

**DEPARTMENT OF HEALTH  
AND SENIOR SERVICES**



**NEW JERSEY**

**STATE  
STRATEGIC PLAN  
ON AGING**

**October 1, 2005-September 30, 2008**



**RICHARD J. CODEY**  
*Acting Governor*

**FRED M. JACOBS, M.D., J.D.**  
*Commissioner*

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## Introduction and Executive Summary

### HISTORY

New Jersey was one of the first states in the nation to establish a state division on aging. Chapter 72 Law of 1957 established, within the State Department of Health, a division of the aging, consisting of a director, the New Jersey State Commission on Aging, and the New Jersey Citizens Council on Aging. In 1973, amendments to the federal Older Americans Act (OAA) of 1965 authorized states to designate geographic Planning and Service Areas (PSA) to be administered by Area Agencies on Aging (AAA). New Jersey designated each of its 21 county AAAs, making each county office eligible for Federal funding under OAA.

Since its creation the New Jersey State Unit on Aging has been placed in several departments and, as a result of the 1996 reorganization and consolidation of senior services, it became part of the New Jersey Department of Health and Senior Services (DHSS). More than 20 senior and long-term care programs from four state agencies were consolidated into this cabinet level department.

In 2002, as a part of DHSS's continuing commitment to evolve senior services, the Divisions of Senior Affairs (State Unit on Aging) and Consumer Support (Medicaid Waiver and Long-term Care Services) and their respective funding sources were consolidated into the Division of Aging and Community Services (DACS). The integration of the State Unit on Aging into this new division brought new leadership, a renewed commitment and energy to provide services for New Jersey's aging population, and a new mission and vision (see Exhibit 1).

### AUTHORITY

More than consolidating funding streams, establishment of DACS brought together within one division the authority and responsibilities for public awareness efforts, information and assistance with private-pay and public programs, Medicare/Medicaid/Medigap counseling services, crisis intervention, care planning, and clinical eligibility for long-term care support services. New Jersey's DACS is today's State Unit on Aging.

### MAJOR INITIATIVES

The 2005-2008 New Jersey State Strategic Plan on Aging is based upon the advancement of three initiatives that are currently underway. They were launched during the 2002-2005 State Strategic Plan for Aging and are fundamental to the future development and delivery of all programs and services of DACS. They are as follows:

#### NEW JERSEY'S MAJOR INITIATIVES

1. The redesign of the aging and disability service system under New Jersey's Aging and Disability Resource Center (ADRC)<sup>1</sup> grant.
2. The development and implementation of a global budget long-term care program.
3. The creation of a pilot fast track eligibility program with presumptive eligibility in Warren and Atlantic Counties, the two ADRC test counties.

<sup>1</sup> In New Jersey, this initiative has been renamed the Aging and Disability Resource Connection (ADRC). The name resulted from focus groups conducted with providers and consumers by the initiative's Public Awareness Work Group.



# DEPARTMENT OF HEALTH AND SENIOR SERVICES

EXHIBIT 1

## 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

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.

**RICHARD J. CODEY**  
*Acting Governor*



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*Commissioner*

## **2005-2008 PRIORITIES**

Within the context of New Jersey's long-term care reform agenda and the implementation of the ADRC initiative, New Jersey's 2005-2008 State Strategic Plan on Aging has adopted the same five strategic priorities that were established as part of AoA's Strategic Action Plan<sup>2</sup>, thus assuring consistency between New Jersey's and AoA's priorities. Further details pertaining to these five priorities and their related goals, objectives, and strategies appear in Chapters 3 and 4.

### **NEW JERSEY'S PRIORITIES**

1. Make it easier for older adults to access an integrated array of health and social supports.
2. Help older people to stay active and healthy.
3. Support families in their efforts to care for loved ones at home and in the community.
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation.
5. Promote an effective and responsive management.

## **NEW JERSEY'S GUIDING PRINCIPLES**

To ensure that each priority is carried out in a manner that is consistent with New Jersey's core values, five guiding principles have been established and are intrinsic to each issue.

### **NEW JERSEY'S GUIDING PRINCIPLES**

1. **Leadership:** guided by the OAA in New Jersey.
2. **Advocacy:** on behalf of New Jersey's 1.5 million older adults.
3. **Consumer Direction:** the flexibility for older adults to choose the services and care that meets their needs and to exert some measure of individual control.
4. **Cultural Competency:** effectively targeting services to meet New Jersey's increasingly diverse population in terms of culture, language, and race/ethnicity.
5. **Quality Assurance/Quality Improvement:** to be able to evaluate program outcomes and make adjustments accordingly.

## **ORGANIZATION OF NEW JERSEY'S STATE STRATEGIC PLAN ON AGING**

Chapter 1 contains the April 2005 preliminary findings of a detailed Profile of New Jersey Older Adults Aged 60+ Years. This document was prepared by New Jersey's Center for Health Statistics in cooperation with DACS and DHSS.

Chapter 2 describes the planning process that generated NJ's State Strategic Plan on Aging, including stakeholder input, and provides further details about NJ's major initiatives, priorities, and guiding principles, which constitute the planning framework.

Chapter 3 encompasses the detailed discussion of each of New Jersey's five strategic priorities and the goals, objectives, implementation strategies, and performance measures related to them, as required in Program Instruction (PI) AoA-PI-05-02. It also addresses these specific requirements in the PI:

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<sup>2</sup> U.S. Administration on Aging, Strategic Action Plan, FY 2003-2008, November 2002, p. 6.

- The development, expansion, and coordination of ADRC, including integration of a comprehensive array of services and expansion of services to private pay and non-elderly clients **(Priority 1, Goal 1)**.
- The steps that New Jersey, its AAAs, and network providers will take to help elderly individuals in the State avail themselves of the benefits under the Medicare Modernization Act (MMA) **(Priority 1, Goal 2)**.
- Assessment of need and coordination of transportation services for the elderly **(Priority 1, Goal 5)**.
- Implementation of evidence-based health promotion and disease prevention programs, including assurance that New Jersey will promote the coordinated vaccination of seniors, particularly for influenza and pneumonia **(Priority 2, Goal 1, Strategy B)**.
- Management information systems to support ADRC **(Priority 5, Goal 9)**.
- The concept of competition in the financing and provision of services under OAA and its effect on cost and quality of care **(Priority 5, Goal 5)**.
- Establishment of measurable performance objectives **(Priorities 1-5)**.

Chapter 4 provides an overview of DACS's many programs and services as well as its organizational structure and Chapter 5 describes the administrative structure and networks related to advocacy and the provision of services to New Jersey's aging population.

Chapter 6 contains comments pertaining to the State Plan Provisions and Information Requirements, including OAA Title III requirements and New Jersey's intrastate funding formula, as required in Attachment B of the PI.

The Attachments contain signed assurances, the signed verification of intent, a list of New Jersey's AAAs with their contact information, copies of Executive Orders 100 and 31, sample AAA plans for a large/urban area and for a small area (there are no rural areas in New Jersey) as required by the PI, and extensive lists entitled "Methods for Carrying out New Jersey's Preference for Providing Services to Target Populations" in Attachments F and G.

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## CHAPTER 1

# A Profile of New Jersey Older Adults Aged 60+ Years

*Preliminary Findings:  
April 2005*



*Center for Health Statistics*

*Division of Aging &  
Community Services*

*New Jersey Department of  
Health & Senior Services*



Richard J. Codey  
Acting Governor



Fred M. Jacobs, M.D., J.D.  
Commissioner

**A Profile of New Jersey Adults Age 60+ Years**  
 Center for Health Statistics  
 Division of Aging and Community Services  
 New Jersey Department of Health and Senior Services  
 April 2005

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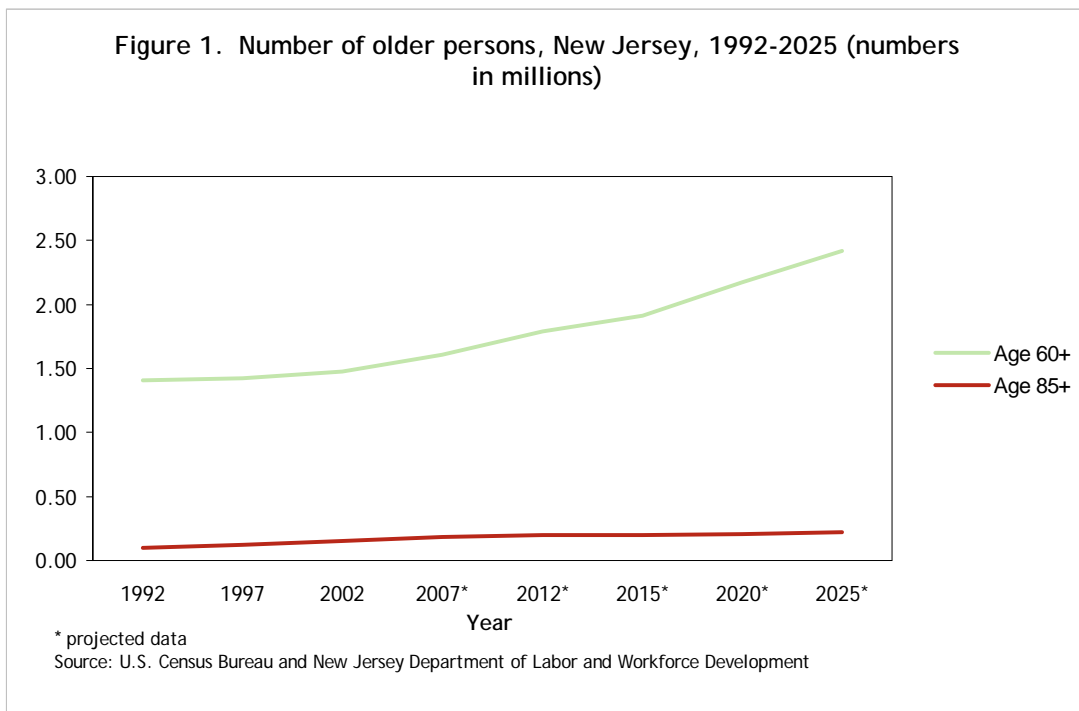
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## Population Trends

- ✚ New Jersey population aged 60 years and over numbered 1,509,900 in 2004, an increase of 104,500 or 7.4 % since 1991.
- ✚ The population over age 60 years is projected to grow substantially in the near future as the baby-boom generation (those born between 1946 and 1964) ages. In 2000, there were 1,443,800 New Jerseyans aged 60 years and over. By 2025, the population is projected to number nearly two and a half million in this age group.
- ✚ People aged 60 and over represented 17.2% of the New Jersey population in the year 2000. It is expected to grow to be 23.6% of the population by 2025.



## Basic Demographics in 2003

- ✚ 17.3% of New Jersey population were 60 years of age and older in 2003.
- ✚ Females significantly outnumbered males at ages over 60 years. Among people aged 60 years and over in New Jersey in 2003, 42.2% were male and 57.8% were female. Among those aged 85 years and over in New Jersey, 30.1% were male and 69.9% were female.
- ✚ Among those aged 60 years and over in New Jersey in 2003, 79.4% were non-Hispanic white, 9.8% were non-Hispanic black, 7% were Hispanic, and 3.7% were Asian and Pacific Islanders. The population aged 60+ has a higher proportion non-Hispanic white than does the state population as a whole.
- ✚ More than half (58%) of the New Jersey population 60 years of age and older in 2003 resided in seven counties: Bergen (177,672), Ocean (140,125), Essex (125,074), Middlesex (124,374), Monmouth (106,774), Hudson (92,031), and Union (91,871).
- ✚ About 60% of the New Jersey minority population 60 years of age and older in 2003 resided in four counties: Bergen, Essex, Hudson, and Union.
- ✚ In 2003, people aged 60 and over exceeded 25% of the county total population in Ocean and Cape May counties.
- ✚ Within counties, the percent of the total population 60 years of age and over that are racial and ethnic minorities ranged from 3.6% (Hunterdon) to 48.6% (Hudson). Essex (46.5%), Union (29.9%), and Passaic (27.7%) 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 high proportion of non-Hispanic black population were: Union (15.9%), Mercer (14.8%), Camden (13.2%), and Atlantic (13.0%).
- ✚ Hudson County had the highest proportion of Hispanic among the population aged 60 years and over (32.2%), followed by Passaic (15.5%) and Union (11.4%).
- ✚ Middlesex County had the largest proportion of Asian and Pacific Islanders among their senior population (8.5%), followed by Hudson (7.2%), Bergen (6.2%), and Somerset (6.0%).

## Social and Economic Indicators (from Census 2000)

## Marital Status

- ✚ The majority of New Jersey adults aged 60 years and over were either married or widowed in 2000. 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, 81% of men compared with 64% of women were married. Among those aged 85 years and over, however, 54% of men were married, compared with only 18% of women.
- ✚ The percent of women widowed (41%) was more than three times of the percent of men widowed (13%) for New Jerseyans age 60 and over in 2000.

## Income

- ✚ Median income for families with the householder aged 60 years and over was \$51,535 in 2000.
- ✚ Four counties had the median income higher than \$60,000. They are Morris (\$68,626), Somerset (64,007), Hunterdon (\$63,543), and Bergen (\$61,579).
- ✚ The median family income declined with the age of householders. The median income for families with the householder aged 85 years and over was only about half that of families with the household aged between 60 and 64 years.
- ✚ As shown in both Table 6 and Figure 3, lower income older New Jerseyans were more likely to be widowed than people in any other marital status.

## Living Arrangements

- ✚ Approximately 75% of the households where the householder is 60 years of age and over were owner-occupied in 2000. Only one county in New Jersey showed home ownership rate for seniors to be below 50%. It was Hudson County, with a rate of 43%.
- ✚ In New Jersey, homeownership was closely connected with income level. Among households in which the householder was 60 years of age and over and the ratio of income to poverty level was above 2.00, 83% were owner-occupied. The proportion fell to 41% for households whose ratio of income to poverty level was below 1.00.

- ✚ Older men were much less likely to live alone than older women in every age groups. Among all New Jersey people aged 60 years and over, 15% of the men lived alone compared with 31% of the women. For those aged 85 years and over, 27% of the men lived alone compared with 41% of the women.

## Disability

- ✚ Approximately 36% of the statewide noninstitutionalized population aged 60 years and over claimed a disability in 2000. The rates did not differ much between men (34%) and women (37%).
- ✚ The prevalence of disability increased substantially with age in 2000. Within the 60-64 age group, 27% of men and 26% of women had a disability. Within the 85 plus age group, about 64% of men and 73% of women had a disability.
- ✚ With older age, people were increasingly likely to have more than one type of disability. In 2000, among men aged 85 years and over, 42% of them had physical disability, 38% had go-outside-home disability that makes it difficult for them to go outside the home alone, 30% had sensory disability, 22% had mental disability, and 20% had self-care disability. Among women aged 85 years and over, 54% had physical disability, 52% had go-outside-home disability, 33% had sensory disability, 28% had mental disability, and 29% had self-care disability

Among the five types of disability that were defined in the Census, physical disability was more widespread than any other types of disability.

Table 1. Estimated population aged 60 years and over by age group, gender, and race/ethnicity, New Jersey, 2003

Age group	Total	All Races		Non-Hispanic White		Non-Hispanic Black		American Indian & Alaska Native		Asian and Pacific Islander		Hispanic	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	1,495,460	630,504	864,956	501,301	685,676	57,755	88,054	990	1,377	25,720	30,222	44,738	59,627
60-64	371,618	175,360	196,258	130,934	142,679	18,819	25,208	307	364	9,729	9,786	15,571	18,221
65-69	288,973	131,427	157,546	99,039	116,116	14,137	19,710	218	284	6,877	7,393	11,156	14,043
70-74	266,538	115,711	150,827	92,963	118,863	10,496	15,659	190	244	4,139	5,358	7,923	10,703
75-79	238,950	96,550	142,400	81,360	118,634	7,330	12,223	131	201	2,524	3,772	5,205	7,570
80-84	176,564	65,393	111,171	56,773	95,787	4,224	8,139	75	132	1,476	2,283	2,845	4,830
85+	152,817	46,063	106,754	40,232	93,597	2,749	7,115	69	152	975	1,630	2,038	4,260
Total by Race/Ethnicity:		1,495,460		1,186,977		145,809		2,367		55,942		104,365	
Percent of Total:		100.0		79.4		9.8		0.2		3.7		7.0	

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, 2003 (frequency and percent)

Geographic Name	Population Total	Age Group (%)											
		60-64		65-69		70-74		75-79		80-84		85+	
New Jersey	1,495,460	371,618	24.8	288,973	19.3	266,538	17.8	238,950	16.0	176,564	11.8	152,817	10.2
Atlantic	46,487	11,061	23.8	9,248	19.9	8,674	18.7	7,652	16.5	5,338	11.5	4,514	9.7
Bergen	177,672	43,234	24.3	33,858	19.1	31,608	17.8	28,337	15.9	21,463	12.1	19,172	10.8
Burlington	75,364	19,336	25.7	15,025	19.9	14,061	18.7	12,173	16.2	8,413	11.2	6,356	8.4
Camden	84,205	21,016	25.0	16,120	19.1	14,891	17.7	13,903	16.5	10,021	11.9	8,254	9.8
Cape May	26,289	5,652	21.5	5,044	19.2	4,984	19.0	4,441	16.9	3,236	12.3	2,932	11.2
Cumberland	24,955	6,007	24.1	4,928	19.7	4,450	17.8	4,112	16.5	2,982	11.9	2,476	9.9
Essex	125,074	32,927	26.3	25,194	20.1	21,448	17.1	18,826	15.1	13,862	11.1	12,817	10.2
Gloucester	41,822	11,016	26.3	8,205	19.6	7,667	18.3	6,667	15.9	4,774	11.4	3,493	8.4
Hudson	92,031	24,299	26.4	18,931	20.6	15,921	17.3	13,660	14.8	10,083	11.0	9,137	9.9
Hunterdon	20,456	6,327	30.9	4,040	19.7	3,485	17.0	2,880	14.1	2,050	10.0	1,674	8.2
Mercer	59,139	14,771	25.0	11,433	19.3	10,312	17.4	9,501	16.1	7,001	11.8	6,121	10.4
Middlesex	124,374	31,028	24.9	23,958	19.3	22,591	18.2	20,554	16.5	14,831	11.9	11,412	9.2
Monmouth	106,774	27,819	26.1	21,048	19.7	18,823	17.6	16,508	15.5	11,860	11.1	10,716	10.0
Morris	81,599	23,511	28.8	16,684	20.4	14,367	17.6	11,625	14.2	8,197	10.0	7,215	8.8
Ocean	140,125	23,641	16.9	23,613	16.9	26,832	19.1	26,349	18.8	21,021	15.0	18,669	13.3
Passaic	78,993	20,265	25.7	15,377	19.5	13,767	17.4	12,055	15.3	9,247	11.7	8,282	10.5
Salem	12,260	3,016	24.6	2,259	18.4	2,173	17.7	2,034	16.6	1,544	12.6	1,234	10.1
Somerset	46,852	13,023	27.8	9,345	19.9	8,284	17.7	7,046	15.0	4,969	10.6	4,185	8.9
Sussex	20,761	6,578	31.7	4,182	20.1	3,408	16.4	2,811	13.5	1,986	9.6	1,796	8.7
Union	91,871	22,416	24.4	17,081	18.6	15,596	17.0	14,907	16.2	11,533	12.6	10,338	11.3
Warren	18,357	4,675	25.5	3,400	18.5	3,196	17.4	2,909	15.8	2,153	11.7	2,024	11.0

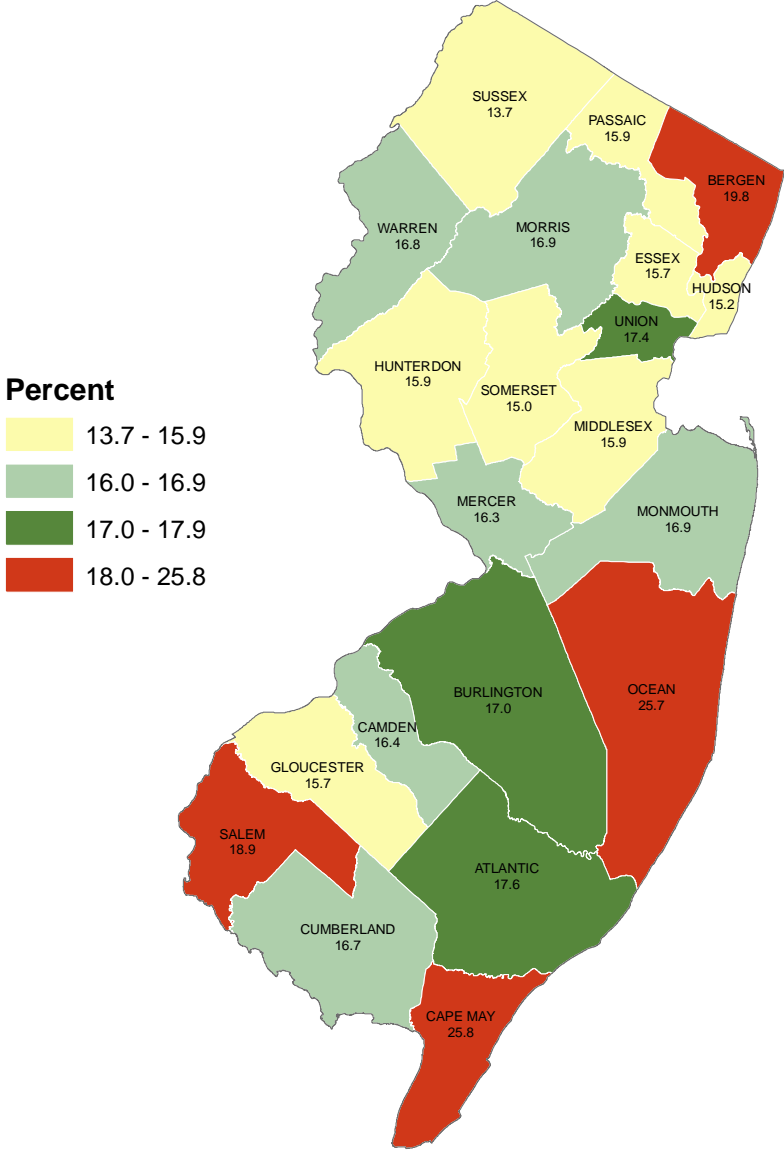
Source: National Center for Health Statistics and U.S. Census Bureau

Table 3. Estimated population aged 60 years and over by race/ethnicity and county, New Jersey, 2003 (frequency and percent)

Geographic Name	Population Total	Non- Hispanic White		Non-Hispanic Black		American Indian & Alaska Native		Asian and Pacific Islander		Hispanic	
		Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
New Jersey	1,495,460	1,186,977	79.4	145,809	9.8	2,367	0.2	55,942	3.7	104,365	7.0
Atlantic	46,487	36,558	78.6	6,047	13.0	112	0.2	1,629	3.5	2,141	4.6
Bergen	177,672	149,135	83.9	7,308	4.1	173	0.1	10,954	6.2	10,102	5.7
Burlington	75,364	62,998	83.6	9,081	12.0	125	0.2	1,674	2.2	1,486	2.0
Camden	84,205	67,138	79.7	11,113	13.2	185	0.2	2,303	2.7	3,466	4.1
Cape May	26,289	25,159	95.7	770	2.9	26	0.1	102	0.4	232	0.9
Cumberland	24,955	19,440	77.9	2,853	11.4	207	0.8	239	1.0	2,216	8.9
Essex	125,074	66,972	53.5	43,542	34.8	288	0.2	3,580	2.9	10,692	8.5
Gloucester	41,822	37,148	88.8	3,618	8.7	80	0.2	457	1.1	519	1.2
Hudson	92,031	47,301	51.4	8,332	9.1	198	0.2	6,596	7.2	29,604	32.2
Hunterdon	20,456	19,720	96.4	164	0.8	27	0.1	273	1.3	272	1.3
Mercer	59,139	45,998	77.8	8,782	14.8	92	0.2	2,144	3.6	2,123	3.6
Middlesex	124,374	98,734	79.4	7,047	5.7	179	0.1	10,558	8.5	7,856	6.3
Monmouth	106,774	93,501	87.6	7,244	6.8	126	0.1	2,990	2.8	2,913	2.7
Morris	81,599	73,292	89.8	1,784	2.2	77	0.1	3,636	4.5	2,810	3.4
Ocean	140,125	134,327	95.9	1,969	1.4	104	0.1	991	0.7	2,734	2.0
Passaic	78,993	57,104	72.3	7,185	9.1	129	0.2	2,324	2.9	12,251	15.5
Salem	12,260	10,491	85.6	1,536	12.5	32	0.3	56	0.5	145	1.2
Somerset	46,852	40,015	85.4	2,441	5.2	34	0.1	2,792	6.0	1,570	3.4
Sussex	20,761	19,941	96.1	164	0.8	26	0.1	182	0.9	448	2.2
Union	91,871	64,392	70.1	14,565	15.9	135	0.1	2,313	2.5	10,466	11.4
Warren	18,357	17,613	95.9	264	1.4	12	0.1	149	0.8	319	1.7

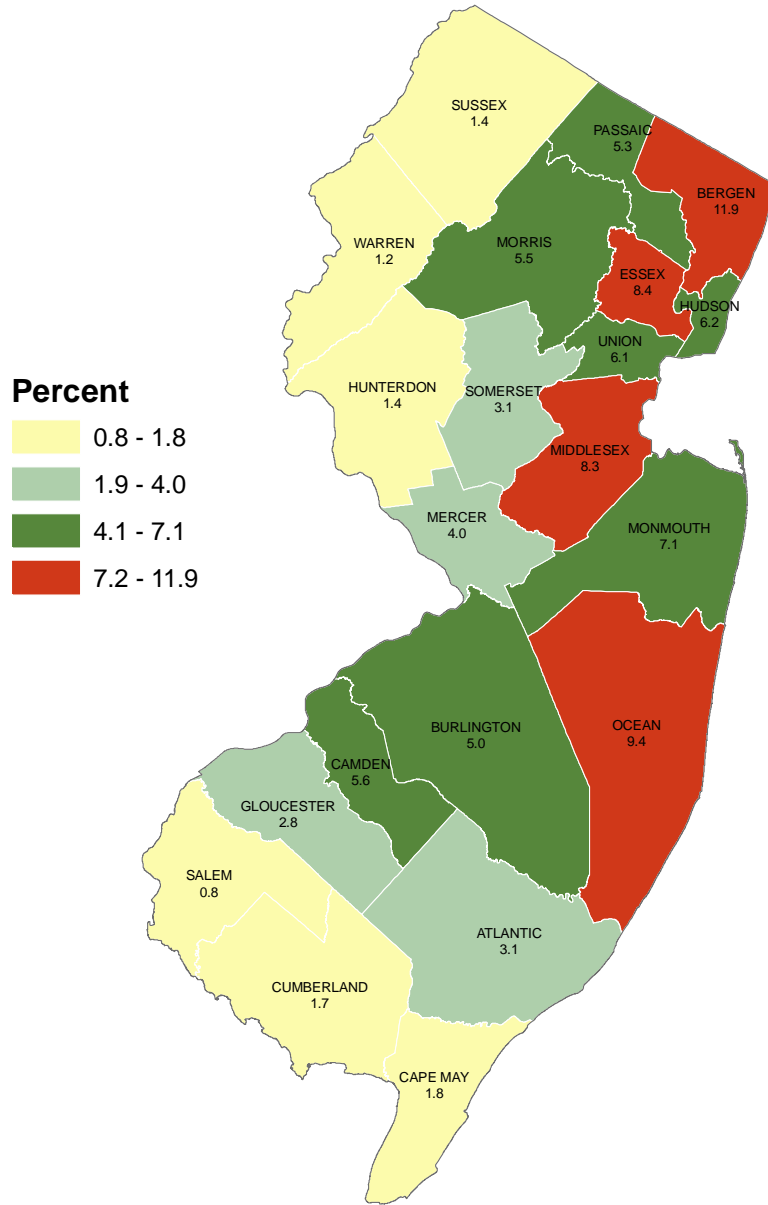
Source: National Center for Health Statistics and U.S. Census Bureau

Map 1. Proportion of county population aged 60 years and over in New Jersey, 2003



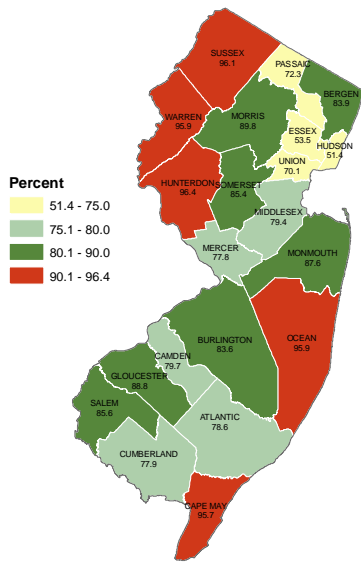
Source: National Center for Health Statistics and U.S. Census Bureau

Map 2. Distribution of New Jersey's population aged 60 years and over, by county of residence, New Jersey, 2003

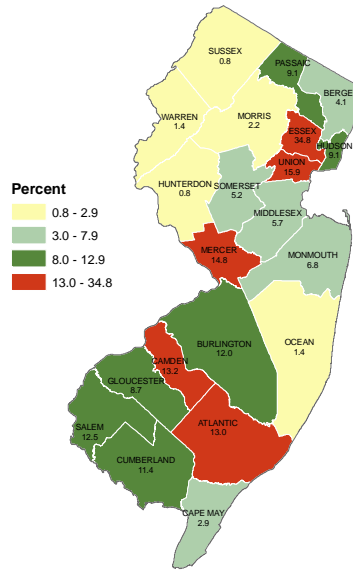


Source: National Center for Health Statistics and U.S. Census Bureau

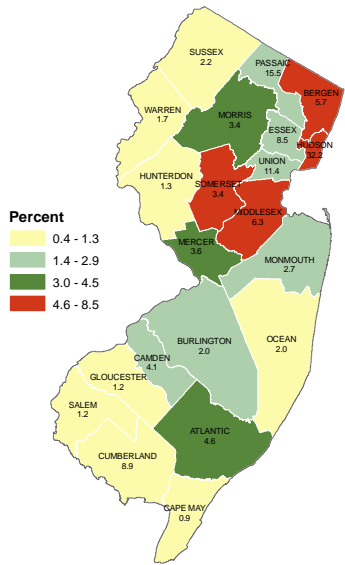
Map 3. Proportion of county population aged 60+ years which is non-Hispanic white, New Jersey, 2003



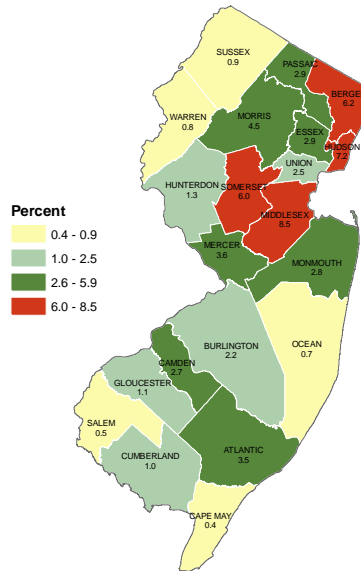
Map 4. Proportion of county population aged 60+ years which is non-Hispanic black, New Jersey, 2003



Map 5. Proportion of county population aged 60+ years which is Hispanic, New Jersey, 2003



Map 6. Proportion of county population aged 60+ years which is non-Hispanic Asian and Pacific Islander, New Jersey, 2003



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

Table 4a. Population aged 60 years and over by age group, gender, and marital status, New Jersey, 2000

	Gender	Population Total	Marital Status			
			Never Married	Married	Widowed	Divorced
New Jersey	Male	601,795	34,545	452,245	76,065	38,940
	Female	841,865	50,535	381,585	344,030	65,715
60-64	Male	155,480	9,150	125,180	6,055	15,095
	Female	175,145	10,475	111,900	28,900	23,870
65-74	Male	255,005	15,380	198,130	24,545	16,950
	Female	322,440	18,240	170,440	105,500	28,260
75-84	Male	153,765	8,085	108,840	30,915	5,925
	Female	248,425	15,140	82,365	139,865	11,055
85 and over	Male	37,545	1,930	20,095	14,550	970
	Female	95,855	6,680	16,880	69,765	2,530

Note: Married includes married, spouse present; married, spouse absent.  
 Universe: Population 60 years and over  
 Source: Census 2000 Special Tabulation on Aging

Table 4b. Population aged 60 years and over by age group, gender, and marital status, New Jersey, 2000 (percent)

Age Group	Gender	Percent Total	Marital Status			
			Never married	Married	Widowed	Divorced
New Jersey	Male	100	5.7	75.1	12.6	6.5
	Female	100	6	45.3	40.9	7.8
60-64	Male	100	5.9	80.5	3.9	9.7
	Female	100	6	63.9	16.5	13.6
65-74	Male	100	6	77.7	9.6	6.6
	Female	100	5.7	52.9	32.7	8.8
75-84	Male	100	5.3	70.8	20.1	3.9
	Female	100	6.1	33.2	56.3	4.5
85 and over	Male	100	5.1	53.5	38.8	2.6
	Female	100	7	17.6	72.8	2.6

Figure 2. Marital status of people aged 60 years and over, by age group and gender, New Jersey, 2000

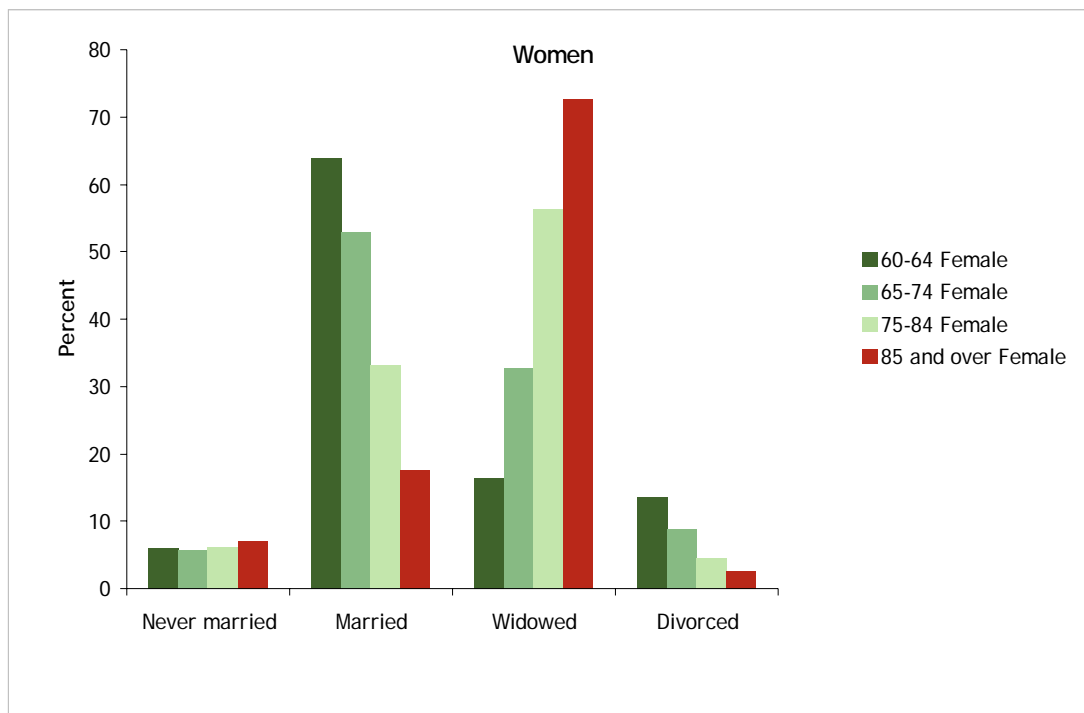
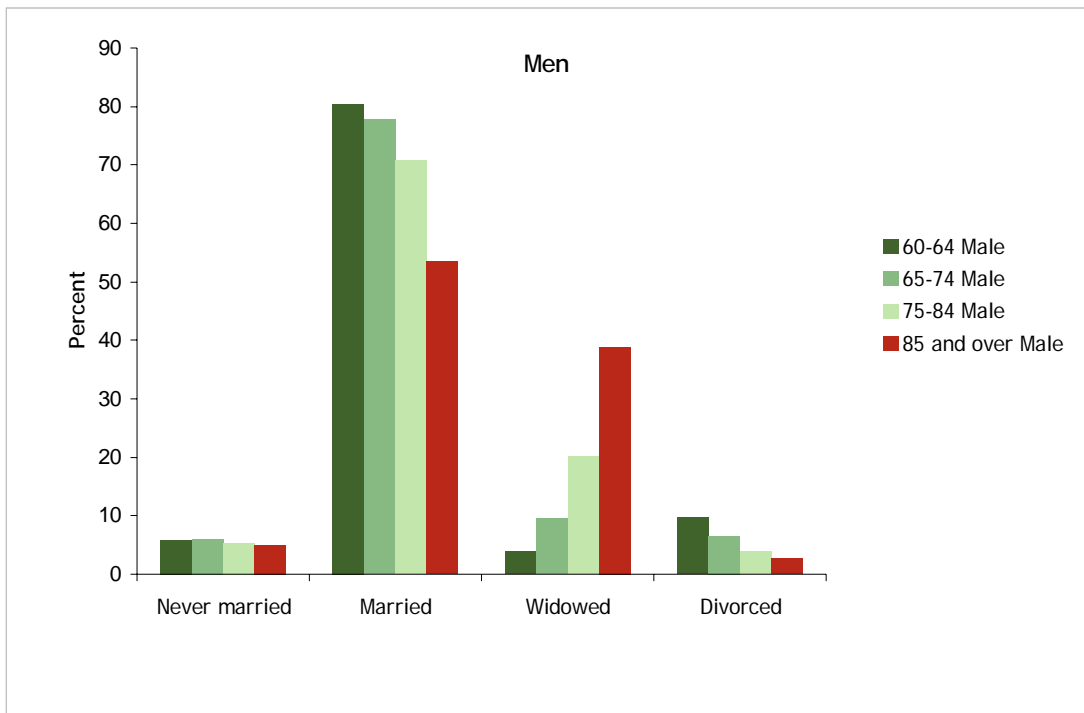


Table 5. Median family income in 1999 (dollars) by age of householder for families with a householder aged 60 years and over, New Jersey

Geographic Name	Median family income in 1999 (dollars)						
	Age 60 and over	Age 60 to 64 years	Age 65 to 69 years	Age 70 to 74 years	Age 75 to 79 years	Age 80 to 84 years	Age 85 years and over
New Jersey	51,535	69,209	54,892	47,205	41,520	38,750	35,835
Atlantic	44,526	57,145	44,872	40,440	36,719	33,668	37,417
Bergen	61,579	82,871	65,787	56,285	49,225	44,703	43,847
Burlington	52,216	69,914	53,161	49,161	42,540	37,544	33,697
Camden	46,173	60,568	50,005	43,422	36,997	35,670	33,287
Cape May	43,297	56,528	47,123	40,819	37,146	31,461	32,826
Cumberland	38,740	50,000	43,708	33,518	32,422	31,699	27,622
Essex	52,528	63,616	54,372	49,792	44,709	41,026	36,951
Gloucester	43,431	57,226	44,366	41,451	35,270	37,731	29,297
Hudson	40,925	50,287	41,842	39,014	34,920	31,232	34,000
Hunterdon	63,543	85,306	67,500	49,221	47,917	40,391	37,569
Mercer	54,397	73,208	61,296	49,003	45,269	44,832	35,719
Middlesex	54,687	76,975	58,611	48,728	43,188	40,140	34,923
Monmouth	57,260	81,419	59,988	51,693	43,343	41,966	34,182
Morris	68,626	88,628	74,265	60,235	53,654	44,432	50,188
Ocean	41,422	58,289	45,390	39,626	35,940	32,500	32,401
Passaic	50,145	67,078	56,070	49,340	37,805	35,587	32,003
Salem	40,468	51,205	39,057	38,077	34,678	37,176	29,063
Somerset	64,007	93,929	66,611	57,485	48,051	44,236	47,469
Sussex	55,034	71,726	51,827	48,232	40,223	43,628	30,625
Union	53,518	68,151	56,125	53,671	44,121	44,315	37,308
Warren	48,380	61,192	47,448	43,811	39,597	34,479	33,462

Note: The income of all family members 15 years old and over related to the householder are summed and treated as a single amount. "Total income" is the sum of the amounts reported separately for wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; social security or railroad retirement income; Supplemental Security Income; public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income.

Universe: Families with a householder 60 years and over

Source: Census 2000 Special Tabulation on Aging

Table 6. Ratio of income in 1999 (dollars) to poverty level by marital status for population aged 60 years and over, New Jersey

Ratio of income to poverty level	Population/ Percent Total	Marital Status			
		Never married	Married	Widowed	Divorced
Under 1.00	106,860	12,960	34,275	44,970	14,655
Percent	100	12.1	32.1	42.1	13.7
1.00-1.49	101,515	8,270	32,325	50,215	10,705
Percent	100	8.1	31.8	49.5	10.5
1.50-1.99	114,570	7,590	48,620	48,730	9,630
Percent	100	6.6	42.4	42.5	8.4
2.00-2.49	112,620	7,170	56,770	40,100	8,580
Percent	100	6.4	50.4	35.6	7.6
2.50-2.99	110,525	6,395	62,840	33,205	8,085
Percent	100	5.8	56.9	30	7.3
3.00 and over	846,165	36,905	575,795	182,830	50,635
Percent	100	4.4	68	21.6	6

Universe: Population 60 years and over for whom poverty status is determined  
 Source: Census 2000 Special Tabulation on Aging

Figure 3. Ratio of income to poverty level by marital status for New Jersey persons 60 and over, 1999

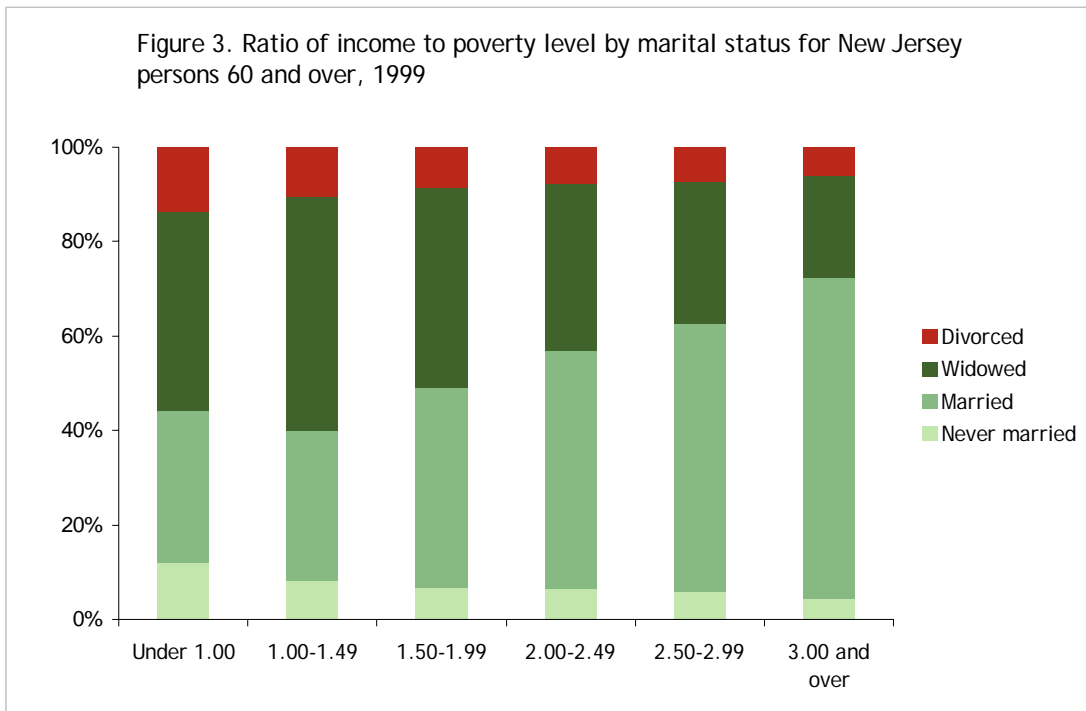


Table 7. Ratio of income in 1999 (dollar) to poverty level by county and tenure for occupied housing units with a householder aged 60 years and over, New Jersey

Geographic Name	Ratio of Income to poverty level									
	Total	Percent owner occupied	Under 1.00		1.00-1.49		1.50-1.99		2.00 and over	
			Total	Percent owner occupied	Total	Percent owner occupied	Total	Percent owner occupied	Total	Percent owner occupied
New Jersey	896,025	74.6	80,885	40.9	79,310	51.1	83,790	63.6	652,040	83.1
Atlantic	28,380	73.6	3,435	45.1	3,055	58.3	3,000	62.7	18,890	82.9
Bergen	104,930	77.0	6,445	46.5	7,750	53.5	7,885	61.4	82,850	83.0
Burlington	43,220	85.7	2,520	65.9	2,775	69.4	3,340	74.3	34,585	89.6
Camden	53,620	74.9	5,330	46.4	5,115	56.7	5,935	64.5	37,240	83.1
Cape May	17,215	81.8	1,415	57.2	1,710	75.1	1,870	77.5	12,220	86.3
Cumberland	15,485	75.9	2,050	45.1	1,915	54.8	1,930	72.5	9,590	87.4
Essex	79,930	56.1	12,030	21.2	8,890	30.1	7,240	39.6	51,770	70.9
Gloucester	24,360	83.4	2,060	59.0	2,080	61.1	2,455	77.8	17,765	89.6
Hudson	59,260	42.9	10,770	17.9	8,190	23.4	6,330	35.4	33,970	56.9
Hunterdon	10,220	85.2	415	60.2	575	59.1	825	66.1	8,405	90.1
Mercer	35,800	75.6	3,430	44.3	2,920	52.2	3,385	68.4	26,065	83.2
Middlesex	72,305	80.3	4,940	49.5	5,310	53.6	6,570	70.3	55,485	86.8
Monmouth	62,515	77.1	4,865	40.3	4,995	47.4	5,310	64.2	47,345	85.4
Morris	43,375	81.8	2,215	51.7	2,255	54.3	2,800	63.2	36,105	86.8
Ocean	86,295	90.5	5,485	79.3	7,605	81.0	9,630	86.4	63,575	93.2
Passaic	46,890	66.7	4,955	32.4	4,645	40.3	4,855	54.5	32,435	77.6
Salem	7,755	78.3	625	50.4	850	61.2	835	63.5	5,445	86.5
Somerset	25,425	83.7	1,200	62.5	1,580	60.4	2,045	72.1	20,600	87.9
Sussex	10,995	83.4	630	57.1	860	65.1	1,030	71.8	8,475	88.6
Union	57,310	72.6	5,255	34.8	4,955	49.3	5,470	61.0	41,630	81.7
Warren	10,740	76.5	815	50.3	1,280	56.6	1,050	60.5	7,595	84.9

Universe: Occupied housing units with a householder 60 years and over  
Source: Census 2000 Special Tabulation on Aging

Table 8. Living arrangement by age group and gender for population aged 60 years and over, New Jersey, 2000

Age group	Male				Female			
	Total	Living alone	Not living alone	Living alone (%)	Total	Living alone	Not living alone	Living alone (%)
New Jersey	601,795	90,630	511,165	15.1	841,865	262,815	579,050	31.2
60 - 64	155,480	17,080	138,400	11	175,140	32,095	143,045	18.3
65 - 69	132,035	16,650	115,385	12.6	160,880	38,170	122,710	23.7
70 - 74	122,970	18,300	104,670	14.9	161,565	50,650	110,915	31.3
75 - 79	95,890	16,620	79,270	17.3	144,600	56,105	88,495	38.8
80 - 84	57,875	12,000	45,875	20.7	103,825	46,490	57,335	44.8
85+	37,545	9,980	27,565	26.6	95,855	39,305	56,550	41

Universe: New Jersey population 60 years and over  
 Source: Census 2000 Special Tabulation on Aging

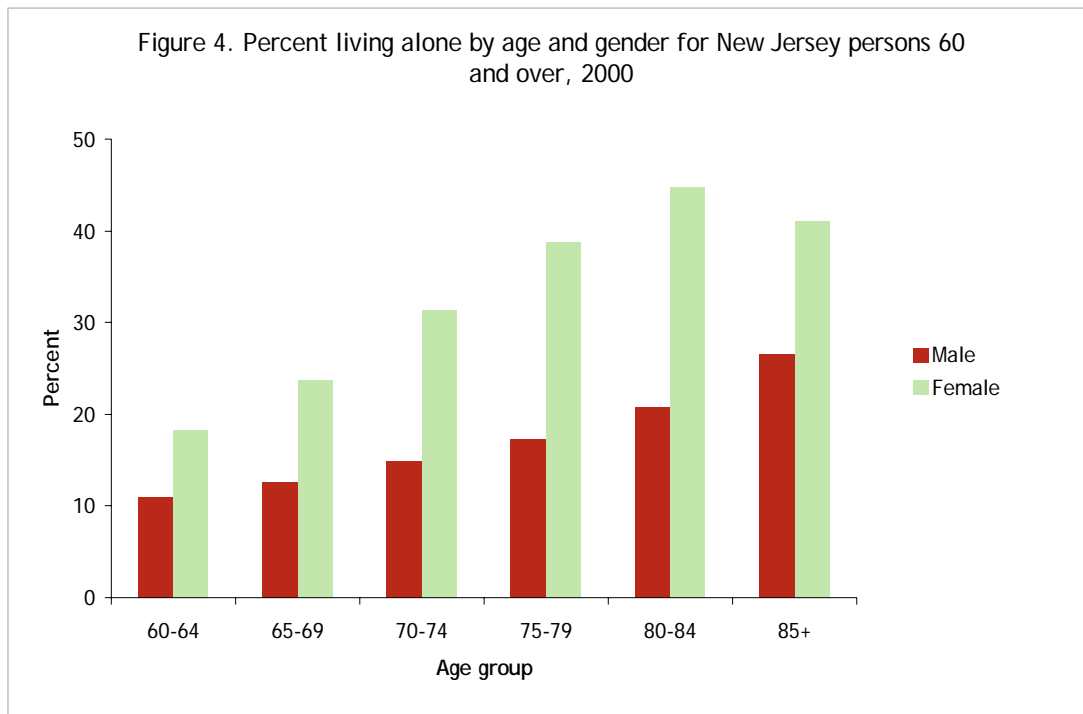


Table 9a. Type of disability for the noninstitutionalized population aged 60 years and over by age and gender, New Jersey, 2000

Age Group	Gender	Population Total	Disability Status		Type of Disability				
			No disability	With any disability	Sensory disability	With physical disability	With mental disability	With self-care disability	With go-outside-home disability
New Jersey	Men	587,000	387,005	199,995	61,450	118,620	41,820	34,555	85,340
	Women	805,285	506,890	298,395	79,805	198,510	69,905	70,485	159,555
60-64	Men	153,975	112,305	41,670	7,490	20,905	6,365	4,485	13,720
	Women	174,310	128,660	45,650	6,380	24,595	7,590	6,560	18,025
65-74	Men	251,050	179,230	71,820	19,350	43,690	12,840	10,880	30,140
	Women	318,675	228,145	90,530	17,985	60,380	15,435	15,455	42,860
75-84	Men	148,295	83,180	65,115	24,445	39,990	15,280	12,615	28,865
	Women	236,260	129,495	106,765	30,710	72,620	25,670	26,630	59,375
85+	Men	33,680	12,290	21,390	10,165	14,035	7,335	6,575	12,615
	Women	76,040	20,590	55,450	24,730	40,915	21,210	21,840	39,295

Note: Sensory disability refers to blindness, deafness, or a severe vision or hearing impairment; physical disability refers to a long-lasting condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying; mental disability refers to a condition lasting 6 months or more that made it difficult to learn, remember, or concentrate; self-care disability refers to a condition lasting 6 months or more that made it difficult to perform activities such as dressing, bathing, or getting around inside the home; going outside the home disability refers to a condition lasting 6 months or more that made it difficult to go outside the home alone to shop or visit a doctor's office.

Universe: Civilian noninstitutionalized population 60 years and over

Source: Census 2000 Special Tabulation on Aging

Table 9b. Type of disability for the civilian noninstitutionalized population aged 60 years and over by age and gender, New Jersey, 2000 (percent)

Age Group	Gender	Disability Status		Type of Disability				
		No disability	With any disability	With sensory disability	With physical disability	With mental disability	With self-care disability	With go-outside-home disability
New Jersey	Men	65.9	34.1	10.5	20.2	7.1	5.9	14.5
	Women	62.9	37.1	9.9	24.7	8.7	8.8	19.8
60-64	Men	72.9	27.1	4.9	13.6	4.1	2.9	8.9
	Women	73.8	26.2	3.7	14.1	4.4	3.8	10.3
65-74	Men	71.4	28.6	7.7	17.4	5.1	4.3	12
	Women	71.6	28.4	5.6	18.9	4.8	4.8	13.4
75-84	Men	56.1	43.9	16.5	27	10.3	8.5	19.5
	Women	54.8	45.2	13	30.7	10.9	11.3	25.1
85+	Men	36.5	63.5	30.2	41.7	21.8	19.5	37.5
	Women	27.1	72.9	32.5	53.8	27.9	28.7	51.7

Note: Definitions for different types of disability are shown in the Note for Table 7a. The percentage is calculated by dividing the number of people having (or not having) a type of disability in each age-sex group over the total number of people in the same age-sex group.

## CHAPTER 2

### Planning Framework

#### MAJOR INITIATIVES

The 2005-2008 New Jersey State Strategic Plan on Aging is based upon the advancement of three initiatives that are currently underway. They were launched during the 2002-2005 State Strategic Plan for Aging and are fundamental to the future development and delivery of all programs and services of DACS. They are as follows:

#### NEW JERSEY'S MAJOR INITIATIVES

1. The redesign of the aging and disability service system under New Jersey's Aging and Disability Resource Center (ADRC) grant.
2. The development and implementation of a global budget long-term care program.
3. The creation of a pilot fast track eligibility program with presumptive eligibility in Warren and Atlantic Counties, the two ADRC test counties.

#### ADRC

In 2003, New Jersey was one of the first 12 states to receive an ADRC grant from the Federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to help redesign the aging and disability service system. In New Jersey, Atlantic and Warren Counties were selected to serve as ADRC pilot counties, and ADRC is expected to go statewide. The initiative is re-engineering New Jersey's aging services delivery system, known as NJEASE (New Jersey Easy Access, Single Entry), well beyond its current structure and capacity.

#### GLOBAL BUDGET

Two Executive Orders were issued by former Governor James E. McGreevey in 2004 and Acting Governor Richard J. Codey in 2005 to reform long-term care (LTC) in New Jersey. These executive orders call for the implementation of a global budgeting process for long-term care supportive services. They involve the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) as the single state agency for Medicaid, and DHS's Medicaid office and Division of Disabilities Services, as well.

Under the mandate of Executive Order No. 31, issued by Acting Governor Codey on April 21, 2005, DHSS is directed to begin a process in State FY 2006 to develop and implement a pilot global long-term care program. The new long-term care system for older adults will have improved access and consumer-directed care across all settings and an array of home care options from which to choose.

This order builds upon Executive Order No. 100, issued by Governor McGreevey in 2004. The centerpiece of order No. 100 was to create a global budget report, which was accomplished in order to study the State's current long-term care financing structure and provide recommendations.

## **PILOT FAST TRACK ELIGIBILITY PROGRAM**

Through Executive Order No. 31, DHSS, in partnership with DHS, will also pilot fast track eligibility (including presumptive eligibility) in State FY 2006. The State of New Jersey is directed to pilot fast track eligibility in the test environment already underway through the ADRC initiative in Atlantic and Warren Counties.

Through the ADRC initiative, DHSS and DHS have already started reengineering the financial eligibility determination process and infrastructure, including making informational, procedural, and systemic changes to eliminate barriers. Fast tracking Medicaid eligibility is also a key objective in the ADRC initiative. The goal, as stated in New Jersey's original ADRC grant application to the AoA and the CMS, is to facilitate seamless, one-stop access to LTC supportive services. The paperwork is to be streamlined and the red tape cut with fast tracking as the outcome.

## **2005-2008 PRIORITIES**

Within the context of New Jersey's long-term care reform agenda and the implementation of the ADRC initiative, NJ's 2005-2008 State Strategic Plan on Aging has adopted the same five strategic priorities that were established as part of AoA's Strategic Action Plan<sup>1</sup>, thus assuring consistency between New Jersey and AoA's priorities. While the priorities are the same, the goals established in this plan are unique to New Jersey. Further details pertaining to these five priorities and their related goals, objectives, and strategies appear in Chapters 3 and 4.

## **NEW JERSEY'S PRIORITIES AND GOALS**

**Priority 1:** Make it easier for older adults to access an integrated array of health and social supports.

- **Goal 1:** Establish an ADRC in two counties and lay the foundation for statewide implementation.
- **Goal 2:** Prepare Medicare counselors and others in the aging network for the launch of Medicare Part D, the new prescription drug benefit.
- **Goal 3:** Ensure DACS and its partners in the aging and disability network attain cultural and linguistic competence to better serve New Jersey's growing diverse population.
- **Goal 4:** Ensure consumer direction throughout the aging services network.
- **Goal 5:** Work with key players in the transportation sector to access the need for, and improve the coordination of, transportation services for older adults.

**Priority 2:** Help older people to stay active and healthy.

- **Goal 1:** Empower older adults to actively engage in health behaviors so they can live longer, maintain their quality of life, and participate in/contribute to their communities.

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<sup>1</sup> U.S. Administration on Aging, Strategic Action Plan, FY 2003-2008, November 2002, p. 6.

Extend health, functional independence, and health-related quality of life as long as possible.

- **Goal 2:** Through **Mission Nutrition**, redefine the New Jersey Nutrition Program as a full service community program, an integral component of a comprehensive and coordinated system of home and community based services.
- **Goal 3:** Promote early and effective life planning and health promotion to younger populations and to adults age 50 and older.

**Priority 3:** Support families in their efforts to care for loved ones at home and in the community.

- **Goal 1:** To improve caregiver skills in using the home environment for dementia care. Create a model for integrating home modifications and assistive technologies into ADRC processes.
- **Goal 2:** Develop a coordinated care management and service delivery model to assist older caregivers who are providing assistance to adults with developmental, physical, and/or mental disabilities.
- **Goal 3:** Implement a caregiver-directed service component statewide through the state-funded Statewide Respite Care Program.

**Priority 4:** Ensure the rights of older people and prevent their abuse, neglect and exploitation.

- **Goal 1:** Ensure, through the Office of the Ombudsman for the Institutionalized Elderly, that nursing home staff and volunteer advocates are trained to spot, prevent, or stop and report incidents of resident mistreatment and promote a culture of caring in institutional settings.
- **Goal 2:** Through the Office of the Public Guardian for Elderly Adults, educate the public and work with professionals to ensure that guardianship and alternatives to guardianship are understood and properly utilized.
- **Goal 3:** Through Adult Protective Services, support county provider agencies and educate and work with partner agencies to ensure that vulnerable adults are identified and services are provided to ensure their safety in the community.

**Priority 5:** Promote an effective and responsive management program.

- **Goal 1:** Continue to implement DACS's annual AAA Assessment Procedure.
- **Goal 2:** Provide new and ongoing technical assistance to the AAAs to support their role as senior planning and service leaders at the local level.
- **Goal 3:** Improve, monitor, and evaluate Home and Community-Based Waiver programs to ensure quality.
- **Goal 4:** Promote DACS's Quality Assurance and Quality Improvement Process throughout all programs and services.
- **Goal 5:** Seek funding for innovative programs that benefit seniors, caregivers, and people with physical disabilities
- **Goal 6:** Reform long-term care by changing the way the budget is structured through a global budgeting process.
- **Goal 7:** Continue an open communications framework established within DACS in order to foster cohesion and efficiency.

- **Goal 8:** Transform information technology to support system change at DACS.
- **Goal 9:** Reorganize the Office of Community Choice Options to meet changing needs and business conditions.
- **Goal 10:** Develop a formal outcomes measurement model for selected programs in order to document changes in the knowledge, attitudes, behavior, and/or physical and/or emotional well-being of recipients of aging services.

## **NEW JERSEY'S GUIDING PRINCIPLES**

DACS is committed to the idea that there are fundamental core values that must be incorporated into the development and implementation of strategic priorities, goals, and objectives. To ensure consistency with these core values, DACS has established five guiding principles, as outlined and defined below.

### **NEW JERSEY'S GUIDING PRINCIPLES**

1. Leadership
2. Advocacy
3. Consumer Direction
4. Cultural Competency
5. Quality Assurance/Quality Improvement

## **LEADERSHIP**

At DACS, leadership is intrinsic to the organization, from managing public funds on the state and local levels to providing direction in the aging network and good internal management within the division. Leadership at DACS means molding, modifying, and modernizing the AAA's when it comes to its role as the State Unit on Aging. The AAAs look to the State for leadership in terms of funding, but also for training, information, and technical assistance. It is an ongoing responsibility.

## **ADVOCACY**

Advocacy for older adults and their caregivers must be promoted. DACS supports policies that enhance the capacity of aging services and programs to meet the needs of older adults and their caregivers.

## **CONSUMER DIRECTION**

As a cornerstone of the ADRC initiative, consumer direction is a principle that empowers older adults to make their own long-term care decisions, one that incorporates the philosophy of individual control in State policies and programs. It must be seen as a right that supports individuals in managing their own affairs and making their own decisions.

DACS is currently working to integrate a consumer-directed philosophy into its programs as a result of the ADRC, but also through the global budget initiative. A number of key activities will be undertaken in 2005 and beyond with state partners that will involve the promotion of consumer direction. Recent focus groups and public forums convened for the development of

this plan, provided evidence of and support for consumer direction. DACS is working to advance higher consumer satisfaction, autonomy and control.

## **CULTURAL COMPETENCY**

Cultural competency focuses on a specific target population, namely minorities. In doing so, it must successfully assist minority older adults to remain healthy, active, and independent in their communities and to eliminate health, social, and economic disparities. The aging network in New Jersey needs to identify approaches and interventions that respect minority cultures and appropriately address their needs.

New Jersey has targeted its services by focusing its efforts on specific population groups, namely all older adults age 60+, older minority adults, older low-income adults, disabled/frail adults, and vulnerable adults. Minorities in New Jersey include Hispanics, African Americans, Asians, and American Indians.

Cultural competency and the targeting of services must assure that vulnerable minority populations have equal access to services that assist them in remaining healthy, active, and independent within their communities. Cultural and linguistic competence is defined as “the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities”. The incorporation of cultural and linguistic competence in program administration and service delivery will likely increase service access, consumer and family satisfaction and improved client/service outcomes.

DACS plans to incorporate cultural and linguistic competence across all levels of the organization – management, policy and procedure development, staff recruitment, training, program administration, service delivery, monitoring and evaluation because this is critical to ensuring that services are meeting the needs of culturally diverse population groups.

DACS will take the lead within the aging network in New Jersey to develop a cultural competency model that measures an organization’s cultural and linguistic competence level and that of the professionals within the agency. The cultural competence model will be pilot tested at DACS and within the two ADRC pilot counties – Atlantic and Warren. The model will be shared with the other nineteen counties once refined.

The cultural competency model specifically addresses such issues as:

- Community stakeholder involvement in the organization’s planning process.
- The hiring practices of the organization.
- Evaluation of the literacy levels of present agency materials (e.g. brochures, videos, signage, and agency applications).
- The availability of translation services.
- The cultural appropriateness of the client assessment application and process.
- Actual service delivery (e.g. location, hours of operation, quality of services).

Performance indicators and appropriate data elements have been identified for collection and evaluation.

The Cultural Competency Subcommittee, established in July 2003, consists of 8-10 active members from various non-profit and state government entities. The Cultural Competency Subcommittee is co-chaired by a New Jersey Commission on Aging member and a Director of a Multicultural Education Center. DACS's Cultural Competency Subcommittee already has a number of accomplishments to its credit, as follows:

- Identified the unique service utilization patterns of the various cultural groups served with Title III funding.
- Identified cultural and linguistic performance measures.
- Developed an introductory cultural competence-training curriculum.
- Developed a cultural self-assessment tool for organizations and their professionals to identify areas of strengths and needed improvements as these relate to working and serving residents of cultural and ethnic communities.
- Provided funding to eleven community-based organizations serving Latino communities to offer a health and wellness activity that specifically targeted Latina women age 60 and older.
- Recently secured funding for the next five years to: **(a)** develop a health literacy initiative and **(b)** expand the cultural competency training curriculum to directly apply to the work performed by care managers and nurses operating within the aging and disability network.

### **QUALITY ASSURANCE AND QUALITY IMPROVEMENT (QA/QI)**

The division has adopted a QA/QI process designing quality assurance and improvement strategies into the Home and Community Based Services (HCBS) program at the initiation of the program. Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement. Taking actions to remedy specific problems or concerns that arise in the discovery process.

Priority areas for quality assessment in New Jersey are:

1. Participant access
2. Participant-centered service planning and delivery
3. Provider capacity and capabilities
4. Participant safeguards
5. Participant rights and responsibilities
6. Participant outcomes and satisfaction
7. Systems performance

### **SUMMARY OF COMMUNITY STAKEHOLDER FORUMS AND PUBLIC HEARINGS ON NEW JERSEY'S STATE STRATEGIC PLAN FOR AGING**

To solicit input into the development of its proposed 2005-2008 Strategic Plan for Aging, DACS held a stakeholders meeting in January 2005. Stakeholders identified several themes that should be addressed in the plan. In March 2005, these themes were refined at a meeting of the AAA directors. The AAA directors also developed guiding principles. Two public hearings were then

held, one each in Atlantic and Warren Counties. Plan input was also received in writing from persons unable to attend these meetings or who wished to provide additional comments. Lastly, a retreat to garner input from DACS management staff was held in April 2005.

Many of the themes, principles and service issues identified by stakeholders and members of the public have been incorporated into this plan as goals and objectives related to DACS's five priorities. A brief discussion on how DACS has or will address stakeholder, public, and other input appears in the discussion of each priority in Chapter 3. In the summaries below, issues have been grouped according to the priority area where they are addressed in Chapter 3.

### **STAKEHOLDER FORUM**

DACS held a meeting of key stakeholders on January 25, 2005, at the State House in Trenton. Fifty stakeholders were invited to participate and 35 attended. Major themes identified by the stakeholders included: caregiver issues, flexible funding, workforce shortage, housing, single point of entry, access to transportation, resource development, education and training, consumer empowerment, support service network, comprehensive disease management, and social isolation.

### **AAA DIRECTORS MEETING**

The March meeting of AAA Directors was dedicated to input for the State Plan. Directors were encouraged to invite members of their AAA Advisory Councils.

Guiding principles developed at this meeting included: stewardship (i.e., the responsible use of public funds), quality, advocacy, consumer direction, cultural competency, partnership, and targeting.

Themes agreed upon included: access/marketing/outreach, advocacy, caregiver, consumer education, funding, health and wellness, home and community-based services/in-home services/disables services/ADRC/mental health services, housing, legal and financial services, nutrition, partnership/coordination, taxonomy, training, transportation, and volunteers.

### **PUBLIC HEARINGS**

Two public hearings were held to solicit input into the strategic plan. Attendance was encouraged through the AAA newsletter in Warren County and a press release in Atlantic County. More than 200 seniors, caregivers and providers attended the public hearings. Four years ago, three public hearings attracted just over 100 attendees.

### **WARREN COUNTY NEWSLETTER ARTICLE**

BELVIDERE – On April 14, 2005, officials from the New Jersey Department of Health & Senior Services, Division of Aging and Community Services, will be accepting comments and looking for input as they develop the 2005-2008 New Jersey State Plan on Aging. The State Plan on Aging is the roadmap through which programs and services addressing the needs and concerns of older adults in New Jersey are developed.

Don't miss your opportunity to provide input into the development of the New Jersey State Plan on Aging.

The Warren County Division of Senior Services is sponsoring the event along with neighboring County Offices on Aging in Sussex, Hunterdon and Somerset Counties.

**When:** 1:30 p.m., Thursday, April 14, 2005  
**Where:** Washington-Area Senior Nutrition and Day Center  
St. Joseph's Community Hall  
200 Carlton Avenue, Washington, NJ

Contact the Division of Senior Services for more information at 1-877-222-3737.

## ATLANTIC COUNTY PRESS RELEASE

**TRENTON** - New Jersey residents will have the opportunity to provide input into the State's plans for services to senior citizens for the period 2005-2008, when the New Jersey Department of Health and Senior Services, in conjunction with the New Jersey Commission on Aging, conducts the second of two public hearings later this week in Atlantic County.

The public hearing will be held Wednesday, May 4, 2005, starting at 11:00 a.m., at the Herman Pogachefsky Senior Services Pavilion, 1102 Atlantic Avenue, in Atlantic City. The first hearing was held in Warren County in April.

State Units on Aging are required to submit service plans to the U.S. Administration on Aging every three years. The plans detail service needs, establish priorities, and outline how each state plans to utilize federal Older Americans Act and state funding to accomplish established goals.

Anyone interested in senior issues may attend the public hearing. Written testimony can be submitted at the hearing or can be mailed to the attention of Assistant Commissioner Patricia Polansky, New Jersey Division of Aging and Community Services, PO Box 807, Trenton, NJ 08625-0807 by June 15, 2005.

### **FIRST PUBLIC HEARING** Warren County, April 14, 2005 (125 Attendees)

The issues raised by members of the public at this hearing are summarized below, by priority area.

#### **PRIORITY 1:**

- Prescriptions
- Maintain dignity of all elders
- Freedom to return to same nursing home after long hospital stay
- Cultural competency

#### **PRIORITY 2:**

- Health Promotion

- Recreation/Exercise: Dancing, Social Events, Work-Outs
- Educate public regarding services and programs: Nutrition

**PRIORITY 3:**

- Medical Adult Day programs, especially in rural areas
- Caregiver Funding
- Help seniors to remain in their own homes/home health aides

**PRIORITY 4:**

- Senior Scams and Safety
- Legal Services
- Financial Services

**PRIORITY 5:**

- Outreach to rural areas: Shared Services with business and other agencies/organizations

**OTHER/OVERLAPPING:**

- Tax Reform
- Property/Real Estate Taxes
- Transportation
- Affordable housing
- Better Medical Coverage
- Better insurance rates
- Limit immigration/reserve services for tax-paying citizens
- Long Term Care
- Dental Program for seniors
- Enforce illegal parking laws
- Cell Phone (911 for emergencies)

**SECOND PUBLIC HEARING** Atlantic County, May 4, 2005 (95 Attendees)

The issues raised by members of the public at this hearing are summarized below, by priority area.

**PRIORITY 1:**

- Sensitivity training to hospital staff for services provided to disabled population (visually impaired). For example: attitude and sensitivity toward visually impaired
- Services to 55+ visually impaired population

**PRIORITY 2:**

- Health Programs for seniors
- Activities for keeping fit
- Encourage congregate meals
- Cost and quality of meals, possibility of delivering cultural food

**PRIORITY 3:**

- Social and Medical Day Care
- Eligibility for Medicaid to pay for Social Day Care

**PRIORITY 4:**

- Age biased employment

**PRIORITY 5:**

- None

**OTHER/OVERLAPPING:**

- Needs transportation to take seniors to senior center
- Transportation for medical needs, for example: dialysis
- Transportation for extended hours, for example: weekend and evening
- Short trip to post office back and forth
- Riding time too long
- Difficult to get into the van, for example: handicap ramp/lift is needed
- Affordable housing is needed
- Middle income housing is needed
- Assist Living program has beds in New Jersey
- DACS rep will visit the Atlantic County to discuss congregate services
- Sliding scale has different rate for different building, why?
- Shortage of Home Health Aide to assist seniors who live in the community
- Slogan to be used: "Beauty is Ageless"

## CHAPTER 3

### New Jersey's Strategic Priorities

The U.S. *Administration on Aging Strategic Plan, 2003-2008* lists five priorities that are intended to guide AoA's activities over the next five years. New Jersey has incorporated these same five priorities into the *New Jersey Strategic Plan on Aging, 2005-2008*, including the priority related to promoting effective and responsive management. Details appear below pertaining to the goals, objectives, strategies, and performance measures related to each priority.

#### **PRIORITY 1: Make it easier for older people to access an integrated array of health and social supports.**

##### **TRENDS AND CONDITIONS**

There are presently two separate service delivery systems in New Jersey, one for older adults and one for people with disabilities. This situation is neither consumer-friendly nor cost-effective.

For consumers, the current system is frustrating, requiring them to go through many doors to obtain information, assess needs and, finally, receive services. This compartmentalization for accessing the system and determining eligibility for services is clearly not consumer-driven. From a governance perspective, there is no single entity at the state or local level that has the authority to coordinate awareness, assistance, and access to the full range of health and community services for long-term care support.

New Jersey's challenge is to unite the aging and disability networks so that the system covers the entire adult lifespan, facilitates continuity of care and services, and empowers consumers to control their own lives. In order to accomplish this, the State must redesign access to New Jersey's aging and disability long-term care support system to enable older adults and adults with physical disabilities to age in place.

#### **GOAL 1: Establish an Aging and Disability Resource Connection (ADRC) in two counties and lay the foundation for statewide implementation.**

##### **ADRC GRANT**

The Department of Health and Senior Services (DHSS), in collaboration with the Department of Human Services (DHS), was awarded an ADRC grant from the AOA and the CMS in 2003. This grant is part of the president's New Freedom Initiative, which aims at overcoming barriers to community living for older adults and people with disabilities and integrating long-term care resources for consumers into a single coordinated system.

DACS is collaborating with DHS's Division of Disability Services (DDS) and the Division of Medical Assistance and Health Services (DMAHS) on this three-year initiative. The purpose of this effort to redesign the State's aging and disability service delivery systems is to:

- Address the changing needs of older adults, people with physical disabilities, and their caregivers, including those from culturally diverse population groups and at all income levels.
- Support those in need of care and their caregivers across the lifespan.
- Empower individuals to make informed quality of life choices.
- Foster viable, affordable and cost-effective options for long-term care support services.
- Ensure a high-quality service delivery system that is visible, trusted and easy to access for both information and assistance.

The redesign of the long-term care delivery system requires both a systematic and cultural approach to change how New Jersey's government entities and their provider partners reach out to consumers, educate them about the full range of public and private community resources, and support them to make quality-of-life choices and access public long-term support programs. Long-term care services are targeted at persons 60 and older and persons 18 years and older who have physical disabilities.

### **ADRC OBJECTIVES**

1. Establish an effective organizational structure for the ADRC project.
2. Establish two ADRC pilot projects to serve as sole sources for home and community-based services.
3. Develop and implement new strategies for making ADRCs more visible, trusted, and consumer-friendly.
4. Become the gateway to programs that connect consumers to basic human need resources.
5. Re-engineer the long-term care financial eligibility and pre-admission screening infrastructure in order to achieve fast track eligibility.
6. Design, develop, and test a management information system that supports client-tracking, needs assessment, care plans, utilization, and costs of services. *(See Priority 5 for more detailed plans, re: management information systems).*

### **ADRC FRAMEWORK**

1. An *ADRC State Management Team* is comprised of 13 administrators, directors, and assistant commissioners from DACS, DDS, and DMAHS. It meets monthly to provide leadership and guidance in the development and implementation of ADRC. The project director apprises the *State Management Team* about the grant's progress and any issues that may impact how their programs interface with the ADRC.

2. **Pilot Projects:** Members of the *Systems Change Advisory Council* in New Jersey include a broad array of stakeholders. A subcommittee of this council developed an RFP and disseminated it to all 21 AAAs, inviting proposals to become a pilot ADRC site. This competitive process was deemed the most likely to assure the selection of two AAAs best suited for this initiative and most committed to succeeding. In April 2004, the RFP subcommittee selected the Atlantic County Division of Intergenerational Services and the Warren County Office on Aging as the two ADRC pilot projects.
3. **Presentations:** The ADRC project director, along with the director of DDS, made numerous presentations to statewide associations to fully apprise them of the initiative and enlist their participation in the development of the ADRC model. These organizations included the Association of Area Agencies on Aging (NJ4A), the County Welfare Directors Association, the Association of Disability Directors, the Association of Centers for Independent Living, the Association of Senior Center Directors, and the New Jersey Commission on Aging.
4. **Formation of Workgroups:** Eleven ADRC workgroups were established to specifically perform the research and development components of the ADRC model. The workgroups are charged with researching other State models that may be applicable to New Jersey and developing products such as a benefits screening tool, clinical assessment, etc.

The workgroups are as follows: Benefits Screening, Clinical Eligibility, Financial Eligibility, Customer Excellence, Cultural Competence, Consumer Direction, NJ 2-1-1 Coordination, Public Awareness, MIS, Website Development, and SHIP Alignment. Co-leaders of each workgroup consist of staff from the aging, Medicaid, and disability networks. The collective membership of these workgroups consists of approximately 210 persons representing consumers and professionals from the aging and disabled networks.

5. **Public Awareness Communications Plan:** To help promote the ADRC, a *Public Awareness Communications Workgroup* was formed with membership from DACS, DDS, the two pilot counties, and other members of the community who volunteered through their County Offices on Aging and/or Disability Services for this function. The workgroup's charge is to: **(a)** identify and expand ways to reach consumers, and **(b)** clearly communicate with consumers so they know where to get answers.

To gauge current public awareness practices and capabilities, the workgroup surveyed providers of aging and disability services statewide and in the two pilot counties and held focus groups with providers and consumers. A comprehensive marketing plan was developed based on the results of this research. Public awareness goals and key messages were developed, and the workgroup, in cooperation with the pilot counties, will produce numerous communication tools for use in promoting the ADRCs.

### **Communications Plan Objectives**

1. Ensure that the ADRCs are visible, trusted, and consumer-friendly.
2. Ensure that seniors, adults with physical disabilities, caregivers, service providers, referral agents, and members of the general public know that the centers exist, what they do, and how to contact them for information and services.

### **Key Communications Messages**

1. Seniors, adults with a physical disability and their caregivers residing in Atlantic or Warren Counties now have a single, shared place to go to and one simple number to remember and call, 2-1-1, to learn about and access home and community-based care.
2. ADRCs provide comprehensive information and assistance from caring, trained, and knowledgeable staff to persons seeking alternatives to nursing home care.
3. Users of the ADRCs will find the experience a positive one as their care options are fully explained and, when possible, connections to services are made.

### **Communications Tools**

1. Develop a project logo and tag line.
2. Print brochures, posters, specialty items, and other campaign materials.
3. Direct mail to targeted agencies and organizations containing information on the ADRC and an order sheet for speakers and/or additional printed materials.
4. Develop talking points and a PowerPoint presentation so that any staff member or volunteer could speak authoritatively on the ADRC.
5. Develop and publicize newspaper ads and public service announcements for radio and cable television stations.
6. Issue press releases to announce the launch of ADRC in both counties and to mark milestones and success stories.

## 6. ADRC Client Pathway Model

**Algorithm:** An algorithm for the ADRC model in New Jersey was developed to identify, define, and outline the client pathway (see Exhibit 2) and decision-making process for determining clinical and financial eligibility and accessing information. The model targets older adults, persons with physical disabilities, and their caregivers. It consists of these six-steps:

1. Build organizational infrastructure.
2. Initiate contact with consumers.
3. Identify consumer needs.
4. Indicate consumer choices through counseling.
5. Implement consumer directed care plans.
6. Inquire about program effectiveness through continuous quality improvement.

**Guiding Principles:** Incorporated into the ADRC Client Pathway model are three guiding principles: customer excellence, cultural competence and consumer direction.

**Atlantic County:** The *ADRC Project Team* is working simultaneously with each county on different components of the ADRC Client Pathway. In Atlantic County, the focus has centered on the “Initiate and Identify” steps of the Client Pathway. Activities include:

- Improving the working relationship with the disability network, specifically the Center for Independent Living.
- Implementing the 2-1-1 system for Atlantic County. The Atlantic Division of Intergenerational Services recently became the designated 2-1-1 agency for Atlantic and Cape May counties.
- Providing AIRS (Alliance of Information & Referral Services) certification training for Information and Referral staff of all key partners.
- Streamlining the Medicaid financial eligibility process.
- Testing a benefit screening tool and consolidated application for LTC supportive services.
- Building a more effective working relationship with culturally diverse communities, specifically developing a culturally competency training, performance standards and indicators.

**Warren County:** In Warren County, the focus has centered on the “Identify, Indicate and Implement” steps of the Client Pathway. Activities include:

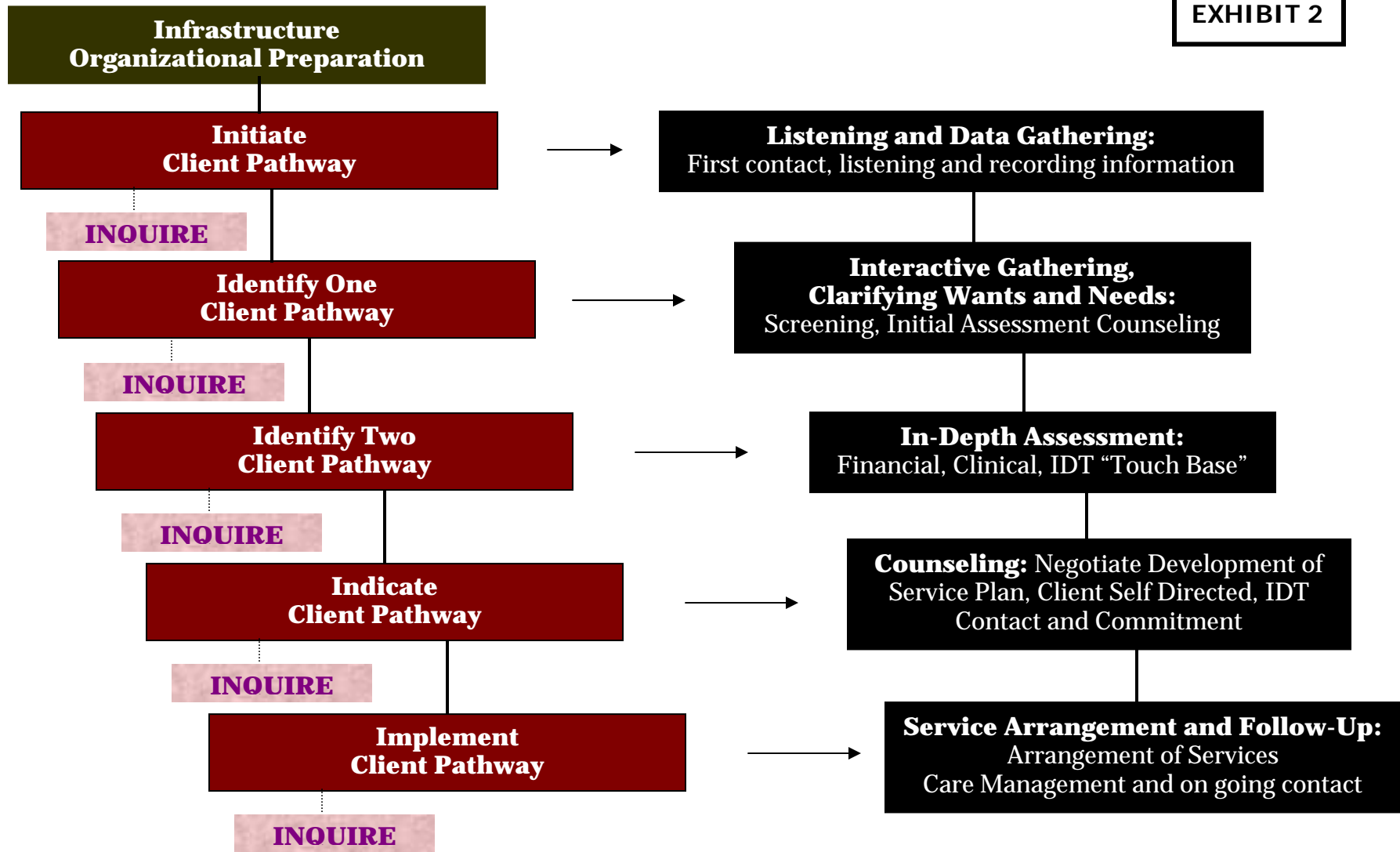
- Pilot testing the in-depth clinical assessment tool that will be used by the aging and disabled networks. The clinical assessment tool will be linked to levels of care, which incorporates consumer’s expressed needs and wants.
- Developing an interdisciplinary team approach.
- Developing policies/protocols for in-depth assessments for all State and Federally funded aging and disability LTC programs.
- Testing protocols for finalizing and authorizing publicly funded services.

## **PERFORMANCE MEASURES**

New Jersey has adopted an ADRC Evaluation Plan to provide a framework for assessing implementation of the six ADRC grant objectives and to validate the ADRC Algorithm – Client Pathway Model. A systems model that focuses on input (system resources, policies, and protocols), throughput (program activities focusing on clients, staff, resource availability, adequacy of resources) and output (initial impact on clients, staff effectiveness, and process effectiveness) serves as the basis for the evaluation approach. Triangulation of evidence will be used including quantitative, qualitative and anecdotal data. The initial focus is on process evaluation in order to ensure that all performance indicators have been defined and to assess system change processes.

# ADRC Model: Concept & Client Pathway

EXHIBIT 2



**GOAL 2: Prepare Medicare counselors and others in the aging network for the launch of Medicare Part D, the new prescription drug benefit.**

**TRENDS AND CONDITIONS**

The Medicare Modernization Act of 2003 (MMA) includes a provision creating Medicare Part D, a new prescription drug benefit in the Medicare program. Throughout the coming year, 1.2 million people with Medicare in New Jersey need to be educated about the new prescription benefit and, if appropriate, will need help enrolling in a plan that best meets their needs. Additionally, many people with Medicare in New Jersey will be eligible for financial assistance to help pay the prescription plan monthly premium, annual deductible, and co-payments.

Under Medicare Part D, different subsidies will be available based on income and resources. Some people will not have to apply for the subsidy while others will be required to complete a lengthy application. All people with Medicare and Medicaid will lose their Medicaid prescription coverage at the end of the calendar year and will have to be enrolled in a Medicare Prescription Drug plan effective January 1, 2006.

People enrolled in New Jersey's Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) will have to be educated about how Part D and PAAD will work together and the necessity that they enroll in Medicare Part D. People with a prescription benefit through an employer group health plan may lose the benefit and have to enroll in a Medicare plan, or they may have to decide between keeping the employer benefit or enrolling in a Medicare plan.

**OBJECTIVES (MEDICARE PART D)**

1. Provide information and assistance to a greater number of Medicare beneficiaries unable to access other channels of information or needing and preferring locally based individual services.
2. Increase targeted outreach in order to provide access to information to low-income, dually-eligible, and hard-to-reach populations.
3. Develop partnerships with community-based organizations/service agencies and enhance the SHIP counselor cadre and equip them to be proficient in the education of and assistance to people with Medicare with regard to the Medicare prescription drug benefit.

**STRATEGY**

1. Offer educational seminars to professionals and providers within the aging and disabled networks about the Medicare prescription drug benefit and low-income subsidies.
2. Offer educational seminars to people with Medicare in every county in New Jersey.
3. Provide additional hours of training to SHIP counselors statewide with regard to the Medicare prescription drug benefit.

4. Collaborate closely with CMS, Social Security Administration, and the AoA as an active partner to provide the most current and accurate information to beneficiaries and assist them in applying for the low-income subsidy.
5. Identify and partner with organizations/agencies that provide services and assistance to low-income, dually-eligible, and hard-to-reach people with Medicare.
6. Participate in the New Jersey Consortium as a member of AoA's Medicare aging network. Share best practices and materials, avoid duplicative efforts, and enhance the collective ability of the group to reach the varied and diverse Medicare population in NJ.
7. Work closely with PAAD to (a) ensure that its beneficiaries enroll in a Medicare prescription drug plan that meets their needs, and (b) facilitate application for the low-income subsidy available to approximately one-third of PAAD enrollees.
8. Increase the number of local sites where people with Medicare can obtain necessary Medicare prescription plan information and help with enrollment.

### **PERFORMANCE MEASURES**

DACS's degree of success will be measured by the numbers of people reached through outreach events and one-on-one counseling with essential information -- as compared to the total number of people with Medicare in New Jersey. Enrollment data from the CMS will indicate the number of people who actually enroll in a Medicare prescription drug plan in the required time frames (i.e. 12/31/05 for dually eligible individuals and 5/15/06 all others).

**GOAL 3:** Ensure that DACS and its partners in the aging and disability network attain cultural and linguistic competence in order to better serve New Jersey's growing diverse population.

### **TRENDS AND CONDITIONS**

Cultural and linguistic competence has been identified by DACS as a guiding principle applicable to all of the work done by the Division. Cultural and linguistic competence is defined as the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. The incorporation of cultural and linguistic competence in program administration and service delivery will likely increase service access, consumer and family satisfaction, and improved client/service outcomes.

Communities in New Jersey have become more racially, ethnically, and culturally diverse. According to statistics from the New Jersey Office of Minority and Multicultural Health, the African American community represents 13.6% of the State's total population (1,141,821); Hispanic or Latino Americans represent 13.3% of the total population (1,117,191); and Asian Americans represent about 5.7% of the total population (480,276). This represents about one-third of the State's total population.

Within each of these population groups there is tremendous diversity among ethnicities and languages spoken (70+ languages are spoken in New Jersey). Minority older adults access aging services at lower rates than their white counterparts. It is a significant challenge for social service and health care providers to meet the needs of such a diverse population.

## **OBJECTIVES**

1. Develop a Cultural Competency Model that will address issues of access, cultural competence, and linguistic competence and contain specific indicators with related outcomes.
2. Continue to identify key players within diverse communities to begin to establish dialogue and trust within these communities.
3. Increase the Division's capacity to contract with potential minority providers (providers whose client base is 51% minority or higher).
4. Continue to develop a training program that promotes cultural competence among DACS staff and all contracted providers across existing community programs.

## **STRATEGY**

1. Pilot test the Cultural Competency Model at DACS as well as in Atlantic and Warren Counties, the ADRC pilot sites.
2. Recruit and train volunteers from community-based and faith-based organizations to become *Community Ambassadors* responsible for sharing key information from DACS with their communities. These leaders can assist the Cultural Competency Subcommittee in the design and implementation of culturally appropriate services.
3. Offer grant-writing workshops for grassroots organizations identified in partnership with the Office of Minority & Multicultural Health, Office of Faith-Based Initiatives, Center for Hispanic Policy, and the like.
4. Develop a cultural competence training curriculum for DACS staff and contracted providers.

## **PERFORMANCE MEASURES**

1. Organizational self-assessment tool and cultural competency plan.
2. Multicultural coalition of key leaders.
3. Number of workshops, number of actual contracted providers.
4. Annual training plan, number of organizations trained, number of professionals trained.

**GOAL 4:** Ensure consumer direction throughout the aging services network and implement New Jersey's *Promoting Consumer Direction in Aging Services* grant.

### **PROMOTING CONSUMER DIRECTION IN AGING SERVICES GRANT**

DACS was one of the five grantees in 2004 to be awarded a *Promoting Consumer Direction in Aging Services* grant funded by the National Council on Aging (NCOA) and the National Association of State Units on Aging (NASUA). The purpose of the grant is to support States' efforts to assess their home and community-based service systems and to identify opportunities to increase consumer choice and control (NCOA and NASUA, 2003).

In combination with this grant, DHSS pooled together resources from its ADRC grant and the Division of Disability Services' *Real Choice Systems Change* grant to identify opportunities of consumer choice and autonomy. A *Consumer Direction Advisory Task Force* was established to oversee the activities of the *Promoting Consumer Direction in Aging Services* grant.

The task force's specific goals were to implement the consumer direction tool in a statewide effort, conduct focus groups regarding the topic of consumer direction, host one public forum with key stakeholders, and produce a report summarizing its activities. The report reflects all of the activities, findings from the survey and focus groups, as well as a proposed plan designed by the key stakeholders who attended the public forum. The report also recommends "Next Steps" for integrating consumer direction into New Jersey's aging and disability networks.

### **TRENDS AND CONDITIONS**

Several overarching issues became apparent from the surveys and the focus groups and these were addressed during the public forum. Ultimately, the key stakeholders who participated in the surveys, the focus groups, and/or the public forum identified productive steps to take to remove barriers that currently hinder consumer choice and autonomy. Among these were the following:

- More training is needed for all participants in the provision of long-term care and support services in terms of consumer direction.
- Consumers need to be educated about the range of decision-making that they have in their care plan and the responsibilities that exist in direction of their own care.
- Consumers would further benefit if front line workers received more training in communication, especially in terms of how to engage consumers in planning the care they want.

The communication skills of case managers and care coordinators are not the only impediment to the provision of consumer direction in care planning and service implementation. Another key issue is the complicated structure of types of services and their funding sources. Therefore, key stakeholders requested that service policies should be more streamlined so that when a consumer identifies the different types of assistance she or he would like to get, those services

are available regardless of funding source. That would do away with the issue of waiver slots being available and thereby remove limits on the types of services that a consumer can receive.

Finally, key stakeholders suggested that more entities work together, especially in terms of different State departments and divisions combining their resources and policies to better serve people who prefer to remain in or return to the community. The development of such collaborative relationships also includes the State and consumers engaging with private industries and organizations to design and build infrastructures that support people with disabilities of all ages who want to live and work in the community.

## **GRANT DELIVERABLES**

1. Establish an advisory committee and hold a minimum of five meetings.
2. Use the *Consumer Direction Tool* developed by NASUA/NCOA to assess program policies that promote or hinder consumer direction.
3. Sponsor at least one focus group to ensure key stakeholder input.
4. Sponsor at least one public forum to ensure key stakeholder participation.

## **KEY FINDINGS**

There were five overarching areas that emerged from the *Consumer Direction Tool* responses and the focus group statements. These areas are:

- Autonomy and independence
- Communication and information
- Workforce/status of the care workers
- Medical model
- Employment

These five themes were presented at a public forum on January 11, 2005. Public Forum attendees were organized into breakout sessions with each group representing one of the themes. Each breakout session was charged with developing an action plan to further develop consumer direction principles in the policy design and program implementation of long-term support services. (See *New Jersey's Road Map to Consumer Direction*, Exhibits 3-7).

## **RECOMMENDATIONS**

There are several general steps that the key stakeholders recommended relating to training, improving communication opportunities, and streamlining long-term care and support policies. More specifically they are as follows:

- All providers of long-term care and support services need consumer direction training. Consumers also need to be educated about the range of decision-making they may have in relation to their care plan and the responsibilities that exist in directing their own care.
- Front line workers need training in communication skills, especially focused on engaging consumers in planning the care they want.
- The complex structure of funding sources is another issue. Key stakeholders requested that policies be streamlined so that services are available regardless of the funding source.
- Entities should work together to promote consumer direction. Different state departments and divisions should combine resources and policies to better serve people who prefer to remain in or return to the community.
- The state and consumers should work with private industry and community organizations to design and build infrastructures that support people with disabilities of all ages who want to live and work in the community.

### **SHORT-TERM GOALS**

1. Develop and provide consumer direction training for:
  - Leadership
  - Professionals
  - Front-Line Workers
2. Consumers want and need consumer direction training
  - Atlantic and Warren County Centers for Independent Living (CILS) will provide training to consumers
3. Develop web-based "Self-Assessment" tool

### **LONG-TERM GOALS**

1. Streamlined policies - regardless of funding streams. Government agencies, counties and private industry work collaboratively.

### **PERFORMANCE MEASURES**

DACS will implement the strategies outlined in *New Jersey's Road Map to Consumer Direction* in order to achieve the desired outcomes and increase consumer direction in New Jersey.

## New Jersey's Road Map to Consumer Direction

**EXHIBIT 3**

### Autonomy & Independence

GOAL	STRATEGY	PARTNERS	OUTCOMES
<p>Establish accessible, affordable, safe housing</p>	<p>Link the development of housing and transportation</p> <p>Explore private/volunteer transportation options</p> <p>Housing subsidies be attributed to person, not housing location</p> <p>Remove age restrictions in senior housing so younger adults can live in and take care of older adults</p>	<p>Developers, legislators, banks, planning boards, Housing and Urban Development agencies (HUD), large employers, Housing Mortgage Finance Association.</p>	<p>Consumers would have choices which support autonomy and independence</p> <p>Accessible and integrated communities</p>
<p>Enable consumers to be informed about all options (care)</p>	<p>Involve hospital and nursing home discharge planners</p> <p>Develop and provide a self-assessment tool for autonomy</p> <p>Develop and provide a checklist regarding level of independence</p> <p>Develop public relations campaign - design brochures re: description of independence required for levels of care</p> <p>Public relations work continues with the use of billboards</p>	<p>Information and assistance, single-point-of-entry workers and managers, all NJ EASE partners/AAA, Boards of Social Services, hospital discharge planners, nursing home discharge planners, AARP, senior centers, senior villages, doctors' offices, churches, rehabilitation centers, home health providers</p>	<p>Informed consumers who are able to make choices and who are provided with assistance before crises occur or worsens.</p> <p>People-centered information and assistance programs.</p>

## New Jersey's Road Map to Consumer Direction

**EXHIBIT 4**

### Communication and Independence

GOAL	STRATEGY	PARTNERS	OUTCOMES
<p>Improve clarity of information</p>	<p>Attach to licensures/certifications</p> <p>Advertise on buses – print ads – Use simple language (doctor's offices, health providers, etc.)</p> <p>One phone number as point of entry;</p>	<p>Social Security, Hospital Social Workers/ discharge planners, Home Health Agencies/VNAs, Medical Society, Hospital Association, AARP (newsletter), municipalities, Employers (for notices /information distribution with check), bulletin boards, Banks</p>	
<p>Improve the eligibility process</p>	<p>Use NJ Helps; Create/utilize web-based information</p> <p>Link the State home page to the benefits screening tool (NJ Helps)</p> <p>Mail out the "required documentation" brochure</p>	<p>State/county program entities</p>	<p>Consumer takes more responsibility for completing the application</p> <p>Reduces burden of the in-take worker</p> <p>Reduces time caregiver has to take off work to handle the paperwork issues</p>
<p>Enhance interpersonal skills</p>	<p>Develop educational programs for professionals to improve interpersonal communication skills – "what do you want me to do for you?"</p> <p>Address issues of automated systems (for some, can't follow the menu, can't hear, etc)</p>	<p>State staff</p>	<p>Consumer Direction will become integral component of service delivery</p> <p>Increase intranet messages; enhance websites with simple links</p>

## New Jersey's Road Map to Consumer Direction

**EXHIBIT 5**

### Status of the Care Worker

GOAL	STRATEGY	PARTNERS	OUTCOMES
Establish better communication and to share information	Educate workers and consumers regarding consumer direction and develop websites regarding programs  Survey former aides to determine why they left and what could have improved their employment situation	Home health care associations, the Board of Nursing, advocacy groups, and employment offices	To have more workers remain in the field; to have more flexibility in terms of activities that home health aides can perform (such as walking in the park with their client); and to have reimbursement for travel in addition to other improved benefits
Engage more consumers involved in advocating for improved workers' status		Same as above	Same as above
Elevate the status of care workers	Explore what other states do and to use a state's (or multiple states) regulations as a model in changing regulations associated with care workers	Same as above	Same as above
Evaluate regulations that oversee workers	Advocate for changes in the Nurse practice Act  Have the home care industry and the Board of Nursing work together on developing policies	Same as above	Same as above

## New Jersey's Road Map to Consumer Direction

**EXHIBIT 6**

### Medical Model

GOAL	STRATEGY	PARTNERS	OUTCOMES
Take a holistic approach in working with consumers	Have customized services that are driven by consumers' needs	Consumers, AAA's, County Offices of Disabilities, Boards of Social Services, Independent Living Centers, medical providers, community based service providers/ home health care agencies	The consumer maintains her or his dignity and to receive services as requested
Create an environment that prevents crisis situations	Change regulations that prohibit flexibility of workers' activities so that regulations allow for more focus on prevention of crises rather than the reactionary process that now occurs	Same as above	Same as above
Provide uniform options for consumers	Educate consumers and providers in terms of consumer direction. Streamline the application process.	Same as above	Same as above
Have the global budget provide a holistic approach	Have customized services that are driven by consumers' needs	Same as above	Same as above

## New Jersey's Road Map to Consumer Direction

**EXHIBIT 7**

### Employment

GOAL	STRATEGY	PARTNERS	OUTCOMES
Improve transportation options for people with disabilities	Training, cross-training and ongoing training	New Jersey WorkAbility program in the Division of Disability Services and DMAHS; Division of Vocational Rehabilitation; Department of Transportation; workforce investment boards, private sector organizations such as corporations, banks, financing entities and professional organizations; discharge planners at rehabilitation facilities and hospitals	More people returning to the workforce  Link state agencies with the disability community  Unify access to employment opportunities  Increase uniformity of service delivery
Disseminate more employment information to the general public	Publishing success stories; Conduct education presentations	Same as above	More public awareness of the needs of people with disabilities and older adults
Improve access to employment information and referral services	Training, cross-training and ongoing training	Same as above	Same as above
Build disability coalition partners	Reaching out to the private sector	Same as the above	Same as above

**GOAL 5:** Work cooperatively with key players in the transportation sector to assess the need for, and improve the coordination of, transportation services for older adults.

### **TRENDS AND CONDITIONS**

The key players in New Jersey with regard to transportation services are the Department of Transportation, which operates New Jersey Transit, and DHS. DHSS also has a clear interest in transportation services because they are so essential for older adults, especially those who are low-income, frail/disabled, or vulnerable.

Although there is some cooperation among these and other agencies regarding transportation, there is also fragmentation of effort. In addition, transportation for older adults can be costly – both to individual riders and to the agencies that endeavor to pay for these services on their behalf. Last year in New Jersey, DACS served 15,825 clients with \$5,578,370 through its transportation services. In addition, it served 6,869 clients with \$917,166 through its assisted transportation services.

### **KEY FINDINGS**

**Public Input:** Participants at public hearings that were held in April and May 2005 to elicit input to this plan addressed transportation needs as follows:

- There are not enough vehicles to accommodate the homebound or for shopping.
- There is a need for transportation to take seniors to a senior center.
- There is a need for transportation for medical needs such as dialysis.
- There is a need for transportation for extended hours, e.g. weekends, evenings.
- Transportation is needed for short trips back and forth to the post office.
- Riding time is frequently too long.
- It's difficult to get into the van if it doesn't have a handicap ramp or lift.
- Scheduling transportation is difficult. For example, a person must call one week ahead for scheduling transportation, e.g. for medical needs

**AAA Transportation Services:** Listed below are just a few of many transportation-related efforts:

- **Bergen County:** Provides funds for an assisted transportation program.
- **Hunterdon County:** Funds and provides transportation services, including nominal cost transportation through the County's LINK program and door-to-door transportation through the Medicaid Sedan Service.
- **Morris County:** Provides assisted transportation and rides for nutrition programs, doctor's visits, and shopping.

## **UNITED WE RIDE OBJECTIVES**

DHSS partners with other agencies to achieve mutually beneficial results. Thus, it is a partner in the *United We Ride* initiative (UWR), which is primarily focused on improving the coordination of transportation services. NJ Transit is the lead agency responsible for the application, implementation, reporting, and evaluation process for the UWR grant because it is the State designated recipient and administrator for FTA grants and state casino revenue funds for transportation.

The project objectives of UWR are as follows:

1. NJ officials, agency directors, and human services program administrators will have an increased knowledge of the UWR Initiative.
2. Regulatory and administrative guidance will be written for UWR activity in NJ.
3. Baseline data will exist on all of the State agencies and programs that provide human service transportation in New Jersey.
4. An Action Plan for a *Statewide Assessment of Human Services Transportation* will be developed by NJ's UWR Interagency Committee.
5. A technological system(s) will be in place to track UWR project activity.
6. A centralized technological system will be identified for storing data on human services programs in New Jersey.

UWR grant funds will be used to conduct a maximum of four statewide seminars/ conferences on the UWR Initiative, disseminate information regarding the NJ UWR Initiative to all stakeholders, and administer expanded interagency coordination committee meetings, among other things.

## **STRATEGY**

**NJCAM:** DHSS is also a member of the New Jersey Council on Access and Mobility (NJCAM). NJCAM's charge is to:

1. Do an inventory of existing State and Federal transportation funding sources used for transportation service within 12 various departments/agencies in New Jersey.
2. Study ways to improve coordination of sources.
3. Make recommendations to the Governor and State Legislature.
4. Coordinate activities with the Federal Council on Access and Mobility.

## **TOOLS**

**AoA Toolkit:** Because New Jersey is committed to enhanced coordination of transportation services for older individuals, it looks forward to reviewing the AoA Transportation Toolkit, entitled *Senior Benefit from Transportation Partnerships – Case Studies from the Aging Network*, when it is disseminated in the near future. The toolkit will focus on assessing transportation needs as well as coordinating transportation services.

## OBJECTIVES

1. Utilize the AoA Transportation Toolkit to assess the transportation needs of aging and physically disabled individuals.
2. Participate actively in interagency efforts, such as *United We Ride*, to coordinate transportation services specifically in terms of the needs of older adults and adults with physical disabilities.
3. Explore best practice models in other States, including funding resources.

## PERFORMANCE MEASURES

DACS will utilize the AoA Toolkit to assess transportation needs and improve the coordination of transportation services.

## PRIORITY 2: Help older people to stay active and healthy.

## TRENDS AND CONDITIONS

**Life Expectancy:** The rapidly growing aging population, together with projections of continued increases in life expectancy and an increasingly diverse aging population, underscores the critical need to assist individuals to practice healthy behaviors and minimize the limitations of chronic disease. Average life expectancy has increased dramatically, from 47 years in 1900 to nearly 77 years in 2000. By 2030 the number of older Americans will more than double to 70 million, or one in every five Americans.<sup>1</sup> Approximately 80% of all persons aged 65 and older have at least one chronic condition, and 50% have at least two.<sup>2</sup> New Jersey is one of the most ethnically representative states in the nation, with more than 2 million New Jersey residents speaking a language other than English at home. Disparity in health status is evidenced by the 16-year difference in healthy life expectancy at birth between white females at 69.6 years, compared to African American males at 53.9 years.<sup>3</sup>

**Leading Causes of Death:** In New Jersey, as in the U.S., the leading causes of death are heart disease, cancer and stroke. Diabetes, influenza/pneumonia and unintentional injuries rank next among the leading causes of death for people age 55 and older.<sup>4</sup> Average per capita personal health care expenditures in New Jersey (\$4,418) are higher than the U.S. average (\$4,026).

<sup>1</sup> *Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans*, 2002. Centers for Disease Control and Prevention.

<sup>2</sup> *Public Health and Aging: Trends in Aging --- United States and Worldwide, Morbidity and Mortality Weekly Report*, February 14, 2003 / 52(06); 101-106, Centers for Chronic Disease Control and Prevention.

<sup>3</sup> *Healthy Life Expectancy at Birth in Years, New Jersey, 1996-1998*. Center for State Health Statistics, <http://nj.gov/health/chs/stats>.

<sup>4</sup> *Leading Causes of Death by Age Group, New Jersey 2002*, Center for State Health Statistics, <http://nj.gov/health/chs/stats02/mort02.pdf#m1>.

**Chronic Conditions:** Most chronic conditions are not a natural part of the aging process and can be prevented. Research has shown that information on healthy practices leading to chronic disease self-management has powerful effects on health and quality of life. While many older adults are aware of and intend to practice healthy behaviors, more than half say they are not always able to practice healthy behaviors, citing lack of motivation, money, time or access as major barriers<sup>3</sup>. In 2002, New Jersey failed to reach these four of the ten *Healthy People 2010* health objectives for older adult health: **(a)** physical activity, **(b)** overweight, **(c)** fruit and vegetable consumption, and **(d)** pneumonia vaccination.<sup>5</sup>

**Preventable Diseases:** In 2004, 69% of New Jersey residents 65 and older received flu shots and 63% received pneumonia shots. New Jersey adults aged 65 and older obtained screenings at a lower rate than the national average (75% of women had mammograms and only 56% of older adults had an annual sigmoidoscopy or colonoscopy screening).<sup>4</sup> Scientific evidence suggests that about one-third of the 570,000 cancer deaths expected to occur in 2005 will be related to nutrition, physical inactivity, overweight and obesity, and thus could be prevented. Regular screening examinations can detect cancers of the breast, colon, rectum, and prostate at early stages when treatment is more likely to be successful.<sup>6</sup>

**Falls:** More than one-third of older adults age 65 and older fall each year and about 30% of these individuals suffer injuries that can decrease mobility and independence. In New Jersey, deaths from falls are the second-leading cause of unintentional injury deaths among the elderly, after motor vehicle related fatalities. Of all deaths of New Jerseyans from falls, about 70% occur among persons 65 and older, with the population 85 and over experiencing the greatest impact.<sup>7</sup> Of all non-fatal injuries, hip fracture is the most serious for older adults. In New Jersey there are about 8,000 hip fractures in individuals 65 and older annually<sup>8</sup>, a number expected to grow as the population ages. People with osteoporosis are at increased risk of hip fracture. Over 900,000 New Jersey residents had osteoporosis or low bone mass (osteopenia) in 1996, and the estimated medical cost of osteoporosis in 2000 was over \$496 million.<sup>9</sup>

**Arthritis:** Arthritis is the State's leading cause of disability, affecting over 2.5 million people<sup>10</sup> at an annual cost of over \$3 billion in medical care and lost productivity<sup>11</sup>. The incidence of

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<sup>5</sup> The State of Aging and Health in America, Merck Institute of Aging & Health and the Gerontological Society of America, 2003.

<sup>6</sup> American Cancer Society, Cancer Facts and Figures 2005.

<sup>7</sup> Healthy New Jersey 2010, A Health Agenda for the First Decade of the New Millennium, New Jersey Department of Health and Senior Services, 1999.

<sup>8</sup> Injury Prevention and Control White paper, NJ Department of Health and Senior Services

<sup>9</sup> *The Cost of osteoporosis in New Jersey: Projections for 2000-2005*, Burge et al., Procter & Gamble Pharm, 2001.

<sup>10</sup> *Behavioral Risk Factor Surveillance Survey, 2001*. Centers for Disease Control and Prevention.

<sup>11</sup> *Direct and Indirect Costs of Arthritis and Other Rheumatic Conditions --- United States, 199*, *Morbidity and Mortality Weekly Report*, November 21, 2003 / 52(46);1124-1127. Cisternas, et al.

arthritis increases with age; by age 65, nearly 60% have some type of arthritis.<sup>12</sup> With the aging baby boomers remaining in the workforce, arthritis as a public health issue is expected to reach epic proportions.

**Health Literacy:** Low health literacy has been identified as a primary factor for both poorer health status and lower service utilization. Nationally, two-thirds of adults age 60 and older have inadequate or marginal literacy skills, and 81% of patients age 60 and older are unable to read or understand basic medical information such as prescription labels. While low health literacy affects people of all races, ethnic backgrounds, income, and age (nearly 50% of all adults in the U.S. have difficulty understanding basic health information), it is more prevalent among older adults and those with limited proficiency in English. New Jersey's unique demographics, as well as the increasing complexities of the health care and social service delivery systems, make culturally and linguistically appropriate health literacy efforts a public health and aging priority.

**Obesity:** Research indicates that the continuing epidemic in obesity among all ages can reduce length of life by 5 to 20 years,<sup>13</sup> yet few older adults engage in recommended levels of physical activity and significant numbers do not engage in any physical activity at all. Fewer than 20% of New Jersey residents aged 55-64 and 10% of residents aged 65 and older meet recommended guidelines for vigorous physical activity (30 minutes or more of activity five or more days per week). In addition, 60% of the 55-64 age group and 66% of the 65+ group report no physical activity at all.<sup>14</sup> Nationally, NJ ranks 8<sup>th</sup> in the number of obese older adults (16.3%). Only one-third of those aged 65 and older consume 5 or more fruits and vegetables daily.<sup>4</sup>

**Minimizing Chronic Disease and Maximizing Quality of Life:** Increasing disease prevention and health promotion opportunities for older adults is one of the few avenues available to address the looming impact of chronic disease and other illnesses, disabling injuries, and long-term health care costs among older Americans. People who are physically active, eat a healthy diet, do not use tobacco, and practice other healthy behaviors, including appropriate health screenings, reduce their risk for chronic disease. They also have half the rate of disability of those who do not practice healthy behaviors.

**Physical Activity:** The single most important step that most adults, including older adults, can take to improve their overall health is to become more physically active.<sup>15</sup> Research

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<sup>12</sup> *Portrait of the Chronically Ill in America*, 2001. Robert Wood Johnson Foundation and Foundation for Accountability (FACCT).

<sup>13</sup> *A Potential Decline in Life Expectancy in the U.S. in the 21<sup>st</sup> Century*, S Olshansky, et al., *New England Journal of Medicine* 352;11, 1138-1145, 2005.

<sup>14</sup> *Behavioral Risk Factor Surveillance System, New Jersey 2003*, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. [www.cdc.gov/brfss/](http://www.cdc.gov/brfss/).

<sup>15</sup> *Physical Activity and Health: A Report of the Surgeon General*. US Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996.

demonstrates the health benefits of increasing physical activity even among “old-old” adults.<sup>16</sup> As reported by the Surgeon General, “the body’s response to physical activity and exercise has important positive effects on the musculoskeletal, cardiovascular, respiratory and endocrine systems.”<sup>17</sup> The benefits of increasing physical activity among older adults also include: **(a)** reducing medical costs by as much as \$77 billion annually<sup>18</sup>; **(b)** lowering the risk of premature death, high blood pressure, diabetes, some types of cancer; and **(c)** reducing depression. Long-term physical activity also helps postpone disability and increase the ability of even the ‘oldest old’ to live independently, including individuals with chronic disease.<sup>19</sup>

**Nutrition:** Since 1974, New Jersey’s Senior Nutrition Program has been a valuable resource to older persons throughout the State. Providing both good nutrition and social engagement, the congregate and home delivered meal programs help adults aged 60 and older stay healthy, active, and independent. New Jersey’s major demographic shifts (increased ethnic/racial diversity and an aging population) are having a significant impact on the nutrition program. In Summer 2004, DACS launched “Mission Nutrition” to assess the current program and set new directions to better meet the changing needs of the 60+ population. The Mission Nutrition Summit, held October 7 and 13, 2004, initiated the process of redefining the future directions of senior nutrition in New Jersey. Findings of the 2004 statewide survey and the review and assessment of focus group data offers baseline information to develop the overall strategy of re-defining the New Jersey Senior Nutrition Program.

**GOAL 1:** Empower older adults to actively engage in healthy behaviors so they can live longer, maintain their quality of life, and participate in/contribute to their communities. Extend health, functional independence, and health-related quality of life as long as possible.

## **STRATEGY**

### 1. Support Healthy Lifestyle Behaviors

- a. Raise awareness among the health/aging provider networks and encourage delivery of evidence-based health promotion/disease prevention programs for older adults in areas such as nutrition, physical activity, cancer screenings, tobacco cessation, and influenza and pneumococcal vaccines.

<sup>16</sup> *The Aging States Project: Promoting Opportunities for Collaboration Between the Public Health and Aging Service Networks.* Chronic Disease Directors/National Association of State Units on Aging, 2003.

<sup>17</sup> *Physical Activity and Health: A report of the Surgeon General.* Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity. (2001). Department of Health and Human Services.

<sup>18</sup> *The State of Health and Aging in America 2004.* Merck Institute of Aging and Health and Centers for Disease Control, 2004.

<sup>19</sup> Spirduso, W. and Cronin, D. (2001). Exercise dose-response effects on quality of life and independent living in older adults. *Medicine and Science in Sports and Exercise Supp: Dose Response issues concerning physical activity and health: An evidence based symposium*, **33(6)**, S530-S550.

- b. Promote educational programs for providers and older adults on healthy lifestyle, chronic disease management and risk factor reduction.
- c. Expand the infrastructure/capacity for a range of evidence-based physical activity programs statewide, including: Live Long, Live Well Walking Program, Project Healthy Bones exercise and education program for people with or at risk of osteoporosis, Arthritis Quality of Life Programs (PACE – People with Arthritis Can Exercise, AFAP – Arthritis Foundation Aquatic Program, T'ai Chi for People with Arthritis), and HealthEASE Exercise Program. Particular focus will be on recruiting and training physical activity leaders from targeted ethnically/culturally diverse communities.
- d. Promote self-efficacy and ensure statewide availability of the HealthEASE education program, the expansion of Chronic Disease Self Management Programs and the Arthritis Self-Help Course utilizing the ADRCs and health/aging provider networks.
- e. Reduce the overall morbidity and mortality related to falls through the development and dissemination of fall prevention brochures; a web-based fall-injury module available on the division's health promotion web site; technical assistance on in-home fall prevention technology for health and aging networks, and provision of in-service education to nursing home transition teams to assist in the transfer of elderly nursing home residents to community settings.
- f. Collaborate with disease management programs within the Department of Health and Senior Services to support initiatives in areas such as cancer, diabetes, cardiovascular disease and immunization.

## 2. Strengthen the Relationship Among Public Health and Aging Networks

- a. Implement evidence-based health promotion and disease prevention programs, including influenza and pneumonia vaccination clinics. Public awareness campaigns, developed by the NJ Communicable Disease Service Program, will be expanded to include a partnership with county offices on aging and aging provider networks. Flu clinics will be coordinated with other major senior wellness events through collaboration with the NJ Influenza Advisory Committee.
- b. Integrate DACS' principles, goals and strategies for improving/maintaining older adult health and wellness as key components in the New Jersey Public Health Practice Standards for local and county public health departments; provide best practice examples/standards for older adult health promotion/disease prevention initiatives.
- c. Utilize the outcomes of the HealthEASE pilot project for coordinated health promotion/disease prevention to encourage local partnership.
- d. Foster aging network collaboration with local public health departments as an element within Title IIID Policy. Broaden access to evidence-based older adult health promotion training/programs to local public health agencies.

3. Increase Health Literacy

- a. Ensure access to older adult health promotion and disease prevention activities for New Jersey's ethnically diverse population through a multi-year health literacy initiative that includes: **(1)** raising awareness of the importance of health literacy competency for public health and aging providers through delivery of a health literacy training curriculum; and **(2)** training a cadre of multidisciplinary health care professionals to deliver health literacy programs to community-dwelling older adults to build and improve their health literacy skills.

4. Increase Provider Knowledge About The Benefits of Evidence-Based Behavior Change Programs and Encourage Their Delivery

- a. Sponsor a statewide forum to: **(1)** educate providers on the availability and benefits of evidence based health promotion programs for older adults; **(2)** demonstrate the use of aging/health network partnerships to implement effective health promotion/disease prevention activities; and **(3)** implement a statewide evaluation tool to evaluate the reach, scope and effectiveness of older adult health promotion/disease prevention programs.

5. Review Title III D Fund Utilization and Current Policy

- a. DACS' policy for the OAA Health Promotion/Disease Prevention funds was written in 1993. Research throughout the past decade has resulted in the emergence of new strategies to best promote the health of older adults. To determine current practice, DACS will conduct an in-depth analysis of Title III D funds in the 21 AAAs. Then, in collaboration with a statewide ad hoc committee, the existing Title III D policy will be reviewed, revised, and reissued to reflect the most current trends and best practices.

**PERFORMANCE MEASURES**

1. Delivery of a statewide forum on evidence-based programs for up to 150 local health and aging providers. Distribution of compendium of "turnkey" evidence-based health promotion programs to forum attendees and other potential providers.
2. Increased availability of evidence-based health promotion programs measured by attendance at leader training programs and requests for program materials.
3. Documentation of increased partnership role of AAA and aging providers in providing/coordinating older adult immunizations and health screenings.
4. Implementation of web-based fall-injury module on DACS' webpage. Promote utilization of webpage through aging, local public health and nursing home associations.
5. Inclusion of DACS' wellness principles in the NJ Public Health Standards for Older Adult Health Promotion/Disease Prevention.
6. Revision of DACS' policy for the administration of Title III D of the Older Americans Act.

**GOAL 2:** Through Mission Nutrition, redefine the New Jersey Nutrition program as a full service community program, an integral component of a comprehensive and coordinated system of home and community based services.

### **STRATEGY**

1. Establish a think tank of high-level representatives from private industry to advise DACS on innovative strategies for enhancing the senior nutrition program.
2. Strengthen the infrastructure of the senior nutrition program through ongoing forums for the nutrition program directors.
3. Conduct an analysis of current financial practices used in nutrition programs. Develop recommendations for improvement.
4. Implement pilot programs for innovative programming to better meet the diverse needs of the senior population. Utilize the pilots as statewide models.
5. Establish quality assurance measures for the Senior Nutrition Program.
6. Identify and collaborate with minority organizations to develop effective outreach methods that will increase the participation of target populations at senior nutrition centers, with emphasis on cultural and racial minorities.
7. Expand ethnic menus to provide appropriate meals for culturally diverse populations.
8. Expand programming at senior nutrition sites through community partnerships.
9. Establish new directions for senior nutrition emphasizing a variety of food selections such as salad/deli bars, fresh food alternatives, flexible menus, and new dining environments.
10. Expand health and wellness activities at senior nutrition sites, with a focus on evidence-based programs.

### **PERFORMANCE MEASURES**

1. Creation of Mission Nutrition “think tank” and establishment of ongoing methods for gathering input from this private sector panel.
2. Inclusion of quality assurance standards and improved financial practices in area plan contracts.
3. Increased participation of cultural and racial minorities in congregate and home delivered meal programs.
4. Attendance of nutrition program staff at evidence-based programs forum and participation in leader training programs.
5. Outcomes from pilot programs in expanded food selections (including ethnic menus).

**GOAL 3:** Promote early and effective life planning and health promotion to adults age 50 and older.

### **STRATEGY**

1. The division will encourage state residents ages 50 and older to learn about long term care options so they can better meet financial, health and housing needs as they age. The initiative will center on the targeted distribution of its newly developed booklet "A Guide to Community-Based Long Term Care in New Jersey". The guide includes 10 pullout sections detailing programs that provide medical, housing, financial, legal and social service assistance. It also includes consumer checklists and helpful resources for those seeking help for themselves, a family member or friend.
2. Broaden the message of older adult health promotion and disease prevention to engage adults 50 and older, especially those in active adult communities.

### **PERFORMANCE MEASURES**

1. Outcome data from the pilot implementation of the HealthEASE program in active adult communities. Expansion of the program to other active adult communities.
2. Establishment of new partnerships to expand the Live Long, Live Well Walking Program and the national *You Can!* campaign.
3. Activities delivered in September 2005 as part of the national *You Can!* campaign.

**PRIORITY 3: Support Families in their efforts to care for loved ones at home and in the community.**

### **TRENDS AND CONDITIONS**

There are approximately 800,000<sup>20</sup> informal caregivers in New Jersey, providing 891,200,000 caregiving hours per year and saving New Jersey taxpayers approximately \$5.9 billion in service dollars annually.

Additionally, the elderly population (especially the 85+ cohort) is expected to increase by 54% between 1990 and 2010. With the existing shortage of home care workers, caregivers represent the backbone of the long-term care system.

New Jersey is responsive to the many unique needs of caregivers. Programs include mechanisms for greater consumer choice, control, and flexibility in order to support and maintain New Jersey's progressive approach to meeting the needs of caregivers and their loved ones.

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<sup>20</sup> The State of the State in Family Caregiver Support: A 50 State Study, November 2004.

## **NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM INNOVATION GRANT: NEW JERSEY EASE FOR CAREGIVERS**

With funding from a *National Family Caregiver Support Program Innovation Grant*, DACS developed the following products:

**Caregiver Best Practices in New Jersey:** a guide to innovative caregiver programs and services developed by New Jersey agencies for New Jersey residents.

**A Pocket Guide to Caregiver Resources in New Jersey:** a brochure designed to help caregivers identify their needs and gain easy access to existing resources within their communities.

**Understanding Caregivers Across Cultures:** a training curriculum for providers. The goal of the training is to enhance sensitivity to and understanding of caregiving challenges across multiple cultures and help to identify caregivers “at risk” so that they may be referred to appropriate services and resources within the community.

**Culturally Sensitive Approaches to Outreach: A Guide for the Aging Services Network:** a brochure offered to provider agencies as a helpful adjunct to its organization’s practices and strategies for outreach to multicultural clients in the communities they serve.

**The Caregiver NJ Website ([www.caregovernj.nj.gov](http://www.caregovernj.nj.gov)):** an on-line guide to available resources for adults and their families living in New Jersey.

**New Jersey Ethnic Multimedia Contact List:** a listing of radio, TV, and print medium targeted to multicultural audiences across the state. The listing is made available to anyone wishing to use media to improve communication about programs and services available in the community. The list is updated by input from people in the community.

**Caregiver Telephone Screening Tool:** a tool intended to screen family caregivers for being “at risk” and referring them to appropriate services and resources or for a more in depth assessment of caregiver needs by a professional care manager.

**Caregiver Intervention Plan:** a form for use by providers to record assistance and services provided to family caregivers. The form can be referred to later determine if further intervention or assistance is needed over time.

## **EXECUTIVE ORDER NO. 100**

In 2004, Executive Order No. 100 was issued by then Governor James E. McGreevey and among other previously mentioned directions, it established the *New Jersey Caring for Caregivers Initiative* (CGI). This initiative includes two elements designed to enhance and prolong the ability

of unpaid adult caregivers to continue to provide care to adults with disabilities 18 years of age: either the caregiver or the care recipient must be aged 60+.

1. AAAs are implementing the following three CGI components statewide during CY 05 to fill gaps in existing caregiver services:
  - Professional In-Home Education and Support
  - Caregiver Mental Health Counseling
  - Trained Volunteer Assistance
  
2. The *Caregiver Direction Respite Pilot Program* has been operational in four counties during CY 05 (Atlantic, Warren, Camden, and Ocean). This pilot program is testing a new way of offering support to caregivers by reimbursing them up to \$250 per month (\$3,000 per year) to help purchase services.

### **ONGOING SERVICES TO ASSIST FAMILIES**

DACS, through its Office of Community Programs, supports a variety of programs that offer HCBS.

HCBS refers to assistance with daily activities that generally help people with disabilities remain in their homes. Services such as personal care, chore assistance, transportation, home delivered meals, or adult day services all constitute HCBS. People of all ages with disabilities who use these services live in a variety of settings: their own homes, assisted living facilities, adult family care homes, or subsidized housing.

HCBS programs administered by DACS include Medicaid Waiver programs, **(a)** the *Community Care Program for the Elderly and Disabled*, which served 4,988 recipients during calendar year 2004, **(b)** the *Assisted Living Program*, through which a total of 3,582 unduplicated individuals were served by October 2004, **(c)** *Adult Family Care (AFC)*, which served 55 unduplicated individuals in calendar year 2004, and **(d)** the *Caregiver Assistance Program (CAP)*, which has served 3,501 unduplicated individuals since 2000 (see Chapter 4 for program details).

HCBS are also available through state funded programs. These programs include **(a)** *Jersey Assistance for Community Caregivers*, which has served 3,694 unduplicated individuals since 2000, **(b)** *Statewide Respite Care Program*, serving approximately 3,900 families each year, **(c)** *Alzheimer's Adult Day Health Services*, which served 721 clients in State Fiscal Year 2004, and **(d)** the *Congregate Housing Services Program* which provided services to 2,658 participants in calendar year 2004 (see Exhibit 8).

### **OLDER AMERICANS ACT SERVICES**

With Title III E funds, New Jersey's AAAs have developed a wide variety of programs to meet the needs of caregivers, including information, assistance, counseling, support groups, training, and respite care. In addition, a variety of supplemental services are provided to *Caregivers of Seniors* and *Grandparents Raising Grandchildren* (see Exhibit 9).

**Division of Aging and Community Services**  
**Comparison of Case-Managed Programs and Services**

**EXHIBIT 8**

WAIVER PROGRAM	ENHANCED COMMUNITY OPTIONS					NON-WAIVER
	CCPED	AL	AFC	CAP	JACC	
Medicaid State plan Services	0. Medical Day Care 1. Transportation 2. Home Health* 3. Prescribed Drugs	4. All except Nursing Facility, Personal Care Assistance, Adult Day Health, and Hospice	5. All except Nursing Facility, Personal Care Assistance, and Hospice	6. All except Nursing Facility, Personal Care Assistance, and Hospice	7. None	
Waiver Services	8. Care Management 9. Homemaker 10. Respite 11. Social ADC	12. Care Management <b>13. Assisted Living</b> 14. Social Adult Day Care (ALP only)	15. Care Management 16. Adult Family Care 17. Environmental Accessibility Adaptation 18. Social Adult Day Care 19. Transportation 20. Respite	21. Care Management 22. Homemaker 23. Respite 24. Env Acc Adapt 25. SME & Supplies 26. Chore 27. PERS 28. Attendant Care 29. Home delivered meal service 30. Caregiver/Recipient training 31. Social Adult Day Care 32. Home-Based Supportive Care 33. Transportation	34. Care Management 35. Homemaker 36. Respite 37. Env Acc Adapt 38. SME & Supplies 39. Chore 40. PERS 41. Attendant Care 42. Home delivered meal service 43. Caregiver/Recipient training 44. Social Adult Day Care 45. Home Based Supportive Care 46. Adult Day Health (Med. Day Care) 47. Transportation	
Eligibility – Financial	48. Medicaid Only (Institutional) Monthly income ≤ \$1,737 Resources ≤ \$2,000	49. SSI Monthly income \$610.25 Resources ≤ \$2,000 50. Medicaid Only (Institutional) Monthly Income ≤ \$1,737 Resources ≤ \$2,000 51. NJ Care Monthly Income < 100% FPL Resources ≤ \$4,000	52. SSI Monthly income \$610.25 Resources ≤ \$2,000 53. Medicaid Only (Institutional) Monthly Income ≤ \$1,737 Resources ≤ \$2,000 54. NJ Care Monthly Income < 100% FPL Resources ≤ \$4,000	55. SSI Monthly income \$610.25 Resources ≤ \$2,000 56. Medicaid Only (Institutional) Monthly Income ≤ \$1,737 Resources ≤ \$2,000 57. NJ Care Monthly Income < 100% FPL Resources ≤ \$4,000	58. Non-Medicaid eligible Assets below: \$40,000 Individual or \$60,000 Couple Countable income*** < 365% FPL	
Other Eligibility	3 <sup>rd</sup> party insurance					
Clinical Eligibility	NF Level of Care	NF Level of Care	NF Level of Care	NF Level of Care	NF Level of Care	
Age Requirements	65 or older; under 65 with disability	65 or older; 21-64 with disability	65 or older; 21-64 with disability	65 or older; 21-64 with disability	60 or older	
Funding	State/Federal Match	State/Federal Match	State/Federal Match	State/Federal Match	State Funds	
Consumer –Directed Approach	NO	NO	NO	YES	YES	
Billing Agent	NO	NO	NO	YES	YES	
Governing Code	NJAC 10:60					
Licensed	NO	YES NJAC 8:36	YES NJAC 8:43B	NO	NO	
Cost Share	NO	YES**	YES	NO	YES	
Cost Cap	70%=\$1,989/month; 100%=\$2,841/month			\$1100/month, \$13,200/year	\$600/month, \$7200 year	

\*Fee for service reimbursed at established rates

\*\*No cost share in ALP

\*\*\*Gross income less allowable medical deductions

**Title III E Populations Served for Calendar Year 2004**

**EXHIBIT 9**

Federal III E Category/ NJ Taxonomy and Unit of Service	Total Units	Total Clients	African American Clients	Hispanic Clients	Asian Clients	American Indian Clients	Total Minority Clients	Non- Minority Clients	Total Poverty Clients	Minority Poverty Clients	Non-Minority Poverty Clients
<b>Information to Caregivers:</b>											
Information and Assistance - contact	28,044	14,348	826	503	302	4	1,635	12,713	1,269	589	680
Newsletter - each edition	4	21,900	995	995	995	-	2,985	18,915	501	173	328
<i>Subtotal Caregivers of Seniors</i>	<i>28,048</i>	<i>36,248</i>	<i>1,821</i>	<i>1,498</i>	<i>1,297</i>	<i>4</i>	<i>4,620</i>	<i>31,628</i>	<i>1,770</i>	<i>762</i>	<i>1,008</i>
<i>Subtotal Grandparents</i>	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>28,048</b>	<b>36,248</b>	<b>1,821</b>	<b>1,498</b>	<b>1,297</b>	<b>4</b>	<b>4,620</b>	<b>31,628</b>	<b>1,770</b>	<b>762</b>	<b>1,008</b>
<b>Assistance to Caregivers:</b>											
Benefits Screening - 1/2 hour	925	322	26	4	2	-	32	290	32	13	19
Extended Assessment - 1/2 hour	747	233	23	2	2	-	27	206	35	12	23
Outreach - contact	5,146	3,485	848	568	33	4	1,453	2,032	571	406	165
Care Management - 1/2 hour	47,613	2,527	307	142	15	1	465	2,062	666	228	438
Legal Assistance - hour	489	66	31	9	-	-	40	26	43	39	4
<i>Subtotal Caregivers of Seniors</i>	<i>54,920</i>	<i>6,633</i>	<i>1,235</i>	<i>725</i>	<i>52</i>	<i>5</i>	<i>2,017</i>	<i>4,616</i>	<i>1,347</i>	<i>698</i>	<i>649</i>
GP, Outreach - outreach	40	25	16	9	-	-	25	-	25	25	-
GP, Care Management - 1/2 hour	2,118	61	24	1	-	-	25	36	21	21	-
GP, Legal Assistance - hour	7	35	32	3	-	-	35	-	35	35	-
<i>Subtotal Grandparents</i>	<i>2,165</i>	<i>121</i>	<i>72</i>	<i>13</i>	<i>-</i>	<i>-</i>	<i>85</i>	<i>36</i>	<i>81</i>	<i>81</i>	<i>-</i>
<b>Total</b>	<b>57,085</b>	<b>6,754</b>	<b>1,307</b>	<b>738</b>	<b>52</b>	<b>5</b>	<b>2,102</b>	<b>4,652</b>	<b>1,428</b>	<b>779</b>	<b>649</b>
<b>Counseling, Support Groups, Training:</b>											
Support Group - group meeting	596	725	48	9	9	-	66	659	39	3	36
Mental Health - hour	5,218	948	183	71	28	1	283	665	246	125	121
Counseling - hour	358	520	1	5	2	-	8	512	9	3	6
Education - hour	9,621	2,523	345	214	26	2	587	1,936	309	126	183
<i>Subtotal Caregivers of Seniors</i>	<i>15,793</i>	<i>4,716</i>	<i>577</i>	<i>299</i>	<i>65</i>	<i>3</i>	<i>944</i>	<i>3,772</i>	<i>603</i>	<i>257</i>	<i>346</i>
GP, Support Group - group meeting	27	72	45	3	-	-	48	24	42	40	2
GP, Mental Health - hour	357	30	21	2	2	-	25	5	9	7	2
<b>Subtotal Grandparents</b>	<b>384</b>	<b>102</b>	<b>66</b>	<b>5</b>	<b>2</b>	<b>-</b>	<b>73</b>	<b>29</b>	<b>51</b>	<b>47</b>	<b>4</b>
<b>Total</b>	<b>16,177</b>	<b>4,818</b>	<b>643</b>	<b>304</b>	<b>67</b>	<b>3</b>	<b>1,017</b>	<b>3,801</b>	<b>654</b>	<b>304</b>	<b>350</b>

**Title III E Populations Served for Calendar Year 2004**

**EXHIBIT 9**

<b>Federal III E Category/ NJ Taxonomy and Unit of Service</b>	<b>Total Units</b>	<b>Total Clients</b>	<b>African American Clients</b>	<b>Hispanic Clients</b>	<b>Asian Clients</b>	<b>American Indian Clients</b>	<b>Total Minority Clients</b>	<b>Non- Minority Clients</b>	<b>Total Poverty Clients</b>	<b>Minority Poverty Clients</b>	<b>Non-Minority Poverty Clients</b>
<b>Respite Care:</b>											
Certified Home Health Aid - hour	21,117	429	148	41	1	-	190	239	281	145	136
Visiting Nurse - visit	50	23	9	1	-	-	10	13	4	4	-
Respite - hour	73,958	804	101	25	4	2	132	672	259	58	201
Adult Day Social - hour	54,379	347	42	18	7	1	68	279	88	29	59
Adult Day Medical - hour	49,488	178	52	4	1	-	57	121	117	43	74
Personal Care - hour	1,781	93	2	-	6	-	8	85	74	6	68
<i>Subtotal Caregivers of Seniors</i>	<i>200,773</i>	<i>1,874</i>	<i>354</i>	<i>89</i>	<i>19</i>	<i>3</i>	<i>465</i>	<i>1,409</i>	<i>823</i>	<i>285</i>	<i>538</i>
GP, Respite - hour	77	10	10	-	-	-	10	-	10	10	-
<i>Subtotal Grandparents</i>	<i>77</i>	<i>10</i>	<i>10</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>10</i>	<i>-</i>	<i>10</i>	<i>10</i>	<i>-</i>
<b>Total</b>	<b>200,850</b>	<b>1,884</b>	<b>364</b>	<b>89</b>	<b>19</b>	<b>3</b>	<b>475</b>	<b>1,409</b>	<b>833</b>	<b>295</b>	<b>538</b>
<b>Supplemental Services:</b>											
Assisted Transportation - contact	2,509	135	5	18	6	-	29	106	30	23	7
Friendly Visiting - visit	6,129	200	4	6	2	1	13	187	29	9	20
Telephone Reassurance - call	3,169	66	7	10	-	-	17	49	6	3	3
Residential Maintenance - hour	1,715	146	15	4	3	-	22	124	45	27	18
Housekeeping - hour	1,944	57	8	15	-	-	23	34	39	18	21
Emergency - contact	179	41	7	2	-	-	9	32	13	2	11
Physical Health - contact	1,649	394	29	13	1	-	43	351	65	8	57
Physical Fitness - activity	341	16	-	-	-	-	-	16	-	-	-
Social Recreation - activity	17	12	-	-	-	-	-	12	-	-	-
Home Delivered Meals - meal	26,285	165	11	9	-	-	20	145	74	20	54
<i>Subtotal Caregivers of Seniors</i>	<i>43,937</i>	<i>1,232</i>	<i>86</i>	<i>77</i>	<i>12</i>	<i>1</i>	<i>176</i>	<i>1,056</i>	<i>301</i>	<i>110</i>	<i>191</i>
GP, Social Recreation	578	72	71	-	-	-	71	1	60	59	1
<i>Subtotal Grandparents</i>	<i>578</i>	<i>72</i>	<i>71</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>71</i>	<i>1</i>	<i>60</i>	<i>59</i>	<i>1</i>
<b>Total</b>	<b>44,515</b>	<b>1,304</b>	<b>157</b>	<b>77</b>	<b>12</b>	<b>1</b>	<b>247</b>	<b>1,057</b>	<b>361</b>	<b>169</b>	<b>192</b>
<b>Grand Total Title III E Services</b>	<b>346,675</b>	<b>51,008</b>	<b>4,292</b>	<b>2,706</b>	<b>1,447</b>	<b>16</b>	<b>8,461</b>	<b>42,547</b>	<b>5,046</b>	<b>2,309</b>	<b>2,737</b>
<i>Subtotal Caregivers of Seniors</i>	343,471	50,703	4,073	2,688	1,445	16	8,222	42,481	4,844	2,112	2,732
<i>Subtotal Grandparents</i>	3,204	305	219	18	2	-	239	66	202	197	5

**GOAL 1:** To improve caregiver skills in using the home environment for dementia care. Create a model for integrating home modifications and assistive technologies into ADRC processes.

### **STRATEGY**

1. Working with New Jersey's two ADRC's, staff will be trained to provide 60 families (at least 20 from diverse communities) with environmental assessments, education, intervention planning and implementation to improve family dementia care. The contractor will also work with a selected Alzheimer's Adult Day Services Program and a community organization serving a diverse population to assess and recommend physical plant changes to better serve individuals with dementia.

### **PERFORMANCE MEASURES**

Products will include a final report with a proposal for a full Alzheimer's Disease Demonstration Grants (ADDGS) program, a "train the trainer" curriculum and a DVD/video and a project evaluation.

**GOAL 2:** Develop a coordinated care management and service delivery model to assist older caregivers providing assistance to adults with developmental, physical, and/or mental disabilities.

### **STRATEGY**

1. DACS will implement a county-based, family-centered pilot program serving the aging and disability community. The purpose of this pilot is to establish an interagency care management model encompassing an interdisciplinary team and family-centered approach to identify consumer needs, obtain supports and secure needs-based delivery of services.
2. Participating agencies include DACS, the New Jersey Division of Developmental Disabilities, the New Jersey Division of Disability Services, the New Jersey Division of Mental Health Services, participating AAAs, and the University of Medicine and Dentistry of New Jersey School of Medicine (UMDNJ).
3. Participating families will be able to benefit from services available through most or all of the above agencies. Eligibility includes older caregivers 60+ and their children with significant disabilities age 35+. Only families already known to one of the participating agencies will be eligible. The partnership's goal is to serve 20 families through this initiative.

### **ALZHEIMER'S DISEASE DEMONSTRATION GRANTS (ADDGS)**

DACS has applied for AoA's *Alzheimer's Disease Demonstration Grants to States* to contract with an architectural research center, specializing in environments for persons with dementia, to conduct a one-year capacity building project utilizing environmental interventions and assistive technologies as tools for dementia care.

## **OUTCOMES**

Expected outcomes include **(a)** improved caregiver skills in using the home environment for dementia care; **(b)** a model for integrating home modifications and assistive technologies into ADRC processes; and **(c)** recommendations for improving provider physical plants to better serve individuals with dementia.

## **PERFORMANCE MEASURES**

DACS will implement the actions listed above in order to help caregivers who care for adults with developmental, physical, and/or mental disabilities.

**GOAL 3: Implement a caregiver-directed service component statewide through the state-funded Statewide Respite Care Program.**

## **STRATEGY**

1. Following the calendar year 2005 Caregiver-Directed Respite Pilot Program, roll out this option statewide in calendar year 2006 as a component of the Statewide Respite Care Program service package.
2. Will begin Caregiver-Directed Respite Program training for all of the program's sponsor agencies in June 2005, so sponsor agencies are ready to implement in January 2006.

## **PERFORMANCE MEASURES**

DACS will implement the Respite Care Program statewide beginning in 2006.

**PRIORITY 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.**

## **TRENDS AND CONDITIONS**

As the American population continues to age and families continue to be geographically dispersed, more and more older Americans are spending their later years in long-term care facilities. It is estimated that by the year 2020, more than 13 million Americans will require nursing home care. Many of these individuals will be suffering from dementias, such as Alzheimer's, and other conditions that make them particularly vulnerable to abuse, neglect, and exploitation.

In 2000 there were 1.4 million persons age 60 or older in New Jersey. By 2025 it is estimated to be 2.5 million. Of men and women 85 years old or older, 22% and 28%, respectively, have disabilities. Given that longevity is increasing, more elderly persons will be disabled in coming years, thus requiring increased care, including guardianships.

Finally, that portion of the population in the community that is considered frail, elderly, and at-risk will likewise continue to grow. With that growth comes the susceptibility to physical, psychological, or sexual abuse, self-neglect or caregiver neglect, and financial exploitation. It will remain a challenge for New Jersey and its partners in the aging and disability services network to keep these individuals in the community with as much independence and safety as possible.

**GOAL 1:** Ensure, through the Office of the Ombudsman for the Institutionalized Elderly, that nursing home staff and volunteer advocates are trained to spot, prevent or stop and report incidents of resident mistreatment and promote a culture of caring in institutional settings.

### **OBJECTIVES**

1. Recruit and place trained and caring volunteer advocates in every New Jersey nursing home and assisted living residence (currently numbering approximately 560).
2. 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.
3. Develop and promote a culture of caring among nursing home administrators and staffs.

### **STRATEGY**

1. Solicit grants to fund a statewide media campaign to **(a)** increase awareness of the Ombudsman program, thereby improving the availability of the advocacy and protections of the program, and **(b)** to reach a greater audience of potential volunteer advocates.
2. Continue the Office of the Ombudsman's program of training and support of the statewide network of Regional Long-Term Care Ethics Committees.
3. Promote "buy-in" by nursing home and assisted living administrators and staff of a culture of caring through continued education and support in the areas of palliative care and leadership, team building, and dispute resolution.
4. Partner with non-profit organizations, educational institutions, and other governmental agencies, as necessary, to accomplish these goals.

### **PERFORMANCE MEASURES**

The Office of the Ombudsman for the Institutionalized Elderly is developing a resident satisfaction survey, to be administered on a regular basis by volunteer advocates.

**GOAL 2:** Through the Office of the Public Guardian for Elderly Adults, educate the public and work with professionals to ensure that guardianship and alternatives to guardianship are understood and properly utilized.

### **OBJECTIVES**

1. Educate family members and friends about the need for advance planning, durable powers of attorney, and health care proxies.
2. Educate the public about the guardianship process and the fiduciary duty of being a guardian.
3. Continue to strengthen the Office of the Public Guardian for Elderly Adults to assure that if family or friends are not willing or appropriate to serve as guardian that the Public Guardian will be available for them.
4. Collaborate with New Jersey State Bar Association, unaffiliated attorneys, agencies, physicians, medical and long term care institutions, and others to assure that guardianship services are available when necessary.

### **STRATEGY**

1. Increase funding for the Office of the Public Guardian through fees, commissions, and other sources of revenue in order to be able to serve the incapacitated elderly as the number and complexity of cases increase.
2. Develop with the New Jersey State Bar Association and other organizations an education campaign for the general public about advance directives or health care proxies.
3. Provide information and promote understanding about guardianships through continuing education with the medical and nursing professions, agencies, and others.
4. Seek grant funds to assist in supporting the educational processes.
5. Produce a short video about the guardianship process that can be given to families and interested parties.
6. Continue to work with the Office of the Ombudsman for the Institutionalized Elderly Volunteer program.
7. Collaborate with non-profit agencies, the Office of the Ombudsman for the Institutionalized Elderly, and government agencies to accomplish the strategies listed above.

### **PERFORMANCE MEASURES**

The Public Guardian is developing a video, has started working with the Office of the Ombudsman for Institutionalized Elderly Volunteer program, and will continue to work toward achieving the strategies during the coming year.

**GOAL 3:** 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 in the community.

### **OBJECTIVES**

1. Continue to support each county Adult Protective Services provider agency with funding, technical support, and training as the program prepares for the rapid growth of the aging population.
2. Educate the public and other professionals with regard to the responsibilities, jurisdiction, and limitations of Adult Protective Services.
3. Work collaboratively with other agencies to insure the safety of clients receiving services from both Adult Protective Services and another service provider. The focus of this collaboration is with the Division of Mental Health Services (DMH) and the Division of Developmental Disabilities (DDD).

### **STRATEGY**

1. Increase funding for Adult Protective Services as the number of investigations and case complexity grows (see Exhibit 10).
2. Intensify the public awareness campaign through brochures and workshops for professionals and the general public.
3. Modify the curriculum of the Adult Protective Services basic training, advanced worker training and Supervisor training to address emerging issues.
4. Complete Memoranda of Understanding with both the Division of Mental Health Services and the Division of Developmentally Disabled that will facilitate service delivery to common clients.

### **PERFORMANCE MEASURES**

APS developed 28 performance standards in 2000. Annually each of the 21 Adult Protective Services provider agencies is monitored and case files are measured against those standards. Particular attention is paid to response times, flexibility of the care plan as circumstances change, interventions used, and respect for the client's rights.

**EXHIBIT 10**

**ADULT PROTECTIVE SERVICES (APS)**

COUNTY	2003 APS		2004 APS		2004 VS. 2003	
	Investigated	Validated	Investigated	Validated	% Investigated	% Validated
Atlantic	436	385	441	407	1%	6%
Bergen	440	189	452	263	3%	39%
Burlington	219	165	251	185	15%	12%
Camden	230	74	239	77	4%	4%
Cape May	10	5	33	7	230%	40%
Cumberland	86	16	83	22	-3%	38%
Essex	266	127	258	188	-3%	48%
Gloucester	93	37	78	33	-16%	-11%
Hudson	541	462	602	474	11%	3%
Hunterdon	97	74	122	85	26%	15%
Mercer	175	97	200	78	14%	-20%
Middlesex	269	134	489	151	82%	13%
Monmouth	249	79	226	68	-9%	-14%
Morris	75	26	74	34	-1%	31%
Ocean	505	394	582	437	15%	11%
Passaic	172	104	203	137	18%	32%
Salem	71	21	68	26	-4%	24%
Somerset	127	44	127	42	0%	-5%
Sussex	75	37	46	15	-39%	-59%
Union	118	52	134	63	14%	21%
Warren	67	35	79	32	18%	-9%
<b>TOTAL</b>	<b>4321</b>	<b>2557</b>	<b>4787</b>	<b>2824</b>	<b>11%</b>	<b>10%</b>

**PRIORITY 5: Promote effective and responsive management.**

**WHAT DACS HAS DONE AND WHAT THIS HAS ACCOMPLISHED**

**INTERNALLY**

WHAT WAS DONE	WHAT WAS ACCOMPLISHED
Reorganized two divisions with common missions to support seniors in the community into one (the Divisions of Senior Affairs and Consumer Support).	Created Division of Aging and Community Service (DACS). Streamlined administrative practices.
Adopted a mission and vision for the new division.	Provided guidance for all activities.
Held regular meetings for all staff (250+), and retreats for managers (25+).	Informed and energized staff. Created forum for open dialog on work issues
Held inter-unit meetings to support division cohesion.	Opened lines of communication throughout DACS Identified efficiencies in program administration

**EXTERNALLY**

WHAT WAS DONE	WHAT WAS ACCOMPLISHED
Reformatted and restructured the AAA Executive Director meetings.	Communications were improved with Executive Directors. Before each meeting an agenda is presented. Meetings include PowerPoint reports from Assistant Commissioner, AAA Administration and AAA Grants Management, among other speakers. Minutes documenting the discussion are written after each meeting for approval at following one.
Conducted roundtable discussions with NJ4A, the Area Agencies on Aging State Board.	Direct input from AAA leadership gained: a platform for dialogue on national issues, county concerns and disparities. Provided an arena to focus on agenda items for the Executive Director meetings. Results included a finance committee and regularly scheduled visits to each AAA office: at least twice per year.
Joined with DACS's partners in the Dept. of Human Services to work on common issues and initiatives including interagency planning, Medicare Part D implementation, and the ADRC grant, and the Developmental Disabilities Council.	Ensured that key partners were involved in all stages of project development and implementation. Improved the ability to implement program changes in shorter period of time.
Worked with Governor's Office on drafting of Executive Orders No. 100 and No. 31.	Governor issued Executive Orders No. 100 and No. 31 taking the DHSS recommendations.
Pursued grants to improve access to information and services.	NJEASE for Caregiver grant; ADRC; PACE Technical Assistance grant.

**WHAT DACS PLANS TO DO AND HOPES TO ACCOMPLISH**

**INTERNALLY**

<b>WHAT DACS PLANS TO DO</b>	<b>WHAT DACS HOPES TO ACCOMPLISH</b>
Continue to hold regular meetings for all staff and retreats for managers.	Inform and energize staff Maintain open dialog on work issues
Continue to hold inter-unit meetings to support division cohesion.	Open lines of communication throughout division. Identify efficiencies in program administration

**EXTERNALLY**

<b>WHAT DACS PLANS TO DO</b>	<b>WHAT DACS HOPES TO ACCOMPLISH</b>
Work with Governor’s office to implement global budgeting.	Flexibility will ensure more seniors and persons with disabilities in need of long-term care services can receive them in the community.
Through advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring, and evaluation, lead the way in developing and enhancing a comprehensive and coordinated system of community care.	Implement ADRC pilot projects in two counties and look to expand further – a streamlined, visible, and trusted system for aged and disabled individuals.
Establish PACE models in NJ.	Build state capacity and partnering Develop rates and requirements
Seek out and establish new partnerships with public and private entities to address service needs.	DD Mental Health (DD & E. Bogg Center) Private industry NJ Business and Industry Association Integrated Health Systems Health Care Associations
Seek funding for innovative programs that benefit seniors, caregivers, and persons with physical disabilities.	Alzheimer’s disease grant Other initiatives under Community Education & Wellness.
Improve, monitor, and evaluate programs to ensure quality.	CMS Model for Home and Community-Based Waivers ADRC AAA Performance Standards Care Management Standards Alliance of Information and Referral Systems (AIRS) standards
Provide updated and ongoing technical assistance to the AAAs, so they may continue as the lead agencies in developing coordinated systems of community based services.	Training and support leading to increased fiscal accountability, data gathering and monitoring capabilities.

**GOAL 1: Continue to implement DACS's annual AAA Assessment Procedure.**

**OBJECTIVES**

1. Ensure that AAAs are accountable with regard to the performance of services they provide under Title III of the OAA.
2. Ensure that DACS is responsive to AAA evaluation of its leadership and its service delivery capacity.

**STRATEGY**

1. Review and evaluate the Self-Assessment Tool completed by each AAA.
2. Review and evaluate the required forms completed by each AAA pertaining to compliance issues, important events, AAA initiatives, best practices, and program highlights during the previous year.
3. Review the AAA evaluation of DACS.
4. Review AAAs' in-house data.
5. Conduct the assessment site visit.
6. Complete post-assessment activities.

**PERFORMANCE MEASURES**

The Office of Area Agencies on Aging Administration has focused its efforts on refining the performance measures for the assessment of services provided under Title III of the OAA as well as provider operations and execution. In addition, the collection of timely, accurate, and comparable data is of growing importance to DACS. Through annual performance reports, the AAA Administration office provides detailed information on the local AAAs and their progress in meeting objectives. DACS will soon be utilizing this accountability system not only to document results but to justify funding under the global budget concept.

**GOAL 2: Provide new and ongoing technical assistance to the AAAs to support their role as senior planning and service leaders at the local level.**

**OBJECTIVES**

DACS's objective is to support the 21 AAAs in New Jersey so that they can successfully accomplish their respective goals.

## **STRATEGY**

1. Each year, DACS offers two training sessions to AAA staff including a four-day information and assistance training and an eight-day core care management training. In addition, a series of one-day training programs are offered throughout the year to AAA staff and other members of the aging network. The topics for these training sessions are determined from surveys that are sent to the AAA directors, care coordinators, and care managers. DACS has also developed and will be offering new training opportunities on cultural diversity, customer service excellence, and consumer direction.

## **PERFORMANCE MEASURES**

DACS will provide technical assistance to the AAAs to support their role as senior planning and service leaders at the local level, leading to increased fiscal accountability, data gathering and monitoring capabilities.

## **AREA AGENCY ON AGING (AAA) ASSESSMENT PROCESS**

Each year DACS conducts an assessment of the AAAs to evaluate their performance and operations during the prior year. All AAAs are required to return a completed Self-Assessment Tool and the forms entitled **(a)** Compliance Issues and Important Events, **(b)** AAA Initiatives, Best Practices and Program Highlights During 2004, and **(c)** AAA Evaluation of the Division of Aging and Community Services. An electronic version has also been sent to AAA Directors. This Self-Assessment Tool was developed to reflect feedback from AAA directors and input from State administration staff.

Annually, DACS conducts a desk review of the required documentation for all 21 counties and an on-site assessment visit to seven counties. Each AAA will be subject to an on-site assessment every third year, unless circumstances warrant a timelier visit. Technical assistance and monitoring visits will continue annually and on an as-needed basis. See a detailed outline of the AAA Annual Assessment Procedures in Attachment G.

## **OPEN COMPETITION FOR OLDER AMERICANS ACT FUNDS STATE AND AREA AGENCY ON AGING (AAA) CONTRACTING POLICY AND PROCEDURES**

DACS, as required under the OAA and in conformance with state law, provides requirements as a component of the Area Plan Contract for a free, open and competitive process for awarding funds. The competitive contracting Request for Proposal (RFP) process and methodology for awarding contracts are administered by the AAA Executive Director in concert with the county designated purchasing agent pursuant to Public Law 1999, Chapter 440.

Other services administered directly by the AAA require that the agency submit to the State a request for a direct service waiver in accordance with division policy. In order to substantiate the need for a waiver, the AAA must provide assurances and supporting documentation to DACS demonstrating the following:

- Provide evidence that the cost of the activity is competitive with other not-for-profit organizations that provide similar services;
- Document their capacity to provide program, fiscal and administrative oversight and;
- Substantiate that the resources and services needed, would best be provided by them.

Counties must use the RFP and/or waiver contract process to ensure service delivery. In addition, direct quality assurance and performance review of the subcontractor is the responsibility of the AAA. However, DACS will review the performance review results and methodology, and will ensure follow-up on any compliance issues.

### **COMPETITION VIS-À-VIS COST AND QUALITY OF CARE**

DACS has begun to address the impact of competition and the provision of services under the OAA and its affect on cost and quality of service by implementing team monitoring visits in select nutrition programs.

### **OFFICE OF COMMUNITY PROGRAMS MONITORING**

In 2005, DACS' Office of Community Programs implemented a new approach to monitoring and promoting quality performance of agencies that locally administer the Community Care Program for the Elderly and Disabled, the Assisted Living, and the Caregivers Assistance Program Medicaid Waivers, as well as the state-funded Jersey Assistance for Community Caregivers program.

Based on the CMS Quality Framework, DACS's on-going oversight and monitoring efforts now rely largely on the ability to demonstrate quality assurance through evidentiary-based information.

**GOAL 3:** Improve, monitor, and evaluate HCBS Waiver programs to ensure quality.

### **OBJECTIVES**

DACS objective is to measure the extent to which policies and procedures have been implemented and quality improvement is practiced. The ability to do so directly enhances the effectiveness and responsiveness of DACS.

## **STRATEGY**

1. Site Visit: The Office of Community Programs monitors care management agencies on an annual basis. Teams of three or four State representatives conduct a two-day on-site visit during which time **(a)** participants are interviewed by mail, phone, and face-to-face consultation, **(b)** care managers are interviewed, and **(c)** participant files are thoroughly examined.
2. Surveys: The care management agency completes and returns a questionnaire to the team prior to the visit so that areas of concern can be discussed on-site.

An array of survey tools are used to discover and quantify findings with regards to program administration in areas such as:

- Process efficiency and timeliness
- Eligibility and level of care determination
- Monitoring plans of care
- Provider qualifications
- Participant health and well-being
- Whether participants are afforded choice and the ability to direct their own care

## **PERFORMANCE MEASURES**

**Interviews:** Extensive entrance and exit interviews are conducted by the team so all parties are aware of the day's agenda and the team's findings. If deficiencies are found, a plan of correction is warranted within thirty days and follow-up occurs as necessary. This system of on-going oversight and data collection enables the division to discover problems as they occur and work toward timely remediation, thereby ensuring continuous program improvement.

## **QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROCESS**

The framework for DACS's Quality Initiative (DACSQI) will be based upon the guidelines developed by CMS for HCBS. This initiative will use the formal CMS Quality Framework using the functions of design, discovery, remedy, and system improvement.

**Design:** *"Designing quality assurance and improvement strategies into the HCBS program at the initiation of the program."* The collection of data for performance measures, indicators and proxies will be to first leverage all available administrative data. Three databases that will be used in QI process are:

- Area Plan Contract Reporting System
- State Aging Funded Programs (e.g., Jersey Assistance Community Caregivers, Statewide Respite, Alzheimer's Adult Day Services Program, Congregate Housing Services Program, etc.)
- New Jersey's Medicaid MMIS (Medicaid Waiver Programs)

**Discovery:** *"Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement."* Opportunities for quality improvement will flow from three primary disciplines: data analyses, business process improvement analyses and through focus groups and interviews.

**Remedy:** *"Taking actions to remedy specific problems or concerns that arise in the discovery process."* Built into the QI process will be the development and implementation of effective solutions for cross-functional and organizational processes. A workgroup comprised of representatives from the Resource Centers, consumer representatives, partners, and principal stakeholders will be established to assist with QI.

**Systems Improvement:** Once a business process has been developed and approved, the protocols documented and appropriate staff trained, the new processes are implemented and the quality cycle begins again leading to continuous quality improvement. In addition, experiences will be documented and reviewed for lessons learned and to determine techniques for reducing time to implementation.

**Priority Areas for Quality Assessment:** DACS's priority areas for quality assessments include the following:

- Participant access
- Participant-centered service planning and delivery
- Provider capacity and capabilities
- Participant safeguards
- Participant rights and responsibilities
- Participant outcomes and satisfaction
- System performance

The State will incorporate best practices as a cornerstone for building its assessment tools. Benchmarking and cost targets are some of the tools that will be used to assess performance.

**GOAL 4: Promote DACS's Quality Assurance and Quality Improvement Process throughout all programs and services.**

DACS intends to monitor its AAA service providers' mission-critical functions and improve service delivery structure. It will do so by implementing integrated and flexible Information Technology (IT) solutions in order to deliver consistent high quality level services, access AAA network performance information, review and optimize resources, and manage change and improvements.

**OBJECTIVES**

DACS' goals, objectives, and activities are designed specifically to ensure that:

1. The model will increase visibility
2. It will be viewed as trustworthy
3. It will make it easier to access information and services
4. It will be more responsive to the needs of consumers
5. The service delivery system will become more efficient and effective

**STRATEGY**

1. Quality improvement will include the following activities:
  - a. Establish management responsibilities
  - b. Define processes and goals and identify consumer/stakeholder requirements
  - c. Define and establish measures
  - d. Assess conformance to consumer/stakeholder requirements
  - e. Investigate process to identify improvement opportunities
  - f. Rank improvement opportunities and set objectives
  - g. Improve process quality

**PERFORMANCE MEASURES**

Performance goals are aligned with desired consumer and stakeholder outcomes, which will be measured through consumer/stakeholder surveys, interviews, and focus group sessions. The indicators are in-process measures that tell DACS how it's doing as it strives to reach its desired outcomes.

**GOAL 5:** Seek funding for innovative programs that benefit seniors, caregivers, and people with physical disabilities

### **ALZHEIMER'S DISEASE DEMONSTRATION GRANTS (ADDGS)**

DACS has applied for AoA's *Alzheimer's Disease Demonstration Grants to States* to contract with an architectural research center, specializing in environments for persons with dementia, to conduct a one-year capacity building project utilizing environmental interventions and assistive technologies as tools for dementia care.

### **PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

PACE is a Medicare and Medicaid comprehensive managed care program, covering health and social services for frail individuals age 55 and older who wish to remain in the community.

### **OBJECTIVES**

New Jersey was selected by the *National PACE Association* to receive technical assistance to analyze potential markets for developing PACE.

### **STRATEGY**

1. In addition to funding feasibility studies to determine the best locations for PACE, this award provided education for State staff and outreach to communities and potential providers. Funding for these studies came from the CMS.

### **PERFORMANCE MEASURES**

DACS will develop Medicaid rates, solicitation strategies, licensing requirements, and program policies to establish PACE in New Jersey.

**GOAL 6:** Reform long-term care by changing the way the budget is structured through a global budgeting process

In 1996, New Jersey started reforming its long-term care system with the creation of the DHSS. In state fiscal year (SFY) 1997, 92.7% of public long-term care funds for older adults were spent on nursing homes while 7.3% were spent for HCBS options. In SFY 2002, funding shifted to 84.7% for nursing homes and 15.3% for HCBS care.<sup>21</sup> In SFY 2004, funding shifted to 83.0% for nursing homes and 17.0% for HCBS care.<sup>22</sup>

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<sup>21</sup> Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

<sup>22</sup> Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

The numbers of people served in nursing facilities dropped by approximately 2,000 individuals, from almost 32,000 in SFY 1997 to about 30,000 in FY 2004.<sup>23</sup> Concurrently the individuals served by New Jersey's HCBS programs for older adults increased from under 6,000 in SFY 1997 to almost 17,500 in FY 2004.<sup>24</sup>

## **OBJECTIVES**

Two Executive Orders were issued by former Governor James E. McGreevey and Acting Governor Richard Codey in 2004 and 2005, respectively. These Executive Orders called for the implementation of a global budgeting process. This will enable the development of a long-term care system that is consumer driven, clinically appropriate, cost-effective, and fiscally responsive.

## **STRATEGY**

1. The market-based approach inherent in global budgeting gives individuals more choice over the location and types of services they receive.

## **PERFORMANCE MEASURES**

Older adults will be able to make their own long-term care decisions because this will be a system that incorporates the philosophy of consumer direction and individual control in State policies and programs.

**GOAL 7:** Continue an open communications framework established within the DACS in order to foster cohesion and efficiency.

## **STRATEGY**

1. DACS will continue to hold annual meetings for all staff and retreats for managers. It will encourage inter-office collaboration on new initiatives in order to keep staff informed, solicit input on work and service-related issues, identify efficiencies in program administration, and maximize staff resources and development.

## **PERFORMANCE MEASURES**

DACS will continue to pursue open communications within the Division and between the Division and the AAAs.

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<sup>23</sup> Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

<sup>24</sup> Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

**GOAL 8: Transform information technology to support systems change at DACS.**

DACS is a product of an internal consolidation of two divisions at DHSS in 2003. Prior to that, all senior services were transferred, consolidated, and reorganized within DHSS in 1996. Current Information Technology (IT) support at DACS is a result of these consolidations; which they took place without an overall systems integration strategy.

**OBJECTIVES**

It is this fragmented integrated IT system that is being enhanced to meet with growing collection, monitoring, client assessment, care planning, and care management needs plus payment systems, program data, and provider information. DACS is at the early stages of developing the infrastructure to integrate these client, program, provider, and payment information systems.

**STRATEGY**

1. To integrate and maintain the systems, DACS will enhance staff resources through new hires and consultative services. For instance, the ADRC has hired an IT consultant to develop an MIS strategy. Included in the MIS strategy is an examination of the existing data systems, a gap analysis, and the researching of benefits screening, information referral, and resource directory applications, among other activities.

**PERFORMANCE MEASURES**

DACS will continue to improve and enhance information technology across all programs and services to advance systems change.

**GOAL 9: Reengineer the Office of Community Choice Options to meet changing needs and business conditions.**

In 2004, the Office of Long Term Care Options became the Office of Community Choice Options to emphasize its mission of transitioning individuals from nursing homes to the community. OCCO has been transforming itself in more than name only (see performance measures).

The plan also refocuses the Pre-Admission Screening (PAS) process on meeting the requirements of acute care hospitals to reduce costs by decreasing the patient length of stay and enabling more individuals to benefit from home and community options.

## **OBJECTIVES**

Since the Office of Community Choice Options performs the clinical eligibility determination for New Jersey's long-term care Medicaid funded programs, the operation of this office is critical to the success of developing a global budget system in New Jersey.

## **STRATEGY**

1. A consolidation proposal has been approved to reorganize the Office of Community Choice Options into three regions from eight. Each of the three regional offices will be divided into a minimum of two teams with responsibility for a geographic area. The streamlining promotes the values of partnership, client self-determination, and access to services by increasing programmatic efficiency, cost effectiveness, and flexibility to meet the changing needs of seniors, caregivers, and the health care services delivery system.

## **PERFORMANCE MEASURES**

In CY2003, Community Choice Counselors facilitated the discharge of 206 individuals from nursing homes. In CY2004, there were 258, a 20% increase in one year.

In 2004, Community Choice Counselors completed a total of 33,746 PAS assessments for nursing home or waiver program placement. This represents a 10% increase in PAS completions from 2003 to 2004. Timeliness in completing PAS assessments improved from 55% to 95% in 2004.

**GOAL 10: Develop a formal outcomes measurement model for selected programs in order to document changes in the knowledge, attitudes, behavior, and/or physical and/or emotional well-being of recipients of aging services.**

The performance measures delineated throughout this plan generally indicate the degree to which DACS will have performed its role and responsibilities with regard to achieving its objectives. These measures are important for holding DACS accountable for commitments it has made in this plan. They do not, however, directly measure the impact on clients, recipients, and beneficiaries of DACS and/or AAA services.

## **OBJECTIVES**

As part of its commitment to promote effective and responsive management, DACS will develop a formal outcomes measurement model, including quantifiable indicators, for at least two selected programs.

## **STRATEGY**

1. DACS will begin this endeavor by selecting at least two programs that lend themselves to outcome measurement. For instance, DACS could focus on the Senior Nutrition program, which currently consists of meals served almost daily at 239 centers throughout New Jersey in a group or congregate setting as well as home delivered meals. DACS would establish pre- and post-intervention evaluation instruments to enable it to document changes occurring directly as a result of these nutrition programs. For instance,
  - Comparison of physical exam results prior to participation in a nutrition program and at periodic intervals following active participation are likely to show improvements in physical well-being.
  - Comparison of responses to questionnaires administered to seniors upon first coming to nutrition centers and at periodic intervals following active participation are likely to indicate improvements in attitude, e.g. seniors may have a more positive outlook on life, a decreased sense of isolation, developing friendships, and the like.

To site an entirely different example, DACS could focus on its Caregiver at Home initiative, in which it provides mental health counseling, professional in-home training and education, and trained volunteer supportive assistance to caregivers. Pre- and post-intervention evaluation could include the following:

- Comparison of responses to questionnaires administered to caregivers prior to and subsequent to their receiving Caregiver at Home services are likely to indicate various improvements in knowledge and attitudes, e.g. caregivers may have more information about where to get needed help, they may have learned specific techniques for handling their frail patient, they may have overcome emotional issues such as loss/denial/depression related to their roles as a caregivers, and the like.

## **PERFORMANCE MEASURES**

DACS will work with an expert on the development of quantifiable outcomes indicators and pre- and post-intervention evaluation instruments for selected programs. The result will be a formal outcomes measurement model for at least two programs.

## CHAPTER 4

### Overview of Division of Aging and Community Services (DACS)

#### PROGRAMS AND SERVICES

The Division of Aging and Community Services (DACS) is one of three senior services divisions in the Department of Health and Senior Services (DHSS) and is designated as the State Unit on Aging for the receipt of federal funds under the Older Americans Act as well as the State Administering Agency for two Medicaid 1915(c) waivers. The Division is responsible for preparing the State Strategic Plan 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 seven offices: the Office of Administration and Finance; Office of Area Agency on Aging (AAA) Administration; Office of Community Choice Options; Office of Community Education and Wellness; Office of Community Programs; Office of the Ombudsman for the Institutionalized Elderly; and the Office of the Public Guardian and Elder Rights (see Exhibit 11).

#### **Aging and Disability Resource Connection (ADRC)**

New Jersey was one of the first 12 states to receive a federal grant from the Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS) to help redesign the aging and disability service systems. While DHSS, through DACS, is the lead agency, the NJ Department of Human Services is collaborating with DHSS on this three-year initiative renamed in New Jersey as the Aging and Disability Resource Connection. In New Jersey, Atlantic and Warren Counties are serving as ADRC pilot counties.

#### **NJEASE (New Jersey Easy Access, Single Entry)**

New Jersey's aging services delivery system is known as NJEASE (New Jersey Easy Access, Single Entry). By dialing a single, toll-free telephone number callers are connected to their Area Agency on Aging (AAA) for information and assistance. That number is 1-877-222-3737.

#### OFFICE OF ADMINISTRATION AND FINANCE

This office oversees and provides administrative and fiscal support to the operational units of DACS including the 2002 consolidation of two divisions into a single division responsible for all home and community based services.

#### OFFICE OF AREA AGENCY ON AGING (AAA) ADMINISTRATION

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.

*No. of beneficiaries served annually: 496,968 in CY2004.*

### **Senior Nutrition Program**

Through more than 200 nutrition centers, New Jersey elders 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. There is no means test for nutrition services. Each meal meets the nutritional standard of one-third of the Recommended Daily Allowance, and complies with the Dietary Guidelines for Americans.

The home delivered meal 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.

The division is working with partners throughout the state to begin implementing changes under its Mission Nutrition initiative. These changes are addressing the state's ethnic and cultural diversity through food and programming, expanding the programs to include health and wellness activities, and building flexibility into food choices and times of operation.

*No. of beneficiaries served annually: 2.1 million meals served to 30,740 individuals in a congregate setting in CY2004; 3.7 million home-delivered meals to 29,177 individuals in CY2004.*

### **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 currently eight regional Long Term Care Field Offices.

#### **Pre-Admission Screening (PAS)**

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. PAS helps applicants and families choose between various long-term care programs, and assists them in securing the selected service delivery placement. PAS was implemented in 1989.

*No. of beneficiaries served annually: During CY2004, Community Choice counselors competed a total of 33,746 PAS assessments (26,686 initial assessments and 7,060 reassessments) for nursing facility or waiver program placement. This represents a 10% increase in PAS completions from 2003 to 2004. Timeliness in completing PAS assessments improved from 55% to 95% during 2004.*

### **Community Choice Program**

The Community Choice Program, established in 1998, is designed to select short-term Medicaid nursing facility residents, provide them with choices on community-based alternatives, and coordinate their discharge. This program encourages those individuals capable of living in the community to do so. Consumers are identified, encouraged to consider alternate housing with the necessary support services, and assisted as they make the transition from a nursing facility to community settings.

*In CY2003, Community Choice counselors facilitated the discharge of 206 individuals from Nursing Facilities (NF). In CY2004, it completed 258, or a 20% increase from 2003 to 2004.*

### **Case Management**

The office has provided Medicaid-eligible waiver clients with assessment and care monitoring since 1996. This service enables participants to remain in the least restrictive environment possible. A client-directed approach is utilized in the development and completion of a plan of care.

### **Nursing Facilities Transition Grant Initiative**

This three-year, federally funded grant, awarded in 2002 and began in 2004, is designed to improve supports for non-senior disabled individuals to allow them to remain in, or transition from the nursing home to, home and community-based services.

### **Adult Day Health Services**

Adult Day Health Services 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 or mental impairment, require services to support community living. Individuals who request Adult Day Health Services must meet financial and medical requirements for Medicaid coverage. Facilities must be licensed by the department and are required to provide medical, nursing, social, personal care and rehabilitative services, a midday meal, activities and transportation to and from the facility. This program was established in 1977.

*No. of beneficiaries served annually: 12,839 individuals in FY2004.*

## **OFFICE OF COMMUNITY EDUCATION AND WELLNESS**

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

### **Information, Assistance and Community Outreach**

This 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 through the development of promotional and educational materials. This core service has been provided since 1973.

*No. of beneficiaries served annually: 167,951 individuals in CY2003.*

### **Aging Network Professional Training**

This unit is responsible for developing and delivering training programs for professionals working for the Division of Aging and Community Services, the County Area Agencies on Aging (AAAs), and other providers of senior services operating in the State of New Jersey. Major trainings include the four-day Basic Information and Assistance Training for those persons who are the first point of contact for consumers seeking help; the eight-day Core Care Management Training for community-based outreach workers and care managers; a one-day continuing education workshops for DACS and AAA staff and local service provider staff including Congregate Housing, the Public Guardian, the Ombudsman, Community Choice, Long Term Care Field Offices, Adult Day Health Services, Adult Protective Services and those working with people with disabilities; and training modules for the ADRC initiative.

### **Older Adult Health and Wellness**

This unit fosters the well-being of older adults and their caregivers through coordinated strategies aimed at health promotion, provider and consumer education and the prevention, early detection and prompt management of disease. Primary areas of concentration includes osteoporosis, arthritis, falls prevention, nutrition, mental health and medication management.

### **HealthEASE**

The division received a \$300,000 grant from the Robert Wood Johnson Foundation's Health Initiatives project in 2002 to develop pilot programs promoting longer and healthier lives for seniors. The grant is funding the expansion of the department's existing *NJEASE* system to create *HealthEASE* pilots in Ocean and Bergen Counties.

### **Arthritis - Quality of Life Initiative**

In compliance with the provisions of a 1999 statute, the unit provides staff support to the Arthritis Advisory Council, its subcommittees, and to two regional arthritis centers. The centers are working to increase awareness about arthritis and the importance of early diagnosis and treatment and to deliver evidence-based programs aimed at prevention of complications and increased quality of life. The activities of the centers include information and outreach; physical activity classes; and self-management programs and services for persons affected by arthritis.

### **Osteoporosis – Project Healthy Bones**

A 1997 law established the New Jersey Interagency Council on Osteoporosis (IOC) and mandated prevention and education services be established in the DHSS. This DACS unit provides leadership to the IOC and implements initiatives in the areas of public and professional education and outreach.

Project Healthy Bones is a peer-led program that engages older adults with or at-risk for osteoporosis in weight bearing exercise and provides education on nutrition, falls prevention and other related topics. The 24-week program is delivered at community sites throughout the state. In 2005, a new system of program delivery is being implemented via partnership with the state's two regional arthritis centers and the Saint Barnabas Osteoporosis Center and Wellness Center.

### **Chronic Disease Self Management**

Through a grant from the Association of State and Territorial Chronic Disease Program Directors, the department is partnering with the Geriatric Education Center at the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine, to establish the infrastructure for Chronic Disease Self Management in Camden County. The initiative focuses on two target older adult populations: Asian Indians and African Americans.

Through this initiative, leaders from each organization are trained as Chronic Disease Self Management class leaders. Following the delivery of four classes with the support of the GEC and DHSS, the leaders will have the capacity to deliver the classes independently. This initiative is being fully evaluated with an emphasis on the delivery of evidence-based programs in target populations.

### **State Health Insurance Assistance Program (SHIP)**

SHIP trains volunteers in 21 counties to assist Medicare enrollees who have problems or questions about their health insurance. The program develops informational packages about Medicare, Medicare supplemental insurance and Medicare contracting HMOs for distribution to Medicare enrollees and their families.

*No. of beneficiaries served annually: 30,300 phone calls and 13,800 in-person contacts in CY2003.*

The program was awarded a supplemental grant of \$274,219 from CMS for increased counseling and assistance on long-term care planning, including insurance options and other financial and service approaches. All SHIP counselors (355) received training in basic long-term care information. Seventy-four counselors completed an intensive training program to be certified as Long-Term Care Specialists. A January to May 2005 long-term care awareness campaign (called *Own Your Own Future*) funded by the federal government further enhances the SHIP grant and puts the concept of the need to plan for long-term care in the spotlight.

Through this campaign, letters from Acting Governor Richard J. Codey encouraging individuals to plan for their long-term care needs, were sent to 821,797 residents aged 50-70. Nearly 10% of those receiving the letter requested the national toolkit. DHSS produced, printed, and is currently distributing *A Guide to Community-Based Long Term Care in New Jersey* to those respondents who requested NJ-specific resource information. More than 15,000 guides have been distributed statewide since mid-May 2005.

## **OFFICE OF COMMUNITY PROGRAMS**

This office establishes policy, and provides support, technical assistance and training to the AAAs, county field staff, community service providers, and other organizations administering programs concerned with the well-being of older citizens. In addition, this office conducts quality assurance measures, monitoring procedures, and data analysis to ensure stable and high quality home and community-based programs for New Jersey's seniors and their caregivers. This office has administrative responsibilities for Medicaid waiver programs and state funded home and community programs for older adults.

### **MEDICAID WAIVER PROGRAMS**

#### **Community Care Program for the Elderly and Disabled (CCPED)**

This Medicaid waiver program, established in 1983, encourages individuals to obtain home-based supportive care as opposed to receiving long-term care services in a nursing facility or hospital setting. Eight services are available under CCPED: case management, home health, homemaker, medical day care, non-emergency medical transportation, respite care, social day care and prescription drugs. While there is no co-pay for CCPED services there is a cost cap on each individual's service package. The program assists persons age 65 and older and younger persons with disabilities. Eligibility includes income and asset tests.

*No. of beneficiaries served annually: 5,020 individuals in CY2004.*

#### **Assisted Living/Adult Family Care (AL/AFC)**

Under this Medicaid waiver program, approved in 1996, services are targeted to individuals who reside in licensed, Medicaid-approved Assisted Living (AL) or Adult Family Care (AFC) settings. Assisted Living promotes a resident's self-direction and provides assistance with personal care, medication management, and everyday activities in one of three settings: Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs in Subsidized Housing. All AL/AFC programs have consumer co-pays, except the Assisted Living Program in Subsidized Housing. In 2004, 750 new slots were funded for AL/AFC, bringing total slots to 3,200.

*No. of assisted living beneficiaries served annually: 3,767 individuals in CY2004.*

Adult Family Care is a service provided under contractual agreement whereby no more than three persons receive room and board, personal care and health services in the home of an unrelated individual. The caregiver is screened, trained and approved by an AFC sponsor agency, licensed by the DHSS.

*No. of beneficiaries served annually: 55 individuals in CY2004.*

#### **Caregivers Assistance Program (CAP)**

Fourteen waiver services, plus full Medicaid State Plan services, are targeted to individuals who reside in a home or an apartment, and not a licensed facility. The Caregivers Assistance Program (CAP), created in 1999, is designed to supplement the assistance an

individual receives from his or her natural support network of family, friends, and neighbors, as well as from community agencies and volunteer groups. CAP recognizes that natural support networks accomplish most caregiving to vulnerable individuals. While services can be provided by traditional waiver service providers, they can also be supplied by qualified providers employed by the client. There is no co-pay in CAP, but income and asset limits must not be exceeded.

*No. of beneficiaries served annually: 1,977 individuals in CY2004.*

### **Programs of All-Inclusive Care for the Elderly (PACE)**

New Jersey was selected by the National PACE Association to receive technical assistance to analyze potential markets for developing Programs of All-Inclusive Care for the Elderly (PACE). PACE is a Medicare and Medicaid comprehensive managed care program, covering health and social services for frail individuals age 55 and older wishing to remain in the community. In addition to funding feasibility studies to determine the best locations for PACE, this award provided education for state staff and outreach to communities and potential providers. The division is developing Medicaid rates, solicitation strategies, licensing requirements and program policies to establish PACE in New Jersey.

## **STATE-FUNDED COMMUNITY BASED PROGRAMS**

### **New Jersey Caring for Caregivers Initiative**

The purpose of this initiative, launched in 2005, is to enhance and prolong the ability of unpaid caregivers to continue to provide care for an elderly or adult disabled individual. The initiative has two components. The first, *Caregiver At Home*, will provide mental health counseling, professional in-home training and education, and trained volunteer supportive assistance through funding allocated to each of New Jersey's 21 AAAs. There are no income or asset tests for this component. The second, a *Caregiver-Directed Respite Pilot*, will be initiated in four counties to test a program of direct payments to caregivers to reimburse expenditures for providing care to a senior or younger adult with disabilities. Reimbursable items are clearly defined and must be identified on a service plan agreement developed by the caregiver and the local coordinator of the Statewide Respite Care Program. Up to \$250 per month can be given to a caregiver for reimbursable items.

### **Jersey Assistance for Community Caregiving (JACC)**

This program, created in 1999, provides thirteen in-home services and supports that enable an individual at risk of placement in a nursing home to remain in his or 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 or prevent placement in a nursing home. The JACC service package mirrors that of the CAP program, making for an easy transition for JACC consumers who spend down to Medicaid eligibility.

*No. of beneficiaries served annually: 1,742 individuals in CY2004.*

### **Home Care Expansion Program (HCEP)**

With the creation of other state-funded home and community based services, this program, established in 1989, stopped enrolling participants in 1996. Today, nine individuals continue to receive services under HCEP.

### **Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders**

This program, created in 1987, 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.

*No. of beneficiaries served annually: 785 individuals in FY2004.*

### **Congregate Housing Services Program**

The program, established in 1981, provides meals, housekeeping, personal care and coordination of services in affordable housing settings. It is designed to incorporate 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. The program has 38 providers serving 70 buildings in 18 counties. Beneficiaries pay a cost-share, based upon a sliding scale.

*No. of beneficiaries served annually: 2,817 individuals in CY2004.*

### **Statewide Respite Care Program (SRCP)**

SRCP 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. The program also helps families avoid making 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 SRCP include companions, homemaker/home health aides, medical or social adult day services, temporary care in licensed health care facilities, camperships, and private duty nursing services. The program was created in 1988 and participants must meet income and asset guidelines.

*No. of beneficiaries served annually: 3,964 families in CY2004.*

## **OFFICE OF THE OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY (OOIE)**

By statute, the OOIE is responsible for investigating, and resolving or referring complaints filed by any source, including anonymous sources, regarding abuse, neglect and exploitation of residents of long-term care facilities in the state, and for promoting, advocating and insuring the quality of care received, and the quality of life experienced, by elderly residents of such facilities. Identities of all complainants are maintained as confidential information. The office is state

funded, and also receives Federal Title VII Older Americans Act funds, which support the office's Volunteer Advocate Program.

*No. of beneficiaries served annually: 3,431 cases representing about 7,034 complaints investigated and resolved in FY2004.*

## **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 for Elderly Adults**

The Public Guardian serves as the guardian or conservator of last resort for those individuals aged 60 and older 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.

*No. of beneficiaries served annually: 664 clients in CY2004.*

### **Adult Protective Services (APS)**

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.

*No. of beneficiaries served annually: 7,450 referrals resulting in 4,321 investigations in CY2003.*

### **Money Management Program**

The office administers this bill paying service program developed by AARP as a way to provide older persons and people with disabilities help with processing routine bills, writing checks, developing budgets, managing financial matters and reconciling bank accounts. The goal is to provide guidance and non-intrusive bill paying assistance to maximize client independence with minimal intervention. The service is currently available in seven counties.

### **Vulnerable Elder Rights Protection – Title VII**

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

### **Legal Assistance**

As mandated by the Older Americans Act, AAAs must fund legal advice, assistance, and representation provided by, or under the supervision of, a lawyer to protect and secure the rights of older persons. The division's 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.



## CHAPTER 5

## Administrative Structure and Aging Network

### AREA AGENCIES ON AGING (AAA)

Almost 500,000 clients receive services through New Jersey's AAA network – a system that operates in the state's 21 counties. The counties are Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren. In New Jersey, there is a statewide network of comprehensive community-based services through the Area Plan Contracts (APC). The services and funding sources are shown in Exhibits 12 and 13 below.

**EXHIBIT 12**

### AREA PLAN CONTRACT SERVICES PROVIDED, 2004

SERVICE	UNITS	CLIENTS	EXPENDITURES
Information & Assistance	360,978	166,645	\$5,021,641
Benefits Screening	25,281	6,483	\$632,532
Extended Assessment	4,311	1,764	\$185,219
Outreach	44,163	23,698	\$1,328,396
Care Management	162,438	8,286	\$4,333,275
Transportation	794,843	15,825	\$5,578,370
Assisted Transportation	95,982	7,004	\$973,031
Newsletter	23	78,323	\$39,775
Friendly Visiting	31,207	937	\$203,482
Telephone Reassurance	290,969	2,735	\$332,320
Residential Maintenance	43,379	4,125	\$1,270,362
Housekeeping	83,425	1,688	\$1,544,580
Certified Home Health Aide	282,366	3,096	\$5,124,102
Visiting Nurse	10,883	855	\$283,443
Respite Care	97,813	1,100	\$1,725,728
Hospice Care	13,082	440	\$214,181
Emergency	9,107	1,984	\$511,398
Homesharing/Matching	981	124	\$34,273
Housing Assistance	1,654	601	\$91,875
Caregiver Support Group	859	884	\$136,054
Adult Day Services – Social	585,100	2,137	\$3,832,351
Adult Day Services – Medical	115,229	510	\$1,308,932
Personal Care	4,660	302	\$79,001
Adult Protective Services	185,394	4,939	\$4,940,813
Legal Assistance	22,444	5,958	\$1,346,684
Physical Health	36,869	14,031	\$1,158,111
Physical Health – Dental	26,524	1,404	\$692,843

**EXHIBIT 12****AREA PLAN CONTRACT SERVICES PROVIDED, 2004**

<b>SERVICE</b>	<b>UNITS</b>	<b>CLIENTS</b>	<b>EXPENDITURES</b>
Mental Health	9,932	1,651	\$819,360
Counseling	7,411	1,058	\$239,759
Physical Fitness	12,100	6,542	\$458,604
Education	30,898	24,779	\$933,839
Language Translation & Interpretation	6,161	1,976	\$148,036
Socialization/Recreation	35,715	13,040	\$1,064,896
Ombudsman	670	180	\$42,749
Congregate Meals	2,033,193	30,740	\$18,875,081
Home Delivered Meals	3,391,576	23,075	\$17,854,643
State Weekend Home Delivered Meals	330,274	6,102	\$1,841,832
Nutrition Education	1,900	29,432	\$202,772
Nutrition Counseling	2,727	2,515	\$188,919
<b>Total of All Services</b>	<b>9,192,521</b>	<b>496,968</b>	<b>\$85,593,262</b>

**EXHIBIT 13****SOURCE OF FUNDS FOR AREA PLAN CONTRACT SERVICES PROVIDED, 2004**

<b>SERVICE FUNDS</b>	<b>EXPENDITURES</b>	<b>PERCENTAGE</b>
Older Americans Act Title III B	\$9,672,226	11.30%
Older Americans Act Title III C1	\$8,916,468	10.42%
Older Americans Act Title III C2	\$5,952,038	6.95%
Older Americans Act Title III D	\$502,920	0.59%
Older Americans Act Title III D - Medication Management	\$217,722	0.25%
Older Americans Act Title III E	\$4,379,100	5.12%
State Matching Funds	\$3,046,378	3.56%
State COLA	\$3,019,682	3.53%
NSIP (Nutrition Services Incentive Program)	\$3,310,264	3.87%
Social Services Block Grant	\$9,095,462	10.63%
Adult Protective Services	\$4,067,383	4.75%
State Weekend Home Delivered Meals	\$913,038	1.07%
Safe Housing and Transportation	\$1,008,524	1.18%
NJ EASE Care Management Quality Assurance*	\$189,778	0.22%
State Home Delivered Meals	\$914,916	1.07%
HealthEASE Grant (Bergen County portion)*	\$33,810	0.04%
PACE (Health and Wellness Grant)	\$4,484	0.01%
Local Public Funds	\$17,084,872	19.96%
Local Private Funds	\$6,399,994	7.48%
Participant Income	\$4,879,842	5.70%
Other Income	\$1,984,361	2.32%
<b>Total Service Expenditures</b>	<b>\$85,593,262</b>	<b>100.00%</b>

## **NJ COMMISSION ON AGING**

The New Jersey State Commission on Aging was created by Chapter 72 of the Laws of 1957. The law specifies that the members of the commission shall be selected from among the citizens of the state who have demonstrated interest in the problems of aging. It states:

The New Jersey Commission on Aging upon Consultation with the NJ Division of Aging and Community Services (DACs), shall:

- Formulate a comprehensive, statewide master plan which identifies the needs of the senior citizens in this state;
- Hold public hearings to solicit input on the needs of older New Jerseyans and their caregivers;
- Advocate for the needs of older New Jerseyans and their caregivers with elected officials at both the state and county level;
- Make recommendations to the Governor and the Legislature on legislation needed in areas related to aging;
- Involve itself with other organizations that share the goal of advancing the quality of life for older adults, and
- Review and approve the State Strategic Plan on Aging.

Membership of the commission is prescribed in Public Law 1995, Chapter 346. There are nineteen members of the commission, as defined below:

- Fifteen members are appointed by the Governor for terms of three years.
- Four members serve in an ex-officio capacity: two legislative members, one appointed by the President of the Senate, one appointed by the Speaker of the Assembly, one representative chosen by and from the Executive Directors of the Area Agencies on Aging and the Assistant Commissioner of DACs.
- The commission elects a chairman, a vice-chairman and a secretary from the members appointed by the Governor. The commission meets regularly on a bi-monthly basis.

To meet the challenges of the 21<sup>st</sup> century, the Commission on Aging met in November of 2000 to reexamine its mission, organizational structure, and goals to ensure that it is fulfilling its obligations and responsibilities as an advocate for older adults and their caregivers. Five committees were established or reaffirmed, and each was given a mission and goals.

## **HEALTH AND WELLNESS COMMITTEE**

The mission of the Health Promotion Committee is to promote the health and wellness of older adults by advocating for programs that encourage healthy lifestyle changes and the utilization of preventive measures to postpone or prevent disease and disability, maintain and improve health status, and enhance independence and quality of life of older adults. This committee does the following:

- Advocates for health promotion for older adults through legislative activities.
- Supports new wellness initiatives initiated by DHSS.
- Serves in an advisory capacity.
- Provides input and identifies opportunities for collaboration with new partners.

## **LEGISLATIVE COMMITTEE**

The mission of the Legislative Committee is to serve as an advocate for the older adults age 60 and over in New Jersey by reviewing, preparing comments and recommending positions on proposed legislation and presenting them to the Commission on Aging for consideration and action. The committee, at the request of the commission, will also research, draft and suggest sponsors for legislation that would positively impact older adults. This committee recommends support of legislative proposals that will:

- Ensure the safety of vulnerable adults.
- Promote older adult health and wellness.
- Expand the availability of home and community-based services for older adults.
- Alleviate financial burdens facing older adults.
- Support caregivers of older adults.

## **ASSISTED INDEPENDENCE, MONEY MANAGEMENT COMMITTEE**

The mission of the Assisted Independence and Money Management Committee is to foster the financial independence of older individuals through the use of volunteer services and technology in managing their finances. This committee does the following:

- Promotes the development of a program that facilitates volunteer services for the provision of money management, care management to certain vulnerable aged and disabled persons.
- Serves as the advisory council to provide oversight for the AARP Money Management Program.

## **COMMITTEE FOR ADVOCACY, RIGHTS AND EDUCATION (CARE)**

The mission of the CARE Committee is to advocate and promote change to enhance the quality of life and protect the rights, dignity and welfare of vulnerable adults by offering education, information, advocacy and training programs to individuals, families and care providers. This committee was established by the state's Adult Protective Services' statute. This committee does the following:

- Advocates for more affordable housing and living arrangements.
- Maintain the public's awareness of various issues affecting the aged population.

## **CULTURAL COMPETENCY COMMITTEE**

The mission of the Cultural Competency Committee is to ensure that the issue of cultural and linguistic competency is institutionalized throughout all programs developed and implemented by DACS and their contract providers. This committee does the following:

- Identifies disparities in service access.
- Identifies cultural and linguistic barriers to service access.
- Develops specific outreach strategies and interventions that ensure services are successfully assisting diverse older adults.

## CHAPTER 6

### State Plan Provisions and Information Requirements

In Chapter 6, NJ's State Strategic Plan on Aging specifically addresses Section I, "State Plan Information Requirements", of the Older Americans Act of 1965, as amended in 2000. In doing so, it is responsive to Attachment B of the Program Instruction AoA-PI-05-02, which requires that State plans include information specified in Sections 102, 305, 307, and 705.

#### SECTION 102 (19)(G)

DACS provides the following in-home services that are not already defined in Section 102(19):

##### 1. Visiting Nurse Services

- **Service Unit:** Each visit.
- **Service Definition:** Services designed to maintain older persons in their own residences or community-based settings by providing skilled nursing services or therapy, thereby avoiding or deterring the need for hospitalization or institutionalization.

##### 2. Hospice Care

- **Service Unit:** Each hour.
- **Service Definition:** A community-based concept of care in which an organized team provides pain relief, symptom management, and supportive services to terminally ill older persons and their families.

##### 3. Emergency Services

- **Service Unit:** Each contact.
- **Service Definition:** Services designed to provide assistance to an older person in those situations where an emergency exists and it is not possible to obtain immediate aid through existing social service agencies.

#### SECTION 305(a)(2)(E)

DACS provides assurance that, although all persons aged 60+ are eligible for aging network services, preference is given to providing services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals<sup>1</sup>.

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<sup>1</sup> See Section 307(a)(3)(B) pertaining to the fact that the State of NJ has no areas that meet the definition of "rural".

DACS uses its Targeting Policy as a primary method of carrying out this preference, and the 21 AAAs in NJ use a wide variety of methods for this purpose (see Attachments E and F, “Methods of Carrying Out NJ’s Preference for Providing Services to Target Populations”).

### **OLDER ADULT POPULATION TREND IN NEW JERSEY**

In 2003, minority older adults aged 60+ comprised 20.6% of the 1,509,900 older adults in NJ. This population is projected to grow substantially in the near future as the baby-boom generation (those born between 1946-1964) ages. By 2025, the population in this age group is projected to number nearly 2.5 million<sup>2</sup> (see Profile in Chapter 1 for details regarding older adults aged 60+ in NJ).

### **TARGET POPULATION RELATED TO MINORITIES**

DACS has updated its racial/ethnic categories for reporting purposes, as outlined below. The category of “Non-Minority” includes all persons not considered a minority according to the four categories below. These categories apply to all income levels.

1. **African American:** A person having origins in any of the black racial groups of Africa.
2. **Hispanic:** A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
3. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, Samoa and the Hawaiian Islands.
4. **American Indian:** A person having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition. This category includes both American Indian and Alaskan Native.

### **TARGET POPULATION WITH GREATEST ECONOMIC NEED**

In 1999, poverty rates in NJ were 5.8% for non-Hispanic Whites, 8.0% for Asian and Pacific Islanders, 16.5% for non-Hispanic Blacks, 16.6% for American Indians and Alaska Natives, and 17.5% for Hispanics and Latinos<sup>3</sup>. The categories of poverty for NJ reporting purposes are as follows:

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<sup>2</sup> Source: “A Profile of New Jersey Older Adults Aged 60+ Years, April 2005,” Center for Health Statistics, Office of the State Epidemiologist Public Health Services, New Jersey Department of Health & Senior Services.”

<sup>3</sup> Source: “A Profile of New Jersey Older Adults Aged 60+ Years, April 2005,” Center for Health Statistics, Office of the State Epidemiologist Public Health Services, New Jersey Department of Health & Senior Services.

1. **Minority Poverty:** Unduplicated breakdown of new minority clients for the quarter, who are at or below the poverty level set by United States Bureau of the Census. Currently, DACS refers to the most recent policy Memorandum regarding the poverty level.
2. **Non-Minority Poverty:** Unduplicated breakdown of new non-minority clients for the quarter, who are at or below the poverty level set by the United States Bureau of the Census. Currently DACS refers to the most recent policy Memorandum regarding the poverty level. *The number reported in this category cannot exceed the total of the unduplicated clients identified in the non-minority category.*

## **TARGET POPULATION WITH GREATEST SOCIAL NEED**

The categories of frail/disabled and vulnerable populations for NJ reporting purposes appears below. Both categories apply to all population groups regardless of minority status. The frail/disabled category also applies to all population groups regardless of income.

1. **Frail/Disabled:** Unduplicated breakdown of new frail/disabled clients who meet the following definition established by the Federal Administration on Aging:
  - Persons aged 60+ having a physical or mental disability, including having Alzheimer's disease or a neurological or organic brain disorder of the Alzheimer's type, that restricts the ability of an individual to perform normal daily tasks or which threatens the capacity of an individual to live independently.
2. **Vulnerable:** Unduplicated breakdown of new vulnerable clients who meet the following definition established by the Federal Administration on Aging:
  - Persons aged 60+ exposed to unfavorable environmental conditions, as well as persons aged 60+ with a lack of social resources, which may include the following:
    - (a) Income levels between 100-200% of the poverty level
    - (b) Language barriers
    - (c) Isolation
    - (d) No informal support system
    - (e) Not previously within service system.

## **TARGETING POLICY**

DACS has a written policy on targeting, consistent with the requirements of Section 305(a)(2)(E). The goal of the policy is to substantially increase the number of target population served by the aging network and other community programs. In an effort to accommodate the diversity of the State's 21 AAAs, the policy was developed with an emphasis on flexibility. To the extent possible, the policy takes into account the individual nature of each AAA and the varied environments in which they each operate.

To meet the upcoming challenges in serving the increasing numbers of target population, NJ will:

- Assess differences in service needs among minority groups.
- Evaluate the effectiveness of DACS interventions with AAAs.
- Measure progress toward targeting goals at the local level.
- Evaluate progress toward state and national objectives.

### **SECTION 307(a)(2)(C)**

As required, DACS has specified a minimum proportion of the Title IIIB funds received by each AAA in NJ to carry out Part B that will be expended on access, in-home services, and legal assistance, as follows:

- 10% for access services
- 10% for in-home services
- 5% for legal assistance

### **SECTION 307(a)(3)(A)**

#### **HISTORY**

The Intra-State Funding Formula (IFF) for the distribution of Title III funds of the Older Americans Act as implemented in NJ was developed in 1992 by a task force comprised of representatives of DACS and NJ's 21 AAAs. The Assistant Secretary for Aging approved the funding formula DACS is currently using as part of the 2002-2005 State Plan on Aging. It includes a minimum allocation to ensure that each Planning and Service Area (PSA) has a functioning AAA.

The allocation formula is used for Title IIIB (Social Services), Title IIIC-1 (Congregate Meals), Title III C-2 (Home Delivered Meals), Title III-E, as well as State Weekend Home Delivered Meals, SHTP, APS, COLA and State Area Plan Contract Matching Funds. The funding formula for title III-D adds medical factor rankings by County.

#### **FORMULA**

The current funding formula, the one that was approved as part of the 2002-2005 State Plan, will remain in effect for the 2005-2008 State Plan. Please see the formula for a full year in Attachment I, 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 PSA has a functioning Area Agency on Aging.
2. For those AAAs that are **not** in minimum funded counties, the formula is as follows:

The allocation for each program is calculated as  $Z \times Q$ .

**Z** = NJ's 2005 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 PSAs, 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  $((S \times .65) + (M \times .15) + (P \times .2))$ .

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

In order to insure that the weight factors are still relevant, DACS examined current spending patterns as they relate to each weighted factor of the funding formula. It was determined that the weight factors as developed by the 1992 task force are still relevant and current expenditures are in line with these weight factors (see Exhibit 14).

## **SECTION 307(a)(3)(B)**

### **DEFINITION OF "RURAL"**

As defined by the U.S. Census Bureau, "Urban" and "Rural" are "type-of-area concepts rather than specific areas on maps." As these concepts are complex and lend themselves to interpretation by different agencies, DACS continues to define them broadly, using the following characteristics to define rural areas:

1. Open country which is not part of or associated with a metropolitan area, or
2. Areas which are not contained within a Standard Metropolitan Statistical Area.

Based on this definition, DACS has determined that New Jersey, the most densely populated State in the nation, does not have any "Rural" areas.

**EXHIBIT 14**

**AGING POPULATION PROFILE BY COUNTY IN NJ  
COMPARISON OF 1990 AND 2000 US CENSUS DATA**

County	1990 Total 60+	2000 Total 60+	Increase/ (Decrease)	1990 Minority 60+	2000 Minority 60+	Increase/ (Decrease)	1990 Poverty 60+	2000 Poverty 60+	Increase/ (Decrease)	1990 % of Funding	2000 % of Funding	% Change
Atlantic	44,491	44,781	290	7,197	9,085	1,888	4,496	3,419	(1,077)	3.6327%	3.3333%	-0.2995%
Bergen	172,992	173,897	905	10,759	23,493	12,734	8,452	7,575	(877)	10.6863%	10.9312%	0.2449%
Burlington	59,319	70,008	10,689	6,274	10,664	4,390	2,935	2,492	(443)	3.9291%	4.3329%	0.4038%
Camden	82,462	82,197	(265)	10,876	15,131	4,255	6,428	4,929	(1,499)	6.1243%	5.7107%	-0.4137%
Cape May	25,404	26,234	830	1,080	1,178	98	2,011	1,431	(580)	1.6661%	1.5889%	-0.0772%
Cumberland	24,672	24,726	54	3,221	5,138	1,917	3,006	2,297	(709)	2.0354%	1.9453%	-0.0901%
Essex	128,265	125,044	(3,221)	39,209	55,161	15,952	16,393	10,906	(5,487)	12.9678%	11.2625%	-1.7053%
Gloucester	35,804	38,931	3,127	3,873	4,264	391	2,436	2,006	(430)	2.5068%	2.4672%	-0.0395%
Hudson	94,151	92,226	(1,925)	11,585	41,641	30,056	13,199	10,594	(2,605)	8.0262%	8.9710%	0.9448%
Hunterdon	15,151	16,780	1,629	213	556	343	669	490	(179)	0.8496%	0.9034%	0.0538%
Mercer	56,928	57,089	161	8,764	11,866	3,102	3,979	3,513	(466)	4.2658%	4.0620%	-0.2038%
Middlesex	110,640	119,933	9,293	8,547	20,710	12,163	6,552	5,334	(1,218)	7.2192%	7.8118%	0.5926%
Monmouth	98,780	100,503	1,723	9,104	11,858	2,754	6,223	5,170	(1,053)	6.6634%	6.4137%	-0.2497%
Morris	64,650	73,933	9,283	3,016	6,678	3,662	2,601	2,733	132	3.7872%	4.3495%	0.5623%
Ocean	129,772	136,367	6,595	1,887	5,078	3,191	6,740	6,034	(706)	7.4759%	7.8651%	0.3891%
Passaic	77,875	77,267	(608)	7,629	19,080	11,451	7,164	5,248	(1,916)	5.7286%	5.7812%	0.0526%
Salem	12,473	12,013	(460)	1,779	1,793	14	1,299	578	(721)	1.0020%	0.7776%	-0.2244%
Somerset	39,606	44,289	4,683	2,640	5,289	2,649	1,437	1,521	84	2.3693%	2.6481%	0.2788%
Sussex	16,679	18,247	1,568	184	712	528	809	654	(155)	0.9441%	1.0174%	0.0733%
Union	98,284	92,422	(5,862)	12,351	24,389	12,038	6,880	5,571	(1,309)	7.0895%	6.8312%	-0.2583%
Warren	16,721	16,895	174	228	614	386	1,229	841	(388)	1.0305%	0.9960%	-0.0345%
<b>TOTALS</b>	<b>1,405,119</b>	<b>1,443,782</b>	<b>38,663</b>	<b>150,416</b>	<b>274,378</b>	<b>123,962</b>	<b>104,938</b>	<b>83,336</b>	<b>(21,602)</b>	<b>1.0000</b>	<b>1.0000</b>	<b>(0.0)</b>

### **SECTION 307(a)(8)(B) and (C)**

DACS recognizes that case management is currently being provided by AAAs in NJ and authorizes them to continue to provide case management services. Likewise, DACS authorizes NJ's AAAs to continue to directly provide information and assistance and outreach services.

### **SECTION 307(a)(10)**

With respect to assurances pertaining to older adults in rural areas, please see the response to section 307(a)(3)(B) above.

While NJ has no "Rural Areas", *per se*, there are areas of farmland in some of NJ's PSAs. This represents a challenge for the AAAs with regard to outreach and the provision of services. The AAAs have developed creative methods of providing services in these circumstances, including the following examples:

- Frozen home delivered meals
- Telecare/Telehealth
- Medication monitoring systems
- Phone reassurance for individuals who are outside of a central town community

In response to the AoA Program Instruction requiring a copy of Area Plans for a large urban or suburban Area agency and for a small, rural Area Agency, we have included Area Plans for the Bergen AAA (large) and the Warren AAA (small) (see Attachments J and K).

### **SECTION 307(a)(15)(A) and (B)**

In 1999, there were 40,911 low-income minority older adults in NJ<sup>4</sup>. Some of the methods used to satisfy the service needs of low-income minority adults are outlined in the discussion of DACS's Targeting Policy. *See response to Section 305(a)(2)(E) in this chapter* and highlights of AAA activities in *Attachments F and G*.

In addition, DACS includes several standards in the Area Agency on Aging Annual Assessment Procedures tool used for yearly assessments of each AAA. This is helpful to identify how each AAA specifically identifies the target population and provides outreach services to underserved and isolated older adults in its county (see Attachment G).

In the Planning and Program Development section of the standards, there is a requirement that each AAA analyze current service utilization data to ensure that the target populations were served proportionately to the county's demographics. Other standards are as follows:

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<sup>4</sup> Source: 2000 Census Special Tabulation, Center for Health Statistics, Profile of Older Adults Aged 60+, April 2005.

- The AAA makes an effort to include minority service providers in the RPF process.
- The AAA has the ability to meet their targeting goals and specify outreach to the target population.
- The AAA establishes methods to collect and utilize accurate demographic and cultural data for racial and ethnic groups in the service area and become informed about the ethnic/cultural needs, resources and assets of the surrounding community.

DACS also partners with the Office of Faith-Based Initiatives and the NJ Office of Minority and Multicultural Health to offer informational sessions targeted to minority providers on how to access Older American Act funds.

### **SECTION 307(a)(21)(B)**

The State provides assurances that DACS will pursue activities to increase access by older individuals who are Native Americans to all of the aging programs and benefits it provides, including programs and benefits provided under Title III.

In 2000, NJ had a total of 1,388 Native Americans aged 60+<sup>5</sup>. In 2004, Older Americans Act programs served an estimated 441 Native Americans. See Exhibit 15 for a listing of outreach methods that increase access to aging programs for Native Americans.

### **SECTION 705(a)(7)(1-6)**

In order to receive an allotment under this subtitle, the State of NJ and DACS provide the required assurances, as outlined below.

1. **Compliance with Requirements:** The State provides assurance that it has and will establish programs in accordance with the requirements of this chapter.
2. **Obtain Others' Views:** The State provides assurance that it has and will hold public hearings and use other means to obtain the views of older individuals, AAAs, recipients of grants under Title VI, and other interested persons and entities regarding programs carried out under this subtitle.
3. **Prioritize Activities to Assure Access:** The State provides assurance that, in consultation with AAAs, it has and will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

**Aging and Disability Resource Connection (ADRC):** New Jersey's ADRC will establish "one door" access to both publicly and privately funded long-term care services and benefits for senior citizens, adults with physical disabilities, and their caregivers. An integrated system of information and referral, options, and counseling services will provide the consumer with access to websites, resource directories, benefit screening tools, and applications. Culturally-appropriate materials will be developed to address language and cultural barriers (see details in Chapter 3, Priority 1, Goal 1).

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<sup>5</sup> Source: 2000 U.S. Census, Special Tabulation on Aging.

**Methods of Carrying Out NJ's Preference for Providing Services to Target Populations:  
Highlights of AAA Services and Outreach to American Indians****ATLANTIC**

- Small population of 67 over the age of 60
- Ongoing contacts with housing complexes to reach out to American Indians.

**BERGEN**

- Multicultural events and health fairs
- Farmers' Market

**BURLINGTON**

- Mailing literature
- Outreach contact and presentations

**CAPE MAY**

- Only 21 American Indians registered via the census

**CUMBERLAND**

- Maintain contact with American Indian organizations
- Representation of American Indians in AAA outreach coordination efforts
- Speaking engagements and information distribution

**MONMOUTH**

- Information and Assistance services provided

**OCEAN**

- Language in contracts with all service providers, re: targeting minorities in proportion to the population
- Coordination with churches, community organizations, schools, key informants

**PASSAIC**

- Distribute information at the Pow Wow in West Milford

**SALEM**

- Door to door and tax list
- Contact with Indian Council

**SUSSEX**

- Visits to senior housing complexes, homebound clients, as well as outreach to the elderly at flu clinics and health screenings
- Staff will work closely with the Division of Social Services and other human service agencies within Sussex County

**WARREN**

- All senior network partner agencies will be trained to accomplish generic outreach
- Continues to partner with church
- Maintains an active alliance with the county-based senior services network. Area medical doctors and professionals are contacted regularly
- Disseminates the county newsletter to older adults who reside in the county
- Continues to work with Municipal officials and the County's Council of Seniors, Inc.

**Transportation:** In 2004, DACS served 15,825 clients in NJ with \$5,578,370 through its transportation services. In addition, it served 6,869 clients with \$917,166 through its assisted transportation services. The State of New Jersey is committed to improving coordination of transportation services for older adults (see details in Chapter 3, Priority 1, Goal 5).

4. **Do Not Supplant Funds:** As demonstrated in the Certification of Maintenance of Effort (OMB NO. –0980-0009), which is submitted to AoA on a yearly basis, the State and DACS provide assurances that the funds provided under this subtitle are in addition to and do not supplant any existing Federal or State or local funds.
5. **Ombudsman:** The State of New Jersey and its Division of Aging and Community Services do not designate local Ombudsman entities.
6. **Prevention/Protection Services:** The State assures that the State Office of the Ombudsman for the Institutionalized Elderly will, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3, conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities.

## **ADULT PROTECTIVE SERVICES (APS)**

The Adult Protective Services Act in NJ (52:27D-406 et seq.) mandates the following:

- A comprehensive public awareness program is to be established. The Committee for Advocacy, Rights and Education operates as a sub-committee of the New Jersey Commission on Aging and is charged with public awareness and education.
- Each of the 21 county APS provider agencies receive reports of elder abuse, neglect or exploitation and intervene on behalf of the vulnerable adult.
- Crisis interventions involve referrals to county boards of social services, county offices on aging, and other social service agencies to assist individuals with necessary services.
- When appropriate, referrals are made on behalf of the vulnerable adult to law enforcement and county prosecutors.

**No Coercion:** The State will not permit involuntary or coerced participation in the APS services described above by alleged victims, abusers, or their households.

**Confidentiality:** All information gathered in the course of receiving reports and making referrals shall remain confidential except for allowable exceptions, as described in Section 705(a)(7)(6)(C).

## ATTACHMENT A

### Listing of State Plan Assurances and Required Activities Older Americans Act, As Amended in 2000

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

This attachment, along with requirements listed in the State Plan Guidance Program Instruction (PI) and Attachment B State Plan Provisions and Information Requirements, make up the package of instructions for development of State Plans.

### ASSURANCES

#### SECTION 305(a)-(c), ORGANIZATION

**(a)(2)(A)** The State agency shall, except as provided in **Subsection (b)(5)**, designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

**(a)(2)(B)** The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

**(a)(2)(E)** The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals and older individuals residing in rural areas and include proposed methods of carrying out the preference in the State plan.

**(a)(2)(F)** The State agency shall provide assurances that the State agency will require use of outreach efforts described in **Section 307(a)(16)**.

**(a)(2)(G)(ii)** The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

**(c)(5)** In the case of a State specified in **Subsection (b)(5)**, the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

**States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.**

**SECTION 306(a), AREA PLANS**

**(2)** Each area agency on aging shall provide assurances that an adequate proportion, as required under **Section 307(a)(2)**, of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services:

- (A)** Services associated with access to services (transportation, outreach, information and assistance, and case management services);
- (B)** In-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
- (C)** Legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

**(4)(A)(i)** Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan.

**(4)(A)(ii)** Each area agency on aging shall provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will:

- (I)** Specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in the area served by the provider;
- (II)** To the maximum extent feasible, provide services to low-income minority individuals and older individuals residing in rural areas in accordance with their need for such services; and
- (III)** Meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals and older individuals residing in rural areas within the planning and service area.

**(4)(A)(iii)** With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall:

- (I)** Identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
- (II)** Describe the methods used to satisfy the service needs of such minority older individuals; and
- (III)** Provide information on the extent to which the area agency on aging met the objectives described in clause **(a)(4)(A)(i)**.

**(4)(B)(i)** Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on:

- (I)** Older individuals residing in rural areas;
- (II)** Older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III)** Older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV)** Older individuals with severe disabilities;
- (V)** Older individuals with limited English-speaking ability; and
- (VI)** Older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in **(A)** through **(F)**, and the caretakers of such individuals, of the availability of such assistance.

**(4)(C)** Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

**(5)** Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities.

**(9)** Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman Program under **Section 307(a)(9)**, will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

**(11)** Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including:

- (A)** Information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
- (B)** An assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under Title VI; and
- (C)** An assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

**(13)(A)** Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

**(13)(B)** Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency:

- (i)** The identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
- (ii)** The nature of such contract or such relationship.

**(13)(C)** Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

**(13)(D)** Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

**(13)(E)** Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

**(14)** Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

**(15)** Each area agency on aging shall provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title.

## **SECTION 307, STATE PLANS**

**(7)(A)** The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

**(7)(B)** The plan shall provide assurances that:

- (i)** No individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
- (ii)** No officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
- (iii)** Mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

**(9)** The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman Program in accordance with **Section 712** and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

**(10)** The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

**(11)(A)** The plan shall provide assurances that area agencies on aging will:

- (i)** Enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
- (ii)** Include in any such contract provisions to assure that any recipient of funds under division **(A)** will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
- (iii)** Attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

**(11)(B)** The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

**(11)(D)** The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals.

**(11)(E)** The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

**(12)** The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for:

- (A)** Public education to identify and prevent abuse of older individuals;
- (B)** Receipt of reports of abuse of older individuals;
- (C)** Active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D)** Referral of complaints to law enforcement or public protective service agencies where appropriate.

**(13)** The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

**(14)** The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area:

- (A)** To utilize in the delivery of outreach services under **Section 306(a)(2)(A)**, the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
- (B)** To designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include:
  - (i)** Taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
  - (ii)** Providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

**(16)** The plan shall provide assurances that the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on:

- (A)** Older individuals residing in rural areas;
- (B)** Older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (C)** Older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (D)** Older individuals with severe disabilities;
- (E)** Older individuals with limited English-speaking ability; and **(F)** older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses **(A)** through **(F)** and the caretakers of such individuals, of the availability of such assistance.

**(17)** The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

**(18)** The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to **Section 306(a)(7)**, for older individuals who:

- (A)** Reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
- (B)** Are patients in hospitals and are at risk of prolonged institutionalization; or
- (C)** Are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

**(19)** The plan shall include the assurances and description required by **Section 705(a)**.

**(20)** The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

**(21)** The plan shall:

- (A)** Provide an assurance that the State agency will coordinate programs under this title and programs under Title VI, if applicable; and
- (B)** Provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in **Section 306(a)(8)**.

(23) The plan shall provide assurances that demonstrable efforts will be made:

- (A) To coordinate services provided under this Act with other State services that benefit older individuals; and
- (B) To provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

#### **SECTION 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS**

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

#### **SECTION 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)**

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

**(3)** The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

**(4)** The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

**(5)** The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses **(i)** through **(iv)** of **Section 712(a)(5)(C)**, on the eligibility of entities for designation as local Ombudsman entities under **Section 712(a)(5)**.

**(6)** The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under **Chapter 3**:

- (A)** In carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
  - (i)** Public education to identify and prevent elder abuse;
  - (ii)** Receipt of reports of elder abuse;
  - (iii)** Active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
  - (iv)** Referral of complaints to law enforcement or public protective service agencies if appropriate;
- (B)** The State will not permit involuntary or coerced participation in the program of services described in subparagraph **(A)** by alleged victims, abusers, or their households; and
- (C)** All information gathered in the course of receiving reports and making referrals shall remain confidential except:
  - (i)** If all parties to such complaint consent in writing to the release of such information;
  - (ii)** If the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
  - (iii)** Upon court order.

## **REQUIRED ACTIVITIES**

### **SECTION 307(a), STATE PLANS**

- (1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of Section 306; and
- (B) The State plan is based on such area plans.

*NOTE: This subsection of statute does **NOT** require that Area Plans be developed prior to State Plans and/or the State Plans develop as compilation of Area Plans.*

- (2) The State agency:
- (A) Evaluates, using uniform procedures described in Section 202(a)(29), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;
  - (B) Has developed a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) have the capacity and actually meet such need.

(4) The State agency conducts periodic evaluations of, and public hearings on, activities and projects carried out in the State under Titles III and VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas. *NOTE: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

- (5) The State agency:
- (A) Affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
  - (B) Issues guidelines applicable to grievance procedures required by Section 306(a)(10); and
  - (C) Affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

**(8)(A)** No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency:

- (i)** Provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
- (ii)** Such services are directly related to such State agency's or area agency on aging's administrative functions; or
- (iii)** Such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

\_\_\_\_\_  
Signature and Title of Authorized Official

\_\_\_\_\_  
Date

## **ATTACHMENT B**

### **Verification of Intent**

The State Plan on Aging is hereby submitted for the State of New Jersey for the period October 1, 2005 through September 30, 2008. It includes all the assurances and plans to be conducted by the Department of Health and Senior Services, Division of Aging and Community Services, Office of Area Agency on Aging Administration 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 Governor 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.

Date: \_\_\_\_\_

\_\_\_\_\_  
Fred M. Jacobs, M.D., J.D., Commissioner

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

Date: \_\_\_\_\_

\_\_\_\_\_  
Richard J. Codey, Acting Governor

## ATTACHMENT C

Office of Area Agency on Aging Administration  
PO Box 807  
Trenton, NJ 08625-0807

### AREA AGENCIES ON AGING



**NJ EASE**  
**1 (877) 222-3737**

♦ **Atlantic** County Division  
of Intergenerational Services  
Marilu Gagnon, Division Director  
Shoreview Building, Office #222  
101 South Shore Road  
Northfield, NJ 08225  
**(609) 645-7700, Ext. 4700**  
**Fax: (609) 645-5940**

♦ **Bergen** County Division of Senior Services  
Anne Ciavaglia, Director  
One Bergen County Plaza, 2<sup>nd</sup> Floor  
Hackensack, NJ 07601-7000  
**(201) 336-7400**  
**Fax: (201) 336-7424**

♦ **Burlington** County Office on Aging  
Cecile Neidich, Acting Executive Director  
49 Rancocas Road  
PO Box 6000  
Mount Holly, NJ 08060  
**(609) 265-5069**  
**Fax: (609) 265-3725**

♦ **Camden** County Division of  
Senior & Disabled Services  
Joy Merulla, Executive Director  
Parkview on the Terrace  
700 Browning Road, Suite #11  
West Collingswood, NJ 08107  
**(856) 858-3220**  
**Fax: (856) 858-2057**

♦ **Cape May** County Department of Aging  
Elizabeth Bozzelli, Executive Director  
Social Services Building  
4005 Route 9 South  
Rio Grande, NJ 08242  
**(609) 886-2784 & 2785**  
**Fax: (609) 889-0344**

♦ **Cumberland** County Office on Aging  
Misono Miller, Executive Director  
Administration Building  
790 East Commerce Street  
Bridgeton, NJ 08302  
**(856) 453-2220 & 2222**  
**Fax: (856) 455-1029**

♦ **Essex** County Office on Aging  
Jaklyn DeVore, Executive Director  
50 South Clinton Street  
3<sup>rd</sup> Floor, Suite #3200  
East Orange, NJ 07018  
**(973) 395-8375**  
**Fax: (973) 395-8309**

♦ **Gloucester** County Department on Aging  
Anna Docimo, Executive Director  
County Offices @ 5-Points  
211 County House Road  
Sewell, NJ 08080  
**(856) 232-4646**  
**Fax: (856) 232-7864**

♦ **Hudson** County Office on Aging  
John Connors, Executive Director  
595 County Avenue, Building #2  
Secaucus, NJ 07094  
**(201) 271-4320**  
**Fax: (201) 271-4366**

♦ **Hunterdon** County Division of Senior Services  
Mary Ann Rodenberger, Executive Director  
PO Box 2900  
Flemington, NJ 08822-2900  
**(908) 788-1361, 1362 & 1363**  
**Fax: (908) 788-1561**

♦ **Mercer** County Office on Aging  
Hattie Blanchard, Executive Director  
PO Box 8068  
640 South Broad Street  
Trenton, NJ 08650  
**(609) 989-6661 & 6662**  
**Fax: (609) 989-6032**

♦ **Middlesex** Department of Aging  
Margaret Chester, Executive Director  
John F. Kennedy Square, 5<sup>th</sup> Floor  
New Brunswick, NJ 08901  
**(732) 745-3295**  
**Fax: (732) 246-5641**

♦ **Monmouth** County Office on Aging  
John Wanat, Executive Director  
21 Main and Court Center  
Freehold, NJ 07728  
**(732) 431-7450**  
**Fax: (732) 303-7649**

♦ **Morris** County Division on Aging,  
Disabilities and Veterans  
Theresa Davis, Executive Director  
340 West Hanover Avenue, Ground Floor  
PO Box 900  
Morristown, NJ 07963-0900  
**(973) 285-6848**  
**Fax: (973) 285-6883**

♦ **Ocean** County Office of Senior Services  
Jane Maloney, Executive Director  
PO Box 2191  
Toms River, NJ 08754-2191  
**(732) 929-2091**  
**Fax: (732) 506-5019**

♦ **Passaic** County Office on Aging  
Mary Kuzinski, Executive Director  
209 Totowa Road  
Wayne, NJ 07470  
**(973) 686-7752 & 7756**  
**Fax: (973) 686-7770**

♦ **Salem** County Office on Aging  
Pamela Pedrick, Executive Director  
98 Market Street  
Salem, NJ 08079  
**(856) 935-7510**  
**Fax: (856) 339-9268**

♦ **Somerset** County Office on Aging  
Carolann Auger, Executive Director  
Somerset County Office Building  
92 East Main Street  
PO Box 3000  
Somerville, NJ 08876  
**(908) 704-6346**  
**Fax: (908) 595-0194**

♦ **Sussex** County Office on Aging  
Mary Lou McCutcheon, Executive Director  
Sussex County Administration Building  
1 Spring Street, 2<sup>nd</sup> Floor  
Newton, NJ 07860  
**(973) 579-0555**  
**Fax: (973) 579-0550**

♦ **Union** County Division on Aging  
Fran Benson, Executive Director  
Administration Building  
Elizabeth, NJ 07207  
**(908) 527-4870/4872**  
**Fax: (908) 659-7410**

♦ **Warren** County Division of Senior Services  
Susan Lennon, Executive Director  
Wayne Dumont Jr. Administration Building  
165 County Road, Suite #245  
Route 519 South  
Belvidere, NJ 07823-1949  
**(908) 475-6591**  
**Fax: (908) 475-6588**

## ATTACHMENT D

### **EXECUTIVE ORDER NO. 100**

WHEREAS, New Jersey is home to 1.4 million older adults 60 years of age and over and the primary mission of the Administration is to promote the independence, dignity and choice of these residents as they age; and

WHEREAS, New Jersey must prepare to meet the individual and societal needs of our growing older adult population and their families; and

WHEREAS, for too long, government has forced older adults to choose between going into a nursing home or giving up the government funds which pay for needed services, thus denying them the right to choose where they receive these services; and

WHEREAS, caregiving by unpaid family or friends has become an important issue because so many New Jerseyans are finding themselves or will find themselves in the role of caregiver for a loved one – with almost 900,000 adults in this capacity today; and

WHEREAS, the Department of Health and Senior Services provides resources and oversight for Medicaid services and special programs, yet it is easier for older adults to get financial help from the State if they go into a nursing home versus getting services through the following home and community services: the Community Care Program for the Elderly and Disabled, Medical Day Care, Assisted Living, Adult Family Care, Caregiver Assistance Program, Home Care Expansion Program, Jersey Assistance for Community Caregiving; and

WHEREAS, policy changes are now critical to support an expanding elderly population that desires to stay at home with supports versus going into a nursing home; and

WHEREAS, AARP, with its membership of 1.3 million state residents, seeks to enhance the quality of life for all persons 50 and older by promoting independence, dignity and purpose through information and education, advocacy and service.

NOW, THEREFORE I, JAMES E. MCGREEVEY, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. The Commissioner of the Department of Health and Senior Services to develop the appropriate fiscal controls and tracking mechanisms, in consultation with the State Treasurer, to implement a “global” long-term care budget similar to the States of Washington and Oregon by January 2005. These mechanisms shall be in place for State Fiscal Year 2006.

2. The funds for Medicaid services and special programs, aforementioned, to be provided to the Department of Health and Senior Services in total under one unique appropriation entitled "Long Term Care Services," as they represent a continuum of care for which eligible consumers are assessed and periodically reevaluated. This provision will provide the Department of Health and Senior Services with the authority and flexibility to move beneficiaries to the appropriate level of care based on their individual needs.
3. The Department of Health and Senior Services to develop and launch by the end of CY 2004 the New Jersey Caring for Caregivers Initiative, which will bring essential services to family caregivers who make it possible for seniors to live in their homes. New Jersey Caring for Caregivers will enhance and prolong the ability of unpaid caregivers to continue to provide care for an elderly or adult disabled individual.
4. The Department of Health and Senior Services and the Department of Human Services to identify specific gaps and requirements necessary to streamline the paperwork and fast track the process of obtaining Medicaid eligibility for home care options for those who qualify. The plan, to be formulated by the end of CY 2004, must address cutting the "red tape" so that seniors are not automatically directed to nursing homes because it takes too long to do the paperwork for home care options.
5. The Department of Health and Senior Services to create an action plan by October 2004 that expands the Adult Family Care program in New Jersey. In this living arrangement, up to three seniors can move in with a trained, capable and caring person – often in their own neighborhoods. Adult Family Care offers individuals, who are no longer able to live alone, the opportunity to move in and share the home of a caretaker who provides needed assistance and supervision.
6. The Department of Health and Senior Services to consult with AARP regarding the planning and implementation of the above-mentioned initiatives, including the development of a "bill of rights" to support New Jersey's aging population.

**EXECUTIVE ORDER NO. 31**

WHEREAS, New Jersey is home to 1.4 million adults 60 years of age who deserve the right to independence, dignity and choice as they grow older; and

WHEREAS, the citizens of New Jersey are entitled to a long-term care system where they can make their own long-term care decisions; and

WHEREAS, the State of New Jersey must support a long-term care reform agenda to ensure a more equitable distribution of funding between home- and community-based services and institutionalization; and

WHEREAS, the State of New Jersey is currently in the second year of a three-year federally funded Aging and Disability Resource Connection initiative, which is being implemented on a pilot basis in Atlantic and Warren counties; and

WHEREAS, the State of New Jersey, through its Aging and Disability Resource Connection initiative, is implementing a clinical assessment tool and fast track eligibility process in a test environment in Atlantic and Warren counties; and

WHEREAS, the clinical assessment tool shall be linked to levels of care, which will then generate a service care plan as well as identify funds to support an individual's choice for long-term care services;

NOW, THEREFORE, I, RICHARD J. CODEY, Acting Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. The Department of Health and Senior Services shall begin a process in State Fiscal Year 2006 to develop and implement a pilot global budget long-term care program. The new long-term care system for older adults shall have improved access and consumer-directed care across all settings and an array of home- and community-based services from which to choose.
2. The Department of Health and Senior Services, in partnership with the Department of Human Services, shall develop a pilot fast track eligibility program with presumptive eligibility in Warren and Atlantic Counties.
3. This Order shall take effect immediately.

GIVEN, under my hand and seal this  
day of

in the Year of Our Lord, Two  
Thousand and Five, and of the  
Independence of the United States,  
the Two Hundred and Twenty-Ninth.

## ATTACHMENT E

### Methods of Carrying Out New Jersey's Preference for Providing Services to Target Populations: Highlights of AAA Services

#### ATLANTIC:

- AAA Advisory Council selects representatives of the African American community to attend the Black Issues of Aging Conference. The AAA then uses this information to hold informational meetings with the community to discuss ways in which the AAA can improve services to this population.
- AAA coordinates and facilitates various services such as nutrition, social activities, and caregiver support for multicultural populations at the Jewish Older Adults Senior Center in Atlantic City which is also connected to the Health Clinic.
- AAA held this year's Public Hearing for the 2005 Area Plan in Spanish and English at an Adult Medical Day with a large Hispanic population. To target this group adequately, they prepared an 8-page outline of services in Spanish and English, as well as having a translator to speak in Spanish after the AAA spoke in English.
- AAA contracts with "Contact Cape Atlantic" for countywide telephone reassurance services. They provide regular daily telephone calls to homebound older adults to assure their well-being and safety, social interaction and psychological reassurance.
- AAA supplies produce vouchers to low-income and minority 60+ individuals for the yearly Senior Farmers' Market Program.

#### BERGEN:

- Provides funds for assisted transportation and caregiver support program serving both the caregiver and care recipient.
- Increased funding to "Friends of Grace Program" which provides care management to their increasing Korean population.
- Continue to add weekly frozen meal delivery routes to serve the homebound elderly.

#### BURLINGTON:

- Schedules ongoing APS training for AAA staff and their service providers to improve services to vulnerable adults.
- Utilizes Advisory Council member to translate literature for Asian church congregants to inform of available services and programs.
- Presentations to Korean Church Groups to inform of available programs and services.

#### CAMDEN:

- Focuses on service to the targeted populations by providing funds for a Hispanic Outreach Program.
- Hired a bilingual social worker to improve the quality of care management services to their large Hispanic population.
- Utilizes bilingual staff in Vietnamese to inform this population of available programs and services.

**CAPE MAY:**

- Works with all county service agencies to inform frail/vulnerable adults of available services to ensure that no one in need is without help.
- Provides community and in-home services such as home health aides and respite for frail adults as well as their caregivers.
- Continues to focus on Home Delivered Meals to homebound frail/vulnerable population.
- SHIP (State Health Insurance Program) volunteers are being placed in minority communities to provide information on current Medicare/Medicaid health insurance/care options.

**CUMBERLAND:**

- Collaborates with County 9-1-1 Emergency Services to provide frail/vulnerable adults with information and assistance in the event of a disaster. Special consent forms were distributed for older adults to authorize 9-1-1 to contact them in the event of a disaster. In addition, AAA purchased emergency kits for distribution.
- Established a Task Force on Elder Abuse with a focus on Hispanic elders. Task force members include representatives from Adult Protective Services, Perfil Latino (TV station), Assisted Living facilities, and other Hispanic Advocacy groups.
- Funds a Senior Fitness Program to provide training to a minimum of 40 trainers and leaders of senior citizen programs and groups which focus on exercise, physical fitness and strengthening of the capability of seniors to be mobile, flexible and physically fit.

**ESSEX:**

- InfoVans have been retrofitted with informational materials to provide information and assistance for minority and vulnerable seniors who have been unaware of the AAA's services.
- The AAA hosts a Senior Health & Wellness Day in the county that attracts hundreds of seniors, including large numbers of African American and Hispanic seniors.
- The AAA participates on an inter-hospital coalition within the county formed for the purpose of enrolling uninsured minority seniors in cancer screening and treatment programs.

**GLOUCESTER:**

- Provides extended health screening services at non-traditional sites and faith-based community sites.

**HUDSON:**

- AAA has extensive community service locations and minority service providers located in target areas throughout the county.

**HUNTERDON:**

- AAA maintains a strong volunteer program that expands services for its older adult consumers. Volunteers oversee the following programs that would not otherwise be available: Bill Payer Program, Mr. Fix-it Program, Income Tax Assistance Program, Grocery Shopper Program, SHIP (State Health Insurance Program), transportation services, and a trained volunteer to answer AAA phone during AAA staff meetings.

- AAA funds transportation services that reach targeted populations including those situated in remote locations. Through "The LINK," the county's transportation service, the AAA provides the county's senior citizens with nominal cost transportation to nutrition sites, medical appointments, senior centers, and food shopping as well as other miscellaneous destinations. Through "Medicaid Sedan Service," door-to-door transportation is provided for seniors who have doctor appointments within and outside the county.

**MERCER:**

- AAA offers Senior Farmers' Market vouchers to target low-income seniors. The annual trips to the Trenton Farmers' Market each summer includes a wide representation of low-income and minority seniors who can select a variety of fruits and vegetables from the farmers.
- AAA collaborates with the Interfaith Caregiver Project that employs Hispanic staff to target Hispanic seniors in need of in-home and support services.

**MIDDLESEX:**

- AAA care management workers, Information & Assistance staff, & Board of Social Services staff collaborate to improve efficiency, response time, and quality of services to meet the needs of frail older adults for in-home services.
- AAA recruits bilingual staff to better serve minority clients such as Asian Americans and Hispanic seniors.

**MONMOUTH:**

- Collaborates with minority and faith-based agencies that have bilingual staff to assist in targeting seniors who are vulnerable due to language barriers.
- Use Senior Information Vans to participate in functions such as special county events and special ethnic celebrations to reach African American, Asian, and Hispanic groups with information about available senior services.

**MORRIS:**

- The AAA is co-located on the grounds with the VA Healthcare Clinic, which encourages and facilitates easy access to services.
- Pro-Alert and Neighbor Alert Fax systems help neighbors communicate concerns regarding frail seniors in their neighborhood. Anonymous forms are distributed to senior clubs, firehouses, police departments, Emergency Medical Treatment (EMT) centers and sub-grantees to report by telephone or facsimile on seniors in need.
- Promotes and encourages senior clubs to assist in neighborhood outreach efforts with special attention to homebound seniors through friendly visits and phone contacts.
- County nutrition sites successfully target African American participation and have increased new attendees at congregate nutrition centers through creative and flexible service options.
- The AAA offers evening hours at Information and Assistance (I&A) centers one day each week in Hispanic neighborhoods, staffed by bilingual representatives.

**OCEAN:**

- Continues to increase volunteer home and respite services to the homebound and their caregivers.
- Provides the safest environment to frail/vulnerable adults by supplemental services such as home modifications and personal emergency response systems.
- Collaborated with the County Sheriff's Department in the "Project LifeSaver" a pilot program that locates a missing person suffering from Alzheimer's or related disorder by supplying them with a bracelet that has a separate radio transmitter that allows officers to hone in on the individual.
- Conducts regular meetings of representatives from the Area Agency on Aging, Board of Social services, Long Term Care Field Office, Adult Protect Services, Medicaid, NJ EASE Care Management to continue enhancements and development of senior initiatives.
- Continues to update inventory of resources, specifically in the areas of health, housing, social services, long-term care options and employment.

**PASSAIC:**

- Networks with hospital discharge planners to establish a continuum of care with community provider. Established related conference calls with hospital planners five times a year.
- Produces "Healthy Matters" a monthly health newsletter for homebound and at risk individuals. Coordinates efforts between municipal Advisory Councils and the County Senior Advisory Council to continue improving the needs of low-income individuals.
- Networks with healthcare facilities to enhance community service options.

**SALEM:**

- Provides outreach services to minority communities by utilizing the services of two minority providers, Nanticoke Lenni-Lenape Indian Council and Puerto Rican Action Committee.

**SOMERSET:**

- Continues to effectively screen and monitor depression in the elderly through in-home services programs.
- Developed a Chronic Disease Care Management Program, which identifies minority persons with congestive heart failure and/or diabetes and provides case management through monthly home visits by a registered nurse, pharmacist, dietitian, social worker or clergy.

**SUSSEX:**

- Coordinates and collaborates with the Office of Public Health Nursing, local hospitals and doctors to conduct health programs, including on-going blood pressure screenings.
- Continues to expand network capabilities by working with community providers and sister agencies such as with Sussex County Sheriff's Office to address fraud and abuse.
- Collaborates with other organizations in an effort to expand the Operation Medication Awareness Program with pharmacists and doctors for hearing and eye screening, blood pressure and consultation regarding medications.

**UNION:**

- Utilizes bilingual staff to do Information & Assistance and outreach at predominantly Hispanic areas.

**WARREN:**

- Continues to recruit volunteers to be trained for Money Management program to assist older adults in paying their bills and balancing their checkbooks.
- Maintains an active alliance with the county-based senior services network, area medical doctors and professionals on issues such as health and dietary needs of the elderly. Utilizes a bilingual social worker to provide outreach to the targeted Hispanic population.
- Continues to match seniors with other seniors as peer interpreters at Senior Nutrition Sites to overcome the language barrier for communication and obtaining senior services.

## ATTACHMENT F

### Methods of Carrying Out New Jersey's Preference For Providing Services to Target Populations: Highlights of AAA Outreach Activities<sup>1</sup>

#### ATLANTIC:

- Raise public awareness about programs and services available to the targeted population by use of an outreach Info-Van that visits low-income housing, shopping centers, municipal complexes, health fairs and local libraries.
- Increased collaboration with Mental Health Agencies to educate frail/vulnerable adults about available services, such as daily telephone calls to homebound older adults to assure their well-being and safety and to provide social interaction and psychological reassurance.
- Increased collaboration with municipalities having the highest concentration of African Americans, Asians and Hispanics and to provide educational seminars on AAA services.
- On-going contacts with faith-based organizations to inform of AAA services.
- Collaborates with the Spanish Community Center to develop additional Hispanic literature.

#### BERGEN:

- Continue mailings to frail/vulnerable residents who receive home delivered meals to inform them of available services.
- Hired a consultant for one year to outreach the late deafened and hard of hearing senior population and provide training for AAA and service provider staff on available resources and methods for working with this population.
- Legal services have established educational programs to reach the vulnerable populations in their communities through senior centers.
- Attends multicultural events, health fairs, and farmers markets to reach out and educate minority and poverty minority consumers about available services.
- Established three senior centers and nutrition programs, each of which targets a specific minority population, i.e., Asian, African American, and Hispanic.

#### BURLINGTON:

- Coordinates with the Burlington County Clerk's Mobile Unit to provide caregiver and general information on available AAA services to older adults around the county.
- Presentations to church groups and civic organizations informing them of AAA services and their provider network for the frail/vulnerable and homebound adults.
- Provides ongoing outreach and educational presentations through the Burlington County's Long-Term Care Network.
- Food baskets with literature are distributed during holidays.

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<sup>1</sup> Note that outreach methods used to reach the Native American population in NJ, in particular, are addressed in Chapter 6, Section 307(a)(21)(B).

**CAMDEN:**

- Distributes literature about available AAA services for frail/vulnerable adults to caregivers, doctors' offices, Health Fairs, and senior housing complexes.
- The AAA has Vietnamese bilingual staff attending events and health fairs to introduce information on available AAA services to the Asian population.
- The AAA has a bilingual care manager on staff and funds a Hispanic outreach program located in an area with a high concentration of Hispanics.
- The AAA meets with church leaders and congregations located in poverty areas with a high concentration of minority consumers.
- The AAA works with utility companies in identifying low-income consumers at risk for shut off notices.

**CAPE MAY:**

- Coordinates referral efforts of frail/vulnerable clients to the AAA through doctors, hospitals, families and support groups.
- Presentations and distribution of informational material at church groups and meetings within the African American community.
- Successful outreach efforts have been obtained through contacts at food stores and pharmacies in addition to the normal outreach at local health fairs and through newsletters.

**CUMBERLAND:**

- Canvass selected client lists for fuel and property tax deduction in areas of high concentration of minorities to identify potential older adults who can benefit from AAA services.
- Efforts to ensure that AAA Advisory Council memberships are representative of the targeted populations in the county.
- Continues to look for activities in areas of high percentage of low-income residents to provide information on available services.

**ESSEX:**

- Provides outreach for frail, vulnerable and poverty adults through articles in the county newspaper, *Essex Advisor*, and through informational programs at community-based agencies.
- Collaborates with the New Jersey Peer Review Organization on health information and education campaigns on diabetes, breast cancer and flu prevention.
- Agency InfoVans travel to minority neighborhoods and areas with large concentration of seniors who may not have easy access to information and assistance.

**GLOUCESTER:**

- Arrange Medication Awareness seminars and health screenings at non-traditional and faith-based sites for their target populations.
- Distribute Senior Farmers' Market Vouchers at senior housing complexes and residences where broad cross-sections of minorities live.
- Senior housing complexes including low-income senior buildings are visited on a regular basis to distribute information on services available to seniors through the AAA and service providers in the county.

**HUDSON:**

- Employs bilingual staff and encourages service providers to do the same in order to better meet the needs of their target population.
- Coordinate efforts through the county nutrition centers to outreach their Asian and Hispanic population.

**HUNTERDON:**

- Continues to translate relevant informational materials/brochures about senior services and make them available to the target population.

**MERCER:**

- Coordinates referrals with the Interfaith Caregiver Program that provides in-home support services for Hispanic elderly with volunteer Hispanic staff.
- The Home Delivered Meals Program targets inner-city frail elderly residents and their multiethnic populations.

**MIDDLESEX:**

- Collaborates with Indian American senior clubs and networks within the Asian Indian community to provide information on senior services available in the county.
- Continues its initiative to translate all informational brochures in a variety of languages including Gujarati, Mandarin, Vietnamese, and Spanish and to widely distribute brochures to target groups and seniors with language barriers.
- Recruit bilingual staff fluent in Gujarati, Hindi, and Punjabi in order to reach these ethnic senior groups.

**MONMOUTH:**

- Two senior information vans travel throughout the county to specific communities and special multicultural events. The vans are equipped with informational brochures and VCR's with videos. Bilingual and bicultural field representatives man the vans.
- Collaborates with area hospitals to increase their outreach efforts to minority populations. Area hospitals have health programs and events that attract a large numbers of the target populations.
- A partnership with Latino Unidos of Ocean and Monmouth Counties enhances the AAA effort to outreach the Hispanic population. They assist in the distribution of informational brochures and announcements about senior services.
- Translate and distribute a quarterly senior newsletter with information about senior services and activities.
- The AAA bilingual outreach worker writes articles and does translations to complement the outreach efforts of the senior information vans.
- Cultural sensitivity training including information on African-American, Asians and Indians is a basic training component for AAA outreach workers.
- Educational health programs with information especially targeted to minority and culturally diverse senior populations such as Haitian, African-American, and Hispanic are offered in collaboration with volunteer nurses, the Parish Nursing Program. One such program is the American Heart Association's "Body, Mind, and Spirit" that provides advice on cardiovascular health and wellness.

**MORRIS:**

- Co-location with the Office of Temporary Assistance has enhanced the ongoing partnership and outreach efforts to meet the service needs of the targeted seniors.
- Utilize bilingual case managers to enhance outreach efforts and services to the Latino population.
- Collaborate with the County Hispanic Affairs Organization to promote AAA services and opportunities to a broader Latino sector. This organization provides assisted transportation and rides for nutrition programs, doctor's visits, shopping and administers the LIHEAP, the state heating and utilities assistance program.

**OCEAN:**

- Collaborates and partners with the county to outreach and provide senior services by utilizing the county established County Connection at the Ocean County's largest mall.
- Collaborates and partners with the county by utilizing the county established County Connection EXPRESS, which is a mobile outreach center bus that travels to communities and libraries.
- Continue efforts to engage in outreach at area hospitals, nursing homes and home health agencies to strengthen the communication network between providers and encourage resource information sharing with the Office of Senior Services.
- Networks with Medicaid/SSI, Board of Social Services, Housing Authorities to identify individuals with needs.

**PASSAIC:**

- Uses telephone reassurance calls to find out additional needs of frail adults.
- Provides updated information through our home health aide, day care, providers, and meals on wheels program drivers on legislative, benefits, long term care insurance and entitlement changes.
- Collaborates with New Jersey Transit to promote awareness of services to Hispanic population by advertising in buses.

**SALEM:**

- Conducts door to door outreach by utilizing AAA staff, staff from the Puerto Rican Action Organization, and staff of Nanticoke Lenni-Lenape Indian Council to deliver information to their respective communities.
- Continues to utilize the county's tax list to identify low-income elderly for senior services.
- Continues to utilize our effective mobile office throughout the county for Information & Assistance, outreach, and for the Farmer's Market Voucher Program.

**SOMERSET:**

- Outreaches frail adults by mailing letters regarding current issues of aging population to reduce isolation and vulnerability. Distribution is conducted through, but not limited to, parish administrators, realtors, funeral directors, and bereavement group leaders.
- Mails follow-up letters to senior center participants who discontinue their participation in the program in order to ensure that their needs are being met.
- Special outreach efforts geared toward recreation directors in the minority communities to ask for assistance with identifying community leaders to gain understanding of available resources and how to access them.

**SUSSEX:**

- Collaborates with the county Sheriff's Department Triad program and other local law enforcement to educate seniors on safety issues. Triad is a community-based partnership between law enforcement agencies, AAAs, and individuals involved in elderly issues. The goal of Triad is to reduce criminal victimization of the elderly by bringing together community agencies to form a relationship of trust with the elderly, enabling them to jointly recognize and solve problems.
- Continues the Gatekeeper program by educating post office workers, clergies, paramedics, volunteer of First Aid Squad and the community to gain awareness about the condition of seniors and where to refer for programs and services.
- Continue to issue periodic press releases through the newspaper and local TV for upcoming events and new programs for seniors.

**UNION:**

- Included a Spanish version of their resources directory on the Internet, which is updated on a regular basis.
- Continues to improve efforts to identify underserved minority due to cultural barriers by evaluating referrals and census data.
- Works with the Minority Task Force on Aging, minority newspapers, radio and television to keep communities informed of services.
- Outreaches to the Hispanic, Haitian, French sections of the community through ethnic supermarkets, doctors' offices and bodegas to increase awareness on senior services and resources.

**WARREN:**

- Establishes local outreach centers at community churches on publicized days to be able to address needs and connect seniors with staff and available professionals.
- Works with Municipal officials and the County's Council of Seniors, Inc. providing them with the most updated information on services and resources available in the county for seniors.

## ATTACHMENT G

### Area Agency on Aging (AAA) Annual Procedures

#### AAA ASSESSMENT PROCESS

Each year DACS conducts an assessment of the AAAs to evaluate their performance and operations during the prior year. All AAAs are required to return a completed Self-Assessment Tool and the forms entitled **(a) Compliance Issues and Important Events**, **(b) AAA Initiatives, Best Practices and Program Highlights During 2004**, and **(c) AAA Evaluation of the Division of Aging and Community Services**. An electronic version has also been sent to AAA Directors. This Self-Assessment Tool was developed to reflect feedback from AAA directors and input from State administration staff.

DACS conducts a desk review of the required documentation for all 21 counties and an on-site assessment visit to seven counties every year. Each AAA will be subject to an on-site assessment every third year, unless circumstances warrant a timelier visit. Technical assistance and monitoring visits will continue annually and on an as-needed basis.

#### ANNUAL ASSESSMENT PROCESS – GENERAL GUIDELINES

##### PRE-VISIT ACTIVITIES:

1. The Assessment Team Leader will convene a pre-visit meeting of the DACS fiscal and programmatic staff who will participate in the on-site visit.
2. The team leader will confirm visit with the county AAA 2-3 days prior to the scheduled visit.
3. The team leader will copy materials to share with AAA staff (e.g. timeliness chart, service activity reports).

The agenda for the pre-visit meeting will include a review of materials returned from the AAA, as listed below:

- **Self-Assessment Tool:**  
Review and note any items which are in need of clarification, appear questionable, or present a problem.
- **Compliance Issues and Important Events:**  
This is a new form added to the Self-Assessment Tool for 2004. "Issues" includes compliance issues identified during the previous evaluation that have not yet been resolved or corrected and compliance issues resolved since the previous evaluation. Important events may include staff vacancies, no legal service provider, relocation of offices, major changes in funding, etc. that occurred since the last evaluation.

- **AAA Initiatives, Best Practices and Program Highlights:**  
“Best Practices” has been added to the previous “AAA Initiatives and Program Highlights” form. “Best Practices” and “Initiatives” may include particularly effective outreach methods to serve the targeted population, activities that generate outside resources; or other effective practices that the AAA is especially proud of that occurred during the past year.

Note that AAAs have been providing information on initiatives they have been conducting for a number of years. We are interested in new initiatives undertaken during the last year.

- **Evaluation of State Agency:**  
Review comments made by AAAs.

The agenda for the pre-visit meeting will also include a review of in-house data, as delineated below.

- **Target Groups Identified in the APC:**  
Be familiar with unique groups identified by the AAA in their Area Plan Contract (APC).
- **Area Plan Contract Reporting Systems, Service/Population Analysis Report:**  
Review activity. Are percentages of target populations in line with census numbers?
- **Area Plan Contract Reporting System, Service/Cost Analysis Report:**  
Review APC System report by county and service for Units, Clients, Budget Expenditures and Unit & Client Costs. Highlight areas over/under 15% of projected levels.
- **Timeliness and Accuracy of Programmatic Reporting Requirements for Prior Year:**  
Note any areas in need of improvement.
- **Public Hearing:**  
Review information filed in the public hearing folder in regard to the public hearing held in prior year in order to discuss areas in need of improvement.
- **Monitoring:**  
Review monitoring reports from visits conducted during prior year for all programs monitored, including nutrition and note any significant recommendations made.
- **Correspondence:**  
Review correspondence folder to identify any additional issues during the prior year that may need to be discussed during the assessment visit.

## **ASSESSMENT VISIT**

### **1. Assessment Recommendations from Prior Contract Year**

Review status of previous recommendations and any outstanding recommendations that continue to need to be addressed.

### **2. Self-Assessment Tool**

Review sections with AAA staff, discussing items that are in need of clarification, appear questionable, or present a problem.

Each section (Administration, Planning etc.) will include a list of "Documents to be Reviewed." Area Agencies have been instructed to have this documentation available for review at the day of the visit (or upon our request). Ensure that documents support the responses within the tool.

### **3. APC System Service/Cost Analysis Report**

Review each service paying close attention to all variances in excess of 15% above or below projected levels. Keep in mind that AAAs should be instructed to provide the rationale for variances in the APC.

Review percentage of funding to the various services. Does the documentation support highest % of funds to those services?

Review Unit Cost of Service to determine appropriateness of figures.

### **4. Targeting Efforts**

Utilizing both the Target Population Service Activity and the Target Groups Identified in the APC, review the targeting efforts of the AAA. Where applicable, discuss how the AAA defines and tracks unique groups (e.g., "seniors in crisis," "mildly disabled").

### **5. Timeliness and Accuracy of Programmatic Reporting**

Review any areas in need of improvement, i.e., why were so many IPS revisions submitted during the year. Determine if the division can be of assistance in improving any areas.

### **6. Public Hearing**

Review any issues or recommendations from the prior year's public hearing.

### **7. Evaluation of State Agency**

Be aware of any comments made and acknowledge any suggestions for improvement. Ask for specific examples for general comments.

**8. Best Practices, Initiatives, Other Notable Activities**

Review the information provided by the AAA to discuss special initiatives or programs that could be replicated in other counties. Remember to look for new initiatives from prior year. Also, check the Executive Summary and Goals section of the APC to see if initiatives included in the plan were successful. If provided, review annual report submitted by AAA with any particular highlighted areas.

Be sure to ask about non-taxonomy services overseen by the AAA that are not “reportable” to DACS.

**9. NJ EASE/ADRC**

Discuss with the Executive Director their progress in coordinating with other agencies and with DACS’ initiatives.

**10. Technical Assistance**

Inquire as to any technical assistance needs.

**11. “Assessment Report”**

Explain to the Executive Director that an “Assessment Report” will be issued in lieu of letters. A draft will be sent for them to review for accuracy before a final is issued.

**POST-ASSESSMENT ACTIVITIES**

1. The team leader will meet with assessment team members individually to review all documents and information related to the standards covered by that individual.
2. The team leader will compile the information.
3. As appropriate, the team leader will contact the AAA for clarification or additional information.
4. The team leader will prepare the draft assessment report within 20 workdays and submit to the Area Agency on Aging Administrator for review.
5. The team leader will send approved draft assessment report to AAA Executive Director for his or her review. Allow 20 business working days for Executive Director to respond. As appropriate, discuss concerns and comments with the Executive Director.
6. The Assistant Commissioner will send the final assessment report to contracting authority with a copy to the Executive Director and others as specified by the Executive Director. Within 20 business working days of receiving the final assessment report, the Executive Director should submit the final corrective action plans to DACS.
7. The Area Agency on Aging Administrator will review corrective action plans. If all findings have been appropriately addressed, send closure letter to Executive Director with a copy to the contracting authority and others, as directed by the Executive Director.

AAA Evaluator: \_\_\_\_\_

**2004 AAA DOCUMENTATION ASSESSMENT REVIEW**

Date: \_\_\_\_\_

The standards below apply to the "Area Agency on Aging 2004 Performance Standards." As you review documentation for each standard, please **circle** or **handwrite** in the documentation you reviewed. Upon completing the documentation, place your rating in the indicated column. Should your rating for that standard **differ** from the AAA rating, please **write** a short justification as to why the rating differs. This justification may be included in the final report.

**Administrative Structure**

**Goal:** To ensure that the AAA has met their responsibility to plan, provide and coordinate multifaceted systems of support services. Directors and staff work together to fulfill the AAA Mission.

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. Personnel resources are effective to meet APC objectives. This includes an adequate infrastructure to serve as a platform for future enhancements of support for family caregivers and individuals in need.		Organizational Chart, Staff Roster, Budget and Business Plan		
2. All budgeted staff positions were filled in 2004.		Verification of hiring dates and Organizational Chart		
3. The Policies and Procedures Manual was updated in 2004 and contains all pertinent policies and procedures.		Policies and Procedures Manual		
4. The AAA obtained fully executed Contracts by April 1, 2004.		Executed Contracts and Letters of Intent to Fund		
5. The AAA submitted timely contract amendment requests for approval by DACS, per PM 91-10, III-5.		DACS Amendment file and 2004 APC		
6. The AAA submitted requests for all proprietary, direct service and priority service waivers for the next 3 year area plan cycle.		Waiver requests, waiver file and Service Delivery System		
7. The AAA submitted revised IPS forms to DACS no later than 11/15/04.		State Records		
8. DACS received the AAA's Area Plan Contract by October 15, 2004.		DACS log book		

**Administrative Structure**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
9. The AAA ensured that administrative and professional staff received job-related training.		Training file, Policy and Procedures		
10. Newly hired care managers completed the 7 day Core Care Management Training.		Training Log, NJ EASE training list and Hiring Dates		
11. I&A staff completed the 3 day basic I &A training.		Training log and NJ EASE training list		
12. The Director's salary is proportionately distributed according to the % of time spent administering to aging services.		Administration Budget and Organizational Chart		
13. The Executive Director had the authority to fulfill the role of director in 2004 as per the federal statute.		Job Descriptions and Organizational Chart		
14. The Director had full authority to award contracts to prospective service providers.		Contracting Policy and RFP Procedures		
15. The Director exercised authority to nominate Advisory Council members according to Older Americans Act requirements.		Nomination letters, Resolutions and Council Minutes		
16. The Director attended all DACS AAA Executive Directors Meetings.		Attendance Records		
17. The AAA ensured that the county record retention policy is in line with the State's recommendation; Fiscal: 3 years from the acceptance of the final expenditure report; Program: 3 years from the close of the case.		Record Retention Policy		

**Score:**

### Planning/Program Development

**Goal:** The AAA leverages other resources, develops partnerships with local service providers and others. Supports critical needs, identifies and expands successful services and helps evaluate the programs to guide it's future direction.

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. I&A results were documented in 2004 and results were incorporated into the planning process.		Record of calls, identified gaps, new programs and Priority Needs Assessment		
2. The AAA articulates and works by a set of goals, objectives and strategies that accurately reflects Area Agency activities consistent with the AAA mission, vision and values.		Area Plan Contract Strategic Plan, Mission and Vision Statement		
3. The AAA effectively uses Advisory Committees, Forums and Focus Groups and solicits comments from the public on the needs of older adults and caregivers in planning efforts.		Advisory Council Minutes, Forum and Focus Group Summaries, Public Hearing Announcements, Attendance Sheets and Meeting Minutes		
4. AAA has a fully functioning Advisory Council and meets on a regularly scheduled basis.		Advisory Council Meeting Minutes and Committee Roster		
5. Advisory Council membership is comprised of individuals who are representative of the required background according to the Older Americans Act (individuals eligible for service, reps from non-profit agencies, veterans, minorities etc...).		Membership Profile		
6. AAA knows and documents the unmet need of individuals and family caregivers for the purpose of planning and program development.		Waiting Lists, Public Hearing minutes, Focus Group Reports, Surveys, Needs Assessments and Records of Calls		
7. AAA Actively solicits consumer input in development and review of area needs and applies gathered information to set and pursue goals.		Waiting Lists, Public Hearing Minutes, Focus Group Reports, Surveys and Needs Assessments		

**Planning/Program Development**

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
8. The AAA looks for creative ways to meet the needs of older adults.		Program Scope of Services, Client records and New Program Initiatives.		
9. The AAA established partnerships with public and private organizations to address the needs of older adults.		Meeting Minutes, Letters of Support, Mailing Lists to public and private agencies.		
10. The AAA Identified and outreached to underserved and isolated populations in the county.		Documented Outreach Efforts, Outreach Statistics and Case Records of Outreached Customers		
11. The AAA analyzed 2004 service utilization data to ensure that the "target" populations were served proportionately to county demographics.		Compare county demographics with actual Service Statistics		
12. The AAA coordinated care management services with the APS provider.		Case Records and Case Conference Meetings		
13. The AAA supported grantees in their efforts to seek additional funding sources for programs.		Technical Assistance, Monitoring Reports and Letters of Support		
14. A minimum of one programmatic monitoring was conducted for each directly provided and subcontracted services.		Program/Fiscal Monitoring Reports		
15. The AAA ensured that contracted services followed Service Taxonomy and State Program standards.		Contracts, Scope of Service and Monitoring Reports		
			<b>Score:</b>	

### Customer Accessibility

**Goal:** The AAA is easy to use and access, easily identified, and provides accurate, consistent information assuring confidentiality to all who enter.

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. The AAA is conveniently located and accessible by public transportation.		County Map		
2. The AAA provided reasonable access to services for disabled or frail customers (location/building structure).		Building Accessibility and Home Visits		
3. The AAA marketed and identified themselves as the "NJEASE" site and the statewide toll-free number was included in marketing efforts.		Written Publications, NJEASE toll-free number on web page and I&A Protocols		
4. Web Page provides pertinent information about the available programs and services and is user friendly.		Web Page, Website content and structure		
5. The AAA provides bilingual services.		Staff Qualifications and Language Line		
6. Focal Point locations were designated throughout the county for those persons unable to go directly to the AAA office.		Area Plan Contract, Interagency Agreements and Access Sites		
7. The AAA ensured that I&A/Outreach services were consistent at each focal point location.		I&A Meetings and Memos and I&A/Outreach Procedures		
8. NJEASE network staff utilized the CAT to assess consumer needs.		Case Records and Monitoring Reports		
9. A confidential area within the AAA office was available to interview walk-in customers.		Office Space		
			<b>Score:</b>	

### Cultural Competency

**Goal:** Programs and services are designed to reach the target population and serve all races and ethnic groups. Services and supports are effectively and efficiently implemented in accordance with each participant’s unique needs and expressed preferences.

Standard	AAA Rating	Indicator	Reviewer’s Rating	Rating Justification (if different from AAA’s Rating)
1. The AAA makes an effort to include minority service providers in the RFP Process.		RFP Distribution List, RFP Request List and Technical Assistance Documentation		
2. The AAA has the ability to meet their targeting goals and specify outreach to the target population.		APC; Quarterly Stats and County Demographics for Target Population		
3. The AAA establishes methods to collect and utilize accurate demographic and cultural data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources and assets of the surrounding community.		Focus Group Reports, Consumer Surveys, Community Needs Assessments and established Committees/Partnerships with represented communities		
<b>Score:</b>				

### Quality Assurance

**Goal:** To objectively evaluate internal/external processes and services against applicable program descriptions. AAA has standards and procedures for continual quality improvement.

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. AAA undertakes activities designed to improve the performance of service providers.		Quality Assurance Plans and Procedures, Technical Assistant Training, Records and Monitoring Reports		
2. AAA utilizes data and quality information to engage in actions that lead to continuous improvement in their programs.		Quality Satisfaction Summary, Service Data Reports and new Program Scope of Services		
3. Solicits comments from the public on the needs of older adults and caregivers and uses input to provide information for advocacy and planning efforts.		Public Hearing Minutes and Needs Assessment		
4. Participants are satisfied with their services and desired outcomes are achieved.		Customer Satisfaction Surveys		
5. The AAA shared their written grievance procedure for those persons denied service or dissatisfied with the service with all clients.		Written Grievance Procedure on file and adapted for distribution and posting at AAA, Focal Points and Service Provider locations		
6. The grievance procedure contained a non-intimidating process to file a grievance and an impartial group to review the grievance.		Grievance Procedure		
7. The AAA supplies information in a timely manner and resolves concerns, complaints and/or problems on behalf of older adults and caregivers.		Record of consumer letters file and State consumer referral file		
<b>Score:</b>				

**Service Delivery**

**Goal:** To provide a wide variety of services that meet the needs of the counties target population and are in line with funding objectives.

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. Ensures effective stewardship of grant funds in order to reach the maximum number of older adult consumers as possible.		Reports and Data Analysis Summary		
2. The AAA identifies and coordinates services based on the changing needs of the service recipients.		Program Rosters and Client Records		
<b>Score:</b>				

**Fiscal Accountability**

**Goal:** To ensure that the AAA is in compliance with all State and Federal regulation regarding the administration of funds granted through the Area Plan Contract.

**Staffing:**

Standard	AAA Rating	Indicator	Reviewer's Rating	Rating Justification (if different from AAA's Rating)
1. The AAA had a full time functioning fiscal person in 2004 assigned to AAA fiscal operations.		Hiring Dates and Organizational Charts		
<b>Score:</b>				

**Fiscal Accountability**

**Policies and Procedures:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. The AAA assured that staff responsible for handling money was bonded.		Bonding Agreement and County Fiscal Policy		
2. AAA has a policy regarding the collection, recording and depositing of funds including but not limited to checks from the state, client contributions, private donations, etc.		County Fiscal Policy		
3. AAA maintained a project income ledger.		Income Ledger		
<b>Score:</b>				

**Monitoring-Test Sample-the Greater of 5 or 10% of Grantees:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. AAA fiscal staff conducted a minimum of one fiscal monitoring of all directly provided services and one fiscal monitoring visit for subcontracted services during the year.		Fiscal Monitoring Report		
2. AAA followed up on all findings identified in the monitoring visit.		Fiscal Monitoring Report		
3. Service provider client contributions were monitored to ensure fiscal accountability and compliance with established policy.		Fiscal Monitoring Report		
<b>Score:</b>				

**Fiscal Accountability**

**Reporting-Test Sample-the Greater of 5 or 10% of Grantees:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. Fiscal and program reports were accurate and submitted on time to the Division of Aging and Community Services.		State Review of Submitted Reports		
2. AAA fiscal staff prepared and maintained all financial records.		Site Review of Fiscal Records		
3. Reports on file at the AAA match reports submitted to the DACS. (Compare database reports to reports on file at AAA)		Site Review of Fiscal Records and State Database Reports		
4. AAA fiscal staff prepared the consolidated analysis in conjunction with database reports submitted to the DACS. (Compare database reports to reports on file at AAA)		Consolidated Analysis and State Database Reports		
<b>Score:</b>				<input style="width: 100px; height: 20px;" type="text"/>

**System-Test Sample-10:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. Cash disbursements and receipts are recorded in a ledger and are reconciled to bank statements on a regular basis.		Receipts and Disbursements Ledgers		
2. Cash disbursements have proper back-up documentation.		Backup Documentation		
3. Cash receipts have proper back-up documentation and are deposited within established timeframes.		Backup Documentation and County Fiscal Policy regarding the depositing of funds		
4. Travel records were properly documented and verified prior to payment.		Travel Documentation and County Travel Policy		
<b>Score:</b>				<input style="width: 100px; height: 20px;" type="text"/>

**Fiscal Accountability**

**Inventory-Test Sample-5 Items:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. Equipment purchases and disposals were followed in accordance with PM95-15.		Site Review of Property Records and Site Review of Inventory Lists		
2. The AAA maintained current inventory records.		Site Review of Inventory Lists		
3. Proceeds from property sold or traded were applied against current program expenditures.		Fiscal Records and Inventory Records		
<b>Score:</b>				<input style="width: 100px; height: 20px;" type="text"/>

**Grant Requirements-Test Sample-the greater of 5 or 10% of Grantees:**

<b>Standard</b>	<b>AAA Rating</b>	<b>Indicator</b>	<b>Reviewer's Rating</b>	<b>Rating Justification (if different from AAA's Rating)</b>
1. AAA met Division requirements regarding match and maintenance of effort per PM 2004-7, III-4.		State Database Reports		
2. Administrative allocation is within Division limits (10%-Title III, 10%-SSBG and 8%-SHTP).		State Database Reports		
3. AAA was within the 8% carry-over limit.		State Database Reports		
4. AAA completed close outs for all sub-grantees.		AAA Closeout Letters		
5. AAA revised reports to the DACS in accordance with final close out of sub-grantees.		AAA Closeout Letters and State Database Reports		
<b>Score:</b>				<input style="width: 100px; height: 20px;" type="text"/>

**Total State Assessment Score:**

**ATTACHMENT H**

**Allocation Percentage: 100%**

Allocation Code	02	03	04	10	24	08	
	Title III B	Title III C1	Title III C2	Title III D	Title III D-Med Mgnt	Title III E	
COUNTY	Allocation	Allocation	Allocation	Allocation	Allocation	Allocation	Total Federal Allocation
Atlantic	350,412	366,880	185,117	20,344	6,831	153,019	1,082,603
Bergen	1,056,591	1,132,684	575,681	30,716	11,342	478,982	3,285,996
Burlington	418,607	448,880	228,020	15,020	4,273	189,890	1,304,690
Camden	591,203	618,992	312,085	22,263	7,387	257,973	1,809,903
Cape May	161,320	168,903	84,904	19,235	7,102	70,182	511,646
Cumberland	196,506	205,742	103,722	17,221	5,583	86,328	615,102
Essex	1,247,177	1,305,801	660,817	53,134	14,756	546,239	3,827,924
Gloucester	242,164	255,497	129,948	13,421	4,956	108,005	753,991
Hudson	891,265	957,827	484,846	40,421	14,925	404,061	2,793,345
Hunterdon	156,381	133,131	46,970	10,212	3,328	39,017	389,039
Mercer	411,520	430,863	217,376	16,774	6,087	179,686	1,262,306
Middlesex	757,493	812,443	412,573	22,008	7,895	343,530	2,355,942
Monmouth	644,058	674,331	339,556	26,752	9,547	280,986	1,975,230
Morris	418,047	447,875	227,866	15,004	5,270	189,471	1,303,533
Ocean	753,653	806,737	411,068	28,677	10,589	341,181	2,351,905
Passaic	565,852	607,309	308,076	29,768	9,802	256,534	1,777,341
Salem	156,623	133,131	51,059	18,640	6,882	42,206	408,541
Somerset	255,022	273,339	138,958	15,271	5,639	115,645	803,874
Sussex	156,454	133,131	53,042	17,561	5,300	44,048	409,536
Union	684,494	716,669	363,885	30,755	10,801	303,228	2,109,832
Warren	156,713	133,131	52,511	11,487	4,145	43,406	401,393
<b>TOTALS</b>	<b>10,271,555</b>	<b>10,763,296</b>	<b>5,388,080</b>	<b>474,684</b>	<b>162,440</b>	<b>4,473,617</b>	<b>31,533,672</b>

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

**ATTACHMENT H**

Allocation Code					06	11	14	20	19
COUNTY	State Match				SWHDM	SHTP	APS	SSBG	STATE HDM
	State Match B-D	State Match Med. Mgnt	State Match E	Total State Match ALLOCATION					
<b>Atlantic</b>	48,852	362	45,906	95,120	32,177	38,998	142,971	378,200	0
<b>Bergen</b>	148,006	600	143,695	292,301	102,724	120,412	374,031	830,684	0
<b>Burlington</b>	58,793	226	56,967	115,986	40,733	47,693	138,636	180,602	0
<b>Camden</b>	81,770	391	77,392	159,553	54,290	65,745	242,126	804,165	66,977
<b>Cape May</b>	22,996	376	21,055	44,427	14,839	17,886	79,056	131,808	7,092
<b>Cumberland</b>	27,698	296	25,898	53,892	18,460	21,850	95,867	493,257	1,057
<b>Essex</b>	172,955	781	163,872	337,608	114,526	139,210	502,909	1,473,166	188,926
<b>Gloucester</b>	33,937	262	32,402	66,601	23,161	27,180	98,532	162,008	19,510
<b>Hudson</b>	125,700	790	121,217	247,707	86,213	101,412	426,929	1,659,255	73,061
<b>Hunterdon</b>	18,354	176	11,705	30,235	13,000	9,824	71,540	77,027	19,560
<b>Mercer</b>	56,993	322	53,906	111,221	38,450	45,793	162,142	573,727	0
<b>Middlesex</b>	106,121	418	103,059	209,598	73,636	86,295	288,274	525,309	24,725
<b>Monmouth</b>	89,190	505	84,296	173,991	60,248	71,532	248,340	736,618	0
<b>Morris</b>	58,701	279	56,841	115,821	40,676	47,661	146,916	97,672	11,258
<b>Ocean</b>	105,890	560	102,354	208,804	73,271	85,980	287,711	232,635	0
<b>Passaic</b>	79,994	519	76,960	157,473	54,888	64,439	254,137	557,253	245,103
<b>Salem</b>	19,030	364	12,662	32,056	13,000	10,756	71,782	235,226	14,964
<b>Somerset</b>	36,137	300	34,694	71,131	24,820	29,065	110,165	223,422	23,340
<b>Sussex</b>	19,069	281	13,214	32,564	13,000	11,094	73,632	13,190	23,236
<b>Union</b>	95,072	572	90,968	186,612	64,888	76,112	254,360	469,726	16,155
<b>Warren</b>	18,733	220	13,022	31,975	13,000	11,063	74,484	106,050	54,485
<b>TOTALS</b>	<b>1,423,991</b>	<b>8,600</b>	<b>1,342,085</b>	<b>2,774,676</b>	<b>970,000</b>	<b>1,130,000</b>	<b>4,144,540</b>	<b>9,961,000</b>	<b>789,449</b>

**ATTACHMENT H**

Allocation Code	17	32	22	27	29				
COUNTY	CARE COOR. (CMQA)	SHIP SBUM Supp.	Allocation SHIP	HealthEASE LLLW	Caregiver Initiative	50% NSIP	State COLA	State/Other Fund Allocations	Grand Total Allocated Funds
<b>Atlantic</b>	23,810	15,000	7,500	10,000	79,000	84,334	132,824	944,814	<b>2,122,537</b>
<b>Bergen</b>	23,810	15,000	10,000	32,785	79,000	200,505	416,678	2,205,629	<b>5,783,926</b>
<b>Burlington</b>	23,810	0	0	0	79,000	37,042	165,245	712,761	<b>2,133,437</b>
<b>Camden</b>	23,810	15,000	7,500	0	79,000	79,720	224,750	1,663,083	<b>3,632,539</b>
<b>Cape May</b>	23,810	15,000	9,000	0	79,000	38,942	60,174	476,607	<b>1,032,680</b>
<b>Cumberland</b>	23,810	15,000	6,000	0	79,000	32,224	74,854	861,379	<b>1,530,373</b>
<b>Essex</b>	23,810	15,000	10,000	0	79,000	115,033	468,393	3,129,973	<b>7,295,505</b>
<b>Gloucester</b>	23,810	15,000	9,000	0	79,000	34,153	93,934	585,288	<b>1,405,880</b>
<b>Hudson</b>	23,810	15,000	6,875	0	79,000	154,911	349,632	2,976,098	<b>6,017,150</b>
<b>Hunterdon</b>	23,810	15,000	7,500	0	79,000	18,677	34,027	368,965	<b>788,239</b>
<b>Mercer</b>	23,810	0	0	0	79,000	57,533	155,952	1,136,407	<b>2,509,934</b>
<b>Middlesex</b>	23,810	15,000	10,000	0	79,000	131,796	298,701	1,556,546	<b>4,122,086</b>
<b>Monmouth</b>	23,810	0	0	0	79,000	124,844	244,358	1,588,750	<b>3,737,971</b>
<b>Morris</b>	23,810	0	0	0	79,000	161,979	164,996	773,968	<b>2,193,322</b>
<b>Ocean</b>	23,810	15,000	10,000	31,810	79,000	79,851	297,161	1,216,229	<b>3,776,938</b>
<b>Passaic</b>	23,810	15,000	9,000	0	79,000	114,450	222,622	1,639,702	<b>3,574,516</b>
<b>Salem</b>	23,810	15,000	5,000	0	79,000	15,633	35,354	519,525	<b>960,122</b>
<b>Somerset</b>	23,810	15,000	10,000	0	79,000	45,533	100,687	684,842	<b>1,559,847</b>
<b>Sussex</b>	23,810	15,000	9,000	0	79,000	19,960	38,390	319,312	<b>761,412</b>
<b>Union</b>	23,810	15,000	9,000	0	79,000	117,389	263,204	1,388,644	<b>3,685,088</b>
<b>Warren</b>	23,810	15,000	7,500	0	79,000	32,777	37,664	454,833	<b>888,201</b>
<b>TOTALS</b>	<b>500,010</b>	<b>255,000</b>	<b>142,875</b>	<b>74,595</b>	<b>1,659,000</b>	<b>1,697,286</b>	<b>3,879,600</b>	<b>25,203,355</b>	<b>59,511,703</b>

**ATTACHMENT I****Acronyms**

<b>AAA</b>	Area Agency on Aging (AAA reads "Triple A")
<b>ADRC</b>	Aging and Disability Resource Center
<b>ADRC</b>	Aging Disability Resource Connection
<b>ADSP</b>	Alzheimer's Day Services Program
<b>AIRS</b>	Alliance of Information and Referral Systems
<b>AoA</b>	Administration on Aging
<b>APC</b>	Area Plan Contract
<b>APS</b>	Adult Protective Services
<b>CAP</b>	Caregiver Assistance Program
<b>CAT</b>	Comprehensive Assessment Tool
<b>CHSP</b>	Congregate Housing Services Program
<b>CGI</b>	Caregiver Initiatives
<b>CMS*</b>	Center for Medicare & Medicaid Services, *formerly known as HCFA
<b>COLA</b>	Cost of Living Adjustment
<b>DACS</b>	Division of Aging and Community Services
<b>DACSQI</b>	Division on Aging and Community Services Quality Assurance and Quality Improvement
<b>DHSS</b>	Department of Health and Senior Services
<b>DHS</b>	Department of Human Services
<b>ECO</b>	Enhanced Community Options Waiver
<b>HealthEASE</b>	Single entry system for health promotion/disease prevention information & coordination
<b>HCBS</b>	Home Community Based Services
<b>HDM</b>	Home Delivered Meals
<b>I&amp;A</b>	Information & Assistance
<b>IM</b>	Information Memorandum
<b>IPS</b>	Integrated Program Summary
<b>JACC</b>	Jersey Assistance for Community Caregivers
<b>MMA</b>	Medicare Modernization Act
<b>MOA</b>	Memorandum of Agreement
<b>N4A</b>	National Association of Area Agencies on Aging
<b>NAPIS</b>	National Aging Program Information System
<b>NASUA</b>	National Association of State Units on Aging
<b>NCOA</b>	National Council on Aging
<b>NFCSP</b>	National Family Caregiver Support Program
<b>NJ4A</b>	NJ Association of Area Agencies on Aging
<b>NJCAM</b>	New Jersey Council on Access and Mobility
<b>NJEASE</b>	<b>New Jersey Easy Access Single Entry</b>
<b>NJEASE CAT</b>	<b>New Jersey Easy Access Single Entry Comprehensive Assessment Tool</b>
<b>NSIP</b>	Nutrition Services Incentive Program
<b>OAA</b>	Older Americans Act

**ACRONYMS**

<b>OCEW</b>	Office of Community Education and Wellness
<b>OCS</b>	Office of Community Support
<b>OEL</b>	One Ease E-Link
<b>OOIE</b>	Office of the Ombudsman for the Institutionalized Elderly
<b>OPG</b>	Office of the Public Guardian
<b>PAAD</b>	Pharmaceutical Assistance to the Aged and Disabled
<b>PACE</b>	Health & Wellness; People with Arthritis Can Exercise
<b>PACE</b>	Program of All Inclusive Care for the Elderly
<b>PAS</b>	Pre-Admission Screening
<b>PM</b>	Policy Memorandum
<b>PSA</b>	Planning and Service Area
<b>QA/QI</b>	Quality Assurance and Quality Improvement
<b>QPR</b>	Quarterly Program Report
<b>RFP</b>	Request for Proposals
<b>SHDM</b>	Supplemental Home Delivered Meals
<b>SHIP</b>	State Health Insurance Program (for Medicare/Medicaid eligibles)
<b>SHTP</b>	Safe Housing & Transportation Program
<b>SSBG</b>	Social Services Block Grant
<b>SUA</b>	State Unit on Aging
<b>SWHDM</b>	State Weekend Home Delivered Meals
<b>Title III B</b>	Supportive Services
<b>Title III C1</b>	Congregate Nutrition Program
<b>Title III C2</b>	Home Delivered Meal Program
<b>Title III D</b>	Health Promotion & Medication Management
<b>Title III E</b>	National Family Caregiver Support Program



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*Acting Governor*



Department of Health and Senior Services  
FRED M. JACOBS, M.D., J.D.  
*Commissioner*