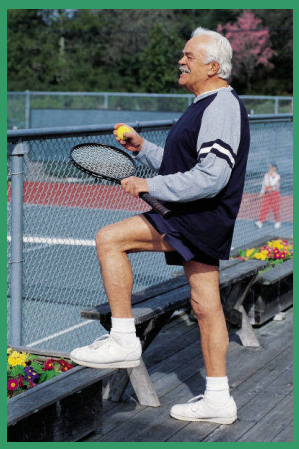

DEPARTMENT OF HEALTH AND SENIOR SERVICES

NEW JERSEY

STATE STRATEGIC PLAN ON AGING

October 1, 2009 – September 30, 2013

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Introduction and Executive Summary

Today's older New Jerseyans want options. They want to have a say in how, when, where and by whom services are delivered, and they are eager to use these services to maintain their independence late into life. This State Plan empowers older adults in New Jersey. This means enabling and supporting them to make lifestyle changes to reduce their risk of disease, disability and injury and to manage their own care and make choices that will allow them to avoid or delay the need for long-term care services.

New Jersey was one of the first states in the nation to create a state division on aging. Chapter 72 Law of 1957 established within the State Department of Health, a state unit on aging. In 1973, amendments to the federal Older Americans Act of 1965 authorized states to designate geographic planning and service areas to be administered by Area Agencies on Aging. At that time, New Jersey designated each of its 21 county offices on aging as Area Agencies on Aging, making each eligible for federal funding under the Older Americans Act.

Since 1957, New Jersey's State Unit on Aging has been placed in several departments. In 1996, it was moved into the cabinet-level Department of Health and Senior Services as a result of a reorganization and consolidation of senior services of more than 20 senior and long-term care programs formerly housed in four state agencies.

In 2002, as part of the Department of Health and Senior Services' streamlining efforts, the Divisions of Senior Affairs (the state unit on aging) and Consumer Support (Medicaid Waiver and long-term care services) and their respective functions and funding sources were consolidated into the Division of Aging and Community Services.

The Division of Aging and Community Services is required to develop and submit a State Strategic Plan on Aging to the U.S. Administration on Aging under the Older Americans Act of 1965, as amended. This plan, covering the years 2009-2013, outlines the direction in which New Jersey's long-term care reform efforts are moving and identifies strategies to address the fast growing new generation of older residents and

their families who want to be served in their homes and communities with senior services.

Since the submission of its last State Plan, the 2006 reauthorization of the Older Americans Act played a major role in redirecting New Jersey's system of long-term care to help elderly residents maintain their dignity in their homes and communities. The provisions of the Act were reinforced in New Jersey with Governor Jon Corzine's passage of the Independence, Dignity and Choice in Long-Term Care Act, also in 2006 (see Appendix A). Because of this historic bill signing, the State's long-term care funding structure is being adjusted to provide more options for older adults through budgetary rebalancing. The Aging and Disability Resource Connection (ADRC) initiative has become the primary catalyst for rebalancing long-term care in New Jersey and is at the core of New Jersey's modernization agenda for long-term care. At the center of the Act's mandates is the implementation of a client-tracking system that advances the ADRC objectives, including easy access to long-term care support services, streamlining eligibility determination and coordinating long-term care service and management.

Through the implementation of the State Plan, the Division of Aging and Community Services is charged with the following mission – to enable its growing aging population and caregiving communities to access a seamless and dynamic system of services that promotes well-being and embodies the values of dignity and choice.

The 2009-2013 State Plan outlines five goals and accompanying strategies to address New Jersey's vision for modernizing the delivery of aging services. They are listed below and set the direction for the Division of Aging and Community Services over the next four years. Each strategy also has performance measures against which the Division of Aging and Community Services can be evaluated in meetings its goals over the life of the State Plan. The State Plan is not a static document and is flexible to meet changing priorities on the state and federal levels. Here is an overview of what is detailed in the New Jersey's State Plan.

Goals and Objectives for 2009-2013

Goal 1 Make It Easier for Older Adults to Access an Integrated Array of Health, Social Supports and Long-Term Care Options.

Objective 1.1: Expand the Aging and Disability Resource Connection to be New Jersey's long-term care service delivery system for older adults and persons with disabilities.

Objective 1.2: Enhance cultural and linguistic competency in the aging network.
Objective 1.3: Improve access to long-term care benefits for older adults, persons with disabilities and caregivers through better management information systems.
Objective 1.4: Empower individuals, including middle-aged adults, to plan for future long term care needs.
Objective 1.5: Enhance existing transportation services and foster more options by collaborating with key partners in the transportation sector.

Goal 2 Promote Home and Community-Based Support Services for Older Adults and Caregivers.

Objective 2.1: Support individuals to direct their own long-term care planning process.
Objective 2.2: Provide more home and community-based options for older adults through budgetary rebalancing of New Jersey's long-term care funding structure.
Objective 2.3: Increase options for innovative programs that benefit seniors, caregivers and people with physical disabilities.
Objective 2.4: Support families to care for loved ones at home and in the community.

Goal 3 Empower Older People to Stay Active and Healthy through Older Americans Act Services and the New Prevention Benefits under Medicare.

Objective 3.1: Expand infrastructure for the delivery of high quality, community-based, evidence-based disease prevention programs.
Objective 3.2: Expand and support the role of Area Agencies on Aging in evidence-based disease prevention.
Objective 3.3: Strengthen state-level partnerships to support healthy aging.
Objective 3.4: Promote the use of the prevention benefits under Medicare.
Objective 3.5: Strengthen the nutrition program for the elderly.

Goal 4 Ensure the Rights of Older People and Prevent their Abuse, Neglect and Exploitation.

Objective 4.1: Increase reporting of neglect and abuse and decrease such incidents by the Office of the Ombudsman for the Institutionalized Elderly.
Objective 4.2: Strengthen the Long-Term Care Ombudsman Program's capacity to provide information to older consumers on elder rights and consumer protection issues and programs, and educate the public on the importance of such programs.
Objective 4.3: Continue to enhance and expand the Regional Ethics Committees to ensure that a person's wishes are honored and not abused at the end of their lives.
Objective 4.4: Increase consumer knowledge and self-direction in long-term care choices and management.
Objective 4.5: Develop in the Office of the Public Guardian for Elderly Adults a group of qualified registered professional guardians to augment public guardianship.
Objective 4.6: Raise awareness through the Office of the Public Guardian for Elderly Adults of the growing numbers of frail elderly with mental illness in need of specialized guardianship services, and increase awareness among those serving this population.

Objective 4.7: Advance the public understanding of guardianship alternatives through the promotion of advance planning documents.
Objective 4.8: Through Adult Protective Services, support county provider agencies and educate and work with partner agencies to ensure that vulnerable adults are identified and that services are provided to them in order to ensure their safety.
Objective 4.9: Enhance legal services education of seniors and aging network professionals.

Goal 5 Maintain Effective and Responsive Management.

Objective 5.1: To develop and implement a Quality Management Strategy to align with the Centers for Medicare & Medicaid Services' Home and Community-Based Services Quality Framework and the algorithm for the Aging and Disability Resource Connection.
Objective 5.2: Continue to implement an annual assessment procedure so the Area Agencies on Aging are accountable under the Older Americans Act.
Objective 5.3: Ensure that the Division of Aging and Community Services provides superior service delivery to the Area Agencies on Aging.
Objective 5.4: Ensure emergency planners statewide consider the special needs of frail elderly when establishing and implementing disaster response plans.

Context

New Jersey has adopted this State Strategic Plan on Aging to formalize its goals and objectives for addressing the current and future needs of the state's senior population. The mission and vision of this plan are those established by the State Unit on Aging – the Division of Aging and Community Services – and closely mirror those set by the U.S. Administration on Aging.

Mission Statement

To enable the growing aging population and their caregiving communities to access a seamless and dynamic system of services that promotes well-being and embodies the values of dignity and choice.

Vision Statement

The Division of Aging and Community Services is New Jersey's lead agency that makes a positive difference in the lives of individuals by addressing the changing needs of a growing and aging population.

Federal and State Goal Cohesion

New Jersey's strategic goals match those established by the U.S. Administration on Aging in its Strategic Action Plan for the years 2007-2013, although the Goals 1 and 2 have been reworded. This symmetry will serve both agencies as they work together to administer accessible, high quality health, social and protective services for seniors and their caregivers. These shared goals are:

1. Make it easier for older adults to access and integrated array of health, social supports and long-term care options.
2. Promote home and community-based support services for older adults and caregivers.
3. Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation.
5. Maintain effective and responsive management.

State Planning Process

To solicit input into the development of it proposed 2009-2013 Strategic Plan on Aging, the Division of Aging and Community Services held a stakeholders meeting and two public hearings in the spring of 2009. A summary of those meetings can be found in Appendix B.

Who are current and future older persons? What are their needs?

New Jersey's senior population is growing and diverse[1]. The state ranks 11th in the nation in overall population, but 9th in the number of individuals age 60 and older. According to U.S. Census data, this cohort grew 8.4 percent from 2000 to 2007 to a total of 1,565,195 individuals. The largest population growth during this period was among the youngest (people aged 60-64 years, 30 percent) and oldest (people aged 85 and over, 24 percent) age groups. This change reflects the aging of the baby boomers (those born between 1946 and 1964) and their parents.

The population over age 60 years is projected to grow substantially in the near future as the baby-boomer generation ages. By 2030, the population in this age group in New Jersey is projected to number 2.5 million. People aged 60 and over represented 18 percent of the state population in 2007: by 2030, this figure is expected to rise to 25.7 percent.

New Jersey is one of the most diverse states in the nation. Among its residents aged 60 years and over in 2007, 9.8 percent were non-Hispanic black, 8.2 percent were Hispanic and 4.8 percent were Asian and Pacific Islanders. Within each of these groups there is a tremendous diversity among ethnicities and languages spoken. In fact, more than 70 languages are currently spoken in New Jersey homes.

For income data, this plan looked to two main sources: the 2000 Census and the Elder Economic Security Standard Index, a new resource for New Jersey to measure how much income seniors need to adequately meet basic needs without public or private assistance. The New Jersey Foundation for Aging developed the Index in partnership with Wider Opportunities for Women (WOW) and the Gerontology Institute at the University of Massachusetts Boston.

The Index, released in May 2009, found that in order to reach economic security, a single senior needed an annual income ranging from $23,452 (for homeowners without a mortgage) to $33,570 (homeowners with a mortgage). For married couples, the standards ranged from $34,324 to $44,442. The standard for renters was roughly $2,500 higher than for homeowners without mortgages. With more than 25 percent of seniors relying solely on their Social Security benefit, it is clear that many cannot adequately meet their basic living expenses. The most significant barriers to economic security for seniors in New Jersey were high housing and healthcare costs. For other key findings of this report, visit the website of the NJ Foundation for Aging at http://www.njfoundationforaging.org.

Census data reveals the median income for families with the householder aged 60 years and over was $51,535 in 1999, and declined with age. The median income for families with the householder aged 85 years and over was about half that of families with the householder aged between 60 and 64 years.

[1] See Appendix C.

In 1999, 7.7 percent of all individuals aged 60 years and over in New Jersey had incomes below the poverty level, which is lower than the proportion for the population as a whole. The poverty rates were higher for minority seniors including 16.5 percent for non-Hispanic blacks, 16.6 percent for American Indians and Alaska Natives, and 17.5 percent for Hispanics and Latinos.

Approximately 36 percent of the statewide non-institutionalized population aged 60 years and over claimed a disability in 2000. The rates did not differ much between men (34 percent) and women (37 percent). The prevalence of disability increased substantially with age. In the 60-64 age group, 27 percent of men and 26 percent of women had a disability. Within the 85+ age group, about 64 percent of men and 73 percent of women had a disability.

In 2003, 60 percent of people aged 60 to 64 years depended primarily upon employment-related health insurance and 17 percent of people within this age group did not have any health insurance. The uninsured rate was reduced to 2 percent for people aged between 65 and 74 years, for whom 92 percent had Medicare as primary insurance. For people aged 75 years and over, 98 percent had Medicare as their primary insurance.

Service utilization of home and community-based services continues to rise. On January 1, 2009, more than 11,000 seniors and adults with disabilities were enrolled in the state's Medicaid 1915 (c) waiver, Global Options for Long-Term Care. Close to 1,500 more were enrolled in the state-funded Jersey Assistance for Community Caregiving. Through efforts to rebalance the state's long-term care system, the percent of government funding now dedicated to home and community based services has risen to a record 28 percent.

In 2008, over 500,000 individuals were serviced through their Area Agencies on Aging. Waiting lists exist for some services, but were eliminated in 2009 for home delivered and congregate meals thanks to an infusion of more than $2.6 million in American Recovery and Reinvestment Act (ARRA) funding. For detailed information on programs and services at the Division of Aging and Community Services, including utilization data, see Appendix E.

When planning to help seniors, it must be taken into account that despite society's hectic pace, caregivers continue to provide the majority of long-term care services in our state and across our country. It is estimated that 980,000 New Jersey residents are currently providing some degree of help to an elderly friend or relative.

These statistics and utilization data mirror the day-to-day anecdotal experience of New Jersey's aging services network. In these figures and throughout our workday, we see an aging population that is expanding at a tremendous rate and, in too many cases, is unprepared for the medical, social and financial challenges that lay before them.

The new generation of seniors also has different expectations than previous ones. They are aging into a system that offers home and community-based services that were unavailable to their parents. Today's seniors want options, want to have a say in how, when, where and by whom their services are delivered, and are eager to use these services to maintain their independence late into life.

To meet the changing demographics, diversity and demands of its consumers, the aging network in New Jersey is changing the way it does business.

How are the Aging Network and long-term care system organized? What is the role of the state agency on aging in long-term care?

New Jersey has a robust aging services network featuring high quality home and community-based services and long-term care facilities. Oversight of the network is the responsibility of the Department of Health and Senior Services and its three senior focused divisions: Aging and Community Services (the designated State Unit on Aging); Senior Benefits and Utilization Management; and Health Facilities Evaluation and Licensing.

- *The Division of Aging and Community Services (DACS)* – The division is responsible for home and community-based services through the receipt of federal funds under the Older Americans Act and is the State Administering Agency for the Medicaid 1915(c) waiver, Global Options for Long-Term Care. The division is also responsible for preparing the State Strategic Plan on Aging for the U.S. Administration on Aging, serving as the focal point for planning services for the aging, developing comprehensive information about New Jersey's elderly population and its needs, and maintaining information about services available to the elderly throughout the state.

  The division is comprised of six offices: Office of Area Agency on Aging Administration and Finance; Office of Global Options for Long-Term Care/Quality Management; Office of Community Education and Wellness; Office of Community Choice Options; Office of the Public Guardian and Elder Rights; and Office of Administration and Finance. For more information on the division and its services, see Appendix F.

- *The Division of Senior Benefits and Utilization Management (SBUM)* – This division administers two state pharmaceutical assistance programs, the Pharmaceutical Assistance for the Aged and Disabled (PAAD) and the Senior Gold programs. It also operates a utility assistance and a $100 hearing aid reimbursement program.

- *The Division of Health Facilities Evaluation and Licensing (HFEL)* – This division regulates a wide range of health care settings for quality of care, such as hospitals, nursing homes, assisted living residences, ambulatory care centers, home health care, medical day care and others. Division staff investigates complaints received from consumers and other state and federal agencies. The division licenses nursing home administrators and certifies assisted living administrators and nurse aides. It also provides consumer information in the form of report cards and other performance information.

In 2006, the Department of the Public Advocate was reestablished in New Jersey. As a result, the Office of the Ombudsman for the Institutionalized Elderly was transferred from the Department of Health and Senior Services to the new department. The Departments of Health and Senior Services and Public Advocate continue to work closely with the Ombudsman to ensure the safety of seniors residing in institutions.

Most home and community-based services for seniors and their caregivers are administered locally through the state's network of 21 county-based Area Agencies on Aging and their contracted provider agencies. Increasingly, whether encouraged to do so through participation in or anticipation of joining the ADRC initiative or of their own accord, the Area Agencies on Aging are working hand-in-hand with state and county-based disability services offices to ensure adults of all ages have access to high quality home and community-based services.

To meet the desires of its aging population to age in place, and with the full support of it federal, state and local partners, New Jersey is rebalancing its long-term care system to support consumer direction. This transition is the focus of the State Unit on Aging (the Division of Aging and Community Services), the Area Agencies on Aging and this State Strategic Plan on Aging.

What are the critical issues/trends? What are the future implications? What are the challenges?

New Jersey has a history of innovative thinking and action in senior services. With the recent and projected growth of the state's aging population, the rising cost of institutional care, and the public's demand for home and community-based options, our focus since the submission of our last State Strategic Plan on Aging in 2005 has been on developing and implementing programs that support consumer direction and choice.

- On June 21, 2006, Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act into law on June 21, 2006. As a result of this historic bill signing, the State's long-term care funding structure is being adjusted to provide more options for older adults through budgetary rebalancing.

- In 2006, New Jersey was awarded a grant from the U.S. Administration on Aging to establish Stanford University's Chronic Disease Self-Management Program (CDSMP) in targeted counties. Prior to the grant, there was no capacity to deliver this evidence-based program as there was only one certified master trainer in the state. Today, CDSMP workshops are offered in 17 counties and the state boasts 54 master trainers and more than 1,000 peer leaders and participants.

- Also in 2006, the State received two federal grants to support its rebalancing efforts – the Systems Transformation Grant and the Aging and Disability Resources Center: Building upon Success grant.

- In 2007, the State received a Nursing Home Diversion Modernization grant, an Alzheimer's Disease Demonstration grant, and was selected to participate in the Money Follows the Person Rebalancing Demonstration.

- In 2008, it received a Nursing Home Diversion grant and a Veterans Directed Home and Community Based Services grant. The National Council on Aging also awarded the state a Sustainable Systems grant to expand the reach of the Chronic Disease Self Management Program (CDSMP) to all 21 counties and additional minority populations.

- In 2009, the State received a Medicare Improvements for Patients and Providers Act (MIPPA) grant.

These initiatives are described in greater detail in the Goals and Objectives section of this plan, but were listed here to demonstrate the political and economic support the Division of Aging and Community Services and its partners in the aging and disability services network have received from federal, state and local officials.

To ensure the success of reforms, old partnerships between federal, state and local aging and disability network agencies and organizations have been strengthened and new ones formed. These are highlighted in the goals section of this plan, and include enhanced collaboration with public health officials to improve adult immunization rates, launch and sustain evidence-based health promotion and disease prevention programs, and ensure emergency preparedness and response plans address populations with special needs.

A major support to the State's efforts was passage of the Older American Act Amendments of 2006. The amendments dramatically changed the way aging services are delivered through the use of Aging and Disability Resource Centers (known as Resource Connections in New Jersey), evidence-based disease and health promotion programs and consumer directed nursing home diversion programs to reach people before they start spending down to Medicaid eligibility.

By incorporating these principles into its comprehensive efforts to rebalance the state's long-term care system, the State is seeing it institutional funding bias wane. In State fiscal year 1997, only 7 percent of public funding for long-term care services in New Jersey was expended on community care while 93 percent went for institutional care. Today the spilt is 28 percent to 72 percent, respectively.

Providing guidance on these efforts is the State's Medicaid Long-Term Care Funding Advisory Council, which was created in November 2006 and has met quarterly since. The Council has been an agent of change and has issued two reports to date updating the Governor and Legislature on its work and recommending strategies, for improving and expanding community services.

Goal 1 Make It Easier for Older Adults to Access an Integrated Array of Health and Social Supports.

Objective 1.1: Expand the Aging and Disability Resource Connection to be New Jersey's long-term care service delivery system for older adults and persons with disabilities.

Progress Update 2005-2009

In 2003, New Jersey was selected by the U.S. Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) as one of 12 states to pioneer the Aging and Disability Resource Center (ADRC) grant to improve access to information and services and streamline the Medicaid eligibility determination process. This first joint venture between the New Jersey Departments of Health and Senior Services and Human Services was to create a "no wrong door" single entry system for persons of all ages, physical disabilities and long-term illnesses regardless of income.

The ADRC focuses on a system-wide change and integration process to improve access to home and community-based services. The State introduced a new client pathway as a model beginning in Atlantic and Warren Counties. An algorithm was developed as a framework for integrating the service delivery system, streamlining clinical and financial eligibility processes and supporting consumer choice. Multiple strategies were used to streamline access to home care services.

In 2006, New Jersey expanded the ADRC model from its two testing counties to Bergen, Camden, Hunterdon, Mercer, Morris and Somerset Counties. By the end of 2010, the ADRC will function statewide, serving as the primary catalyst for rebalancing the long-term care budget in New Jersey, and will allow for the following:

- A system that is visible, trusted and easy to access for information and assistance on all home and community-based services regardless of one's income;
- The education and counseling of consumers and their caregivers on the range of support services so they can make informed decisions for today and future long-term care needs;
- The ability to serve older adults, persons 18 years and older with physical disabilities and their caregivers, including those from culturally-diverse populations and all income levels; and
- The streamlining of the clinical and financial eligibility process for long-term care Medicaid services and other federally and state funded programs.

Strategies

- Formalize agreements with State and county leadership regarding the ADRC model.
- Expand organizational capacities, resources and funding under the ADRC model.
- Ensure that all counties take responsibility for implementing the new client pathway and protocols under the ADRC with their local networks.
- Provide training and technical assistance to partners on the ADRC business processes.
- Ensure that the partners achieve quality performance measures to align with the CMS Home and Community-Based Services Quality Framework.

Performance Measures

- Ensure that New Jersey's one-stop systems consistently provide comprehensive information and referrals on long-term care and community supportive services.
- Increase the average number of monthly telephone calls for long-term care from the aging services network.
- Consumers report satisfaction with the information received when accessing the State and county websites related to senior services.
- Consumers report satisfaction with the information received when accessing the State and county telephone numbers for Information and Assistance.
- Increase the number of non-English calls to the information and referral lines maintained by the Division of Aging and Community Services and the Division of Disability Services assisted by interpreter services.
- Train care managers in cultural competency within 18 months of their hire date.

Objective 1.2: Enhance cultural and linguistic competency in the aging network.

Progress Update 2005-2009

Effectively targeting services to meet New Jersey's increasingly diverse population in terms of culture, language and race/ethnicity is a guiding principle of the Division of Aging and Community Services and the aging services network. It was incorporated into cultural and linguistic competence across all levels of the division, from management, policy and procedural development to staff recruitment, training and administration and service delivery. To embed this principle at the county level, these steps were taken:

- Cultural competency educational sessions were held for frontline staff at the Area Agencies on Aging (AAAs) so that minority populations could be better reached.
- Presentations to minority organizations on services, programs and Medicare were held and participation at community events occurred.
- An emphasis was put on recruiting minority providers to reach the Hispanic, Asian and American Indian communities; attracting minority members to serve on the AAA Advisory Councils; and creating partnerships to share information with diverse populations.
- Public announcements of grant opportunities in Spanish and English were placed in newspapers serving the Hispanic community.

Strategies

- Foster relationships with leaders in senior housing; at medical, mental health and education institutions; and at faith-based and community organizations.
- Use a multi- and inter-generational approach to advance programs and services.
- Promote the aging services network through linguistic services and programs.
- Ensure people know where to turn for information on long-term care and community services and find them free of all barriers.
- Engage culturally sensitive "community ambassadors."
- Work with schools and universities.

Performance Measures

- Track volume of non-English calls; non-English traffic to the website; the number of consumer satisfaction surveys translated into other languages; the number of Area Agencies on Aging that create community ambassadors; and the number of trainings for community professionals on cultural competency.

Objective 1.3: Improve access to long-term care benefits for older adults, persons with disabilities and caregivers through better management information systems.

Progress Update 2005-2009

In November 2006, the Department of Health and Senior Services submitted a waiver of advertising to purchase a complex web-based client tracking data system from Synergy Software Technologies, Inc. (now, Harmony Information Systems). This integrated application – the Social Assistance Management Systems (SAMS) application – advances the Aging and Disability Resource Connection's (ADRC) objectives. The application includes intake, case management, service planning, service provision, service invoicing, and the federal reports mandated under the Older Americans Act known as the National Aging Program Information System (NAPIS).

By October 2009, the MIS system is expected to serve as the database for the aging services network to collect, analyze and transfer data elements to the U.S. Administration on Aging (AoA). There are about 1,200 licensed users for the project's first step—the largest part of the implementation.

In February 2009, a standardized ADRC information and assistance and screening process for New Jersey was developed. Atlantic and Warren Counties, the two pilot ADRC counties, then began using SAMS to capture the Consumer Profile and Screen for Community Services data elements. Included in the Screen were the financial eligibility questions that enabled the Fast Track Medicaid Eligibility Determination process to begin. The ADRC business process will be integrated into SAMS by the end of 2010.

Strategies

- Deploy and support SAMS statewide in a three-phase rollout:
  1. Use SAMS as the reporting system for the area plan contract service planning and delivery functions in the 21 AAAs and their 400 providers;
  2. Integrate the ADRC business process into SAMS, and
  3. Integrate into SAMS the additional requirements to support the State's rebalancing of long-term care towards more home and community-based services.
- Automate the Fast Track Eligibility process for Medicaid determination in SAMS.
- Create a model to provide ongoing system-wide support to the 700 aging and disability networks' community-based agencies and 2,100 end users.
- Improve access to long-term care services through the use of integrated IT systems.

Performance Measures

- Ensure that SAMS is fully customized and implemented in the 21 counties.

Objective 1.4: Empower individuals, including middle-aged adults, to plan for future long-term care needs.

Progress Update 2005-2009

The Division of Aging and Community Services produced and distributed "A Guide to Community-Based Long Term Care in New Jersey" to encourage adults and caregivers to consider and plan for long-term care needs. More than 40,000 copies of the 10-section guide were distributed statewide, providing information on medical, housing, financial, legal and social service issues. The guide was posted on the division's website. At least two counselors in each county-based State Health Insurance Assistance Program (SHIP) were trained on long-term care, making expertise available locally.

New Jersey has received a *Medicare Improvements for Patients and Providers Act (MIPPA) for Beneficiary Outreach and Assistance* grant from the Centers for Medicare & Medicaid Services and the U.S. Administration on Aging to enroll more eligible seniors in the Low-Income Subsidy (LIS) and Medicare Savings Programs (MSP). The focus will be on increasing participation among low-income seniors in minority groups and rural areas.

Strategies

- Make presentations to consumer groups on long-term care needs and resources.
- Provide training on long-term care to SHIP counselors.
- Distribute long-term care information packages to consumers who call the SHIP and/or the State Information and Assistance Hotline.
- Form a consortium to implement the MIPPA grant, including representation from the Departments of Health and Senior Services and Human Services.
- Provide information on LIS and MSP to SHIP counselors at thrice annual trainings.
- Develop and deliver instructions and a training course on how to complete the state pharmaceutical assistance program application, the form used to determine eligibility for LIS and two of the three MSPs.
- Develop and distribute marketing materials that detail the savings eligible individuals can realize by enrolling in LIS or MSP.
- Fund county-based agencies to market LIS and MSP.

Performance Measures

- Track the number of update training sessions held for SHIP counselors; the number of long-term care information packages distributed to consumers and/or caregivers; the number of LIS and MSP trainings held; the number of outreach efforts completed and persons reached; and the number of new LIS and MSP applications approved.

Objective 1.5: Enhance existing transportation services and foster more options by collaborating with key partners in the transportation sector.

Progress Update 2005-2009
Last year, the Division of Aging and Community Services provided 709,005 units of transportation services to 13,579 clients at a cost of $5.7 million and provided 107,411 units at a cost of $884,612 serving 7,586 clients, with assisted transportation services.

The Division of Aging and Community Services participated on the Governor's Executive Council on Access and Mobility, a United We Ride interagency effort to coordinate transportation services for older adults and individuals with physical disabilities. In addition, the Area Agencies on Aging (AAAs) are active members of their County Transportation Councils/Committees. Each County Council developed Inter-Agency coordinated transportation plans through identification of strategies and recommendations for system improvement.

The division has also participated in a variety of transportation improvement initiatives, including intersection improvement pilot projects to promote senior citizens' mobility, safety and health; a planning task force to support the reduction and severity of crashes among the aging population; and a roundtable group involved in projects and initiatives to create an action plan to create a healthier and more mobile New Jersey.

Strategies
- Collaborate with state departments and aging network and state transportation lead agencies to enhance public and private transportation systems statewide.
- Explore best practice models in other states, including funding resources.
- Develop services and programs with partners to meet the changing transportation needs of seniors.
- Educate physicians, families and individuals on skills for independent travel.
- Create a bank of travel independence assessment tools, programs and assessors.

Performance Measures
- Increase the public awareness and availability of transportation programs.
- Strengthen the assisted transportation pilot programs.

Goal 2 Promote Home and Community-Based Support Services for Older Adults and Caregivers.

Objective 2.1: Support individuals to direct their own long-term care planning process.

Progress Update 2005–2009
New Jersey is witnessing a fundamental change in its long-term care policy for older adults and persons with disabilities across all incomes. It is a transformation that is directed at giving more

people better control over their care and providing greater support for community living. The plan for New Jersey is a money-follows-the-person long-term care system: a person-centered approach of providing service delivery promoting dignity, choice and independence in the most integrated community setting.

It is also Governor Jon S. Corzine's vision for New Jersey, which was reaffirmed when the Governor signed the Independence, Dignity and Choice in Long-Term Care Act into law on June 21, 2006. As a result of this historic bill signing, the State is changing the long-term care funding methodology to a more flexible State budgeting process that promotes more home and community-based service options. Additionally, the Act directed the Department of Health and Senior Services to implement a system of statewide long-term care service coordination and management; to identify home and community-based long-term care models that are alternatives to nursing home care; to develop and implement a consumer assessment instrument that is designed to expedite the provision of supportive services through Fast Track eligibility prior to formal Medicaid financial eligibility determination; to develop a quality assurance system; and to make information available to the general public.

Medicaid Home and Community-Based Waiver Consolidation

New Jersey received approval from the Centers for Medicare & Medicaid Services (CMS) to consolidate three Medicaid-supported home and community-based service programs into a single program known as Global Options (GO) for Long Term Care. The consolidation, effective January 1, 2009, improved access to a wider range of in-home long-term supportive services for a greater number of seniors and adults with physical disabilities who meet the income, asset and nursing facility level of care requirements established by Medicaid. GO participants can hire and direct their own service providers.

Community Living Program

In 2007 and 2008, New Jersey was awarded federal Nursing Home Diversion and Modernization grants to develop and implement a cash-and-counseling model for individuals at risk of nursing home placement and spend down to Medicaid. An infrastructure is being developed to support consumer direction and flexible service dollars and to enable participants to purchase services that meet their care needs. Additionally, the grants are providing the State with an opportunity to introduce a cost-share sliding scale for home and community-based services.

Veterans-Directed Home and Community-Based Services

In 2007, Governor Corzine mandated in legislation that the New Jersey Department of Military and Veterans Affairs (DMAVA) evaluate the resources available and the costs and benefits of providing home healthcare to elderly or disabled veterans through approved agencies, organizations or other entities to enable these veterans to remain in their homes.

According to DMAVA, the biggest obstacle confronting elderly veterans is that they "make too much money" to be eligible for VA healthcare. Additional obstacles identified include: (1) the availability of long-term care options as veterans tend to be on waiting lists so long that families have no alternative but nursing home placement; (2) lack of home health nurses, social workers, and aides to provide services in their homes; (3) lack of public transportation to take veterans to medical appointments or community services; (4) shortage of mental health professionals to provide counseling services; (5) availability of only three veteran nursing homes, and no veteran

assisted living facilities; and (6) the lack of affordable housing options for homeless veteran.

To address the growing long-term care needs of veterans and their caregivers, the Departments of Health and Senior Services and Military and Veterans Affairs, with U.S. Lyons Healthcare System, formed a partnership that resulted in the awarding of federal funding under a Veterans-Directed Home and Community-based Services (VD-HCBS) grant. Lyons Healthcare System is a part of the Veterans Integrated Services Network 1 (VISN 1) that covers northern/central New Jersey. The VD-HCBS program is being piloted in the Morris and Somerset counties and will become statewide as the Aging and Disability Resource Connection (ADRC) rolls out.

Strategies

- Grow the Consumer Living Program from a pilot basis in Camden, Morris and Somerset Counties and expand the cash-and-counseling option statewide by 2011.
- Pilot the cash-and-counseling approach under the VD-HCBS initiative that can be expanded to the other counties within the Lyons Healthcare System.
- Transform Older American Act funds to support a cash-and-counseling option.
- Create policies to ensure that no consumer is denied services because they can't pay.
- Integrate Medicaid waiver Quality Strategies into the Older Americans Act programs.
- Integrate the ADRC model to screen, assess, and educate non-Medicaid consumers on home and community-based services.
- Educate consumers to direct and control the planning process and counsel participants on their role and responsibilities as an employer.

Performance Measures

- Track the number of consumers who were screened, assessed, received options counseling and were referred or enrolled in other services.
- Track the number of consumers enrolled in the Community Living Program
- Track consumer satisfaction.
- Create policy and procedures for the cash-and-counseling option for Older American Act services.

Objective 2.2: Provide more home and community-based options for older adults through budgetary rebalancing of New Jersey's long-term care funding structure.

Progress Update 2005-2009

In accordance with the Independence Dignity and Choice in Long-Term Care Act, the State is directed to create a process for expanding home and community-based services within the existing budget allocation by diverting persons from nursing homes to allow maximum flexibility between nursing homes and home care options.

The Department of Health and Senior Services engaged Mercer Government Human Services Consulting (Mercer) to assist in its efforts to advance rebalancing and establish funding parity between nursing homes and home and community-based services.

Mercer created a budget projection model that allows for financial projections to avoid unusually large, unanticipated surpluses or deficits. A forecasting model was developed that captures New

Jersey's current budget situation and then projects the State general and total fund expenditures for current and upcoming budget years. State staff will use the budget projection model to realign New Jersey's long-term care budget to support home and community-based services.

Strategies

- Use New Jersey's budgetary process to capture the current budget situation and project the State's general and total fund expenditures for now and in the future.
- Create a new budgetary process by which individual service plans are created to drive individual budgets: a money-follows-the-person or cash-and-counseling approach.
- Develop and implement a new home and community-based services provider reimbursement system.
- Educate county welfare agencies about the Fast Track Medicaid Eligibility Determination process.
- Implement the Social Assistance Management Systems (SAMS) client tracking system.

Performance Measures

- Track the amount and distribution of long-term care service funding between nursing homes and home and community-based services.
- Establish policies and procedures governing the long-term care budget allocations so the State can rebalance funds from one system of care to another.
- Track the number of educational seminars to county welfare agencies on the Fast Track Medicaid Eligibility Determination process.
- Track the number of Area Agencies on Aging and provider agencies that are using the Social Assistance Management Systems (SAMS).

Objective 2.3: Increase options for innovative programs that benefit seniors, caregivers and people with physical disabilities.

Progress Update 2005-2009

The Community Choice Program identifies nursing home residents on Medicaid who can be supported in the community, counsels them on community-based alternatives and coordinates their discharge through an Inter-Disciplinary Team approach. Since 1998, over 5,500 residents have been transitioned from nursing homes into home care options. In 2005, New Jersey's Nursing Home Transition program increased funding, expanded options and provided more flexibility for residents to control and direct their services. It was developed to support consumer choice through a more comprehensive and coordinated team approach – and reach those most at risk for nursing home placement.

By December 2007, the Fast Track Medicaid Eligibility Determination process was operational statewide. Fast Track enables consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria to receive home and community based services for up to 90 days while they complete the Medicaid application and eligibility determination process. The State has had contact with over 11,390 individuals, from December 2007 through June 2009, who were potentially eligible for Medicaid and received counseling on long-term care options. Of this number, 278 individuals received Medicaid services in an expedited fashion.

In spring 2009, New Jersey opened its first Program of All-inclusive Care for the Elderly or PACE site. The PACE model provides a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate. The PACE sites are operating as LIFE St. Francis (Living Independently For Elders) in Trenton and LIFE at Lourdes Hospital in Pennsauken. Six other sites across the State are being proposed and are at various stages of development.

Strategies

- Strengthen the Nursing Home Transition Program/Money Follows the Person initiatives and transition individuals though an Inter-Disciplinary Team approach.
- Ensure that the Fast Track Medicaid Eligibility Determination process is fully operational in the 21 counties.
- Expand PACE in New Jersey to a statewide program serving several thousand individuals.

Performance Measures

- Track the number of community dwellers at risk for admission to nursing facilities who are diverted; home and community-based services waiver enrollments; enrollments in the Community Living Program and the Veterans-Directed Home and Community Based Services Program; and the number of transitions from nursing facilities to home care options and consumer satisfaction.

Objective 2.4: Support families to care for loved ones at home and in the community.

Progress Update 2005-2009

There are approximately 980,000[2] informal caregivers in New Jersey, providing over one billion hours of unpaid care, with an economic value of $11.2 billion annually. New Jersey continues to address the various needs of caregivers. Efforts include continued support of consumer choice, caregiver-targeted research, evidence-based practice, interagency and stakeholder collaboration, and caregiver coalition building in order to strengthen New Jersey's broad approach to meeting the needs of caregivers.

The Division of Aging and Community Services reorganized the administration of its caregiver-focused programs within the Office of AAA Administration to better coordinate the work from a more global perspective, assuring quality improvement and responsiveness to caregiver issues. The National Family Caregiver Support Program (Title IIIE), Statewide Respite Care Program (SRCP) and Adult Day Services Program for Persons with Alzheimer's Disease and Related Disorders (AADSP) are housed in the Office of AAA Administration.

New Initiatives were also launched: The New Jersey Caring for Caregivers Initiative (CGI), which was created in 2004 by Executive Order, launched 3 new caregiver components: Professional In-Home Caregiver Education and Support, Mental Health Counseling, and Trained

[2] Valuing the Invaluable: Economic Value of Family Caregiving, 2008 AARP Update, Nov. 2008

Volunteer Assistance. A Statewide Respite Care Program Caregiver Directed Option was implemented in 17 of 21 counties. Caregivers may purchase eligible services and receive reimbursement less applicable cost-share. Approximately 40 clients used this service option in State Fiscal Year 2008. For a summary of the top ten services accessed by caregivers see Appendix D.

Strategies

- Review 2009 New Jersey Behavioral Risk Factor Survey (BRFSS) data and trends on caregiver status and examine how the information may be used to benefit New Jersey. (A question on caregiver status was added to the 2009 BRFSS questionnaire.)
- Support dementia caregiver-targeted research.
- Implement evidence-based practice to support dementia caregivers under the Administration on Aging-funded Alzheimer's Disease Supportive Services Program.
- Implement evidenced-based practices that guide nursing and social work professionals in their support of those caring for persons at risk of institutionalization. The Division has partnered with the AARP Foundation, National Association of Social Workers and other project partners to conduct the *Professional Partners Supporting Family Caregivers* initiative funded by the Hartford Foundation.
- Strengthen the partnership with the Department of Human Services to support grandparents caring for grandchildren through its Kinship Navigator program.
- Collaborate with community stakeholder agencies – Caregivers of New Jersey, the Epilepsy Foundation, Family Support Center of New Jersey and Autism Family Services of New Jersey – to strengthen caregiver coalition building efforts and develop infrastructure to support Lifespan Respite initiatives.

Performance Measures

- Report the results of the caregiver status information date collected from the BRFSS telephone health survey in a *Topics on Health Statistics* publication produced and disseminated by the department's Center for Health Statistics.
- In partnership with the New Jersey Adult Day Health Services Association, work with Penn State University on its Daily Stress and Health Study (DASH Study). Completion target date is December 2012.
- Produce a project manual, training modules and a cost analysis to support the replication of evidence-based projects.
- Train Occupational Therapists who will deliver an evidence-based intervention to caregivers of persons with Alzheimer's disease and related disorders.
- Establish social work standards of practice to support family caregivers across diverse health care settings.
- Develop a work plan to coordinate efforts with the Department of Human Services Kinship Navigator Program.
- Expand the number of county caregiver coalitions at the AAAs from one to three.
- Ensure that Caregivers of New Jersey's initiatives, through the division's role on its Advisory Board, support the Aging and Disability Resource Connection (ADRC).

Goal 3 Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Objective 3.1: Expand infrastructure for the delivery of high quality, community-based, evidence-based disease prevention programs.

Progress Update 2005-2009

The receipt of grants from the U.S. Administration on Aging (AoA) and the National Council on Aging has enabled DACS to build a statewide infrastructure for delivery of the Chronic Disease Self-Management Program (CDSMP). Prior to receipt of the AoA grant in 2006, there was no capacity for delivery of CDSMP, as there was only one known CDSMP master trainer in New Jersey. Delivery capacity now exists throughout the state, and more than 1,200 people have participated in a CDSMP workshop. More than 400 individuals are trained as master trainers or peer leaders. The division's ongoing partnership with the Office of Minority and Multicultural Health in the Department of Health and Senior Services enables the program to partner with faith-based and other community-minded organizations to target minority populations, including training of individuals to deliver CDSMP in Spanish, Chinese, Korean and French.

In October 2007, the "Blueprint for Healthy Aging in New Jersey" was created and disseminated to increase awareness of the benefits of healthy behaviors, and foster an environment to support such behaviors. This document, which was produced with funding by a Senior Opportunity Grant from the National Association of Chronic Disease Directors, has been used extensively in New Jersey and has been identified as a best practice by several national organizations.

The AoA grant also supported the introduction of two additional evidence-based disease-prevention programs in New Jersey: Healthy IDEAS and A Matter of Balance. Healthy IDEAS was piloted in two local community agencies. Imbedded in the agencies' ongoing care management programs, Healthy IDEAS identifies risk for depression and implements a behavioral activation program to reduce this risk. Individuals from 10 Area Agencies on Aging (or their partner agencies) attended a master training program for A Matter of Balance. The master trainers implemented the eight-session program in local community sites and trained local coaches to act as lay leaders.

Project Healthy Bones, DHSS' 24-week exercise and education program for older adults with or at-risk of osteoporosis, continues to flourish. Each year, more than 1,500 people take part in the program statewide as lead coordinators, peer leaders or program participants. An evaluation of outcomes is currently being conducted with the intention of establishing Project Healthy Bones as an evidence-based disease prevention program.

Fall prevention brochures entitled "Fallen Down?" and "Medications, Falls & You" were given to consumers and professionals and posted on the DHSS website for download. Total hits on the brochures exceeded 1,000. Educational programs on falls were given to a variety of offices and professional associations including the Office of the Ombudsman for the Institutionalized Elderly, the Association of Area Agency on Aging Directors, the New Jersey Health Officers Association, the American College of Surgeon's Trauma System Consultation, Congregate Housing Coordinators and hospital staff.

Earlier this year, DACS staff delivered a five-hour workshop "Introduction to Evidence-Based Disease Prevention for Older Adults" through Rutgers University, School of Social Work's Continuing Education Program. The program was designed to provide an overview of evidence-based programming, as well as to promote the replication of evidence-based programs currently available in the state.

The division currently supports five evidence-based disease prevention programs: the Chronic Disease Self-Management Program (called Take Control of Your Health), A Matter of Balance, Project Healthy Bones (an exercise and education program for people with or at-risk of osteoporosis), HealthEASE Health Education (a six-week curriculum), and HealthEASE Move Today (an exercise program for older adults).

To ensure statewide availability of these programs, as well as to provide technical assistance for program delivery and quality assurance, the division will:

Strategies

- Provide regional training programs to expand the train-the-trainer model of delivery for each evidence-based program.
- Hold in-service meetings and conference calls to provide training, respond to inquiries, provide program updates, foster mentoring relationship, share resources, and offer leaders an opportunity to network.
- Develop and implement a quality assurance protocol to ensure outcomes are assured through adherence to program design.
- Continue to operate listservs for each of the evidence-based programs to provide information and motivate continued program involvement.
- Establish a uniform data collection protocols for all evidence-based programs.
- Provide data to local partners to highlight program achievements to gain support.

Performance Measures

- Increased number of community agency partners delivering or hosting state-supported evidence-based disease prevention programs.
- Quality assurance protocol implemented across evidence-based disease prevention programs.
- Uniform data collected for all state-supported evidence-based disease prevention programs.
- Peer leader engagement assessed through implementation of evidence-based programs and participation in in-service training.

Objective 3.2: Expand and support the role of Area Agencies on Aging in evidence-based disease prevention.

Progress Update 2005-2009

In April 2009, New Jersey's policy for administering Older Americans Act Title III D funds was revised to require that they be spent on outcomes-driven programs and activities. In addition, revised taxonomy codes related to health promotion and disease prevention were issued in May

2009. The changes in these revisions take effect with the Area Plan Contract (APC) starting in 2010. A section documenting the services to be funded with Title III D funds is included in the APC 2010-2012. The Office of Community Education and Wellness staff will assist the Area Agencies on Aging (AAAs) in this development of this section of their contract and will review all submissions as part of the APC approval process.

Strategies

- Develop and deliver a half-day workshop on evidence-based disease prevention for AAA staff. The workshop will provide staff with an understanding of the definition and components of evidence-based practice, the role of AAAs in supporting evidence-based disease prevention, and the various models that have been established in New Jersey to support local programs.

Performance Measures

- Title III D-funded service plans approved for the AAAs as part of the Area Plan Contract 2010-2012.
- Evidence-based disease prevention workshop held for AAA staff.

Objective 3.3: Strengthen state-level partnerships to support healthy aging.

Progress Update 2005-2009

The Division of Aging and Community Services increased awareness of and engagement in evidence-based disease prevention programs presentations to professional associations/ conferences, including: Area Agency on Aging (AAA) Executive Directors, Local Public Health, NJ Prevention Network, New Jersey Association of RSVP Directors, New Jersey Partners, New Jersey Society on Aging, Grotto Foundation, Senior Center Directors Association and New Jersey Grantmakers Association.

The division established strong intra-departmental relationships with the Office of Chronic Disease Prevention and Control Services, the Office of Local Public Health Infrastructure and the Office of Minority and Multicultural Health. Priorities within each of these offices align closely with those of the division. The Office of Community Education and Wellness will continue to foster these relationships to maximize resources (funding and staff) and expand access to community-based programs.

This intradepartmental partnership fostered the imbedding of CDSMP into local health departments and state-funded chronic disease programs. From the initial steps of establishing the Chronic Disease Self-Management Program (CDSMP), staff with DHSS' Chronic Disease Prevention and Control Services Office has been engaged as master trainers and lay leaders. This includes the state's chronic disease director, who is a master trainer and committed program champion. The office has established policy to integrate CDSMP into its asthma, diabetes, and cardiovascular health programs. The Office of Public Health Infrastructure, which oversees the state's 115 local health departments, has supported CDSMP by promoting the program among the local health departments, particularly in response to the priorities identified in the networks' recently completed needs assessment process.

One of the bedrock partnership efforts between public health and the aging services networks has been the annual influenza immunization drives. At the state level, seniors are urged to visit the

DHSS website or call their AAA through a single, statewide toll-free number to locate a flu clinic in their area. At the local level, AAAs promote immunization and work with their local health departments to host clinics in senior centers, nutrition sites and within retirement communities. In 2008, the division and the AAAs were invited to join, and continue to participate on, the New Jersey Influenza Advisory Committee (IAC), a diverse body of professionals lending their expertise to combating seasonal and pandemic influenza.

Strategies

- Imbed the CDSMP into the Office of Chronic Disease Prevention and Control Services' asthma, cardiovascular disease and diabetes programs.
- Promote evidence-based disease prevention programs to local health departments to address priorities in their recently completed Community Health Improvement Plans.
- Raise awareness among the Office of Minority and Multicultural Health's provider networks, including faith-based organizations, of the proven benefits of evidence-based health programs that can help to address health disparities.
- Provide leadership to state groups striving to advance the health and wellness of older adults, including the leadership of the Health Promotion Subcommittee, the New Jersey Interagency Council on Osteoporosis and its Falls Prevention Workgroup, the State Chronic Disease/ Health Promotion Steering Committee, Leadership in New Jersey Partners: Aging, Mental Health and Substance Abuse, and the newly formed New Jersey Health Literacy Coalition.

Performance Measures

- Increased number of evidence-based disease prevention programs supported through New Jersey's public health offices.
- Older adult health and evidence-based disease prevention programs included in the integrated chronic disease plan of the Department of Health and Senior Services.

Objective 3.4: Promote the use of the prevention benefits under Medicare.

Progress Update 2005-2009

The Division of Aging and Community Services produced and distributed "A Guide to Community-Based Long Term Care in New Jersey" to encourage mid-age adults and caregivers to broadly consider and plan for long term care needs. More than 40,000 copies of the 10-section guide were distributed statewide, providing information on medical, housing, financial, legal and social service issues. The guide was placed on the division's website. A minimum of two people in each county-based State Health Insurance Assistance Program (SHIP) office were trained on long-term care issues, making expertise available on a local level.

Strategies

- Utilize all tools/resources provided by the Centers for Medicare & Medicaid Services to promote awareness and utilization of Medicare's prevention benefits. Specifically, Medicare's double-sided prevention benefits sheet will be distributed at all presentations given to consumers and professionals. Thrice annual SHIP counselor training will include a focus on the prevention benefits and strategies for encouraging utilization.
- Highlight and update the Medicare prevention benefits as necessary in the Federal Programs for Older Persons resource directory. The directory is distributed annually to aging network information and assistance units and is on the division's website.

- Promote prevention benefits by integrating them into all activities undertaken as part of NJ's activities under the *Medicare Improvements for Patients and Providers Act (MIPPA) for Beneficiary Outreach and Assistance* grant.

Performance Measures

- SHIP counselors receive regular update training on prevention benefits and methods for encouraging utilization among individuals they counsel.
- Track number of people educated on prevention benefits through the MIPPA grant.

Objective 3.5: Strengthen the nutrition program for the elderly.

Progress Update 2005-2009

Through a three-year Comprehensive Planning Grant from the U.S. Administration on Aging (AoA), the division redefined its nutrition program for the elderly under Title III CI and CII as a full-service community program in a comprehensive and coordinated system of home and community–based services. Outcomes of the *Mission Nutrition* initiative included: a revised state policy for reporting nutrition program costs through the Area Plan Contract; a module for integrating nutrition assessment into the Aging and Disability Resource Connection (ADRC) intake process, and a "Directory of Promising Practices for Diverse Populations" that was developed and distributed nationally.

Across New Jersey, there has been a rising demand for home delivered meals. In 2008, the AAA Advisory Councils, along with seniors across the State, organized a campaign in which paper plates were sent to the State Legislature. The senior constituents mailed actual paper plates with a printed message asking for support of the nutrition programs for the elderly. This advocacy demonstrated that nutrition was a priority need. Indeed, over 8,000 seniors served in 2008 were evaluated to be at high nutritional risk.

With the economic crisis in New Jersey, the American Recovery and Reinvestment Act (ARRA) dollars could not have come at a better time. The influx of the ARRA dollars in April 2009 enabled New Jersey to begin to eliminate the waiting list for home delivered meals. The State received more than $2.6 million in funding to support an expansion of senior nutrition services statewide. Currently, the Nutrition Program for the Elderly provides about 6 million meals each year helping 63,000 seniors either at home or at nutrition sites. With the new funding it is estimated that New Jersey will be able to serve an additional 100,000 meals to thousands of seniors. The AAAs have responded by eliminating waiting lists and adding new meal programs where none existed and some were able to create jobs to support the expansion.

Strategies

- Continue advocacy efforts to reach those who may be on waiting lists or who have not yet been identified through education, peer support and the coordinated efforts of the AAAs and their Advisory Councils.
- Track the data, including the waiting lists, number of people served, meals served, jobs created or saved and the amount of ARRA funds expended.

- Ensure that the Older Americans Act Nutrition Program for the Elderly is fiscally sound by the yearly budget review in accordance with the division's policy Nutrition Program Budget Preparation – PM 2007 – 13, III – 7.
- Review AAA requests for direct service waivers for nutrition to ensure the most effective and efficient nutrition programs for the elderly.

Performance Measures
- Decrease waiting lists for all nutrition services.
- Increase number of congregate meal sites opened or saved.
- Increased attendance at congregate meal sites.
- Fully expended ARRA budget.
- Increased accountability within all nutrition programs.

Goal 4 Ensure the Rights of Older People and Prevent their Abuse, Neglect and Exploitation.

Objective 4.1: Increase reporting of neglect and abuse and decrease such incidents by the Office of the Ombudsman for the Institutionalized Elderly.

Progress Update 2005-2009
Neglect remains the most frequent type of complaint received by the New Jersey Office of the Ombudsman for the Institutionalized Elderly. The daily misery, indignity, preventable decline and premature death cause by neglect in nursing homes remains the most serious challenge. Investigations have shown that the chief causes of neglect in long-term care facilities are low staffing levels and inadequate staff training. Also, the incidents of financial exploitation by family and or friends continue to increase. Most of the complaints for financial abuse come to the Office when the resident is no longer able to pay for their care and the facility is ready to discharge for non-payment. The Office is working with the state's Attorney General Medicaid Fraud Unit to prosecute these cases whenever possible.

Strategies
- Provide effective monitoring of programs and services in long-term care facilities to reduce the incidence of abuse and neglect in long-term care facilities.
- Provide training on mandatory reporting requirements to long-term care facilities to increase reporting.
- Work with the state's Attorney General Medicaid Fraud unit to identify and prosecute incidents of abuse and exploitation of the elderly in long-term care facilities.
- Provide information to families, residents, and the community about the importance of reporting incidents of abuse and neglect.

Performance Measures
- Track number of substantiated complaints received about long-term care facilities and the number of referrals and actual prosecutions of criminal cases.

Objective 4.2: Strengthen the Long-Term Care Ombudsman's capacity to provide information to older consumers on elder rights and consumer protection issues and programs, and educate the public on the importance of such programs.

Progress Update 2005-2009

Verification that a poster is on display in the general area in all long-term care facilities is now required with every site visit by a field investigator. The Office of the Ombudsman for the Institutionalized Elderly has increased the number of in-service trainings to facilities and staff over the last two years with special attention to the assisted living industry. The Office has been involved in a statewide effort to implement a new assisted living disclosure form that is intended to assist consumers in making well informed decisions about long-term care facilities.

Strategies

- Provide nursing home and assisted living home residents with a copy of a pamphlet about the Ombudsman Program and how to access a long-term care Ombudsman.
- Visit long-term care facilities and meet with residents on a regular basis.
- Provide Ombudsman contact posters and resident rights information to all long-term care facilities and encourage staff to prominently display them.
- Work with the media to inform the general public about long-term care resident rights and the Ombudsman Program.
- Continue to provide in-service trainings to long-term care provider staff.
- Recruit, train and assign volunteer ombudsmen to all nursing homes and assisted living facilities.

Performance Measures

- Track the number of complaints of abuse, neglect and exploitation; increase in variation in sources of complaint; the request for information and visitors to website, the increase in intake calls requesting information only; and the increase in number of in-service trainings.

Objective 4.3: Continue to enhance and expand the Regional Ethics Committees to ensure that a person's wishes are honored and not abused at the end of their lives.

Progress Update 2005-2009

The Office of the Ombudsman for the Institutionalized Elderly maintained the 14 Regional Ethics Committees (RECs) that serve the long-term care industry and strengthened its alliance with regional hospital ethics committees and the Medical Society of New Jersey's Ethics Committee. The Office created a pamphlet that was sent to facilities reminding them of the RECs' availability for ethical issues. The Office was involved in court cases around end-of-life decisions.

Strategies

- Revitalize the 14 existing Regional Ethics Committees (RECs).
- Strengthen the existing relationships with the RECs and the ethical committees of hospitals in New Jersey.

- Sensitize nursing home and assisted living administrators and staff to the special needs and ethical dilemmas confronting their residents and to provide them with the resources to address same, in the form of regional ethics advisory committees.
- Identify opportunities to partner with aging advocacy groups and other interested parties to further public awareness of this important topic.
- Add to the resource library for posting on the Office's Website.
- Prepare materials that will be useful to individuals and families who are planning or facing end-of-life issues.
- Continue making advance directive booklets and other end-of-life planning documents available to the public.

Performance Measures

- Track the increase in the number of members certified to participate on the RECs and increase the number of consultations.
- Measure the participation of each REC in the bi-monthly consortium meeting.

Objective 4.4: Increase consumer knowledge and self-direction in long-term care choices and management.

Progress Update 2005-2009

The Office of the Ombudsman for the Institutionalized Elderly provided numerous outreach training programs to the community on Durable Power of Attorney and Resident's Rights. The Office appeared on local cable stations and radio to promote the office and resident rights issues. Its website is updated regularly and provides links to resources for both the institutionalized elderly and the community-based senior citizen.

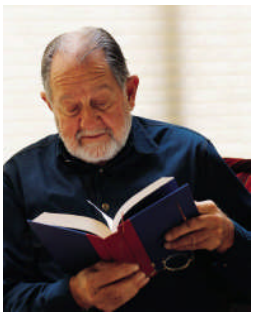
Strategies

- Expand consumer and family education of long-term care choices, including publishing consumer guides for choosing assisted living and residential care facilities.
- Conduct training for older citizens and their families, attorneys and social service providers about long term care options, resident rights and remedies.
- Promote local efforts to educate older citizens about tax relief programs, Medicaid rules, retirement planning, and long-term care insurance.
- Train lawyers, social service workers, and elders to know and enforce the rights of those residing in facilities, including the benefits and limitations of the Durable Power of Attorney.

Performance Measures

- Secure the adoption of the Assisted Living Disclosure Form regulation for consumers.
- Track the number of outreach programs and attendees; the number of lawyers and social services professionals trained; the number of presentations and seminars made; the number of press releases and newsletters disseminated and media contacts made, and the number of mass mailing of informative letters (i.e. *Messages from the Ombudsman*) that are done.

Objective 4.5: Develop in the Office of the Public Guardian for Elderly Adults a group of qualified registered professional guardians to augment public guardianship.



Progress Update 2005-2009

In 2006, the Professional Guardianship Registration law came into effect. It provides for the registration and oversight of private professional guardians. The Office of the Public Guardian for Elderly Rights (OPG) is responsible for screening and verifying a private professional guardian's eligibility and registration, including successful completion of criminal, child abuse and domestic violence background checks. The law also requires education programs for persons working as registered professional guardians.

Strategies

- Create and disseminate regulatory standards and procedures for registration as a private professional guardian.
- Develop and implement protocols for monitoring private professional guardians and handling complaints of abuse, neglect and exploitation by such professionals.
- Work with the state judiciary and pertinent public organizations to identify individual matters particularly suited to private professional guardianship.

Performance Measures

- Create a list of registered professional guardians approved for participation in the Office of the Public Guardian Registered Professional Guardian program (OPG-R).
- Track statistics regarding diversion of complex cases from public guardianship to registered professional guardians.
- Monitor quantity and outcomes of OPG-R investigations of reported abuse, neglect and exploitation by registered professional guardians.

Objective 4.6: Raise awareness through the Office of the Public Guardian for Elderly Adults of the growing numbers of frail elderly with mental illness in need of specialized guardianship services, and increase awareness among those serving this population.

Progress Update 2005-2009

The Office of the Public Guardian for Elderly Adults (OPG) has been receiving an increasing number of requests to become the guardian of individuals who are psychiatric patients. While many of these individuals are not candidates for involuntary commitment, their safety is of great concern since they have serious mental health issues.

Strategies

- Collaborate with the Division of Mental Health Services at the Department of Human Services to develop early intervention opportunities for geriatric elderly to avoid institutionalization.
- Promote geriatric placement for incapacitated individuals with mental illness.
- Examine possible biases surrounding end-of-life issues with respect to the incapacitated elderly population suffering from mental illness.

Performance Measures

- Compile statistics to determine whether voluntary psychiatric admissions by guardians result in a pattern of long-term commitment.
- Monitor number of elderly dementia clients moved from inappropriate psychiatric placements to more appropriate geriatric settings.
- Decrease number of medical providers who identify mental illness as a factor in end-of-life decision-making.

Objective 4.7: Advance the public understanding of guardianship alternatives through the promotion of advance planning documents.

Progress Update 2005-2009

The Office of the Public Guardian for Elderly Adults (OPG) has seen a substantial rise in the number of wards since 2005 – an increase of about 35 percent up from 581 to over 900 in 2009. Besides an increase in volume, the cases have also grown increasingly complex, including cases involving non-citizens, persons without any identification, individuals who have been exploited, and persons with serious mental illness.

Strategies

- Enhance the OPG website content regarding alternatives to guardianship.
- Pursue public outreach opportunities regarding the importance of proper planning to targeted senior citizen audiences.
- Work with attorneys, medical providers and ethics professionals regarding emerging issues in end-of-life decision-making and augmentation of instructional directives.

Performance Measures

- Compile statistics regarding the OPG's caseload in proportion to New Jersey's geriatric population.
- Track the proportion of cases in which an individual has attempted advance planning and ascertain reasons for public guardianship in spite of such planning.
- Explore the percentage of individuals in states using advance directive banks for possible implementation in New Jersey.

Objective 4.8: Through Adult Protective Services, support county provider agencies and educate and work with partner agencies to ensure that vulnerable adults are identified and that services are provided to them in order to ensure their safety.

Progress Update 2005-2009

As New Jersey's population ages, that portion considered frail, elderly and at-risk will grow. Consequently, there arises the susceptibility to physical, psychological or sexual abuse, self-neglect or caregiver neglect and financial exploitation. The challenge for Adult Protective Services (APS) is to continue to keep these individuals living independently while protecting their right of self-determination.

Strategies

- Provide each county APS provider agency with funding, technical support and training in support of the aging population's growth and more complex cases.
- Educate the public and other professionals about APS.
- Work with other agencies, including the Divisions of Mental Health Services and Developmental Disabilities within the Department of Human Services.
- Adopt APS regulations.
- Intensify the public awareness campaign through brochures and workshops for professionals and the general public.
- Modify the curriculum of the APS basic training course, advanced worker training and supervisor training to address emerging issues.

Performance Measures

- Monitor provider agencies annually and review case files against performance standards from 2000.
- Complete Memorandums of Understanding with the Divisions of Mental Health Services and Developmental Disabilities at the Department of Human Services.

Objective 4.9: Enhance Legal Services education of seniors and aging network professionals

Progress Update 2005-2009

The Division of Aging and Community Services requires the Area Agencies on Aging (AAAs) to utilize a minimum of 5 percent of the Title IIIB fund they receive for Legal Services. Many counties exceed the minimum plus use other funding sources to help seniors understand and resolve legal issues. Areas of legal assistance most often accessed include: landlord-tenancy, advance directives, and wills and estate planning.

In the current fiscal environment there has been pressure on homeowners of all ages to meet housing and other costs. To prevent foreclosures, many seniors have the option to seek reverse mortgage counseling. The AAAs have provided this counseling as needed.

Strategies

- Host lectures and seminars that provide older adults, caregivers, aging advocates and referral staff information on legal problems and remedies.
- Provide written materials on legal issues affecting seniors and available resources.

Performance Measures

- Lectures and seminars are held at least annually in all 21 counties.
- Written materials are produced, distributed and posted on-line.

Goal 5 Maintain Effective and Responsive Management.

Objective 5.1: To develop and implement a Quality Management Strategy to align with the Centers for Medicare & Medicaid Services' Home and Community-Based Services

Quality Framework and the algorithm for the Aging and Disability Resource Connection.

Progress Update 2005-2009
The Division of Aging and Community Services established five guiding principles to ensure that all activities and efforts meet the needs of older adults. These principles include: leadership, advocacy, consumer direction, cultural competency and quality assurance and improvement.

The Quality Management Strategy was launched in 2008 and involved all programs at the Division of Aging and Community Services. All offices were told to follow the quality improvement continuum and be accountable for quality performance of their roles and responsibilities. A management infrastructure was established to support the strategy that includes: (1) quality management team leaders; (2) a quality review committee, and (3) a senior management component.

Strategies
- Use the Home and Community-Based Services Quality Framework established by the Centers for Medicare & Medicaid Services to establish priority performance areas.
- Identify and select performance indicators, including those necessary to serve as indicator or proxies for mandated federal assurance.
- Identify internal partners and external stakeholders that impact quality of services and involve them in the quality management strategy.
- Analyze data from performance indicators.
- Initiate quality improvement activities as necessary for primary performance areas.
- Accept and incorporate internal recommendations into quality improvement efforts.

Performance Measures
- Data is collected and analyzed.
- Issues are identified, recommendations are made and changes in policies and procedures result to the benefit of services and programs.

Objective 5.2: Ensure accountability of Area Agencies on Aging under the Older Americans Act through a comprehensive annual assessment procedure.

Progress Update 2005-2009
The performance measures for the assessment of services under Title III of the Older Americans Act were reviewed and updated annually. The Area Agencies on Aging (AAA) were able to give input into the measures and evaluation process. As part of the annual process, each AAA completed an evaluation of the division's performance and identified areas for training. The feedback was valuable for continuous quality improvement. Through onsite visits, quarterly and annual performance reports, the Office of AAA Administration can provide detailed information on the local AAAs and their progress in meeting the objectives outlined in their Area Plans.

Strategies
- Annually, review and update all sections of the AAA Self-Assessment Tool.

- Conduct a desk review of the required documentation for all 21 counties and perform an on-site assessment visit to seven counties every year.
- Conduct additional on site assessments of counties as necessary.
- Complete post-assessment activities: i.e., review AAAs' corrective actions, provide technical assistance, and prepare final assessment letter and report for AAA and county government officials.

Performance Measures

- The assessment scores improve.
- Increased programmatic and fiscal accountability and data gathering result.

Objective 5.3: Ensure that the Division of Aging and Community Services provides superior service delivery to the Area Agencies on Aging.

Progress Update 2005-2009

Ongoing support and training for the Area Agencies on Aging (AAAs) is critical to ensure the best possible service delivery for New Jersey's seniors. Since 2003, approximately half of the 21 AAAs are under the management of new Executive Directors. By providing orientation, ongoing training and on-site assistance and information exchange, the division has provided support to the network. The division is currently working with the AAAs to fully implement the use of the Social Assistance Management Systems (SAMS) software for automated federal reporting thereby eliminating a long arduous paper process. Over the past three years, the Division of Aging and Community Services and the New Jersey Association of Area Agencies on Aging (NJ4A) finance committee has been meeting to discuss a variety of fiscal issues. In 2007, the group worked collaboratively with the Office of AAA Administration to issue an updated fiscal policy manual. Additionally, the Office of AAA Administration conducted two workgroups over the past year in partnership with the AAAs. The Taxonomy workgroup and the Area Plan Contract Redesign workgroup both proved effective in streamlining service delivery. The division recognizes the strong peer support in our aging services network and the value that the AAAs bring to each other.

Strategies

- Share AAA feedback on the performance of the Division of Aging and Community Services with management team and state staff.
- Supply technical assistance on the Area Plan Contract, fiscal issues and other topics.
- Provide orientations to new AAA Executive Directors at their AAA locations.
- Offer assistance to AAA staff and their service providers as they manage their work to ensure accurate and timely data collection through the use of SAMS software.
- Provide training by State subject matter experts with the support of the division's Training Academy on a variety of topics, including Information and Assistance, Core Care Management and Cultural Diversity.

Performance Measures

- Productive, informative quarterly meetings and conference calls are held with the AAA Executive Directors.
- Regularly scheduled conference calls are held with the New Jersey Association of Area Agencies on Aging.
- Lines of communication remain open between the AAAs and the Division of Aging and Community Services.
- Improved count of unduplicated clients served statewide resulting in meeting federal reporting guidelines.

Objective 5.4: Ensure emergency planners statewide consider the special needs of frail elderly when establishing and implementing disaster response plans.

Progress Update 2005-2009

The New Jersey Division of Aging and Community Services and the 21 Area Agencies on Aging (AAAs) have partnered with Offices of Emergency Management (OEM) at the state and local levels to plan for and respond to natural disasters and other emergencies. The agencies have access to New Jersey's Health Alert Network (NJ LINCS), where up-to-the-minute information and resources on emergent situations, such as H1N1, are posted. The Department of Health and Senior Services recently funded the Department of Human Services to deliver behavioral health services to at-risk populations, including seniors; health and long-term care associations to support their members' emergency preparedness efforts; and NJ LINCS agencies to upgrade preparedness for and response to terrorism, pandemic influenza and other public health emergencies.

As part of the above efforts, the division has developed business continuity plans for operating the State Unit on Aging (the Division of Aging and Community Services) and communicating with the U.S. Administration on Aging and the AAAs in times of emergency. The AAAs: have continuity plans; participate in shelter simulation and disaster drills; distribute information on preparedness to seniors; and participate in other statewide and local initiatives, such as NJ Register Ready, Reverse 911, and distribution of cell phones programmed to call 911.

Strategies

- Continue to partner with state and local OEMs.
- Encourage seniors, through website postings, newsletters and other methods, to enroll in NJ Alert, New Jersey's emergency alert email and texting system, and/or NJ Register Ready, a web-based service that allows New Jersey residents with special needs the opportunity to provide vital information about themselves to emergency response agencies so these agencies can better plan to serve them in a disaster or other emergency situation.
- Establish and maintain local databases of vulnerable individuals and those on the home delivered meal list who would need special assistance in an emergency.

- Provide shelf-stable meals to those participating in the home delivered meal program for use in an emergency.

Performance Measures

- AAA disaster plans and business continuity plans are reviewed during monitoring visits.
- The Division of Aging and Community Services and the AAAs actively promote NJ Alert and NJ Register Ready registration.

Independence, Dignity and Choice in Long-Term Care Act

P.L. 2006 CHAPTER 23
AN ACT concerning long-term care for Medicaid recipients and supplementing Title 30 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*
C.30:4D-17.23 Short title.

1. This act shall be known and may be cited as the "Independence, Dignity and Choice in Long-Term Care Act."

C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.

2. The Legislature finds and declares that:
   a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;
   b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;
   c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;
   d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;
   e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in *Olmstead* v. *L.C.* and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;
   f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health and Senior Services, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global long-term care budgeting process designed to provide the Department of Health

and Senior Services with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;

g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;

h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and

i. The enactment of this bill will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.

3. As used in this act:
"Commissioner" means the Commissioner of Health and Senior Services.
"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.
"Home and community-based care" means Medicaid home and community-based long-term care options available in this State, including, but not limited to, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of

funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner, in consultation with the Commissioner of Human Services, shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) Commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) The provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and

(b) The use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and

(2) Commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:
   a. No later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and
   b. No later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community- based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:
   a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community- based long-term care options available to Medicaid recipients; and annual percentage changes in both long-term care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;

b. Commence the following no later than January 1, 2008:
   (1) Implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;
   (2) Identify home and community-based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;
   (3) Develop and implement with the Commissioner of Human Services a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and
   (4) Develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and
c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.

7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Health and Senior Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health and Senior Services, Human Services and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.
b. The advisory council shall:
   (1) Monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and
   (2) Develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.
c. The advisory council shall comprise 15 members as follows:
   (1) The commissioner, the Commissioner of Human Services and the State Treasurer, or their designees, as ex officio members; and
   (2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the

recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.

d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.
e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

C.30:4D-17.30 Waiver of federal requirements.

8. The Commissioner of Human Services, with the approval of the Commissioner of Health and Senior Services, shall apply to the federal Centers for Medicare and Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

C.30:4D-17.31 Tracking of expenditures.

9. The commissioner, in consultation with the Commissioner of Human Services, shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.

10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.
11. This act shall take effect immediately. Approved June 21, 2006.

Summary of New Jersey's Stakeholder Forum and Public Hearings on New Jersey's State Strategic Plan for Aging

To solicit input into the development of its proposed 2009-2013 Strategic Plan for Aging, DACS held a meeting of nearly 100 key stakeholder's on April 3, 2009. Stakeholders identified and prioritized the needs and developed strategies. Two public hearings were then held on May 13 and May 20, 2009, one for each of the counties in North and South Jersey. At the public hearings, compelling testimony was received from 34 older adults and service providers, testifying to the importance of continued funding for programs and services for older adults.

Top Priorities Identified at the Stakeholder Forum

Access to Services: Includes information and assistance, transportation, cultural competency and education on how to use information technology such as improved telephone automated systems and user-friendly web sites to access information and assistance from home or after hours for caregivers.

Support Services: Includes home modification, coordination of health care and social needs, sufficient home care workers, physical and mental health promotion, insurance issues, caregiver services.

Funding: Increase funding and expand eligibility.

Public Hearings

South Jersey

Main concern: Continue funding of senior centers and services to help older adults maintain independence, dignity and quality of life as they age in their communities.

Summary of specific, essential services most mentioned:

- Transportation to/from senior centers and for doctor visits, shopping and outings
- Meals on Wheels
- Socialization/Recreation to ward off depression and loneliness
- Physical exercise to remain healthy
- Dealing with chronic illness
- Assistance in completing paperwork, paying bills and dealing with difficult situations: *i.e.*, problems with utility providers and personal abuse
- Continued opportunities to volunteer their talents—one gentleman spoke of teaching art classes. Commented that he "retired" and then "refired." Others spoke of gratification as volunteers in a Resident Fix-It Program; Hospice; serving on the Governor's Council on Drug Abuse, and working on a first-in-the-nation Resource Guide for Military, Veterans & Families.

North Jersey

Main concern or message: Continue funding to maintain and increase services.

Summary of Needs:

- Transportation: increase to allow crossing of county lines; outings with few time constraints of many days' advance notice; trips to banks and other non-medical destinations; provide for seniors living in own homes who are isolated.
- Home-based services: expand to seniors living in own homes who are isolated; expand to all seniors; visits by dentists, doctors, nurse practitioners. Provide Personal Emergency Response System (PERS).
- Nutrition Support: more home-delivered meals; healthy foods—Farmers' Market. Seniors need fish and fresh produce.
- Affordable housing: build apartments with two bedrooms so people can share with others, including grandchildren.
- Day Care: limit size of day care so smaller programs can provide services.
- Mental Health Counseling for caregivers and other seniors who do not have caregivers.
- Osteoporosis Prevention services.
- Education on HIV/AIDS for older adults.
- Money/assistance to combat problem with bed bugs in public housing.
- Job Placement assistance for people above the eligibility levels.
- Help with relocation costs from own home to the community.
- Lower taxes for seniors in certain situations; help with renovations, utilities and shopping when the senior is ill.

NJ STATISTICS ON AGING POPULATION 2007 DATA FROM CENSUS

Basic Demographics in 2007

- The total population for all ages in New Jersey was 8,685,920 in 2007. Among them, 18.0% were 60 years of age and older in 2007.

- Females significantly outnumbered males at ages over 60 years. Among people aged 60 years and over in New Jersey in 2007, 42.7% were male and 57.3% were female. Among those aged 85 years and over in New Jersey, 31.1% were male and 68.9% were female.

- Among those aged 60 years and over in New Jersey in 2007, 77.0% were non-Hispanic white, 9.8% were non-Hispanic black, 8.2% were Hispanic, and 4.8% were Asian and Pacific Islanders. While population in all racial and ethnic groups increased between 2003 and 2007, Hispanic and Asian population increased at a faster rate than non-Hispanic whites and blacks.

- In 2007, people aged 60 years and over exceeded 25% of the county total population in Ocean and Cape May counties.

- More than half (56.4%) of the New Jersey population 60 years of age and older in 2007 resided in seven counties: Bergen (182,706), Ocean (143,967), Middlesex (130,560), Essex (126,434), Monmouth (118,088), Union (91,415), and Morris (90,231).

- About 58.3% of the New Jersey minority population 60 years of age and older in 2007 resided in five counties: Essex (61,618), Hudson (49,079), Bergen (35,920), Middlesex (31,919), and Union (31,062).

- Within counties, the percent of the total population 60 years of age and over that are racial and ethnic minorities ranged from 4.6% (Hunterdon) to 54.7% (Hudson). Essex (48.7%), Union (34.0%), and Passaic (33.3%) counties had the largest concentration of minorities after Hudson County.

- Nearly 35% of Essex County's population aged 60 years and over were non-Hispanic blacks. Other counties that also had a high proportion of non-Hispanic black population were: Union (16.5%), Mercer (15.0%), Camden (13.4%), and Atlantic (13.0%).

- Hudson County had the highest proportion of Hispanic among the population aged 60 years and over (36.5%), followed by Passaic (18.8%) and Union (14.0%).

- Middlesex County had the largest proportion of Asian and Pacific Islanders among their senior population (10.5%), followed by Hudson (9.1%), Bergen (8.0%), and Somerset (7.6%).

English Proficiency, 2000

- Among people aged 60 years and over in New Jersey in 2000, 4.2% did not speak English well and an additional 2.3% did not speak English at all.

- Nearly a quarter of Hudson County's population aged 60 years and over either did not speak English well (14.2%) or did not speak it (10.1%) in 2000. Passaic and Union counties also had a high proportion of people aged 60 years and over who had limited English skills. In Passaic County, 7.3% did not speak English well and 5.1% did not speak English at all. In Union County, 6.3% did not speak English well and 3.4% did not speak English at all.

Table X. Limited English proficiency by age group and county for population aged 60 years and over, New Jersey, 2000

County	Population Total (60+ years)			60-64 years			65-74 years			75-84 years			85 years and over		
	Total	Speak English not well" (%)	Speak English "not at all" (%)	Total	Speak English not well" (%)	Speak English "not at all" (%)	Total	Speak English not well" (%)	Speak English "not at all" (%)	Total	Speak English not well" (%)	Speak English "not at all" (%)	Total	Speak English not well" (%)	Speak English "not at all" (%)
New Jersey	1,443,655	4.2	2.3	330,620	5.3	2.3	577,440	4.5	2.4	402,195	3.1	2.1	133,400	3.0	2.0
Atlantic	44,600	2.5	1.1	10,515	3.3	1.6	18,320	2.8	1.1	11,965	1.5	0.9	3,795	1.3	0.8
Bergen	172,980	5.2	2.0	38,515	6.4	2.1	68,745	5.5	2.0	49,110	4.4	2.1	16,615	3.6	2.0
Burlington	70,160	1.2	0.4	16,915	1.9	0.3	29,165	1.0	0.2	18,675	1.0	0.6	5,400	1.3	0.7
Camden	82,850	2.2	1.2	19,195	3.1	1.1	33,165	2.0	1.5	23,160	1.6	0.8	7,325	2.3	1.1
Cape May	26,605	0.8	0.1	5,835	0.5	0.0	10,680	1.1	0.3	7,510	0.5	0.1	2,580	0.6	0.0
Cumberland	24,430	2.9	2.0	5,530	4.5	1.7	9,705	2.3	2.2	6,855	2.6	2.2	2,340	2.8	1.1
Essex	125,575	5.3	2.9	30,745	6.0	3.2	49,950	6.3	3.2	32,860	3.7	2.6	12,015	3.2	2.6
Gloucester	39,420	0.9	0.1	9,850	0.8	0.0	15,990	1.1	0.2	10,575	1.0	0.2	3,000	0.3	0.3
Hudson	93,125	14.2	10.1	23,155	18.2	9.2	37,300	16.0	10.8	24,575	10.1	9.6	8,095	6.7	10.4
Hunterdon	16,720	1.4	0.2	4,525	1.3	0.1	6,840	0.6	0.1	4,005	2.2	0.5	1,350	3.7	0.7
Mercer	56,860	2.4	1.1	12,960	1.9	1.0	22,085	2.5	1.2	16,270	2.5	1.0	5,550	2.9	1.4
Middlesex	119,560	4.7	2.6	27,155	5.5	2.7	48,870	5.2	2.5	34,500	3.5	2.8	9,035	3.9	2.5
Monmouth	100,570	2.4	0.8	23,320	2.0	0.6	40,845	2.7	0.9	27,160	2.4	0.8	9,245	2.5	0.8
Morris	74,285	2.7	1.4	19,825	3.2	1.4	29,135	2.6	1.5	18,705	2.4	1.6	6,620	2.3	0.9
Ocean	135,950	1.1	0.3	22,710	1.5	0.2	54,420	1.0	0.2	43,465	1.1	0.3	15,355	1.3	0.3
Passaic	77,175	7.3	5.1	18,070	9.8	5.1	30,370	8.1	6.3	21,265	5.1	3.9	7,470	5.0	3.5
Salem	11,925	0.6	0.1	2,645	0.6	0.2	4,675	0.7	0.0	3,560	0.4	0.0	1,045	1.0	0.4
Somerset	43,975	2.9	1.5	10,590	3.3	0.9	17,835	2.9	1.6	11,430	2.1	2.1	4,115	3.8	0.4
Sussex	18,315	0.9	0.3	5,290	0.6	0.2	7,070	0.9	0.2	4,190	1.3	0.2	1,770	0.6	1.4
Union	91,660	6.3	3.4	19,535	9.6	3.4	35,595	7.1	3.7	27,515	3.8	3.1	9,015	4.3	2.9
Warren	16,915	1.2	0.1	3,735	1.2	0.0	6,675	1.0	0.1	4,840	1.3	0.2	1,665	1.2	0.2

Universe: Population 60 years and over
Source: Census 2000 Special Tabulation on Aging
Table 1. Estimated population aged 60+ years by age group, gender, and race/ethnicity, New Jersey, 2007

Age Group	Total	All Races		Non-Hispanic White		Non-Hispanic Black		American Indian and Alaska Native		Asian and Pacific Islander		Hispanic	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	1,565,195	668,122	897,073	516,622	689,199	59,940	92,677	1,123	1,448	34,848	40,708	55,589	73,041
60-64	430,559	203,148	227,411	151,974	165,058	19,155	25,939	357	400	12,599	13,652	19,063	22,362
65-69	315,598	144,768	170,830	106,438	122,913	14,746	21,086	247	274	9,533	9,770	13,804	16,787
70-74	252,956	111,281	141,675	84,696	105,183	10,869	16,483	189	277	5,877	6,947	9,650	12,785
75-79	222,304	91,359	130,945	73,950	104,262	7,409	12,311	143	197	3,456	4,888	6,401	9,287
80-84	174,592	64,987	109,605	54,745	91,740	4,436	8,732	102	134	1,900	3,015	3,804	5,984
85+	169,186	52,579	116,607	44,819	100,043	3,325	8,126	85	166	1,483	2,436	2,867	5,836
Total by Race/Ethnicity:		1,565,195		1,205,821		152,617		2,571		75,556		128,630	
Percent of Total:		100.0		77.0		9.8		0.2		4.8		8.2	

Source: National Center for Health Statistics and U.S. Census Bureau

Table 2. Estimated population aged 60 years and over by age group and county, New Jersey, 2007 (frequency and percent)

Geographic Name	Population Total	60-64		65-69		70-74		75-79		80-84		85+	
		Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
New Jersey	1,565,195	430,559	27.5	315,598	20.2	252,956	16.2	222,304	14.2	174,592	11.2	169,186	10.8
Atlantic	50,081	12,549	25.1	10,096	20.2	8,890	17.8	7,604	15.2	5,783	11.5	5,159	10.3
Bergen	182,706	50,497	27.6	36,776	20.1	29,017	15.9	25,799	14.1	20,391	11.2	20,226	11.1
Burlington	80,299	22,117	27.5	16,451	20.5	13,491	16.8	11,968	14.9	8,857	11.0	7,415	9.2
Camden	87,510	24,543	28.0	17,434	19.9	14,046	16.1	12,454	14.2	9,945	11.4	9,088	10.4
Cape May	25,548	5,676	22.2	4,874	19.1	4,398	17.2	4,238	16.6	3,194	12.5	3,168	12.4
Cumberland	26,560	7,147	26.9	5,386	20.3	4,387	16.5	3,769	14.2	3,103	11.7	2,768	10.4
Essex	126,434	35,939	28.4	26,690	21.1	20,310	16.1	16,610	13.1	13,000	10.3	13,885	11.0
Gloucester	46,348	13,427	29.0	9,750	21.0	7,627	16.5	6,636	14.3	4,939	10.7	3,969	8.6
Hudson	89,658	24,597	27.4	19,225	21.4	14,822	16.5	12,123	13.5	9,117	10.2	9,774	10.9
Hunterdon	22,383	7,924	35.4	4,865	21.7	3,302	14.8	2,667	11.9	1,926	8.6	1,699	7.6
Mercer	61,042	17,270	28.3	12,220	20.0	9,741	16.0	8,406	13.8	6,892	11.3	6,513	10.7
Middlesex	130,560	35,788	27.4	26,343	20.2	21,024	16.1	19,006	14.6	14,994	11.5	13,405	10.3
Monmouth	118,088	35,479	30.0	24,115	20.4	18,975	16.1	15,905	13.5	12,148	10.3	11,466	9.7
Morris	90,231	28,653	31.8	19,690	21.8	14,385	15.9	11,607	12.9	8,451	9.4	7,445	8.3
Ocean	143,967	26,773	18.6	22,557	15.7	24,123	16.8	25,471	17.7	21,925	15.2	23,118	16.1
Passaic	82,343	23,046	28.0	17,293	21.0	13,222	16.1	11,184	13.6	8,809	10.7	8,789	10.7
Salem	12,660	3,524	27.8	2,542	20.1	1,939	15.3	1,771	14.0	1,466	11.6	1,418	11.2
Somerset	53,673	16,034	29.9	11,522	21.5	8,708	16.2	7,301	13.6	5,172	9.6	4,936	9.2
Sussex	23,928	8,534	35.7	5,298	22.1	3,517	14.7	2,797	11.7	1,919	8.0	1,863	7.8
Union	91,415	25,550	27.9	18,638	20.4	13,876	15.2	12,164	13.3	10,353	11.3	10,834	11.9
Warren	19,761	5,492	27.8	3,833	19.4	3,156	16.0	2,824	14.3	2,208	11.2	2,248	11.4

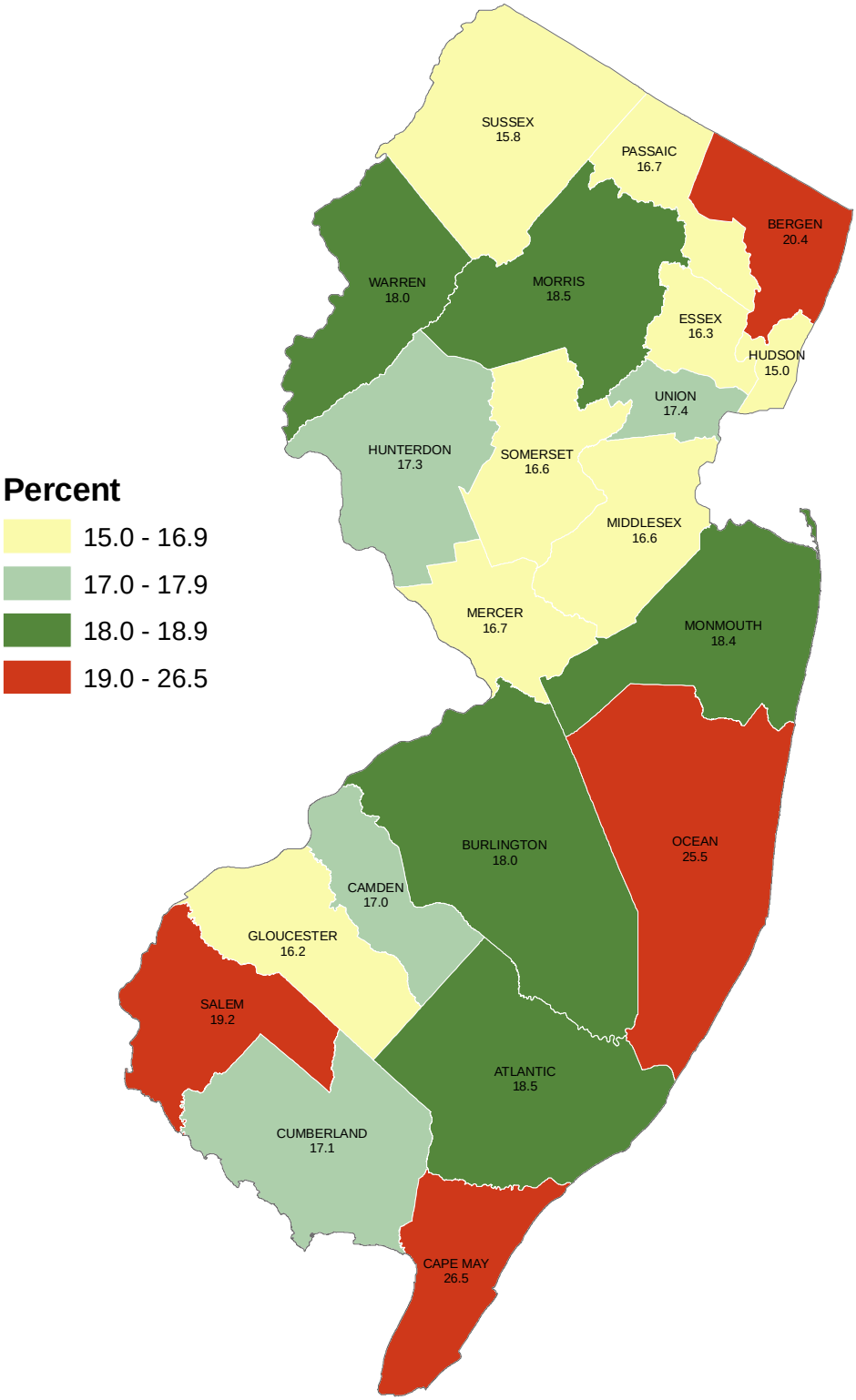
Source: National Center for Health Statistics and U.S. Census Bureau

Table 3. Estimated population aged 60 years and over by race/ethnicity and county, New Jersey, 2007 (frequency and percent)

Geographic Name	Population Total	Non- Hispanic White		Non-Hispanic Black		American Indian and Alaska Native		Asian and Pacific Islander		Hispanic	
		Total	%	Total	%	Total	%	Total	%	Total	%
New Jersey	1,565,195	1,205,821	77.0	152,617	9.8	2,571	0.2	75,556	4.8	128,630	8.2
Atlantic	50,081	38,305	76.5	6,534	13.0	104	0.2	2,303	4.6	2,835	5.7
Bergen	182,706	146,786	80.3	7,852	4.3	201	0.1	14,606	8	13,261	7.3
Burlington	80,299	66,099	82.3	9,883	12.3	171	0.2	2,327	2.9	1,819	2.3
Camden	87,510	67,926	77.6	11,724	13.4	201	0.2	3,331	3.8	4,328	4.9
Cape May	25,548	24,260	95.0	821	3.2	29	0.1	156	0.6	282	1.1
Cumberland	26,560	20,071	75.6	3,120	11.7	215	0.8	310	1.2	2,844	10.7
Essex	126,434	64,816	51.3	43,407	34.3	290	0.2	4,659	3.7	13,262	10.5
Gloucester	46,348	40,741	87.9	4,027	8.7	95	0.2	776	1.7	709	1.5
Hudson	89,658	40,579	45.3	7,987	8.9	205	0.2	8,186	9.1	32,701	36.5
Hunterdon	22,383	21,349	95.4	200	0.9	17	0.1	498	2.2	319	1.4
Mercer	61,042	45,984	75.3	9,139	15.0	93	0.2	3,070	5	2,756	4.5
Middlesex	130,560	98,641	75.6	7,918	6.1	176	0.1	13,657	10.5	10,168	7.8
Monmouth	118,088	102,158	86.5	7,709	6.5	142	0.1	4,177	3.5	3,902	3.3
Morris	90,231	79,086	87.6	2,007	2.2	84	0.1	5,120	5.7	3,934	4.4
Ocean	143,967	136,385	94.7	2,377	1.7	112	0.1	1,485	1	3,608	2.5
Passaic	82,343	55,787	67.7	7,711	9.4	162	0.2	3,164	3.8	15,519	18.8
Salem	12,660	10,788	85.2	1,554	12.3	52	0.4	81	0.6	185	1.5
Somerset	53,673	44,222	82.4	3,048	5.7	51	0.1	4,063	7.6	2,289	4.3
Sussex	23,928	22,721	95.0	209	0.9	23	0.1	278	1.2	697	2.9
Union	91,415	60,353	66.0	15,112	16.5	136	0.1	3,046	3.3	12,768	14.0
Warren	19,761	18,764	95.0	278	1.4	12	0.1	263	1.3	444	2.2

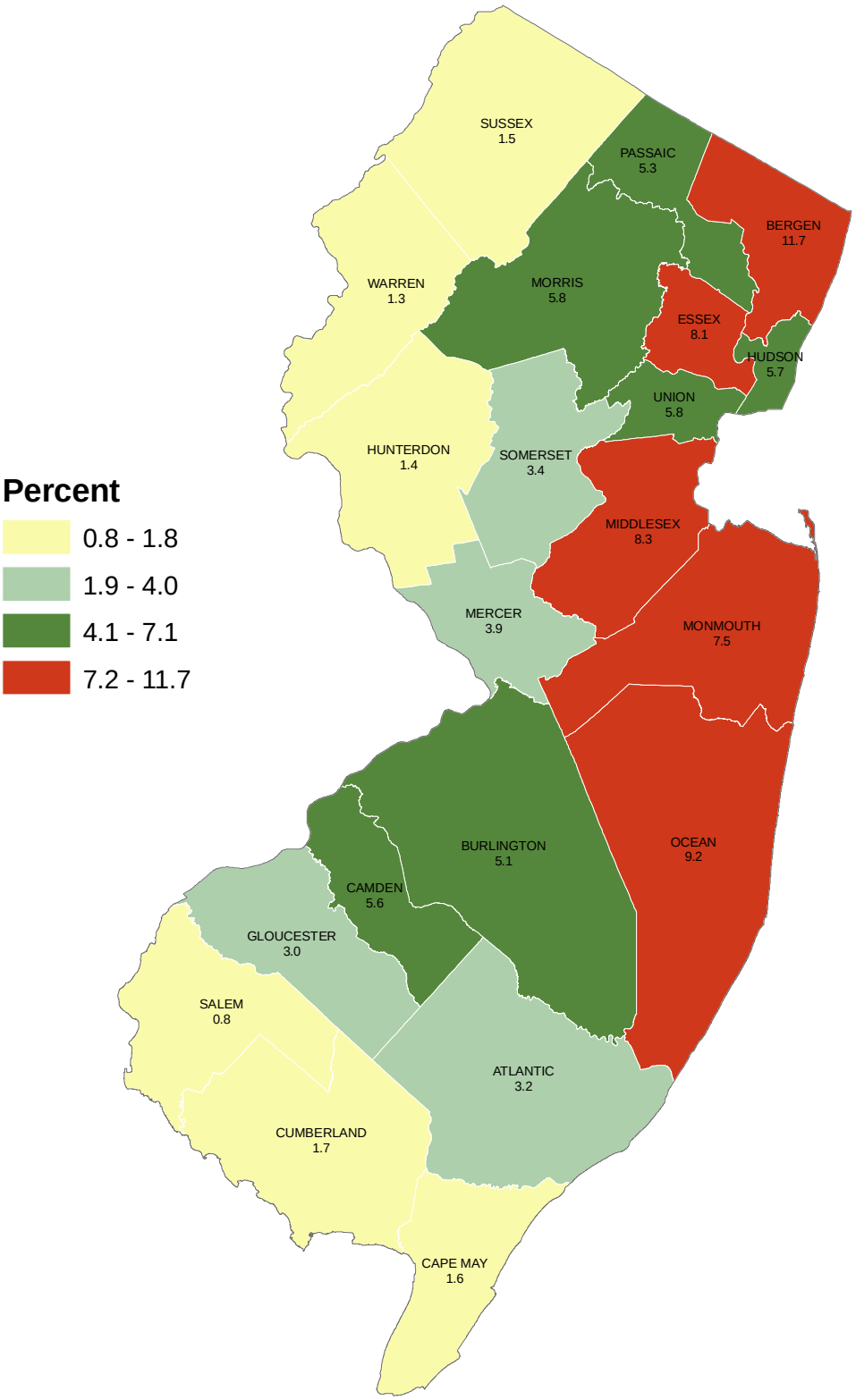
Source: National Center for Health Statistics and U.S. Census Bureau

Map 1. Proportion of county population aged 60 years and over in New Jersey, 2007



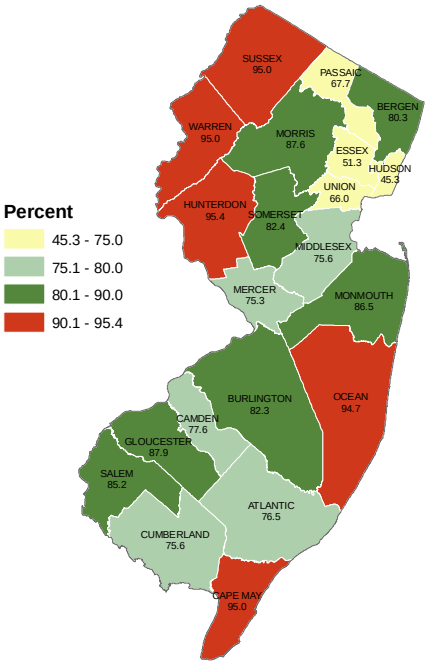
Source: National Center for Health Statistics and U.S. Census Bureau

Map 2. Distribution of New Jersey's population aged 60 years and over, by county of residence, New Jersey, 2007

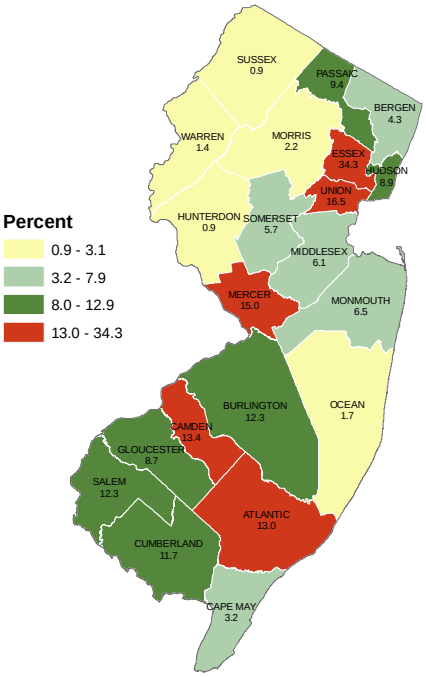


Source: National Center for Health Statistics and U.S. Census Bureau

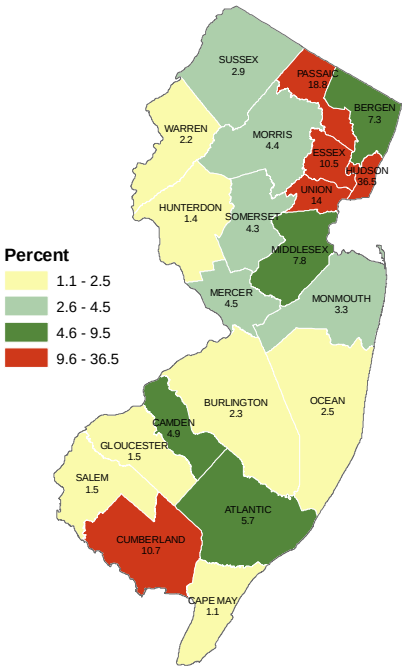
Map 3. Proportion of county population aged 60+ years which is non-Hispanic white, New Jersey, 2007



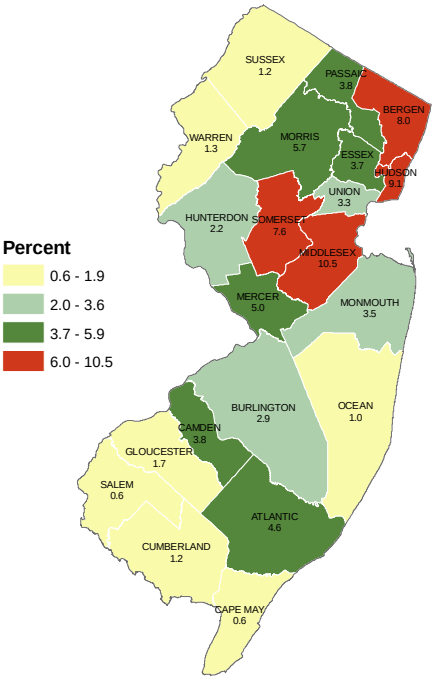
Map 4. Proportion of county population aged 60+ years which is non-Hispanic black, New Jersey, 2007



Map 5. Proportion of county population aged 60+ years which is Hispanic, New Jersey, 2007



Map 6. Proportion of county population aged 60+ years which is non-Hispanic Asian and Pacific Islander, New Jersey, 2007



Source: National Center for Health Statistics and U.S. Census Bureau

Marital Status

Table 4a. Population aged 60+ years by age group, gender, and marital status, New Jersey, 2006-2008

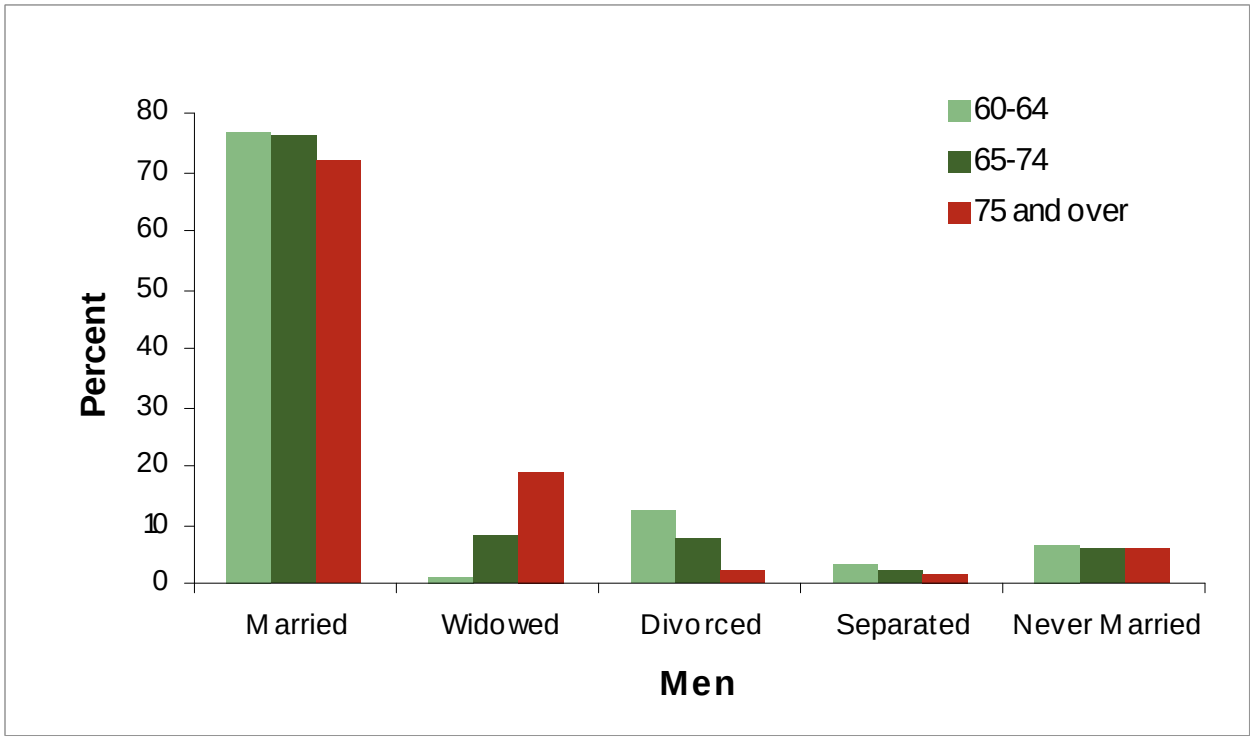
			Marital Status				
	Gender	Population Total	Married	Widowed	Divorced	Separated	Never Married
New Jersey	Male	634,488	475,793	60,984	44,618	14,770	38,322
	Female	853,739	394,213	320,896	72,318	21,019	45,293
60-64	Male	172,781	132,853	1,611	21,468	5,800	11,048
	Female	219,905	132,909	23,021	33,053	6,609	24,313
65-74	Male	257,859	196,161	21,225	18,976	5,839	15,657
	Female	302,463	165,097	98,074	22,850	9,439	7,002
75 and over	Male	203,849	146,779	38,148	4,174	3,131	11,617
	Female	331,371	96,207	199,800	16,415	4,971	13,977

Note: Married includes married, spouse present; married, spouse absent.
Universe: Population 60 years and over
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2008

Table 4a. Population aged 60+ years by age group, gender, and marital status, New Jersey, 2006-2008 (Percent)

			Marital Status				
	Gender	Percent Total	Married	Widowed	Divorced	Separated	Never Married
New Jersey	Male	100	75.0	9.6	7.0	2.3	6.0
	Female	100	46.2	37.6	8.5	2.5	5.3
60-64	Male	100	76.9	0.9	12.4	3.4	6.4
	Female	100	60.4	10.5	15.0	3.0	11.1
65-74	Male	100	76.1	8.2	7.4	2.3	6.1
	Female	100	54.6	32.4	7.6	3.1	2.3
75 and over	Male	100	72.0	18.7	2.0	1.5	5.7
	Female	100	29.0	60.3	5.0	1.5	4.2

Figure 2. Marital status of people aged 60 years and over, by age group and gender, New Jersey, 2006-2008



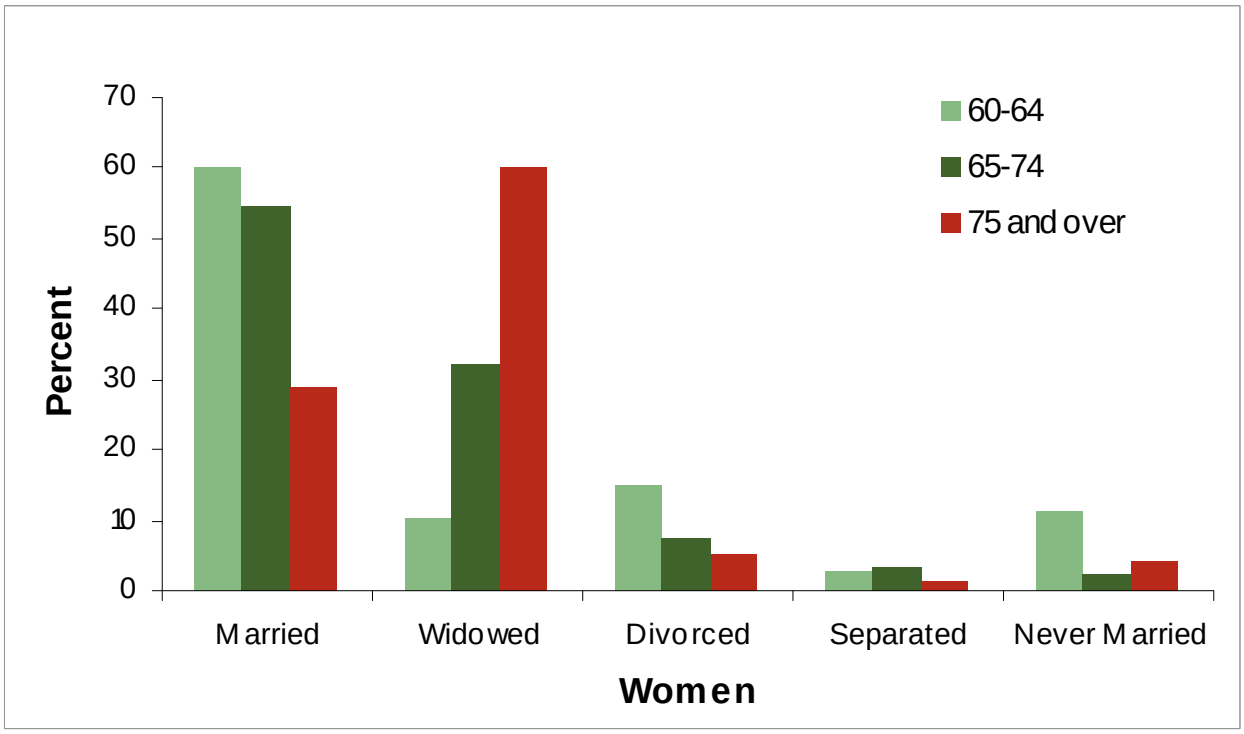
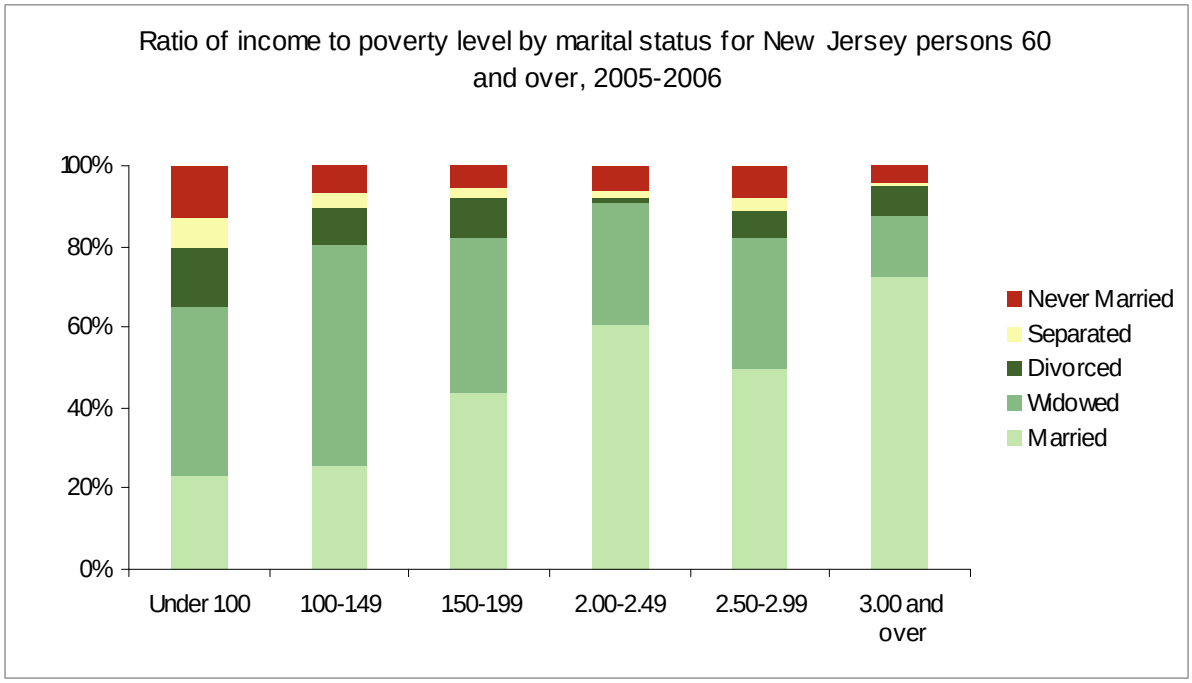


Table 6. Ratio of income to poverty level in 2005 to 2006 by marital status for population aged 60+ years, New Jersey

Ratio of income to poverty level	Population/ Percent Total	Marital Status				
		Married	Widowed	Divorced	Separated	Never Married
Totals	1,467,841	867,631	374,726	114,989	26,660	83,834
Percent	100	59.1	25.5	7.8	1.8	5.7
Under 1.00	112,759	26,420	46,813	16,969	8,265	14,292
Percent	100	23.4	41.5	15.0	7.3	12.7
1.00-1.49	128,402	33,029	69,680	12,359	4,932	8,401
Percent	100	25.7	54.3	9.6	3.8	6.5
1.50-1.99	126,970	55,466	48,716	12,524	3,187	7,077
Percent	100	43.7	38.4	9.9	2.5	5.6
2.00-2.49	163,961	100,124	49,141	2,145	2,403	10,148
Percent	100	61.1	30.0	1.3	1.5	6.2
2.50-2.99	106,541	53,061	34,498	7,076	3,225	8,682
Percent	100	49.8	32.4	6.6	3.0	8.1
3.00 and over	829,209	599,531	125,879	63,917	4,648	35,234
Percent	100	72.3	15.2	7.7	0.6	4.2

Note: Married includes married, spouse present; married, spouse absent.
Universe: Population 60 years and over for whom poverty status is determined
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007.



Marital Status

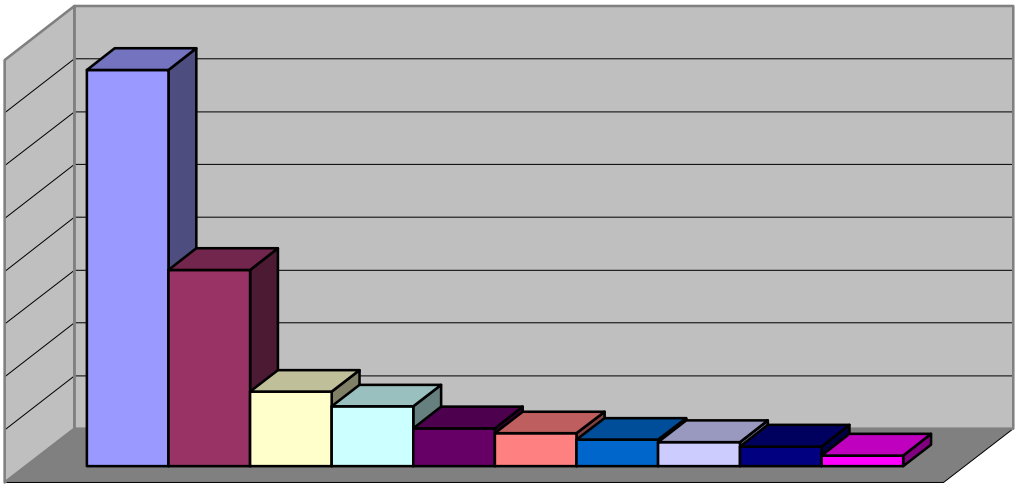
- The majority of New Jersey adults aged 60 years and over were either married or widowed between 2006 and 2008. Older men were more likely to be married than older women.

- The gender difference became larger as age increased. Among those aged between 60 and 64 years, 77% of men compared with 60% of women were married. Among those aged 75 years and over, however, 72% of men were married, compared with only 29% of women.

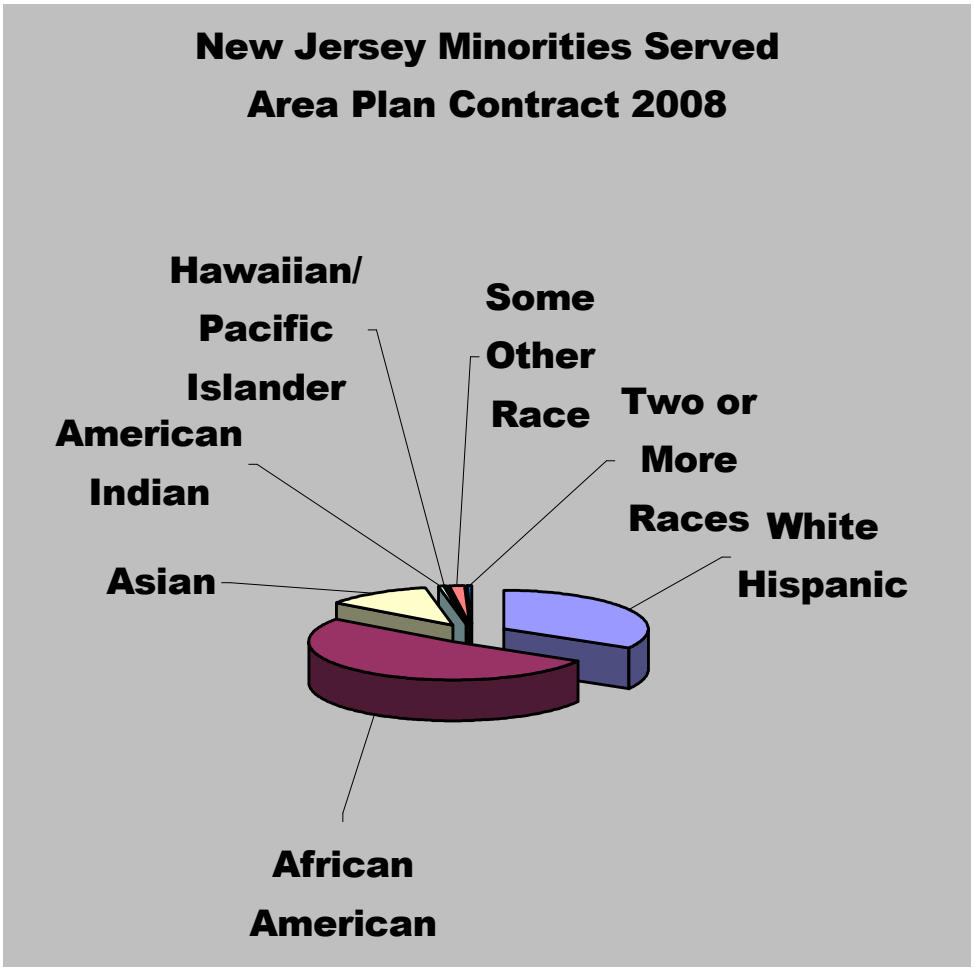
- The percent of women widowed (38%) was nearly four times of the percent of men widowed (10%) for New Jerseyans aged 60 years and over between 2006 and 2008.

- As shown in Table 6, lower income older New Jerseyans were more likely to be widowed and much less likely to be married than people of other income levels.

New Jersey Top Ten APC Services to Seniors Based on Units Served in 2008

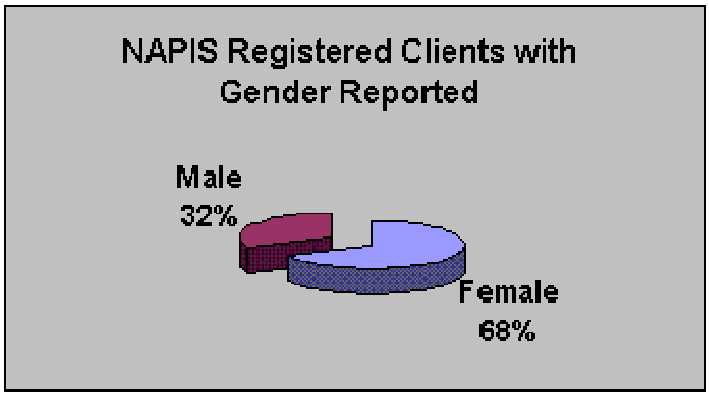


3,753,998 Weekday Home Delivered Meals	1,860,087 Congregate Meals
709,005 Transportation one-way trips	569,249 hours of Social Adult Day Service
360,090 Information & Assistance contacts	313,202 Weekend Home Delivered Meals
251,522 Telephone Reassurance calls	229,727 hours of Certified Home Health Aide
185,982 Adult Protective Service contacts	104,727 Assisted Transportation contacts



NAPIS Services to Seniors

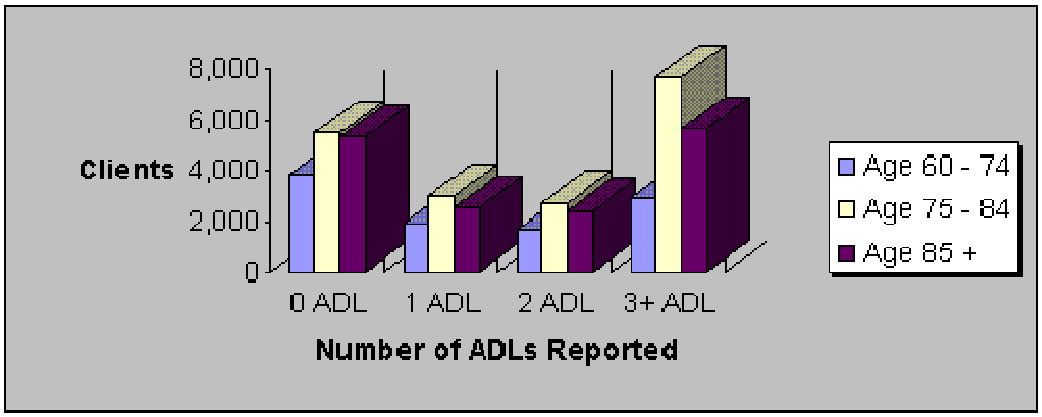
	Total Clients	% Of Total
Total Registered Clients (Clusters 1 and 2)	81,205	
Female	51,273	67.87%
Male	24,268	32.13%
Total with Gender Reported	**75,541**	
In Poverty	23,411	28.83%
Poverty Missing	9,228	11.36%
Live-Alone	35,293	43.46%
Live-Alone Missing	9,543	11.75%
Age Groups		
60 - 74	20,071	27.10%
75 - 84	31,384	42.38%
85 +	22,605	30.52%
Total with Age Reported	**74,060**	



NAPIS Services to Seniors

Total Cluster 1 Clients with Age and ADL Status Reported

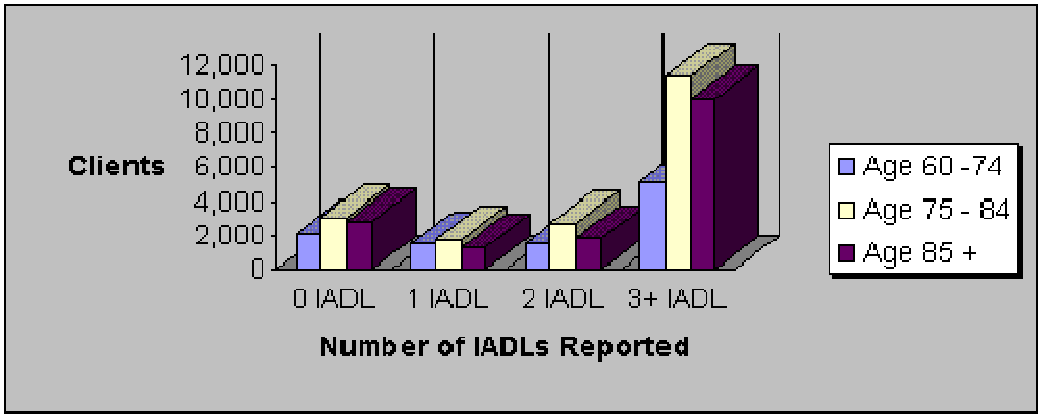
		ADL Status			
Age Groups	**Total**	**0 ADL**	**1 ADL**	**2 ADL**	**3+ ADL**
60 - 74	10,327	3,846	1,909	1,657	2,915
75 - 84	18,820	5,488	2,974	2,702	7,656
85 +	15,901	5,323	2,516	2,404	5,658
Total with Age Reported	**45,048**	**14,657**	**7,399**	**6,763**	**16,229**



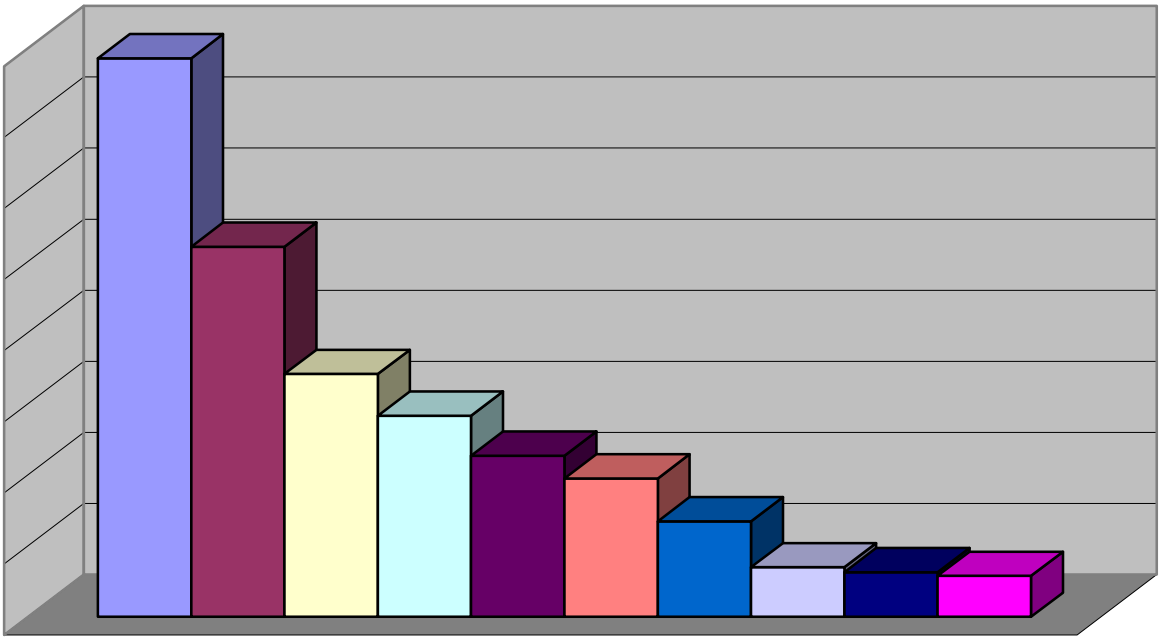
NAPIS Services to Seniors

Total Cluster 1 Clients with Age and IADL Status Reported

		IADL Status			
Age Groups	**Total**	**0 IADL**	**1 IADL**	**2 IADL**	**3+ IADL**
60 - 74	10,327	2,138	1,486	1,561	5,142
75 - 84	18,820	3,030	1,737	2,691	11,362
85 +	15,901	2,781	1,298	1,831	9,991
Total with Age Reported	**45,048**	**7,949**	**4,521**	**6,083**	**26,495**



New Jersey Top Ten APC Services to Caregivers Based on Units Served in 2008



78,580 hours of Respite Care	52,065 hours of Social Adult Day Service	34,171 half hours of Care Management
28,296 hours of Certified Home Health Aide	22,677 Information & Assistance contacts	19,474 hours of Medical Adult Day Service
13,446 Home Delivered Meals	6,978 hours of Education	6,282 Friendly Visits
5,772 Trained Volunteer Assistance visits		

DIVISION OF AGING AND COMMUNITY SERVICES PROGRAM DESCRIPTIONS

The Division of Aging and Community Services (DACS) is responsible for home and community-based services through the receipt of federal funds under the Older Americans Act and is the State Administering Agency for the Medicaid 1915(c) waiver, Global Options for Long-Term Care. The Division is also responsible for preparing the State Strategic Plan on Aging for the U.S. Administration on Aging, serving as the focal point for planning services for the aging, developing comprehensive information about New Jersey's elderly population and its needs, and maintaining information about services available to the elderly throughout the state.

DACS is comprised of five offices: Office of Area Agency on Aging Administration and Finance; Office of Global Options for Long-Term Care/Quality Management; Office of Community Education and Wellness; Office of Community Choice Options; Office of the Public Guardian and Elder Rights; and Office of Administration and Finance.

OFFICE OF ADMINISTRATION AND FINANCE

Program Description:
Oversee and provide administrative and fiscal support to the operational units of DACS, which resulted from the 2002 consolidation of the two divisions in Senior Services responsible for all home and community based services.

AREA AGENCY on AGING (AAA) ADMINISTRATION

Program Description: The Office of AAA Administration is responsible for the oversight of the statewide network of comprehensive community based services provided by the county Area Agencies on Aging (AAAs) through Area Plan Contracts. These services include: information and access services; legal assistance; in-home services; care management; health and wellness programs; congregate and home-delivered nutrition services; and adult protective services.

The Office of AAA Administration also runs the home and community based programs funded through solely through State funding for individuals above the Medicaid income eligibility requirements.
# of Beneficiaries Served Annually: *Over 500,000 individuals*

Senior Nutrition Program

Program Description: Through more than 200 nutrition centers, New Jersey adults 60 years and older receive at least one nutritious meal, five or more days per week in a group or congregate setting. Title III home delivered meals (HDM) are available to homebound persons who are eligible for service based on need due to frailty, disability, illness, or isolation. Each meal meets the nutritional standard of one-third of the Recommended Daily Allowance (RDA), and complies with the Dietary Guidelines for Americans.

The HDM program has been expanded through State funds to meet the growing number of homebound elderly. In 1987 Casino Revenue Funds were allocated to provide weekend and holiday HDM. In 2000, State General funds were allocated to provide supplemental funds to reduce the HDM waiting list of eligible older adults.
# of Beneficiaries Served Annually: *1.9 million meals served to 329,615 individuals in a congregate setting; 4.1 million home-delivered meals to 31,000 individuals (CY2008)*

Adult Day Services Program For Persons with Alzheimer's Disease or Related Disorders

Program Description: The program provides relief and support to family caregivers of persons with Alzheimer's disease or a related disorder through provision of subsidized adult day care services. Clients are provided up to three days of service per week, depending on their need and the availability of funds. Priority is given to those persons in the moderate to severe ranges of dementia. Participants pay a cost-share, based upon a sliding scale.
# of Beneficiaries Served Annually: *711 individuals in CY2008*

Alzheimer's Disease Demonstration Grant

Program Description: In 2007, the DHSS was one of three states awarded the *Translating Evidence-Based Alzheimer's Diseases and Related Dementia Direct Services Research into Practice* grant from AoA. With $187,500 in funding, the grant's model will replicate the National Institute on Aging-sponsored Philadelphia Resources Enhance Alzheimer's Caregiver Health (REACH) Initiative, a nationally renowned research project in the field. The initiative targets persons with Alzheimer's Disease or related disorders and their caregivers. In 2005 and 2006, the DHSS received $150,000 in federal funding from AoA for another Alzheimer's Disease Demonstration grant—*Environmental Interventions for Dementia Care*.

Congregate Housing Services Program

Program Description: Congregate housing is defined as "subsidized" housing which incorporates shelter and services needed by the functionally impaired and socially deprived elderly to enable them to maintain or to return to a semi-independent lifestyle. It provides meals, housekeeping, personal care and coordination services in affordable housing. There are 36 providers serving 70 buildings in 17 counties. Participants pay a cost-share, based upon a sliding scale.
# of Beneficiaries Served Annually: *2,833 individuals in CY2008*

Statewide Respite Care Program

Program Description: The Statewide Respite Care Program provides respite care services for elderly and functionally impaired younger adults to relieve their unpaid caregivers of the stress arising from the responsibility of providing daily care. A secondary goal of the program is to help families avoid premature nursing home placement of their loved ones. Services are available for emergency and crisis situations, as well as for routine respite care. Participants pay a cost-share, based upon a sliding scale. Services provided under the Statewide Respite Care Program (SRCP) include: companions; homemaker/home health aides; medical or Social Adult

Day Services; temporary care in licensed health care facilities, including Assisted Living and Adult Family Care; camperships and private duty nursing service.
# of Beneficiaries Served Annually: *4,578 families in CY2008*

OFFICE OF GLOBAL OPTIONS FOR LONG-TERM CARE/QUALITY MANAGEMENT

The Office of Global Options for Long-Term Care/Quality Management is facilitating and coordinating a multi-year change process to redesign New Jersey's long-term care system across the target populations. This is being done by: (1) developing/implementing a process that rebalances the overall allocation of funding from institutional care to home and community-based services (HCBS); (2) developing/implementing a consumer assessment instrument that expedites authorization of HCBS, prior to formal financial eligibility determination, through fast-track eligibility; (3) developing/implementing a web-based data system that will track expenditures by consumer, provider, and types of services authorized and utilized; (4) developing/implementing a statewide system of long-term care service coordination and management; (5) developing/implementing a comprehensive quality management strategy to assure and improve New Jersey's HCBS long-term care system; and (6) establishing a comprehensive HCBS long-term care system that is visible accessible, helpful and trusted by residents, regardless of financial need or health status.

GO provides a broad array of supportive services to enable nursing home residents who are clinically and financially approved for long-term care through Medicaid to return to the community. Participants are eligible for all NJ Title XIX Medicaid State Plan services authorized in a plan of care except for Personal Care Assistant and Medicaid Hospice. In addition, participants are eligible for 14 waiver services ranging, from assisted living and homemaker services to respite care and special medical equipment.

This Office also has administrative and fiscal responsibilities for Global Options for Long-Term Care (GO), the state-funded Jersey Assistance for Community Caregiving (JACC) and the Programs of All-Inclusive Care for the Elderly (PACE) program.

The following are highlighted initiatives:

Aging and Disability Resource Connection (ADRC)

Program Description: While the ADRC began as a grant initiative in New Jersey with the two pilot counties of Atlantic and Warren, the ADRC has become the primary catalyst for rebalancing long-term care in New Jersey. Consumers are informed about appropriate long-term care options and based on their eligibility criteria, they are counseled on appropriate home and community based services. Starting in 2008, the Division began planning and implementation for the expansion of the ADRC business model across the State. The Division anticipates that the ADRC model will be expanded to all counties by the end of 2010 with the support of the Social Assistance Management Systems (SAMS) integrated tracking system.
# of Beneficiaries Served: *The ADRC handled a total of 100,200 contacts in Atlantic and Warren Counties since January 2006—or 66,551 consumers.*

Fast Track Eligibility Determination (Fast Track)

Program Description: Fast Track is the process through which consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria receive home and community based services (HCBS) for up to 90 days while they complete the full Medicaid application and eligibility determination process. Because federal financial participation is not available for services delivered to applicants who are not eligible for Medicaid, the State of New Jersey will pay for services should the applicant be determined ineligible. The Fast Track Eligibility process is operational in all 21 counties and the screening criteria have been broadened to increase program participation.
# of Beneficiaries Served: *The State has had contact with over 11,390 individuals, from December 2007 through June 2009, who were potentially eligible for Medicaid and received counseling on long-term care options. Of this number, 278 individuals received Medicaid services in an expedited fashion.*

Veterans Directed Home and Community Based Service Program

Program Description: The U.S. Department of Veterans Affairs awarded New Jersey $2.5 million in supplemental funding from the U.S. Department of Veterans Affairs to help New Jersey seniors and injured veterans of all ages at risk of nursing home placement to remain in their homes and communities. Partners are DHSS, the Department of Human Services (DHS) and Military and Veterans Affairs (DMAVA); the U.S. Department of Veterans Affairs New Jersey Healthcare System; the Morris County Division on Aging, Disabilities and Veterans; and the Somerset County Office on Aging.
# of Beneficiaries Served*: The New Jersey Lyons Healthcare System has entered into contractual agreements with Morris and Somerset counties and referred 57 veterans for functional assessments, financial counseling and cash management planning (CMP). Tthe average monthly budget is $2,489.50.*

Community Living Program (formerly known as Nursing Home Diversion & Modernization) – In 2007 and 2008 NJ was awarded Nursing Home Diversion and Modernization grants for a total of $1,065,151 to develop and implement a cash-and-counseling model for individuals at risk of nursing home placement and spend down to Medicaid. Building upon the ADRC model, the infrastructure is being developed to support consumer direction and flexible service dollars to enable participants to purchase services that meet their care needs. Additionally, the grants are providing the State with an opportunity to introduce a cost-share sliding scale for home and community-based services. New Jersey is committed to implementing the cash-and-counseling option and cost-share for Older Americans Act programs statewide by 2011.

Training Academy

Program Description: The DACS Training Academy is responsible for developing and delivering training programs for professionals working for the Division of Aging and Community Services, the County Offices on Aging, and other providers of senior services operating in the

State. Major activities include: the four-day Basic Information and Assistance Training for those persons who are the first point of contact for consumers/caregivers seeking information/assistance; the eight-day Core Care Management Training for community-based outreach workers and care managers; and training modules for the ADRC initiative and Global Options for Long-Term Care.

Real Choice Systems Change Grants for Community Living

Program Description: The DHSS, in partnership with the Department of Human Services (DHS), is the recipient of a five-year Systems Transformation Grant of $2.3 million from CMS. It serves as a catalyst for continued infrastructure, process and delivery of long-term support services changes for older adults and persons with disabilities across all income levels. This grant was awarded in 2006.

MEDICAID WAIVER PROGRAM

The Division is the State Administering Agency for the Medicaid 1915(c) waivers called Global Options for Long-Term Care.

Global Options for Long-Term Care (GO)

Program Description: Effective January 1, 2009, the DHSS received approval from the U.S. Centers for Medicare & Medicaid Services (CMS) to consolidate three Medicaid-supported home and community-based service programs currently operated by DHSS into a single program known as Global Options (GO) for Long Term Care.

The three waivers that were consolidated into GO are Community Care Program for the Elderly and Disabled (CCPED); Assisted Living (AL), which offers Medicaid waiver services in residential settings; and Enhanced Community Options (ECO) waiver offers services in the home. The consolidation improves access to a wider range of in-home long-term supportive services for a greater number of seniors and adults with physical disabilities who meet the income, asset and nursing facility level of care requirements established by Medicaid. GO participants have the options to hire and direct their own service providers.

A GO individual is clinically and financially eligible for Medicaid nursing facility level of care. An applicant must be 65 years or older or between the ages of 21 and 64 who shall be determined disabled* by Social Security Administration (SSA) or be determined disabled* by the Division of Medical Assistance and Health Services, Disability Review Section. Additionally, there is a reasonable indication that the recipient might need the level of care provided in a hospital, a nursing facility or an intermediate care facility in the near future (that is, a month or less) unless he or she receives home and community-based services. [* Individuals between the ages of 21 and 64 who are chronically mentally ill, mentally retarded or developmentally disabled may be eligible after a service needs review by the DHSS/DHS Service Review Team.]

GO participants are eligible for all New Jersey Title XIX Medicaid State Plan services authorized in a Plan of Care. They must also receive Care Management services and at least one

additional waiver service. Based upon the person's assessed level of service needs, the participant can choose among a wide selection of waiver services, including Assisted Living/Adult Family Care, Attendant Care, Respite Care and Transportation.
# of Beneficiaries Served Annually: *When GO was approved and implemented on January 1, 2009, about 11,000 Medicaid Waiver participants were seamlessly moved into GO.*

MEDICARE PROGRAM

PACE Initiative

Program Description: In Spring 2009, New Jersey opened its first PACE sites – the CMS' approved managed care model providing a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate. The open PACE sites are operating as LIFE St. Francis (Living Independently For Elders) in Trenton and LIFE at Lourdes Hospital in Pennsauken. Other PACE sites are underway throughout New Jersey and are at various stages of development. Once fully implemented across New Jersey, PACE could assist as many as 3,000 individuals.

STATE-FUNDED COMMUNITY BASED PROGRAMS

Jersey Assistance for Community Caregiving (JACC)

Program Description: Provides 14 in-home services and supports that enable an individual at risk of placement in a nursing home to remain in his/her community home. By providing a uniquely designed package of supports for the individual, JACC is intended to supplement and strengthen the capacity of caregivers, as well as to delay/prevent placement in a nursing home. JACC services individuals who are not eligible for Medicaid or Medicaid waiver services. This program is supported totally with state funds. JACC has a consumer co-pay.
# of Beneficiaries Served Annually: *1,484 individuals in SFY2008*

Office of Community Education and Wellness

The Office of Community Education and Wellness serves to inform and educate consumers and professionals about programs and services for older adults, helping them to make informed decisions for successful aging. There are three program units: Older Adult Health and Wellness; Information, Assistance and Community Outreach; and State Health Insurance Assistance Program (SHIP).

Information, Assistance and Community Outreach

Program Description: The unit is responsible for providing information on and promoting the use of state and federal programs for senior citizens and caregivers via the department's website; one-on-one, toll-free telephone counseling and the development of promotional and educational materials.
# of Beneficiaries Served Annually: *181,500 individuals in CY2007.*

OLDER ADULT HEALTH AND WELLNESS

Program Description: The unit fosters the well-being of older adults and their caregivers through coordinated strategies aimed at evidence-based health promotion; provider and consumer education and the prevention, early detection, and prompt management of disease. Primary areas of concentration include chronic disease self-management, osteoporosis, falls prevention, physical activity, health education and medication management.

Health Promotion Subcommittee
Originally created under the auspices of the New Jersey Commission on Aging, the Health Promotion Subcommittee (HPS) assists DHSS in identifying program priorities, designing and implementing programs, and assessing outcomes. Members include consumer advocates and leaders of community-based provider organizations, hospital administrators and health care providers, academia, state health associations, Area Agencies on Aging and local public health. The HPS serves as the key advisory board for the Chronic Disease Self Management Program (CDSMP) and other evidence-based disease prevention programs (EBDP), and includes representation from each of DACS' major EBDP partners.

HealthEASE

Program Description: Through a grant from the Robert Wood Johnson Foundation in 2002, the Division developed a county-based model for promoting longer and healthier lives for seniors. The model was introduced in Ocean and Bergen counties, and components are now available statewide. Indeed, HealthEASE is now the trademark for the Division's wellness programs. HealthEASE consists of health education and physical activity that is offered in through regional train-the-trainer programs around the State.

Chronic Disease Self-Management Program (CDSMP)

Program Expansion Description: CDSMP is an evidence-based, six-week course designed by Stanford University that meets once a week for 2 ½ hours and is designed to give people with chronic conditions (such as arthritis, heart disease, diabetes, emphysema, asthma, bronchitis, osteoporosis) and/or their caregivers the knowledge, skills and confidence they need to take a more active part in their health care. The program is led by volunteer lay leaders who complete a 4-day training program led by master trainers certified by Stanford University. Participants learn strategies for managing symptoms, working with health care professionals, setting weekly goals, problem-solving, relaxing, handling difficult emotions, eating well, and exercising safely and easily. Established outcomes include reduced hospital days, ER visits and physician visits; better self-reported health; and healthier behaviors.

In 2006, NJ was one of 16 states to receive a three-year grant from the U.S. Administration on Aging to establish two evidence-based disease prevention programs (one of which was CDSMP) in targeted counties. A system to expand and sustain program delivery is being developed through a three-year grant from the National Council on Aging (awarded May 2008). This sustainability grant will build capacity in all 21 counties, with a focus on reaching minority populations. The program will be sustained through partnerships with statewide service delivery systems and more than 100 local agencies. In addition, through a partnership with the

Department's Division of Family Health Services, CDSMP in being integrated into CDC-funded chronic disease programs such as asthma, diabetes and cardiovascular disease; a partnership with the Department's Office of Minority and Multicultural Health is allowing CDSMP to be delivered in multiple languages to targeted minority populations.
# of Beneficiaries Served Annually: *To date, more than 1,000 individuals have participated in the program. An estimated 2,500 will participate over the next two years. As of January 2009, there are master trainers and/or peer leaders in every county.*

A Matter of Balance
In January, 2009*,* a master trainer program was held in NJ to introduce A Matter of Balance in New Jersey. *A Matter of Balance* is a community-based program specifically designed to reduce fear of falling, stop the fear of falling cycle, and improve activity levels among older adults. The program includes eight classes, each lasting two hours, presented over a four-week period by trained coaches using a detailed training manual, two instructional videos and a visit from a guest health professional. The program focuses on practical coping strategies to reduce fear of falling and to diminish the risk of falling.
# of Beneficiaries Serviced Annually: *Program is being piloted in select counties in 2009.*

Osteoporosis/Healthy Bones

Program Description: In 1997, the Osteoporosis Prevention and Education Program Act established the NJ Interagency Council on Osteoporosis. Staff provides leadership to the Council and implement initiatives in the areas of public and professional education and outreach. Peer-led Project Healthy Bones engages older adults in weight bearing exercise and related education on osteoporosis prevention in the 21 counties.

State Health Insurance Assistance Program (SHIP)

Program Description: Trains volunteers in 21 counties to assist Medicare enrollees who have problems or questions about their health insurance. Since the launch of Medicare Part D prescription drug benefit in 2006, the SHIP unit has been playing a major role in educating Medicare beneficiaries statewide about the program. In addition, the SHIP unit will be responsible for implementing the Medicare Improvements for Patients and Providers Act for Beneficiary Outreach and Assistance (MIPPA) funding of $478,139 that New Jersey will receive. The grant runs from June 2009 to May 2011 and will be used to supply outreach and assistance efforts directed towards helping Medicare beneficiaries understand and apply for their Medicare benefits.
# of Beneficiaries Served Annually: *32,611 phone calls and 20,904 in-person contacts in CY2008*

OFFICE OF COMMUNITY CHOICE OPTIONS

The Office of Community Choice Options implements nursing facility level regulations, policies and procedures to ensure that Medicaid beneficiaries in need of long term care receive quality services and appropriate service delivery in the least restrictive care setting. There are three regional Long Term Care Field Offices, which were recently consolidated down from eight locations.

Pre-Admission Screening

Program Description: The Pre-Admission Screening (PAS) program is a care needs assessment process available to persons applying for Medicaid reimbursed long-term care in either nursing facilities or home and community-based alternatives. The PAS program helps applicants and families choose between various long-term care programs, and assists them in securing the selected service delivery placement.
# of Beneficiaries Served Annually: *In 2008, Community Choice Counselors completed more than 47,000 PAS assessments for nursing facility or waiver program placement.*

At-Risk Criteria (ARC) Pre-Admission Screening Initiative

Program Description: In 2006, DHSS launched the At Risk Criteria (ARC**)** Hospital Pre-Admission Screening Initiative in the two ADRC test counties of Atlantic and Warren. The program authorizes a transfer to a nursing home, where the community choice counselor can spend more time counseling the person and family members on more alternative long-term care options. By March 2008, the Hospital PAS was operating statewide.
# of Beneficiaries Served: *In 2008, 7,406 individuals were served by the ARC Pre-Admission Screening.*

Community Choice Counseling/Global Options Nursing Home Transitions

Program Description: The statewide Community Choice Program is designed to identify Medicaid Nursing Facility residents who can be supported in the community, counseled on community-based alternatives and then discharged through an Inter-Disciplinary Team. This program encourages and assists those individuals capable of living in the community to do so. The Nursing Home Transition component has increased funding, expanded HCBS options and provided more flexibility for residents to control and direct their services.
# of Beneficiaries Served: *Since August 1998, over 5,500 individuals were served. In CY2008, 574 individuals were transitioned from nursing homes into home and community based services.*

Adult Day Health Services

Program Description: Adult Day Health Services (ADHS) is a program which provides medically necessary services in an ambulatory care setting to persons who are non-residents of the facility and who, due to their physical and/or mental impairment, require services to support community living. Individuals who request ADHS must meet financial and medical requirements for Medicaid coverage in a prior authorization process.
# of Beneficiaries Served Annually: *The average number of recipients served through ADHS averaged 11,296 per month for State FY 2008.*

OFFICE OF THE PUBLIC GUARDIAN AND ELDER RIGHTS

This Office administers guardianship services, Adult Protective Services, the Title III Legal Assistance Program, and Elder Rights.

The Public Guardian

Program Description: The Public Guardian serves as the guardian or conservator of last resort for those individuals aged 60 and over who have no willing or responsible family member or friend to act in that capacity. The Public Guardian accepts cases as assigned by Judges of the Superior Court of New Jersey.
# of Beneficiaries Served Annually*: 823 clients in CY2008*

Adult Protective Services

Program Description: Adult Protective Services (APS) helps vulnerable adults who are being subjected to abuse, neglect or exploitation and lack sufficient understanding or capacity to make, communicate or carry out decisions concerning their well-being. APS serves adults who live in the community in their own homes, apartments, or with others and suffer from a physical or mental illness or disability.
# of Beneficiaries Served Annually: *6,122 referrals resulting in 4,081 investigations in CY2007*

Vulnerable Elder Rights Protection – Title VII

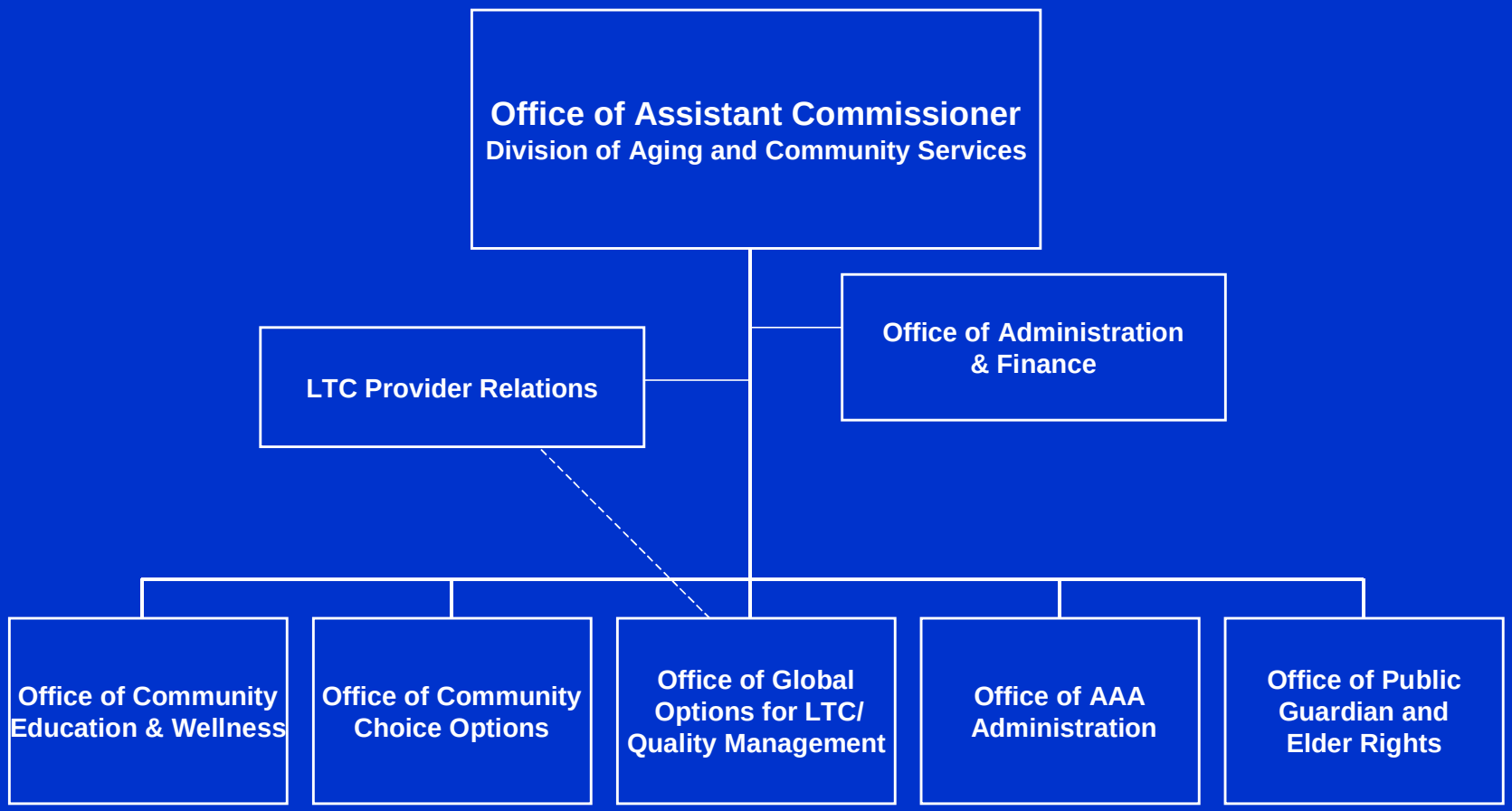
Program Description: Title VII responsibilities as stipulated in the Older Americans Act are dispersed among several offices within the DACS. In New Jersey, Adult Protective Services is a State funded program, which is administered through the 21 AAA Area Plan Contracts (APC) and provided by local community agencies. Title VII funds are used for public education, outreach, and training for APS workers/supervisors.

Legal Assistance

Program Description: Legal advice, assistance, and/or representation is provided by or under the supervision of a lawyer, in order to protect and secure the rights of older persons. DACS Legal Assistance Coordinator, in consultation with AAAs, is responsible for identifying and prioritizing statewide activities that will ensure older adults have access to and assistance in securing and maintaining benefits and rights.

Division of Aging and Community Services

An Overview



Intra-State Funding Formula

Background

The intra-State Funding Formula (IFF) for the distribution of Title III funds of the Older Americans Act as implemented in the State of New Jersey was developed in 1992 by a task force comprised of representatives of the Division of Aging and Community Services (DACS) and NJ's 21 Area Agencies on Aging (AAAs). The Assistant Secretary for Aging approved the funding formula as part of the 2005-2008 State Plan on Aging. The formula includes a minimum allocation to ensure that each Planning and Service Area (PSA) has a functioning AAA.

In 2005, a Finance Committee was established consisting of 6 representatives from the Area Agencies on Aging and staffed by professionals of the Division of Aging and Community Services to examine the validity of the current funding formula. The Finance Committee considered many factors when reviewing the funding formula such as senior population, minority, poverty, 100-150% of poverty, prior spending and minimum funding levels. The membership also reviewed other state's formulas to assess what factors are being used throughout the United States. There was consensus in the committee that the formula must be fair, defendable and capable of being regularly updated. It was determined that the US Census would continue to serve as the source of any factor being used, as it could be easily updated. As required by the Older Americans Act, the most current available data must be used to calculate each State's and each AAA's yearly allocation amounts.

The Finance Committee began its review of the funding formula in August 2005. After many meetings over the course of the next three years to review a variety of scenarios and factors, in February 2008, The Committee submitted a formal recommendation to DACS, the State Unit on Aging to: 1) continue with the current floor amounts for minimum funded counties; 2) for minimum funded counties, initiate a percentage base to be applied to all Title III funded programs that have a minimum funding amount, to enable those counties to share in any increases; and 3) continue with the current funding formula for all non-minimum funded counties.

These recommendations are being enacted effective October 1, 2009.

The allocation formula is used for Title IIIB (Social Services), Title IIIC-1 (Congregate Meals), Title IIIC-2 (Home Delivered Meals), Title IIIE, as well as State Weekend Home Delivered Meals (SWHDM), Safe Housing and Transportation Program (SHTP), Adult Protective Services (APS), Medicaid Match, American Recovery and Reinvestment Act (ARRA), Cost of Living Adjustment (COLA) and State Area Plan Contracted Matching Funds. The funding formula for Title IIID adds medical factor rankings by county.

Formula

The current funding formula, the one that was approved as part of the 2005-2009 State Plan, will remain in effect for the 2009-2013 State Plan with the following exception. A minimum funding percentage will be established to allow the minimum funded counties to share in any

increases in future years. This minimum funding percentage will be based on the 2009 floor amounts for Title III B, C1, C2 and E. Please see the formula for a full year in Attachment G-2, entitled "Midyear Amendment".

1. For those AAAs that are in minimum funded counties, minimum allocation is defined as the minimum amount of funding needed in each title in order to ensure that each Planning and Service Area (PSA) has a functioning Area Agency on Aging.

2. For those Area Agencies on Aging that are not in minimum funded counties, the formula is as follows:

The allocation for each program is calculated as Z x Q.

Z= NJ's 2009 allocation minus the sum of minimum-funded counties.
Q=The AAA funding index S+M+P
S=The % of those age 60+ in each PSA x weight factor A
M=The % of those age 60+and minority in each PSA x weight factor B
P=The % of those age 60+ and low-income in each PSA x weight factor C

Weight Factors

The formula above includes three weighted factors related to the number of individuals aged 60+, the number of minority individuals aged 60+, and the number of low-income individuals aged 60+ in each of the PSA as defined below.

A = 0.65 (60+)
B = 0.15 (60+ and minority)
C = 0.20 (60+ and low-income)
Based on these weighted factors, Q is calculated as ((S x .65)+(M x .15) + (P x .20)).

The most recent census data is applied to the factors above periodically in order to accurately reflect each PSA's population breakdown.

2009 Midyear Allocation

Allocation Percentage: 100%

County	Title III B 100% Allocation	Title III C1 100% Allocation	Title III C2 100% Allocation	Title III D 100% Allocation	Title III D-Med. Mgt. 100% Allocation	Title III E 100% Allocation	State Match B-D	State Match Med. Mgnt	State Match E	Total Federal and State Match ALLOCATION
Atlantic	334,242	357,674	202,188	18,852	6,831	139,503	48,333	362	41,851	1,149,836
Bergen	1,098,447	1,175,453	663,063	31,299	11,341	457,565	157,143	600	137,269	3,732,180
Burlington	435,335	465,854	262,821	12,234	4,273	181,369	62,272	226	54,411	1,478,795
Camden	573,026	613,197	346,396	20,387	7,387	239,016	82,218	391	71,705	1,953,723
Cape May	159,939	171,152	96,380	19,598	7,102	66,514	23,668	376	19,954	564,683
Cumberland	194,994	208,664	117,999	15,408	5,583	81,412	28,433	296	24,424	677,213
Essex	1,125,330	1,204,219	683,157	43,276	14,753	471,262	161,787	781	141,378	3,845,943
Gloucester	248,004	265,390	149,656	13,676	4,955	103,275	35,827	262	30,983	852,028
Hudson	896,120	958,942	544,161	41,190	14,923	375,361	129,198	790	112,608	3,073,293
Hunterdon	156,381	133,131	54,800	10,212	3,328	37,824	18,769	177	11,347	425,969
Mercer	407,397	435,957	246,390	16,799	6,087	170,006	58,582	322	51,002	1,392,542
Middlesex	784,330	839,315	473,844	21,790	7,895	326,975	112,197	418	98,093	2,664,857
Monmouth	644,585	689,773	389,042	26,346	9,546	268,468	92,634	505	80,540	2,201,439
Morris	437,624	468,304	263,830	14,545	5,270	182,079	62,698	279	54,624	1,489,253
Ocean	792,184	847,719	477,075	29,222	10,588	329,261	113,622	561	98,778	2,699,010
Passaic	579,361	619,977	350,672	27,049	9,801	241,947	83,491	519	72,584	1,985,401
Salem	156,623	133,131	47,167	18,995	6,882	34,378	18,843	364	10,313	426,696
Somerset	266,275	284,942	160,627	15,561	5,638	110,852	38,510	298	33,256	915,959
Sussex	156,454	133,131	61,711	14,626	5,300	42,593	19,373	281	12,778	446,247
Union	684,486	732,471	414,365	29,807	10,800	285,894	98,530	572	85,768	2,342,693
Warren	156,713	133,131	60,416	11,437	4,144	41,696	19,149	219	12,509	439,414
TOTALS	10,287,850	10,871,527	6,065,760	452,309	162,427	4,187,250	1,465,277	8,599	1,256,175	34,757,174

*- Allocation Code for Title III Admin - 01, SHTP Admin - 12, SSBG Admin - 21 and CGI - 30.

2009 Midyear Allocation - Continued

County	SWHDM	SHTP	APS	SSBG	State HDM	Care Coordination (CMQA)	Allocation SHIP	Med Match	NSIP	State COLA	ARRA Congregate	ARRA HDM	State/Other Fund Allocations	Grand Total Allocated Funds
Atlantic	31,758	37,649	141,585	378,200	0	23,810	17,834	14,408	173,793	173,943	57,283	30,475	**1,080,738**	**2,230,574**
Bergen	104,367	123,488	370,400	830,683	0	23,810	21,484	47,250	471,305	570,487	187,855	99,940	**2,851,069**	**6,583,249**
Burlington	41,363	48,948	137,290	180,603	0	23,810	0	18,729	81,370	226,128	74,461	39,614	**872,316**	**2,351,111**
Camden	54,446	64,506	239,777	804,164	46,605	23,810	16,500	24,684	138,768	298,015	98,139	52,210	**1,861,624**	**3,815,347**
Cape May	15,197	17,951	79,056	131,808	7,287	23,810	16,550	6,868	105,419	82,926	27,306	14,527	**528,705**	**1,093,388**
Cumberland	18,527	21,971	94,937	493,257	1,087	23,810	13,200	8,409	71,389	101,512	33,431	17,785	**899,315**	**1,576,528**
Essex	106,923	127,184	498,035	1,473,166	146,871	23,810	20,150	48,682	185,345	587,655	193,549	102,969	**3,514,339**	**7,360,282**
Gloucester	23,564	27,872	97,576	162,008	20,044	23,810	17,150	10,665	108,982	128,761	42,400	22,557	**685,389**	**1,537,417**
Hudson	85,144	101,303	422,792	1,659,255	75,063	23,810	13,684	38,777	397,300	468,078	154,169	82,018	**3,521,393**	**6,594,686**
Hunterdon	13,000	10,208	71,540	77,027	20,097	23,810	16,300	3,905	45,652	47,155	15,526	8,260	**352,480**	**778,449**
Mercer	38,709	45,881	160,568	573,727	0	23,810	0	17,558	152,485	211,973	69,806	37,137	**1,331,654**	**2,724,196**
Middlesex	74,523	88,244	285,477	525,309	25,402	23,810	20,834	33,766	297,118	407,675	134,247	71,420	**1,987,825**	**4,652,682**
Monmouth	61,245	72,454	245,931	736,618	0	23,810	0	27,723	273,917	334,723	110,221	58,638	**1,945,280**	**4,146,719**
Morris	41,581	49,139	145,489	97,672	11,566	23,810	0	18,801	506,611	227,005	74,747	39,766	**1,236,187**	**2,725,440**
Ocean	75,269	88,861	284,918	232,635	0	23,810	25,284	33,997	219,450	410,495	135,163	71,907	**1,601,789**	**4,300,799**
Passaic	55,048	65,297	251,672	557,253	166,360	23,810	19,684	24,989	232,454	301,680	99,351	52,855	**1,850,453**	**3,835,854**
Salem	13,000	9,222	71,782	235,226	15,373	23,810	13,600	3,361	24,865	43,024	13,363	7,109	**473,735**	**900,431**
Somerset	25,300	29,917	110,165	223,422	15,851	23,810	19,450	11,446	112,163	138,205	45,508	24,210	**779,447**	**1,695,406**
Sussex	13,000	11,495	73,632	13,192	19,486	23,810	20,334	4,398	25,442	53,100	17,484	9,301	**284,674**	**730,921**
Union	65,036	77,157	251,892	469,725	16,598	23,810	17,684	29,528	268,809	356,476	117,396	62,455	**1,756,566**	**4,099,259**
Warren	13,000	11,253	74,486	106,050	37,310	23,810	16,450	4,305	57,140	51,984	17,117	9,106	**422,011**	**861,425**
TOTALS	**970,000**	**1,130,000**	**4,109,000**	**9,961,000**	**625,000**	**500,010**	**306,172**	**432,249**	**3,949,777**	**5,221,000**	**1,718,522**	**914,259**	**30,073,677**	**64,594,163**

State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF AGING AND COMMUNITY SERVICES
PO BOX 807
TRENTON, N.J. 08625-0807

www.nj.gov/health

JON S. CORZINE
Governor

HEATHER HOWARD
Commissioner

Appendix H

Verification of Intent

The State Plan on Aging is hereby submitted for the State of New Jersey for the period October 1, 2009 through September 30, 2013. It includes all the assurances and plans to be conducted by the State of New Jersey, Department of Health and Senior Services, Division of Aging and Community Services under the provisions of the Older Americans Act, as amended, for the period identified. The State Agency named above has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act, and is primarily responsible for the coordination of all State activities related to the purposes of the Act, i.e., the development of comprehensive and coordinated systems for the delivery of supportive services and to serve as the effective and visible advocate for the elderly in the State.

This State Plan on Aging is hereby approved by the Commissioner and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary for Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

_____ _____
Patricia A. Polansky, Assistant Commissioner Date
Department of Health and Senior Services

I hereby approve this State Plan on Aging and submit it to the Assistant Secretary for Aging for approval.

_____ _____
Heather Howard, Commissioner Date
Department of Health and Senior Services

State of New Jersey
Department of Health and Senior Services
Division of Aging and Community Services
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