

**A. General Information - SUBMITTED****Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia**Organization Information****1. Full Name of Grantee Organization**

Georgia Department of Community Health Medicaid Division/Aging and Community Health Services

**2. Program's Public Name**

Georgia Money Follows the Person Project

**3. Program's Website**

http://dch.georgia.gov/mfp

**Project Director****4. Project Director Name**

Pamela R Johnson

**5. Project Director Title**

Project Director

**6. Project Director Phone**

(404) 651-9961

**7. Project Director Fax**

(770) 408-5883

**8. Project Director Email**

pajohnson@dch.ga.gov

**9. Project Director Status** Full Time Acting Vacant New Since Last Report**10. Project Director Status Date: Change date if status is different from last report.**

4/16/2012

Skip this section if your state did not have any self-direction programs in effect during the reporting period.

**Grantee Signatory****11. Grantee Signatory Name**

Pamela R Johnson

**12. Grantee Signatory Title**

Project Director

**13. Grantee Signatory Phone**

(404) 651-9961

**14. Grantee Signatory Fax**

(770) 408-5883

**15. Grantee Signatory Email**

pajohnson@dch.ga.gov

**16. Has the Grantee Signatory changed since last report?** Yes No**Other State Contact****17. Other State Contact Name**

Marcey Alter

**18. Other State Contact Title**

Deputy Director Division of Medicaid Aging and Special Populations

**19. Other State Contact Phone**

(404) 657-5463

**20. Other State Contact Fax**

(770) 344-3899

**21. Other State Contact Email**

MAlter@dch.ga.gov

**Independent State Evaluator****22. Independent State Evaluator Name**

Glenn Landers

**23. Independent State Evaluator Title and Organization****24. Independent State Evaluator Phone****25. Independent State Evaluator Fax****26. Independent State Evaluator Email****Report Preparer****27. Report Preparer Name****28. Report Preparer Title****29. Report Preparer Phone****30. Report Preparer Fax****31. Report Preparer Email****CMS Project Officer****32. CMS Project Officer Name****B. Transitions - SUBMITTED****Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

- All figures are for the current reporting period.

1. Please specify your MFP program's "Other" target population(s) here. Once "Other" population has been specified in this location, it need not be specified again, and the specification will carry forward throughout the report any time "Other" target population is selected as an option. [The report will update after this page is saved.]

2. Please note the characteristics and/or diagnoses of your MFP program's "Other" target population(s).

n/a

3. Number of people assessed for MFP enrollment. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
First Period	31	48	0	72	0	151
Second Period	0	0	0	0	0	0
Total	31	48	0	72	0	151

Cumulative Number Assessed	662	698	0	859	5	
Transition Targets, all grant years (by population and total)	401	1,139	0	565	17	
Cumulative Number Assessed as a Percent of Total Transition Target	165.09%	61.28%		152.04%	29.41%	

Please indicate what constitutes an assessment for MFP versus any other transition program.

An assessment for GA MFP includes a consent and information release, screening form and individualized transition plan or individual service plan. The number assessed for MFP enrollment consists of three groups: (a) those assessed but did not yet transition because arrangements were not yet complete; (b) those who were assessed and made the transition during the reporting period, and (c) those who were assessed but cannot be transitioned. Division of Aging Services (DAS) individuals are referred through the MDSQ or non-MDSQ referral process from SNF found eligible and interested in MFP are screened by the MDSQ Options Counselor and referred to the Transition Coordinator. In DBHDD-DD we verify the MFP eligibility criteria of individuals in transition planning process. Individuals sign the MFP Consent for Participation and Authorization for Use of Information documents. These items document their desire to utilize the MFP Transition Services and agreement to participate in the MFP process. Other transition programs outside of MFP may not require that individuals become Medicaid eligible or that they spend a specified time in a Long-Term Care Facility.

4. Number of institutional residents who transitioned during this reporting period and enrolled in MFP. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
First Period	56	48	0	87	0	191
Second Period	0	0	0	0	0	0
Total	56	48	0	87	0	191

Annual Transition Target	50	150	0	75	75	
% of Annual Transition Target Achieved	112.00%	32.00%		116.00%	0.00%	

5. The reporting system automatically totals cumulative transitions to date, by tallying the new transition counts entered in each reporting period. If your records show different cumulative transition totals than those in the table below, you can adjust them by checking 'yes' below.

Yes: Please provide an explanation as to why your cumulative transition counts do not match those in the table below.

No

Cumulative number of MFP transitions to date. If you answered 'yes' above, please enter the positive

and/or negative adjustment value in the corresponding cell of the table below. For example, if your records show 5 fewer elderly transitions than the table shows, you should enter '-5' in the adjustment value row under elderly. A revised total will then appear in the Adjusted Cumulative Total row. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
	378	534	0	474	0	1,386
Adjustment value for cumulative transitions	0	0	0	0	0	0
Total	378	534	0	474	0	1,386

Transition Targets, all grant years (by population and total)	94.26%	46.88%	N/A	83.89%	.00%
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6. Total number of current MFP participants. Current MFP participants excludes individuals whose enrollment in the MFP demonstration ended because they completed their 365 days of MFP eligibility, died before they exhausted their 365 days of eligibility, or were institutionalized for 30 days or more and did not subsequently re-enroll in the MFP program. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
First Period	138	73	0	55	0	266
Second Period	0	0	0	0	0	0

7. Number of MFP participants re-institutionalized. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
For less than or equal to 30 days	0	0	0	0	0	0
For more than 30 days	8	0	0	4	0	12
Length of stay as yet unknown	0	0	0	0	0	0
Total	8	0	0	4	0	12

Total re-institutionalized for any length of time (total of above)	8	0	0	4	0
Number of MFP participants re-institutionalized as a percent of all current MFP participants	5.80%	0.00%	0.00%	7.27%	0.00%
Number of MFP participants re-institutionalized as a percent of cumulative transitions	2.12%	0.00%	N/A	0.84%	N/A

Please indicate any factors that contributed to re-institutionalization.

Factors that contribute to reinstitutionalization of individuals are: 1)Medication administration – this includes no access to pharmacy prescriptions due to lack of Community Medicaid. 2)hospitalizations due to Chronic disease. 3)Lack of community Mental Health supports. 4)Lack or degeneration of informal supports. 5)Accidents(i.e.,falls)

8. Number of MFP participants re-institutionalized for longer than 30 days, who were re-enrolled in the MFP program during the reporting period. [Click on Help link for explanation]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
First Period	0	0	0	0	0	0
Second Period	0	0	0	0	0	0
Total	0	0	0	0	0	0

Elderly	MR/DD	MI	PD	n/a	TOTAL
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9. Number of MFP participants -who ever transitioned -who completed the 365-day transition period during the reporting period (leave blank for first report). [Click on Help link for explanation]

First F  
Secor  
Total

Please indicate any factors that contributed to participants not completing the 365-day transition period.

For the Elderly and PD populations, factors contributing to participants not completing the 365 are identical to the factors contributing to reinstitutionalization described above as well as, participant choice to leave program or death.

10. Did your program have difficulty transitioning the projected number of persons it proposed to transition in the Operational Protocol? If yes, please check the target populations that apply.

Yes

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe your difficulties for each target population.**

Pre and post transitions were undergoing a performance improvement.

No

11. Does your state have other nursing home transition programs that currently operate alongside the MFP program?

Yes

**Please approximate the number of individuals who transitioned through other transition programs during this reporting period:**

11

**Please explain how these other transition programs differ from MFP, e.g. eligibility criteria.**

The Centers for Independent Living (CILs) transition individuals that do not meet the MFP criteria. Their requirements are that individuals have a self-reported disability and desire to transition from the nursing home. Their eligibility is based on a Nursing Home placement of less than 2 months and do not need waiver services to thrive in the community.

No

12. Does your state have an ICF-MR transition program that currently operates alongside the MFP program?

Yes

No

13. Do you intend to seek CMS approval to amend your annual or total Demonstration period transition benchmarks in your approved OP?

Yes**Please explain the proposed changes to your transition benchmarks.**

We have been approved to add a new population for Mental Health -Children and youth transitioning from Psychiatric Residential Treatment Facilities (PRTF). A request to add these numbers was included in our 2013 Supplemental Budget Request and in a revised Operational Protocol. We will integrate these numbers and DBHDD numbers for State FY2014 as needed to ensure ongoing quality transitions.

 No

Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

**C. Qualified HCBS Expenditures - SUBMITTED****Grant Report: 2013 First Period (January - June) - GA13SA01, Georgia**

1. Do you require modifying the Actual Level of Spending for last period?

 Yes No

**Qualified expenditures are total Medicaid HCBS expenditures (federal and state funds) for all Medicaid recipients (not just MFP participants), including: expenditures for all 1915c waiver programs, home health services, and personal care if provided as a State Plan optional service, as well as HCBS spending on MFP participants (qualified, demonstration and supplemental services), and HCBS capitated rate programs to the extent that HCBS spending can be separated from the total capitated rate.**

**Qualified HCBS Expenditure**

**Qualified HCBS Expenditures: Actual level of spending for each Calendar Year (CY) or State Fiscal Year (SFY) (column 4) is the sum of:**

- 1) HCBS expenditures for all 1915c waivers and state plan HCBS services -- from CMS 64 data and
- 2) MFP expenditures -- from MFP Financial Reporting Forms A and B.

**Grantees should enter total annual spending once each year. When making updates or corrections to actual spending amounts reported for the previous year, please check the 'yes' box at the top of this page to flag such changes.**

Year	Target Level of Spending	% Annual Growth Projected	Total spending for the Calendar Year	% Annual Change (from Previous Year)	% of Target Reached
2006	\$0.00	0.00	\$0.00	0.00%	
2007	\$673,914,419.00	11.77	\$173,230,003.00	0.00%	
2008	\$807,308,376.00	19.79	\$723,364,048.00	417.57%	89.60%
2009	\$899,802,856.00	11.46	\$762,236,360.00	105.37%	84.71%
2010	\$946,274,550.00	5.16	\$712,299,646.00	93.45%	75.27%
2011	\$995,862,771.00	5.24	\$970,733,617.00	136.28%	97.48%
2012	\$0.00	0.00	\$1,091,322,670.00	112.42%	
2013	\$0.00	0.00	\$0.00	0.00%	
2014	\$0.00	0.00	\$0.00	0.00%	
2015	\$0.00	0.00	\$0.00	0.00%	

**Please explain your Year End rate of progress:**

2. Do you intend to seek CMS approval to amend your annual benchmarks for Qualified HCBS Expenditures in your approved OP?

Yes

No

3. Please specify the period (CY or SFY) and the dates of your SFY here.

4. Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

## D. 1. Additional Benchmarks - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

### Benchmark #1

Increase the rate of successful transitions by 5 percentage points each year of the demonstration by improving processes for screening, identifying and assessing candidates. A successful transition is considered to be (1) a Medicaid eligible older adult or person with a disability, (2) who needs HCBS services to reside in the community, (3) who transitions to a qualified community-based residence and (4) who resettles in the community for a minimum of six months, with or without interruptions in that period due to short-term institutional admissions. The measures will be tracked once the MFP program begins transitioning individuals in 2008. [MEASURES #1-2 INACTIVE: REPORTED BY STATE FROM 2008 - 2011]

#### Measure #1

Percent of transitioned individuals that resettle in the community for a minimum of 6 months. [REPORTED BY STATE FROM 2008 - 2011]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	65.00	22.00	99.00	121.00	33.85%	152.31%	186.15%
2010	95.00	171.00	182.00	353.00	180.00%	191.58%	371.58%
2011	95.00	98.74	99.63	198.37	103.94%	104.87%	208.81%
2012	0.00	98.50	0.00	98.50	0.00%	0.00%	0.00%
2013	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2014	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

GA no longer reports on this information.

#### Measure #2

Percent of transitioned individuals that complete 365 days of MFP. [REPORTED BY STATE FROM 2008 - 2011]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	60.00	0.00	22.00	22.00	0.00%	36.67%	36.67%
2010	90.00	60.00	66.00	126.00	66.67%	73.33%	140.00%
2011	90.00	98.29	93.80	192.09	109.21%	104.22%	213.43%
2012	0.00	92.40	0.00	92.40	0.00%	0.00%	0.00%
2013	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2014	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

GA no longer reports on this information.

**Measure #3**

Number of completed transition screenings. [REPORTED BY STATE STARTING IN 2012]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Entire Year	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2010	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2011	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2012	327.00	258.00	168.00	426.00	78.90%	51.38%	130.28%
2013	392.00	108.00	0.00	108.00	27.55%	0.00%	27.55%
2014	471.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	565.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

This data represents the mid point progress.

**Measure #4**

Number of completed Individualized Transition Plans (ITPs/ISPs). [REPORTED BY STATE STARTING IN 2012]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Entire Year	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2010	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2011	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2012	278.00	273.00	162.00	435.00	98.20%	58.27%	156.47%

2013	320.00	159.00	0.00	159.00	49.69%	0.00%	49.69%
2014	368.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	423.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

This data represents the midpoint progress.

**Measure #5**

Number of MFP participants discharged from institutions, entering waivers. [REPORTED BY STATE STARTING IN 2012]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Entire Year	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2010	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2011	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2012	275.00	251.00	190.00	441.00	91.27%	69.09%	160.36%
2013	303.00	231.00	0.00	231.00	76.24%	0.00%	76.24%
2014	333.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	366.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

This data represents the midpoint progress.

**Measure #6**

Number of individuals ever transitioned who completed their 365 days in the community. [REPORTED BY STATE STARTING IN 2012]

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Entire Year	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2009	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2010	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2011	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2012	275.00	208.00	124.00	332.00	75.64%	45.09%	120.73%
2013	301.00	195.00	0.00	195.00	64.78%	0.00%	64.78%
2014	316.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	332.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

**Please explain your Year End rate of progress:**

This data represents the midpoint progress.

**Benchmark #2**

Georgia will increase HCBS expenditures relative to institutional long-term expenditures under Medicaid for each year of the demonstration program; the benchmark represents the percent of HCBS expenditures to total Medicaid long-term care expenditures.

### Measure #1

Percent of total Medicaid LTC expenditures spent on HCBS

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	30.90	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	35.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	38.50	0.00	38.46	38.46	0.00%	99.90%	99.90%
2009	39.00	36.97	38.98	75.95	94.79%	99.95%	194.74%
2010	39.70	40.12	43.80	83.92	101.06%	110.33%	211.39%
2011	40.20	43.97	50.97	94.94	109.38%	126.79%	236.17%
2012	49.00	44.79	63.00	107.79	91.41%	128.57%	219.98%
2013	49.00	76.20	0.00	76.20	155.51%	0.00%	155.51%
2014	49.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	50.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

#### Please explain your Year End rate of progress:

At the midpoint we are at 76.20%.

### Benchmark #3

[INACTIVE: REPORTED BY STATE FROM 2008 - 2011] Increase participation of self (participant)-directed care in all HCBS waivers by 5% per year of the demonstration project, by conducting enhanced outreach, marketing, and education in order to increase understanding and awareness by Medicaid eligible persons about self-directed service options. Targets are projected based on current self-direction trends (CY 2008).

### Measure #1

Number of participants in three (3) HCBS waiver programs choosing to self-direct services: 1) Elderly and Disabled Waiver - self-directed Personal Support Services; 2) MRWP - Natural Support Enhancement Services; and 3) Independent Care Waiver Program - Consumer-Directed Personal Support Services.

Year	Measure: Target	Measure: First Period	Measure: Second Period	Measure: Entire Year	% Achieved: First Period	% Achieved: Second Period	% Achieved: Entire Year
2006	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2007	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2008	267.00	0.00	667.00	667.00	0.00%	249.81%	249.81%
2009	282.00	966.00	1,152.00	2,118.00	342.55%	408.51%	751.06%
2010	297.00	1,204.00	516.00	1,720.00	405.39%	173.74%	579.12%
2011	312.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2012	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2013	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2014	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2015	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%
2016	0.00	0.00	0.00	0.00	0.00%	0.00%	0.00%

#### Please explain your Year End rate of progress:

GA MFP does not self direct. This is included in the waivers.

#### Benchmark #4

[NEW BENCHMARK STARTING IN 2012] Increase the number of participants living on their own or with family instead of a

#### Measure #1

MFP will identify, monitor, and report on the following housing development goals: (1) Number and location of MFP participants returning to home owned by participant; (3) Numbers selecting this option as data to create projected targets for 2013 - 2016.

#### Please explain your Year End rate of progress:

(1) 39 participants are living with family members in the following counties:

Bacon, Baldwin, Barrow, Bibb, Bryan, Burke, Chatham, Clarke, Clayton, Cobb, Colquitt, Crisp, Dekalb, Early, Effingham, Elbert, Franklin, White (2) Division of Aging Services is in the process of entering data into a new system that is currently unable to track for MFP using the new Harmony System. Minimal data has been collected at this time. However, we do know that at least during the planning process.

Do you intend to seek CMS approval to amend your additional benchmarks in your approved Operational Protocol?

Yes

No

## D. 2. Rebalancing Efforts - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

• All MFP grantees are required to complete this section during this period to report on the cumulative amount spent to date and use of rebalancing funds. MFP Rebalancing Funds refers to the net revenue each state receives from the enhanced FMAP rate (over the state's regular FMAP) for qualified and demonstration HCBS services provided to MFP participants. MFP grantees are required to reinvest the rebalancing funds in initiatives that will help to rebalance the long-term care system. The rebalancing fund amount is calculated on your annual Worksheet for Proposed Budget --- see Rebalancing Fund Calculation box in the middle of the Excel Worksheet.

#### Rebalancing Initiative #1

**Name of Initiative:** Review and Analysis of Sentinel Events

**Brief Description of the Initiative** (If the grantee only has one large initiative, please list all sub-initiatives or components within this description):

Georgia previously indicated the desire to re-invest in identification and analysis of MFP participant sentinel events that have led to reinstitutionalizations. Georgia has moved forward in establishing a state-level position for a Registered Nurse as part of the Long-Term Care Team. The Nurse will work closely with the MFP Clinical Specialist to develop a longitudinal study to look at the type of event, trends and outcomes over time. The expenditure will be \$24,000 annually, beginning 1st quarter 2014.

**Total Actual Expenditures for this initiative** (that is, cumulative spending from start of MFP grant program through end of last calendar year) 0.00

- . Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

Georgia MFP resides under the Chief of Medicaid which now has a new Deputy Chief. Discussions have ensued regarding the use of re-balancing funds. The MFP Director and her team has developed a list of rebalancing initiatives which the Deputy Chief will be discussing further with the Department's Federal Funds Manager and the Finance Director. Rebalancing initiatives are responsive to the assessment of state's needs in the areas of housing and the provision of quality HCBS services. Georgia has hired a Balancing Incentives (BIP) Project Director to collaborate with MFP and provide input into ongoing development of initiatives.

## E. 1. Recruitment & Enrollment - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. Did anything change during the reporting period that made recruitment easier? Choose from the list below and check all target populations that apply. Check "None" if nothing has changed.

- Type or quality of data available for identification

### Populations Affected

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Please describe by target population.

A line of communication has been established with the State of Georgia's vendor/contractor and holder of the MDS/MDSQ Data. We will begin to look more closely at how this data can best serve the MFP Project and other Long Term Care Initiatives.

- How data are used for identification

### Populations Affected

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Please describe by target population.

We will begin to use data to answer questions regarding how Georgia compares in National findings to other States that serve those in Nursing Facilities who have responded affirmatively about leaving the Nursing Facility and for some reason were unable to be discharged; We will also look at why many have indicated no desire to discharge according to the data collected.

- Obtaining provider/agency referrals or cooperation

### Populations Affected

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Please describe by target population.

Began working with DAS, ARC and regions to be aware of individuals in the nursing home.

- Obtaining self referrals

- Obtaining family referrals

- Assessing needs

Other, specify below

 None

2. What significant challenges did your program experience in recruiting individuals? Significant challenges are those that affect the program's ability to transition as many people as planned. Choose from the list below and check all target populations that apply.

 Type or quality of data available for identification

 Obtaining provider/agency referrals or cooperation

 Obtaining self referrals

 Obtaining family referrals

 Assessing needs

 Lack of interest among people targeted or the families

 Unwilling to consent to program requirements

 Other, specify below

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe other challenge(s) by target population**

DBHDD put the transitions on hold for 45 days. This was to review individuals, providers, and services in their placement for health and safety. The goal was to ensure identified placements can provide for the health and safety of the individuals served.

**What are you doing to address the challenges?**

We continue to include DBHDD in our stakeholder meetings and work with them through MFP program monitoring to ensure fidelity of the process by assigned Field Personnel.

**Current Issue Status: In Progress**
 None

3. Did anything change during the reporting period that made enrollment into the MFP program easier? These changes may have been the result of changes in your state's Medicaid policies and procedures.

 Determination of initial eligibility

 Redetermination of eligibility after a suspension due to reinstitutionalization

 Other, specify below

 None

4. What significant challenges did your program experience in enrolling individuals? Significant challenges are those that affect the program's ability to transition as many people as planned.

Determining initial eligibility

Reestablishing eligibility after a suspension due to reinstitutionalization

Other, specify below

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Other, please specify below**

DBHDD put the transitions on hold for 45 days. This was to review individuals, providers, and services in their placement for health and safety. The goal was ensure identified placements can provider for the health and safety of the individuals served.

**What are you doing to address the challenges?**

We continue to include DBHDD in our stakeholder meetings and work with them through MFP program monitoring to ensure fidelity of the process by assigned Field Personnel.

**Current Issue Status: In Progress**

None

5. Total number of MFP candidates assessed in this period, or a prior reporting period, who are currently in the transition planning process, that is "in the pipeline," and expected to enroll in MFP.

**Total** 838

6. Total number of MFP eligible individuals assessed in this period for whom transition planning began but were unable to transition through MFP.

**Total** 48

## 7. How many individuals could not be enrolled in the MFP program for each of the following reasons:

<b>Individual transitioned to the community, but did not enroll in MFP</b>	23
<b>Individual's physical health, mental health, or other service needs or estimated costs were greater than what could be accommodated in the community or through the state's current waiver programs</b>	10
<b>Individual could not find affordable, accessible housing, or chose a type of residence that does not meet the definition of MFP qualified residences</b>	0
<b>Individual changed his/her mind about transitioning, did not cooperate in the planning process, had unrealistic expectations, or preferred to remain in the institution</b>	15
<b>Individual's family member or guardian refused to grant permission, or would not provide back-up support</b>	0
<b>Other, Please Specify</b>	0

. If necessary, please explain further why individuals could not be transitioned or enrolled in the MFP program.

## 8. Number of MFP participants transitioned during this period whose length of time from assessment to actual transition took:

<b>less than 2 months</b>	34
<b>2 to 6 months</b>	83
<b>6 to 12 months</b>	32
<b>12 to 18 months</b>	9
<b>18 to 24 months</b>	3
<b>24 months or more</b>	0

. Please indicate the average length of time required from assessment to actual transition.

The average length of time required from assessment to actual transition was 6 to 9 months.

Percentage of MFP participants transitioned during this period whose length of time from assessment to actual transition took:

<b>less than 2 months</b>	17.80%
<b>2 to 6 months</b>	43.46%
<b>6 to 12 months</b>	16.75%
<b>12 to 18 months</b>	4.71%
<b>18 to 24 months</b>	1.57%
<b>24 months or more</b>	N/A%

9. Total number of individuals who were referred to the MFP program through MDS 3.0 Section Q referrals during the reporting period. Please report an unduplicated count.

Total 172

10. Of the MDS 3.0 Section Q referrals ever received by the MFP program, number of individuals who subsequently enrolled in MFP and transitioned to the community during this reporting period.

Total 123

11. What types of activities were supported by ADRC/MFP Supplemental Funding Opportunity C grant funds during this reporting period, awarded in 2010 to 25 MFP grantee states to support activities that help to expand the capacity of ADRCs to assist with MFP transition efforts, and partner in utilizing the revised Minimum Data Set (MDS) 3.0 Section Q referrals? Choose from the list below. Check "Not Applicable" if your State did not receive this grant.

Develop or improve Section Q referral tracking systems—electronic or other

Education and outreach to nursing facility or other LTC system staff to generate referrals to MFP or other transition programs

Develop or expand options counseling or transition planning and assistance

Train current or new ADRC staff to do transition planning in MFP or other transition programs

Expansion of ADRC program in State

Other activities – please describe in text box

Not applicable – state did not receive this grant

12. Please describe progress in implementing the activities identified in Question # 11 during this past reporting period, and how they have helped your state achieve MFP goals. In addition, describe the results or outcomes of these activities; if you specified numerical targets in your grant proposal, please provide counts during the reporting period.

13. Please describe any barriers or challenges in implementing the activities proposed in your grant application and the steps you are taking to resolve them.

Challenges-Lack of provider capacity and competency. Steps for resolution-Enhancing transition planning process, implementing standards of higher quality selection, quality monitoring that appropriate placements are sustainable. Early engagement of support coordination while in the hospital to assist in all part of the transition process and service delivery.

## E. 2. Informed Consent & Guardianship - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What changed during the reporting period that made obtaining informed consent easier?

Revised inform consent documents and/or forms

Provided more or enhanced training for transition coordinators

Improved how guardian consent is obtained

Other, specify below

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Continued partnership with Public Guardianship Office to assess whether wards residing in nursing facilities are eligible/appropriate for transition using the MFP program.

Nothing

**2. What changed during the reporting period that improved or enhanced the role of guardians?**

The nature by which guardians are involved in transition planning

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

We enhanced efforts to provide education and information to guardians and families about community placement options. Contracted with 2 provider agencies to specifically engage families to provide education regarding community placement option, community resources, in order for the family or guardian to be more involved in the transition placement. To help them advocate and participate in their own transition planning.

Communication or frequency of communication with guardians

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

We enhanced efforts to provide education and information to guardians and families about community placement options. Contracted with 2 provider agencies to specifically engage families to provide education regarding community placement option, community resources, in order for the family or guardian to be more involved in the transition placement. To help them advocate and participate in their own transition planning.

The nature by which guardians are involved in ongoing care planning

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

We enhanced efforts to provide education and information to guardians and families about community placement options. Contracted with 2 provider agencies to specifically engage families to provide education regarding community placement option, community resources, in order for the family or guardian to be more involved in the transition placement. To help them advocate and participate in their own transition planning.

The nature by which guardians are trained and mentored

Other, specify below

Nothing

**3. What significant challenges did your program experience in obtaining informed consent?**

Ensuring informed consent

Involving guardians in transition planning

Communication or frequency of communication with guardians

Involving guardians in ongoing care planning

Training and mentoring of guardians

Other, specify below

None

**E. 3. Outreach, Marketing & Education - SUBMITTED**

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

**1. What notable achievements in outreach, marketing or education did your program accomplish during the reporting period?**

Development of print materials

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

During this period Georgia has developed "Desk Aids" to assist those individuals working as Field Personnel better understand and be able to implement and or refer participants for appropriate Waiver and State Plan Services. The Desk Aids will be assist with marketing as well as helping to increase quality of referrals. Additionally, the Sub-Committee on Marketing and Awareness met to discuss the purchasing of small tokens to spread the word about MFP throughout the State.

Implementation of localized/targeted media campaign

Implementation of statewide media campaign

Involvement of stakeholder state agencies in outreach and marketing

Involvement of discharge staff at facilities

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The interdisciplinary team at nursing homes participated in DD Transitions. This included the nurses, social workers, direct support staff, and other professionals (OT, PT, Nutrition, etc.) staff involved with the individual during their time in the nursing home.

Involvement of ombudsman

Training of frontline workers on program requirements

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

On February 4-5, the state MFP staff lead a training for MFP Field Personnel. Day-One Topics included: -Person centered Planning Overview -MFP Logic Model/Project Evaluation Overview -Conducting the Quality of Life Survey (Components) -Referrals, Denials and Terminations -Dignity of Risk-Independent Living -Screening and Pre Individual Transition Plan (ITP) -Reporting QOL Data -Waiver Application Process -Housing Program and Search Tools Day Two Topics included: -Post ITP/Discharge Planning -New MFP Demonstration Seervices -Caregiver Outreach and Education -Vendor Payments -Family Conflict Management -Home Care Ombudsman Services -Supported Employment Evaluation -Reporting MFP Data

Other, specify below

None

2. What significant challenges did your program experience in conducting outreach, marketing, and education activities during the reporting period?

Development of print materials

Implementation of a localized / targeted media campaign

Implementation of a statewide media campaign

Involvement of stakeholder state agencies in outreach and marketing

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

We are encouraging our Contractors to involve more of the participants in quarterly meetings or conference calls designed to take input on services being provided.

**What are you doing to address the challenges?**

We continue to host stakeholder meetings in various parts of the state in hopes that new individuals will attend and want to be considered a stakeholder. Our next step will be to contact participants directly from the state office.

**Current Issue Status: In Progress**

Involvement of discharge staff at facilities

Involvement of ombudsman

Training of frontline workers on program requirements

Other, specify below

None

#### E. 4. Stakeholder Involvement - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. How are consumers and families involved in MFP during this period and how did their efforts contribute to MFP goals and benchmarks, or inform MFP and LTC policies?

	Provided input on MFP policies or procedures	Helped to promote or market MFP program	Involved in Housing Development	Involved in Quality of Care assurance	Attended MFP Advisory Meeting(s)	Other (describe)
<b>Consumers</b>	X	X	X	X	X	
<b>Families</b>						
<b>Advocacy Organizations</b>					X	
<b>HCBS Providers</b>						
<b>Institutional Providers</b>						

Labor/Worker Association(s)						
Public Housing Agency(ies)		X	X			
Other State Agencies (except Housing)					X	
Non-profit Housing Assn.						
Employment Initiative		X				University of Georgia/MIG Grant

**Please explain the nature of consumers' and families' involvement in MFP during this period and how it contributed to MFP goals and benchmarks, or informed MFP and LTC policies**

In this category we receive support and input from Mr. D. Zilles who works diligently to help improve all aspects of Georgia's MFP Project. Mr. Zilles has a relative who was impacted by the Settlement and tries to help move Georgia forward to accomplish identified goals. Other consumers/families have been contacted by Transition Coordinators as we host stakeholder meetings in various locations around the state however, none have been able to attend. Recently, Mr. Zilles was able to speak to management regarding the MDSQ data that Georgia receives. His input is very important as move forward to do new things. Mr. Zilles is part of the stakeholder committee and attends evaluation team meetings.

**Please explain the nature of others' (non-consumers) involvement in MFP during this period and how it contributed to MFP goals and benchmarks, or informed MFP and LTC policies.**

During this period we have been able to collaborate with the University of Georgia an more fully establish a new MFP Service to provide supported employment evaluation. This new service area is designed to inform MFP policy on the "benefits and value" of work. We are looking to add to the body of knowledge in this area by showing how a participant's choice to work will lead to a more positive attitude and how expectations for success will lead to a more productive lifestyle.

2. On average, how many consumers, families, and consumer advocates attended each meeting of the MFP program's advisory group (the group that advises the MFP program) during the reporting period?

Specific Amount

**Please Indicate the Amount of Attendance**

During the January 17, 2013 meeting MFP hosted 25 stakeholders (in person and by tele-conference) During the April 17, 2013 meeting MFP hosted 33 stakeholders (in person and by tele-conference)

Advisory group did not meet during the reporting period

Program does not have an advisory group

3. What types of challenges has your program experienced involving consumers and families in program planning and ongoing program administration?

Identifying willing consumers

Identifying willing families

Involving them in a meaningful way

**What are you doing to address the challenges?**

The reluctance to participate is that the families and guardians were used to status quo, as nursing facilities were all that they had known for years. We enhanced efforts to provide education and information to guardians and families about community placement options. Contracted with 2 provider agencies to specifically engage families to provide education regarding community placement option, community resources, in order for the family or guardian to be more involved in the transition placement. To help them advocate and participate in their own transition planning.

Keeping them involved for extended periods of time

Communicating with consumers

Communicating with families

Other, specify below

None

**4. Did your program make any progress during the reporting period in building a collaborative relationship with any of the following housing agencies or organizations?**

State agency that sets housing policies

**Please describe**

MFP is represented at Quarterly Steering Committee Meetings hosted by the Department of Community Affairs.

State housing finance agency

**Please describe**

Department of Community Affairs meetings on Inter-Agency HUD Projects 811 and Tenant Based Rental Assistance Program (TBRA)

Public housing agency(ies)

**Please describe**

Housing Manager presented information on MFP at a local meeting of United States Housing Authority (USHA Housing)-3/25/13 -Decatur Housing Authority 3-29-13 -Bartow County Public Housing Authority 4-12-13 -Housing Policy Academy 5-29-13 through 5-30-13

Non-profit agencies involved in housing issues

**Please describe**

-Housing manager attended North Fulton Inter-Agency Council 3-28-13 -Housing Manager attends "Shut out, Priced Out, and Segregated" (SOPOS) monthly meetings

Other housing organizations (such as landlords, realtors, lenders and mortgage brokers)

**Please describe**

Housing Manager was invited by APD Solutions Real Estate Group to attend a meeting 3/7/13, with Developers and other non-Profit entities that support community/neighborhood revitalization projects. -Housing Manager attended Housing and HealthCare-Atlanta meeting 4-18-13 and -HEAL Program at Georgia Tech University 4-23-13

None

5. Has your program experienced significant challenges in building a collaborative relationship with any of the agencies involved in setting state housing policies, financing, or implementation of housing programs?

Yes

No

## E. 5. Benefits & Services - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What progress was made during the reporting period regarding Medicaid programmatic and policy issues that increased the availability of home and community-based services DURING the one-year transition period?

Increased capacity of HCBS waiver programs to serve MFP participants

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

The request for Supplemental Grant funding for 2013 included a request to cover the cost of providing Waivers for newly transitioned MFP Project participants. The average cost of a Waiver in Georgia is about \$30,500. Georgia requested funds to cover the cost of adding additional slots to eliminate having MFP participants delay transitioning due to being on a "waiting" list for Home and Community-based Services.

Added a self-direction option

Developed State Plan Amendment to add or modify benefits needed to serve MFP participants in HCBS settings

Developed or expanded managed LTC programs to serve MFP participants

Obtained authority to transfer Medicaid funds from institutional to HCBS line items to serve MFP participants

Legislative or executive authority for more funds or slots or both

Improved state funding for pre-transition services (such as targeted case management)

Other, specify below

 None

2. What significant challenges or barriers did your program experience in guaranteeing that MFP participants can be served in Medicaid HCBS DURING the one-year transition period?

 Efforts to increase capacity of HCBS waiver programs to serve more individuals are delayed or disapproved

 Efforts to add a self-direction option are delayed or disapproved

 State Plan Amendment to add or modify benefits needed to serve people in HCBS settings are delayed or disapproved

 Plans to develop or expand managed LTC programs to serve or include people needing HCBS are delayed or disapproved

 Efforts to obtain authority to transfer Medicaid funds from institutional to HCBS line items to serve people transitioning out of MFP are delayed or disapproved

 Legislative or executive authority for more funds or slots are delayed or disapproved

 State funding for pre-transition services (such as targeted case management) have been delayed or disapproved

 Other, specify below

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

We have been working diligently to solve challenges with the switch from institutional Medicaid to Community Medicaid for some participants We continue to work closely with the Department of Family and Children Services on a process to ensure that the change (switch) occurs timely enough so that services are not cut-off for the participant.

**What are you doing to address the challenges?**

We have been meeting with the various coordinators and responsible parties to see how we can best move the required and necessary paperwork through the process by obtaining the necessary approvals as early in the process as possible.

**Current Issue Status: In Progress**

 None

3. What progress was made during the reporting period on Medicaid programmatic and policy issues to assure continuity of home and community based services AFTER the one-year transition period?

 Increased capacity of HCBS waiver programs to serve more Medicaid enrollees

 Added a self-direction option

<input type="checkbox"/> Developed State Plan Amendment to add or modify benefits needed to serve MFP participants in HCBS settings
<input type="checkbox"/> Developed or expanded managed LTC programs to serve more Medicaid enrollees
<input type="checkbox"/> Obtained authority to transfer Medicaid funds from institutional to HCBS line items to serve more Medicaid enrollees
<input type="checkbox"/> Legislative or executive authority for more funds or slots or both
<input type="checkbox"/> Improved state funding for pre-transition services, such as targeted case management
<input type="checkbox"/> Other, specify below
<input checked="" type="checkbox"/> None

4. What significant challenges or barriers did your program experience in guaranteeing continuity of care for MFP participants in Medicaid HCBS AFTER the one-year transition period?

<input type="checkbox"/> Efforts to increase capacity of HCBS waiver programs to serve more individuals are delayed or disapproved
<input type="checkbox"/> Efforts to add a self-direction option are delayed or disapproved
<input type="checkbox"/> State Plan Amendment to add or modify benefits needed to serve people in HCBS settings is delayed or disapproved
<input type="checkbox"/> Plans to develop or expand managed LTC programs to serve or include people needing HCBS are delayed or disapproved
<input type="checkbox"/> Efforts to obtain authority to transfer Medicaid funds from institutional to HCBS line items to serve people transitioning out of MFP are delayed or disapproved
<input type="checkbox"/> Legislative or executive authority for more funds or slots are delayed or disapproved
<input type="checkbox"/> State funding for pre-transition services have been delayed or disapproved
<input type="checkbox"/> Other, specify below
<input checked="" type="checkbox"/> None
<input type="text"/>
<b>Current Issue Status: Resolved</b>
<b>How was it resolved?</b>
<input type="text"/>

## E. 6. Participant Access to Services - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What steps did your program or state take during the reporting period to improve or enhance the ability of MFP participants to access home and community based services?

Increased the number of transition coordinators

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

In late December 2012-Early January an additional Transition Coordinator was hired in Metro-Atlanta to accommodate the vast number of transition requests. The Individual Transition Plan (ITP) was also revised to be more user-friendly and expedite transitions. The ITP can be done in two phases or all at once depending on the TC's time and the type of community setting being considered for the participant. A standard of promptness for this phase is being closely monitored.

Increased the number of home and community-based service providers contracting with Medicaid

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Engaged multiple providers to acquire strategically located homes. Examples of providers are Sunrise, Mentor, Support Solutions, and Volunteers of America. Some were from out of state.

Increased access requirements for managed care LTC providers

Increased payment rates to HCBS providers

Increased the supply of direct service workers

Improved or increased transportation options

Added or expanded managed LTC programs or options

Other, specify below

None

2. What are MFP participants' most significant challenges to accessing home and community-based services? These are challenges that either make it difficult to transition as many people as you had planned or make it difficult for MFP participants to remain living in the community.

Insufficient supply of HCBS providers

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Actively working to engage multiple providers to acquire strategically located homes.

**What are you doing to address the challenges?**

The providers, Regions, and Division of DD/DBHDD are working together locate appropriate homes, explore and complete necessary modifications, hiring and training staff to be competent. person centered, health, safety, and welfare focused service providers for the individuals with DD that are served.

**Current Issue Status: In Progress**

Insufficient supply of direct service workers

Preauthorization requirements

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

MFP Participants continue to have issues with the timing of the conversion from nursing home Medicaid to community Medicaid. All populations are affected by this issue, however the PD population has a disproportionate amount due to the delays receiving ICWP. DBHDD Population -Challenges with getting the Medicaid codes flipped. This is due to a variety of reasons. Which include excess resources, burial accounts, annual DFCS renewals around the time of discharge, etc.

**What are you doing to address the challenges?**

As of the July DCH-DAS Monthly MFP meeting, DCH staff indicated they would review their process for potential changes that would support a more effective system "switch" from Nursing Home Medicaid to Community Medicaid. For the DD Population - The Division of DD transition team has looked at the challenges and is putting together a more comprehensive transition checklist to address these issues and hopefully avoid as many as possible in the future. With DFCS, DCH, SSA, and DBHDD involved with the Medicaid conversion, teamwork and communication has been very helpful.

**Current Issue Status: In Progress**

Limits on amount, scope, or duration of HCBS allowed under medicaid state plan or waiver program

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Individuals are denied waiver services because the plan of care exceeds the individual cost caps set in place for the waiver. These individuals will not be able to transition.

**What are you doing to address the challenges?**

All populations are effected, but primarily OA individuals as the E&D waiver does not waive hospital level of care like ICWP. This places a low monetary threshold for waived community supports.

**Current Issue Status: Abandoned**

**Why is it no longer being persued?**

E&D waiver was just reauthorized.

Lack of appropriate transportation options or unreliable transportation options

Insufficient availability of home and community-based services (provider capacity does not meet

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Medicaid Non Emergency Transportation (NET) is available to participants across the state. However, reliable, non-medical transportation is still a major barrier to community integration.

**What are you doing to address the challenges?**

All populations that live in rural areas that do not have accessible public transportation. Transition Coordinators make every attempt to build strong circles of support with the Participant to assure their minimum needs are met. Currently there are no systematic, state-wide programs that have the means to address the issue.

**Current Issue Status: Abandoned****Why is it no longer being pursued?**

Currently there are no systematic, state-wide programs that have the means to address the issue.

demand)

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Personal Care Home capacity (for those less than 4 beds) is inconsistent across the state. Inventory of spaces in existing MFP-qualified Personal Care Homes are rare. For the DD population - Actively working to engage multiple providers to acquire strategically located homes. The providers, Regions, and Division of DD/DBHDD are working together locate appropriate homes, explore and complete necessary modifications, hiring and training staff to be competent. person centered, health, safety, and welfare focused service providers for the individuals with DD that are served.

**What are you doing to address the challenges?**

All Populations are affected by this issue. DAS cannot create provider capacity. There does not seem to be a concerted effort within any provider associations to increase the number of PCHs with less than four beds. DD population - The providers, Regions, and Division of DD/DBHDD are working together locate appropriate homes, explore and complete necessary modifications, hiring and training staff to be competent. person centered, health, safety, and welfare focused service providers for the individuals with DD that are served.

**Current Issue Status: Abandoned****Why is it no longer being pursued?**

There does not seem to be a concerted effort within any provider associations to increase the number of PCHs with less than four beds. DD population is still in progress.

Other, specify below

None

**E. 7. Self-Direction - SUBMITTED**

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

. Did your state have any self-direction programs in effect during this reporting period?

Yes

No

1. If YES is selected in previous question, how many MFP participants were in a self-direction program during the reporting period?

	Elderly	MR/DD	MI	PD	n/a	TOTAL
	0	0	0	0	0	0

2. Of those MFP participants in a self-direction program how many:

	Elderly	MR/DD	MI	PD	n/a	TOTAL
Hired or supervised their own personal assistants	0	0	0	0	0	0
Managed their allowance or budget	0	0	0	0	0	0

3. How many MFP participants in a self-direction program during the reporting period reported abuse or experienced an accident?

	Elderly	MR/DD	MI	PD	n/a	TOTAL
Reported being abused by an assistant, job coach, or day program staff	0	0	0	0	0	0
Experienced an accident (such as a fall, burn, medication error)	0	0	0	0	0	0
Other, Please Specify	0	0	0	0	0	0

4. How many MFP participants in a self-direction program disenrolled from the self-direction program during the reporting period?

	Elderly	MR/DD	MI	PD	n/a	TOTAL
	0	0	0	0	0	0

5. Of the MFP participants who were disenrolled from a self-direction program, how many were disenrolled for each reason below?

	Elderly	MR/DD	MI	PD	n/a	TOTAL
Opted-out	0	0	0	0	0	0
Inappropriate spending	0	0	0	0	0	0
Unable to self-direct	0	0	0	0	0	0
Abused their worker	0	0	0	0	0	0
Other, Please Specify	0	0	0	0	0	0

. Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

## E. 8. Quality Management & Improvement - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What notable improvements did your program make to your HCBS quality management systems that affect MFP participants? These improvements may include improvements to quality management systems for your state's waiver programs.

Improved intra/inter departmental coordination

Implemented/Enhanced data collection instruments

Implemented/Enhanced information technology applications

Implemented/Enhanced consumer complaint processes

Implemented/Enhanced quality monitoring protocols DURING the one-year transition period (that is, methods to track quality-related outcomes using identified benchmarks or identifying participants at risk of poor outcomes and triggering further review at a later point in time)

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

The MFP Policies and Procedures Manual now includes more specific standards of promptness and reporting protocol responsibilities for field personnel, as well, as MFP staff. A Clinical Specialist has been hired to establish an approach for on-site monitoring of TC processes and reviews of participant files.

Enhanced a critical incident reporting and tracking system. A critical incident (e.g., abuse, neglect and exploitation) is an event that could bring harm, or create potential harm, to a waiver participant.

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

The MFP Clinical Specialist is also responsible for closely monitoring and tracking trends of Sentinel Events and emergency episodes that may have led to re-institutionalization or suspension of services.

Enhanced a risk management process

Other, specify below

None

2. How many calls did your program receive from MFP participants for emergency back-up assistance during the reporting period by type of assistance needed? Emergency refers to situations that could endanger the health or well-being of a participant and may lead to a critical incident if not addressed. (Please note this question only captures calls that were considered to be emergencies and not those that are informational or complaints.)

	Elderly	MR/DD	MI	PD	n/a	TOTAL
Transportation: to get to medical appointments	0	0	0	0	0	0
Life-support equipment repair/replacement	0	0	0	0	0	0

Critical health services	0	0	0	0	0	0
Direct service/support workers not showing up	0	0	0	0	0	0
Other, Please Specify	0	0	0	0	0	0
Total	0	0	0	0	0	

3. For what number of the calls received were you able to provide the assistance that was needed when it was needed?

	Elderly	MR/DD	MI	PD	n/a	TOTAL
	0	0	0	0	0	0

4. Did your program have to change back-up services or quality management systems due to an identified problem or challenge in the operation of your back-up systems?

Yes

No

5. Did your program experience any challenges in:

Developing adequate and appropriate service plans for participants, i.e., developing service plans that address the participant's assessed needs and personal goals

#### Populations Affected

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Please describe by target population

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

#### What are you doing to address the challenges?

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

<b>Current Issue Status: In Progress</b>
--

Assessing participants' risk

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Developing, implementing or adjusting risk mitigation strategies

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Addressing emergent risks in a timely fashion

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Delivering all the services and supports specified in the service plan

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

- Modifying the service plan to accommodate participants' changing needs or circumstances, i.e., increasing units of a service, adding a different type of service, changing time of day when services are delivered, etc.

#### Populations Affected

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Please describe by target population

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

#### What are you doing to address the challenges?

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Identifying threats to participants' health or welfare

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Addressing threats to participants' health or welfare

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

Transitions are resuming at a deliberate pace that will emphasize quality of care. Pre and post transition activities are undergoing a performance improvement and fidelity process in collaboration with the independent reviewer in an ongoing effort to improve provider competencies and capacities. DBHDD wants to assure and is committed to serving individuals and contracting with providers that are competent, and making sure transition plans are able to be fulfilled in a successful manner for the individuals that are discharging from the institutions into the communities.

**What are you doing to address the challenges?**

The DBHDD provider network is making adjustments to ensure quality service delivery to each individual with ID/DD transitioning to their care. This includes securing additional homes and developing the skills and capacity to care for the increasing medical and behavioral complexity of the individuals transitioning from state hospitals. The focus and objective for the remainder of the calendar year is to work with Central State Hospital - Craig Center in Milledgeville and Southwestern State Hospital in Thomasville to transition the individuals remaining there to competent and capable Providers offering, person-centered, community placements. Work is ongoing to increase the capacity and competency of existing DD Providers as well as entering into new contractual relationships to bring in established, competent DD providers from out of state to ensure a provider network capable of meeting the needs of medically fragile and behaviorally challenged individuals transitioning out of state hospitals. At the Regional level additional staff resources have been secured to implement quality monitoring of service delivery and to assist Providers in developing and implementing effective corrective action plans to address identified service delivery issues. At the state Central Office level, additional staff have been hired to facilitate statewide coordination of Regional transition planning and quality management activities.

**Current Issue Status: In Progress**

Other, Please Specify

None

**6. Please specify the total number of participant deaths that occurred during the reporting period:**

Elderly	MR/DD	MI	PD	n/a	TOTAL
5	0	0	6	0	11

**7. Please provide information on the circumstances surrounding the reported deaths:**

Natural causes

**8. How many critical incidents occurred during the reporting period?**

79

**9. Please provide information on the circumstances surrounding the reported critical incidents:**

The MFP Clinical Specialist has begun a quarterly review of Sentinel Events to assess the health status pre and post of the event. Many of the events are occurring due to "follow-up" care that may be provided less frequently in the community environment than in the LTC facility.

10. Please describe the nature of each critical incident that occurred. Choose from the list below.

Abuse

Neglect

Please specify the number of times this type of critical incident occurred:

**Did the state make changes, either for the consumer(s) or its system, as a result of the analysis of critical incidents?**

Yes, the MFP Contractor that oversees the transitions is being required to follow up with the Clinical Specialist in writing, all adjustments to services that were required following the assessment of the event.

**Current Issue Status: In Progress**

Exploitation

Hospitalizations

Please specify the number of times this type of critical incident occurred:

**Of these hospitalizations, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?:**

15

Emergency Room visits

Please specify the number of times this type of critical incident occurred:

**Of these emergency room visits, approximately how many occurred within 30 days of discharge from a hospital or other institutional setting?:**

8

Deaths determined to be due to abuse, neglect, or exploitation - During the current reporting period, how many deaths occurring either in the current or previous reporting periods were determined to be due to abuse, neglect or exploitation?

Deaths in which a breakdown in the 24-hour back-up system was a contributing factor - During the current reporting period, for how many deaths occurring either in the current or previous reporting periods did an investigation determine that a breakdown in the 24-hour back-up system was a contributing factor?

Involvement with the criminal justice system

Medication administration errors

Please specify the number of times this type of critical incident occurred:

**Did the state make changes, either for the consumer(s) or its system, as a result of the analysis of critical incidents?**

Yes, the Transition Contractor that oversees the TCs is being asked to follow up with the Clinical Specialist in writing and detail any changes that were required following the assessment of the event.

**Current Issue Status: Resolved**

Other, Please Specify

Please specify the number of times this type of critical incident occurred:

**Did the state make changes, either for the consumer(s) or its system, as a result of the analysis of critical incidents?**

Yes, the Transition Contractor that oversees the TCs is being asked to follow up with the Clinical Specialist in writing any changes that were required following the assessment of the event.

**Current Issue Status: Resolved**

None

. Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

## E. 9. Housing for Participants - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What notable achievements in improving housing options for MFP participants did your program accomplish during the reporting period?

Developed inventory of affordable and accessible housing

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe the achievements**

-Housing Manager communicated with HUD housing to obtain a list of 750 properties not listed on the hud.gov website and funded with subsidy. -Housing Manager communicated with USDA to obtain a list of 400 properties not listed on the usda.gov website and funded with subsidy.

Developed local or state coalitions of housing and human service organizations to identify needs and/or create housing-related initiatives

Developed statewide housing registry

Implemented new home ownership initiatives

Improved funding or resources for developing assistive technology related to housing

Improved information systems about affordable and accessible housing

Increased number of rental vouchers

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe the achievements**

-Housing Manager collaborated with the Department of Community Affairs to administer the TBRA Tenant Based Rental Assisted funds, provide 75 additional vouchers for MPF participants to apply to the waiting list.

Increased supply of affordable and accessible housing

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe the achievements**

-HUD 811 awarded Georgia 4.1 million; 150 units are expected to be available for MFP and DBHDD (DOJ) Settlement participants. Currently Georgia's InterAgency Agreement between DCH and DCA is pending.

Increased supply of residences that provide or arrange for long term services and/or supports

Increased supply of small group homes

Increased/Improved funding for home modifications

Other, specify below

None

2. What significant challenges did your program experience in securing appropriate housing options for MFP participants? Significant challenges are those that affect the program's ability to transition as many people as planned or to keep MFP participants in the community.

Lack of information about affordable and accessible housing

Insufficient supply of affordable and accessible housing

Lack of affordable and accessible housing that is safe

Insufficient supply of rental vouchers

Lack of new home ownership programs

Lack of small group homes

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe the challenges**

-Locating qualified and high quality group homes providers that are appropriate (4 beds or less) for MFP participants continues to be a challenge.

**What are you doing to address the challenges?**

-MFP is working with Wavier Specialists who are working with providers to develop additional PCH to support MFP unique housing criteria.

**Current Issue Status: In Progress**

Lack of residences that provide or arrange for long term services and/or supports

Insufficient funding for home modifications

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe the challenges**

-It is challenging to accommodate services needed in the home modification category. MFP will need to look more closely at the allocation of funds in this area.

**What are you doing to address the challenges?**

-MFP continues to monitor expenses regarding modifications to assess the need to adjust cost in this area. Possible realignments in line items could be key in resolving the high cost of modifications for MFP. -Cost analysis and monitoring expenses per client per calendar year.

**Current Issue Status: In Progress**

Unsuccessful efforts in developing local or state coalitions of housing and human services organizations to identify needs and/or create housing related initiatives

Unsuccessful efforts in developing sufficient funding or resources to develop assistive technology related to housing

Other, specify below

None

3. How many MFP participants who transitioned to the community during the reporting period moved to each type of qualified residence? The sum total reported below should equal the number of individuals who transitioned to the community this period, reported in Question #4 (Transitions). [This question is required.]

	Elderly	MR/DD	MI	PD	n/a	TOTAL
Home (owned or leased by individual or family)	27	0	0	31	0	58
Apartment (individual lease, lockable access, etc.)	31	0	0	50	0	81
Group home or other residence in which 4 or fewer unrelated individuals live	1	1	0	6	0	8
Apartment in qualified assisted living	0	0	0	1	0	1

4. Have any MFP participants received a housing supplement during the reporting period? Choose from the list of sources below and check all target populations that apply.

202 funds CDBG funds Funds for assistive technology as it relates to housing Funds for home modifications HOME dollars**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

 Housing choice vouchers (such as tenant based, project based, mainstream, or homeownership vouchers) Housing trust funds Low income housing tax credits Section 811**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

 USDA rural housing funds Veterans Affairs housing funds Other, Please Specify None

. Use this box to explain missing, incomplete, or other qualifications to the data reported on this page.

-Tenant Based Rental Assistance (TBRA) is funded through HOME funds which will support 75 MFP participants -150 units throughout the state of Georgia will be available to support MFP and DOJ Settlement participants

## E.10 Employment Supports and Services - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What types of ongoing employment supports are provided through your MFP program to help participants find or maintain employment?

 Job coaching or ongoing support planning Job training or re-training

Peer to peer consultation and support

Service or Support Funded by \_\_\_\_\_

Other

**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Please describe by target population**

The Centers for Independent Living (CILs) work with the disabled population to assist in vocational training and finding jobs. CIL funds are Federally funded through the Department of Education (DOE).

**How is this service or support funded?** Employment monitoring or mediation with employer/employees to resolve barriers to work Mediation with family/friends to secure their support for individuals' work-related needs Assistance with transportation to and from work Assistance with budgeting**Populations Affected**

Elderly	MR/DD	MI	PD	n/a
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Service or Support Funded by \_\_\_\_\_

Other

**Please describe by target population**

In Georgia, Peer Supporters with Centers for Independent Living are skilled as life coaches and provide a wide array of support to those they serve. CIL funds are Federally funded through the Department of Education.

**How is this service or support funded?** Assistance developing interpersonal or employment skills Other, Please Specify None

2. What activities or progress was made this period to utilize MFP resources to support the goals of MFP participants?

Hired employment specialists to help MFP participants achieve employment goals

Produced training resources or delivered employment training to MFP staff, transition coordinators, or waiver staff

Activity Funded by  
MFP Demonstration Services

Incorporated information about disability- and employment-related agencies and services into outreach materials

Financed services or supports (such as adaptive equipment, transportation, personal assistance services) to help address barriers to employment

Leveraged Medicaid Infrastructure Grant program resources or funds (via supplemental grants or no-cost extension of previous grants) to support employment of participants with disabilities

None

3. What progress was made during the reporting period to establish collaborative relationships with your state employment agencies (i.e., state departments of labor, vocational rehabilitation, workforce development, or commissions for the blind)?

Participated in cross-agency awareness training

Participated in multi-agency working groups that address employment for individuals with disabilities

Participated in state or local Workforce Investment Boards

Shared enrollment information to determine eligibility for services

Shared the costs of direct services for shared clients

Shared a database that allows the agencies to access one another's intake and client information

Shared knowledge and continue to explore programs available to ID/DD population with the Supported Employment Coordinator for the Division of Developmental Disabilities.

None

4. Were there any other developments or progress this period toward increasing the availability of employment services and supports for MFP participants?

Georgia has re-instated the Training and Workforce Development Sub-Committee which looks at longterm support for employment for MFP participants. Georgia MFP has partnered with the University of Georgia (UGA) to develop an Orientation Manual for Field Personnel to use to discuss this very important issue with participants. The Manual titled, "WorkWorks for Everyone" covers how a participant can receive support and lists the options that will support a choice to work or volunteer. Supported Employment is available to all that are a part of MFP. The challenge is the ability for Supported Employment to meet the needs of the individuals that are currently transitioning out of institutions and into the communities. The individuals disabilities and medical challenges are a barrier to their participation in the Support Employment Program.

## F. Organization & Administration - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. Were there any changes in the organization or administration of the MFP program during this reporting period? For example, did Medicaid agency undergo a reorganization that altered the reporting relationship of the MFP Project Director?

Yes

**Please describe the changes.**

A new Deputy Chief of Medicaid was employed on June 1, 2013. Marcey Alter was previously a Program Director in Medicaid/Long Term Care and is therefore knowledgeable of MFP operations in Georgia.

No

2. What interagency issues were addressed during this reporting period?

Common screening/assessment tools or criteria

Common system to track MFP enrollment across agencies

Timely collection and reporting of MFP service or financial data

Common service definitions

Common provider qualification requirements

Financial management issues

Quality assurance

**Which agencies were involved?**

-The Division of Aging Services (DAS) -The Department of Behavioral Health and Developmental Disabilities (DBHDD)

Other, specify below

None

3. Did your program have any notable achievements in interagency communication and coordination during the reporting period?

Yes

**What were the achievements in?**

MFP staff sponsored a training on Policies and Procedures that allowed for input from all involved in the process. Both the Chief and Deputy Chief of Medicaid have attended the "standing" monthly Inter-Agency meetings with the Division of Aging Services (DAS). Additionally, time and funding have been dedicated to making sure that the integration into MFP of the CBAY population will be as seamless as possible. A flow-chart has been introduced that will assist in the quality management of these transitions.

No

4. What significant challenges did your program experience in interagency communication and coordination during the reporting period?

Interagency relations

Privacy requirements that prevent the sharing of data

Technology issues that prevent the sharing of data

Transitions in key Medicaid staff

Transitions in key staff in other agency

**Please describe the challenges. What agencies were involved?**

DBHDD has reduced the state staff responsible for coordinating transitions however, they continue to work to meet prescribed benchmarks.

**What are you doing to address the challenges?**

We are in constant contact with the Transition Coordinator in the state DBHDD office for updates on what, if anything, will be impacted by these changes. All processes and procedures continue to be in compliance.

**Current Issue Status: In Progress**

Other, specify below

None

## G. Challenges & Developments - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. What types of overall challenges have affected almost all aspects of the program?

Downturn in the state economy

Worsening state budget

Transition of key position(s) in Medicaid agency

Transition of key position(s) in other state agencies

Executive shift in policy

Other, specify below

**Please describe**

Georgia was notified of data reporting issues by MPR (Mathematica) The issue was identified in February 2013 and has been acknowledged and determined to be a systems issue. It is currently under review by our state IT Contractor HP.

None

2. What other new developments, policies, or programs (in your state's long-term care system) have occurred that are not MFP initiatives, but have affected the MFP demonstration program's transition efforts?

Institutional closure/downsizing initiative

**Please describe**

We have a Long Term Care Nursing Facility that is located at one of the State MH Institutions slated for "closing" December 30, 2013 based on the Georgia Olmstead/DJJ Settlement Agreement. We are working diligently in collaboration with DBHDD to transition individuals that qualify for MFP. The MH Region in which the facility is located has been very cooperative as we work to provide safe, person centered transitions.

New/revised CON policies for LTC institutions

New or expanded nursing home diversion program

Expanded single point-of-entry/ADRC system

New or expanded HCBS waiver capacity

New Medicaid State Plan options (DRA or other)

New managed LTC options (PACE, SNP, other), or mandatory enrollment in managed LTC

Other, specify below

None

## H. Independent Evaluation - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

1. Is your state conducting an independent evaluation of the MFP program, separate from the national evaluation by Mathematica Policy Research?

Yes

**Please explain the proposed changes to your Qualified HCBS Expenditures benchmark.**

It is not a totally separate evaluation; it looks more intently at the findings that we report to MPR and provides an analysis of the Survey questions.

No

**2. Were there any outputs/products produced from the independent state evaluation (if applicable) during this period?**

Yes

**Please describe**

The information gathered from the evaluation is provided in a Report of Analytic Results on a quarterly basis to the MFP Project.

No

## I. State-Specific Technical Assistance - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

### List of Technical Assistance Events for this Reporting Period

<p><b>Date:</b> 3/6/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Group Teleconference  <b>Describe the focus of the TA you received:</b> Bridge Subsidies  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/14/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Group Teleconference  <b>Describe the focus of the TA you received:</b> Affordable Housing  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/21/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Individual by Phone  <b>Describe the focus of the TA you received:</b> GA Housing Concerns  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/21/2013 12:00:00 AM</p>

<p><b>Type:</b> Others  <b>Delivery Method:</b> Group Teleconference  <b>Describe the focus of the TA you received:</b> TAC Website Orientation  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/21/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Group Teleconference  <b>Describe the focus of the TA you received:</b>  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/27/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Group Teleconference  <b>Describe the focus of the TA you received:</b> 811 TACINC  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 3/28/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Individual by Phone  <b>Describe the focus of the TA you received:</b> Ellen Speckman GA-Concerns  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 4/1/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Group in Person  <b>Describe the focus of the TA you received:</b> Ellen Speckman at Dept Community Affairs Meeting  <b>Usefulness:</b> Very Useful  <b>If useful, describe what changed as a result - if not useful, explain why:</b></p>
<p><b>Date:</b> 4/2/2013 12:00:00 AM  <b>Type:</b> Housing  <b>Delivery Method:</b> Individual in Person  <b>Describe the focus of the TA you received:</b> Ellen Speckman -With GA MFP  <b>Usefulness:</b> Very Useful</p>

**If useful, describe what changed as a result - if not useful, explain why:**

**Date:** 4/30/2013 12:00:00 AM  
**Type:** Housing  
**Delivery Method:** Group Teleconference  
**Describe the focus of the TA you received:** Engaging Your Public Housing Associations  
**Usefulness:** Very Useful  
**If useful, describe what changed as a result - if not useful, explain why:**

## J. Overall Lessons & MFP-related LTC System Change - SUBMITTED

**Grant Report:** 2013 First Period (January - June) - GA13SA01, Georgia

- . Are there any other comments you would like to make regarding this report or your program during this reporting period?

Thank you for the input that we consistently receive from CMS. I especially appreciate the fact that there has not been a break in services even though we have had a few changes in Project Officer assignments in the past 6 months.