time.

The Georgia Olmstead Plan does not obligate funding. The Plan provides strategic direction by identifying the ends (goals and objectives), ways, and means (resources necessary) to achieve our aspirations. The Plan establishes requirements for budget submissions to the Governor and coordinated efforts to obtain necessary resources from the legislature. Additionally, to prevent future hospitalizations, the Plan identifies individuals in the community who are at risk of institutionalization as a target population. Resources to serve this population are significant and exceed the normal Olmstead costs for transitioning to the community. We aspire to build a community system of care that prevents individuals with disabilities from entering institutions whenever possible.

The Plan requires person centered planning for transition from institutions, diversion from institutionalization, and services and supports in the community that are available for the duration of time needed by the individual. Individual plans must identify what services and supports are necessary and have been chosen by the individual. The Plan requires an inventory of services and supports currently available, identification of individuals on funding or waiting lists seeking each service and support, and what additional services must be developed. To manage the systems in the Plan, state agencies must develop effective, timely, and coordinated collection and reporting processes.

The Plan recognizes the difficult economic conditions that exist nationally and in Georgia. Home and community based care is more economical than institutional care. While the Plan does not obligate state funding, it does provide strategic direction for optimum utilization of resources and major change to the existing system of care. Communities, not hospitals, must become the safety net in Georgia. The Plan requires ongoing needs assessments, multi-year funding forecasts, and implementation of an Olmstead Budget Process aligned with the Governor's Budget Process. The Plan will not succeed if person centered service and support requirements are not developed, if sufficient funding is not identified and appropriated, and if "champions" from state agencies, the legislature, advocacy groups, other stakeholders, and individuals with disabilities do not emerge to lead our efforts during difficult economic times. The Olmstead Planning Committee (OPC) has major responsibilities in monitoring the implementation of the Plan. OPC leadership and involvement are critical to success in Georgia.

The structure of the Plan includes nine broad strategic goals with measureable objectives. The measurable objectives assign a metric and fix responsibility for accountability. The nine strategic goals are:

Olmstead Compliance
Transition
Diversion
System Capacity
Resources
Evaluation
Sustainability

Policy
Data

Each goal has measurable objectives. The format for each objective consists of: (a) objective, (b) standard, and (c) responsible. The first part (a) is a statement of what is to be accomplished (the objective). The second part (b) is the standard which is measurable in amount, time, or other metric (the standard). The final part (c) assigns responsibility for accomplishing the objective. The individual, agency, group, or other entity is responsible for accomplishing the objective according to the standard that has been established.

The Olmstead Planning Committee (OPC) must approve the Plan and any recommended changes. The OPC monitors each strategic goal and measurable objective according to the assigned metrics. The OPC will require and approve a corrective action plan for any objective that is not achieved. The Olmstead Coordinator is responsible for coordinating the Plan and providing manageable data on progress in meeting objectives in the Plan. After obtaining approval by the Olmstead Planning Committee, the Olmstead Coordinator will forward the document for approval by the Governor. If additional funding is made available to support the Plan, there must be an appropriation approved by the General Assembly.

Guiding Principles Governing Georgia's Provision of Home and Community Based Services

The Georgia Olmstead Plan is grounded in a set of values that were developed in 2001 and reiterated in the 2009 strategic planning effort. These values govern the State of Georgia's approach to persons with disabilities of all ages. Every individual has the right to live in the most integrated setting of his or her informed choice in the community with the services and supports necessary to be an independent and productive citizen and will:

- Be served in the most integrated and inclusive environment allowing for full participation in all aspects of life in the community, including work,
- Have opportunities to exercise meaningful, informed choices of services, providers and staff. Service systems are timely, consistent, dependable and appropriate,
- Have opportunities to choose the level of family involvement in decisions concerning his or her services or services and supports. Individuals are the focus and their choice of the level of involvement with their family and significant others in the planning, delivery and evaluation of their services is respected,
- Receive the highest quality of services, provided by people who are competent and skilled to meet his or her need,

- Be provided relevant services with sufficient intensity, based on individual strengths, needs and choices, and will be designed and delivered with sensitivity to individual and cultural differences,
- Be a partner with their family, other stakeholders, and the State in establishing policy and priorities for the use of community and public resources related to their support, taking into account the needs of persons already being served and those waiting for services.

To the extent possible, the state intends to foster and support collaboration and partnerships among stakeholders, individuals receiving services, their families, advocacy groups, faith-based organizations, nonprofit organizations, public and private entities, and federal, state and local agencies to achieve the goals of this strategic plan.

Olmstead Plan Goals and Objectives

I. **Olmstead Compliance Goa**l: Develop a Georgia Olmstead Plan that supports the U.S. Supreme Court decision which indicates: "*If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable modifications standard would be met.*"

1. **Approve Georgia Olmstead Plan**
   a. Objective: The Georgia Olmstead Plan that ensures the state remains in compliance with the federal Olmstead requirements will be formally approved by the Governor.
   b. Standard: The final plan will be published by January 31, 2013.
   c. Responsible: Olmstead Coordinator.

2. **Comply with Georgia and DOJ Settlement Agreement (2010)**
   a. Objective: The requirements specified in the Settlement Agreement will be accomplished.
   b. Standard: The annual requirements will be achieved according to the schedule in the Settlement Agreement. The Olmstead Planning Committee will receive annual progress reports within 60 days of the annual report by Independent Reviewer. Unless agreed upon by DBHDD, the Plan cannot increase requirements beyond those specified in the Settlement Agreement.
   c. Responsible: State of Georgia, DBHDD lead agency.

3. Review and Update the Olmstead Plan

a. Objective: The Georgia Olmstead Plan will be reviewed formally according to a published schedule.

b. Standard: The Plan will be reviewed 12 months after the initial release and 12 months after any update is approved by the Olmstead Planning Committee (OPC).

January 31, 2013	Plan approved
January 26, 2014	OPC Plan Review 1 begins
June 20, 2014	OPC approves Review/Update 1
June 22, 2015	OPC Plan Review 2 begins
December 2015	OPC approves Update 2

c. Responsible: Olmstead Coordinator and the Olmstead Planning Committee.

4. Transition to an Integrated Setting

a. Objective: All individuals in civil institutions desiring to live in an integrated community setting and who have been determined to be clinically ready for discharge will be discharged from state facilities or publicly funded programs in institutional settings. This includes all individuals currently in state institutions and those admitted between now and 2017, except those institutionalized because of criminal charges. For publicly funded programs in institutional settings, this includes individuals who are MEDICAID eligible.

b. Standard: By 2017, individuals will be discharged and receive individualized services and supports appropriate to their needs in the community.

October 1, 2012	Baseline established
October 1, 2013	15% reduction in baseline
October 1, 2014	30% reduction in baseline
October 1, 2015	50% reduction in baseline
October 1, 2016	75% reduction in baseline
October 1, 2017	Objective completed; 100% reduction in baseline.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

5. Reduce Readmissions

a. Objective: Readmissions to state institutions and readmissions for long term stay in publicly funded programs in institutional settings will be reduced. For publicly funded programs in institutional settings, readmissions are for MEDICAID funded individuals remaining beyond crisis intervention, emergency care, or other defined short term care situations.

b. Standard: By 2014, readmissions will be less than 10% annually.

c. Responsible: DBHDD, DCH, DHS and DCA.

6. Stop Readmissions to State Institutions.

a. Objective: All individuals transitioned from state hospitals and publicly funded programs in institutional settings will be provided necessary, individualized services in the community to meet crisis and routine referrals. Short term care situations will be maintained for publicly funded programs in institutional settings.

b. Standard: By December 2016, there will be no readmissions to state institutions of individuals meeting Olmstead criteria, unless the institution has a specialty mission defined in the system of care and presented to the Olmstead Planning Committee.

. c. Responsible: DBHDD.

7. Provide Olmstead Plan Training

a. Objective: Provide ongoing training to agency staff and providers regarding their roles and responsibilities to accomplish the objectives of this plan.

b. Standard: Beginning within 90 days of approval of the Georgia Olmstead Plan.

c. Responsible: All state agencies involved in Olmstead compliance.

II. <u>Transition Goal</u>: Move individuals with disabilities, who meet Olmstead criteria for placement, from institutions to integrated community settings with services and supports appropriate to their needs. The Olmstead criteria are:

- The state's treatment professionals reasonably determine that such placement is appropriate;
- Affected persons do not oppose such placement;
- Placement can be reasonably accommodated, taking into account the resources available to the states and the needs of others who are receiving state supported disability services (119.S.Ct.2176, *2189).

8. Define Procedure for Determination of Transition Readiness

a. Objective: A procedure for determining readiness to transition to the community will be established. Reasons the interdisciplinary team determines that individuals are not recommended for transition to the community will be reviewed by the Olmstead Planning Committee.

b. Standard: Within 90 days of approval of the Olmstead Plan, a procedure regarding how the interdisciplinary team will determine readiness for transition to the community will be presented to the Olmstead Planning Committee. The Olmstead Planning Committee will work with state agencies to receive quarterly status reports from each institution regarding the number of individuals not recommended for community transition. The Olmstead Coordinator, as part of the facility tours, will review reasons for the delay in transition beyond 90 days of the anticipated discharge date from a minimum of 6 randomly selected files

quarterly and provide a summary report to the Olmstead Planning Committee.

c. Responsible: Olmstead Coordinator working DBHDD, DCH, DHS and the Olmstead Planning Committee.

9. Create and Implement a Transition Education Plan

a. Objective: Develop and implement a plan for educating individuals with disabilities, their families, and/or guardians about transitioning to the community.

b. Standard: Within 90 days of approval of the Plan, state agencies will collaborate in writing a plan regarding how they will educate individuals with disabilities, their families, and/or guardians regarding community transition and services and supports available to avoid institutionalization. The plans will be presented to the Olmstead Planning Committee for review and comment prior to June 28, 2013 with semi-annual education updates thereafter.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

10. Provide Olmstead Related Training

a. Objective: Provide ongoing training, evaluated for relevance in content and delivery, to staff and providers regarding person centered planning principles and documentation, community services, placement and transition responsibilities.

b. Standard: Beginning within 90 days of approval of the Plan**,** state agencies will provide quarterly education updates regarding trainings conducted and content to the Olmstead Planning Committee.

c. Responsible: DBHDD, DCH, DCA, DJJ, and DHS.

11. Provide Educational Materials Regarding Olmstead Activities

a. Objective: Provide multi-media educational materials regarding services, supports, and quality control associated with transitioning from state institutions and publicly funded programs in institutional settings to community services to individuals in institutions and individuals at-risk of institutionalization, families, and other stakeholders.

b. Standard: By June 28, 2013, the Olmstead Coordinator will assemble materials from each agency that can be distributed together. Copies of materials and future updates will be reviewed annually by the Olmstead Planning Committee.

c. Responsible: Olmstead Coordinator lead, DBHDD, DCH, DHS, DJJ and DCA.

12. Provide Person Centered Planning

a. Objective: Transition planning for individuals on the Olmstead List will be person centered.

b. Standard: Within 90 days of approval of the Plan, state agencies will provide the Olmstead Planning Committee the procedural timeline for

completion of person centered planning for each population (i.e. within 30 days of eligibility determination for transition). The plan will include as appropriate:

- All areas of assessed need,
- Specific community services that could be provided to meet the identified needs of the individual and include the nature, frequency, and duration of the services,
- Transition services to prepare the individual for community services including counseling, habilitation, skill development or testing, peer mentoring, trial visit or other services as necessary and appropriate,
- Consideration of the basic needs identified for individuals: personal care services, housing, residential supports, employment, transportation, case management, crisis stabilization, medical management, counseling, and other community-based mental health and substance use disorder services,
- Assistive technology, durable medical equipment, accessible housing, environmental modifications, physical and occupational therapy, and personal support services,
- Anticipated discharge date.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

13. Ensure Best Practices with Assessment Tools

a. Objective: State agencies will use validated assessment tools for person centered planning, health risk assessment and supports intensity to identify each individual's preferences, strengths, capacities, needs, and desired outcomes.

b. Standard: If new assessment tools are adopted, agencies will inform the Olmstead Coordinator of the change and particularly to the extent the assessment tool could impact eligibility. Whenever possible, the state agency will inform the Olmstead Coordinator 90 days prior the change. The Olmstead Coordinator will inform the Olmstead Planning Committee and assist in including the information in the education plan.

c. Responsible: Olmstead Coordinator, DBHDD, DCH, DHS and DJJ.

14. Identify and Resource Services and Supports Prior to Transition

a. Objective: All services and supports needed by an individual will be resourced prior to transition to the community.

b. Standard: Each service and support will be person centered, identified and resourced prior to discharge, and provided upon discharge or prior to discharge if required (for example: training in blood sugar testing and insulin injections, OT, for transfers, medication identification and receipt of durable medical equipment (DME) such as wheelchairs). Where a required service or support is not available, a suitable alternative will be

provided and state agencies will report the service shortfall in the annual gap analysis (see Objective 34).

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

15. Involve Providers Early in Transition Planning

a. Objective: Home and community based care providers will be involved in transition planning for individuals on the Olmstead List and will provide input in planning the transition to community services. The care provider responsible for the individual's community services and supports should participate in transition planning.

b. Standard: As soon as possible after admission to an institution and not later than 10 working days prior to discharge.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

16. Collaborate in Medications Management

a. Objective: State agencies will facilitate stability of medications for individuals prior to transition from state hospitals and publicly funded programs in institutional settings.

b. Standard: Medications should be available immediately upon discharge and coordinated between the transitioning facility and community physicians to ensure continuity of care until the initial appointment with the community physician. Whenever possible, physicians should discuss proposed changes of medications during the transition.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

17. Provide Substance Use Disorder Screening

a. Objective: DBHDD will provide substance use disorder screening for all individuals with mental illness in state institutions and for other populations as clinically appropriate.

b. Standard: Screening will be provided upon admission.

c. Responsible: DBHDD.

18. Provide Co-Occurring Assessment and Treatment Planning

a. Objective: Provide co-occurring assessments and treatment planning.

b. Standard: For all individuals who screen positive for substance use disorder. The assessment will be for co-occurring disorders and be the basis for a co-occurring treatment plan, if necessary. The co-occurring treatment plan will be part of the person centered planning to transition the individual to community services. DBHDD will continue co-occurring treatment as required beyond the transition.

c. Responsible: DBHDD.

19. Provide Co-Occurring Treatment in the Institution

a. Objective: If recommended in the assessment, DBHDD will provide co-occurring treatment in the institution.

b. Standard: Co-occurring treatment and recovery support will be part of the preparation for the individual to transition into the community.

c. Responsible: DBHDD.

20. Review if Discharge Date is Missed

a. Objective: Review transition status of individuals who are beyond 90 days of the planned discharge date. Corrective action plans will be requested by the Olmstead Coordinator as appropriate.

b. Standard: The review will include barriers encountered and solutions, resources identified, and target dates to include the new anticipated discharge date. A quarterly summary of the reviews will be presented to the Olmstead Planning Committee (OPC) with recommendations for OPC follow-up. When a systems problem is identified, the Olmstead Coordinator will request a corrective action plan from the agencies involved. For the duration of the Settlement Agreement, this objective will not apply to individuals being transitioned from state operated hospitals.

c. Responsible: The Olmstead Coordinator lead, working with DBHDD, DCH, DJJ, and DHS.

21. Report Transition Waiver Status

a. Objective: Report the status of all transition waiver expenditures to the Olmstead Planning Committee including the appropriation/availability and current utilization.

b. Standard: Within 90 days of approval of the Plan, the report will include for each waiver:

- Number of individuals on the waiver,
- Number of individuals on the waiting list (MFP and non MFP),
- Number of individuals removed from the waiting list and reason,
- Number of individual screenings,
- Number of discharges and reasons,
- Number of applications denied with reason and primary diagnosis code (for individuals in nursing facilities, if available and other than self report).

c. Responsible: DBHDD, DCH and DHS.

22. Provide Formal Notification of Individual Rights

a. Objective: Ensure individuals in state hospitals and publicly funded programs in institutional settings, who are determined not appropriate for community services, are provided notification of individual rights in writing.

b. Standard: Notification will be provided verbally and in writing to the individual and his/her designated representative as appropriate. The state will provide an oral explanation of the determination, along with a document providing notice of the determination. As required by law,

the letter of notification must identify reasons for the determination, steps to be taken if the individual disagrees, and the right to contest the ruling. The right to an administrative hearing must be included in the notification. Individuals will be provided contact information for legal aid organizations. The provisions of these individual rights will be posted in all treatment and visitation areas.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

23. Review Court Administrative Hearings Regarding Continuing Involuntary Commitment and Treatment

a. Objective: Provide the Olmstead Coordinator a copy of any request for administrative hearing. The Olmstead Coordinator will monitor the administrative hearing process and provide summaries of hearing results to the Olmstead Planning Committee.

b. Standard: The Olmstead Coordinator will review a sample, not less than 5%, of all cases referred to Office of State Administrative Hearings (OSAH) for continuing involuntary commitment and treatment and at least 90% of all contested cases.

c. Responsible: Olmstead Coordinator, DBHDD, DCH, and DJJ.

24. Present Advance Notice of Transition to the Community

a. Objective: Provide written notice to all individuals their families, and others, if designated, that they have been placed on a list of persons eligible for community transition.

b. Standard: Within 30 days of being placed on a transition list. The written notice will indicate that the discharge date is an estimate only and the actual date of discharge may change based on the conditions or choice of the individual or the guardian. The notice will be placed in the individual's medical records. Written notice will only be provided to persons designated by the individual, authorized representatives or guardians, including legal representatives, consistent with the requirements of the Privacy Rule.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

25. Complete Ongoing Assessment for Transition

a. Objective: Individuals not recommended for transition from state hospitals and publicly funded programs in institutional settings will be reassessed.

b. Standard: Every 30 days. The reasons for the recommendation and other assessment notes will be placed in the individual's medical record.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

III. <u>Diversion Goal:</u> Divert individuals at risk for institutionalization into the most integrated settings with adequate supports appropriate to the needs of the individual

26. Implement Community Triage and Care

a. Objective: State agencies will identify priority populations at risk of institutionalization and develop triage capacity and plans that identify individuals for crisis intervention, person centered planning, and/or sustainment planning. Priority populations may include:

- Individuals previously discharged from a state hospital and publicly funded programs in institutional settings,
- Homeless individuals with disabilities,
- Individuals with disabilities who are vulnerable due to lack of care-giving support,
- Frail elderly living in the community,
- Individuals with disabilities being released from jail or prison.

b. Standard: By December 2015.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

27. Develop Person Centered Care Plan for Individuals in the Community

a. Objective: Provide a person centered plan for individuals identified as at-risk for institutionalization, to include individuals recently discharged.

b. Standard: The plan will:

- Implement the individualized service plan developed in the institution. Remain individualized and reflect the individuals' preferences, strengths, capacities, needs, and desired outcomes,
- Provide an initial needs assessment with services and supports required identified,
- Identify family, peer, and/or support network,
- Be continued indefinitely if needed, or until the individual or guardian deems services and supports are no longer required.

c. Responsible: DBHDD, DCH, DHS, and DJJ.

28. Reduce the Rate of Readmissions

a. Objective: Community based crisis services including assessments will be available to prevent readmissions to state hospitals and publicly funded programs in institutional settings to meet all crisis and routine referrals.

b. Standard: By December 2015.

c. Responsible: DBHDD, DCH, DHS, and DJJ.

29. Provide Substance Use Disorder Screening

a. Objective: DBHDD will provide substance use disorder screening for individuals with mental illness identified as at-risk for institutionalization and for other populations as clinically appropriate.

b. Standard: Within 30 days of being identified in the community.

c. Responsible: DBHDD.

30. Provide Service Options Counseling

a. Objective: The Gateway/Aging and Disability Resources Connections (ADRCs) will provide community-based alternatives counseling to individuals seeking long-term care services, including those considering nursing facility placement. Individuals with developmental disabilities are screened in the ADRC for enrollment in community services.

b. Standard: By April 2013, Gateway/ADRCs will provide assessments, benefits, and options counseling, and facilitate diversion or transition from nursing facilities to the community. They will provide information and make referrals on the full range of long-term service and support options in the community. Prior to long term placement through a nursing facility admission, individuals will have the opportunity to explore the full range of community-based alternatives. Short term, rehabilitation-oriented nursing facility admissions are expected to continue. Nursing home residents desiring community placement will be identified through the following process:

- Eliminate MEDICARE nursing home stays as they are short term in nature (sort MDS data for stays of 100 days or more),
- Use the data subset to identify Section Q affirmative responses indicating the individual wishes to return to the community,
- Verify individual is recommended by the treatment team to live in the community,
- Identify that a referral has been made to a community alternative,
- Track this list as the nursing facility Olmstead Planning List.

c. Responsible: DCH and DHS.

31. Facilitate Access to Public Programs

a. Objective: Gateway/ADRCs will have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to perform the following administrative functions for all public programs (including both home and community-based services programs and institutional programs):

- Consumer intake,
- Screening,
- Assessing an individual's needs,
- Developing service/care plans,
- Determining programmatic and financial eligibility,
- Assist individuals in receiving the services for which they are eligible.

b. Standard: By February 2013, create a statewide process that is both administratively seamless for consumers regardless of which program they are eligible for or the types of services they receive.

Quarterly updates to the Olmstead Planning Committee will provide utilization data, diversion from nursing facility statistics, and readmission rates to state institutions.

c. Responsible: DHS with the Gateway/ADRCs system in the Division of Aging Services and the Area Agencies on Aging and DCH.

32. Develop ADRC in a "No Wrong Door" model for Information and Access to Long-Term Services and Supports.

a. Objective: In order to function efficiently and serve as the service options counseling resource for the full array of long-term services and support programs in the state, the Gateway/ADRCs must have the capacity to serve as a "no wrong door" for information and access to long-term care supports for individuals with disabilities. Gateway/ADRCS will need the documented support and active participation of the Single State Agency on Aging, the State Medicaid Agency, and the State Agency(s) serving the target population(s) of people with disabilities. Gateway/ADRCs should also establish strong partnerships with the State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), Benefit Outreach and Enrollment Centers, Department of Family and Children Services (DFCS) eligibility, Vocational Rehabilitation, Centers for Independent Living (CILS) and other programs instrumental to Gateway ADRC activities.

b. Standard: Quarterly presentations to the Olmstead Planning Committee will indicate the status of collaborations and partnerships in the state. The presentations will also identify priorities that the collaborations are working to accomplish.

c. Responsible: DBHDD, DCH, DHS, and DCA.

IV. Systems Capacity Goal: Develop providers, support networks, systems and communities to assist individuals with disabilities in obtaining person centered services that are relevant and of sufficient intensity.

33. Develop Comprehensive Array of Services

a. Objective: Provide a status report to the Olmstead Planning Committee regarding the availability of services statewide. The Olmstead Plan recognizes that there are differences among the services and supports required for individuals with disabilities. Part of the Plan includes, but is not limited to the CMS "Taxonomy of Home and Community Based Services". The Plan's array of services is in Appendix C.

b. Standard: Within 90 days of approval of the Plan, state agencies will determine if the array of services and supports identifies necessary home and community based services. Services and supports not included in the array will be added to this list. The Service Capacity and Gap Analysis will be based on this array.

c. Responsible: DBHDD, DHS, DCH, DJJ, and DCA.

34. Complete Service Capacity and Gap Analysis

a. Objective: Define and quantify current service and support capacity and service and supports gaps for individuals with mental illness, substance use disorder, developmental disabilities, physical disabilities, and brain injury by county.

b. Standard: By March 2013, state agencies will request funding to determine what array of service defined in the Olmstead Plan is and is not available.

c. Responsible: DBHDD, DCA, DCH, DJJ, and DHS.

35. Project Need for Services and Supports Annually

a. Objective: Create an annual estimate of anticipated discharges and need for community services for individuals institutionalized or at-risk of institutionalization. The estimate will be used for budget requests, provider identification and training, and expansion of the continuum of care.

b. Standard: The annual estimate will be included with the evaluation of the progress in implementing the Olmstead Plan. Each agency will provide an estimate of anticipated discharges, services, and supports needed to include type of service, geographic location of the service, amount of services per geographic area, and individual unit/total cost of services and supports. State agencies will include data from the gap analysis required in the previous objective and any corrective action plans (CAP) in calculating the services and supports needed and their costs. The estimate will include data for individuals in the community at-risk of institutionalization. Emphasis must be given to serving individuals in rural areas. Beginning in 2013, and annually thereafter, the estimate should be presented to the Olmstead Planning Committee and aligned with the Governor's Budget Cycle.

c. Responsible: Olmstead Coordinator lead, OPB, DBHDD, DCH, DHS, DJJ, and DCA.

36. Determine Status of Community Readiness

a. Objective: Provide the Olmstead Planning Committee the status of community readiness to provide the adequate array of services and supports, and strategic plans to identify and reduce gaps in service.

b. Standard: Annually as part of the budget analysis.

c. Responsible: DBHDD, DCA, DHS, DJJ, and DCH.

37. Increase Systems Capacity

a. Objective: Provide adequate systems capacity in the community to prevent Olmstead related admissions to state institutions or extended stay in publicly funded programs in institutional settings subject to adequate appropriations of federal and state funding.

b. Standard: By December 2015. State agencies will develop community systems of care that enable individuals with disabilities to avoid institutionalization. Evaluate provider reimbursement rates to encourage increased capacity and quality of services.
c. Responsible: DBHDD, DCH, DHS, and DJJ

38. Improve Access to Benefits, Services and Supports

a. Objective: Update the Olmstead Planning Committee on federal and state benefits, services, supports, and initiatives that increase access for individuals in state-operated facilities, publicly funded programs in institutional settings, or at-risk of institutionalization.
b. Standard: Provide a quarterly update which will include Olmstead pertinent information such as, but not limited to, DCH update regarding any significant expansion of the state's MEDICAID Plan, DCA summary of housing status and initiatives supporting integration, DHS initiatives, and summary of barriers to accessing benefits, services, and supports.
c. Responsible: The Olmstead Coordinator working with DBHDD, DCH, DHS, DJJ, and DCA, will present the update.

39. Improve Crisis Services

a. Objective: Develop a plan to build statewide capacity for crisis services in the community and reduce reliance on hospitals. Involve community service boards, private community organizations, and hospital alternatives.
b. Standard: During the March 2013 Olmstead Planning Committee meeting, provide a plan that identifies required community crisis services and request necessary funding; creates partnerships among providers, agencies, and law enforcement; and expands Crisis Intervention Team Training statewide. The plan must identify strategies, funding, and training. Departments will align terminology and definitions of crisis resources whenever possible. The plan should include a report that documents:

- Existence and effectiveness of comprehensive community crisis services,
- Presence of evidence-based practices, including Assertive Community Treatment teams.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

40. Develop Housing Capacity Strategy

a. Objective: Develop a housing capacity strategy that meets the terms of the Georgia and Department of Justice Settlement Agreement and includes all individuals with disabilities. The strategy should support the preservation of existing supportive housing.
b. Standard: By April 2013, present a Quarterly Housing Capacity Strategy Report to the Olmstead Planning Committee. The report should

include the status of state agencies participating in an interagency collaboration to implement a strategic housing strategy which:

1. Provides for a Strategic Housing Plan Steering Committee,
2. Establishes a unified communications strategy between collaborative State agencies,
3. Establishes and defines outreach and referral processes in order to fill newly available housing units,
4. Improves access to the supply of safe, decent and affordable housing for individuals with disabilities, including:
    a. Prioritizing federally funded Housing Choice Vouchers for individuals covered under the Settlement Agreement and provides a link for the transition of individuals from the state funded Georgia Housing Voucher Program administered by DBHDD,
    b. Expanding Shelter Plus Care (SPC), for persons who are homeless and have a disability,
    c. Securing U.S. Department of Housing and Urban Development, (HUD) Section 811 Project Rental Assistance (PRA) Funding to expand housing options in the community,
    d. Marketing units in Tax Credit Developments to individuals with disabilities,
    e. Establishing the HOME-funded Tenant Based Rental Assistance in order to transition individuals eligible under the Money Follows the Person Initiative to community-based, integrated settings,
    f. Implementing outreach activities to other Public Housing Agencies.

c. Responsible: DCA lead agency, DBHDD, DCH, and DHS.

41. Expand Housing Capacity

a. Objective: Develop capacity to create community integrated, scattered-site and other supportive residential options for individuals who are currently in institutional placements or at risk of institutionalization.

b. Standard: The Strategic Housing Plan Steering Committee will work to expand housing capacity by:

- Prioritizing efforts to ensure the requirements in the Georgia/US Department of Justice Settlement Agreement take precedence through 2015,
- Projecting annual housing requirements and seeking additional funding to transition individuals from state institutions or publicly funded programs in institutional settings to the community integrated setting,
- Determining current estimates of housing needs to meet the requirements of those individuals transitioning from institutional

placement, preventing institutionalization of individuals at risk, and maintaining sustainment of current housing placements,

- Encouraging the development of community integrated housing based on standards established in the Frank Melville Act while also preserving existing supportive housing options,
- Determining the current availability of community integrated housing, determined by the existence of supportive housing units, the number of housing vouchers, other subsidies available and the number of units affordable to individuals with income less than 30% of the Area Median Income,
- Determining the number of homeless persons with disabilities and living in the state and the number of individuals with disabilities who are precariously housed and, thus, threatened with homelessness,
- Identifying and taking steps to eliminate the policy barriers to accessing affordable housing opportunities for individuals with disabilities seeking to transition to community-based housing,
- Eliminating policy barriers systemic to accessing affordable housing options for individuals leaving jails, prisons, and juvenile justice facilities, or with a history of involvement in the criminal justice system.

c. Responsible: DCA lead agency, DBHDD, DCH, DJJ, and DHS.

42. Improve Transportation Access

a. Objective: Determine what transportation services are currently available from state departments, local governments, providers, and families to determine methodologies to better align these resources and to optimize existing resources. Coordinate with existing workgroups to improve transportation support to individuals supported by the Olmstead Plan. Provide education on existing resources.

b. Standard: 90 days after approval of the Plan, the Olmstead Coordinator will coordinate transportation partner participation in the Olmstead Plan including identification of opportunities to prioritize resources for individuals transitioned from state hospitals and publicly funded programs in institutional settings and individuals with disabilities at risk of institutionalization. Implementation of recommendations in the "Mental Health Service Delivery Commission Report" (June 2008) will be evaluated and recommendations for future action and funding determined. Existing plans and workgroups will be utilized as a basis for meeting the objectives in the Olmstead Plan and the needs of individuals we serve. Utilize the outcomes from the Georgia Coordinating Committee for Rural and Human Services Transportation to bring together the various agencies and programs that provide rural and human services transportation to work together to deliver the most cost-effective transportation solutions.

c. Responsible: Olmstead Coordinator.

43. Develop Supportive Employment Plan

a. Objective: Develop capacity to provide supportive employment services to individuals with disabilities.

b. Standard: By July 2013, DBHDD will present to the Olmstead Planning Committee the supportive employment plan to increase capacity. The plan should include a report regarding the presence of evidence-based employment supportive program practices.

. c. Responsible: DBHDD lead working with DCH, Georgia Vocational Rehabilitation Agency and other employment agencies.

44. Expand Peer Support Programs

a. Objective: Identify resources and barriers in expanding peer support for individuals with disabilities.

b. Standard: By December 2013, identify opportunities and plan for expansion of peer support. Include annual funding requests to continue the expansion for peer specialist and certified addiction recovery specialists. The plan should include a report to OPC regarding evidence-based practices for peer support and any workforce shortage.

c. Responsible: DBHDD, DCH, DHS, and DJJ.

45. Build Detoxification Capacity

a. Objective: Develop a plan to increase substance use disorder detoxification capacity to include residential detoxification and social/ ambulatory detoxification options for those with substance use disorders.

b. Standard: The plan will include funding requirements in the budget proposal for the agency. The plan will be presented to the Olmstead Planning Committee during the July 2013 meeting.

c. Responsible: DBHDD and DCH.

46. Facilitate Access to Sober Living Resources

a. Objective: Create a link between the Georgia Crisis and Access Line (GCAL) and the Georgia Association of Recovery Residences (GARR) to provide information and referrals for sober living environments.

b. Standard: By July 1, 2013, GCAL will be able to provide information and/or referrals for sober living with GARR.

c. Responsible: DBHDD.

47. Create Addictions Recovery Centers

a. Objective: Develop a plan to create recovery centers that provide a comprehensive array of support services that assists in sustaining recovery that include the following:

- Peer support,
- Employment services,
- Recovery support groups,

- Social supports/activities,
- Vocational /educational services,
- Family supports,
- Relapse prevention,
- Housing resources.

b. Standard: The plan will include funding requirements for the budget proposal from the agency to the Governor and Legislature. The plan will be presented to the Olmstead Planning Committee during the July 2013 meeting.

c. Responsible: DBHDD and DCH.

48. Create Olmstead Criminal Justice Workgroup

a. Objective: Create a criminal justice workgroup including state agencies, individuals with disabilities, advocates, and stakeholders.

b. Standard: By July 2013, create a workgroup to discuss the implications of the Olmstead decision on actions involving individuals with disabilities in the criminal justice system. The workgroup will create the data required in the data goal of this plan.

c. Responsible: The Olmstead Coordinator, or designated chairman.

49. Develop Criminal Justice Data

a. Objective: Develop data regarding individual with disabilities involved in the criminal justice system.

b. Standard: By December 2013, develop a quarterly report for the Olmstead Planning Committee indicating:

- Number of individuals with disabilities in jails and prisons,
- Number of arrests and re-arrests involving these populations,
- Existence of transition, reentry, and jail diversion programs,
- Existence of community-based programs that have been proven to reduce arrests and recidivism, including ACT, intensive case management, crisis intervention teams, mobile crisis units, and supportive housing being used by these population,
- Funding dedicated toward training for law enforcement and corrections officers to increase tolerance,
- Presence of services in jails and prison.

c. Responsible: Olmstead Coordinator working with criminal justice workgroup.

V. <u>Resources Goal:</u> Develop resources to eliminate the unnecessary institutionalization of individuals with disabilities whose needs can be met in the community and who do not oppose such community services. These resources will be in a multi-year funding plan based on existing and potential resources from all fund sources and corresponding gap analyses.

50. Transfer Resources from Institutions to Community Service Funding

a. Objective: Determine and report to the Olmstead Planning Committee and to the Behavioral Health Coordinating Council the projected annual reduction in institutional capacity and funding to be moved to support the community system of care.

b. Standard: Within 90 days of closure of the Settlement Agreement in 2015. The report should include estimates of reprogramming in the next two fiscal years.

c. Responsible: The Olmstead Coordinator, working with state agencies and stakeholders.

51. Identify Resources to Fund the Individual Plan

a. Objective: Determine estimated costs for specific community supports identified in person centered planning and ensure appropriate resources are provided.

b. Standard: By January 2014 this capability should be in place prior to any individual discharge. These costs will be included as anticipated individual budget estimates in annual needs assessments and budget proposals.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

52. Project Annual Budget Funding Requirements

a. Objective: Project the number and costs of community services needed by individuals with disabilities as a basis for the annual budget proposal that is submitted to the Georgia Legislature by the Governor.

b. Standard: By April annually, provide the estimates determined in Objective 35 (Project Need for Services and Supports Annually) to state agencies for consideration in their annual budget request to the Governor's Office.

c. Responsible: The Olmstead Coordinator, working the Office of Planning and Budget, State Agencies and stakeholders.

53. Strengthen Medicaid Funded Home and Community Based Care

a. Objective: Convene a workgroup to discuss recommendations to improve current Medicaid funding of home and community based care.

b. Standard: By July 1, 2013, the workgroup will report recommendations to the Olmstead Planning Committee.

c. Responsible: DCH lead, working with DBHDD, DHS, DJJ, stakeholders, and individuals with disabilities.

54. Report Status of Medicaid "Rebalancing" Effort

a. Objective: Provide increased Medicaid funding for community services versus long term nursing facility care.

b. Standard: Define the current funding baseline by March 15, 2013. By December, 2015, the percentage of Medicaid funding for community care for individuals at-risk of institutionalization in nursing facilities will be increased by 5%. Provide quarterly status to OPC regarding:

- HCBS participants per 1,000 of the population,
- HCBS expenditures per capital,
- % of HCBS participants compared to the total long-term care population,
- % of HCBS participant compared to long-term care expenditures.

c. Responsible: DCH lead with DHS recommendations to the Governor and approval by the Georgia General Assembly.

55. Expand Case Management, Supported Housing, and Supported Employment Services in the State Medicaid Plan

a. Objective: Provide an update to the Olmstead Planning Committee regarding efforts to expand the state Medicaid Plan for case management, supported housing, and supported employment services. The objective is to maximize the value of leveraging available state dollars to expand the availability of these services to all major and secondary population centers that can serve enough people to sustain a financially viable provider network. The update should include the feasibility of including funding for substance use disorder detoxification in the state plan.

b. Standard: Beginning within 90 days of approval the Plan, a semi-annual status report will be provided to the OPC.

c. Responsible: DBHDD, DCH, DHS, and Vocational Rehabilitation.

56. Modify State Medicaid Plan--Home and Community-Based Services

a. Objective: Modify the state Medicaid Plan to include flexible home and community-based services throughout the state to individuals who:

- Have Severe and Persistent Mental Illness who are on the state hospital Olmstead List,
- Other groups of individuals with disabilities when feasible,
- Readmitted more than three times in one year or ten times within their lifetime,
- History of frequent incarcerations,
- Chronically homeless,
- People who have neurobehavioral services requirements.

b. Standard: By January 28, 2013, priority should be given to individuals in the Olmstead population. By December 2013, provide a status report with:

- Ratio of Medicaid dollars spent on community-based services versus funds dedicated to institutional services,
- Availability of home and community-based services as determined by the amount of funds spent on 1915c waivers and other Medicaid HCBS.

c. Responsible: DCH lead working with the Centers for Medicare and Medicaid Services and DBHDD.

57. Align Olmstead Budget Projections with the OPB Budget Timeline

a. Objective: Align Olmstead annual budget process with the Governor's budget timeline that results in a distinct Olmstead component of the Governor's budget.

b. Standard: Within 60 days of completion of the legislative session, present to the Olmstead Planning Committee a budget planning, approval, and implementation timeline that parallels Olmstead funding with the Governor's Budget Process.

c. Responsible: The Olmstead Coordinator working with the Governor's Office of Planning and Budget.

58. Present Olmstead Budget and OPB Annual Budget Request Briefing

a. Objective: Identify all Olmstead related funding in the Governor's Budget Report and the projected need.

b. Standard: Within 60 days after the end of the legislative session, present to the Olmstead Planning Committee a report of the current and proposed Olmstead related funding and projected need. The report should include:

- Two years of actual expenditures,
- Current year budget,
- Governor's budget to be amended and next fiscal year,
- Number of people and/or slots served in the prior two years,
- Projected number of people and/or slots to be in served in Olmstead related areas.

c. Responsible: The Office of Planning and Budget and the Olmstead Coordinator with input from State Agencies.

59. Present Olmstead Budget and OPB Annual Budget Appropriation Briefing

a. Objective: Identify all Olmstead related appropriations in the approved State Budget. Identify appropriations shortfalls in any category or agency as compared to the Annual Budget Request documents.

b. Standard: Annually, a report will be presented to the Olmstead Planning Committee within 30 days of completion of the legislative

session. The report will include actual funding appropriated for Olmstead related services and identify any shortfall in requested funding.
c. Responsible: The Office of Planning and Budget and the Olmstead Coordinator with input from State Agencies.

60. Complete Multi-Year (5-year) Budget Plan

a. Objective: Develop a 5-year budget document that accomplishes the objectives of this plan and any settlement agreement negotiated by the state.
b. Standard: By December 2013. The multi-year (5-year) budget is a projection of systems demands and the related costs. The multi-year plan will identify potential gaps or excess capacity in the system of care of Olmstead services. It will be updated annually with the required service capacity and gap analysis (see Objective 37). Each year's budget proposal should reflect funding to move the waiting list at a "reasonable pace". The multi-year (5 –year) budget is a working document for state agencies to consider in developing the annual agency budget projection. Funding must be appropriated during the Legislative Budget Process and approved by the Governor annually.
c. Responsible: Governor's Office, Office of Planning and Budget (OPB), DBHDD, DCH, DHS, DJJ, and DCA.

VI. <u>Evaluation Goal:</u> Create a practical structure for reviewing progress and barriers to implementation of the Olmstead Plan. Obtain input from individuals we serve, families, guardians, stakeholders, providers, state agencies, legislators, and others involved in our Olmstead effort. Optimize automation and personal interviews to document progress in comprehensive evaluations. Design all evaluation to provide lessons learned and recommendations for corrective action.

61. Evaluate Olmstead Plan Progress

a. Objective**:** Develop a quality assurance plan that evaluates progress in each objective of this plan.
b. Standard**:** By December 2013, present a summary of progress in implementing the Olmstead Plan to the Olmstead Planning Committee that addresses:

- Effectiveness of person centered transition planning for individuals in state institutions of publicly funded programs in institutional settings,
- Effectiveness of person centered planning for individuals at risk for institutionalization,
- Services, supports, health, safety, and quality of life of individuals transitioning into the community,
- Quality of provider delivered services and supports,
- Funding for home and community based services,
- Extent of community integration,

- Each objective in the Olmstead Plan.

c. Responsible: Olmstead Coordinator working with the Olmstead Planning Committee, state agencies, stakeholders, and individuals with disabilities.

62. Ensure Efforts to Build an Integrated System of Care

a. Objective: Community services and supports that provide stability will be available through a coordinated system of care. These services include direct support services, personal care services, housing, health care, mental health services, substance use disorder treatment, information about and assistance in obtaining income supports and benefits, life skills training, education, employment preparation and assistance, recovery supports (if applicable), and others listed in the continuum of care for each population in this plan.

b. Standard: Beginning in December 2013 and every 2 years thereafter, the Olmstead Planning Committee will review statewide utilization data from state agencies and provide program and budget recommendations for state agencies and the Governor's Office of Planning and Budget. The OPC will also examine the extent of state agency collaboration in building the integrated system of care.

c. Responsible: Olmstead Planning Committee with DBHDD, DCH, DHS, DJJ, and DCA input.

63. Conduct State Agency Progress Meetings

a. Objective: State agencies will be convened to review progress in implementing the Olmstead Plan, barriers to transitioning, adequacy of community services, and designated corrective action plans for individuals beyond 90 days of their planned discharge date. Meetings regarding corrective action plans (CAPs) will be conducted as needed to respond to recommendations and to reduce barriers. An item of emphasis will be the correlation of services and supports actually received compared to what was identified in the individualized, person-centered plan. Agencies will determine what policy, administrative, resource, and budgetary changes are necessary to implement the Olmstead Plan.

b. Standard: Meetings will be called as necessary, but not less than semi-annually. Results of the meeting will be presented to the Olmstead Planning Committee during the next monthly meeting following the State agency meeting.

c. Responsible: Olmstead Coordinator.

64. Align State Agency Plans and the Olmstead Plan

a. Objective**:** State agency strategic plans, budgets, quality assurance, and other related plans should contain specific measurable objectives that align with the Olmstead Plan.

b. Standard: State agencies should have measurable performance goals and objectives that contain specific standards from the Olmstead Plan. The agency quality assurance plan should measure the agency's services and supports regarding visibility, trust, ease of access, consumer responsiveness, efficiency, and effectiveness. Beginning in January 2013, state agencies will present how they plan to accomplish Olmstead Plan objectives to the Olmstead Planning Committee during the annual Olmstead Plan evaluation period (January – March).
c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA with the Olmstead Coordinator.

65. Complete Satisfaction Surveys

a. Objective: Provide annual report to the Olmstead Planning Committee on satisfaction surveys from individuals transitioned to community settings or at-risk of institutionalization.
b. Standard: Individuals receiving services due to being at risk of institutionalization or individuals who have transitioned from state institutions and publicly funded programs in institutional settings will be surveyed regarding satisfaction with their services and supports. The surveys will be administered to a representative sample of each disability population in order to achieve statistically significant results. An annual report will be provided to the Olmstead Planning Committee with corrective action plans which address concerns indicated in the surveys.
c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

66. Continue Olmstead Coordinator Monitoring

a. Objective: The Olmstead Coordinator will visit state institutions to monitor implementation of the Olmstead Plan. Additionally, there will be a plan for periodic monitoring of nursing facilities.
b. Standard: Visit a minimum of one state hospital and one nursing facility quarterly and monitor transition activities and barriers to discharge impacting timely, effective transition to the community. Provide annual updates to the Olmstead Planning Committee regarding barriers to discharging individuals from the institutions and nursing facilities and other Olmstead Plan related observations.
c. Responsible: Olmstead Coordinator with DBHDD, DCH, DHS, and DJJ.

VII. <u>Sustainability Goal</u>: Ensure long term funding and quality of service and support delivery through strategies, policies, and procedures that can be sustained over the lifetime. Establish a Georgia value that individuals are served in the community as opposed to institutions. Sustain systems that meet person centered planning need requirements.

67. Update Individual Service and Support Plans Annually

a. Objective: All individuals transitioning into the community from state hospitals and publicly funded programs in institutional settings, who require case management, will receive the required level of case management services to ensure health, safety, and quality of life as indicated in the individualized plan that is updated as least annually. Individuals at risk of institutionalization, who are receiving services, will also have updated plans.

b. Standard: The individual will meet with the appropriate case manager at least every 12 months to update the individualized plan. Service and support plans will remain person centered. Individuals at risk of institutionalization who have received services should also have their plan updated annually.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

68. Obtain Case Management Services

a. Objective: Improve access to and the quality of case management services for individuals transitioned from state hospitals, publicly funded programs in institutional settings, or at-risk of institutionalization. Each individual being served in the community will receive the level of case management necessary to access required services and supports.

b. Standard: Within 90 days of approval of the Plan, state agencies will provide status of case management resources available to support individuals receiving home and community based services. By January 2014, state agencies will report shortfalls in providing case management to the target populations.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

69. Involve National Subject Matter Experts in Implementation of the Georgia Olmstead Plan

a. Objective: The Olmstead Planning Committee will seek access to technical assistance from state and national experts as needed. Assistance will be requested through federal agencies whenever possible. The Olmstead Planning Committee may recommend technical assistance opportunities to state agencies.

b. Standard: As requested by the Olmstead Planning Committee, preferably within 45 days of the request.

c. Responsible: Olmstead Coordinator working with federal partners.

70. Designate Olmstead Lead Person in Each State Agency

a. Objective: A lead person will be identified in each state agency to provide expertise, access to data, ongoing analysis of barriers to transition, recommendations for systems improvement, participation in regular Olmstead State Agency meetings, and creation of status reports concerning areas the agency has responsibility designated in the Olmstead Plan.

b. Standard: Within 90 days of approval of the Plan, state agencies will designate the agency lead person. The individual must have timely access to the Commissioner for decisions that impact Olmstead actions. The lead person will begin to develop status reports on Olmstead objectives. The lead person is expected to attend each Olmstead Planning Committee meeting, Olmstead state agency meetings, and meetings called for resolution of time-sensitive issues.

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

71. Sustain Education Plan

a. Objective: Sustain a plan for educating individuals with disabilities, their families, guardians, and advocates.

b. Standard: Evaluate the plan during July each year after approval of the Plan. The initial plan must be developed by July 2013 (see Objective 9).

c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

72. Implement Provider Training and Education

a. Objective: To implement training to new and existing providers regarding services and supports, crisis response, behavioral management, direct support professional's curriculum, the special needs of the Olmstead population, and other topics that assist in meeting Olmstead Plan objectives.

b. Standard: During the March 2013 Olmstead Planning Committee meeting, state agencies will present their training plan to the Olmstead Planning Committee. The plan will include concepts for new providers and continuing training and education for providers already under contract.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

VIII. <u>Policy Goal</u>: Create and implement policies to support Olmstead compliance.

73. Develop an Annual Legislative Update

a. Objective: Develop an annual legislative update that will include:

- Summary of the Georgia Olmstead Plan,
- Status of implementation of the Olmstead Plan,
- Policy recommendations submitted by state agencies that support the Olmstead Plan.

b. Standard: By December 2013. The Legislative Update should be presented to the Appropriations and Human Services Committees prior to the start of each legislative session.
c. Responsible: Olmstead Coordinator working with state agencies.

74. Review and Support Olmstead Proposed Legislation

a. Objective: Agencies seek the review and support of the Olmstead Coordinator and the Olmstead Planning Committee for any necessary Olmstead related legislation.
b. Standard: Beginning in July 2013 and annually thereafter.
c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

75. Circulate Education Materials for Legislature

a. Objective: Provide ongoing education to Georgia's Legislature regarding the Olmstead Plan and services and supports provided in the communities across the state.
b. Standard: Within 90 days of approval of the Olmstead Plan.
c. Responsible: Olmstead Coordinator working with state agencies, public information officials, and stakeholders.

76. Conduct a Policy and Procedure Review

a. Objective: Conduct an analysis of existing policies and procedures to determine barriers to transitioning to the community and successful community living.
b. Standard: By March 31, 2013 complete the identification of policy and procedural barriers that adversely impact transitioning to the community and successful community living. The Olmstead Coordinator will provide the Olmstead Planning Committee a biennial report which provides recommendations for policy/procedure revision.
c. Olmstead Coordinator working with state agencies and stakeholders.

77. Provide Advance Notice of Policy Change

a. Objective: State agencies will report any significant change to state or federal policy change being implemented or considered that impacts the Olmstead Plan to the Olmstead Coordinator, the Olmstead Planning Committee, the Medicaid Community Advisory Committee (MCAC), any affected agency, and when possible, affected service recipients.
b. Standard: Whenever possible, the Olmstead Coordinator should have enough time to provide an impact statement regarding the Olmstead Plan. A minimum of 90 days notice is preferred before any change is enacted.
c. Responsible: DBHDD, DCH, DHS, DJJ, and DCA.

IX. **Data Goal:** Create data systems that provide accurate, timely information to provide safe and healthy environments, manage resources, develop strategies, and evaluate progress.

78. Provide Automation Support to the Olmstead Effort

a. Objective: State agencies should use electronic information systems to monitor, evaluate, and improve services, supports, performance, costs, and compliance with the Olmstead Plan. This should include linkage with other data systems, such as Medicaid information systems and electronic health records.

b. Standard: Formal processes for obtaining input and feedback from consumers and their families on the services and supports will be established. State agencies will provide status of Olmstead related information systems during the annual evaluation period for the Olmstead Plan. This report should include what Olmstead related data is being tracked and what critical information supporting the Olmstead Plan is not available.

c. Responsible: DBHDD, DCH, DHS, DJJ and DCA.

79. Prepare Quarterly Olmstead Progress Report

a. Objective: Provide the Olmstead Planning Committee timely and accurate data to make recommendations and decisions regarding the Olmstead Plan.

b. Standard: Within 90 days of approval of the Plan, develop Olmstead Quarterly Reports for the Olmstead Planning Committee. Reports will protect privacy and provide pertinent Olmstead information. At a minimum, the report will include the number of individuals with disabilities in state hospitals, publicly funded programs in institutional settings, and at risk of institutionalization; transitions, admissions, and discharges; opposition to placement in the community; timely receipt of services; use of crisis systems in the community; and major barriers that prevent transitions to the community or increase risk of institutionalization. Where possible the Quarterly Olmstead Progress Report should indicate:

- Hospital census,
- Ration of individuals served in the community compared to those in institutional settings,
- Length of stay for individuals in institutional settings,
- Number of individuals on any community services waitlist, other than Medicaid waivers.

c. Responsible: Olmstead Coordinator, DBHDD, DCH, DHS, DJJ, and DCA.

80. Prepare Quarterly Readmission Report

a. Objective: To review reasons for readmissions of individuals previously on the Quarterly Olmstead Report to a state institution or publicly funded program in an institutional setting.

b. Standard: Within 90 days of the first Quarterly Olmstead Report, the Olmstead Coordinator will review reasons for readmissions of individuals previously on the Olmstead List during monthly visits and statewide calls with state hospitals and publicly funded programs in institutional settings. The Olmstead Coordinator will provide a summary report quarterly to the Olmstead Planning Committee. Where possible, this report should include:

- Readmission rate,
- Number of days elapsed between discharge and readmission.

c. Responsible: Olmstead Coordinator with DBHDD, DCH, DHS, and DJJ.

81. Develop Diversion Report Section of Olmstead Quarterly Report

a. Objective: Expand the Quarterly Olmstead Report to include diversion efforts for individuals at risk of institutionalization in the community. DBHDD and DCH will provide recommendations for the expanded Monthly Progress Report to the Olmstead Planning Committee. The report should include the number of individuals with disabilities identified in the Olmstead Quarterly Report as "at risk of institutionalization", the utilization date for services and supports available to prevent institutionalization, and barriers to diversion efforts.
b. Standard: By July 2013.
c. Responsible: DBHDD, DCH, DHS, and DJJ.

82. Recommend Nursing Facility Quarterly Data Reporting Format

a. Objective: DCH and DHS will recommend Olmstead data about individuals in nursing facilities that should be included in the Quarterly Olmstead Report.
b. Standard: Within 90 days of approval of the Plan.
c. Responsible: Olmstead Coordinator working with DCH and DHS.

83. Report Nursing Facility Preference Statistics

a. Objective: DCH will determine the number of individuals living in nursing facilities who prefer to live in an integrated community setting as evidenced in the MDS Q/A. This report should also indicate the number screened by an ADRC and referred for possible placement utilizing community resources. This data will be included in the Quarterly Olmstead Progress Report.
b. Standard: Within 90 days of approval of the Plan.
c. Responsible: DCH and DHS.

84. Develop Common Data Collection Protocol

a. Objective: Develop a protocol and common definitions for reporting Olmstead data for all individuals transitioned to the community since July 2008. Agencies will recommend summary reports from the database.
b. Standard: By December 12, 2013.

c. Responsible: DBHDD, DCH, DJJ, and DHS.

85. Create an Annual Data Forecasting Capability

a. Objective: Create and implement a process for collecting the following data:

- Community infrastructure needs of individuals with disabilities in institutions or at substantial risk of institutionalization,
- The number of individuals in institutions categorized by disability, specific community service needs, and length of institutionalization,
- The number of individuals at substantial risk of institutionalization categorized by disability and community service needs,
- The approximate per-person cost of providing each community service specified.

b. Standard: By July 2013.

c. Responsible: DBHDD, DCH, DHS, DCA, and DJJ.

86. Review Waiting List Report

a. Objective: Review currently available waiting lists for housing, residential supports, care coordination, or other community service and supports and provide data to the Olmstead Planning Committee. As appropriate, include short term and long term lists. Determine if this data should be included in the Quarterly Olmstead Report.

b. Standard: Quarterly beginning in July 2013.

c. Responsible: Olmstead Coordinator and state agencies.

Appendices

Appendix A: Acronyms

ABA	Applied Behavior Analysis
AD	Addictive Disease
ADRC	Aging and Disability Resource Connection
APS	Adult Protective Services, Aging Services Division, DHS
CILS	Centers for Independent Living
CMS	Center for Medicare and Medicaid Services
COMP	Comprehensive Supports Waiver
DAS	Division of Aging Services
DBHDD	Department of Behavioral Health and Developmental Disabilities
DCA	Department of Community Affairs
DCH	Department of Community Health
DD	Developmental Disability
DFCS	Department of Families and Children Services
DHS	Department of Human Services
DJJ	Department of Juvenile Justice
DME	Durable Medical Equipment
DOJ	Department of Justice
GCAL	Georgia Crisis and Access Line
HCV	Housing Choice Voucher
HUD	U.S. Department of Housing and Urban Development
ICF	Intermediate Care Facilities
ISP	Individual Service Plan
MDS	Minimum Data Set
MFP	Money Follows the Person
MH	Mental Health
NOW	New Options Waiver
OC	Olmstead Coordinator
OCR	Office of Civil Rights, Department of Health and Human Services
OPB	Office of Planning and Budget, Governor's Office
OPC	Olmstead Planning Committee
OSAH	Office of State Administrative Hearings
PRA	Project Rental Assistance
RARC	Repeat Admissions Review Coordinator
SA	Settlement Agreement
SHIP	State Health Insurance Assistance Program
SPC	Shelter Plus Care
TIC	Temporary and Immediate Care

Appendix B: Definitions

Aging and Disability Resource Connection (ADRC): Georgia's Aging and Disability Resource Connection (ADRC) is a collaborative effort between aging and disability partners. The ADRC serves as the "no wrong door" for long-term supports and services for older adults and persons with disabilities. Through integration or coordination of existing service systems, ADRCs raise the visibility of options available to consumers and provide objective information, guidance, counseling and assistance to empower people to access and make informed decisions about their long term supports.

Assertive Community Treatment (ACT): A service that delivers comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work. ACT is provided through a multidisciplinary team that may include a psychiatrist, nurse, psychologist, social worker, substance abuse specialist, vocational rehabilitation specialist, and peer specialist. Services are highly individualized and customized to address the constantly changing needs of the individual over time. Among the services that ACT teams provide are: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live successfully in the community. ACT services are available 24 hours a day, 7 days a week.

Adult Occupational Therapy: Promotes fine motor skill development, coordination, sensory integration, and facilitates the use of adaptive equipment or technology.

Adult Physical Therapy: Promotes gross and fine motor skills, and facilitates independent functioning.

Adult Speech and Language Therapy: Helps promote communication capacity and function.

Behavioral Supports Consultation: Assists the person with challenging behaviors by providing an expert to develop a positive behavior support plan and to train people supporting that individual in how to implement that plan consistently

Brain Injury: The beginning of a lifelong disease process that impacts brain and body functions resulting in difficulties in physical, communication, cognitive, emotional, and psychological performance that undermines health, function, community integration and productive living. Brain injury is also disease causative and disease accelerative in that it predisposes individuals to re-injury and the onset of other conditions. Brain injury impacts neurologic disorders such as epilepsy, vision and hearing impairments, psychiatric disorders, and orthopedic, gastrointestinal, urologic, sexual, neuroendocrine, cardiovascular and musculoskeletal dysfunction). Care for brain injury must focus on health care which includes neurobehavioral services that is medically necessary with access to the full continuum of care to manage the disease. While brain injury is

included in the physical disability group, the Plan recognizes that there are people with brain injuries who do not have physical impairments.

Community Access: Supports people in being involved in their community. It can be done individually or in a group. It can take place during the day, the evening, or the weekend.

Community Guide: Designed to help people who are learning how to self-direct their supports. It can involve obtaining community resources, problem solving, skills, development in self directing, or building supportive relationships.

Community Living Support: Helps the person live at home. It can help with bathing, dressing, toileting, eating, shopping, banking, exercising, decision making, supervision of the person taking their medicine, or other activities that assist the person in being able to live in their home. Community living supports are part of the broader community support required to help sustain an individual living at home.

Community Residential Alternative: Assists people who are living in a residential home operated by a provider agency. The person can receive supports in daily living activities, life skills, and household chores. The agency staff provides the training and supervision in the home. It is only available in the COMP waiver.

Developmental Disability: A related developmental disability meeting ICF-MR level of care is defined as follows in 42 C.F.R. 435.1010: Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to—

(1) Cerebral palsy or epilepsy; or,

(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons,

(b) It is manifested before the person reaches age 22,

(c) It is likely to continue indefinitely,

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care,

(2) Understanding and use of language,

(3) Learning,

(4) Mobility,

(5) Self-direction,

(6) Capacity for independent living.

Developmental Disability Facility: Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and state operated skilled nursing facilities.

Developmental Disability Funding Year List: The number of individuals with developmental disabilities on the DD Olmstead List who:

- Are designated to receive services utilizing funding allocated for a particular fiscal year,
- Are selected for the Funding Year List according to preference to transition to the community and available funding slots.

Environmental Accessibility Adaptations: Makes adaptations to accommodate the person in their home. It might include ramps, grab bars, doorway widening, or bathroom modifications.

Family Supports: An array of goods and services aimed at providing families with the highly individualized support needed to prevent institutionalization and continue to care for a family member at home.

Financial Support Services: Draws down the funds and pays the bills for people who are self directing their services. They manage payroll, taxes, and background checks and make sure the participant knows how their funds are being used.

Home and Community Based Waiver Services: The program approved by the Centers for Medicare and Medicaid for the purpose of providing services in community settings for eligible persons with disabilities who would otherwise be served in institutions.

Individual Directed Goods and Services: Includes services, equipment, or supplies that address the person's needs specified in the Individual Service Plan (ISP) but not otherwise available in the waiver.

Individual's Informed Choice: A choice that is made consistent with a protocol that ensures that adequate information is provided as well as education and support to facilitate available choices, and that the individual's preference, when able to be determined, is taken into account. If the choice is made by a guardian, the protocol should address situations in which the guardian is unable to be located.

Mental Health Hospital: State-operated adult mental health units (MH) and Forensic Units.

Natural Support Training: Allows for training and education to families or individuals who provide unpaid support, training, companionship, or supervision. It is only available in the NOW waiver.

Olmstead Decision: The 1999 US Supreme Court case of Olmstead vs. L.C. which ruled that unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability.

Peer Support Services: Services delivered by peers to improve an individual's community living skills, including their ability to cope with and manage symptoms and to develop and utilize existing community supports. Peers support services may be provided face-to-face or by telephone contact and include outreach, wellness training, and training in self-advocacy. Individuals who provide peer support are coaches, mentors, and partners for an individual with a disability.

Personal Care Services: Services that assist individuals with physical disabilities needs such as assistance with daily personal care, bathing, feeding, and dressing.

Physical Disability: Any physical, or neurological impairment which severely restricts a person's mobility, manual dexterity, or ability to climb stairs; substantial loss of sight or hearing; loss of one or more limbs or use thereof; or significantly diminished reasoning capacity.

Prevocational Services: Designed to help people work towards employment. It might include teaching concepts of completing tasks, safety, social interaction skills, or problem solving.

Public Funded Program in an Institutional Setting: Includes any Medicaid or other state funded program in an institutional setting. Medicaid funded nursing facilities are included in this definition.

Respite Services: Provides caregivers, family members, and individuals with disabilities brief periods or relief. It can be hourly or overnight. It is only available in the NOW Waiver.

Serious and Persistent Mental Illness: A diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that has occurred within the last year, has resulted in functional impairment which substantially interferes with or limits one or more major life activities, and has episodic, recurrent, or persistent features.

Specialized Medical Supplies: Includes supplies that are needed by the individual and are written into their Individual Service Plan. It might include food supplements, clothing, disposable briefs, and latex gloves.

Specialized Medical Equipment: Provides various equipment that would help the person perform daily living activities or interact more independently in their environment. The needed equipment must be included in the Individual Service Plan.

State Hospitals/Facilities/Institutions: Facilities, services, and programs supplied or provided to patients admitted to the hospital at Georgia Regional Hospital at Atlanta (GRHA), Georgia Regional Hospital at Savannah (GRHS), Central State Hospital (CSH), Southwestern State Hospital (SWSH), West Central Georgia Regional Hospital (WCGRH), and East Central Regional Hospital (ECRH).

Support Coordination: Assembling professionals and non-professional who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, to include those required by the State's HCBS Waiver Program, that are individualized; assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Support Plan; and monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified and needed.

Supported Employment: Supports people become employed and to maintain their employment in the community. It can include job development, job coaching, and long term supports on the job.

Supports Intensity Scale (SIS): An assessment instrument developed by the American Association of Intellectual and Developmental Disabilities. The SIS measures the intensity of supports a person needs. The SIS helps planning teams, agencies, and organizations to understand the support needs of people with intellectual disabilities and closely related developmental disabilities.

Transportation: A critical support that enables individuals with disabilities to travel to community activities, to access services and supports, to visit places and to interact with others. These important interactions would normally not be available through Medicaid non-emergency transport or as part of another waiver service.

Traumatic Brain Injury (TBI): An injury caused by a jolt, blow or penetrating injury to the brain. Georgia defines traumatic brain injury as "an injury to the brain, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma from acceleration-deceleration forces, that is associated with any of these symptoms or signs attributed to the injury:

- decreased level of consciousness,
- amnesia,
- other neurological or neuropsychological abnormalities,
- skull fracture,
- diagnosed intracranial lesions.

These impairments may be either temporary or permanent and can result in a partial or total functional disability."

Vehicle Adaptation: Provides adaptations to the individual's or family's vehicle and may include lifts, ramps, special seats or other modifications to the interior of the vehicle

Appendix C: Array of Services

(Note: See Objective 33. The Array of Services contains services and supports that may be provided to individuals with disabilities. The CMS "Taxonomy of Home and Community Based Services" is included as part of the Plan's array of services and supports.)

Category 01: Case Management
- Case management

Category 02: Round-the-Clock Services
- Residential mental health services
- Residential substance abuse services
- Group living
  - Group living, residential habilitation
  - Group living, other
- Sub-category 02.04: family living
  - Family living, residential habilitation
  - Family living, other
- In-home round-the-clock services
  - In-home residential habilitation
  - In-home round-the-clock services, other
- Family Support
- Peer Support

Category 03: Supported Employment
- Job development
- Ongoing supported employment
  - Ongoing supported employment, competitive
  - Ongoing supported employment, individual
  - Ongoing supported employment, group

Category 04: Day Services
- Prevocational services
- Day habilitation
- Education services
- Day treatment/partial hospitalization
- Adult day health/adult day care
- Community integration
- Medical day care for children

Category 05: Nursing
- Private duty nursing
- Skilled nursing

Category 06: Home Delivered Meals

Home delivered meals

Category 07: Rent and Food Expenses for Live-In Caregiver

Rent and food expenses for live-in caregiver

Category 08: Home-Based Services

Home-based habilitation
Home health aide
Personal care
Companion
Homemaker/chore

Category 09: Caregiver Support

Respite
  Respite, out-of-home
  Respite, in-home
Caregiver counseling and/or training

Category 10: Other Mental Health and Behavioral Services

Mental health assessment
Assertive community treatment
Crisis intervention
Behavior support
Peer specialist
Counseling
Psychosocial rehabilitation
Clinic service
Substance abuse treatment

Category 11: Other Health and Therapeutic Services

Health monitoring
Health assessment
Medication assessment
Nutritional consultation
Physician services
Prescription drugs
Dental services
Occupational therapy
Physical therapy
Speech, hearing, and language therapy
Respiratory therapy
Cognitive rehabilitative therapy
Other therapies

Category 12: Services Supporting Participant Direction

Financial management services

Information and assistance in support of participant direction

Category 13: Participant Training

Participant training

Category 14: Equipment, Technology, and Modifications

Personal emergency response systems (PERS)
Home and vehicle accessibility adaptations
Equipment, technology, and supplies
Equipment and technology
Supplies

Category 15: Non-Medical Transportation

Non-medical transportation

Category 16: Community Transition Services

Community transition services

Category 17: Other Services

Goods and services
Interpreter
Housing consultation
Other

Appendix D: History

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

Over the decades, Georgia has moved from one state asylum to several state hospitals. These hospitals have served and continue to service persons with mental illness and developmental disabilities. In Georgia, Central State Hospital in Milledgeville reached a population of nearly 13,000 patients by the 1960s – making it one of the largest institutions of its kind in the United States. Since that time, services for people with mental illness and developmental disabilities have increasingly focused on community-based solutions.

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

These two waiver programs provide the community-based services and supports that allow for the transition of residents with developmental disabilities to the community. As a result, since 1996, Georgia has closed three institutions for individuals with developmental disabilities:

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

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

Since the early 1980s, the Community Care Service Program (CCSP) waiver has existed to help physically and functionally impaired elderly and disabled individuals live

dignified and reasonably independent lives – either in their own home or with relatives or caregivers – through various community-based services. Since many older Georgians desire to live at home or with their families for as long as possible, the Georgia General Assembly has recognized the need for a continuum of care that assures Georgians aged 60 and older have the least restrictive environment suitable to their needs. In addition, the General Assembly has recognized the need to maximize existing community social and health resources to prevent the unnecessary placement of individuals into long-term care facilities.

In addition to the waiver programs for persons with developmental disabilities and the elderly/disabled CCSP program, Georgia has another home and community-based waiver for persons between the ages of 18 and 64 with significant disabilities (Independent Care Waiver Program, ICWP) and a Medicaid case management program (SOURCE).

Community services for persons with mental illness are provided through a state-wide system of public and private providers funded through the Medicaid Rehabilitation Program and state funds.

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

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

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

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

- State spending on public behavioral health services was not keeping pace with Georgia's population growth or demand for community-based services,
- Public behavioral health services reached less than a third of those estimated to have a serious mental illness or a serious emotional disturbance who would be eligible for publicly funded services,

- The behavioral health system struggled to serve special populations, such as transitional youth (aged 17 to 24), individuals with limited English proficiency or sensory impairment, certain minorities, and older adults, in Georgia,
- Many were not receiving the intensity of care their condition required,
- Community providers had inadequate staffing ratios to meet the minimum needs for services,
- A fragmented infrastructure for financing, accounting and managing information did not support the goal of measuring utilization, trending and planning for system needs,
- State hospitals appeared to be overburdened trying to make up for the lack of community-based services,
- Focus groups and surveys revealed a fragmented vision for an improved behavioral health system.

The Georgia Mental Health Gap Analysis also identified areas where Georgia had excelled:

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

Developmental Disability Gap Analysis: In 2005, Georgia became the 26th state to join the National Core Indicators (NCI) Consortium, sponsored by the Human Services Research Institute. The resulting NCI survey identified gaps in Georgia's service delivery for people with developmental disabilities by benchmarking the State's efforts with other NCI states. Georgia's NCI developmental disability gap analysis revealed that Georgia families perceived the following gaps in community services compared to other NCI states:

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

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

Closure of Northwest Georgia Regional Hospital (NWGRH): In 2011, the Department of Behavioral Health and Developmental Disabilities (DBHDD) closed the NWGRH located in Rome, Georgia. DBHDD stopped admissions to the hospital in April 2011. Approximately 185 individuals with disabilities were being served at the time of the closure announcement (54 with mental illness, 58 with developmental disabilities, and 73 forensic, court ordered placements). Community services in the region were expanded to accommodate the individuals being transitioned and to prevent institutionalization of individuals at-risk of being admitted to the hospital. Private hospital beds were contracted and new crisis stabilization programs beds were added in the region. The forensic residents were moved to other state-operated hospitals. The hospital closure signals a major event in Georgia's efforts to meet Olmstead requirements. Savings from the hospital closure are being used to support the state's behavioral health service objectives.

Appendix E: Olmstead Planning Committee (OPC)

History: The former Department of Human Resources (DHR), acting as the lead state agency, applied for and received a grant from the Center for Health Care Strategies that established the OPC in 2000. The 2000 OPC included:

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

In 2001, the Olmstead Planning Committee was charged with the following:

- Guide the Departments of Human Resources and Community Health in the development of a set of recommended action plans for implementation by the state; and,
- Develop action plans that will facilitate service delivery in the most integrated setting appropriate to the needs of individuals with disabilities (children and adults with mental illness, children and adults with intellectual and developmental disabilities, and individuals with physical and other disabilities, including the elderly).

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

2002 Olmstead Planning Committee Recommendations: The OPC's final report included recommendations for identifying, educating, assessing, planning and transitioning institutionalized individuals organized by different populations. In addition, the Committee made recommendations for system capacity and resources for housing and transportation infrastructure, service expansion, provider development and workforce development.

2009 OPC Responsibilities and Composition: The OPC was reconstituted by the Governor in 2009 by executive order and housed under the Governor's Office. It was chaired by the Olmstead Coordinator, who was appointed by the Governor. The key functions of the OPC included:

- Approving Georgia's Olmstead Plan,
- Soliciting and including the views of a cross-section of stakeholders,

- Addressing all issues pertinent to creating a comprehensive and effective Olmstead Plan, including:
    - Data collected by the State to assess the need for community services,
    - State resources for providing community services and determining how resources can be better utilized,
    - Determining whether the State's policies are consistent with Olmstead goals and the Voluntary Compliance Agreement (and if not, what policy changes are necessary to meet obligations),
    - Any other issues the OPC believes are important to the Olmstead Plan effort,
- Reviewing regular progress reports,
- Issuing an annual Olmstead Report each December that includes:
    - Solicitations for stakeholder comments and concerns,
    - Assessment of the State's community service needs,
    - Policy proposals,
    - Recommended funding for initiatives.

Membership of the Olmstead Planning Committee is as follows:

- The Olmstead Coordinator, as Chair of the Committee,
- The Commissioner of Human Services, or designee (formerly Human Resources),
- The Commissioner of Community Health, or designee,
- The Commissioner of the Department of Behavioral Health and Developmental Disabilities, or designee,
- Two parents of children with disabilities, including one parent of a child with a developmental disability and one parent of a child with a behavioral health disability,
- One youth citizen with a behavioral health disability or developmental disability,
- One adult citizen with a behavioral health disability,
- One adult citizen with a developmental disability,
- One adult citizen with a physical disability (added in 2010),
- One family member/relative of a person with a behavioral health disability,
- One family member/relative of a person with a developmental disability,
- One citizen associated with the advocacy community for persons with behavioral health disabilities,
- One citizen associated with the advocacy community for persons with developmental disabilities,
- One provider of community-based treatment services.

2010 Olmstead Planning Committee

- Governor Sonny Perdue designated a position on the OPC for an individual with a physical disability,

- The Office of Civil Rights terminated the Voluntary Compliance Agreement,
- The Olmstead Planning Committee approved the Georgia Olmstead Plan (draft) and forwarded it to the Governor's Office in August 2010,
- The Olmstead Planning Committee did not meet again in 2010 after the draft Plan was submitted to the Governor's Office.

2012 Olmstead Planning Committee

- The Olmstead Planning Committee was reconvened in 2012. Olmstead Plan Workgroup Meetings began in April 2012,
- During the January 5, 2012 Olmstead Planning Committee meeting, the following responsibilities were approved for the Committee:
    a. Clarify through the Georgia Olmstead Plan how Georgia will organize and make available Federal, State, and local resources to ensure that qualified persons with mental illness, developmental disabilities, addictive disease, physical disability and/or brain injury receive services in the most integrated setting appropriate to their needs in full compliance with the spirit, intent, and letter of the ADA and Section 504,
    b. Recommend State Olmstead Plan for Governor's approval,
    c. Solicit and include in the Olmstead Plan the views of a cross-section of individuals who are personally and/or professionally involved in community services for institutionalized individuals and those at risk or institutionalization,
    d. Discuss any other issues the OPC determines pertinent to the creation of a comprehensive and effective Olmstead Plan (data required, resources, and policy adequacy),
    e. Receive regular reports regarding progress in meeting goals in the Olmstead Plan,
    f. Identify policies, processes, and other problems that may frustrate the State from achieving the goals of the Olmstead Plan,
    g. Assess all items addressed in the Olmstead Plan, and as appropriate, include an update of the Olmstead Plan,
    h. Review agency budgets, strategic plans, and other documents to provide recommendations to the Governor's Office that reduce duplication of effort and increase effectiveness and efficiency.

Appendix F: Voluntary Compliance Agreement (VCA)

(The VCA ended during 2010. New negotiations began during March 2010.)

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

In addition to this Olmstead Plan, the State was required to comply with all provisions of the Voluntary Compliance Agreement.

Key Planning Provisions of the Voluntary Compliance Agreement included the following:

The appointment of an Olmstead Coordinator

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

The Assessment of Statewide Need for Community Services

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

Planned Transitions, Service Expansions and Special Initiatives

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

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

Revision of the State Olmstead Plan

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

This revised plan must include:

- An annual schedule of anticipated discharges of institutionalized individuals with developmental disabilities and mental illness,
- A comprehensive and effective plan to treat all institutionalized persons having a preference to be served in the community,
- Information on obtaining and maintaining necessary community services for individuals at risk of being institutionalized,
- Approval by the Olmstead Planning Committee.

Appendix G: 2010 Georgia and Department of Justice Settlement Agreement

In October 2010, Georgia and the Department of Justice signed a Settlement Agreement.

After the Settlement Agreement was signed, the Governor's Office released the following:

"The State of Georgia and the United States Department of Justice signed a statewide Settlement Agreement on October 19, 2010. The agreement provides community alternatives to institutionalization for individuals with developmental disabilities and mental illness. The agreement also provides services for individuals at-risk of institutionalization to prevent future admissions to state hospitals. The basis of the agreement is the Olmstead v. L.C., (1999) Supreme Court decision, which requires states to provide services in the most integrated setting enabling individuals with disabilities to interact with people without disabilities as much as possible. The new agreement furthers the State's commitment to comply with the Olmstead decision, replacing and expanding upon the Voluntary Compliance Agreement entered into on July 1, 2008.

The agreement supports the recommendations of Governor Sonny Perdue's Mental Health Service Delivery Commission, Final Report (delivered December 4, 2008). The Commission, which began work in August 2007, concluded "…that our systems should be based on a recovery model of care and delivered primarily in community settings, with housing, employment, transportation and case management to supplement the crisis stabilization, medical management and counseling services necessary for recovery and safety." Further, "…the Commission supports the ongoing appropriate deinstitutionalization and community reintegration initiated by the Office of the Governor…. of inpatients and prisoners with mental illness, developmental disabilities, and addictive disease in order to promote better quality of care, achieve cost savings and stretch the state funds that are necessary to ensure all our citizens with special needs are served."

The comprehensive settlement agreement resolves the lawsuit brought against the state. Under the agreement, over the next five years, Georgia will increase assertive community treatment, intensive case management, case management, supported housing and supported employment programs to serve 9,000 individuals with mental illness in community settings. The agreement also increases community crisis response through crisis services centers, crisis stabilization programs, mobile crisis response and crisis apartments. Under the agreement, the state will stop admitting people whose primary diagnosis is a developmental disability into state hospitals by July 2011 and instead place them directly into community services. The agreement creates additional Medicaid waivers to transition individuals with developmental disabilities from state hospitals to community settings. Increased crisis, respite, family and housing support services will be available to individuals with developmental disabilities."

The Settlement Agreement focuses on mental illness and developmental disabilities. The Georgia Olmstead Plan addresses all disabilities. The terms of the Settlement Agreement continue through 2015; the Georgia Olmstead Plan is a long term strategy. The Settlement Agreement is a first priority for the Georgia Olmstead Plan. The lead agency responsible for implementing the Settlement Agreement is the Department of Behavioral Health and Developmental Disabilities. Requirements of the Settlement Agreement take precedence through 2015."